This is the published version


Available from Deakin Research Online

http://hdl.handle.net/10536/DRO/DU:30010521

Reproduced with the kind permission of the copyright owner

Copyright: 2007, Deakin University
G21 Healthy Region Project
Part 1: Research Report

This document has been prepared for:
G21 Geelong Region Alliance

Prepared by:
A/Prof Louise Johnson, Dr Iain Butterworth and Ms Melissah Edwards
Deakin University

In collaboration with:
Coomes Consulting

December 2007
# Table of Contents

Acknowledgements ................................................................................................. i
Executive Summary .................................................................................................. ii

1. Introduction ............................................................................................................ 1
   1.1 Origins of the Healthy Cities approach ........................................................... 1
   1.2 What is a Healthy City? .................................................................................... 3
   1.3 Relevance of Healthy Cities approach relevant to the G21 Region .......... 6
   1.1 Project Aims ..................................................................................................... 7

2. Project Methodology ............................................................................................... 8
   2.1 Participants ...................................................................................................... 8
   2.2 Data Collection ............................................................................................... 8
   2.3 Data Analysis .................................................................................................. 8

3. Data Collection and Analysis .............................................................................. 10
   3.1 Literature Review ........................................................................................... 11
   3.2 Implementing Healthy Cities Concepts ......................................................... 12
   3.3 International application ............................................................................... 19
   3.4 Healthy Cities: Case studies .......................................................................... 24
   3.5 Monitoring and evaluation of Healthy Cities: Issues and Case Studies .......... 33
   3.6 Summary: Implications for the G21 Region .................................................. 45
   3.7 Conclusion ...................................................................................................... 51

3.2 Document Analysis .............................................................................................. 53
   3.2.1 Framework for Document Analysis ............................................................ 54
   3.2.2 Document Analysis Methodology ............................................................... 54
   3.2.3 Document Analysis Findings ...................................................................... 55

3.3 Stakeholder Consultations .................................................................................. 75
   3.3.1 Consultation Methodology .......................................................................... 76
   3.3.2 Consultation Findings ................................................................................ 78

4. Discussion and Recommendations ....................................................................... 89

References .................................................................................................................. 91
Appendices ................................................................................................................... 95

Appendix A: Stakeholder Matrix .............................................................................. 95
Appendix B: G21 Document Flowchart ................................................................. 98
Appendix C: Project Flyer .......................................................................................... 97
Appendix D: Focus Group Schedule ......................................................................... 99
Appendix E: ‘Healthy Initiatives’ ............................................................................... 100
Figures

Figure 1: Healthy Cities Model ................................................................. 4
Figure 2: Elements of a healthy city or community ................................. 5
Figure 3: Characteristics of Healthy Cities Initiatives .............................. 5
Figure 4: Project Overview .................................................................. 9
Figure 5: Twenty Steps for Developing a Healthy Cities Project ............... 13
Figure 6: Types and Examples of Partnerships Developed as a Result of the Californian Healthy Cities and Communities Initiatives .......... 16
Figure 7: Factors Influencing Inter-Organizational collaboration ............. 18
Figure 8: Healthy Cities Illawarra Organisational Chart ......................... 25
Figure 9: Groups historically convened and resourced by Healthy Cities Illawarra ............................................................................. 25
Figure 10: Agencies with which Healthy Cities Illawarra has collaborated ... 26
Figure 11: Healthy Cities Illawarra Strategic Priorities 2005-2008 ............. 27
Figure 12: California Healthy Cities and Communities Evaluation Framework 34
Figure 13: What makes a good indicator? ............................................. 37
Figure 14: Revised Baseline Healthy Cities Indicators .............................. 38
Figure 15: Watch Out for Health Checklist - Healthy Urban Design Unit .. 40
Figure 16: VCIP Domain: Healthy, safe and inclusive communities .......... 42
Figure 17: VCIP Domain: Sustainable built and natural environments .. 43
Figure 18: Indicators – Lessons from Experience .................................... 44
Figure 19: Application of Healthy Cities model to transport policy .......... 48
Figure 20: Tools Needed for Healthy and Sustainable Urban Planning .... 51
Figure 21: Framework for Analysing the Project Environment ............... 64
Figure 22: G21 Operating Framework .................................................. 65
Figure 23: Percentage of Respondents who were aware of the Healthy Cities concept ................................................................. 79
Figure 24: Percentage of stakeholders who feel G21 is in a position to facilitate a Healthy Cities approach ............................................. 87
Figure 25: Percentage of stakeholders who feel there is another organisation or structure better placed to facilitate the Healthy Cities approach .. 88
Tables

Table 1: Commonalities between G21 Vision, Values and Principles with Healthy Cities Characteristics

Table 2: Comparison of the Planning for Healthy Communities in the G21 Region Document with Characteristics of Healthy Cities

Table 3: Number of Participants by Consultation Format

Table 4: Organisations Consulted by Pillar

Table 5: Barriers and enablers to a Healthy Region
Acknowledgements

This research benefited greatly from the expertise and input of members of the project Reference Group. The support and insights of these people were crucial to all stages of the research, see below for member details.

The time and views of all those who participated in the interviews, focus groups and online survey was extremely valuable and greatly appreciated.

The evaluation team comprised: Dr Iain Butterworth, Associate Professor Louise Johnson and Ms Melissah Edwards from Deakin University.

The research was funded by G21 Geelong Region Alliance.

Steering Group Members

G21 Geelong Region Alliance
Chris Balaam

Surf Coast Shire
Cr Libby Mears
Katherine Kelly
Cecilia Brady

Colac Otway Shire
Greg Fletcher

Golden Plains Shire
Lenny Jenner

City of Greater Geelong
Karen Valentine
Carmel Boyce

Borough of Queenscliff
Trudi Toyne

Barwon Health
Anna Fletcher

Barwon Primary Care Forum
Carla Woodyard

Department of Human Services
Sandy Austin
Executive Summary

Background

G21 Geelong Region Alliance (G21), through the partnership activities of the G21 Health & Wellbeing Pillar, seeks to position health and wellbeing as a central element to all regional planning processes and outcomes. As a result, G21 wanted to explore the potential application of the World Health Organisation’s (WHO) ‘Healthy Cities’ approach across the region to provide a comprehensive framework and set of principles to inform future planning and decision-making.

With this aim, G21 commissioned Deakin University to undertake a 6-month independent research project. The research project involved two stages:

Part 1: A Healthy Region Research Report involved scoping and determining:

- The suitability of the World Health Organisations (WHO) ‘Healthy Cities’ approach to the G21 region; and
- The capacity of G21 Geelong Region Alliance to be the organisation to facilitate this approach across the region.

Part 2: A Healthy Region Business Plan involved the:

- Development of a Business Plan for creating a ‘G21 Healthy Region’ which includes the features of a preferred model that would encompass a comprehensive framework for achieving G21’s Vision for the region to be a desirable place to live, work and invest within a vibrant community.

Methodology

Several data collection methods were employed including:

- A review of the ‘Healthy Cities’ literature;
- A document analysis comparing the Healthy Cities approach with G21’s existing frameworks and systems; and
- Stakeholder consultations involving interviews, focus groups and an online survey to investigate G21’s capacity, activities, governance and relevant Healthy Cities activities and issues.

Together, these data collection methods provided a picture of the suitability of the Healthy Cities approach to the G21 region and analysed the capacity of G21 to facilitate this approach.

Data Analysis

Data from the document analysis and consultations were compared against the WHO Healthy Cities approach and principles identified from the literature; namely, a commitment to health, political decision-making, intersectoral action, community participation, innovation and healthy public policy.

G21’s strengths and weaknesses were then mapped and any gaps or discrepancies highlighted throughout the process were used to inform the recommendations made in Part 2 of this report, the Healthy Region Business Plan.
Findings

**Literature Review of the WHO ‘Healthy Cities’ Approach**

In order to ascertain the appropriateness of the Healthy Cities approach to the G21 region, an extensive review of the literature was undertaken.

The World Health Organisation’s (WHO) Healthy Cities approach argues that health and well being emerges from positive environmental, social and economic conditions. The approach is consistent with G21’s triple bottom line approach to regional planning which recognises a society cannot be well if its environment is polluted and unsustainable, if its members have limited say over its governance, if its member’s mobility and connectivity are restricted, unemployment is high, poverty widespread and violence pervasive, cultural life stifled and basic needs for food, shelter and health care unaffordable. A healthy city therefore far more than one where health services are adequate and accessible, it is a healthy built and physical environment, active citizenship, social equity, safety, lively culture and the meeting of basic needs.

The literature review highlights an internationally recognised Healthy Cities framework entitled *Twenty Steps for Developing a Healthy Cities Initiative*. It defines a number of Healthy Cities principles in which an initiative needs to address. In particular, a Healthy Cities is characterised by an inter-sectoral political commitment to health and wellbeing in its broadest ecological sense, a commitment to innovation and democratic community participation and healthy public policy. Since 1986, thousands of cities and municipalities have used this approach and it has been internationally effective in progressing health and wellbeing. The idea of adapting the Healthy Cities approach to a regional level or a sub regional (G21) level (i.e., a Healthy Region approach) is new.

A number of international and national case study examples are outlined and the learnings for G21 are illustrated to provide G21 with direction in adopting this approach at a regional level.

Furthermore, to assist Healthy Cities stakeholders to document their progress, a monitoring and evaluation framework is specified and advocated in order to generate evidence that the approach is making an impact. Case studies are provided as examples of the application of WHO Healthy Cities indicators.

It was concluded that the G21 region is well positioned to embrace this approach to better address disadvantage, chronic health problems and the challenges presented by growth and an ageing population.

**Analysis of G21 Geelong Region Alliance**

**G21 Document Analysis**

G21’s documents were analysed against the internationally tested approach by the WHO, *Twenty Steps for Developing a Healthy Cities Project*. This framework outlines three main phases necessary for development of a Healthy Cities initiative: start-up, project organisation, and areas for action and strategic work.

It was concluded that G21 have a good foundation to facilitate a Healthy Cities approach across their region. They document strong commitment to the characteristics of Healthy Cities including increasing health awareness, intersectoral action, influencing political decision-making, advocating strategic
planning, utilising community consultation to inform planning, and a commitment to a process of innovation.

However, it was also noted that G21 also faces many challenges which may impact their ability to be an effective advocate. Most notably, work at a regional level requires the commitment and dedication of networks to continue to invest their time, interest and resources. It also relies on the effectiveness of their strategic planning to not only capture community needs, but also provide clear pathways for planning partners to implement action and evaluate health impact outcomes. It was identified that stronger intersectoral action pathways and development of formal and comprehensive data collection and evaluation methods are needed.

Stakeholder Consultations

Consultations with stakeholders were conducted via focus groups, interviews and an online survey. Given the findings in the document analysis which identified that stronger intersectoral partnerships are needed, questions asked were aimed at illuminating the nature of stakeholder knowledge of, commitment to and barriers towards the adoption of a Healthy City approach. Questions were also aimed at exploring the perceived ability of G21 to oversee this process in the region.

This process clarified that a Healthy Cities approach across the region is not only considered suitable and timely, but G21 are also considered well placed to facilitate the application of this approach. In fact, the vast majority of stakeholders (over 90%), saw G21 as the best organisation to realise and facilitate a Healthy Region approach across the G21 region.

Stakeholders perceive G21 to have a number of strengths. Namely, they are considered an innovative organisation with established good will and credibility as a solid regional planning platform. Stakeholders also view G21 as being a capable organisation due to the high level political support they have secured and the broad network of members it has attracted. However, while it is acknowledged that G21 already have a good foundation for working in a way that is consistent with a Healthy Cities approach, a number of gaps and weaknesses were identified through the research analysis and consultations which could impact upon their effectiveness. Key weaknesses included:

- Ambiguity in G21’s role
- Reliance on stakeholder engagement and investment and lack of roles and responsibilities
- Lack of communication pathways between Pillars and between the Pillars and the G21 Board
- Lack of coordination of projects/duplication of work and resources
- Sustaining momentum and motivation of projects and volunteers
- Health as a de-centralised focus due to a separate Health and Wellbeing Pillar
- Lack of monitoring and evaluation processes and health impacts
- All sectors are not engaged
- Good at planning but poor at implementation
Recommendations

A number of key recommendations were drawn from the research findings including:

- Need to define roles and responsibilities of G21
- Restructure G21 Board and Pillar communication pathways through establishment of a Pillar Leader Group and appointing Pillar Leaders to G21 Board
- Focus on large, cross sectoral projects
- Enhance resources in the G21 office
- Regularly engage and reward members/stakeholders to sustain motivation
- Create a data base to monitor progress and evaluate health impacts

These recommendations provide the framework for the structure and recommendations outlined in Part 2: G21 Healthy Region Business Plan. The Business Plan proposes a number of small changes which will build on G21’s existing strengths and addresses their weaknesses to ensure that they can be an effective advocate for the health and wellbeing across the region.

Conclusions

A Healthy Cities approach (i.e., a Healthy Region approach) has the potential to provide an overarching framework which can be applied to G21’s existing organisation and its processes to build on their strengths and address their weaknesses. It is also offers a clear and internationally recognised approach for stakeholders to embrace. Additionally, a Healthy Cities approach applied to the G21 region would further enhance its reputation as a progressive and innovative region while also adding demonstrable improvements to the health and wellbeing of the region’s population. Such an approach would thereby progress G21’s Vision of the region to be “Australia’s most desirable destination for living, working, visiting and investing...renown for its vibrant, cohesive community, exceptional physical environment and vigorous economy” and see the region as an exemplar for the nation.
1. Introduction

1.1 Origins of the Healthy Cities approach

As part of its 1948 Constitution, the World Health Organisation defined ‘health’ very broadly as ‘the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief or economic and social condition’ (WHO, 1948, p.1).

During the last 20 years, Public Health professionals have increasingly appreciated that many of the factors that affect people’s health lie outside their personal control, and instead can be found in the complex physical, social and political environments in which they live. Ten key social determinants of health include: addressing the need to prevent long-term disadvantage; the effects of the social and psychological environments; the importance of a good childhood environment; the impact of work on health; problems of unemployment and job insecurity; the role of friendship and social cohesion; the dangers of social exclusion; the effects of alcohol and other drugs; the need to ensure access to healthy food; and the need for healthier transport systems (Wilkinson & Marmot, 2003).

According to Baum (1993), places can be judged for their health – and equity – according to three sets of criteria:

1. Physical form, including the use of land, housing type and standard, communications infrastructure, transport provision and the quality of the built and natural environment
2. Interaction, recognizing that people come to regions, cities and towns for contact with others. This contact includes politics, work, economic activity, caring, education, recreation and home life
3. Individual experiences of a place, which includes the sense of history and tradition, life-style, culture, expressions of creativity and art (p. 32).

A healthy city is dependent upon the quality of environment and the attainment of equity between inhabitants. Especially, Baum (1993) argued that to be ‘healthy’, any urban development initiative must address poverty and its root causes, and the way poverty and wealth are expressed in urban form.

Despite these advances in thinking in the public health domain, much human activity is still arranged and governed according to outdated modes of thinking. For much of the past 100 years, planners, health professionals and policymakers have failed to integrate health, well-being and equity as a core consideration of their work. This has been exacerbated by fragmented economic, planning and policy environments that ‘externalise’ the ecological, social and health costs of inappropriate development. Suburban sprawl, loss of habitat and biodiversity, car dependency, gentrification of inner urban areas, privatisation of public space, and marginalisation of lower income populations are some of the results (Butterworth, Thompson & Knox, 2007).

In the developed world, there is growing concern about rising rates of serious physical and psychological conditions—such as obesity, heart disease, diabetes, asthma, depression and emotional stress—in urban populations. Research shows that urban planning and health patterns are closely related. Urban sprawl, with its low residential densities, car dependency and separation of
home and work, is being linked to behaviour patterns that contribute to poor physical and mental health. Individuals are dissuaded from taking regular physical exercise in heavily trafficked, polluted and often unsafe and unpleasant environments. In many suburban localities shops are a long way from houses so it is difficult to get there other than by car. Indeed, many large shopping centres are designed with the car user in mind and are very unfriendly to pedestrians. Increasingly, children do not walk to school or play games outdoors. The single family dwelling can be an isolating residential form, particularly for the elderly and disabled. People who must travel long distances from home to work often do not have the time or energy to form meaningful relationships with their neighbours. Family relationships can also suffer from long absences from home. These factors result in reduced community interaction and social capital (Frumkin, Frank & Jackson, 2003; Gebel et al, 2005; Mead, Dodson & Ellaway, 2006).

During the 1980s, the WHO’s very broad-based notion of health was manifested in its ‘Healthy Cities’ initiative. Healthy Cities is a systematic community development approach that seeks to place health on the agenda of cities, municipalities and communities around the world, and build a local constituency of support for public health (Tsouros, 1995). At the 1984 Toronto ‘Beyond Healthcare’ conference at which Healthy Cities concept was born, co-founder Prof. Leonard Duhl outlined the case for a “comprehensive, community-based approach to improving public health by working on the broad range of factors that influence the health and quality of life in cities” (National Civic League, 1998, p. 283). It was the first time since the late nineteenth century that a holistic view of health was proffered that required integrated planning and intersectoral collaboration.

The Healthy Cities concept was subsequently taken up by Ilona Kickbusch at WHO Europe; the first WHO Healthy Cities conference was held in Lisbon in 1986, in which a small number of cities officially joined the WHO pilot initiative. However, the Healthy Cities approach rapidly gained momentum around the world as a popular community development initiative aimed at fostering social change to promote more equitable access to the resources that promote health (Ashton, 1992; Baum, 1993). The rapid spread of Healthy Cities programs coincided with world-wide growth of environmental concern in mid-1980s. Also, the Healthy Cities philosophy has drawn on pre-existing social movements, such as women’s movement, gay and lesbian equality, social justice, ecology, and community development. Healthy Cities needs to be seen in the light of other relevant city ‘movements’ – for example Green/sustainable cities, Safe cities, Livable cities, New Urbanism, Smart growth and so on. “Above all else, Healthy Cities is about directing social change to achieve more health and a more equitable distribution of the resources that create health” (Baum, 1993, p. 31).

It is estimated that during the last 20 years, the Healthy Cities approach has spawned up to 10,000 initiatives worldwide. The concept is evolving to encompass healthy villages and municipalities, and has a close relationship to municipal public health planning (National Civic League, 1998). The G21 Healthy Region Business Plan provides an opportunity to explore ways to apply Healthy Cities principles to a regional level, and share the findings of this initiative internationally.

This paper will outline the concepts and history of the World Health Organisation’s Healthy Cities approach, and explore its regional application to the G21 Region. In particular, the paper will focus on the importance of integrating urban, social and economic planning, and the need for innovative forms of governance to facilitate this. The historical links between public health
and urban planning will be highlighted in order to stress their centrality to achieving a health region.

1.2 What is a Healthy City?

A Healthy City is “one that is continually creating and improving those physical and social environments and expanding those community resources which enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential.” (Hancock & Duhl, 1988). Linking the seminal Ottawa Charter for Health Promotion (WHO, 1986) with evidence on the social determinants of health (Wilkinson & Marmot, 2003), ‘Healthy Cities Initiatives’ are characterised by broad-based, intersectoral political commitment to health and well-being in its deepest ecological sense; commitment to innovation; an embrace of democratic community participation; and a resultant healthy public policy. Health and well-being must be planned and built ‘into’ cities; this process is presented as everyone’s business. Political endorsement is seen as crucial to ensuring intersectoral collaboration. Systems for participatory decision-making must be developed to ensure that all voices are heard, especially those of marginalised people (Baum, 1993). Healthy Cities is essentially an empowerment process, that embeds the Ottawa Charter’s core definition of health—“The process of enabling people [in a community or city] to increase control over and improve [all the many different factors that affect] their health” (WHO, 1986).

Healthy Cities is based on the recognition that city and urban environments affect citizens’ health, and that healthy municipal public policy is needed to effect change (Ashton, 1992). In the early stages of the Healthy Cities approach, 11 key parameters were identified for healthy cities, communities, and towns (Hancock & Duhl, 1988):

1. A clean, safe, high-quality environment (including housing).
2. An ecosystem that is stable now and sustainable in the long term.
3. A strong, mutually supportive and non-exploitative community.
4. A high degree of public participation in and control over the decisions affecting life, health, and well-being.
5. The meeting of basic needs (food, water, shelter, income, safety, work) for all people.
6. Access to a wide variety of experiences and resources, with the possibility of multiple contacts, interaction, and communication.
7. A diverse, vital, and innovative economy.
8. Encouragement of connections with the past, with the varied cultural and biological heritage, and with other groups and individuals.
9. A city form (design) that is compatible with and enhances the preceding parameters and forms of behaviour.
10. An optimum level of appropriate public health and sick care services accessible to all.
11. High health status (both high positive health status and low disease status).

Whilst there is some degree of overlap and possibly redundancy among these parameters, at their inception in the 1980s they presented a landmark point of difference from the then dominant clinical and individualistic notions of health. These parameters showed that health and well-being have many determinants that are influenced by policy and activity in many sectors and institutions outside the ‘health’ sector. These include infrastructure planning, urban design, architecture, the business sector, developers, environment, education, art, and culture (Wilkinson & Marmot, 2003). ‘Health’ thus needs to be seen as everyone’s business, and not just the role of the health sector. Governments
need to understand the importance of integrated planning approaches that consider the overall well-being of the whole person and the whole community.

The parameters also presented an alternative way of viewing health, in terms of human potential, and human capital. Human capital grows when development encourages the balanced growth of social capital, environmental capital and economic capital. Environmental and social problems arise when economic capital is valued above and beyond social and natural capital, and the environmental and social consequences of economic growth are not considered when making economic decisions or reporting on economic activity.

Baum (2000) identified three ways in which Healthy Cities programs can add to social capital around civic engagement, and be evaluated as such: (i) the Healthy Cities framework presents a “space in which civil society and formal government structures can meet, interact and form partnerships and alliances in order to promote health (p. 11), thereby making encouraging good governance by making government more open, integrated and responsive; (ii) Healthy Cities programs reinstate the view and role of community members as democratically-participating citizens rather than customers or consumers; (iii) “Healthy Cities players can be powerful advocates for a view of cities which sees them as far more than places to promote economic growth. The ideology of Healthy Cities stresses the importance of history, culture and social interaction” to overall health and wellbeing (p. 11). As Healthy Cities co-founder, Dr Trevor Hancock stated (2006), “surely the ultimate purpose of communities, governments and societies is the development of human beings (citizens) so they can achieve their maximum potential?”

Hancock (1993) conceived of a Healthy Cities and Communities model in which human health and wellbeing – or human capital – is the ultimate outcome of a sustained, integrated effort to build community (social) capital, environmental capital and economic capital (See Figure 1).
In his model, Hancock presented six interlocking elements of sustainability, liveability, equity, conviviality, viability and prosperity, as described in Figure 2 below.

**Figure 2. Elements of a healthy city or community (Hancock, 2006)**

<table>
<thead>
<tr>
<th>Element</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sustainability</td>
<td>Human health depends upon ecosystem health. Planning must protect and enhance ecosystem health</td>
</tr>
<tr>
<td>Liveability</td>
<td>We are 80% urbanised and spend 90% of our time indoors, so the built environment is our ‘natural’ environment. Planning must create livable and safe built environments for people</td>
</tr>
<tr>
<td>Equity</td>
<td>Poorer people live downwind, downstream and downhill, live in the worst homes and neighbourhoods, have the worst working conditions. Planning must address and reduce, and certainly not exacerbate these conditions</td>
</tr>
<tr>
<td>Conviviality</td>
<td>Humans are social animals; our health is linked to our social networks. Planning must encourage and support social interaction, and not foster social isolation or segregation</td>
</tr>
<tr>
<td>Viability</td>
<td>We are what we eat, drink and breathe. Planning must not contribute to the burden of toxicity to which people are exposed</td>
</tr>
<tr>
<td>Prosperity</td>
<td>Both people and communities need enough wealth to acquire the basic needs for health. Planning should not impose unwanted additional costs on people or communities</td>
</tr>
</tbody>
</table>

As detailed in Figure 3 below, Healthy Cities initiatives are characterised by six core characteristics, including: a broad-based, intersectoral political commitment to health and wellbeing in its deepest ecological sense; commitment to innovation; an embrace of democratic community participation; and a resultant healthy public policy that addresses health inequalities (WHO, 1995; 1997).

**Figure 3. Characteristics of Healthy Cities Initiatives (WHO, 1997, pp. 13-14)**

<table>
<thead>
<tr>
<th>Characteristics of Healthy Cities Initiatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Commitment to health</strong></td>
</tr>
<tr>
<td>They are based upon a commitment to health. They affirm the holistic nature of health, recognizing the interaction between its physical, mental, social and spiritual dimensions. Promotion of health and prevention of disease are their priorities. They assume that health can be created through the cooperative efforts of individuals and groups in the city.</td>
</tr>
<tr>
<td>2. <strong>Political decision-making</strong></td>
</tr>
<tr>
<td>They require political decision-making for public health. Housing, environment, education, social service and other programs of city government have a major effect on the state of health in cities. Healthy Cities initiatives strengthen the contribution of such programs to health by influencing the political decisions of city council.</td>
</tr>
<tr>
<td>3. <strong>Intersectoral action</strong></td>
</tr>
</tbody>
</table>
| They generate intersectoral action. The term “intersectoral action” describes 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. Healthy Cities initiatives create
Characteristics of Healthy Cities Initiatives

organizational mechanisms through which city departments and other bodies come together to negotiate their contribution to such action.

4. Community participation
They emphasize community participation. People participate in health through their lifestyle choices, their use of health services, their views on health issues and their work in community groups. Healthy Cities initiatives promote more active roles for people in all of these areas. They provide means by which people have a direct influence on initiative decisions and, through the initiative, on the activities of city departments and other organizations.

5. Innovation
They work through processes of innovation. Promoting health and preventing disease through intersectoral action requires a constant search for new ideas and methods. The success of Healthy Cities initiatives depends upon their ability to create opportunities for innovation within a climate that supports change. Initiatives do this by spreading knowledge of innovative methods, creating incentives for innovation and recognizing the achievements of those who experiment with new policies and programs.

6. Healthy public policy
Their outcome is healthy public policy. The success of Healthy Cities initiatives is reflected in the degree to which policies that create settings for health are in effect throughout the city administration. Initiatives achieve their goals when homes, schools, workplaces and other parts of the urban environment become healthier settings in which to live. Political decisions, intersectoral action, community participation and innovation promoted through Healthy Cities initiatives work together to achieve healthy public policy.

1.3 Relevance of Healthy Cities approach relevant to the G21 Region

The case for utilising a Healthy City approach across the G21 Region is a strong one. This approach presents an innovative opportunity to embed concern for health and wellbeing across all levels of governance and decision making in the G21 Region. Not only does a broad based analysis of health and well being ensure more effective solutions, but a Healthy City approach applied to the G21 region would further enhance its reputation as progressive and innovative while also adding demonstrable improvements to the health and well being of the region’s population. Such an approach would thereby progress the Vision of the region to be “Australia’s most desirable destination for living, working, visiting and investing...renown for its vibrant, cohesive (and we would add healthy) community, exceptional physical environment and vigorous economy”, align with State Government policy and see the region as an exemplar for the nation.

It has been widely recognised that health and well being emerge from a range of positive environmental, social and political conditions. In particular, a society cannot be well if its environment is polluted and unsustainable, if its members have limited say over its governance, mobility and connectivity are restricted, unemployment is high, poverty widespread and violence pervasive, cultural life stifled and basic needs for food, shelter and health care unaffordable. The social determinants of health are broad ranging and a healthy region has to engage with all of them, ameliorating negatives as well as developing and supporting positives to achieve higher levels of well being. A healthy region is therefore far more than one where health services are adequate and accessible – though this
remains a core element – but includes a healthy built and physical environment, active citizenship, social equity, safety, lively culture and the meeting of basic needs. Such an approach has been internationally effective in progressing health and well being. Within the G21 region there is a strong sense that more can be done to enhance well being, to build on but go beyond a highly effective health sector to embrace this broader notion of Healthy Cities.

1.1 Project Aims

The key research question of the G21 Healthy Region Project – Business Plan was “to explore the potential application of the WHO Healthy Cities approach across G21 to provide a comprehensive framework and set of principles to inform future planning and decision making”.

The research project involved two stages:

**Part 1** involved scoping and determining:

- Scope and determine the suitability of the World Health Organisations (WHO) ‘Healthy Cities’ approach to the G21 region; and
- Scope and determine the capacity of G21 Geelong Region Alliance to be the organisation to facilitate this approach across the region.

**Part 2** of the research involved the:

Development of a Business Plan for creating a ‘G21 Healthy Region’ which includes the features of a preferred model that would encompass a comprehensive framework for achieving G21’s Vision for the region to be a desirable place to live, work and invest within a vibrant community.
2. Project Methodology

2.1 Participants

The project team adopted an action research approach to ensure that interested stakeholders had an opportunity to participate collectively in the generation and application of knowledge (Chesler, 1991; Fetterman, 1994).

Consistent with this approach, a Steering Group was established to assist the research team oversee the project. The Steering Group involved representatives from G21, members of the G21 Health and Wellbeing Pillar, G21 Councils including Borough of Queenscliff, City of Greater Geelong, Colac Otway Shire, Golden Plains Shire and Surf Coast Shire plus other key stakeholders including Barwon Health, Barwon Primary Care Forum and the Department of Human Services (Barwon Region).

Through snowball sampling via the Steering Group, other relevant stakeholders were identified for participation in the consultation phase of the research (see Data Collection section below). People targeted included senior personnel and key decision makers who can help shape the future of the G21 Region. In addition, a key characteristic of a Healthy Cities approach is about the importance of collaboration between stakeholders across a wide range of sectors, including urban development, education, transport, business and economics, non-government organisations, the community sector and health and human services. Therefore, a Stakeholder Matrix (Appendix A) was developed to ensure that the research engaged with people from across a wide range of sectors. This was achieved by mapping G21’s Pillars against the eleven parameters identified for Healthy Cities (see section 1.2 above) and drawing out the associated organisations and key stakeholders within each parameter.

2.2 Data Collection

Several data collection methods were employed including:

- A review of the ‘Healthy Cities’ literature;
- A document analysis comparing the Healthy Cities approach with G21’s existing frameworks and systems; and
- Stakeholder consultations involving interviews, focus groups and an online survey to investigate policy contexts, activities, governance and relevant Healthy Cities activities and issues.

The rest of this document (Part 1: Research Report) outlines the specific methodology and findings from each of these data collection methods.

2.3 Data Analysis

Both a quantitative and qualitative approach was used to analyse the findings. Data from the document analysis and consultations was compiled and tabulated in order to facilitate the identification of the commonalities and differences with the Healthy Cities approach as demonstrated in the literature.

Findings from the data analysis were used to formulate a ‘Healthy Region Business Plan’ (Refer to Part 2: Business Plan). The contents of the Business Plan were then refined through a workshop run with the project team, Steering Group and participating stakeholders.
The stages of the project are illustrated in Figure 4 below.

**Figure 4: Project Overview**

1. Literature Review
2. Document Analysis
3. Stakeholder Consultations
   - Focus Groups
   - Interviews
   - Online Survey

**Stage 1: Research Report**

**Stage 2: Develop Business Plan**

- Select a Healthy Cities Framework for G21 Analysis
3. Data Collection and Analysis

The following sections outline the findings from the three phases of data collection, which included:

- A 'Healthy Cities' literature review;
- A G21 document analysis; and
- Consultations with key stakeholders across the G12 Region.
3.1 **LITERATURE REVIEW**

3.2 **Implementing Healthy Cities Concepts** ........................................... 12  
3.2.1 Twenty Steps for Developing a Healthy Cities Initiative ........... 12  
3.2.2 The Centrality of Governance ............................................................ 14  
3.2.3 Intersectoral collaboration: Brokering effective partnerships ... 15  

3.3 **International application** ................................................................. 19  
3.3.1 Healthy Cities Europe .................................................................. 19  
3.3.2 Healthy Cities and Communities – USA ........................................ 20  
3.3.3 Healthy Cities – Canada ................................................................. 21  
3.3.4 Taiwanese and Chinese examples .................................................. 21  
3.3.5 Australian context ...................................................................... 21  
3.3.6 Western Pacific Regional Alliance of Healthy Cities ................. 22  
3.3.7 Discussion .................................................................................... 23  

3.4 **Healthy Cities: Case studies** ......................................................... 24  
3.4.1 Healthy Cities Illawarra ................................................................. 24  
3.4.1.1 Healthy Cities Illawarra: Lessons for G21 .......................... 29  
3.4.2 Plumas County, California ............................................................ 30  
3.4.2.1 Plumas County: Lessons for G21 .......................................... 32  

3.5 **Monitoring and evaluation of Healthy Cities: Issues and Case Studies** ................................................................. 33  
3.5.1 Using community capacity as an evaluation framework ............ 34  
3.5.2. Indicators of health and wellbeing ............................................. 36  
3.5.2.1 Indicator Case Study - WHO Healthy Cities Indicators ........ 37  
3.5.2.2 Indicator Case Study - Colorado ‘Operation Healthy Communities’ ........................................... 39  
3.5.2.3 Indicator Case Study - Watch Out for Health Checklist ....... 40  
3.5.2.4 Indicator Case Study - Victorian Community Indicators Project 41  
3.5.3 Comments on Victorian Community Indicators Project .......... 43  
3.5.4 Reflections on Indicators .............................................................. 43  

3.6 **Summary: Implications for the G21 Region** ................................ 45  

3.7 **Conclusion** .................................................................................... 51
3.2 Implementing Healthy Cities Concepts

A broad-based Healthy Cities initiative typically involves the establishment of a peak intersectoral working group comprising senior personnel from key organisations. A project team assists the working group by conducting community diagnosis; developing strong links with education bodies at all levels, for educative purposes as well as to collect data; assisting participating agencies to examine ways of engaging in health promotion; helping to generate public debate, with a view towards fostering city-level health advocacy; developing and evaluating targeted health promotion interventions. The project team works across sectors to break down the barriers between them and develop better linkages (Ashton, 1992; WHO, 1997).

A Healthy Cities approach is built on community involvement; political commitment, in which local government is a key player; intersectoral partnerships; and enabling, healthy public policy to create the conditions for health. Healthy Cities approaches build on local capacity, by building on assets, strengths and resources. Unlike deficit-reduction approaches to community problem solving, they do not focus on weaknesses or needs. Local health promotion (the application of the concepts, principles and practice of health promotion at the local level) is crucial. Central to local health promotion is the key role played by local government. Many of the major determinants of health are within the scope of local government.

Based on consultations with 1200 community initiatives, the US Coalition for Healthier Cities and Communities (cited by Hancock, 2006) identified that a healthy community approach must: (i) practice ongoing dialogue; (ii) generate leadership everywhere; (iii) shape its own future; (iv) embrace diversity; (v) strive to know itself; (vi) connect people and resources; (vii) create a sense of community. City-wide support for neighbourhood action is needed, in terms of endorsement, leadership and allocation of resources. Partners for a healthy community approach include community organizations, local institutions, government (local, state, federal), local business, faith-based groups, local citizens and so on. The form of organisation needs to suit the local context. Hancock (2006) stressed the long-term incremental nature of healthy cities approaches to community development: ‘A Healthy City approach is built one neighbourhood at a time; one street at a time; one block at a time; one home at a time; and one day at a time.’

3.2.1 Twenty Steps for Developing a Healthy Cities Initiative

WHO (1997) offers a systematic strategy for progressing through three phases of development of a Healthy Cities initiative in their document, Twenty Steps for Developing a Healthy Cities Project. As depicted in Figure 5 below, three main phases are necessary: start-up; initiative organisation; and areas for action and strategic work. Twenty Steps makes it clear that the overarching role of a Healthy Cities initiative is to offer effective advocacy to promote healthy public policy. However, in order to achieve this, first we need a Vision of a Healthy City or community: ‘A Vision is values projected into the future’ (Clem Bezold, Founder, Institute for Alternative Futures, cited in Hancock, 2006).

Getting started is the informal phase of initiative development. It comprises seven steps. It begins when one or two people decide that their city would benefit from new approaches to public health that can be fostered through a Healthy Cities initiative. It ends with city council approval of a initiative proposal. It involves understanding and acceptance of initiative
Getting organized begins after city council approves an initiative proposal and continues until the initiative has the capacity to be an effective public health advocate. This phase also has seven steps. During this building phase, organizational structures and administrative mechanisms are introduced to provide the foundation for leadership, intersectoral action and community participation. The people, money and information needed for the initiative are found at this time.

Taking action begins when the initiative has sufficient leadership and organizational capacity to be an effective public health advocate and continues as long as the initiative lasts. It involves action in six areas, each leading to its own set of results. It covers those activities that build support for new approaches to public health and makes organizations throughout the city active partners in health development. One important result is healthy public policy followed throughout the city administration and by other partners in the initiative.

Initiatives do not evolve in a continuous, systematic way. They are experimental and grow by trial and error. Sometimes they develop rapidly and at other times they grow slowly because conditions are complex and contradictory. Each Healthy Cities initiative must find its way through the maze of changing circumstances in which it works. This requires exercise of careful judgement based upon an understanding of methods that have succeeded for others. The steps for initiative development offer ways to find the probable source of problems and apply solutions that have worked for others (WHO, 1997, pp. 15, 17).

**Figure 5. Twenty Steps for Developing a Healthy Cities Project (WHO 1997, p. 19)**

<table>
<thead>
<tr>
<th>Getting organized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appoint committee</td>
</tr>
<tr>
<td>Analyse environment</td>
</tr>
<tr>
<td>Define project work</td>
</tr>
<tr>
<td>Set-up office</td>
</tr>
<tr>
<td>Plan strategy</td>
</tr>
<tr>
<td>Build capacity</td>
</tr>
<tr>
<td>Establish accountability</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Taking action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase health awareness</td>
</tr>
<tr>
<td>Advocate strategic planning</td>
</tr>
<tr>
<td>Mobilize intersectoral action</td>
</tr>
<tr>
<td>Encourage community participation</td>
</tr>
<tr>
<td>Promote innovation</td>
</tr>
<tr>
<td>Secure healthy public policy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Getting started</th>
</tr>
</thead>
<tbody>
<tr>
<td>Build support group</td>
</tr>
<tr>
<td>Understand ideas</td>
</tr>
<tr>
<td>Know the city</td>
</tr>
<tr>
<td>Find finances</td>
</tr>
<tr>
<td>Decide organization</td>
</tr>
<tr>
<td>Prepare proposal</td>
</tr>
<tr>
<td>Get approval</td>
</tr>
</tbody>
</table>
Central to the ‘open-source’ nature of Healthy Cities literature is the requirement that local communities adapt concepts and strategies to suit their own context. In adapting Twenty Steps for use in the African region, WHO Regional Office for Africa (2002) noted that many African initiatives had “chosen to combine several of these steps or have found that their order has to be modified to local circumstances” (p. 14).

Because of its ubiquity in the Healthy Cities arena as a planning resource, Twenty Steps (WHO, 1997) will be used in Section Three as a foundation document for examining the application of Healthy Cities concepts and practice across the G21 Region.

3.2.2 The Centrality of Governance

Governance has been defined as ‘the process by which we collectively solve our problems and meet our society’s needs. Government is the [an] instrument we use.’ (Osborne & Gaebler, cited in Hancock, 2006). For Gleeson and Low, planning is a form of governance. They see it as “the activity of governance required to make sure that all services that people need in a city are provided, when and where the need occurs at a price that they can afford” while also ensuring that a good environment is provided for all (2000, pp.1 & 5). They describe governance as the overall set of state institutions, policies and actions which shape environments. For Lyndsay Neilson, governance refers to the arrangements that societies agree to set in place between civil society, business and government to address issues of collective interest, to solve problems or to create and draw on benefits (2002: 97). For Williams, ‘management’ refers to physical and economic management activities and the day to day decision making associated with these. Governance refers to the decision making structures, mechanisms and systems of administration that influence the operation of the management systems (2007, p. 32).

The quality of governance itself is a marker of population health, in terms of the systems and processes of political decision-making and coordination that are developed to build a city or region’s capacity to enhance and strengthen the health of the population (Hancock, Labonté & Edwards, 1999). In measuring population health at the community level, Hancock et al argued that we need to consider change at three broad levels. These are: health determinants (inputs), processes of change, and health outcomes (outputs):

1. Population health determinants, including: sustainable ecosystems (sustainability), environmental viability (viability), livable built environments (livability), communal conviviality (conviviality), social equity (equity), and adequate prosperity.

2. Population health processes of change, such as education and governance.

3. Population health outcomes, including positive health (quality of life), health promoting behaviours, negative health (disability, morbidity, mortality and functional measures).

In Hancock’s (2006) view, the deepest meanings and implications for embracing a Healthy Cities approach are for notions of governance. In particular, Hancock argued that a deep commitment to HC involves rethinking capitalism, democratic reform and civic diplomacy. Hancock identified five implications for governance, including the purpose, approach, the level at which it occurs, the style of governance, the structure, and the nature of the democratic process.
Firstly, making a political commitment to Healthy Cities requires that a city, town or region identifies health/human development as its central purpose. It will commit to integrate economic development, social development and sustainable development to achieve human development. Secondly, a cross sectoral/ holistic approach to governance is required, such as through the establishment of a healthy city office with coordinators of mobility, sustainable resource management, food and shelter, safety and human development. Thirdly, the levels at which governance occurs need to be considered. Drawing on the ideas of Jan Eric Gibland, a Swedish political scientist, Hancock identified that nationally, we currently have ‘supra-nationalism’ and ‘parochialism’ occurring, including the emerging power of ‘city states’. Locally, we might have regionalism and ‘neighbourhood-ism’. Fourthly, the style of governance needs to be considered. A Healthy Region approach implies the formation of collaborative intersectoral partnerships, in which public, private and non-profit sectors work together. The philosophy is of ‘power with, not power over’. Fifth, the structure of governance may need to change to suit the need for intersectoral, collaborative relations. Hancock argued that form needs to follow function; that we need to move away from 19th century vertical silos to 21st century horizontal networks, roundtables and so on. (The Regional Managers’ Forum, G21 Pillar Groups and G21 itself are good examples of this.) Finally, the democratic process itself needs to be considered. Hancock (2006) argued that creating a healthy city is building democracy. Healthy City/Region governance structures and processes themselves constitute a form of civic diplomacy. Citing Draper and Harrison, Hancock argued that a healthy democracy is essential to achieving healthy public policy. In addition, given the centrality of consensus to sustainability, Hancock noted Doering’s premise that the central issue for sustainability is democracy. It is through notions of intersectoral collaboration that a pragmatic discussion of governance can occur.

3.2.3 Intersectoral collaboration: Brokering effective partnerships

Intersectoral collaboration is a key form of governance that is central to the Healthy Cities approach. Intersectoral collaboration was perhaps seen as something of a novelty when Hancock and Duhl (1988) developed the Healthy Cities framework. It has since become the lingua franca of ‘joined up government’ as typified by the British Blair Labour administration since 1997, and emulated by the Labor government in Victoria since 1999 (Meijers & Stead, 2004; Pollitt, 2003; Stead & Meijers, 2004; Wilson, 2003).

To drive intersectoral collaboration, healthy public policy across all sectors and government portfolios must be identified as a key goal. High-level political endorsement is crucial to ensuring a viable and sustainable intersectoral approach. Successful intersectoral collaboration may require the overturning of entrenched, fragmented ways of seeing and working among stakeholders and sectors. In order to promote intersectoral collaboration, Healthy Cities initiatives need champions, skilled in acting as catalytic leaders and social entrepreneurs, to elevate health to become everyone’s core business, find creative ways to bring different people, perspectives, and organisations together into a coordinated approach, to help them learn to understand issues from other people’s perspectives, and seize opportunities to broker more effective political relations (Catford, 1997, 8). However, as Stead and Meijers (2004) have noted, there is scant published literature on the intersectoral mechanisms by which successful policy integration can be achieved:

One landmark study that has documented the proliferation of intersectoral partnerships is Kegler, Norton and Aronson’s (2003) evaluation of Californian Healthy Cities and Communities (CH/C) initiatives. This study was designed to
explore two major themes: (i) the process of community development undertaken by the initiatives; (ii) the changes resulting from these initiatives. The study used a social ecology framework to analyse community capacity building processes and outcomes associated with the initiatives. Inter-organizational activity was one of the levels of the social system analysed.

*An important premise underlying the healthy cities and communities movement is the involvement of sectors of the community not generally considered health-related. Of significance, they control many resources and policies that affect health and well-being. For this reason, in combination with the synergy created by blending diverse perspectives and talents, cross-sectoral linkages and new partnerships are valuable outcomes stemming from these types of efforts. Related outcomes in this evaluation include: new and expanded partnerships, bridging of community sectors, and linkages to organizations external to the community.* (Kegler et al, 2003, p. 72.)

Kegler et al’s (2003) identified a wide range of intersectoral activity across the 20 HC/C initiatives. Five different types of partnerships were documented, ranging from exchanging information, co-sponsoring events, coordinating services, undertaking joint initiatives or programs, and sharing substantive resources. Representation on governance teams was documented across a wide range of sectors, including education, community-based organizations and social/human service agencies, media, housing, neighbourhood and civic groups, criminal justice/safety, public health, recreation, faith, political/elected officials and interested residents. Interestingly, the representation of interested residents tended to decline over time, whilst the level of engagement of community organisations increased over the same period. Numerous new and expanded partnerships were documented in Kegler et al’s evaluation. These were grouped into six general categories, and are described in Figure 6 below.

**Figure 6. Types and Examples of Partnerships Developed as a Result of the Californian Healthy Cities and Communities Initiatives (Kegler et al, 2003, p74)**

<table>
<thead>
<tr>
<th>Partnership Type and Description</th>
<th>Example</th>
<th>Percentage of new partnerships formed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program or Service-Related</strong></td>
<td>Regional time exchange network with partners including an HC/C collaborative, children’s hospital, county health and human services, senior centre, city government, school districts, family resource centre, after school program and health care district.</td>
<td>42%</td>
</tr>
<tr>
<td><strong>Limited Purpose</strong></td>
<td>Partnership between a teen centre and a sheriff’s office for court-mandated community service placement and supervision.</td>
<td>28%</td>
</tr>
<tr>
<td><strong>Information Exchange and Mutual Support</strong></td>
<td>Partnership between an HC/C collaborative and a town council for promoting each other's programs and sharing information.</td>
<td>14%</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Community Health Improvement Coalition</strong></td>
<td>Partnership that provides oversight to many initiatives, including HC/C, Healthy Start, after school programs, career centre, etc. Partners include: city government, neighborhood associations, park and recreation district, police department, chamber of commerce, and public library, among others.</td>
<td>Relatively small proportion</td>
</tr>
<tr>
<td><strong>Technical Assistance</strong></td>
<td>Technology support network to help support internet access for non-profit cafe. Partners include: HC/C collaborative, technology foundation, community clinic, private industry council, technology business and consulting firms.</td>
<td>Relatively small proportion</td>
</tr>
<tr>
<td><strong>Advocacy</strong></td>
<td>Network of groups advocating for the development of a new Parks and Recreation Joint Powers Agency. Partners include: HC/C collaborative, recreation committees, Board of Supervisors, school districts, city councils and a private consultant.</td>
<td>Relatively small proportion</td>
</tr>
</tbody>
</table>

Although Kegler et al’s (2003) study did not examine systematically the full range and nature of linkages made with organizations and resources external to the HC/C initiatives, the study noted that “evidence from new partnerships created and resources generated documents that communities were able to reach beyond their boundaries for funding, new ideas and approaches, and other resources” (p. 77). Many initiatives successfully obtained additional funding from higher levels of government. Kegler et al summarised the many factors that facilitated and/or inhibited development of new partnerships and collaboration across community sectors. The major themes are listed in Figure 7 below, in order of their strength.
Intersectoral action can be achieved through a range of approaches. By establishing steering committees with diverse membership, discussion plays an essential role in achieving shared understanding of differing perspectives and encourages building alliances. Intersectoral action provides opportunities for senior executives and professionals to compare their experiences and develop an action learning approach to testing new policies (Butterworth & Duhl, 2007). Strategic planning is a core function of intersectoral planning (WHO 1997, p. 48). Financial incentives for policy change are a core means to promote intersectoral action. For example, a budget allocation can be made to fund changes in policy and initiatives that will to strengthen their contribution to health. Community participation strategies are also seen to assist intersectoral action, by providing citizen perspectives on changes that are needed and strategies for enhancing intersectoral action. Accountability mechanisms, in which reports on the state of play are made public, create strong political and managerial impetus for intersectoral action.

Political commitment is the first step in working towards a healthy city. Cities that have entered the WHO network...have been asked to formulate intersectoral health promotion plans with a strong environmental component and to secure the resources for implementing them. These should include an intersectoral political committee, mechanisms for public participation and a initiative office with full-time staff. Central to the initial commitment to WHO has been agreement to report back regularly on progress and share information and experience. (WHO, 1997, p. 8).
3.3 International application

Healthy Cities co-founder, Prof Leonard Duhl, has described Healthy Cities concepts and strategies as a form of open-source software, like Linux, that is open for adaptation to suit local contexts. Indeed, different approaches are needed in different countries, which take account of political, cultural, and administrative systems. It is the sharing of learning from each approach that can add to the range and sophistication of initiatives world-wide (Butterworth & Duhl, 2007). This section will describe some notable international applications of the Healthy Cities approach, and discuss in the context of the G21 region.

3.3.1 Healthy Cities Europe

As the site of the first pilot Healthy Cities initiatives by WHO in the mid-1980s, Europe has in many ways served as the engine house of Healthy Cities concepts and approaches. WHO Europe has developed a legacy of theory and practice; strategy and methodology, buttressed by a huge bureaucratic initiative. Typically, the European approach has featured large cities, in which local governments play a key role as both planner and health provider. Many HC initiatives are administered at the senior corporate level of a city (such as Copenhagen or Dublin). The European Healthy Cities approach has typically involved the establishment of a peak intersectoral working group, supported by a project team, as described above.

The European Healthy Cities approach has progressed through several phases: First phase 1986-1992; Second phase 1993-1998; Third phase 1998-2002; Fourth phase (2002 onwards). Only the European region of WHO has had rigorous entry requirements to the Healthy Cities initiative. For all phases of HC initiative, member cities have had to demonstrate: (i) a political commitment to Health for All and the Healthy Cities vision; (ii) that they have adequate resources to employ a full-time initiative coordinator and support staff in a HC office; and (iii) commitment to specific objectives leading to development of local health policies (De Leeuw, 2001).

During the first phase of the Healthy Cities initiative, a primary objective for all cities was to establish an Urban Health Profile through completion of a Healthy Cities Questionnaire. This phase produced the well-regarded document, "Twenty Steps for setting up Healthy Cities Initiative" which is described in detail below. The second phase objective for cities was to create a City Health Plan. ‘A City Health Plan is a policy document including the Health Profile identifying health challenges, their determinants, and roles various actors should play in targeting those challenges’ (de Leeuw, 2001, pp. 37-38). This phase produced a plethora of case studies and models of good practice. The third phase objectives were to produce a City Health Development Plan, and engage in rigorous internal and external monitoring and evaluation. A City Health Development Plan builds on Phases I and II in that it ‘identifies strategic development issues, incorporating also urban planning, sustainable development and equity concerns on a long-term basis’ (de Leeuw, 2001, p. 38).

In Phase III of European HC initiatives, City Health Development Plans were required to embody a more rigorous internal and external monitoring and evaluation process to identify the impact of actions identified in Health profiles and City Health Plans. WHO established an extremely comprehensive (some would argue over-bureaucratic and unwieldy) requirement that HC initiatives would assess their performance against ‘health determinants analyses, and sound and responsible approaches towards influencing determinants of health’
Deakin University 20

(De Leeuw, 2001, p. 41). Initial annual reports were eventually received from 25 out of 40 cities: many struggled with the human resources needed to complete the reports. Over 1000 HC-related activities were reported. However, ‘very few of those activities showed a strategic perspective, thus underscoring [a] degree of ‘projectism’ in cities... that would hinder the development of healthy urban policies’ (De Leeuw, 2001, p. 42) and thus City Health Development Plans in Phase III. It was anticipated that the requirement to produce these Annual Reports might help create a cultural shift away from ‘projectism’ towards a more strategic planning approach.

Phase IV of Healthy Cities (2003 – 2007) has attempted to address health development comprehensively, with an emphasis on partnerships, determinants and governance. This phase has also focused on developing knowledge, tools and expertise on core developmental themes of healthy urban planning, health impact assessment and healthy ageing:

- **Healthy urban planning.** Urban planners should be encouraged to integrate and supported in integrating health considerations in their planning strategies and initiatives with emphasis on equity, well-being, sustainable development and community safety.

- **Health impact assessment.** Health impact assessment processes should be applied within cities to support intersectoral action for promoting health and reducing inequality. By combining procedures, methods and tools, health impact assessment provides a structured framework for mapping how a policy, initiative or initiative affects health.

- **Healthy ageing.** Healthy ageing works to address the needs of older people related to health, care and the quality of life with special emphasis on active and independent living, creating supportive environments and ensuring access to sensitive and appropriate services. (WHO, 2003, pp. 2-3).

### 3.3.2 Healthy Cities and Communities - USA

The Healthy Cities scene in Europe compares interestingly with that in the United States. Leonard DuHl noted that whilst the Europeans made Healthy Cities a bureaucratic initiative, the Americans have seen it as a pseudo-anarchic process (personal correspondence, 10 September 2004). The approach adopted in the United States, for instance, has been driven more at a grassroots level, reflecting the realties of an individualistic cultural tradition of ‘life, liberty and the pursuit of happiness’ and small government (National Civic League, 1998: 287), from which the collective notions of the Ottawa Charter may be viewed by some with suspicion (Baum, 1993). Furthermore, with a somewhat chaotic private health care system, much government attention in the US is focused on ensuring access to basic health care, rather than addressing, at the intersectoral community level, the social determinants of health advocated in Healthy Cities (Wolff, 2003). The long and ‘embedded’ history of the involvement of health care industry in US health policy also needs to be considered. Wolff argued that the term ‘healthy communities’ is a problem in a country like the US, in which ‘health’ is dominated by privatized health care industry. Although many community organizations may be working along the lines of the Ottawa Charter to enhance population health through civic engagement and community building, they may not in fact identify ‘health’ as a primary goal of their efforts. Intersectoral collaboration has frequently been harder to achieve in the US than in countries such as Australia or Canada, in
which government is expected to provide some sort of leadership (Twiss & Duma 2003, Wolff 2003).

### 3.3.3 Healthy Cities - Canada

As mentioned above, the term ‘Healthy Cities’ was born in Toronto; Canada initiated the Healthy Cities approach in North America. The Canadian approach began with tripartite system of urban planners, public health and local government, and had an early focus on promoting the economic sustainability of Healthy Cities initiatives. As a result, the early initiatives tended to survive after official government funding ceased (Healthy Cities researcher, Brian Dunn, personal communication December 1999). Dunn argued that the Canadian approach differed from the Australian experience, which embodied a cultural expectation of government to maintain funding throughout the life of an initiative.

### 3.3.4 Taiwanese and Chinese examples

In contrast to European, American and Australian experiences, the Taiwanese expression of Healthy Cities reflects a strong Confucian tradition of the integration of politics and academe. Many senior government personnel met during Dr Iain Butterworth’s visits to Taiwan in 2004 and 2005 – including the Ministers for Health and Culture - had held academic positions. As a result, strong national government support existed for forging collaboration across sectors. As a relatively new democracy with a culture evolving as a reaction to mainland China, there also exists a strong commitment to grass-roots civic engagement and participation. In comparison, Chinese Healthy Cities-style initiatives might be characterised by central government-mandated edicts to establish initiatives and for various sectors to participate. Western notions of democratic participation led by grass-roots activists with the potential to advocate and dissent do not translate readily or easily into a description of a Healthy Cities initiative led and driven by a more centralised, interventionist state.

### 3.3.5 Australian context

In the late 1980s, three Australian pilot Healthy Cities initiatives were established with WHO funding. There were Noarlunga (25km south of Adelaide), Canberra and the Illawarra region of NSW. Noarlunga and Illawarra survive as official WHO-designated Healthy Cities approaches. Because of its regional approach, Healthy Cities Illawarra will be outlined in more detail as a case study in Section [3.4.1] below.

Shortly after the establishment of the three Healthy Cities initiatives, the Victorian Healthy Localities initiative was funded by VicHealth. This initiative implemented the Healthy Cities framework on the assumption that the local community acted as mediator between level of city and level of individual. Six Healthy Localities initiatives were funded to a total of $3m (Altona, Benalla, Broadmeadows, Coburg, Colac, Maffra Shire). One of these, in Benalla, aimed to “halt negative effects of rural decline, [and] deteriorating sense of community” (Garrard, Hawe, & Graham, 1995, p. 5). In part, participants campaigned for improved public transport. Garrard et al’s (1995) evaluation of the Victorian initiatives indicated that they needed a stronger systems-change focus, and that they needed to have been more adequately controlled by sufficiently resourced and skilled community members. Indeed, concern over insufficient levels of meaningful participation by community members has been
levelled at Healthy Cities initiatives world-wide (Baum, 1993; Petersen & Lupton, 1996).

Since 1999, a strong awareness has developed across the Victorian state, local and non-government sectors about the ways in which consideration for health and wellbeing are the core business of many departments and policy areas outside the traditional health realm. Such systems herald a paradigm shift towards a systemic, ecological approach to promoting and strengthening the health of whole populations, in policy areas that have not been traditionally concerned with health and well-being. Such areas include transport, neighbourhood renewal, community building, infrastructure and urban planning (see National Heart Foundation, 2004). Through Environments for Health, the municipal public health planning framework, the Victorian Department of Human Services has strongly encouraged local governments to make use of international Healthy Cities concepts and frameworks, and to integrate urban planning and health planning as a core business priority (DHS, 2001; Hay, Frew & Butterworth, 2001). Recently, the Victorian government has been exploring ways to integrate health impact assessment into its core business (Blau & Mahoney, 2005). The recent evaluation of Environments for Health has shown a significant shift in the understanding and uptake by Victoria’s 79 local governments of many of the Healthy Cities principles and concepts (DHS, 2007).

The Victorian examples described above show that official, WHO-designated and funded Healthy Cities initiatives are not required for cities and communities to use the concepts and approach. However, if desired, cities (and regions) can apply to join the WHO Western Pacific Regional Alliance of Healthy Cities by demonstrating their congruence with the Healthy Cities approach.

3.3.6 Western Pacific Regional Alliance of Healthy Cities

The Alliance for Healthy Cities is an international network of cities using the Healthy Cities approach. Supported by the Western Pacific Regional Office of the WHO, its members include municipal governments, national governments, NGOs, private sectors, academic institutions, and international agencies (Alliance for Healthy Cities, 2007a). The Alliance promotes the interaction of people and information exchange, research development, and capacity building programs. The Alliance was founded in 2003 at the First Organizational Meeting, an inaugural meeting held at the World Health Organization Regional Office for the Western Pacific in Manila, Philippines. The participants of the inaugural meeting were cities, national coordinators, NGOs, and academic institutions engaged in the Healthy Cities program worldwide. In October 2008, the Third Global Assembly of the Alliance for Healthy Cities will be held in Ichikawa, Japan.

Chapters of the Alliance for Healthy Cities (AFHC) are organized at the national, sub-national, or inter-country level. AFHC Chapters are supporting the achievement of the goal and objectives of AFHC by advancing information sharing among members of individual Chapters, promoting membership expansion, disseminating information of Healthy Cities in the respective regions, advocating for advancement of Healthy Cities, and encouraging international partnership. An interim Australia Chapter has existed since September 2007; secretariat is provided by Dr Peter Davey – Healthy Cities and Shires, Qld Centre for Environment and Population Health (CEPH).

The Alliance accepts membership applications from cities, municipalities, NGOs, universities, national agencies, the private sector, and others. Full Membership
includes: city governments, governing units of cities/ municipalities/ equivalent organizations. Associate Membership includes: individuals; non-city entities such as non-government organizations, national government agencies, private organizations, international agencies or academic institutions.

Full details on the procedure for applying for membership are available at Alliance for Healthy Cities (2007b). In brief, application for membership involves several steps:

a) Payment of the membership fee and annual dues (Full membership: US$ 500; Associate membership: US$ 500)
b) Completion of an information sheet (mandatory for the first year, update when necessary); and
c) Submission of documentation of the following (mandatory for the first year, update when they are ready):
   a. written policy statement in support of Healthy Cities
   b. future vision and goal
   c. profile of the city (baseline data)
   d. analysis of health priorities

Submission of the following documentation is also recommended (when available):

- intersectoral coordination mechanism in place
- mechanism for community participation
- local action plan to build on capacity and resolve problems
- a set of indicators for monitoring and evaluation
- a system of information dissemination and sharing (Alliance for Healthy Cities, 2007c)

Approximately fifty cities have full membership from across nine counties. Healthy Cities Illawarra and Healthy Cities Noarlunga (a Member of the Steering Committee) are Associate members, by virtue of their NGO status. It is feasible that, were it to lead a Healthy Regions strategy, G21 similarly could join with Associate membership. (Alliance for Healthy Cities, 2007d). Visitors to this website will note a certain emphasis on health-centric and problem-focused language. This reflects, in part, the significant variation in cultural expression of health and wellbeing across the many countries represented, and the fact that English is not the first language for most members.

3.3.7 Discussion

For Hancock (2006), the Healthy Cities approach represents a powerful strategy. However, he stressed that it requires investment of political, human and financial resources. It also requires effective organisation, national/regional support, and new styles of collaboration and governance. Finally, it may lead to new organising and governing structures. Hancock stresses that this model takes a long time to evolve – possibly several years. Finally, he argues that whilst the health care sector can play a key role, it preferably should not be the lead agent. After all, if we revisit the 11 parameters, we note that Hancock and Duhl (1988) deliberately placed health outcomes last – not only to signify the role placed by other determinants of health, but that health benefits would flow by other sectors taking a lead role. This approach also serves to “de-healthify” the rhetoric of health promotion, and allow other sectors to find a point of connection. As will be seen from two selected case studies, Healthy Cities initiatives world-wide have been more or less successful in achieving this broad-based approach in which ‘healthist’ messages and ideology were subdued and
subtle, and thus more engaging and less confronting to non-health stakeholders.

3.4 Healthy Cities: Case studies

Two case studies have been chosen for their regional approach and ease of comparison with the G21 region. These are Healthy Cities Illawarra, and the Vision 2020 initiative in Plumas County, California.

3.4.1 Healthy Cities Illawarra

According to its Mission Statement, Healthy Cities Illawarra (HCI) exists to promote and support “actions to establish a social, economic and physical environment that is conducive to good health. We share in the development of local policy to effect change. In our work the needs of disadvantaged people are especially recognised.” (Healthy Cities Illawarra, 2006, p. 2).

HCI publications state that it is committed to take action to improve the health of the people of the Illawarra by: working together co-operatively; supporting community action; developing personal skills and worth; ensuring effective health advocacy; protecting and enhancing the physical environment; recognising the right of the individual to work and contribute (Healthy Cities Illawarra, 2006, p. 1). Stated values include: diversity of people; biodiversity; every individual’s right and responsibility to participate in creating better health in their community; every individual’s equal right to his or her optimum level of health; co-operative relationships that create positive change; partnerships with indigenous Australians towards achieving health and reconciliation (p. 2).

Healthy Cities Illawarra was established as a pilot initiative in 1987, initially funded by the Federal government along with Noarlunga and Canberra. These three Australian initiatives were officially endorsed by WHO during the start-up phase of the international Healthy Cities strategy. In 1988, funding was provided by the NSW Health Department to appoint a full time manager, secretarial support and provide some operating budget. This funding was an enhancement to the Illawarra Area Health Service budget and was administered by them through the area Health Promotion budget. In 1998, Healthy Cities moved onto a three yearly funding cycle, however this is reviewed on an annual basis (Healthy Cities Illawarra, 1997).

In 1990, the NSW Minister for Health attended the first national Healthy Cities conference and committed further funding to Healthy Cities through the non-government organisation funding initiative. Healthy Cities Illawarra became an incorporated body in 1990 managed by an intersectoral management group comprising three local government authorities, Illawarra Area Health Service, University of Wollongong, Department of Education, Catholic Education Office, and community representatives. In 1997 the Council of Reference was disbanded and replaced with a membership base of individuals and organisations. Today Healthy Cities Illawarra is a non-government, community-based organisation operating from offices in Wollongong and Nowra (Healthy Cities Illawarra, 1997).

The organisational chart shown in Figure 8 below identifies a management committee made up of two state government departments, four local governments, a local university and a range of NGOs. The education sector plays an important role in the governance of HCI. A reference group has also been established in a neighbouring shire.
Four initiative areas were identified in this organisational chart: community development, children’s health, sexual health and HIV/AIDS, and environmental health. Early strategic priorities included: health promotion and education in nutrition and food security; tobacco control; child drowning prevention; child restraints; encouraging physical activity; sexual health and HIV/AIDS prevention; men, aged, indigenous populations; driveway and road safety; environmental health activities including submissions to planning processes; advocacy; marine care; urban planning and active/sustainable transport.

A wide range of groups were convened and resourced by Healthy Cities Illawarra, as shown in Figure 9 below.

<table>
<thead>
<tr>
<th>Area Assistance Scheme – Men’s Initiative Steering Committee</th>
<th>Aged Taskforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged Taskforce - Oral Health Stakeholder Group</td>
<td>Aged Taskforce - Photographic Library Working Party</td>
</tr>
<tr>
<td>Aged Taskforce - Seniors &amp; Banking Working Group</td>
<td>Bay and Basin Youth - Health and Wellbeing Working Party</td>
</tr>
<tr>
<td>Bay and Basin Youth - Hubb Initiative Committee</td>
<td>Bay and Basin - Fun and Fitness Health Promotion Initiative</td>
</tr>
<tr>
<td>‘Can Do Koonawarra’ Initiative Interagency</td>
<td>Child Injury Prevention Taskforce</td>
</tr>
<tr>
<td>Food Fairness Networking, Funding and Partnerships Working Party</td>
<td>Food Fairness Coordination Working Party</td>
</tr>
<tr>
<td>Illawarra Enviro-Challenge Working Party</td>
<td>Illawarra Active Transport Taskforce</td>
</tr>
<tr>
<td>Sexual Health Service Providers Network</td>
<td>Shoalhaven Healthy Cities Reference Group</td>
</tr>
<tr>
<td>Shoalhaven Men’s Sheds working group</td>
<td>Shoalhaven Safety Week Working Party</td>
</tr>
<tr>
<td>World Environment Day Working Party</td>
<td>World AIDS Day Organising Committee</td>
</tr>
</tbody>
</table>
In working towards achieving its mission, HCI has also collaborated with a wide range of agencies, as depicted in Figure 10 below.

<table>
<thead>
<tr>
<th>Agency Name</th>
<th>Collaborated With</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Eastern Sydney and Illawarra Area Health Service</td>
<td>NSW Health Department, Environment Protection Authority (EPA)</td>
</tr>
<tr>
<td>Dept. of Fisheries</td>
<td>Wollongong, Shellharbour, Kiama, Shoalhaven Councils</td>
</tr>
<tr>
<td>Southern Councils Group (SCG)</td>
<td>Division of General Practitioners</td>
</tr>
<tr>
<td>National Heart Foundation</td>
<td>NSW Cancer Council</td>
</tr>
<tr>
<td>Futureworld</td>
<td>Illawarra Forum</td>
</tr>
<tr>
<td>Illawarra Residents Against Toxic Environments</td>
<td>Bluescope Steel</td>
</tr>
<tr>
<td>Bellambi, Berkeley, Warilla North, Koonawarra, Dapto &amp; Sanctuary Point Neighbourhood Centres</td>
<td>AIDS Council of NSW (ACON)</td>
</tr>
<tr>
<td>Meals on Wheels</td>
<td>NSW Red Cross</td>
</tr>
<tr>
<td>Aboriginal Medical Services</td>
<td>International Healthy Cities Alliance</td>
</tr>
<tr>
<td>Taipei City Government</td>
<td>World Health Organization -Western Pacific Region</td>
</tr>
<tr>
<td>Flinders University</td>
<td>Griffith University</td>
</tr>
<tr>
<td>University of Wollongong</td>
<td></td>
</tr>
</tbody>
</table>

The HCI Strategic Plan 2005-2008 identifies four principles from which the initiative works. These are: promoting health equity, empowerment, building capacity and being proactive (HCI, 2005). This strategic plan also identified significant shifts in its operating environment, including major state government restructuring and a retreat from funding ‘upstream’ initiatives; a decline in funding overall; and funding models that have become increasingly short term initiatives- as opposed to longer-term strategies. As a result, HCI elected to focus its energies, “and reflects our efforts to work more intensively on fewer issues to avoid spreading our resources too thinly” (p. 4). Three interconnected action areas are identified in the Strategic Plan: Healthy People; Healthy Place and Healthy Cities. These are summarised in Figure 11 below. This strategic plan would appear to represent a significant maturation of HCI from a complete reliance on short-term, compartmentalised ‘project’ orientation of the initial organisational chart shown in Figure 8, to a more strategic brokering, advocacy and catalysing role.
<table>
<thead>
<tr>
<th>Action Area</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy People</td>
<td><strong>We will develop and conduct initiatives, create partnerships and have input into social policy which is aimed at improving opportunities for better health and well being for those demographic, geographic and cultural communities which suffer the worst health.</strong></td>
</tr>
</tbody>
</table>

1. Use place based approaches to enhance, strengthen and support local initiatives in communities with particular health needs.

   a) Engage communities in processes which will identify local health issues and establish initiatives to address these needs.
   
   b) Support, provide referral and advocate for people and local groups which have specific health needs.
   
   c) Identify and pursue opportunities to attract resources for local health and social initiatives.
   
   d) Support and foster initiatives which enhance and develop the cultural and spiritual identity of local communities.

2. Enhance the capacity of local communities to address their health issues.

   a) Support and assist community groups and member organisations to resolve their health issues.
   
   b) Build local capacity to resolve health issues through skill building, mentoring and development of partnerships.
   
   c) Support unincorporated organisations or community groups in planning and conducting relevant community health initiatives.
   
   d) Strengthen community connections through the organisation and support of a recognition initiative.

3. Act to initiate, develop or have input into social and health policy which creates greater equity in health.

   a) Develop and strengthen partnerships with government and business to develop policies and plans which recognise and integrate Healthy Cities principles.
   
   b) Contribute to regional planning and development for emerging high priority public health issues.

4. Provide an independent forum for the development of cooperative approaches to regional health issues.

   a) Continue to develop productive partnerships with government, non-government and community organisations on innovative community based, social health initiatives.
   
   b) Continue regional efforts to promote the safety, health and well being of at risk population groups.
   
   c) Coordinate and support community development and education initiatives aimed at reducing the transmission of sexually transmitted infections including HIV/AIDS.
   
   d) Continue to support and assist regional efforts to focus on the underlying causes of ill health as they relate to specific health issues such as tobacco control, nutrition and physical activity.
<table>
<thead>
<tr>
<th>Action Area</th>
<th>Goals</th>
</tr>
</thead>
</table>
| Healthy Place    | **1. Advocate for an environment that is ecologically sustainable and conducive to good health.**  
                           a) Support the community through advocacy, submissions and public comment to ensure that the highest environmental health standards and ecologically sustainable development principles (ESD) are consistently applied in urban planning.  
                           b) Represent and promote the health perspective on relevant committees and forums.  
                           c) Support and assist government and business in developing plans, policies and regulations which integrate ESD and Healthy Cities principles.  |
|                  | **2. Initiate, develop and support community based environmental health initiatives.**  
                           a) Support community initiatives, campaigns and initiatives which aim to improve environmental outcomes in local areas.  
                           b) Coordinate and deliver initiatives for the community on environmental health issues.  
                           c) Conduct and/or coordinate action research on priority environmental health issues.  
                           d) Identify and pursue opportunities to attract resources for local environmental initiatives.  |
| Healthy Cities   | **1. Enhance the capacity of other organisations and individuals to understand and apply Healthy Cities principles.**  
                           a) Develop Healthy Cities expertise locally, nationally and internationally by providing training, information, advice and assistance.  
                           b) Continue to support the development of Healthy Cities in the Western Pacific Region by participating in the Healthy Cities Alliance and relevant WHO forums.  
                           c) Strengthen public awareness of the philosophy and purpose of Healthy Cities Illawarra.  |
|                  | **2. Continuously monitor and improve the way in which we conduct our work.**  
                           a) Regularly review and evaluate our initiatives to ensure high quality.  
                           b) Plan and apply action research principles in our initiatives to evaluate outcomes.  
                           c) Undertake a quality review and act upon the recommendations.  
                           d) Build capacity of staff through training and opportunities to participate in professional development.  
                           e) Seek and develop initiatives which effectively utilise the combined expertise of the Healthy Cities team.  |

*Figure 11. Healthy Cities Illawarra Strategic Priorities 2005-2008*
With a geographical and demographic profile that in many ways complements that of G21, HCI offers many comparisons. The most instructive insight of the HCI initiative has been its evolution from a very health-centric orientation to that of an more strategic broker and enabler of partnering organisations. In many ways, the evolution of HCI to this organisational role now reflects more the current role of G21 in working to support, guide and catalyse the thinking and actions of its five partnering local government constituents and allied organisations.

### 3.4.2.1 Healthy Cities Illawarra: Lessons for G21 Region.

**The need to work strategically**

A significant lesson for G21 is the way that HCI has refocused from a dependency on project-based funding (the tyranny of ‘projectism’, see De Leeuw, 2001), to a more catalytic role in the region that embraces forging strategic alliances, helping to shape public discourse and decision-making, and engaging in systems advocacy. HCI’s Strategic Plan 2005-2008 warned of the dangers inherent in relying increasingly on opportunistic funding:

> Accessing grants and consultancies has implications for the way we work. Our work will become more project based rather than longer term ‘process’ driven. Staff will spend a greater proportion of their time involved in identifying, applying for, negotiating and reporting for grants and consultancies. The overall impact of this funding environment is that HCI must wisely invest its time in the areas where it can leverage the resources we are investing. This means forging and capitalising on productive partnerships and withdrawing from projects or relationships which are not proving productive. (HCI, 2005, p. 4).

In order to ensure that its work fulfilled the broad, intersectoral, upstream remit of the healthy cities approach, a ‘project screening tool’ was developed to be applied to prospective projects and opportunities. This approach could be used profitably by G21.

**The need to engage meaningfully with stakeholders outside the ‘health’ sector**

Given that most of the factors that impact on people’s health occur outside the health sector (Wilkinson & Marmot, 2003), it is incumbent of people working in health promotion to engage with stakeholders outside the health sector, in ways that they can understand and to which they can relate. HCI’s continued focus on the word ‘health’ may actually work to its detriment. For example, research conducted by Butterworth, Palermo and Prosser (2005) on Melbourne’s urban planning framework, *Melbourne 2030*, indicated that many stakeholders outside the health sector are quickly alienated by health-centric rhetoric – even though their work might be impacting directly on ‘health’ and wellbeing in its broadest sense. A truly strategic Healthy Cities approach committing to engaging stakeholders outside the health sector could well need to reduce or remove the number of references to health and wellbeing, and present its work in the language of its potential allies – for example framing priorities using the economic terminology favoured by private developers.

**The value of a place-based approach**
By adopting a place-based approach, HCI has attempted to address (i) the geographical variation of health inequalities (Butterworth, 2000, DHS, 2001); and (ii) the often fragmented and uncoordinated efforts of multiple stakeholders whose work impacts on the same territory and frequently engages the same stakeholders and communities. Consideration of social justice issues is enabled through a place-based approach: if resources are seen to be scarce and needing to be rationalised, then place-based approaches can identify the geographical areas least served by social and political institutions, least enabled and supported to participate in civic decision-making, and most vulnerable to poor physical and social health outcomes. Embracing a place-based approach also can build on local community capacity and identity by bringing all stakeholders together to harness existing social capital and make better – coordinated- use of existing resources.

The Department of Human Services (BSWR) has increasingly been embracing a place-based approach when formulating its regional objectives and strategies. The Department for Victorian Communities (now DPCD) also has utilised place-based approaches in its regional development strategies. A G21 Healthy Region approach thus could capitalise on – and catalyse - this state-level activity.

**The need for an organisational structure and function that embraces strategic approach and ‘de-healthifies’ the health promotion agenda of healthy cities**

Whilst HCI’s 2005-2005 Strategic Plan is definitely quite ‘upstream’ in its focus on place-based approached to healthy people and healthy environments, its organisational structure (see Figure 7), appears to present a fairly traditional approach to project-based strategies with health-centric themes (community development, children’s health, sexual health and HIV/AIDS, and environmental health.) It is considered likely that this approach could alienate people from outside the health sector who most need to be engaged in intersectoral collaboration. Likewise, the management committee, whilst definitely intersectoral, does not include any representation from business, industry or developers. It is considered incumbent upon visionary Healthy Cities advocates to forge these collaborative alliances with sectors traditionally considered outside the realm of health promotion, or even possibly hostile to it. Early adopters in these sectors do indeed exist, and are quite possibly looking for opportunities to engage in corporate philanthropy. It would be advantageous for G21 to regard the formation of these alliances as essential to promoting health and wellbeing and fulfilling the healthy cities theoretical framework.

An example of a region-wide Healthy-Cities initiative that de-emphasised its reliance on health-related thinking and embraced a broad range of goals more consistent with G21’s Strategic Priorities can be found below in the case study of Plumas County’s Vision 2020 initiative.

**3.4.2 Plumas County, California**

Plumas County is a fairly remote, sparsely populated and impoverished rural county in the Sierra Nevada mountains in Northern California, not far from the Oregon and Nevada borders. The county has perhaps 25,000 residents, and has struggled with a loss of logging-related employment, a high youth unemployment, and hidden burden of domestic violence (County of Plumas, 2003a). The Vision 2020 initiative, based at the city of Quincy, is one of 20 Californian Healthy Cities and Communities initiatives funded between 1998 and
Vision 2020 was a community-based initiative involving Plumas County citizens in a grass-roots effort to form a vision of what Plumas County could be in the year 2020, and a framework for achieving this desired future. The project was designed to develop a clear vision, a series of goals, expectations and actions which decision-makers, community groups and individuals can follow, and use to measure success and results (County of Plumas 2003b). The goals included:

- Establish a regional vision and direction for Plumas County
- Involve citizens of all walks of life throughout Plumas County to establish agreed upon priorities for the county
- Develop strategic actions which will address many aspects of life in Plumas County
- Unite citizens throughout the region to openly discuss problems as opportunities for change
- Create a structure to support the implementation of the work plans
- Establish a series of benchmarks for measuring the results and the health of the county and publicize these results through an annual report.

Vision 2020 addressed many aspects of quality of life including arts, culture and heritage; business, economy and tourism; communications and technology, community organization; community safety; education; environment; government; health; housing; infrastructure and transportation; natural resources; recreation and open space; and youth. These goals were developed by community members during extensive consultation and engagement. Community members worked together to identify how to move the county towards achieving their vision.

Detailed results from 30 community meetings and more than 1000 returned surveys were reviewed and discussed by the project partners. Seven topic areas were identified based on those results: (i) Arts, Culture and Heritage; (ii) Business, Economy and Tourism; (iii) Communication and Technology; (iv) Health and Safety; (v) Land Use; (vi) Recreation; and (vii) Youth. Work groups were formed to focus on each topic, using the data report and input from the meetings and surveys. In each topic area, a goal was identified that reflected the wishes, concerns and ideas of those who attended the community meetings and completed surveys. The goals were identified as follows:

- To preserve and promote a rich environment of arts, culture and heritage in Plumas County into the 21st century
- To create and retain jobs, and reinvest wealth through our economy, community and natural resources
- To increase the communications and technology capability of Plumas County to function successfully in the 21st century
- To promote a future for Plumas County citizens in which land use decisions balance social, economic, and natural resource health
- To improve the health and well-being of all Plumas County residents
- To provide a range of facilities, programs and activities for the health & enjoyment of residents and visitors
- To recognize the well-being of local youth as fundamental to the health of the community as a whole

1 During his time as Fulbright Visiting Scholar at the School of Public Health at UC Berkeley, Iain Butterworth spent several days in 2004 visiting Plumas County, Northern California. The Vision 2020 initiative, based at the city of Quincy, was one of 20 a Healthy Cities and Communities initiative contacted during his visit. Vision 2020 stakeholders extended an invitation for Iain to consult with them on matters relating to program evaluation and indicator development.
The aim was for topic groups to continue refining their objectives and create action plans specific to each strategy. It was intended that each community would have the opportunity to receive training and resources to seek further funding to implement projects identified as local priorities in the Vision 2020. The core committee was committed to reviewing the goals and objectives annually for progress, and had a responsibility to report annually to the Plumas County Board of Supervisors (elected officials for the whole county). It was intended that that progress would be tracked using a suite of 20 indicators developed during the project (County of Plumas, 2003b). Of particular interest was the fourth goal relating to land use, for which the indicator developed demonstrated an understanding of the link between the built environment, participation and quality of life (e.g., Perkins, Brown & Taylor, 1996):

*Participation by local residents in land-use decision-making increases perception that “quality of life” and “sense of belonging” by community members increases*

Vision 2020 received sustained support from local government, community organizations and residents of Plumas County. It was intended that all stakeholders would play a key role in implementing the vision. It was also intended that Vision 2020 would be updated annually, reflecting actions taken on key elements of the Vision, and incorporating topic areas not previously developed.

As part of his engagement with project stakeholders Iain Butterworth learned that the Project commenced in 1994; its funding was derived from variety of sources, including Healthy Cities and National Forests funding. Plumas County Health Services coordinated the program for some time. The community-driven Plumas Community Foundation accepted the responsibility for Vision 2020 from the Plumas County Health Dept. after funding from Healthy Cities and Counties expired. However, as is the case for many isolated rural districts, the Foundation is fairly new and also experienced difficulty in attracting a skilled worker to drive the process onwards. Plumas county had lost key staff due to relocation to more populated urban centres, and had encountered difficulty in attracting replacement staff with highly honed administrative and leadership skills. Many existing Vision 2020 core group members were already over-committed and fatigued, and there were concerns that the project was losing momentum. Community stakeholders were struggling with the logistical issues of determining who was going to deliver the Vision 2020 programs and collect the indicators, and how they would do this. Despite its inclusive long-term vision, limited support within the County office meant that personnel were struggling to provide sufficient ‘evidence’ of change in the quantitative format demanded, despite the fact that ample qualitative evidence existed about the overall benefit that the initiative had had on community capacity. Core group members wanted to prove to sceptical and even unsupportive stakeholders within the County that the Vision 2020 project was indeed viable. The consultancy was designed to assist core group members to reflect on progress, reformulate their approach for the short-term, and renew their determination to locate the financial and human resources needed to drive the program forward.

---

2The Plumas County Board of Supervisors is established by State law and consists of 5 elected members. Each member represents a geographic area in the County equal to approximately 20% of the population as determined in the last decennial census. Members of the Board of Supervisors are considered non-partisan and are elected for four year, staggered terms. See http://www.countyofplumas.com/board/index.htm
3.4.2.1 Plumas County: Lessons for G21

Lessons for G21 from this case study include the value of broad-based goals that address the social model of health in subtle ways; the need for sustained, high-level political endorsement (not guaranteed within Plumas County); and sufficient resources to ensure that enough skilled staff are employed to support core organisers.

The value of broad-based goals that address the social model of health

Plumas County’s Vision 2020 Goals, funded via a five-year Californian Healthy Cities and Communities grant, addressed seven broad topic areas in ways that could and did engage the whole community: (i) Arts, Culture and Heritage; (ii) Business, Economy and Tourism; (iii) Communication and Technology; (iv) Health and Safety; (v) Land Use; (vi) Recreation; and (vii) Youth. Whilst concern for health and wellbeing formed the cornerstone of the entire initiative, it was understood that the broad vision for the region could promote health and wellbeing in subtle ways that engaged stakeholders from outside the health sector.

Plumas County’s goals can be seen to be quite similar to G21’s Pillar domains. G21 is already well-positioned rhetorically to embrace the approach taken by Plumas County’s Vision 2020 initiative.

The need for sustained, high-level political endorsement

Vision 2020 organisers were left vulnerable when the membership of the Plumas County Board of Governors changed, resulting in a new Board that was not so sympathetic to the Vision 2020 approach of developing indicators to address broad social determinants of health and wellbeing. Interested G21 stakeholders may need to examine the way that the G21 Board is presently composed, elected and trained for providing a continuity of effective governance.

The need for sufficient resources to employ skilled staff to drive a Healthy Region strategy

The Vision 2020 initiative was left vulnerable as a whole when key staff left their positions and could not be replaced quickly. Dedicated professionals and community members became fatigued and demoralised after several years of advocating and driving the process on top of their existing roles. For a G21 Healthy Region initiative to thrive, it must be funded adequately and sustainably to ensure that a skilled employee is appointed and remunerated appropriately to perform a high-level of entrepreneurial, coordinating and reporting activity. Given that systems change efforts can take time to reach critical mass (Hancock, 2006), funding needs to be secured for several years.

3.5 Monitoring and evaluation of Healthy Cities: Issues and Case Studies

The Ottawa Charter (WHO, 1986) and Healthy Cities initiatives call for nothing less than systems change across multiple levels of analysis and between multiple sectors. As a community empowerment strategy, fostering intersectoral collaboration is a long-term, labour-intensive, and transforming process achieved through many actions and ‘small wins’ (Kieffer, 1984, Perkins & Zimmerman 1995; Weick, 1984). One way to gain support for intersectoral
collaboration is to document evidence on how it can benefit communities. To have ecological validity, our monitoring and evaluation strategies need to attempt to reflect the complex reality of the social system by tracking the multiplicity of actions taken to enhance intersectoral collaboration, and the related ripple effect of change across and between levels of the social system (Rappaport, 1987; Reppucci, 1990).

Baum (2000) argued that the Healthy Cities approach has achieved significant progress in five domains: (i) promoting a holistic view of health across the built, social, natural and economic environmental domains subsequently used in Environments for Health (Hay, Frew & Butterworth, 2001). This has resulted in ecological approaches involving intersectoral decision-making and the achievement of healthy public policy; (ii) Encouraging integrated (inclusive) planning approaches; (iii) innovative models of community participation; (iv) utilizing effective leadership through training of key stakeholders (see Wolff, 2003); (v) developing an evidence base. Baum argued that whilst there have always been calls for Healthy Cities programs to be evaluated, the sheer complexity and long-term nature of the Healthy Cities approach renders evaluation similarly complex. Causality is difficult to determine when Healthy Cities is one of many influences on the overall quality of life of a city. However Baum argued that elements of Healthy Cities programs can be evaluated, for example individual projects, the process of establishing projects, and the policy making process.

3.5.1 Using community capacity as an evaluation framework

Community capacity, a community’s ability to mobilize, identify and solve community problems, is a major outcome of intersectoral collaboration, and relates to Healthy Cities principles as well as the Ottawa Charter. Building community capacity (including organisational capacity) is a key social determinant of health (Wilkinson & Marmot, 2003). In their evaluation of 20 Healthy Cities and Communities initiatives in California, Kegler, Norton and Aronson (2003) identified community capacity as including:

- measures of civic participation;
- mechanisms for community input and for the distribution of community power;
- skills and access to resources;
- sense of community and social capital/trust;
- social and inter-organizational networks;
- community values and history; and
- capacity for reflection and learning.

Changes in community capacity were assessed by Kegler et al. (2003) according to a range of criteria grouped across five levels: (i) changes in individuals; (ii) changes in civic participation; (iii) organizational development; (iv) inter-organizational activity; (v) community level changes (see Figure 12).
Kegler et al (2003) noted that at the individual level of analysis, the Healthy Cities and Communities process “has the potential to change people in significant ways – by expanding their views of health and enhancing skills they can apply to community improvement... helping community residents and leaders see health through a broader lens increases the likelihood of more systemic and effective community health improvement efforts that target meaningful community change“ (p. 43). Some community members noted that “a broad view of health conflicted with how a few key organizations and government agencies, usually those with a more traditional, service-delivery focus, viewed health” (p. 43). Communities participating in the Californian Healthy Cities and Communities initiative were required to have “both process and outcome evaluation methods in place to monitor progress” (Kegler et al, 2003, p. 39).

In order to map the impact of HC/C initiatives across the social spectrum, the researchers designed a detailed, multiple case study with cross-case comparisons. Data collection involved: review of program documents; participant surveys in year 1 and year 3; 165 in-depth interviews with coordinators, community leaders, sponsoring organization directors and HC?C staff, 26 focus groups in the nine communities selected as primary sites, analysis by ‘type of community’, based on population density, proximity to a large metro area, and its urban/rural character.

The evaluators worked with HC/C programs to develop both process and outcome evaluation methods to monitor progress. Common process measures included: attendance records, sign-in sheets, logbooks used to track participation, completion certificates, membership lists, copies of media coverage, press releases, program publicity materials, meeting minutes, meeting agendas, and memoranda of understanding. Common outcome measures included knowledge and skills in: leadership, vocational / life skills, community-building, project specific areas, learning, civic education, and sense of community.

Kegler et al’s (2003) evaluation identified sense of community as a community-level outcome of the HC/C initiatives. Participants from almost all communities felt that their local initiative had aimed to increase sense of community amongst area residents, and that their programs had helped to increase the cooperation and communication in the community and created a new gathering place and the opportunities it provided for diverse people to interact and form relationships. Other community-level outcomes included changes in civic...
activity and changes to the physical environment. The evaluation identified that the second round of Californian Healthy Cities and Communities programs had created over 1,100 new civic leadership roles, with 1500 people acting in these roles over the grant period.

Many organizational changes were identified, including: a broadened definition of health; increased community input into decision-making; expanded and new forms of inter-organizational collaboration; adoption of shared HC/C vision; expanded or restructured programs/services aimed at increasing equity; administrative policy changes designed to enhance service delivery and equity. The evaluation identified that CH/C programs were able to leverage these kinds of changes in other organizations, including private organizations, non-profit, county government, city government, schools, and so on. Most HC/C reported at least one public (government) policy change arising from their efforts. Seven communities identified policy change as explicit goal area, yet only two of the 20 communities (both rural) had made public policy change the central focus of their activities.

The evaluators used Putnam’s definition of social capital: “the features of social life—networks, norms, and trust—that enable participants to act together more effectively to pursue shared objectives” (Kegler et al, 2003, p4). The evaluation survey indicated that trust was strengthened among people who were directly involved in the local initiatives. However, the evaluators noted that there was little confidence that the HC/C initiatives has helped build trust across the community. No significant changes were observed in social capital as it had been defined and measured in the survey. However, through the use of qualitative data, the evaluators showed firm evidence of increased perceptions of trust and community engagement.

Kegler et al (2003) concluded:

“Overall, the evaluation findings point to a central outcome: participation in the California Healthy Cities and Communities Program fostered development of increased community capacity. Specific aspects of capacity that appeared to flourish in the participating communities included leadership, mechanisms for civic participation, inter-organizational and social networks, skill-building in participants, and the ability to leverage resources. At the same time, local context partially governed the unique set of achievements and results for each and every participating community. This finding suggests that there is not a single path to community health. Programs, like California Healthy Cities and Communities, clearly provide tools that facilitate the unique journey of capacity-building and health improvement that each community takes” (p. xiii).

Because of its utility, Kegler et al’s (2003) community capacity framework has since been used effectively to evaluate the Victorian Environments for Health municipal public health planning policy framework (DHS, 2007). It is suggested that the community capacity framework would be well-served to monitor the progress and impacts of any G21 Healthy Region strategy. Indicators, currently under development across a number of domains in Victoria, could be used as some of the tools to assess the attainment of community capacity.

3.5.2 Indicators of health and wellbeing

The following section on indicators is intended to show where much effort has been expended since the advent of Healthy Cities. However, as demonstrated by Kegler et al (2003), having a sound conceptual framework is essential for
interpreting the results of sustained efforts to achieve holistic change. The following section will highlight the importance of linking indicators to an overarching theoretical framework for analysing and interpreting change.

The World Health Organization defines an indicator as ‘a variable with characteristics of quality, quantity and time used to measure, directly or indirectly, changes in a health and health-related situation and to appreciate the progress made in addressing it. It also provides a basis for developing adequate plans for improvement.’ (WHO, 2002, p5) Indicators can ... “act as a tool for health promotion by raising public awareness of what is going well and what is threatening a community’s well-being” To be useful, indicators must ensure interest, relevance, commitment, utility and policy application by key stakeholders (Innes & Booher, 1999). The importance of defining ‘health’ and ‘quality of life’ according to a community’s unique values has also been stressed (Conner, Easterling, Tanjasiri, & Adams-Berger, 2003).

The Baltimore Neighborhood Indicators Alliance has identified a range of factors that determine what makes a good indicator (Baltimore Neighborhood Indicators Alliance, 2006): these are presented in Figure 13 below.
2.5.2.1 Indicator Case Study – WHO Healthy Cities Indicators

Following the rapid proliferation of Healthy Cities initiatives across Europe, during the 1990s the WHO established a multi-city indicators project to gather baseline data on health-promoting ‘processes and actions’ across each Healthy Cities initiative. Distributed to 47 Healthy Cities programs across Europe, the initial survey was considered to have a “broad multisectoral focus” (p 289), the sheer scope of which made data collection very difficult (Doyle et al, 1999).
An initial set of 53 indicators was found to be too many, and involved a huge variation across cities in data gathering and interpretation. A revised indicator set was developed, which included several measures of the built environment (WHO, 1998, p2). Many of these indicators were already collected by urban planners. These are outlined in Category ‘C’ in Figure 14 below.

**A Health indicators**
A1 Mortality: all causes
A2 Cause of death
A3 Low Birth weight

**B Health service indicators**
B1 Existence of a city health education programme
B2 Percentage of children fully immunized
B3 Number of inhabitants per practicing primary health care practitioner
B4 Number of inhabitants per nurse
B5 Percentage of population covered by health insurance
B6 Availability of primary health care services in foreign languages
B7 Number of health related questions examined by the city council every year

**C Environmental indicators**
C1 Atmospheric pollution
C2 Water quality
C3 Percentage of water pollutants removed from total sewage produced
C4 Household waste collection quality index
C5 Household waste treatment quality index
C6 Relative surface area of green spaces in the city
C7 Public access to green space
C8 Derelict industrial sites
C9 Sport and leisure
C10 Pedestrian streets
C11 Cycling in city
C12 Public transport
C13 Public transport network cover
C14 Living space

**D Socio economic indicators**
D1 Percentage of population living in substandard accommodation
D2 Estimated number of homeless people
D3 Unemployment rate
D4 Percentage of people earning less than the mean per capita income
D5 Percentage of child care places for pre-school children
D6 Percentage of all live births to mothers > 20; 20-34; 35+
D7 Abortion rate in relation to total number of live births
D8 Percentage of disabled persons employed

**Figure 14. Revised Baseline Healthy Cities Indicators, WHO (1998)**

Investigators Doyle and colleagues concluded that “barriers to uniformity of reporting at the city level are as formidable as at the national level”... Information was not comparable across cities nor do we believe it should be used in this way” (Doyle et al., 1998, p298). The authors warned against ‘league tables’ of cities being developed for these indicators, most of which defied uniformity of comparison across cities. The investigators recommended that a smaller core of indicators be developed from the most useful of the initial 53, but that the focus remain broad. They also recommended that more work
be done on documenting local innovations in projects. Finally, it was argued that 'chief coordinators' be trained to ensure completion of all surveying tasks.

WHO proceeded to establish a Monitoring, Accountability, Reporting and Impact Assessment (MARI) reporting framework (De Leeuw, 2001). Despite “striv[ing] to empower cities in their own research and evaluation efforts” (p. 41), it would appear to have overwhelmed participating cities with bureaucratic requirements. Initial annual reports were eventually received from 25 out of 40 cities: many struggled with the human resources needed to complete the reports.

3.5.2.2 Indicator Case Study – Colorado ‘Operation Healthy Communities’

In the Colorado Community Indicators Project, a Healthy Community was defined as “a place in which residents are healthy (physically, emotionally, mentally, spiritually) and where the various systems that define community life (economic, environmental, cultural, political and social) are operating to support local residents” (Conner, et al., 2003, p. 48). Fifteen communities received funding to identify and develop locally relevant indicators. The task of each community was to define ‘health’ and ‘quality of life’ according to their unique values. "This approach was based on the assumption that only through an in-depth, locally driven process of indicators selection would the measurement task become valid and meaningful, and, thus, have any substantive impact on local decision making” (p. 47). One of the 15 projects was titled ‘Operation Healthy Communities’. This community began their indicator development process by establishing a community vision statement that outlined that community's values regarding quality of life:

"We envision strong, cohesive communities where involved citizens of all ethnic backgrounds work together to preserve our small-town, rural lifestyle, promote stewardship of the land, preserve open space, and value clean air. We envision communities where people have a high regard for their neighbours, have a strong sense of place and attachment to the land, and have a commitment to sustaining a community-oriented way of life. We envision communities that establish an open dialogue between leaders and citizens and where volunteerism is highly valued. Our communities provide ample opportunities to share cultural heritage, enjoy the arts, and participate in a variety of recreational and cultural events” (cited in Conner et al, 2003, p. 63)

The community indicators project team embarked on an exhaustive process that whittled down 125 indicators to about 99. The Project group reviewed Visioning documentation produced locally during the last five years, and arrived at four broad categories: (i) Human services; (ii) Quality of life (Environment, Cultural heritage, Community, Recreation, Recycling); (iii) Economy-transportation-communication; and (iv) Family life.

The Project group then identified four dimensions that underlie Quality of Life values, and derived several supporting measures:

1. Strong cohesive communities
   a. Involved citizens (The number of registered voters participating in off-year election)
b. Open dialogue between citizens and government (The number of times in the preceding year that the respondent had attended a meeting on a community issue)

c. Strong neighbourhoods
  • ‘Do you feel safe walking in your neighborhood at night?’ Y/N
  • ‘Do you feel comfortable giving something to or asking something from a neighbour?’ Y/N

2. Recreation
3. Healthy environment
4. Cultural heritage

3.5.2.3 Indicator Case Study - Watch Out for Health Checklist

The ‘Watch Out For Health - Planning Checklist’, developed by the British National Health Service’s Healthy Urban Design Unit for use in the London Plan, offers an excellent example of how an understanding of and commitment to the social determinants of health can be developed into a checklist to guide the thinking and decision-making of planners and developers before any development is signed off (HUDU, 2006). The Checklist is shown in Figure 15 below.

<table>
<thead>
<tr>
<th>WATCH OUT FOR HEALTH – A GUIDE TO HEALTHY SUSTAINABLE COMMUNITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Housing Quality – Do planning policies and proposals encourage and promote housing quality? Lifetime homes standards. Adaptability and flexibility. Are homes well designed and oriented; have the highest energy efficiency rating; and constructed from environmentally friendly materials as locally sourced as possible? Tenure mix. Affordability.</td>
</tr>
<tr>
<td>✓ Access to Work – Do planning policies and proposals encourage and promote access to employment and training opportunities? Does the development or policy promote diversity in jobs for local residents; and provide opportunities for business?</td>
</tr>
<tr>
<td>✓ Accessibility – Do planning policies and proposals encourage and promote accessibility? Encourage mobility. Public transport. Reduce car dependency. Minimise the need to travel. Is the community served by frequent, reliable, cheap public transport? Are the streets pedestrian-friendly and cycle-friendly?</td>
</tr>
<tr>
<td>✓ Food Access – Do planning policies and proposals encourage and promote access to wholesome locally produced food? Address food deserts. Does the development or plan allow for allotments, city farms or healthy living centers, safeguard good agricultural land from development, and avoid centralisation of shopping and provision of large supermarkets?</td>
</tr>
<tr>
<td>✓ Air Quality and Neighbourhood Amenity – Do planning policies and proposals encourage and promote air quality and an attractive environment? Good urban design. High quality public spaces. Minimise air and noise pollution and conserve existing quality townscapes.</td>
</tr>
<tr>
<td>✓ Social Cohesion and Social Capital – Do planning policies and proposals encourage and promote social cohesion and social capital? Opportunities for social interaction, leisure activities and local empowerment. Avoid community severance by major roads or large commercial schemes. Are existing health inequalities likely to be reduced?</td>
</tr>
<tr>
<td>✓ Public Services – Do planning policies and proposals encourage and promote access to good public services? The right services in the right place. Sustainable design and construction in public buildings. Are community facilities provided and is community involvement encouraged?</td>
</tr>
<tr>
<td>✓ Resource Minimisation – Do planning policies and proposals encourage waste reduction, minimise energy and water use, minimise use of non-renewable resources, promote recycling and waste reduction, promote sustainable urban drainage, minimise land contamination?</td>
</tr>
<tr>
<td>✓ Climate Change – Do planning policies and proposals encourage and promote climate stability and minimisation of greenhouse gases? Does the plan or development reduce energy use in buildings and transport?</td>
</tr>
</tbody>
</table>

Figure 15. Watch Out for Health Checklist - Healthy Urban Design Unit (HUDU, 2006)
3.5.2.4 Indicator Case Study - Victorian Community Indicators Project

The Victorian Community Indicators Project (VCIP) was to establish an agreed framework and sustainable process for the development and use of community wellbeing indicators at the local government level across Victoria. The VCIP, which was funded by VicHealth with support from the Department of Human Services, was implemented from January 2005 to July 2006 (Community Indicators Victoria, 2007).

VCIP identified that the particular importance of local community wellbeing indicators lies in their capacity to be:

- A democratic tool for engaging citizens and communities in informed discussions about shared goals and priorities.
- A policy tool, guiding evidence-based planning and action to address the issues identified as important by communities.
- A reporting tool, tracking and communicating progress towards agreed goals and outcomes (VCIP, 2006).

VCIP recommended that an integrated, sustainable system of local community wellbeing indicators be established in Victoria as a key tool for improving citizen engagement, community planning and evidence-based policymaking by local and state governments. VCIP recommended that a new independent organisation to be known as Community Indicators Victoria (CIV) be established to support local governments and communities identify local wellbeing indicators; collect, disseminate and analyse indicator trend data; and improve capacity to use indicators for citizen engagement, community planning and policymaking.

The indicator framework developed through the VCIP identifies an initial suite of core indicators organised into five broad domains:

- healthy, safe and inclusive communities
- dynamic, resilient local economies
- sustainable built and natural environments
- culturally rich and vibrant communities
- democratic and engaged communities.

VCIP identified an exhaustive range of initial indicators and data sources to be used in preparing 2006–2007 Victorian local community wellbeing reports (VCIP, 2006). A summary of social and urban environmental measures of interest to VicUrban are included below.

**Domain: Healthy, safe and inclusive communities (VCIP, 2006, p41)**

A vibrant, resilient and sustainable community recognises the efforts of its volunteers and seeks equality for its citizens. Its members are physically and mentally healthy, have a sense of wellbeing, are connected to others and have access to a range of services. It is a community that nurtures its children and young people and embraces learning. Attributes such as meaningful work – be it paid or unpaid – or spending more time with the family are important to such a society. The social dimension reinforces the desire to have a society built on mutual respect, self-restraint and generosity of spirit, one that creates opportunities for people to participate in community life and self-realisation.

Indicators in this domain will provide important information for council policies and plans, including: Public Health Plans, Safety Plans, Neighbourhood Action Plans, Social Policy and Planning, Best Start, Aged Care, Community Services and Urban Design.
It is recognised that we are dependent on the natural world to sustain our lives. The natural world provides clean air and water; detoxifies pollutants, and provides raw materials for building, transport and food production. Landscapes, plants and animals have intrinsic value and enrich our lives by providing experiences and recreational opportunities. In urban settings, parks and gardens contribute to people’s sense of wellbeing. A community that values the environment minimises its impacts, uses resources wisely, and protects biodiversity. Renewable energy is used to power our lifestyles and industry, combined with reliable public transport networks and bicycle and walking paths, which reduce reliance on the car, minimising greenhouse gas emissions. New houses are built to incorporate sustainable design features and older houses are retrofitted to maximise efficiency. Waste is minimised, and waste and water recycled with the overall aim of reducing our ecological footprint to allow sustainable living.

Indicators in this domain will provide important information for council policies and plans, including: an MSS, Environmental Policy, Transport, Economic

---

**Figure 16. VCIP Domain: Healthy, safe and inclusive communities**

**Domain: Sustainable built and natural environments (VCIP, 2006, p43)**

<table>
<thead>
<tr>
<th>Policy areas</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal health and wellbeing</td>
<td>Physical activity (adequate exercise to derive health benefits)</td>
</tr>
<tr>
<td></td>
<td>Obesity (Body Mass Index from self-assessed weight and height)</td>
</tr>
<tr>
<td></td>
<td>Self-assessed health</td>
</tr>
<tr>
<td></td>
<td>Percentage of people who rate quality of life as adequate or better</td>
</tr>
<tr>
<td></td>
<td>Nutrition (fruit and vegetable consumption)</td>
</tr>
<tr>
<td></td>
<td>Illness and deaths from smoking, alcoholism and illicit drug use</td>
</tr>
<tr>
<td></td>
<td>Mental health (incidence of mental illness)</td>
</tr>
<tr>
<td></td>
<td>Life expectancy</td>
</tr>
<tr>
<td>Community connectedness</td>
<td>Percentage of people who like living in their local community</td>
</tr>
<tr>
<td></td>
<td>Percentage of people who can get help from friends, family or neighbours</td>
</tr>
<tr>
<td></td>
<td>Percentage of people who could raise $2000 in an emergency</td>
</tr>
<tr>
<td></td>
<td>Volunteer rates</td>
</tr>
<tr>
<td></td>
<td>Percentage of parents with school age children that are involved in</td>
</tr>
<tr>
<td></td>
<td>activities at their school</td>
</tr>
<tr>
<td>Early childhood development</td>
<td>Australian Early Development Index</td>
</tr>
<tr>
<td></td>
<td>Percentage of key child health assessments completed up to three years of</td>
</tr>
<tr>
<td></td>
<td>age</td>
</tr>
<tr>
<td></td>
<td>Breastfeeding rates</td>
</tr>
<tr>
<td></td>
<td>Percentage of eligible infant immunisations completed</td>
</tr>
<tr>
<td>Personal and community safety</td>
<td>Perceptions of safety (at home, in the street, on public transport, day</td>
</tr>
<tr>
<td></td>
<td>and night)</td>
</tr>
<tr>
<td></td>
<td>Incidence of crime (crimes against the person and property)</td>
</tr>
<tr>
<td></td>
<td>Incidence of family violence</td>
</tr>
<tr>
<td></td>
<td>Road accident death and injuries (per 100,000 residents)</td>
</tr>
<tr>
<td></td>
<td>Work-related deaths, injuries and illnesses</td>
</tr>
<tr>
<td>Lifelong learning</td>
<td>Primary school literacy and numeracy rates (permission needed)</td>
</tr>
<tr>
<td></td>
<td>Home internet access</td>
</tr>
<tr>
<td></td>
<td>Library usage</td>
</tr>
<tr>
<td></td>
<td>Apprenticeships and vocational training enrolments</td>
</tr>
<tr>
<td></td>
<td>Destination of school leavers (pathways after Year 12)</td>
</tr>
<tr>
<td></td>
<td>School retention rates</td>
</tr>
<tr>
<td>Service availability</td>
<td>Access to services</td>
</tr>
<tr>
<td></td>
<td>Extent to which residents feel that they can access services when</td>
</tr>
<tr>
<td></td>
<td>needed (parents of young children, young people, older people,</td>
</tr>
<tr>
<td></td>
<td>people with a disability)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Policy areas</th>
<th>Progress measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to open space</td>
<td>Percentage of people living within 3 km of public open space (metro only) \ Satisfaction with accessibility and appearance of public areas</td>
</tr>
<tr>
<td>Transport accessibility</td>
<td>Percentage of the community who say lack of transport significantly limits capacity to achieve key work and/or life goals \ Public transport patronage \ Percentage of community who perceive that they have practical non-car transport opportunities \ Rating for local roads and footpaths \ Kilometres of dedicated walking and cycling trails</td>
</tr>
<tr>
<td>Energy use</td>
<td>Greenhouse gas emissions (from gas, electricity, fuel and landfill processes) \ Household energy use \ Renewable energy use, total non-renewable energy use and per GDP</td>
</tr>
<tr>
<td>Housing affordability</td>
<td>Housing affordability (housing rental, prices as percent of income)</td>
</tr>
<tr>
<td>Air quality</td>
<td>Number of days when pollution concentration exceeds NEPM guidelines</td>
</tr>
<tr>
<td>Water quality</td>
<td>Water consumption per capita and per sector \ Waste water recycling \ Condition of natural streams and waterways</td>
</tr>
<tr>
<td>Biodiversity</td>
<td>Native vegetation cover of habitat hectares (Ha or km²) tied with rates of carbon sequestration \ Weeds and pests (further work required)</td>
</tr>
<tr>
<td>Waste management</td>
<td>Total waste generation per household \ Waste recycling per household</td>
</tr>
</tbody>
</table>

Figure 17. VCIP Domain: Sustainable built and natural environments

3.5.3 Comments on Victorian Community Indicators Project

Clearly, the work of the Victorian Community Indicators Project has potential to resource and support the work of G21. At a meeting held on 31 October 2007 with senior personnel from Community Indicators Victoria, an opportunity was identified for CIV to engage with key stakeholders in the G21 region to track the efforts and impacts of a health region approach. Several indicator databases remain to go ‘live’ with the relevant data sources identified and accessed. However, it could be advantageous for CIV to engage with a G21 Healthy Region initiative in order to obtain the resources and develop the capacity necessary to monitor systematically a Healthy Region approach. G21 potentially could serve as a state-wide test-site for CIV.

3.5.4 Reflections on Indicators

The Colorado Community Indicators Project team observed that before people are willing to act on the data collected, they need to answer questions such as: (i) Which indicators are the most vital for us to focus on?; (ii) Why are these indicators going up / down?; (iii) Where should this community be on each of these indicators?; (iv) What actions could we take to move these indicators in the right direction? (Conner et al., 2003, p74). Conner et al noted that: “None of these questions has an absolute answer; they all hinge on a community’s underlying values, current realities, and opportunities” (p74). Indicator
development, collection and dissemination can help encourage deep community reflection and action, as will be discussed below.

Reflecting on several decades of working in the indicator field, Innes and Booher (1999) argued that indicator projects often focus on developing the numbers instead of considering how they will be used. Producing the report is often made a priority, as opposed to considering how the report may be used, or how the community can learn from the process of developing indicators in the first place. It is the joint learning that can occur among stakeholders, and the changes in practices that can occur, that is considered more important than the indicators themselves. However what is learned and how practices may change depends on the way information is developed and who is involved. If it is collaborative and iterative, then the indicators can become part of the players’ meaning systems. “They act on the indicators because the ideas the indicators represent have become second nature to them and art of what they take for granted” (p7).

**Indicators - Lessons from experience**

- Huge sets of all-purpose indicators are enormously expensive and their collection may never be repeated, thus limiting their use in terms of gathering information about trends.
- Aggregated measures (eg GDP) make specific assumptions and value judgments about what is considered important in society.
- Indicators should not be used to judge the efficacy of a particular policy because of “the impossibility of holding the context constant so that changes can be associated with the measure”
- Indicators do not drive policy – conversion requires more than reading a report!
- Indicators can be influential if they measure something that has public value
- Indicators’ main influence is not after they are published, but while they are being developed. “Agreement on indicators helps get agreement on policy” (p. 10).
- Indicators influence most through collaborative learning process, when they help influence stakeholders’ thinking and ordinary decision making.
- It matters how indicators are produced. Stakeholders and other users must be meaningfully involved
- If an indicator is to be useful, it must be linked to policy or set of potential actions
- “For indicators to be used, there must be not just opportunity, but a requirement to report and publicly discuss the indicators in conjunction with policy decisions that must be made” (p. 10).
- Development of an influential indicator may take time. It may take between 5-10 years for an indicator that has been developed collaboratively to be linked to policy and then begin to make a difference.

Figure 18. Indicators – Lessons from Experience (Innes & Booher, 1999)

Innes and Booher noted that the lack of sustainability in many cities – sprawl decaying infrastructure, overcrowding, comes from participants making unilateral decisions with no sense of the ‘big picture’ or even of the immediate impacts of their own decisions and actions on their own wellbeing. They recommended three types of indicators for use in a complex, adaptive urban system, comprising:
• System performance indicators – need to have a few carefully designed, high-profile indicators that give feedback on the overall health and wellbeing of a community or region, to help frame public discussion;
• Policy and program measures to provide policy makers with feedback about the operation of specific programs and policies;
• Rapid feedback indicators for individuals, agencies and businesses to help all people who are part of the city system – individual residents, commuters and businesses – make better decisions about their own actions, based on accurate and timely information.

Innes and Booher describe this three-level system as contributing to “distributed intelligence” – multiple levels of indicators to distribute coherent, integrated information to a broad cross section of the populace in such a way that people could all make decisions based on information that all pointed people in a creative, coordinated way towards sustainability. “Many individual participants, following simple rules for adjusting their actions without seeing or understanding the dynamics of the larger system, can deal with complex reality” (p12).

In terms of G21’s potential efforts to track progress towards achieving a Healthy Region, Innes and Booher’s taxonomy of indicators could be used to help identify where G21’s indicators might ‘sit’ in the overall suite of indicators under development or in use throughout Victoria and nationally. For example, it could be suggested that system performance indicators of health and wellbeing already exist through the work of the Australian Bureau of Statistics, the Victorian Department of Human Services’ ‘Burden of Disease’ research, and the partnership between DHS and DPCD to develop indicators of social capital at the LGA level. The Victorian Community Indicators Project may be working to extend the level of detail to include postcode and neighbourhood-level data, which could be the point of intersection with VicUrban developments.

In the absence of clear indicator data at the neighbourhood level, then the Watch Out for Health Checklist could provide G21 with a decision-making tool needed to advocate for better mapping and weighing of proposed development decisions against criteria established through the mass of evidence gathered about the influence of the social determinants of health.

3.6 Summary: Implications for the G21 Region.

_Need for an understanding of what Healthy Cities initiatives are_

‘Healthy Cities Initiatives’ are characterised by broad-based, intersectoral political commitment to health and well-being in its deepest ecological sense; commitment to innovation; an embrace of democratic community participation; and a resultant healthy public policy. A broad-based Healthy Cities initiative typically involves the establishment of a peak intersectoral working group comprising senior personnel from key organisations. A project team assists the working group by conducting community diagnosis; developing strong links with education bodies all levels, for educative purposes as well as to collect data; assisting participating agencies to examine ways of engaging in health promotion; helping to generate public debate, with a view towards fostering city-level health advocacy; developing and evaluating targeted health promotion interventions.
It is incumbent on interested G21 personnel to consider the ways in which G21 presently complements this approach, and what would be needed for it to strengthen its organisational capacity to lead a Healthy Region strategy.

The need for a supportive vision

Twenty Steps for Developing a Healthy Cities Project (WHO, 1997) clearly states that the overarching role of a Healthy Cities initiative is to offer effective advocacy to promote healthy public policy. However, in order to achieve this, first we need a Vision of a Healthy City or community: ‘A Vision is values projected into the future’ (Clem Bezold, Founder, Institute for Alternative Futures, cited in Hancock, 2006). Interested G21 personnel need to consider the extent to which its current Vision adequately embraces health and wellbeing in its broadest sense and addresses the social determinants of health.

The value of broad-based goals that address the social model of health

Plumas County’s Vision 2020 Goals, funded via a five-year Californian Healthy Cities and Communities grant, addressed seven broad topic areas in ways that could and did engage the whole community. Whilst concern for health and wellbeing formed the cornerstone of the entire initiative, it was understood that the broad vision for the region could promote health and wellbeing in subtle ways that engaged stakeholders from outside the health sector. G21 is already well-positioned rhetorically to embrace the approach taken by Plumas County’s Vision 2020 initiative.

The need for supporting governance structures

Governance refers to the arrangements that societies agree to set in place between civil society, business and government to address issues of collective interest, to solve problems or to create and draw on benefits (Neilson, 2002: 97). Governance is central to a Healthy Cities initiative. Any organisation that chooses to lead and drive a Healthy Cities approach needs to ensure that its vision, mission, strategic plan and governing structures are established to promote civic democracy and social justice. Central to this is the need for effective integration of policy and effort between the state and local levels of government:

... enlightened local government and community initiatives may be frustrated by policies and regulations at higher levels of government that make it difficult, if not impossible for these local initiatives to achieve their aim. This calls for a strategy both to establish “partnerships” between upper and lower levels of government around a common aim or purpose (in this case human and ecosystem health improvement) and a need to work with higher levels of government to encourage them to adopt policies that strengthen and support the capacities of local governments and communities to work in an integrated way to improve human and ecosystem health (Hancock, 2000).

A G21 Healthy Region strategy would need clearly to identify, through its governing structures and systems and each member local government’s community engagement approach, how citizen perspectives and input would be ensured.
The need for place-based approach

Healthy Cities initiatives are conducted in a geopolitical space or locale. Place thus serves as a context for Healthy Cities initiatives, irrespective of whether the initiatives specifically identify place as a goal area. When one considers the Burden of Disease, place and locale form the backdrop to many of the more pressing issues that communities must address – for example, who lives there, resources in that community, presenting health issues (DHS, 2001). HC initiatives are also inherently about power and control, namely the power of communities to determine - and drive - their own health agenda.

Kegler et al’s (2003) evaluation of Californian Healthy Cities and Communities initiatives noted the power of place: a factor that influenced initiatives was “the value of a central, community location that took on the identity of the Healthy Cities and Communities initiative, as well as the value of rotating locations to highlight the contributions of each area and encourage participation from geographic pockets” (p. 29) In addition, whilst most Healthy Cities and Communities initiatives had not set out to make changes to the physical environment, “changes in physical conditions in communities seemed to be an almost natural by product of these efforts” (p. 84). Almost all Healthy Cities and Communities initiatives reported at least one change directly related to their efforts, with an average of three changes per community. The most common types of changes were neighbourhood and community beautification, followed by facilities construction, expansion and renovation; public utilities and public safety; and construction and renovation of parks and recreation facilities.

The Department of Human Services (Barwon-South Western Region) has increasingly embraced a place-based approach when formulating its regional objectives and strategies (Department of Human Services Barwon-South Western Region, 2007). The Department for Victorian Communities (now DPCD) also has utilised place-based approaches in its regional development strategies. A G21 Healthy Region approach thus could capitalise on – and catalyse - this state-level activity.

The need to work strategically

It is important that G21 steer away from a dependency on project-based funding to a more catalytic role in the region that embraces forging strategic alliances, helping to shape public discourse and decision-making, and engaging in systems advocacy.

The need for effective engagement in partnerships

Partnerships can range across a continuum of engagement, from informal networking through to formal collaboration with shared resourcing. The text below illustrates the various levels of partnership (VicHealth, 2005).

Partnerships are an important vehicle for bringing together a diversity of skills and resources for more effective health promotion outcomes. Partnerships can increase the efficiency of the health and community service system by making the best use of different but complementary resources. Collaborations, joint advocacy and action can also potentially make a bigger impact on policy-makers and government. If partnerships are to be successful, however, they must have a clear purpose, add value to the work of the partners and be carefully planned and monitored (VicHealth, 2005, p. 1)
The need to engage meaningfully with stakeholders outside the ‘health’ sector

Given that most of the factors that impact on people’s health occur outside the health sector (Wilkinson & Marmot, 2003), it is incumbent of people working in health promotion to engage with stakeholders outside the health sector, in ways that they can understand and to which they can relate. A truly strategic Healthy Cities approach committing to engaging stakeholders outside the health sector could well need to reduce or remove the number of references to health and wellbeing, and present its work in the language of its potential allies – for example, framing priorities using the economic terminology favoured by private developers.

The need for an organisational structure and function that embraces strategic approach and ‘de-healthifies’ the health promotion agenda of Healthy Cities

It is considered incumbent upon visionary Healthy Cities advocates to forge collaborative alliances with sectors traditionally considered outside the realm of health promotion, or even possibly hostile to it. Early adopters in these sectors do indeed exist, and are quite possibly looking for opportunities to engage in corporate philanthropy. It would be advantageous for G21 to regard the formation of these alliances as essential to promoting health and wellbeing and fulfilling the Healthy Cities theoretical framework.

The need for sustained, high-level political endorsement

Interested G21 stakeholders may need to examine the way that the G21 Board is presently composed, elected and trained for providing ongoing, effective governance.

The need for sufficient resources to employ skilled staff to drive a Healthy Region strategy

For a Healthy Region initiative to thrive, it must be funded adequately to ensure that a skilled employee is remunerated appropriately and sustainably for the high-level entrepreneurial, coordinating and reporting role that they will be performing.

Healthy Cities model as a policy analysis tool

The six elements of a Healthy Cities orientation (see figure 19) provide a creative opportunity for all stakeholders in a Healthy Region to develop their policies in such a way that they (i) attempt to create positive outcomes in each element, and (ii) develop performance measures to document progress across these elements. Hancock (2000) provided a detailed example of how transportation policy could be developed across these elements, and evaluated accordingly.

<table>
<thead>
<tr>
<th>Element</th>
<th>Application to transport policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sustainability</td>
<td>The ecological footprint of our cities is massive. Global warming in particular presents a threat to human health, and vehicular emissions are a significant source of carbon dioxide. Transit can reduce our overall energy and raw materials consumption and our CO2 emissions and thus contribute to sustainability.</td>
</tr>
<tr>
<td>Liveability</td>
<td>High volumes of traffic reduce the livability of our communities, not only because of their emissions but because of noise, congestion, etc. Transit can make our cities more livable.</td>
</tr>
</tbody>
</table>
Equity  A good transit system makes the city more accessible for people with low incomes, seniors, people with disabilities and other disadvantaged groups. It reduces the costs of travel for these groups.

Conviviality  Some years ago, former Toronto Mayor John Sewell commented that Toronto’s transit system is "the great democratizer", because it is used by everyone and people literally rub shoulders with each other. This social role of transit is an important one to consider.

Viability  This refers to the degree to which the quality of air, water and soil is a threat to health. By reducing overall emissions of smog precursors, acid emissions and particulates, transit can reduce the threat to health posed by air pollution.

Prosperity  Good transit reduces the need for a car, thus increasing disposable income, reducing energy and time wasted in traffic jams, reducing the costs of accidents and pollution and in a variety of other ways contributing to the overall prosperity of the community.

Figure 19. Application of Healthy Cities model to transport policy (Hancock, 2000)

Holistic monitoring and evaluation required

To assist Healthy Region stakeholders to document their progress in enhancing community capacity, a monitoring and evaluation framework is required at the outset to generate evidence that the Healthy Region strategy is meaningful, substantive, generating 'currency' that is useful to stakeholders and the wider community, and that it has adequate leveraging resources.

Regardless of the best intentions of policy makers, cities are being impacted upon daily by millions of decisions and actions made by residents, business people, commuters, workers, elected officials. This adds up to “the evolving form, structure and character of the cities, and which shape their economies, their vitality and the direction of change ... the best planners and others can do is to help the players in these places to influence the direction of change. Today cities are under stress and it can be argued that political, economic, and social change are so rapid that urban players operate in an environment at the edge of chaos” (Innes & Booher, 1999, p 12, 14).

The globalizing economy is also impacting greatly on cities (Butterworth, 2000), which means that any local indicator sets need to be viewed from the position that any attempts at local change must be seen a truly global context. Innes and Booher (1999) warn that “the result of using societal indicators for evaluation is that all too often the public or analysts declare that some policy has failed when in reality we would be worse off without it, or when we would have different results if we changed it a bit” (p9). Therefore, indicators need to be assessed for their scale – whether they are general systems-level indicators, policy level indicators, or rapid feedback indicators.

For these reasons, it might be argued that municipal indicator development needs to be part of a state (and arguably national) approach, in which state and local governments work together to identify the best ways to identify and collect systems, policy and rapid feedback-level indicators, and how this information can be used to inform policy at the municipal and state levels. The work of the Victorian Community Indicator Initiative is going some way towards addressing this, although questions remain about the capacity of local governments to collect or access many of the data sources identified. At the very least, systems
indicators need to be collected to highlight changes in conditions, and stimulate discussion towards taking action.

People engaged in community change initiatives and indicator development initiatives must acknowledge complexity theory, in which the social system is essentially dynamic, unpredictable, intertwined and transformative (Innes & Booher, 1999). Dynamic social environments depend on constant feedback, information and learning. Transformational learning involves the power to create new insights, moving to a new vision, and changing to new stories. Enablers of learning include: (i) Guiding principles - agreed rules of engagement; (ii) Development and support of leadership; (iii) Local decision-making and governance; (iv) Public accountability; (v) Data and information (Paterson, 2004)

For this, we need simultaneously to be creating an information infrastructure, a learning infrastructure, and a policy infrastructure. We need to foster a ‘culture of enquiry’, where we reward, not punish, people for asking questions and for taking diverse approaches.

Ecological approaches to Healthy Cities evaluations offer innovative opportunities to explore links between social policy and the social determinants of health. This is a key goal of Healthy Cities principles and the Ottawa Charter, and needs to be encouraged in order to highlight the political dimension to civic democracy and wellbeing. Evaluation approaches that use a range of quantitative and qualitative methods are more likely to document the range of actions initiated by a Healthy Cities initiative, and their ripple effects across the social spectrum over time.

Including consideration for sense of community, psychological conceptions of place and social capital can help to anchor Healthy Cities in this broader social ecological model that includes consideration for place, belonging, participation, social networks and power. An empowerment framework can make manifest the process of power transference to community members to gain some control over the issues that determine their health and wellbeing.

Healthy Cities initiatives are well served by a central evaluation team, such as a university partnership, that can provide ongoing consultancy throughout the initiative, using an action research approach or ‘empowerment evaluation’ approach (Fetterman, 2004), assist initiative stakeholders to keep track of process and outcome milestones, and apply some theoretical rigor and organizational support to the questions posed and information collected. Indicators are best developed through praxis as part of a collaborative, participatory approach involving the community in a meaningful way.

Furthermore, there is the opportunity to engage with the CIV to track the efforts and impacts of a health region approach. As outlined in section 3.5.3 above, several indicator databases in the Victorian Communities Indicators Project remain to go ‘live’ with the relevant data sources identified and accessed. However, it could be advantageous for CIV to engage with a G21 Healthy Region initiative in order to obtain the resources and develop the capacity necessary to monitor systematically a Healthy Region approach.
3.7 Conclusion

Baum (2000) identified two key challenges for Healthy Cities initiatives: (i) addressing the impact of globalization and (ii) strengthening the links between civil society and governments. Firstly, Baum questioned the role that Healthy Cities initiatives might play in leveraging local equitable health outcomes in the face of external ownership and control of the resources that impact locally on health, especially in light of the international pressure to water down local environmental and trade laws that impact on people’s work and quality of life (see Klein, 2000). In other words, how can Healthy Cities play an influential role, through advocacy, on the global factors that influence determinants of health at a local level? The second challenge identified by Baum was for Healthy Cities initiatives to strengthen the links between civil society and governments. How can Healthy Cities initiatives demonstrate their contribution to promoting a "vibrant and supportive civil society [that] encourages a social fabric in which people feel part of the community and do not feel excluded’’?

Strategic and statutory planners, health planners, corporate planners, developers and urban planning authorities are increasingly accepting that their policies and decisions have consequences, both intended and unintended, for health and wellbeing. Yet not only can planning lead potentially not only to ill-health and compromised well-being within communities, but also to enhanced quality of life and social and ecological sustainability. WHO (1999) has summarised many of the tools needed for health and sustainable urban planning, as shown in Figure 20 below:

| Policy tools | General and specific guidelines and indicators such as biophysical, health, economic, social and cultural indicators |
| Planning tools | Techniques and information for day-to-day planning in transport, residential housing, natural landscaping and initiatives to reduce, reuse and recycle. |
| Information tools | Baseline and periodic data within reports on the state of the environment, or health reports such as city health profiles, impact monitoring and exchange of information through networks. |
| Fiscal tools | These draw attention to equity: for example, incentives such as tax relief for those who live close to where they work; disincentives such as tax subsidies for commuting by car; subsidies for public transit; life cycle costing; and appropriate government procurement policies. |
| Decision making tools | Urban planning, environmental impact assessment, strategic environmental assessment or strategic sustainability assessment, mediation skills, stakeholder and interdisciplinary teams and mechanisms to ensure greater public involvement. |
| Educational tools | These target urban planners and health practitioners and can include conferences, workshops, task forces, case studies, training and small-group sessions. |
| Participation tools | Innovative techniques such as participatory mapping of a settlement, modelling of new housing designs, collective planning, seasonal calendars and forums for ideas. |

Figure 20. Tools Needed for Healthy and Sustainable Urban Planning (WHO, 1999)
Some universally applicable questions that all planners can ask (Duhl & Sanchez, 1999) are:

- What are the potential unintended consequences of the planning efforts?
- Are the planning efforts addressing the symptoms of a problem, or the root causes? For example:
  - Are housing initiatives that are aimed at people on low incomes simply displacing this population, or are they truly working to solve the underlying issues behind the scarcity of safe, clean, affordable housing?
  - Will planning serve to enhance the social inclusion and participation of women with children, people with disabilities and older people (through provision of local services, well-lit streets, and accessible buildings, footpaths, streets and transport), or extend their isolation?
- Are planning efforts working on behalf of healthy urban public policy? A system must be in place that enforces checks and balances between policy-makers, policies and plans.
- What are the direct and indirect effects of planning decisions? How will these decisions affect the built, natural, social, political and economic environments? Politicians, planners, government officials and citizens must all be able to understand fully the reasoning and implications behind policies: that is, asking questions that look at the whole picture.

Asking these kinds of questions promotes critical analysis of decisions about the future of cities. Such questions – which need to be incorporated into all indicator development and analysis – are indispensable to the process of healthy urban planning and sustainable development.
3.2 DOCUMENT ANALYSIS

3.2.1 Framework for Document Analysis .................................54

3.2.2 Document Analysis Methodology .................................54
   3.2.2.1 Procedure .........................................................54

3.2.3 Document Analysis Findings ........................................55

Phase 1: Getting Started..................................................57
   Phase 1.1 Building a Support Group .................................57
   Phase 1.2 Understanding Healthy Cities Ideas.....................57
   Phase 1.3 Getting to Know Your City [Region].....................60
   Phase 1.4 Finding Project Funds......................................61
   Phase 1.5 Deciding Organisational Location.......................61
   Phase 1.6 Preparing a Project Proposal..............................62
   Phase 1.7 Getting City Council Approval............................62

Phase 2: Getting Organised .............................................63
   Phase 2.1 Appointing the Steering Committee......................63
   Phase 2.2 Analysing the Project Environment.......................64
   Phase 2.3 Defining Project Work .....................................66
   Phase 2.4 Setting up the Project Office ..............................66
   Phase 2.5 Planning Project Strategy .................................67
   Phase 2.6 Building Project Capacity ................................68
   Phase 2.7 Establishing Accountability Mechanisms ...............70

Phase 3: Taking Action ....................................................70
   Phase 3.1 Increasing Health Awareness .............................71
   Phase 3.2 Advocating Strategic Planning ............................71
   Phase 3.3 Mobilising Intersectoral Action ...........................72
   Phase 3.4 Encouraging Community Participation ..................72
   Phase 3.5 Promoting Innovation .....................................73
   Phase 3.6 Healthy Public Policy .....................................73
3.2.1 Framework for Document Analysis

A Healthy Cities framework was chosen from the research literature to assess G21’s capacity to adopt and facilitate a Healthy Cities approach to their regional planning.

The framework chosen was based around the internationally tested approach by the World Health Organisation (WHO; 1997b) referred to in, *Twenty Steps for Developing a Healthy Cities Project*. This framework is depicted in Figure 5 in the literature review above. This framework outlines three main phases necessary for development of a Healthy Cities initiative: start-up, project organisation, and areas for action and strategic work.

G21 documents were compared against the *Twenty Steps* framework to map G21’s strengths and weaknesses in developing and facilitating a Healthy Cities initiative. Gaps or discrepancies highlighted throughout the process were used to inform recommendations for the *Healthy Region Business Plan* attached.

In addition to the above framework, consideration was given to the key characteristics of a Healthy Cities project that are also described in the WHO *Twenty Steps* document. These characteristics are presented in Figure 3 above and represent what strengths G21 need to reflect in order to effectively facilitate a Healthy Cities initiative; namely, a commitment to health, political decision-making, intersectoral action, community participation, innovation and healthy public policy.

3.2.2 Document Analysis Methodology

An analysis of G21’s documentation was undertaken against the above mentioned Healthy Cities framework to assess G21’s capacity to adopt a Healthy Cities approach to their regional planning.

3.2.2.1 Procedure

With all of G21’s documents publicly accessible through their website, a list was compiled of documentation needed for analysis and G21 provided hard-copies of these documents. The documents included:

- Constitution
- Board Charter
- Memorandum of Understanding (MOU)
- Profile of the Geelong Region (2002)
- Geelong Region Strategic Plan (2003)
- The G21 Region Report 2005
- Geelong Region Plan – Regional Context
- Geelong Region Plan – Background Report
- Geelong Region Plan 2007 – Strategy
- Geelong Region Plan 2007 – Actions (only available online at: http://www.g21geelongsplan.net)
- G21 Annual Report 2005/06
- Planning for Healthy Communities in the G21 Region 2007
- Pillar to Pillar Magazines
- G21 Membership Brochure

Appendix B illustrates a flow-chart representation of the documents collected.
To ensure that the framework was relevant to the local setting of G21, key questions were drawn from each the Twenty Steps framework and adapted to suit a regional, rather than city perspective.

Findings from the document analysis are described in the following section.

### 3.2.3 Document Analysis Findings

Before analysing G21’s structure and process, it is important to determine the extent to which the core Vision, Values and Principles which underlies G21 is consistent with the characteristics of a Healthy Cities approach listed in Table 21 above.

Table 1 below demonstrates that G21’s Vision, Values and Principles reflect many of the Healthy Cities characteristics. In particular, they are focused on Intersectoral Action, Political Decision-Making, Community Participation and Innovation. It is the overt Commitment to Health that appears to be lacking, with the focus more vaguely placed on community wellbeing.

#### Table 1. Commonalities between G21 Vision, Values and Principles with Characteristics of Healthy Cities projects

<table>
<thead>
<tr>
<th>G21 VISION</th>
<th>Features in Common with Healthy Cities</th>
</tr>
</thead>
</table>
| The Geelong Region is Australia’s most desirable destination for living, working, visiting and investing; it is renowned for its vibrant, cohesive community, exceptional physical environment and vigorous economy. | ▪ Acknowledges the important interrelationship between community, environment and economic factors on the desirability of the region
▪ However, is not fully consistent with Healthy Cities characteristic of ‘Commitment to Health’ as no direct link to health is made |

<table>
<thead>
<tr>
<th>G21 VALUES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sustainability</strong></td>
<td>The Region’s community, economy and environment are interdependent and outcomes must foster sustainable relationships</td>
</tr>
</tbody>
</table>
| **Community Engagement** | The regional communities diversity of needs requires broad involvement in planning, delivering and evaluating outcomes | ▪ Community Engagement
▪ Political Decision-Making |
<p>| <strong>Community Wellbeing and Capability</strong> | Outcomes must add to the overall wellbeing and capability of the regional community | ▪ Commitment to overall well being as an indirect commitment to Health |</p>
<table>
<thead>
<tr>
<th><strong>G21 PRINCIPLES</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Building Consensus</strong></td>
<td>Developing a common Vision, goals and objectives, sharing information and joint support of projects builds trust and benefits the Region</td>
</tr>
</tbody>
</table>
|  | ▪ Intersectoral Action  
  ▪ Political Decision-Making |
| **Building Partnerships** | A key driver of G21 is building relationships to enhance coordinated regional planning that encouraged innovative and efficient use of resources |
|  | ▪ Intersectoral Action  
  ▪ Political Decision-Making  
  ▪ Innovation |
| **Communication** | Open communication underpins G21 as an imperative that will foster understanding, coordination, cooperation and alignment of purpose and outcomes |
|  | ▪ Intersectoral Action  
  ▪ Political Decision-Making |
| **Community Focused** | Identifying those served by a project, distinguishing their needs and involving them purposefully in planning, implementation and evaluation processes |
|  | ▪ Community Participation  
  ▪ Intersectoral Action |
| **Diverse Non-Partisan Membership** | A diverse non-partisan membership recognises and values the role that each sector and the community has in planning for the Region’s future and therefore ensures that membership is balanced and representative of all interests |
|  | ▪ Intersectoral Action  
  ▪ Community Participation |
| **Resourcing** | Partners will collectively identify resources outside of G21 to fund activities or projects beyond the scope and means of any single public or private organisation |
|  | ▪ Innovation |
| **Support Existing Efforts** | G21 enhances rather than duplicates the efforts of existing public and private organisations working on social and economic development and environmental sustainability |
|  | ▪ Intersectoral Action  
  ▪ Innovation |
The following details the analyses of G21’s structure and processes against the framework outlined in Twenty Steps of Developing a Healthy Cities Project.

**Phase 1: GETTING STARTED**

While G21 has clearly progressed well beyond the first phase of Getting Started, it is worth reviewing each of the seven steps in this phase to see how G21’s overall approach compares with Healthy Cities. It is an important exercise as it will highlight any important gaps or weaknesses where recommendations can be made in the Healthy Region Business Plan to be developed in Phase 2 of the research.

**Phase 1.1 Building a Support Group**

A Healthy Cities initiative begins with a small group of people who are interested in finding new ways to promote public health and who agree to work together for a healthier region (WHO, p20).

**Q: Who are G21’s supports?**

Throughout the G21 documentation, it is acknowledged that the success of G21 relies on the involvement of a network of people who are working together for the wellbeing of the region.

G21 has 50 member organisations and more than 100 other participating agencies from a variety of sectors within the region which includes:

- Local Government
- Statutory Authorities
- Proprietary Companies
- Public Companies
- Incorporated Associations
- Cooperatives
- Federal and State
- Government Departments or Agencies

**Q: What qualities do these supports bring G21?**

G21 supports all voluntarily commit time, interest, resources and funding into projects. The support of all three levels of government is particularly vital in providing political influence.

**Phase 1.2 Understanding Healthy Cities Ideas**

For many, Healthy Cities means new ideas and many people, some of whom are not interested in change, will have to be convinced that better approaches to public health can be found. Therefore, it is important to have a clear grasp of the principles, strategies and practices that are part of Healthy Cities in order to deliver this approach effectively (WHO, p20).

**Q: How is Healthy Cities addressed in G21’s health promotion strategy?**

While there are many implicit parallels between G21’s planning approach and Healthy Cities, the only overt reflection of the Healthy Cities concept being used to inform regional planning is demonstrated in the document Planning for Healthy Communities in the G21 Region 2006-2009. This document was
developed utilising international, national and state policy directions and frameworks, including the Healthy Cities philosophy and the Ottawa Charter for Health Promotion. It also considered and encourages the following frameworks and documents:

- The Jakarta Declaration on Leading Health Promotion
- Social Determinants of Health
- National Health Priority Areas
- National Strategy for Ageing Australia
- Healthy By Design
- DHS Integrated Health Promotion (IHP) Priorities
- DHS Health Promotion Kit
- A Fairer Victoria
- Environments for Health
- Leading the Way

In addition, while there is no overt reference, the Healthy Cities philosophy of creating healthy communities is also reflected in G21’s most recent strategic plan *The Geelong Region Plan – A Sustainable Growth Strategy*. The Healthy Cities approach highlights that there are many factors that can affect health status and differences in health: including genetics, environmental, social and economic factors. Direction 3 of G21’s *Geelong Region Plan* is to ‘Strengthen our Communities’ and considers health to be determined by many factors including the environment, opportunities for sport and recreation, education, basic needs such as safety, adequate housing and access to health services, participation in arts and culture and sustainable transport options. Refer to Section 2.5 for more information on the *Geelong Region Plan*.

**Q: Is health and wellbeing integrated as a priority across all Pillars? Or is it relegated to the Health and Wellbeing Pillar?**

Health and wellbeing is identified as a priority interest area in the region through the existence of the Health and Wellbeing Pillar. However, health and wellbeing issues are not overtly acknowledged as a priority for the other nine Pillar Groups. Pillar group members are also comprised of people with experience, expertise and interest in a particular Pillar theme. Therefore, people with experience and interest in health are largely confined to the Health and Wellbeing Pillar. This situation potentially encourages a siloed approach to planning despite one of G21 aims being to encourage a culture of intersectoral planning and action.

The new *Geelong Region Plan – A Sustainable Growth Strategy*, does aim to promote a more integrated planning approach across Pillars than its predecessor, the 2003 *Geelong Region Strategic Plan*. However, while it is recognised that all of the Pillars have a role to play in health promotion, the roles and responsibilities of each Pillar are not provided in the document. Therefore, the pathways for implementation are unclear.

The new *Planning for Healthy Communities* document, set to be launched in September 2007, aims to create a more integrative working environment through setting up the mechanisms to build these partnerships and to develop communication pathways with the other Pillars and agencies outside the health sector. It aims to achieve this by:

- Strengthening the understanding that the health and wellbeing of a community is influenced by a number of interrelated factors, many of which fall outside the traditional role and influence of the health sector.
Recognising that each of the G21 Pillars has a varying effect on the health and wellbeing of the community.

Providing research evidence detailing how each G21 Pillar relates to and influences health and wellbeing.

Encouraging each Pillar to contribute to health and wellbeing planning not only in a monitoring and advisory role, but by directly addressing health and wellbeing issues in their planning.

Despite this, the commitment to promoting health and wellbeing primarily falls under the role of the Health and Wellbeing Pillar. The level of intersectoral action achieved amongst the Pillars in developing and implementing the plan appears largely dependant upon the strength of G21’s integrated planning capacity and the willingness of the Pillar groups to consider the impact of their planning activities on the health and wellbeing of the region.

The following table summarises how the elements outlined in the *Planning for Healthy Communities* document compares to the characteristics of a Healthy Cities approach.

**Table 2: Comparison of the Planning for Healthy Communities in the G21 Region Document with Characteristics of Healthy Cities**

<table>
<thead>
<tr>
<th>Healthy Cities Characteristics</th>
<th>G21 Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commitment to Health</td>
<td>• Recognises and promotes a holistic view of health.</td>
</tr>
<tr>
<td></td>
<td>• Consideration of Healthy Cities and other established frameworks for health planning including social determinants of health and the Ottawa Charter.</td>
</tr>
<tr>
<td>Political Decision Making</td>
<td>• Promotes integrated planning between the 5 LGAs by identifying a set of key shared local priority areas.</td>
</tr>
<tr>
<td></td>
<td>• Provides a platform upon which all of the 5 LGAs can develop their Municipal Public Health Plans (MPHP) in the context of a whole region perspective.</td>
</tr>
<tr>
<td>Intersectoral Action</td>
<td>• Focuses on strengthening collaborative inter-agency approaches to regional health planning.</td>
</tr>
<tr>
<td></td>
<td>• Aims to identify opportunities for LGAs to work in partnerships with each other and to strengthen their links with community services.</td>
</tr>
<tr>
<td></td>
<td>• Provides research evidence and examples of how each G21 Pillar is associated with health to broaden understanding of health and to foster responsibility and commitment from people outside the health sector.</td>
</tr>
<tr>
<td></td>
<td>• Level of intersectoral action delivered is reliant on strength of G21’s integrated planning partnerships and the willingness of Pillar Groups to incorporate health into their planning processes.</td>
</tr>
<tr>
<td>Community Participation</td>
<td>• Community group representatives were engaged in the development of the Plan.</td>
</tr>
<tr>
<td></td>
<td>• Regional health priority areas were informed, in part, through a series of G21 Regional Strategic Plan Consultation Forums (representing a variety of community groups).</td>
</tr>
</tbody>
</table>
Innovation

- The Plan offers an innovative approach to promoting health as it is regionally focused.
- The search for new ideas and methods for health planning is evident in G21's consideration of a broad range of existing frameworks such as Healthy Cities and through sharing experiences of successful projects throughout the document.
- The only incentive for people outside of the health sector to become involved in the implementation of the Plan is compassion based and through a desire to work with others to reduce health impacts.

Healthy Public Policy

- Healthy public policy is the outcome of all of the above work. The impact of this Plan on the political decision making in the 5 LGAs is unknown as the Plan is yet to be launched officially.

Phase 1.3 Getting to Know Your City [Region]

The practical application of a Healthy Cities approach requires an adaptation to G21s specific needs. Therefore, it is essential to have a good understanding of your region and how it works in order to develop a locally-relevant initiative (WHO, p21).

Q: To what extent do G21 stakeholders 'know their region'?

The Twenty Steps document states that research and analysis to gain knowledge of your local area can be organized around ten important questions:

- What are the important health problems within the Region?
- How do economic and social conditions affect health?
- Whose support is essential for project success?
- How do the regional politics work?
- How does the regional administration function?
- What are the concerns of the regional health care system?
- What part do community groups play in regional life?
- Where can information/data for G21 project development be found?
- How do national or other regional programmes affect G21?
- Do business, industry and labour support G21?

The new G21 Geelong Region Plan is based on robust research, information and extensive consultation with a number of background reports completed to ensure that the strategic directions were based on sound regional data.

These background documents include:

- G21 Geelong Region Plan Report One - Regional Context Report
- G21 Geelong Region Plan Report Two – Background Report
- G21 Region Research Report 2006

Without a particular health focus, these background research reports present a comprehensive demographic and economic picture without direct connections being drawn to health and wellbeing with the one exception being the implications of an ageing population.
**Phase 1.4 Finding Project Funds**

Project funds can come from many sources and should be canvassed from a wide variety of potential funding sources. Funders should also be involved in planning as much as possible (WHO, p23).

**Q: Where does G21 source its funding?**

Funding for G21 comes from a number of sources. The Memorandum of Understanding (MOU) between G21 and the Member municipality’s states that funding received by Member councils will be used for the core operation of G21 which includes staff, oncosts, overheads and outgoings required to achieve G21 objectives. Additional supplementary funding for the core operation for G21 is to be obtained from Federal and State government sources.

**Phase 1.5 Deciding Organisational Location**

Deciding the location of the Healthy Cities project within the organizational hierarchy of the region is an important choice as it influences organizational structure and administrative mechanisms. It also determines relationships with politicians, partner organizations and community groups (WHO, p24).

Several organizational models have emerged in European Healthy Cities projects. They reflect different political systems, social dynamics and project sponsorship. Below are the four patterns that occur most frequently (WHO, p24):

1. Projects are set up as autonomous, non-profit organizations with their own charter and an independent board of directors. Such projects tend to be politically neutral and work closely with community groups giving them a strong flavour of citizen participation.

2. Projects are located within city government and are associated with its central administration. They may be part of the office of the mayor, city manager or city clerk. They tend to have strong links to city council that make them effective in promoting intersectoral action among departments within the city administration.

3. Projects are located within city government as part of the health department. Such projects are well located to promote health care reform but they are often viewed as particularly favouring the interests of the health care system. This makes it more difficult for them to negotiate with organizations outside the health care sector.

4. Projects have sponsorship and representation from two levels of government. Such projects exist where jurisdiction over matters that affect health is divided between city and county or regional governments. For example, one government may be responsible for health and the other for environment. Coordination of activity between governments is an important priority for such projects.

The organisational model chosen should be the one most suited to local circumstances and an analysis of how local politics and city administration work should provide the basis for this choice (WHO, p24).
Q: Where does G21 sit in the region’s organisational hierarchy?

G21 reflect the organisation model of both 1 and 4. G21 is referred to in its Membership Brochure as an autonomous, not-for-profit Company Limited by Guarantee with its own charter and Board of Directors. However, G21 also has sponsorship and representation with all three levels of government. The coordination and partnership between regional players is the top priority for G21.

It is not specified in G21’s documentation how this organisation model was identified or developed as being the most appropriate. However, when G21 started in 2001, a range of meetings were held which involved the Mayors and Chief Executive Officers of the 5 LGAs in the region as well as state government, community, and business leaders brainstorming the initiative. It is possible that through this process, it was identified that G21 needed to be a separate entity within the region to act as mediator between all the regional partners.

Phase 1.6 Preparing a Project Proposal

Preparation of a formal project proposal should begin when the support group has a good understanding of how Healthy Cities strategies apply in the region, and have reached agreement on how to proceed. The proposal should reflect priorities of city council and are practical while being forward looking and innovative (WHO, p25).

Q: Does G21 have a formal project proposal developed that addresses the Healthy Cities approach?

G21 Members are in the beginning phase of developing a plan focused on the Healthy Cities approach with their Planning for Healthy Communities in the G21 Region document. To be officially launched in September 2007, this document has the support of all five G21 local councils and has the potential to provide an overarching framework and reference for G21 and their planning partners in promoting health and wellbeing in the region.

Outcomes of this research will further develop a preferred model for adopting the Healthy Cities approach across the region which could also be integrated into the Healthy and Well Being Pillar Group.

Phase 1.7 Getting City Council Approval

City council approval marks the end of the start-up phase. It achieves the first goal, which is to become formally recognized as part of the regional system for making local public health policy. An important part of getting started is building city council support to ensure support and approval of projects and plans (WHO, p26).

Q: How is the nature of the relationship between G21 and the five councils defined?

G21 has all five councils within the region committed to a shared Vision for the future and developing a regional approach to planning. This support is documented through the signing of the MOU which articulates the
arrangements and expectations between G21 and Member Councils as funding partners for the core operation of G21. This MOU is for a period of 4 years (2004-2008).

However, while commitment from all five Councils is confirmed, there is also an indication that the strength of that commitment may be weak due to tensions caused by the scale and financial influence of the City of Greater Geelong, which contributes significantly more money than other participating Councils’. This is evident in Section 3.6 of the MOU, which states that Colac Otway Shire agreed to support G21 on the provision that “the alliance is not Geelong centric”.

The strength of the relationship between G21 and the Member councils is important in getting their on-going commitment to not only providing funds, but also influencing and shaping policy and political decision-making within the region.

**Phase 2: GETTING ORGANISED**

This stage refers to setting up the organization and administrative mechanisms through which the Healthy Cities initiative will work including a steering committee to lead and coordinate and a project office to provide support and follow-up action. An essential part of getting organized is securing the personnel, money and information that the project will need (WHO, p27).

**Phase 2.1 Appointing the Steering Committee**

The steering committee provides the leadership and legitimacy that makes the Healthy Cities project an effective advocate for public health. It is the vehicle through which partners in the project come together to negotiate agreement on ways to improve health in the city (WHO, p28).

Effective committees should have well-defined responsibilities, representative membership, efficient working structures and clear, but flexible, procedures. Membership should provide for effective political links with city council and representation of potential partners. Members should also be selected for their interest in health, their knowledge of the city and their ability to mobilize support and selected through nomination and election processes (WHO, p27).

**Q: Who comprises G21’s Steering Committee?**

G21 is managed by the G21 Board of Directors which is comprised of 11 people. The G21 Board Charter reports that the role of the Board is to oversee the management of G21 and to determine the strategic direction for the organisation. Although, this does not assume that G21 embeds Healthy Cities as a core business function. The Board may be a different Steering Committee to a Healthy Regions Steering Committee.

**Q: What is G21’s Membership selection process?**

G21’s Constitution states that members of the Board are selected through nomination and election processes with Directors, Nominated (by the
participating Councils), Elected (by the members) and Appointed (by the Board).

The G21 Board Charter specifies in some detail the competencies each Director and Chairperson must have to be considered for a position on the Board. While these competencies do include fundamental leadership qualities such as communication skills, ability to establish quality relationships and ability to influence and persuade, there are no requirements specified for interest or experience in public health, environment or urban development or for a thorough understanding of the region and its political system both of which are important attributes for facilitating a Healthy Region approach.

**Q: Are their responsibilities and structures clear and accessible?**

The Board’s structure and responsibilities are documented in G21’s Constitution and Board Charter, both of which are accessible to the public through the G21 website. The Constitution contains the overall governance structure, arrangements and company processes, the Board Charter contains more specific details about the ethos and arrangements by which the company is established and operates at the Board level.

**Phase 2.2 Analysing the Project Environment**

The purpose of analysing the working environment is to ensure that the project will work with organizations in its network in ways that recognize their mandates and systems (WHO, p30). Figure 21 illustrates the framework for analysing the project environment. Within this analytical framework the Healthy Cities project is a mediator between the system for making political decisions and the network of organizations whose activities determine whether the region is a healthy setting in which to live. The essence of the process is for the project to provide a vehicle for two-way communication between the political system and project partners (WHO, p30).

![Figure 21: Framework for Analysing the Project Environment (WHO, p30).](image)
For comparison, G21’s operating framework is illustrated in Figure 22. It is clear from these figures that G21 structure is comparable to that outlined for Healthy Cities projects. Like the Healthy Cities approach, G21 defines itself as an independent but integral part of the strategic direction and community building processes within the region. G21 provide connecting links that become the vehicle or medium through which different groups agree to cooperate in making the city a healthier place in which to live.

**Figure 22. G21 Operating Framework**

**Q: How does G21 understand how members in their network function?**

Effective action requires G21 to have an understanding of how the regional system works and how each part of the G21 network functions in practice, to be an effective advocate and mediator of healthy public policy. It is not clear in the documentation whether there is a formal process for understanding how the organisations function in G21’s network. However, G21 report that their structure is based on communication and feedback which allows it access to their networks organisational information and creates an awareness of multi-agency issues.
Phase 2.3 Defining Project Work

Project success depends upon good working relationships with the individuals, organizations and groups who become its partners. Good relationships will develop more easily if other people have a precise understanding of the unique role and activities of the project (WHO, p32).

*Q: How does G21 describe and promote its role within the region?*

G21 is described as the only regional development organisation of its type in the country. Throughout G21’s documentation, G21 describe the organisation as an independent advocate for regional issues to be identified and solutions or projects implemented. They achieve this by providing the mechanisms for intersectoral partners to come together and work on these regional issues.

This role is consistent with the Healthy Cities approach which defines the role of a Healthy Cities project office as being a mediator between the system for making political decisions and the network of organizations whose activities determine whether the region is a healthy setting in which to live. The essence of the process is for the project to provide a vehicle for two-way communication between the political system and project partners.

Phase 2.4 Setting up the Project Office

The project office is a vital component to success as it provides the operational arm of the project; it provides the link between regional partnerships and it provides the initiative, continuity and follow-up essential for translating decisions into practical action. Effective project offices have a sufficient number of personnel, an accessible location and simple and clear administrative procedures (WHO, p34).

*Q: G21’s Personnel?*

According to the Twenty Steps document, with a regional population of 270 000, G21 needs at least five people in the project office. The project office also needs a coordinator to build essential support within the city government and throughout the community.

G21 have 4 people in their well established project office; an Executive Officer, Executive Assistant, Project & Planning Coordinator and a Marketing & Communications Officer.

According to a recent media release, G21 have recently appointed a new Executive Officer. This new coordinator needs to have strong interests in public health, environment, urban development and strategic thinking. They will also need a thorough understanding of the region and its political system. Their most important skills will be communicating, negotiating and planning and they must be sensitive to the views of the community and be able to work comfortably and flexibly in an environment of innovation and experimentation.

The responsibilities of the EO are documented in G21’s Constitution and Board Charter. Part 3 of the Constitution specifies matters relating to the Executive Officer, although these clauses relate to the EO’s general duties and financial and compliance responsibilities rather than skills, attributes and experiences. The Board Charter is more specific although it only specifies the delegation to
and from the EO. The EO is reportedly only responsible for the employment, management and performance evaluation of all staff employed/contracted to the organisation and it is the Board’s role to appoint and supervise the EO.

From these foundation documents, it appears that the G21 Board leads the coordination of G21. Therefore, it is important that they, as individuals and as a group, embody the leadership qualities required to facilitate a Healthy Cities approach (as listed above). Refer to ‘Developing a Steering Committee’ above for more information on Board members.

Q: G21’s office location?

A small office is set up at Ground Floor, 199 Moorabool Street, Geelong. This office is accessible to the public. It is not stated in the documentation whether the office is a ‘shopfront’ which actively invites entry from the community.

Q: Is information on G21’s administration and governance procedures clear and accessible to the public?

The governance arrangements for G21 outlined in the following documents and are available online.

- G21 Constitution
- G21 Board Charter
- G21 Memorandum of Understanding

Phase 2.5 Planning Project Strategy

Long-term strategic planning is one of the means by which projects persuade politicians and executives to adopt healthy public policy. It encourages region officials to take a wide view of what can be accomplished through cooperation between sectors and better relationships with the community (WHO, p38).

Q: G21 Strategic Planning

G21 have developed a long-term strategic plan for the region; the first 2003 Geelong Region Strategic Plan and the recently developed Geelong Region Plan – A Sustainable Growth Strategy.

G21’s first Geelong Region Strategic Plan was developed in 2003. While this Plan provided the mechanism for partnerships to develop and gained the attention and support from all three levels of government, it also suffered from a lack of integrated planning pathways. Specifically, the strategies and actions in this Plan are divided by the Pillar themes which present a relatively siloed approach to planning with each Pillar focused on their respective projects. This also meant that the focus on health was confined to the Health and Wellbeing Pillar.

G21 identified that they needed to evolve the scope of the Plan to make it more integrative and far-reaching in its application. The new Geelong Region Plan, to be officially launched in September 2007, incorporates a new set of priorities for the region that look towards the year 2040 and achieving sustainable social and environmental outcomes as well as economic development.
This plan is not structured around the ten G21 Pillars, although the Pillars reportedly will continue to exist and play a key role in planning and implementation. This movement away from grouping activities under Pillar headings aims to promote greater integration of planning.

The Plan also adopts a more Healthy Cities approach (although this is not overtly specified) with the Plan built around identifying strategic issues facing the region and developing responses to address those issues.

Health is directly addressed in Direction 3: ‘Strengthening our Communities’ with policy areas listed as:

▪ Build strong and safe communities
▪ Encourage healthy and active lifestyles
▪ Increase appreciation of diversity, arts and culture
▪ Improve access to services, infrastructure and housing
▪ Address disadvantage

Through addressing the above priority areas, health and wellbeing is identified as being influenced and determined by a broad range of factors including:

▪ Feelings of safety
▪ Social networks and communication
▪ The environment
▪ Opportunities for physical activity and good nutrition
▪ Education
▪ Employment
▪ Opportunities to participate in arts and culture
▪ Available housing
▪ Sustainable transport options
▪ Access to health and support services

Through this process, the Plan provides all G21 Pillar groups with a broader understanding of how their work relates to and impacts upon health, which may help to foster a more integrative planning approach to promoting health along the lines suggested by Healthy Cities.

**Phase 2.6 Building Project Capacity**

*People, money and information are needed to make projects work (WHO, p39).*

**Q: Does G21 have a plan to access funds over the next 3-5 years?**

G21 have a 4-year funding agreement with all of the five regional councils which is formalised through the signed MOU. Members also provide funding to projects; however acquiring future and more long-term funding will be reliant on the quality of funding proposals based on the outcomes of G21’s strategic planning, project implementation, measurement and reporting outcomes.
**Q: Does G21 have an appropriate number of personnel for effective administration?**

Refer to Section 2.4, G21 Personnel above.

**Q: Does G21 have an information-gathering system?**

G21 gains access to information and data via their networks that collect, store, and use information for topics related to health, wellbeing and the local community. These organisations include local government, state government, universities, businesses and rural and regional health services.

There is no formal information-gathering system specified. However, a potential information-gathering system is reported to be in development through the Health and Wellbeing Pillar called the *Centre for Population Health*. This centre is still under development. When it is underway, it is proposed to provide:

- Demographic, epidemiological, social, economic and service data and information necessary for human services, infrastructure, environmental and economic planning and development;
- Development and support evidence-based regional strategies for promotion of health and wellbeing, prevention of disease, clinical research and risk management; and the reduction of inequalities and disadvantage within the region;
- Collaboration between key health, education, local government and business participants in identifying opportunities for research, and strategies for improved coordination of and communication between services;
- Access to further development of a skilled and knowledgeable resource base in research, analysis, ethics and study design to support these functions.

In their *2003 Geelong Region Strategic Plan*, the development of a Regional Indicators Framework is identified as a Foundation Project. Regional Indicators have been identified to provide a snapshot of the region with respect to the various Pillar themes. The framework is to be monitored on an annual basis to assess economic, social and environmental change.

This framework is reported to be further developed when the Centre for Population Health begins to produce comprehensive and informative data. It is anticipated that this Centre will invest in the tools needed to gain, collect, monitor and report on meaningful regional data and indicators. This investment, in turn, enables assessment of regional change and the impact of G21 projects and strategies.

The *Geelong Region Report 2005*, which provides a progress up-date of Pillar Group projects listed in the *2003 Geelong Region Strategic Plan*, outlines that the Centre for Population Health is still under development, so it is unclear to what level G21 have evaluation methods available to them.
Phase 2.7 Establishing Accountability Mechanisms

The term “accountability” describes the process by which organizations are held responsible for the results of their decisions and actions. The project should have a clear strategy for promoting accountability (WHO, p40).

Q: How do G21 evaluate their impact on the health and wellbeing of the region?

As outlined above, there is no formal information-gathering system in place though each planning exercise involves collation of existing demographic and economic data and use of various population projections. Within the Regional Indicators Framework the only indicator relating to health outcomes includes disease rates.

The Planning for Healthy Communities document also has limited methods for health impact evaluation. They acknowledge that it is difficult to capture improvement as a result of an intervention. This is due to:

- Implementation plans are not outlined in the Plan but in further G21, local government and Barwon Primary Care Forum planning that supports and enhances this plan; and
- Many of the health and wellbeing issues in the Plan are due to a complex combination of factors and determinants. While activity and interventions addressing one or more of these determinants may reduce risk it is often not possible to directly link a single intervention with a specific health improvement.

G21 therefore focus on developing process outcomes including leadership, partnerships, organisational development, capacity building and commitment to quality and best practice.

Q: How do G21 publicise their findings?

G21 publicise their findings through a variety of media. The primary source of media is the G21 website which provides the public with access to all of G21’s plans and documents as well as meeting minutes and agendas. G21 also produce a monthly newsletter Pillar to Pillar which provides up-dates on G21 progress and successes. There are also ongoing press releases on key G21 activities.

Phase 3: TAKING ACTION

Taking action is the final phase of project development and begins when the project has sufficient leadership and organizational capacity to be an effective public health advocate. It involves action in six areas, each leading to its own set of results. It covers those activities that build support for new approaches to public health and makes organizations throughout the region active partners in health development. One important result is a healthy public policy followed throughout city government and among project partners (WHO, p44).

The following section will provide an overview of G21’s capacity to facilitate a Healthy Cities approach and deliver healthy public policy.
Phase 3.1 Increasing Health Awareness

Project activities to increase awareness and understanding of health issues are an essential step in building strong and continuing political support. They generate public demand for healthy public policy and create willingness within government departments and other organizations to work on such policies (WHO, p53).

**Q: How does G21 raise awareness of health in the Region?**

A comprehensive action strategy for increasing awareness includes several strategies. G21 raises awareness of health in the following ways:

- Promotes a holistic view of health with consideration to the social determinants of health.
- Provides mechanisms through which intersectoral action for health can be planned and promoted creating opportunities for people in the region to have a stronger voice and a more active role in public health.
- Activities of the Health and Wellbeing Pillar in gathering knowledge about public health problems in the region.
- Providing access to information on the health issues in the region through their website.
- Promoting strategic planning to secure comprehensive long-term action for health.
- Promoting and utilising established frameworks for health promotion including Healthy Cities, Ottawa Charter and Social Determinants of Health.

Phase 3.2 Advocating Strategic Planning

It is essential for projects to promote strategic health planning that will encourage city government to take an ambitious proactive approach to healthy public policy (WHO, p46).

**Q: How does G21 advocate strategic planning within the region?**

G21 have been able to influence political decision-making in the region through intersectoral action in the development of their strategic plans. For example, development of G21’s strategic planning documents, both the 2003 Geelong Region Strategic Plan and the new Geelong Region Plan, have provided the platform for enabling people from various sectors such as environment, education and transport to come together and work in partnership for the benefit and wellbeing of the region.

This cooperative approach to regional planning has gained the attention of all levels of government. With all three levels of government engaged in the G21 agenda, G21 has the capacity to influence political decision-making and actually have an impact on the wellbeing of the region.

Development of the new G21 Region Plan has the full backing of all five Local Government as well as three State Government Planning Departments in: Regional Development Victoria; Sustainability and Development and; Victorian Communities. It is believed to be a first in Victoria and Australia.
Phase 3.3 Mobilising Intersectoral Action

An essential responsibility of Healthy Cities projects is to create organizational structures and administrative systems that mobilize intersectoral action. Intersectoral action is essential in new approaches to public health. Through such action city departments and other organizations thought of as working outside the health sector change their policies and programmes and strengthen their contribution to health (WHO, p47).

Q: How does G21 manage/foster intersectoral relationships and action?

Planning for G21 initiatives are founded on the Healthy Cities principle of intersectoral action with all levels of government, local business leaders and the community involved and committed to developing a collaborative approach to planning for the wellbeing of the Region.

G21’s regional focused Strategic Plans provide the mechanism needed for intersectoral action by providing a platform for people to come together to work on a common goal. In addition, their extensive consultation processes also help foster partnerships through providing a sense of inclusion and ownership in shaping the future of the region.

However, while partnerships are strongly promoted, intersectoral action is ultimately reliant on the strength of regional organisations commitment to G21 and to health promotion activities. Collaborative partnerships are weakened when they are solely promoted through encouragement. Defined roles and responsibilities of all planning partners in health promotion need to be specified and incentives provided to foster these relationships. G21’s new Geelong Region Plan and the Planning for Healthy Communities document have begun this process, although clearer communication and accountability pathways would strengthen this process.

Phase 3.4 Encouraging Community Participation

People participate in health through their lifestyle choices and their use of health care. In broader terms they also participate by expressing opinions that influence political and managerial decisions, working through voluntary organizations, self-help groups or neighbourhood associations. Healthy Cities projects are committed to strengthening community participation in all of its forms. The organizational structure, administrative systems, workstyle and priorities of the project should encourage and support community participation (WHO, p49).

Q: To what extent is community participation in G21 enabled and encouraged?

Community consultation features as a strong element of G21’s planning throughout their documentation. All of G21’s strategic plans and documents have involved significant community consultation. In addition, the G21 Constitution reports that at least one Strategic Forum is to be held annually. This Strategic Forum is open to all Members and interested members of the public to discuss the strategic direction of G21, facilitate an exchange of priorities for G21 and provide a forum at which the Board and Members have the opportunity to understand each other’s perspectives and aspirations for the Region and for G21.
Phase 3.5 Promoting Innovation

Strategies for promoting health through multisectoral action need development and refinement. The success of Healthy Cities projects in laying the groundwork for healthy public policy depends upon their ability to generate innovation in several areas. Achieving success through innovation depends upon creating a climate that supports change (WHO, p51).

Does G21 embrace innovation and adapt to change?

The concept of G21 itself is an indicator of innovation. G21 is the first and only regional development organisation of its type in the country. From its inception G21 recognised that a city approach to planning was limiting as geographical boundaries no longer determine issues or opportunities as people live, work and play in various cities and regions. Therefore, a regional approach to planning was identified. Throughout the five years that G21 has been in development, G21 have also adapted and embraced change to its strategic planning, realising that they needed to evolve the scope of its Strategic Plan to make it more far-reaching in its application.

Given the long-term thinking documented in G21’s regional planning documents, G21 acknowledge that the organisation must be versatile and innovative in responding to the changing environment, needs and aspirations of the region and Member organisations.

Phase 3.6 Healthy Public Policy

Local healthy public policy is perhaps the most important outcome of successful Healthy Cities projects. Such policy uses the leadership and resources of government to create healthier settings for daily life at home, in schools, workplaces and health care centres, and throughout the urban environment (WHO, p53).

It is essential for activities of the project in all of the five other areas in this phase to come together in a coordinated way to make the project an effective advocate of healthy public policy. Health awareness, intersectoral action, community participation, strategic planning and innovation are all contributors to the planning and implementation of healthy public policy. Political support is the foundation for healthy public policy. The project uses its links to city council as a vehicle for communication and advocacy. It becomes a credible advocate to the extent that it shows sensitivity to the community, skill in practical innovation and the ability to illicit support from project partners (WHO, p53).

What is G21’s capacity to advocate healthy public policy?

Overall, G21 have a good foundation to facilitate a Healthy Cities approach across their region. They document strong commitment to the characteristics of Healthy Cities including increasing health awareness, intersectoral action, influencing political decision-making, advocating strategic planning, utilising community consultation to inform planning, and a commitment to a process of innovation.

However, G21 also faces many challenges which may impact their ability to be an effective advocate of healthy public policy in the region. Most notably, work at a regional level requires the commitment and dedication of
networks to continue to invest their time, interest and resources. It also relies on the effectiveness of their strategic planning to not only capture community needs, but also provide clear pathways for planning partners to implement action and evaluate health impact outcomes. At present, stronger intersectoral action pathways and development of formal and comprehensive data collection and evaluation methods are needed.

The future success of G21 will be determined by their ability to maintain and foster their relationships and the united ambition to see the region reach its full potential and to effectively demonstrate their impact upon the health of the region.

In the next phase of the research, the nature of stakeholder knowledge of, commitment to and barriers to the adoption of a Healthy City framework will be explored along with the perceived ability of G21 to oversee this process in the region.
3.3 STAKEHOLDER CONSULTATIONS

3.3.1 Consultation Methodology .............................................76
   (i) Focus Groups............................................................. 76
   (ii) Interviews ............................................................ 76
   (iii) Online Survey........................................................ 76
   (iv) Research Questions.................................................. 76
   (v) Participants............................................................. 77
   (iv) Organisations Consulted .......................................... 77

3.3.2 Consultation Findings ....................................................78
   a) Awareness and Understanding of Healthy Cities ........... 79
   b) Current ‘Healthy’ Initiatives ....................................... 80
   c) Key Challenges and Ideas for Progress ....................... 80
   d) Role of G21 Geelong Region Alliance ......................... 82
   e) Recommendations for G21 ......................................... 84
   f) G21 Capacity to Facilitate a Healthy Region Approach ... 86
   g) The Most Suitable Organisation or Structure for
       Facilitating a Healthy Region Approach ...................... 88
3.3.1 Consultation Methodology

Participants were invited to engage in a variety of ways including focus groups, interviews, or an on-line survey.

(i) Focus Groups

As outlined in the Stakeholder Matrix (Appendix A), key organisations were identified and grouped according to their relationship to the Healthy Cities parameters. Focus groups were held for each of these parameters. A specific focus group was also held with members of the private sector.

Focus groups were 2 hours in length and were conducted at City of Greater Geelong, Surf Coast Shire and Colac Otway Shire (refer to Appendix C for the Focus Group Schedule).

(ii) Interviews

Interviewed were identified from each parameter in the Stakeholder Matrix and invited to be interviewed on a one-on-one basis. Interviewees were selected due to their role as key decision-makers in the Region and people who would potentially have a great impact upon the delivery of a Healthy Cities approach.

Interviews were between 30-60 minutes in length and were conducted at the participants place of work, an arranged meeting room, or via the telephone by members of the research team.

(iii) Online Survey

An online survey/forum was provided to those who are unable to attend either a focus group or interview.

The on-line survey could be completed at participant’s convenience and took approximately 20 minutes to complete.

(iv) Research Questions

A semi-structured questioning format was used for all consultations to ensure uniformity of questions across consultations while also allowing for flexible responses from the variety of participants and organisations.

The following topics were explored:

- Awareness and understanding of the Healthy Cities approach
- Awareness of current local and Regional based ‘healthy’ initiatives
- Barriers and enablers to a coordinated regional approach to promoting health and wellbeing
- Understanding of G21 and its role
- Capacity of G21 to lead this approach and to participate in a Healthy Region strategy
- Possible areas for enhancement and/or future development of G21 to support a Healthy Cities approach
- Alternative options for facilitating a Healthy Region approach
(v) Participants

Table 3 below outlines the number of people who participated in the project and in what format they were consulted - focus group, interview or the online survey.

Table 3. Number of Participants by Consultation Format

<table>
<thead>
<tr>
<th>Consultation Format</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus Groups</td>
<td>49</td>
</tr>
<tr>
<td>Interviews</td>
<td>16</td>
</tr>
<tr>
<td>Online Survey</td>
<td>19</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>84 Participants</strong></td>
</tr>
</tbody>
</table>

(vi) Organisations Consulted

We consulted with 41 organisations across the G21 Region. The following table lists the wide variety of the organisations who participated in the project split by Pillar groups.

Table 4. Organisations Consulted by Pillar

<table>
<thead>
<tr>
<th>Pillar/Sector</th>
<th>Organisation Consulted</th>
</tr>
</thead>
</table>
| Environment & Transport                      | - Public Transport Users Association  
- Barwon Water  
- Corangamite Catchment Management Authority  
- Department of Planning and Community Development (DPCD)  
- Surf Coast Shire  
- DHS Neighbourhood Renewal  
- Wathaurong Aboriginal Cooperative  
- Mayson Properties and Dennis Family  
- Draper’s Civil Contracting  
- Blue Cov Homes  
- Sinclair Knight Merz |
3.3.2 Consultation Findings

Consultations focused on the following areas of enquiry:

a) Awareness and Understanding of Healthy Cities
b) Current ‘Healthy’ Initiatives
c) Key Challenges
d) Ideas for Progress
e) Role of G21 Geelong Region Alliance
f) G21 Capacity to Facilitate a Healthy Region Approach
g) Recommendations for G21
h) The Most Suitable Organisation or Structure for Facilitating a Healthy Region Approach

The following outlines the key findings under each of these areas.
a) Awareness and Understanding of Healthy Cities

**Q1: Are you aware of the Healthy Cities concept?**

The purpose of the following questions was to identify stakeholder’s level of understanding of the WHO Healthy Cities concept. As presented in Figure 23, 53.8 percent of stakeholders expressed an awareness of the Healthy Cities concept, 38.5 percent were somewhat familiar and 7.7 percent were not at all familiar with the concept.

![Figure 23. Percentage of stakeholders who are aware of the Healthy Cities concept](image)

**Q2: How would you define a Healthy City/Region?**

Despite the amount of stakeholders consulted who were unaware or unfamiliar with the Healthy Cities concept, when prompted to try define a Healthy City/Region, all stakeholders exhibited a thorough and broad understanding of what a Healthy Region should look like.

Consistent with the Healthy Cities approach, stakeholders viewed a Healthy Region as working from a holistic, triple bottom line approach with a strong commitment to a social model of health, intersectoral collaboration and action and engagement from both political players (top down) and the community (bottom up). Emphases was also placed on equity and creating a place which is considered accessible and desirable to live, work, visit and invest as articulated in G21’s Vision.

This broad level understanding was consistent regardless of which sector was being consulted; highlighting that key stakeholders within the region are not only aware of the broad nature of health and what a Healthy Region should look like but the various sectors are also on the same page.
b) Current ‘Healthy’ Initiatives

Q3: What current (local or regional) initiatives are you aware of that support a Healthy Region approach?

Stakeholders came up with a list of over 100 initiatives or programs that support a Healthy Region approach and which are already in place either locally or across the Region (refer to Appendix E for a list of these initiatives).

Most of the initiatives identified were small, locally-based programs with a singular focus such as encouraging children to eat healthy and nutritious foods or promoting physical activity as a few examples. Fewer large, regional based initiatives which involved collaboration between sectors were highlighted. A few key examples included Neighbourhood Renewal, Armstrong Creek Development, G21, and the initiatives of the Primary Care Partnership (PCP).

While the smaller initiatives tended to have an overt health focus (i.e., improve nutrition, reduce obesity, promote physical activity) the larger initiatives provide more of an implicit focus which is more consistent with a Healthy Cities approach (i.e., providing broadband access, education, transport connections). A good example of an initiative which promotes health without an overt focus on health is provided in the text box.

Connected Seniors Program

Telstra Corporation has launched a $3 million grant program to help older Australians use mobile and internet technology to improve communication and social interaction.

Telstra Connected Seniors will provide $1 million each year for the next three years to community organizations such as bowls clubs and gardening groups to run programs that equip their members with new skills as connecting with other seniors online, making video calls or sending text messages.

"Learning new skills to stay mentally active is not only personally enriching, but a stimulating and enjoyable way to interact with the outside world, which in turn contributes to better health and well being". Telstra Group Managing Director, Mr David Moffatt, said.

Source: International Business Times, 16 August 2007

c) Key Challenges & Ideas for Progress

Q4: What, if any, are the barriers to the development of a Healthy Region? Q5: Can you identify any solutions to these barriers or ideas that might enable the progress of a Healthy Region approach?

A number of issues were raised which form barriers to adopting and implementing a Healthy Region approach in the G21 region. The following table provides the most frequently noted barriers identified along with a number of ideas for progress which were suggested throughout the consultation process.
Table 5. Barriers and enablers to a Healthy Region

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Ideas for Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resource dependency whereby the agenda tends to be run by what funding is available, rather than the other way around</td>
<td>Provide a clear agenda for whole region to create regional priorities</td>
</tr>
<tr>
<td>▪ Provide a clear agenda for whole region to create regional priorities</td>
<td>▪ Create data/evidence base to support advocacy efforts</td>
</tr>
<tr>
<td>▪ Create data/evidence base to support advocacy efforts</td>
<td></td>
</tr>
<tr>
<td>Attitudes- ‘We’ve always done it this way’ approach</td>
<td>Provide a clear agenda for whole region to create regional priorities</td>
</tr>
<tr>
<td>▪ Provide a clear agenda for whole region to create regional priorities</td>
<td>▪ Engage Regional Managers Forum (RMF) for top down support</td>
</tr>
<tr>
<td>▪ Engage Regional Managers Forum (RMF) for top down support</td>
<td></td>
</tr>
<tr>
<td>Maintaining commitment and energy of volunteers</td>
<td>Recognise and reward achievement and efforts of volunteers</td>
</tr>
<tr>
<td>▪ Recognise and reward achievement and efforts of volunteers</td>
<td></td>
</tr>
<tr>
<td>Difficulty sustaining initiatives with predominately short-term funding available</td>
<td>Create and use database to collect evidence on impact and effectiveness which can support funding advocacy efforts</td>
</tr>
<tr>
<td>▪ Create and use database to collect evidence on impact and effectiveness which can support funding advocacy efforts</td>
<td>▪ Recognise and reward achievement and efforts of volunteers</td>
</tr>
<tr>
<td>▪ Recognise and reward achievement and efforts of volunteers</td>
<td></td>
</tr>
<tr>
<td>Data and evidence base lacking to report on progress</td>
<td>Create data/evidence base</td>
</tr>
<tr>
<td>▪ Create data/evidence base</td>
<td>▪ Regulate the use of Health Impact Assessment (HIA)</td>
</tr>
<tr>
<td>▪ Regulate the use of Health Impact Assessment (HIA)</td>
<td></td>
</tr>
<tr>
<td>Duplication - too many projects, no coordination, resource consuming</td>
<td>Coordinate initiatives more strategically to avoid duplication</td>
</tr>
<tr>
<td>▪ Coordinate initiatives more strategically to avoid duplication</td>
<td>▪ Fewer, bigger projects</td>
</tr>
<tr>
<td>▪ Fewer, bigger projects</td>
<td></td>
</tr>
<tr>
<td>All sectors not engaged</td>
<td>Create a common language for health and wellbeing which is more accessible to other sectors, possibility avoiding the actual word ‘health’</td>
</tr>
<tr>
<td>▪ Create a common language for health and wellbeing which is more accessible to other sectors, possibility avoiding the actual word ‘health’</td>
<td></td>
</tr>
<tr>
<td>▪ None provided</td>
<td></td>
</tr>
<tr>
<td>All sectors not engaged (e.g. private sector)</td>
<td>▪ None provided</td>
</tr>
<tr>
<td>▪ None provided</td>
<td></td>
</tr>
<tr>
<td>Equity in funding (e.g., sports versus arts)</td>
<td>▪ None provided</td>
</tr>
<tr>
<td>▪ None provided</td>
<td></td>
</tr>
<tr>
<td>Limited infrastructure available in regional area (e.g. broadband fibre)</td>
<td>▪ None provided</td>
</tr>
<tr>
<td>▪ None provided</td>
<td></td>
</tr>
</tbody>
</table>
d) Role of G21 Geelong Region Alliance

**Q6: What is the role of G21?**

The Healthy Cities approach defines the role of a Healthy Cities project office as a mediator between the system for making political decisions and the network of organizations whose activities determine whether the region is a healthy setting in which to live (WHO, 1997b). The essence of the process is for the organisation to provide a vehicle for two-way communication between the political system and project partners (WHO, 1997b; refer to Figure 22 above).

Consistent with this definition, G21 is described in its documentation as an independent advocate for regional issues to be identified and solutions or projects implemented and that they achieve this by providing the mechanisms for intersectoral partners to come together and work on these regional issues.

When posed with the question of G21’s role, stakeholders expressed uncertainty. In fact, clarification of their role was identified as being one of the primary ways G21 could progress as an organisation. Generally, stakeholders were unsure whether G21 is a planning body or a facilitator. It was typically felt, even by members of G21, that the organisation has more of a planning role at this stage with focus recently placed on the development on the new *Geelong Region Plan*. However, it was recognised that G21 need to take on more of a facilitating role now in order to implement the actions outlined in their new Plan. Specifically, G12 stakeholders want to see G21 act as a:

- Facilitator
- Leader
- Advocate
- Coordinator
- Monitor

By working in these ways, G21 becomes more or a mediator like that defined by the Healthy Cities approach whereby they bring together the relevant people from across sectors to ensure projects and actions are comprehensive in their scope. Routine monitoring could also establish their impact and effectiveness which can help advocacy efforts and ultimately strengthen the leadership power of G21. Moving more towards this type of role would also be consistent with a Healthy Cities approach.

**Q7: What strengths does G21 have to facilitate a Healthy Region agenda?**

*Credible and innovative organisation*

Stakeholders identified that beyond already being established as an innovative organisation with its regional focus, G21 has also gained credibility with a solid regional planning platform based upon a bottom-up approach.

*Provides a regional planning platform*

Stakeholders stated that G21’s provides a good regional planning platform with their documents used to gain information and insight into:
- Key regional priorities;
- Projects that their organisation can add value to; and
- Demographic data for the G21 Region.

This information was said to be used by stakeholders to inform the development of their own local goals, ensuring that they align with the direction of the broader region in which they sit. For example, the local governments Municipal Public Health Plans (MPHP) are modelled according to the key themes outlined in the *Planning for Healthy Communities in the G21 Region 2006-2009*.

**High level political support**

Stakeholders also stated that they view G21 as being a capable organisation due to the commitment from the five local governments in the G21 region and the high level political support they have secured.

**Broad stakeholder participation and representation**

The network of sectors G21 have established (i.e. Pillar groups) and the broad level of members who represent each sector was also identified as a strength.

**Q8: What weaknesses do G21 have which could hinder their facilitation of a Healthy Region agenda?**

**Ambiguity in G21’s role**

As mentioned above, stakeholders expressed some uncertainty about the role of G21 within the region. This uncertainty is based around the recent focus of G21 towards a more planning function and the deviation from the facilitating and advocacy role in which they promote themselves. Stakeholders expressed that they feel it important to see G21 enhance their function as a facilitator and advocate within the region to ensure that they can now bring together the necessary players to carry through with the implementation and evaluation phase of the new *Geelong Region Plan*.

**Reliance on stakeholder engagement and investment**

It was noted that G21 have a heavy reliance on the engagement and investment from other agencies, particularly the local governments who provide their running costs, and are therefore vulnerable to changing political climates.

**Lack of communication pathways**

More centrally to the mechanisms of the G21 organisation, stakeholders expressed that there is a lack of communication occurring across the G21 Pillars and between the Pillars and the G21 Board. This is hampering the level of intersectoral action which is being fostered and smaller, more sectoral or Pillar based projects are the outcome. Stakeholders also stated that this tends to also result in a duplication of effort and resource consumption by the Pillar groups.

**Sustaining momentum and motivation**

It was identified that there tends to be a disengagement of Pillar members over time. Reasons were stated as being volunteers losing their momentum or time to participate due to changing schedules or circumstances, lack of reward for
their efforts, personal clashes between Pillar members and lack of leadership to arrange and coordinate Pillar meetings.

**Health as a de-centralised focus**

Stakeholders believe that the presence of the Health & Wellbeing Pillar tends to take the focus on health out of the other Pillars.

**Lack of monitoring and evaluation processes**

A particularly significant issue was said to be the lack of data and evidence available to monitor and publicise progress.

**All sectors not engaged**

No connection to the business and private sector.

**Plans, projects, where to next...? Challenges with implementation**

From a broad perspective, stakeholders stated that they view G21 as being a good planning organisation but rather weak in the implementation and action stages; they view G21 as being at a cross-road between planning and implementation. Historically, G21 have been a bottom-up, grass roots organisation which has many pluses but it also has many limitations in that it’s harder to get things done. Stakeholders have identified that the challenge now is for G21 to get buy-in from the top-down while also being informed by the bottom-up.

A significant contributor to this issue is the lack of clear communication pathways between Pillar groups and the specification of their roles and responsibilities.

e) **Recommendations for G21 to Progress**

**Q9: What would you recommend G21 need to do (or do better) to facilitate a Healthy Region approach across the Region?**

**Clarify role within the region**

The most significant recommendation expressed by the G21 stakeholders was for G21 to clarify their role within the region. It was suggested that G21 hold a re-launch to:

- Clarify their role in the planning and development of the region;
- Provide an up-date on progress to date and achievements;
- Introduce and promote any changes to the organisation structure and/or systems to compliment a Healthy Region approach;
- Re-engage with all existing stakeholders and introduce potential new networks; and
- Highlight stakeholder’s roles and responsibilities in light of the new focus on a Healthy Region agenda.

**Large, key projects that unite all Pillars rather than separate Pillar projects**

At present, stakeholders identified that there is a problem with duplication and fragmentation of effort with too many small Pillar-based projects and initiatives
running parallel with no coordination or cross-sectoral collaboration. It was put forward that G21 focus on identifying large, key projects based on the regional challenges and priorities identified in their *Geelong Region Plan*. A focus on larger projects could not only serve to reduce the duplication of effort and resources which is occurring, it could also foster a more cross-sectional approach which is necessary for conducting a Healthy Region approach. It may also have the added benefit of more people being involved with a project, lessening the impact of lost motivation or time from volunteers and therefore enhancing the sustainability of initiatives.

*Map existing initiatives across the region and their commonalities*

It was suggested that G21 undertake a mapping exercise to identify all of the current initiatives, projects and programs which are currently running to identify where overlap is occurring and where resources can be shared. It was further suggested that in order to provide coordination for future efforts, G21 could map key groups, networks and meetings which are occurring in each Pillar to assist them with partnering groups to work together on larger, more united projects.

*Create a Pillar Leader Group*

One of the most frequently cited weaknesses of G21 is the lack of communication pathways across Pillar groups. In order to address this weakness, stakeholders felt that the Pillar Leader Group needs to be re-established. Or, the Executive Group formed for the management of the *Geelong Region Plan* needs to be extended following the development of the plan.

Communication between the Pillars and the G21 Board, another cited weakness, could also be enhanced if the Pillar Leaders are also made members of the Board. This would provide a forum for communication pathways both horizontally and vertically across the organisation.

*Provide adequate staff in the G21 project office*

As outlined above in Phase 2.4 Setting up the Project Office, important to the success of a Healthy Region approach is the provision of adequate staff within the project office. According to the *Twenty Steps* document, with a regional population of 270,000, G21 needs at least five people in the project office (WHO, p34). G21 have 4 people in their project office; an Executive Officer, Executive Assistant, Project & Planning Coordinator and a Marketing & Communications Officer. If the Healthy Region approach is adopted, it could be argued that further resources will be needed in the G21 office to ensure its effective delivery. A Healthy Region coordinator could be employed to foster and provide the link between regional partnerships.

*Create a common language around health*

A direct and overt focus on health may in fact be detrimental to G21. The term/notion of health is typically ignored or misunderstood by people outside the health sector. Being that G21 relies on partnerships across sectors, a broader focus on ‘healthy’ or ‘wellbeing’ may be more appropriate to gain intersectoral buy-in and action. Health impacts and outcomes across sectors, however, should be evaluated, documented and publicised.
The term ‘sustainability’ was also offered as an alternative to enhance buy-in and commitment from a variety of sectors. It strength is that it draws authority from the current global focus on climate change issues.

**Engage the Regional Managers Forum (RMF)**

The RMF consists of Regional Directors of state government departments, as well as the CEOs of local governments in the Barwon-South Western Region.

The RMF is considered a key political player within the region and it was suggested that there could be a close relationship between G21 and the RMF to roll out the Healthy Cities initiative across the wider region, not just the G21 region.

**Create a database for measuring progress**

Stakeholders have also recognised the importance of being able to show evidence that G21 projects are having an impact on the health and wellbeing of the region. Having access to an evidence-base could aid G21 to seek and advocate support from stakeholders and to make the case for funding requests.

**Provide opportunities for education, information & achievement sharing**

Stakeholders identified the potential benefit of hosting a periodic forum for all G21 members and affiliates to get together to meet, discuss, learn and acknowledge the work of others. For instance, a forum held annually could provide G21 members a chance to meet and talk about the work they are doing in their Pillar groups, offer chances for intersectoral networking and potential partnership opportunities and provide a platform for G21 to express their status and up-date their members on achievements and success stories.

It was felt that this could provide a way for G21 to not only re-engage with their stakeholders but to ensure that people’s individual efforts, particularly volunteers, are acknowledged and rewarded in front of their peers. This could serve to offset drop-offs in volunteer’s energy and commitment to their role in G21 projects.

While in the stages of adopting a Healthy Region approach, a forum could also provide G21 with the opportunity to educate members about the approach and their individual roles and responsibilities in the roll out.

**f) G21 Capacity to Facilitate a Healthy Region Approach**

**Q10: Is G21 in a position to facilitate a Healthy Cities approach?**

To ascertain how to best support a Healthy Region agenda, stakeholders were asked whether they felt G21 has the capacity to facilitate the implementation of this approach across the Region. As shown in Figure 24, 71.2 percent of stakeholders felt that G21 is in a position to lead the Healthy Cities approach, 5.5 percent felt that G21 was not suitable and 23.3 percent were unsure.
While the majority of stakeholders did feel the G21 was capable, many stipulated that this was on the basis of a number of factors. Firstly, stakeholders felt that G21’s capacity is determined by the level of support and commitment they receive from their stakeholders. With G21’s role aimed at being a facilitator and advocate, they rely on their members to aid implementation and service delivery. Given that implementation has been considered a weak point with G21, stakeholders expressed that G21 need to be able to follow through with their plans and be more active in implementation.

The level of seniority of this support was also considered an important factor. It was felt that more senior and political players are needed on the G21 Board and leaders need to be identified to advocate the approach to ensure the agenda is embraced and championed.

It was further mentioned that G21’s capacity to carry this approach is determined by their ability to fulfil and sustain the changes underpinned by the G21 Governance Review and selling it to their stakeholders.

Stakeholders who felt G21 does not have the capacity to facilitate this approach expressed that there are too many other pressing agenda’s and reinforced the need for senior level people in the region providing their full commitment to backing this approach which was considered a challenging and long-term effort.
g) The Most Suitable Organisation or Structure for Facilitating a Healthy Region Approach

**Q12: Is there any other organisation or structure that is better placed to facilitate the Healthy Cities approach?**

As shown in Figure 25, the vast majority of stakeholders feel no other organisation is more suitable than G21 to facilitate a Healthy Region agenda. The small proportion of stakeholders who considered another organisation as better placed suggested the Primary Care Partnership (PCP) or the local governments as an alternative facilitating body.

*Figure 25. Percentage of stakeholders who feel there is another organisation or structure better placed to facilitate the Healthy Cities approach*
4. Discussion and Recommendations

As described in the literature review, a Healthy Region strategy would need to involve a broad-based, intersectoral political commitment to health and well-being in its deepest ecological sense; commitment to innovation; an embrace of democratic community participation; and a resultant healthy public policy.

Overall, the research has shown that a Healthy Region approach is not only a suitable approach for the G21 region, but G21 are also considered by key stakeholders within the region as the organisation which should facilitate its implementation.

Through the G21 document analysis and stakeholder consultations, it is clear that G21 have a number of important strengths working in their favor. Namely, they are considered an innovative organisation which established good will and credibility as a solid regional planning platform. Stakeholders also view G21 as being a capable organisation due to the high level political support they have secured and the broad intersectoral network of members it has attracted. However, while it is acknowledged that G21 already have a good foundation for working in a way that is consistent with a Healthy Cities approach, a number of gaps and weaknesses were identified through the research analysis and consultations which could impact upon their effectiveness. Key weaknesses included:

- Ambiguity in G21’s role
- Reliance on stakeholder engagement and investment and lack of roles and responsibilities
- Lack of communication pathways between Pillars and between the Pillars and the G21 Board
- Lack of coordination of projects/duplication of work and resources
- Sustaining momentum and motivation of projects and volunteers
- Health as a de-centralised focus due to a separate Health and Wellbeing Pillar
- Lack of monitoring and evaluation processes and health impacts
- All sectors are not engaged
- Good at planning but poor at implementation

From these, stakeholders identified a number of ideas for progress. These recommendations included:

- Need to define roles and responsibilities of G21
- Restructure G21 Board and Pillar communication pathways through establishment of a Pillar Leader Group and appointing Pillar Leaders to G21 Board
- Focus on large, cross sectoral projects
- Enhance resources in the G21 office
- Regularly engage and reward members/stakeholders to sustain motivation
- Create a data base to monitor progress and evaluate health impacts

These recommendations are used to formulate the content of Part 2: G21 Healthy Region Business Plan.

Overall, a Healthy Cities approach (i.e., a Healthy Region approach) has the potential to provide an overarching framework which can be applied to G21s existing organisation and its processes to build on their strengths and address their weaknesses. It is also offers a clear and internationally recognised approach for stakeholders to embrace. Additionally, a Healthy Cities approach
applied to the G21 region would further enhance its reputation as progressive and innovative region while also adding demonstrable improvements to the health and wellbeing of the region’s population. Such an approach would thereby progress G21’s Vision of the region to be “Australia’s most desirable destination for living, working, visiting and investing...renown for its vibrant, cohesive community, exceptional physical environment and vigorous economy” and see the region as an exemplar for the nation.
References


Victorian Community Indicators Project (2006). Developing a Community Indicators Framework for Victoria: The final report of the Victorian Community Indicators Project. Published by the Institute of Community Engagement and Policy Alternatives (ICEPA), Victoria University, the VicHealth Centre for the Promotion of Mental Health and Social Well Being, School of Population Health, University of Melbourne and the Centre for Regional Development, Swinburne University of Technology.


## Appendix A

### STAKEHOLDER MATRIX

<table>
<thead>
<tr>
<th>Health Cities Parameters</th>
<th>Associated G21 Pillar</th>
<th>Relevant Organisations</th>
<th>Consultation Format</th>
</tr>
</thead>
</table>
| 1. Built and Natural Environment (1, 2, 9) | Transportation, Environment | Dept. of Sustainability & Environment (DSE)  
Environment Protection Authority (EPA)  
Dept. Of Infrastructure  
Planning Institute of Australia (PIA)  
VicRoads  
Geelong Environment Council  
Vline  
Barwon Water  
LG Environment & Transport Planners, Engineers | 1 x Focus Group plus interviews with 4-5 key informants |
| 2. Supportive Community & Social Interaction (3, 6) | Sport & Recreation | Dept. Victorian Communities (DVC)  
Council of the Ageing (COTA)  
LG Social and Community Planners  
Local sporting Associations | 1 x Focus Group plus interviews with 3-4 key informants |
| 3. Civic Engagement (4) | Lifelong Learning, Research | Municipal Association of Victoria (MAV)  
Victorian Local Government Association (VLGA)  
Victorian Aboriginal Education Association  
BSW Dept. of Education & Training  
Deakin University  
Gordon Institute of TAFE  
Schools (Bellarine Secondary College, Belmont High School)  
Geelong Regional Library  
Neighbourhood Housing | 1 x Focus Group plus interviews with 4-5 key informants |
Regional Managers Forum  
Committee for Geelong  
Geelong Chamber of Commerce  
Geelong Business Club  
LG Economic Developers  
Otway Tourism  
Alcoa Australia  
Ford | 1 x Focus Group plus interviews with 4-5 key informants |
Reference: Healthy Cities Parameters (Hancock & Duhl, 1988)

1. A clean, safe, high quality environment (including housing)
2. An ecosystem that is stable now and sustainable in the long-term
3. A strong, mutually supportive and non-exploitative community
4. A high degree of public participation in and control over the decisions affecting life, health, and wellbeing
5. The meeting of basic needs (food, water, shelter, income, safety, work) for all people
6. Access to a wide variety of experiences and resources, with the possibility of multiple contracts, interaction and communication
7. A diverse, vital, and invocative economy
8. Encouragement of connections with the past, with the varied cultural and biological heritage, and with other groups and individuals
9. A city form (design) that is compatible with and enhances the preceding parameters and forms of behaviour
10. An optimum level of appropriate health and sick care services accessible to all
11. High health status (both high positive health status and low disease status)
Appendix B

G21 DOCUMENT FLOWCHART

Structure

- Memorandum of Understanding 2004-2008
- Constitution
- Board Charter

Geelong Region Strategic Plan (2003)

Strategic Planning

- Profile of the Geelong Region (2002)

Geelong Region Plan 2007

Part 1: Strategy

Actions/Outcomes

- G21 Membership Brochure
- Annual Report
- Planning for Healthy Communities in the G21 Region 2006-2009
- Geelong Region Plan 2007 Part 2: Actions
- Pillar to Pillar Magazine

The G21 Region Report 2005

Geelong Region Plan 2007

1. Regional Context

2. Background Report
Appendix C

PROJECT FLYER

Background Information
G21 are exploring the potential of applying the World Health Organisation’s ‘Healthy Cities’ approach to the G21 Region.

‘Healthy Cities’ is an approach that seeks to place health and wellbeing on the agenda of cities around the world, and build a local constituency of support. [http://www.euro.who.int/healthy-cities](http://www.euro.who.int/healthy-cities)

Healthy Cities is not just about being healthy, or levels of health, but continually working to achieve/improve human potential (human development). This is not a new concept, Healthy Cities has existed in cities and municipalities across the world since 1986. However, the idea of adapting Healthy Cities to a regional level is new and presents an exciting opportunity for G21 to lead the way again!

Healthy cities model recognises the need for growing a healthy community and strongly aligning environment, economic, social and psychological factors. A healthy city is ‘constantly creating and improving physical and social environments and expanding community resources which enable people to mutually support each other in performing all the functions of life’.

G21 is keen to investigate how a healthy region/cities concept could be instigated across the region, in order for official recognition as a Healthy Region to be sought.

What we will do?
We are keen to engage people and organisations in the G21 Region to participate in focus groups, individual interviews or an online survey.

During September and October the consultation sessions will explore:

- Your understanding of health and wellbeing and the Healthy Cities approach
- The possibility of adopting Healthy Cities approach across the Region
- Your organisations’ commitment to promoting health and wellbeing
- G21 and its role
- Barriers, incentives and benefits of adopting Healthy Cities initiatives
- The level of interest in adopting the program
- Healthy Cities program and policy development

The Researchers
G21 has engaged Deakin University to undertake the independent research for the Project. G21 has established a Project Steering Group consisting of key representatives from G21 Health and Wellbeing Pillar.

With your help we will:
- Establish the benefits of a G21 “Healthy Region”
- Assess our capacity to become a Healthy Region
- Develop a Business Plan for creating a Healthy Region.

If you require further information, please contact:
Ms Melissa Edwards, phone 9244 6452; email: melissah.edwards@deakin.edu.au
Dr Iain Butterworth, phone 9251 7631; email: iain.butterworth@deakin.edu.au
## Appendix D: FOCUS GROUP SCHEDULE

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Venue</th>
<th>Workshop Pillar Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 Sept</td>
<td>10am-12pm</td>
<td>City Hall Geelong</td>
<td>Focus Group Pilot with Steering Group</td>
</tr>
<tr>
<td>26 Sept</td>
<td>10am-12pm</td>
<td>Colac Visitor Information Centre, Colac</td>
<td>Community Safety and Security, Health and Wellbeing</td>
</tr>
<tr>
<td>1 Oct</td>
<td>10am-12pm</td>
<td>Surf Coast Shire offices, Torquay</td>
<td>Sport and Recreation</td>
</tr>
<tr>
<td>4 Oct</td>
<td>10am-12pm</td>
<td>City Hall, Geelong</td>
<td>Environment and Transport</td>
</tr>
<tr>
<td>4 Oct</td>
<td>3pm-5pm</td>
<td>City Hall, Geelong</td>
<td>Arts, Culture and Heritage</td>
</tr>
<tr>
<td>8 Oct</td>
<td>10am-12pm</td>
<td>City Hall Geelong</td>
<td>Life Long Learning and Research</td>
</tr>
<tr>
<td>9 Oct</td>
<td>10am-12pm</td>
<td>City Hall Geelong</td>
<td>Economic Development Telecommunications</td>
</tr>
<tr>
<td>18 Oct</td>
<td>10am-12pm</td>
<td>City Hall Geelong</td>
<td>Private Sector</td>
</tr>
</tbody>
</table>
Appendix E:

‘HEALTHY’ INITIATIVES

1. Adult Learning
2. After School Activity Program
3. Armstrong Creek
4. Australian Business Excellence Framework
5. Barwon Sports Academy
6. Be Active, Eat Well
7. Bio-Geelong
8. Broadband Access
9. Business Workshops on ‘Creative Cities’ – Mental Health Forum
10. Careers and Skills Centre
11. Centre for Sexual Assault (CASA)
12. Child Safety Programs
13. Church Groups
14. Club Development Program, Leisure Networks
15. Community Building Initiatives (CBI)
16. Community Festivals/Events
17. Community Gardens (Norlane/Corio)
18. Community Transport Project (LGAs)
19. Connected Seniors Program
20. Corio Community Park
21. Council of the Ageing (COTA)
22. Crisis Assessment Team (CAT)
23. Cultural Precinct Study
24. Deakin Peer Health Coaching
25. Diabetes Prevention/Self-Care
26. Diversitat
27. Do Care
28. Early Childhood Development
29. Early Years Network
30. ELive – Distance Education Program (Deakin)
31. Falls Prevention Programs
32. Family Relationship Centre
33. Fluoride Campaign
34. Folk Sundays
35. Food Safety
36. FREEZA – Youth Participation Program
37. G21 Geelong Regional Alliance
   a. Health and Wellbeing Pillar
   b. Community Safety Pillar
   c. Planning for Healthy Communities
   d. Geelong Region Plan
38. Glastonbury – Early Learning
39. Grais Groups
40. ‘Go for Your Life’
41. Good Sports
42. Hats/Sunscreen in Schools (No Hat, No Play)
43. Head Space (Mental Health)
44. Health Services eHealth
45. Healthy Ageing Forums
46. Healthy Eating Programs
47. HIA Screening/Demonstrating Project
48. Housing Diversity Strategy (CoGG)
49. Integrated Fire Management Plan (IFMP) (CFA)
50. Karingal Gallery
51. Kool Schools – Arts and Music
52. Leopold Strategic Footpath Project
53. Lets Read
54. Lifelong Learning Skills Centre
55. Living Library Projects
56. Local Arts Group
57. Neighbourhood House
58. Neighbourhood Renewal
59. Northern Suburbs Alliance of Health Workers – Art Projects (CoGG)
60. Mates Program
61. Meals on Wheels
62. Municipal Public Health Plans (MPHPs)
63. Musical Mornings Program
64. Obesity Sentential Site
65. Open Space Provisions
66. Open Space Strategy (Surf Coast Shire)
67. PICSAR (Planning in Communities Sport and Recreation)
68. PLAY – Training for Parents Program
69. Primary Care Partnership (PCP)  
   a. Community Health Plan
70. Rebates on Solar Power, Gas Conversion for Cars
71. Recycling Programs
72. Regional Managers Forum (RMF)  
73. Regional Migration Incentive Fund (RMIF) (CoGG)  
74. Regional Tracks and Trails Strategy
75. Regional Youth Charter  
76. Reskilling and Retraining Agenda
77. Romp and Chomp
78. RSA Projects – Clubs
79. Rural Access Program
80. Save a Mate (SAM)
81. Security and Surveillance of Public Spaces
82. Skate Parks
83. Skills Taskforce
84. Smiles for Miles
85. Sports Link Website
86. Sporting Groups
87. Structured Active Play (SAP)
88. The Ford Response
89. Trail Strategy (Surf Coast Shire)
90. Transport Connections Project
91. Urban Renewal Program
92. Vic Active
93. Victorian Local Government Health Measure
94. Volunteer Engagement Project
95. Walk/Ride to Work Day
96. Walkability Research (Deakin)
97. Walking School Bus
98. Water Saving Measures
99. Water Sensitive Urban Design
100. Women and Drought
101. Work for the Dole
102. Work Training for Stress in Small Business
103. Young Persons Safety Forum – Youth Council
104. Youth Foundations
105. 10,000 Steps