California Healthy Cities and Communities
Twenty-Five Years of Cultivating Community and Advancing a Movement

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"So, you're trying to change the way people think?" That was the question posed after a description of what the California Healthy Cities Project was setting out to do over twenty-five years ago. "Well, yes we are . . . we want health to be everybody's business because we know that it is profoundly influenced by our environment, i.e., where we live, go to school or work, recreate, worship, and socialize."

It was an ambitious experiment, the first health cities program in the United States. It borrowed from the emerging work of the World Health Organization's Central European region and from Canadian cities and towns, especially the city of Toronto and Quebec. For several compelling reasons, California municipalities were the initial focal point. The rationale included their capacity for:

- Sponsoring public debate.
- Responding to local needs and values.
- Enacting policy.
- Allocating resources for personnel, planning, infrastructure, land use, safety, and enforcement functions.
- Engendering civic pride and a sense of place.

Cities, as permanent entities with constancy of mission, provide fertile ground for the norm change necessary to sustain the work of changing the way people think.

Program Sponsorship and History

The Center for Civic Partnerships (the Center), based in Sacramento, is the home of the California Healthy Cities and Communities (CHCC) program. The Center is part of the Public Health Institute. Since the program's inception, very modest funding has been awarded by the California Department of Public Health (previously the Department of Health Services) through a Preventive Health and Health Services Block Grant. Categorical funding from the Network for a Healthy California, the California Wellness Foundation, and Food for All has also been awarded to the program office for technical assistance and the educational campaign and for re-granting to participating communities.

With a five-year grant from the California Endowment (TCE) in 1998, the CHCC's expanded program funded twenty sites to engage in capacity building for community health improvement efforts. These communities included unincorporated areas that were geographically or socially isolated and those with populations "at risk" for inequities in health status. In addition, the Central Valley was a region of great interest and significant participation.

In general, CHCC participating communities receive a local assistance award of approximately $20,000. (Initially, grants were for lesser amounts.) With TCE's support for the expanded program, these awards ranged from $25,000 for planning to $50,000 for implementation with an escalating match requirement each year.

Participating cities have ranged from populations of approximately five thousand to almost one hundred times that number. Unincorporated areas with fewer than a thousand residents have participated. The communities have resident profiles representative of the diversity of California's demographics and civic personalities. Most have median incomes below the state average, with a sizable number very far below.

By design, local CHCC initiatives are community driven. They cover the gamut of community life, including various strategies to support healthier eating and physical activity, injury prevention (intentional and unintentional), safe and active transportation, smart growth, neighborhood

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improvement, tobacco control policies, and quality-of-life indicators, among others. They span generations from youth to older adults. Local assistance awards come with technical assistance from the Center for planning, implementation, and evaluation as well as how to leverage the award for other resources.

Methods and Results

The Center's emphasis is always to build capacity and ensure that communities are stronger as a result of their participation in the CHCC program. In a span of twenty-five years, well over one hundred cities and communities, from every region of the state, have participated in the local assistance program or been members of the CHCC Network. The Network is a membership program created for groups interested in the principles and practices of healthy cities and communities.

At the state program level, the Center has strategic partnerships with good government groups (state and national), health care associations, and discipline-specific membership organizations—for example, city managers, park and recreation specialists, city planners, and public health professionals. These groups were vitally important for credibility with the priority audience, leveraging opportunities for training and resource dissemination.

The CHCC program's cyclical model of Inspire, Support, Sustain and Celebrate has been highly effective in laying a solid foundation for community building and community health improvement for years to come. Inspiration comes in the form of an educational campaign and hundreds of presentations, many at venues where the priority audiences already participate.

Support is provided through distance and on-site technical assistance. The Center has developed fifty audience-specific guides, journal articles, and tool kits. These publications and over eighty issues of the CHCC newsletter, *Connections*, have been sent to thousands of locally elected and appointed officials and public health/administration professionals throughout the state. Most publications include the latest data or rationale for why the issue is important, case studies, resources, and local contacts.

Sustainability is fostered through a peer support network, resource brokering and sponsorship of professional education opportunities, and statewide and regional conferences. Keynote speakers have included some of the most highly respected national and international leaders from the fields of public health, smart growth, media, elected office, philanthropy, social welfare, and policy advocacy organizations. In 1993, the CHCC program cosponsored the first International Healthy Cities and Communities Conference held in the United States (San Francisco), which brought 1,600 healthy community advocates together and profoundly influenced the hundreds of Californians in attendance.

Celebration has included statewide awards programs and publications which recognize exemplary achievements that can be tailored to fit multiple community contexts. Over 325 cities have been recognized for efforts to improve livability through groundbreaking tobacco control policies, brownfield redevelopment, community safety and revitalization, among others.

An external evaluation of the CHCC Expanded Program found over one thousand new leadership roles were created in this twenty-site subset alone. In this same group of twenty communities, the CHCC local assistance awards provided an average 8.4 return on investment, leveraging an estimated $21 million in financial resources in a three-year grant period.

A long-term contractual relationship with the Network for a Healthy California has resulted in local assistance awards, support for numerous conference sessions, and at least seven widely distributed standalone publications on improving opportunities for healthier eating and physical activity in communities. Tens of thousands of articles and resources have been shared via print and electronic media. As a consequence, action on the part of municipalities to improve neighborhood environments and policies for better nutrition and exercise has been remarkable.

Among the numerous outcomes of all the CHCC projects are increased fruit and vegetable consumption, decreases in prevalence of adult and youth obesity, improved academic scores as a result of intergenerational tutoring, development of quality-of-life indices that guided policy development and

resource allocation, and incorporation of health elements into general plans. Health-promoting public policies, from tobacco control to healthier food access, have passed in hundreds of jurisdictions. Innumerable physical improvements—for example, community gardens, improved walkways, and bike lanes—have made communities safer and more livable for residents across the life span.

Impact

Impact can be manifested in multiple ways. The strength of support for the Healthy Cities and Communities movement is one way. The CHCC Network was established in 2000. It has been a way for like-minded communities, local public health departments, and nonprofits to affiliate, or stay connected, with both the state and the international movement. Many members have been active for ten or more years. In addition, when asked in the evaluation of the recent annual meeting the primary reason influencing their participation, the answer, from two-thirds of the respondents was "commitment to Healthy Cities and Communities' principles."

During the last two and a half decades, the roles that the many actors have in this work have come into sharper focus. California Smoke-Free Cities (a CHCC collaboration with the state municipal league, health officers association, and a national nonsmokers' rights organization) worked for six years beginning in 1990 within a state-supported tobacco control network and media campaign to reinvigorate and support an interest in policy as a public health strategy. Today, the conviction that the physical environment and public policy shape and determine opportunities for population health and quality of life is very much in the forefront of our public and political discourse.

Another sign of the movement's momentum is TCE's ten-year Building Healthy Communities strategic direction to support the development of communities where kids and youth are healthy, safe, and ready to learn. National philanthropies—Robert Wood Johnson Foundation, Bloomberg Philanthropies, and Rockefeller Foundation—recently announced awards or plans for city-based investments that are testimony to the leverage point that cities offer for improved population health.

Challenges

Funding insecurity (both amount and length of commitment) is the largest single obstacle the CHCC program has endured. The steady decrease or threatened elimination of the Preventive Health and Health Services Block Grant at the federal level during most of the years the program has been operational has had a hugely deleterious impact. This has been experienced in an extremely acute fashion in the last few years. A threshold of resources with a multiple-year commitment is clearly necessary to engage, and retain, local and statewide partners.

Noncategorical support has been hard to come by, except for the CHCC expanded program funded by TCE. Funders often look to have a distinguishing brand for the work they support. A program that is already operational is challenged to position itself accordingly.

Initially the name "healthy city/community" itself was a barrier. It often connoted more of a health care orientation or individual level of responsibility. Significant progress has been made in understanding its more socio-ecological perspective. Nonetheless, the term sometimes is still used without appreciation of the philosophy and principles at its core.

Lessons Learned/Confirmed

Among the many lessons learned or confirmed during the past twenty-five years of the California Healthy Communities and Cities experience, ten come to mind.

1. *Leadership and community participation need to be diverse, broad, and deep.* Stakeholders need to come from the essential fabric of the community—education, civic organizations, neighborhood associations, business interests, faith-based groups, and local government (especially planning, community services, and recreation departments) as well as all the other entities that comprise community ecology. In particular, residents must be engaged from the outset. They have invaluable insights for every phase of the work.

   Leadership for the community collaboration must be diverse in every way—for example, age, gender race/ethnicity, culture, and worldview.

It is critical to have both planners and implementers. Strong political support, community champions, and alliances with respected organizations are all critical components of success. For example, land use planners appreciate that health leaders can make the case to link better land use to the likelihood of improved health and quality-of-life outcomes.

Good leadership development is characterized by a continual process of renewal. This is often achieved through a committee that is charged with training and recruitment. If it isn't a specific responsibility of an individual or group, momentum will be lost with the inevitable transitions. For long-term sustainability, avoid the perception that the project is tied to any one individual or administration.

2. *Respectful relationships are key to success.* It has been said that everything boils down to relationships. Successful programs have a win-win ethos as the basis of strong partnerships. It is not so much about the given healthy city/community project per se as it is about a commitment to ongoing introspection about what's working, or not, who's benefiting or being adversely impacted, and community regeneration. Every discipline and sector has a different language, culture, and set of incentives that must be respected. It is important to take the time to learn and appreciate their meanings, relevance, and nuances.
3. *Geopolitical context and history matter.* Policy makers are most concerned with that which is in their sphere of control. Data that blurs jurisdictional boundaries will not be readily embraced. Make data accessible and ready to use. Learn how your local government is organized, and appreciate current context. Most of the time, there is baggage between and among public and social sectors that needs to be appreciated and addressed before the real work can begin. In one participating community, the city and county governments were in litigation over a landfill, yet they were able to carve out a zone of collaboration for a multifaceted Healthy City program.
4. *Sound governance and management will foster and maintain momentum.* It is extremely important to establish a strategic orientation—that is, to have a vision and to be clear on the mission. Second, ensuring effective operational procedures—meeting schedules, publishing minutes, and adhering to good record-keeping /accounting procedures—are the basics of any productive endeavor. Making good personnel decisions and following through with commitments are vital to credibility.
5. *Plans will be embraced when they are home grown and locally driven.* Professionals can name what they see as the community's challenges, based on data and facts, *and* they need to be open to alternative narratives and solutions. If the community's priorities aren't attended to, then the data will be necessary but insufficient as a call to action. Start with where the people are. Build on assets. Connect the dots to the health agenda as the momentum builds.
6. *A regional fishbowl will provide incentives.* The principle of *diffusion of innovation* by Everett Rogers (in his 1995 book *Diffusion of Innovations*) takes on added value when resources are scarce. In the professional realm, finding the 10 percent of the priority population who will embrace the desired change will be a natural bridge to enlisting their peers. Find the creative examples and showcase them. Enlisting a person in a position of influence who has access to, and credibility with, leaders in many sectors and communities can expedite progress. In San Bernardino County, one such champion enthusiastically endorsed the healthy city philosophy and model with business leaders, academics, county supervisors, and school superintendents. One result was a county-funded, multiple-city initiative supported through the general fund with staffing from the sponsoring supervisor's office.
7. *Progress and results need to be reported and celebrated.* Staying visible is a must. Everything from formal communications to mass and social media should be utilized with informal networks engaged as well. Whenever possible, involve elected and appointed officials or their staff in coalitions and task forces and invite them to communitywide celebrations.
8. *Long-term commitment is required.* Planning, implementation, and evaluation are part of a fluid cycle that can't be rushed by arbitrary one-size-fits-all guidelines designed to meet externally driven needs. The initial planning can

take eighteen months or more, depending on the size of the community and complexity of the challenge. Remaining flexible allows for taking advantage of serendipitous events and to adapt as needed. Approach the work as more than a grant-funded or point-in-time activity. Be there for the long haul.

9. *Sustainability needs to be built in from the beginning*. The Center has been involved in numerous population health improvement initiatives both statewide and on a national scale. Consequently, we have designed a ten-step process that defines sustainability as "the continuation of community health or quality of life benefits over time." Inherent in the CHCC program's relatively modest financial award strategy is the increased likelihood of communities having "skin in the game." Developing a plan to sustain community benefits is ideally done more than a year before funding termination.
10. *Evaluation must be transparent and benefit all parties*. Establish a system to continuously track progress and evaluate programs and policies. Checking in on evaluation measures and processes throughout an initiative prevents surprises (and resentments) at the end. Again, assigning an individual or group to be responsible for ensuring that this component stays on track enhances the likelihood that it will happen. Recognize the different drivers that each sector has, and factor those into what will be monitored and reported.

The Future

Whether the term is cross-sectoral partnerships, collective impact, or something else, we're talking about a community-building approach that has come of age, not a novel trend or passing fad. Healthy Cities and Communities wasn't the first, nor will it be the last, incarnation of civic democracy in action. What is certain is that a siloed way of working is anachronistic. The idea of healthy, sustainable, strong, resilient cities has permeated the consciousness of a wide swath of society at the right time. The twenty-first century is poised to be the century of the city. The largest US cities have just recorded population gains that have more than reversed those lost in the last decade. All indications are that this will continue, especially in international mega-cities.

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In the United States, 80 million boomers (born between 1946 and 1964) combined with greater longevity overall means that there will be significant demands for affordable and accessible housing and more convenient mobility options. Accordingly, land use patterns will evolve, with smart growth and infill strategies preferred over sprawl. If local governments and their partners do not plan and organize for this demographic shift, they will witness greater infrastructure and service demands and usage, increased costs and resource deficits, and lost opportunities. Conversely, capturing this age dividend will provide greater prospects for social innovation, increased local investment, and community benefit, including civic contributions and intergenerational exchange. The Healthy Cities and Communities model is the ideal vehicle to reengineer our physical environments, in particular, with the concept of cobenefits across the life span.

At an early retreat for representatives from the first ten California Healthy Cities, one of the participants asked, "How will you know when you are successful?" The somewhat off-handed reply was that the term *Healthy City/Community* would be a household word. Well, it certainly has permeated the consciousness of elected officials and professionals in diverse fields, including public health, public administration, planning and community development, in ways we couldn't have imagined. Numerous foundations, non-profit organizations, and even corporations have embraced a healthy community orientation and philosophy. Community members have always intuitively known what it takes to have a good place to live, learn, work, and play. What the Center for Civic Partnerships and the CHCC program have contributed are some well-traveled road maps for the journey. Visit

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us at www.civicpartnerships.org and enjoy your journey.

The mission of the Center for Civic Partnerships is to provide leadership and management support to build healthier communities and more effective nonprofit organizations. The Center is part of the Public Health Institute, which generates and promotes research, leadership, and partnerships to build capacity for strong public health policy, programs, systems, and practices.

Reference

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