Interim report on the role of local governments in childhood obesity prevention

Study of literature in the framework of the EPODE European Network and the Committee on Involvement of Political Representatives

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'Most indicative of all perhaps is the reversal in the social distribution of obesity. For centuries the rich have been fat and the poor have been thin, but when we came out of the epidemiological transition the pattern reversed and the tendency became, as it is now, for the poor to be fatter than the rich.'

Citation of Wilkinson on the epidemiological transition in: Wilkinson, R., The impact of inequality, How to Make Sick Societies Healthier, New York, London: The New Press, 2005, p11

1. Situation and executive summary

This interim report is situated in the ongoing EEN research project on the implementation of *'community based interventions' (CBI's)* for childhood obesity prevention (COP). EEN stands for Epode European Network. CBI's are prevention projects or programmes which involve systematically the environment and community obese people live in. EPODE is the abbreviation of 'Ensemble Prévenons l'Obésité Des Enfants' and is a CBI-like approach spreading in France and neighbouring countries.

In this project four universities (Ghent, Amsterdam, Lille and Zaragoza) are undertaking research activities in *diverse aspects of the implementation* of those systematic prevention projects or programmes to tackle childhood obesity. Protéines, a company in health communication, is coordinating this international research project. It is obvious that these universities can execute their scientific study in complete indepence. More information can be consulted at http://www.epode-european-network.com/

In this EEN project the Department of Public Health of the Ghent University is doing research on the *role of local governments*. These researchers argue that a local authority should engage in assuming a steering role in the networks on the promotion of diet, physical activity and healthy lifestyles to effectively reach for the target on sustainable changes in relevant behavioral patterns. This hypothesis is based on the exploration of literature and will be further developed by means of case-studies about the role of Flemish city authorities really play in the promotion of diet, physical activity and healthy lifestyles.

From that screening of literature we have learned that public intervention is necessary in order to deal with childhood overweight and obesity and that the local administrative level constitutes the tailpiece of any public intervention in this field. The key task of the (local) government in obesity prevention consists of supporting the target groups (such as children, adolescents, etc.) and the first-level actors (such as parents, schools, sports organisations, associations for a healthy diet, etc.), so that the intended groups start to eat more healthy food and to take more physical exercise. In this respect we also have learned 1) that the (local) government should play four different major parts to show real leadership, and 2) that furthermore various other institutional factors determine to what degree childhood obesity prevention is translated into reality.

The (local) government can **take the lead** by assuming four major parts, notably:

1) by assuming the leadership of prevention programmes, by being visible as "puller" and by showing sufficient readiness to take action,
2) by assuming the steering role of a multi-actor, multi-level and multi-sector prevention network, by 'advocating' the preventive approach of the partners' actions,
3) the role of fund raiser,
4) and the role of policy pursuer, in terms of stimulator of the policy process.

We could deduce from the study of literature that the degree to which the (local) government can effectively assume the four different parts might determine the degree of success to which childhood obesity can be prevented and/or counteracted.

Furthermore, the screening of literature provides an insight into a extra number of institutional factors which might determine the success of prevention programmes for dealing with

childhood obesity. In this respect we can distinguish four major issues, namely internal governmental factors, the societal and managerial support, the direct context and external factors at the background of the local governments.

Possible important **internal governmental factors** are:

- the relation between political administrators and leading civil servants,
- the internal capacities of the departments involved,
- the expertise of leading civil servants and project managers,
- the competences of change managers and frontline workers.

The **societal and managerial support** refers to the existing forms of collaboration between the stakeholders in the public health network for promoting a healthy diet and physical activities. That kind of support will to a large degree be determined by the attitude and behaviour of actors involved:

- the attitude can be characterised by values such as openness, willingness to cooperate, willingness to build a consensus about the priority in public health matters, involvement, trust, etc.
- also their behaviour is an important element, certainly in consultation, mutual and external communication, follow up of engagements, division of tasks, competence in conflict resolution, etc.
- the relation of the most powerful (or strongest) actors in the prevention network with the rest of the actors within this same network.

In the **immediate context** of the local governments, the most important institutional factors which can determine the promotion of a healthy diet and physical activities might be:

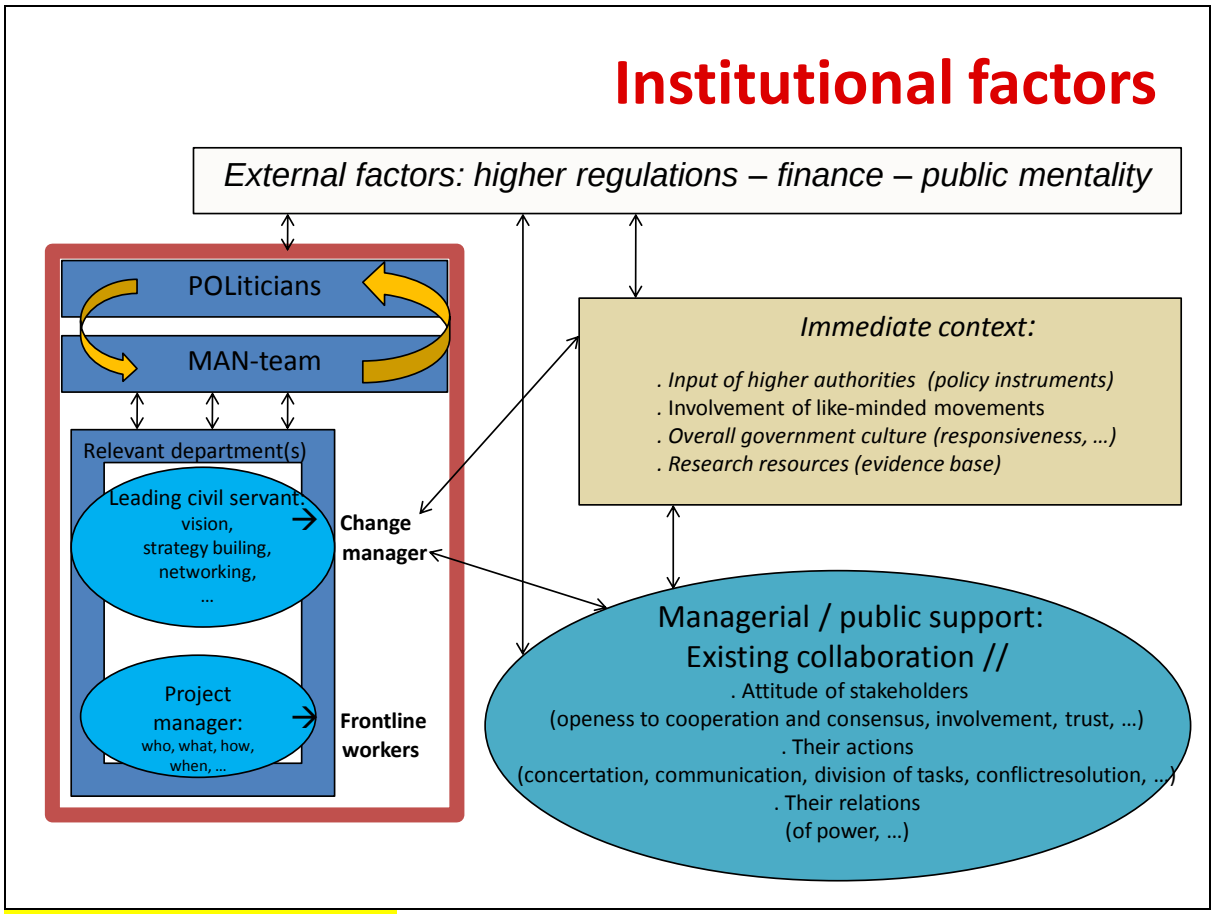
- the input of the supra-local authority (e.g. via regional health consultation, organisations of sports promotion, etc.),
- a mix of policy instruments, in which 'hard' policy measures constitute the backbone for more 'soft' measures,
- the mobilisation of like-minded movements (e.g. on climate, mobility, healthy diet, fitness, alternative medicine, sports, etc.),
- overall corporate culture in local governments,
- research resources (evidence base).

Also **external factors** (in the background of the local governments) could possibly have an effect on the implementation of prevention programmes for handling childhood obesity:

- the nature and quality of laws and regulations of the national or regional public policy,
- the attitude (or mentality) of the population towards its own body weight and the problem of overweight and obesity.

In the scheme there is a systematic oversight of all those institutional factors, relevant for the role local governments can play to improve the degree of success in the CBI's on childhood obesity prevention.

Scheme: Overview of institutional factors, relevant for role of local governments in COP



Source: *DPH-CLP-CSD, 2010*

2. Who wants to know more about …

The screening of literature has produced three types of documents. Firstly, we have found in the policy documents themselves quite some data on the way in which authorities should deal with phenomena such as overweight and obesity. It is particularly noticeable that those policy documents on all supra-local administrative levels point out the important role that should be played by the local authorities in the matter. The second type of literature gives a rather theoretical and advisory description of what the policy should look like, and of which models, strategies or actions should lead to the best results in terms of reducing obesity among the respective target groups. Thirdly, there are the reports on the research into the implementation of innovations in public health on a local administrative level. These documents provide relevant insights that can be useful for drawing a reliable picture of the reality of the policy pursued in preventive health care (for instance concerning overweight). In preparation to the interviews for a case study in our research it is important to verify which are the most important factors for the (local) authorities' intervention in case of a 'community based intervention' in the field of preventive health care and specifically for 'childhood obesity prevention' or abbreviated as COP.

3. List with definitions and abbreviations

Some of the key concepts out of literature are defined in the list beneath:

'Community based intervention': projects in public health policy, which aim at the involvement of target audiences by pointing at the environments and communities they live in, in order to reach for the target of sustainable changes in behavioral patterns.

Overweight: when BMI for adults (M+W) is situated between 25 and 30. For children there are limits according to their age (so called 'cut off's').

Obesity: when BMI for adults (M+W) is higher than 30. For children there are limits according to their age (so called 'cut off's').

Preventive public health policy: refers to three different kinds of prevention, namely health promotion, health protection and prevention of disease. This policy execution is situated partly in the domain of health care (and is known as the preventive health care policy), but partly also outside the public health domain (in which case the concept of multi-sector policy is used).

Health promotion policy is aimed at changing the living environment and life-styles of people to improve their health (or at least conserve it).

Health protection has the objective to limit the potentially dangerous impact of factors, such as consumer-goods and installations, in contact with people.

Policy on the prevention of disease contains measures to prevent specific diseases or to detect them in an early stage, so they can be treated.

Multi-level policy: government action at different governmental levels or echelons, such as e.g. the international, national, regional, provincial and local level.

Multi-actor policy: collaboration of government with different actors, coming from public or private sectors of society. Multi-actor policy can refer to public-public collaboration (with several government organisations) and public-private cooperation (between public authorities and several private organisations). The concept of 'private organisations' refers to actors 'in the market' (companies, trade unions, etc.) as well as to non-governmental organisations (or NGO's). Multi-actor and multi-level policy can have overlap, because actors can function at different governmental levels.

Multi-sector policy: collaboration of government with different sectors in society. In the promotion of healthy diets and physical activities authorities in public health policy should cooperate with relevant sectors such as agriculture, nutrition, finance, trade, business, consumer affairs, education, research, mobility, town and country planning, social policy, employment, sports, culture, tourism, media, etc.

Integral approach of public health policy: is a public health policy where health is seen as a resource for the quality of life. In that sense health promotion goes beyond healthy lifestyles towards a general well-being.

Integrated public health policy: is a public health policy where targets of different policy domains are tuned to each other and where public authorities (from in and out of the public health sector) cooperate to reach for those targets

Coordination within public health sector: the activities in the policy execution of different public authorities (from in and out of the public health sector) are geared to one another

'Hard' policy measures: enforceable laws with orders and prohibitions and fiscal instruments, etc.

'Soft' policy measures: social marketing, promotion, education, communication, etc.

Implementation: putting in practice of policy goal, realization of a concept, principle, or design, the execution of a plan or the concretization of an abstract idea, etc. Implementation refers to policy execution, as one of the phases in the policy cycle.

Governmental embedding: arrangements, at the governmental level within an organization, on the input of means to reach for a target of that organization (e.g. an innovation in local public health policy).

Frontline workers: people in public authorities who have the responsibility in their daily job to deliver public services and to involve the relevant communities. See also: 'every day maker' (Bang & Sorensen, 1999) or 'street level bureaucrat' (Lipsky, 1971).

Local knowledge in public health policy: local reading of the health situation of specific communities, in which mostly a broader social perspective is used, which can undermine more specific approaches of the higher public health care authorities.

Policy networking: collaboration between autonomous, but interdependent public authorities. The mutual dependence within stresses the fact that the public authorities in those networks do need each other to reach for the own targets, where hierarchy would be lost.

Power: refers to the possession or activation of power resources, such as money, prestige, knowledge, rights, ideology, laws, decrees, regulations, directives, etc.

Institution: is a collective pattern of behavior, which is historically developed, and that refers to (in the broad sense of the word) different phemonena, such as social customs and etiquette, more complex behavioral patterns such as marriage or formally organized management behavior in a democratic system

Here you will find the abbreviations of this report:

BMI: Body Mass Index = the relation between the body weight (in kg) and the body length, raised to the square (in m)
EEN: Epode European Network
EPODE: Ensemble Prévenons l'Obésité Des Enfants
COP = childhood obesity prevention
WHO = 'World Health Organisation'
HOPE = abbreviation of the title of an European research project 'Health promotion through Obesity Prevention across Europe'
EU = Europese Union
EC = Europese Commission
OCMW = a Dutch abbreviation of 'Openbaar Centrum voor Maatschappelijk Welzijn', which is a local agency on public welfare
NGO's = non-governmental organisations
RIVM = a Dutch abbreviation of the Ministry of Environment and Public Health in the Netherlands, called 'RijksInstituut voor Volksgezondheid en Milieubeheer'
IoM = Institute of Medicine (USA)
LA21 = Local Agenda for the 21st century
IMGZ = a Dutch abbreviation of an academic institute on public health in the Netherlands, called 'Instituut Maatschappelijke Gezondheidszorg (Rotterdam Erasmus University)
GGD = a Dutch abbreviation of a kind of National Health Service in the Netherlands, called 'Gemeenschappelijke GezondheidsDienst'
VNG = a Dutch abbreviation of the Local Government Association in the Netherlands, called 'Vereniging van Nederlandse Gemeenten'
WIZ = a Dutch abbreviation of a research centre on integrated health care in the Netherlands, called 'Werkgroep Integrale Zorg' (Universiteit Maastricht)
DISC = Diagnosis of Sustainable Collaboration
GVO = a Dutch abbreviation of a government institute in the Netherlands for health information and education, called 'gezondheidsvoorlichting en –opvoeding'

LOGO = a Dutch abbreviation of a kind of National Health Service in the Flanders Region (Belgium), called 'Lokaal GezondheidsOverleg'

4. Policy documents themselves

Policy documents of various administrative levels pay attention to the evolution of the phenomena overweight and obesity, throughout all layers and ages of the population. Policy efforts should tackles those health problems. In those policy documents we frequently find similar elements, such as texts on points of view, state analyses and descriptions of the relevant phenomena, political leaders' objectives, strategies or action plans, with a mix of policy measures to achieve the set objectives.

In these policy documents the importance of a **multilevel approach** is also pointed out. This means that authorities on all administrative levels should contribute to a coherent approach of the health promotion for a balanced diet and enough physical activity.[1] Within this framework, both the World Health Organisation (WHO) and various European expert institutions argue that each country should translate the international and European plans, strategies and charters into a balanced national policy on diet and physical activity, adapted to the population's culture and the lifestyles of the various priority groups within that population. It is remarkable to find that authorities on supra-local levels **allot various roles to local administrations** in order to draw the policy closer to the citizens, to deliver custom-made work to the various target groups within society, to involve the citizens in the policy, etc. The WHO wants local administrations to be closely involved in the global strategy on diet, physical activity and health.[2] For that matter, the European WHO department has published a book containing the best available examples of the role local administrations can play in creating an urban environment that offers opportunities for physical activities and an active lifestyle.[3] In the White Paper on a EU strategy for nutrition, overweight and obesity-related health issues, the European Commission advises to strengthen local action networks.[4] In Flanders the central government wants to achieve a set of five health objectives by developing a strategic action plan on diet and physical activity, both on local and supra-local level. Through the 2004 decree on local social policy, the local public administration (municipality along with the Social Service Department) is awarded the steering role in order to strengthen the cooperation between the players so as to safeguard and promote the fundamental social rights, including health, for all citizens.[5] The Flemish urban policy wants to encourage towns to close the health gap (including in the field of obesity) up to district level for people on a low income. In order to do so, the Flemish government wants to extend the role of district health centres in deprived neighbourhoods with activities on preventive

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1 A good survey of international and European policy plans and strategies can be found in the 'Vlaams Actieplan voor Voeding en Beweging', Piece 112 (2009) – nr.1, submitted to the competent committee of the Flemish Parliament on 31st July 2009, see pp30-35. The survey also covers the Belgian and Flemish levels.

2 World Health Assembly (2004), Global Strategy on Diet, Physical Activity and Health, Resolution WHA 57.17, WHO, Geneva, ISBN 92 4 159222 2, 21p.

3 Edwards P, Tsouros A, (2006), Promoting physical activity and active living in urban environments: The role of local governments, World Health Assembly Europe, Copenhagen, 54p.

4 Commission of the European Communities (2007), White Paper on a EU strategy for nutrition, overweight and obesity-related health issues. COM (2007) 279, 13p., to be consulted on http://ec.europa.eu/health/ph_determinants/life_style/nutrition/keydocs_nutrition_en.htm

5 Op. Cit. (2009), pp. 35 and 50.

health care.[6] In the United Kingdom local administrations have included dealing with obesity as one of the priorities in 99 out of a total of 150 cooperation agreements with the higher authorities (the so-called 'local area agreements').[7] For that purpose the national health department and the department for children, schools and families work jointly on a strategy aimed at children's health in general and at pushing back the level of obesity to that of the year 2000 by 2020. In that respect the organisation IDeA (Improvement and Development Agency) has been given the task of supporting the local administrations with useful information and exchanges of experience.

In many policy documents there is also being argued for a **multi-actor approach**. This means that authorities on all administrative levels should work together with all 'stakeholders' on issues concerning unbalanced diet and lack of physical activity. The WHO wishes for authorities on different administrative levels to acknowledge the need of partners from civil society, the market and the media in order to bring the global strategy on diet, physical activity and health to a favourable conclusion. The WHO itself has set a good example and has consulted numerous NGOs, the private sector and intergovernmental institutions when developing the global strategy itself. Since 2003 a network on diet and physical activity advises the European Commission on the development of the policy concerning diet and physical activity. This network is composed of experts from the WHO, the EU Member States and NGOs that are active in the field of health promotion. Furthermore, in 2005 the European platform for Action on Diet, Physical Activity and Health was established in order to promote voluntary actions from the business sector, NGOs and the public sector. As to Flanders, the competent minister called a health conference in 2008. This conference was extensively prepared, based on intensive consultations of experts and on the input of hundreds of practical experts from various sectors. This consultation process resulted in a list of priorities that was handed to the minister on the very day of the health conference.

In most of these policy documents a **multi-sector approach** is also mentioned. This means that authorities on all administrative levels should work together with all 'key' sectors within the framework of preventive health care. In its global strategy the WHO advocates a multi-sector approach, both to promote healthy diet as well as sufficient physical activity towards various target groups. So, in this approach there should be room for other sections of the care sector, but also for agriculture, education, town and country planning, mobility and the communication sector. Also in the European Charter all relevant public sectors should play a part in counteracting obesity.[8] In this Charter the health departments are explicitly awarded a steering role in order to approach the issue in a multisectoral way. It also indicates all relevant policy fields that should encourage health promotion: agriculture, nutrition, finance, trade, business, consumer affairs, mobility, town and country planning, education, research, social policy, employment, sport, culture and tourism. Within the framework of the HOPE project the national policy plans for obesity prevention have also been examined in 31 European countries. These plans provide for target groups to be reached through different sectors, such

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[6] Van den Bossche, F. (2009), Beleidsnota voor Steden [Policy Paper for Towns], Flemish Minister of Energy, Housing, Towns and Social Economy, piece 213 (2009-2010) - nr. 1, submitted to the Flemish Parliament on 27th October 2009

[7] Jones, N., Rogers, R., Tackling childhood obesity, in: Firstonline, weekly magazine Local Government Association, 03 June 2009, to be consulted at http://www.lga.gov.uk/lga/core/page.do?pageId=1959470

[8] World Health Organization Europe (2006), European Charter on counteracting obesity, WHO European Ministerial Conference on Counteracting Obesity, November 2006, Istanbul.

as education and schools, employment and the work floor, etc.[9] In Flanders the decree on preventive health policy (2003) constitutes the basis for the multi-sector approach, but it uses the term 'aspect policy'. The implementation of the Flemish action plan concerning diet and physical activity would imply an aspect policy, where different sectors must take their responsibility with a view to be able to influence the entire environment and to systematically promote healthy diet and more physical activity. This Flemish action plan explicitly demands the participation of the following policy fields: employment, education, domestic policy (towns and municipalities), youth, sport, culture, town and country planning, traffic and media.

To conclude, we state that in the policy documents there is a large agreement on the necessity of an **integral approach** with mutually supportive measures. This unanimity is often founded on the 1986 Ottawa Charter. This charter aims at getting an effective health promotion onto the political agenda (on all administrative levels). *'Health is, (…), seen as a resource for everyday life, not the objective of living. (…) Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.'*[10] However, the Ottawa Charter demands an integral approach, according to which institutions and organisations from both within and outside of the care sector must work together. It pleads to re-orientate health institutions from a curative approach towards a preventive approach. A healthy lifestyle (diet and physical activity) must be supported by realising a health promoting environment. Authorities have indeed a role to play as a defender of a health promotion policy in which civil society is involved as much as possible. Building a well thought-out strategy can lead to the desired long term results in terms of improving daily life quality.[11] Many international initiatives that promote a balanced diet and healthy physical activity start from the very same integral approach. To a different degree they combine a multi-level, multi-actor and multi-sector approach.

In some countries, the state analyses from the planning documents of the competent authority are complemented by **long-term foresights** of the expected increasing tendency concerning overweight and obesity. Attention is thereby also being paid to policy scenarios for counteracting this phenomenon. The long-term foresights are important because they show the overall picture. The most recent Dutch long-term foresight indicates the persistency of unhealthy behaviour. *'An important reason for this is the fact that unhealthy behaviour is not an isolated fact, but shows a strong connection with the social and physical environment in which people are born, grow up and live.'*[12] Therefore, the RIVM also pleads for an intensive and integral approach, with a combination of the necessary policy instruments. Moreover, such an approach should not only be aimed at the individual, but also at his or her environment. Furthermore, this report indicates the unused possibilities of improving health through other policy fields such as working conditions, environment, education, socio-economic policy, town and country planning and housing. Based on a sample survey the public health inspection observes that local administrations increasingly pay attention to the

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[9] Yngve A, Stockley L, Lynch C, Kugelberg S, National and multinational obesity prevention policies in Europe, Report within framework of HOPE-project, to be consulted at http://www.hopeproject.eu/index.php?nav_id=8&subnav_id=14

[10] World Health Organization (1986), Ottawa Charter for Health Promotion, First international conference on Health Promotion, The move towards a new public health, Ottawa, November 1986,

[11] Barr, V.J., Pedersen, S., Rootman, I. (2006), Evidence review: Healthy communities. Population Health and Wellnes, BC Ministry of Health.

[12] De Hollander AEM, Hoeymans N, Melse JM, van Oers JAM (eds), Polder JJ (2006), Gezondheid op koers?, Zorg voor gezondheid – Volksgezondheid Toekomst Verkenning 2006, (Health on track? Care for health – Public health foresight 2006), RIVM rapport, Houten: Bohn Stafleu, Van Loghum, Nederland, 348p.

health consequences of decisions made in other fields such as environmental affairs, industrial policy and social work. At the same time the inspection points out that Dutch municipalities still apply too few measures in other policy fields so as to improve public health, whereas the approach of a number of health problems (such as obesity) is very suitable to do so. Therefore, the RIVM points out the task of the central government to actively support the municipalities in the implementation of a local and integral health policy.

The British Government Office for Science also argues that the long-term foresights on public health offer a surplus value by including the context in the analysis of unhealthy behaviour, that is by showing 'the big picture'.[13] According to the 'Foresight project' the obesity epidemic can no longer be stopped by individual action alone, but requires a social approach. In this context the key words are mentioned again from a 'multiple'-approach (actors, levels and sectors). The 'Foresight project' for instance gives the example of the similarities between obesity prevention and the climate policy: *'Many climate change goals would also help prevent obesity, such as measures to reduce traffic congestion, increase cycling or design sustainable communities. Tackling them together would enhance the effectiveness of action.'* And Foresight documents mention up to five types of key factors that play a role in the evolution of obesity: social, technological, economic, environmental and political trends. With these factors one can set to work on a better description and understanding of 'nutrition transition'.[14] It may be interesting to add the eight types of determinants in the Shift^n system model to the 'big picture': food production, food consumption, physiology, individual physiology, physical activity, environment, individual psychology and social psychology.[15] From this insight into the broad obesity problem the long-term foresights can often play a part as a middleman between different disciplines and can stimulate the debate on an effective and efficient approach of the phenomenon. The long-term foresights on public health confirm the need of an integral approach (on several levels, with several actors and sectors). They confirm the crucial part of local administrations in a successful obesity prevention. They are called upon to play their part as the administrative levels closest to the civilians.

5. Theory on (local) government action in obesity prevention

'Obesity can be considered a robust sign of commercial success – consumers are buying more food, more cars and more energy-saving machines',[16] says Swinburn. In his view it also seems improbable for strong economic powers to change sufficiently so that they could provide an answer to the consumers' demand to eat less and be more physically active or to the companies' demand to have more corporate social responsibility. When the market mechanism entails disadvantages for the population and its health, **government action becomes necessary** in order to protect and promote public health.

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[13] Government Office for Science (2007), Foresight on Tackling Obesities: Future Choices – Summary of Key Messages, Department of Innovation Universities and Skills, October 2007, to be consulted at http://www.dius.gov.uk

[14] X, (?), Trends and drivers of obesity: a literature review for the Foresight project on obesity, text sent by email from Science Department, to be consulted at http://www.foresight.gov.uk/Obesity/Literature_Review.pdf

[15] X, (2008), Obesity system influence diagram, ShiftN cbva, Clarity in Complexity, to be consulted at http://www.shiftn.com/obesity/Full-Map.html

[16] Swinburn, B.A., Obesity prevention: the role of politics, laws and regulations, in: Australia and New Zealand Health Policy 2008, 5:12

Meanwhile, more and more governments become aware of the extent of obesity and the risks involved for public health. In more and more countries this awareness of the extent and complexity of the problem leads to a consensus on the need of a multi-sector approach, in which governments, business, civil society and the broad public work together. Swinburn also wonders what part the governments play in this 'governance' approach. He thinks that public authorities (on all administrative levels) can play **four major parts** in order to confine the obesity epidemic: leadership (visibility and readiness to take action), advocate of a multi-sector approach, fund raiser and policy pursuer (stimulator of the policy process with attention for objectives, instruments, implementation and monitoring).

According to the WHO there are two important factors that can boost obesity prevention, notably a sufficient degree of leadership and the use of a combination of 'soft' and 'hard' policy measures.[17] These are policy measures which on the one hand fall under the denominator of 'soft' paternalism such as social marketing, health promotion, making people aware of conduct changes, etc. and which on the other hand also relate to 'hard' paternalism of enforceable laws with orders and prohibitions and fiscal instruments. According to Swinburn there can only be an effective counteracting of obesity and of other threats to public health when the hard policy measures constitute a **backbone** around which are set softer policy measures that enhance their effectiveness. There are numerous examples: orders and prohibitions plus taxes constitute the backbone of the anti-tobacco policies, but they are surrounded by awareness campaigns, social marketing, and communication. We notice the same pattern in the fight against traffic deaths: regulation concerning speed, drunkenness, safety belts, vehicle safety, etc. completed by education and communication campaigns.

Clearly, an all-embracing backbone for an obesity prevention policy relates to all administrative levels and to all 'stakeholders' from the market, the civil society and the government. However, we must not be blind to reality and therefore the public authorities will still have to take the initiative, according to Swinburn. From the politicological and especially administrative literature the policy framework outlined by Swinburn is very recognisable. It is described there in terms of 'multi-level and multi-actor governance', with the government assuming a steering role in order to direct the whole.[18] In an accompanying article two matrixes are elaborated with the 'policy fields' in which action must be taken on various administrative levels (from local to international) and in different sectors.[19] The first matrix relates to the food system policy, where administrative levels are combined with sectors from that food system, such as the primary production (agriculture, stock breeding, etc.), food industry, distribution, marketing, retail trade, catering and food services. The second matrix concerns the policy on physical activity, in which the administrative levels are combined with town and country planning, public works, education, employment, transport, sport and recreation. From the intersections of rows and columns it becomes clear which policy fields are situated on which administrative levels and which sectors they relate to. From this, one can also deduce deficiencies in the policy or determine inconsistencies.

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[17] World Health Organization (2004), Global strategy on diet, physical activity and health, WHO Library, Geneva, Cataloguing-in-Publication Data, ISBN 92 4 159222 2

[18] Block, T., (2009), Besluitvormingsprocessen en beslissingsmacht bij stadsontwikkelingsprojecten, Doctoraal proefschrift Politiek wetenschappen, Ghent University, pp9-12.

[19] Sacks, G., Swinburn, B.A., Lawrence M.A., (2008), A systematic policy approach to changing the food system and physical activity environments to prevent obesity, in: Australia and New Zealand Health Policy 2008, 5:13

Drawing up multi-level and multi-sector matrices is indeed an interesting exercise in order to determine whether the **policy chain** for obesity prevention is able to rotate. Filling in the cells (on the intersection of rows and columns) enables us to determine whether there are mssing links or whether they are mutually overlapping, in which case there is no policy chain at all. When laws and regulations are well worked out in all areas of the matrix, one can search for the weakest link. For as the saying goes, a chain is only as strong as its weakest link. In that way one can improve the quality of the policy chain for obesity prevention. Last year Australia did the exercise. It offers sufficient inspiration to set to work with it in any other country of the world.

Within the framework of the EEN-project we will focus our study on the role of local governments in childhood obesity prevention. In order to do so we take the existing regulations as a given factor and focus our attention on the role local governments assume in this respect. According to Swinburn the government (on any administrative level) could at least play four major parts. In continuation of the EEN-study we could therefore systematically pay attention to those four major parts: leadership (visibility and readiness to take action), advocate of an integral approach, fund raiser and policy pursuer (stimulator of the policy process with attention for objectives, instruments, implementation and monitoring). However, let us first complete the study of literature before drawing any conclusions.

Furthermore, Swinburn also asks our attention for the combination of obesity prevention with other policy fields. This policy field of obesity prevention has the disadvantage that the necessary problematisation phase could all too well cause a stigmatisation of the target group. It is not exactly the corpulent people themselves who are asking for a preventive approach, the pressure comes mostly from the professional sector. It is therefore important for the advocates of obesity prevention to **combine their approach with other 'like-minded' movements**. In this respect Swinburn refers to three social movements, notably the environmental movement working around 'climate change', the mobility movement working around liveable towns and the movement around healthy diet and the 'new nutrition science', in which environmental criteria are being integrated in the policies of food supply and food safety. *'There is a substantial overlap between the solutions for obesity and the solutions for environmental sustainability, reduced congestion, and urban liveability. Indeed, it may be that these* ***'stealth interventions'*** *prove to be powerful forces for reducing obesity.'* (Swinburn, 2008).

Also this point of Swinburn can be important for the EEN-study into the role of local governments. We must have attention for the combination possibilities or the 'function as a hook' of other policy fields in order to hang the obesity prevention cart onto it. In other words, this is the theme of the strategic character of the prevention approach. To which degree are other policy objectives being geared to obesity prevention? This is a question which deserves the necessary attention in the continuation of the EEN-study. Before searching for an answer to this question, we want to mention that Swinburn really does introduce 'building stones' to map out the role of public authorities. He is right in mentioning the policy chain, which should be composed of policy fields which are geared to one another and are situated on different administrative levels in different sectors, which are to be defined according to whether they relate to healthy food or to sufficient physical activity. In addition to this matrix approach he also pays attention to the fact that in any policy field combined action is required between public authorities, private market and civil society. To conclude, in order to complete the picture (and also make it even more complex), it is important to approach each policy field in a strategic way and to look at possible combinations with 'adjacent' policy themes such as

climate change, mobility behaviour and urban livability. These are '**building stones'** which must contribute to a promising childhood obesity prevention strategy.

The American 'Institute of Medicine' (IoM) has recently published a study on the role of local governments in the most promising childhood obesity prevention strategies and actions.[20] In this study the 'Committee on childhood obesity prevention actions for local governments' argues that local governments are ideally placed to promote behaviour that can help children and adolescents to preserve a healthy body weight. It also refers to the relevant experiences of local administrations in promoting children's health, for instance by encouraging them to let themselves be vaccinated or to wear bicycle helmets. The IoM also indicates the fundamental role of parents and other adult health professionals who play a more direct or relevant role in the education towards healthy behaviour. It is however the role of the local administration to **support** those positive efforts of these first-level **actors**, or at least not to let them be undermined by a lack of facilities in the place of residence. In this respect the IoM gives the example (specific of the US or not?) of a lot of neighbourhoods where there are no grocery shops or supermarkets where one can buy healthy food every day. Or where it is dangerous for children to ride their bicycles, to walk or play in the streets. In these surroundings even the most motivated child or youngster can experience difficulties to feed itself in a healthy way and to have sufficient physical activity, the American IoM argues.

In this study, this 'Committee on childhood obesity prevention actions for local governments' very clearly states that various urban and municipal services must be involved and that they must be supported politically by various elected officials such as mayors, town councillors and other executive staff in the local authorities concerned. In other words, a systematic promotion (education, communication, marketing) of healthy food en sufficient physical activity cannot be realised by one single distinct service for preventive health care. Many different services are **forced to work together** if they really want to achieve results in terms of permanent changes in conduct. In the study local departments of public works, mobility, park management, recreation, security, town and country planning, housing and economic development are being encouraged to work together with the social health care service with a view to successful promotion campaigns in terms of effective permanent changes of conduct. To conclude, the 'Committee' also argues to involve civilians in determining the local needs and top priorities. The participation of civilians and the civil society will also help in determining the local assets, in focussing on the local sources or capacities and in improving the implementation.

In this study the 'Committee on childhood obesity prevention actions for local governments' formulates recommendations for nine strategies concerning healthy diet and six for strategies concerning physical activities.[21] These strategies are intended for local authorities: they must use them in their policy planning and policy implementation. Within the framework of these **fifteen strategies** the 'committee' has looked for examples of actions that have the best chance of success. From a set of some 600 articles from 'peer reviewed published literature and reports' the 'committee' has taken criteria determining which strategies and actions are

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[20] Parker, L., Burns, A. C., Sanchez, E. (ed.) (2009), Local Government Actions to Prevent Childhood Obesity, Committee on Childhood Obesity Prevention Actions for Local Governments, Institute of Medicine, National Research Council, ISBN 0-309-13928-7, 120p

[21] The study is a true source of inspiration for people working in practise. They can consult the website of the 'National Academies Press', http://www.nap.edu/catalog/12674.html. A survey of the different strategic objectives, the corresponding strategies and more concrete actions is mentioned in a separate article in the summary of the study.

the most promising.[22] So, 'committee members' are of the opinion that certain strategies and actions have the potential of having a positive effect on behaviour concerning healthy food and sufficient physical activity, based on the following conditions:

- They are within the competences of the local administrations,
- They are focussed directly on children,
- They are based on the experience of local authorities or their partner organisations,
- They take place outside of school day hours,
- They imply the possibility of healthy diet and adapted physical activity.

This book serves as a source of inspiration for local administrations in the US, so they can set to work on child overweight and obesity.[23] It is the third book in the series 'preventing childhood obesity' and continues on the taken path of recommendations. In the previous two books the 'committee' already appealed for public leadership on all administrative levels, respect for the unique features of the local context, systematic evaluation of prevention programmes and communication on these programmes. The third book also wants to convince the reader to take action by encouraging him/her to do so through powerful quotes. For instance, a quote from former representative Tip O'Neill is mentioned: '**All politics is local'**. Whereupon the 'committee' argues that all health issues are also local matter. '*Health is, first of all, a personal matter. It is very 'local' and extends outward from the individual to include the family, close relationships, and the community. Second, although health is strongly influenced by state, regional, national, and international trends and actions, many strategies for addressing childhood obesity must be carried out at the local level to make a difference.'* So, the local administration constitutes the tailpiece of any obesity prevention policy. Also in Flanders/Belgium a source book could be an important source of inspiration for more effective forms of child obesity prevention.

In one of the five chapters a few institutional factors are identified which are relevant for the role of local administrations in childhood obesity prevention. First of all attention is drawn to the importance of the leadership assumed by the local administration. This local leadership requires a firm establishment of political involvement, policy development, allocation of funds and coordination of all related programmes. In this respect it is an additional advantage of local leadership when **local coalitions** are supported by, for instance, the creation of an **information network** for all preventive health care actors.[24] Furthermore, it is pointed out that local administrations are important for making sure that relevant policy programmes are harmonised. And respect is asked for the differences between local administrations, for rural, suburban and urban administrations all have different fish to fry.

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[22] The 600 articles on the basis of which are formulated the recommendations on the promising character of prevention strategies and actions come from (online) databanks, such as Scopus (15.000 peer-reviewed magazines of 4000 publishers), TRIS (the world's biggest bibliographical source on transport and mobility), EMBASE (biomedical and pharmaceutical databank containing more than 9 million files coming from 4000 magazines), PsycINFO (psychological literature with some 1.9 million files), Medline (bibliographical databank on medicine and also the health care system from more than 4600 biomedical magazines from 70 countries). Furthermore, there were also articles from the screening of documents of all large organisations which in the past 10 years have worked together with local administrations to counteract child obesity. Finally, experts were invited and their input was also used to show the potentials of preventive actions and strategies.

[23] The previous two books are: IoM, (2005) 'Preventing Childhood Obesity: Health in the Balance', Washington, DC: The National Academies Press; and IoM, (2007) 'Progress in Preventing Childhood Obesity: How Do We Measure Up? Washington, DC: The National Academies Press.

[24] Baker E L, Porter J, (2005), Practicing management and leadership: Creating the information network for public health officials, in: *Journal of Public Health Management and Practice* 11(5):469-473.

Only recently have public policy scholars devoted serious work on the public health policy addressing childhood obesity.[25] This kind of research has primarily been conducted by experts in nutrition, psychology and medicine. A survey of American experts in health nutrition and health policy pointed out that they viewed federal policy options having a great impact on childhood obesity were viewed as politically infeasible.[26] In contrast, education and information dissemination policies were viewed as favorable for national policy makers, but with little potential public health impact. Another research project focuses on community characteristics that interact with children's weight status. [27] It concludes with suggestions for intervention efforts and funding priorities focusing on high-risk populations of low-income overweight women of childbearing years. In the special journal issue is argued that many policy changes are required in multiple policy environments. [28] In a recent project key-informant interviews were conducted with 16 legislators and staffers from 11 states to examine qualitative factors that enable and impede state level legislation on childhood obesity prevention.[29] Commonly cited factors positively influencing the passage of childhood obesity prevention legislation included national media exposure, introduction of the policy by senior legislators, and gaining the support of key players including parents, physicians, and schools. Noteworthy barriers included powerful lobbyists of companies that produce unhealthy foods and misconceptions about legislating foods at schools.

6. Implementation research of innovations on the local administrative level

We can treat the question of the role of local administrations in the implementation of obesity prevention programmes in a more general way, in the sense that we can screen the administrative research for the role of local administrations in the implementation of other plans, programmes of measures. From an administrative point of view the implementation processes of innovative projects or campaigns show a lot of similarities, certainly on the local administrative level. A Local Agenda 21 (LA21) is an innovative procedure or step-by-step plan to put sustainable development into practice in local communities. As a result of the 1992 Rio conference[30] all local administrations were invited to draw up such a LA 21, in consultation with the society and the market. The implementation of these LA21s was supported by campaigns on international and European levels. From these levels interested

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[25] In an extra edition of 'The Annals of the American Academy of Political and Social Science' (Vol. 615) American social and political scientists devoted several articles on the prevention of childhood obesity.

[26] Brescoll V L, Kersh R, Brownell, K D, (2008) Assessing the feasibility and impact of federal childhood obesity policies, in: *The Annals of the American Academy of Political and Social Science*, vol. 615, pp 178-194

[27] Demattia L, Denney S L (2008), Childhood obesity prevention: successful community-based efforts, in: *The Annals of the American Academy of Political and Social Science*, vol. 615, pp 83-99

[28] Dietz W, Robinson T N (2008), What can we do to control childhood obesity?, in: *The Annals of the American Academy of Political and Social Science*, vol. 615, pp 222-224

[29] Dodson E A, Fleming C, Boehmer T K, Haire-Joshu D, Luke D A, Brownson R C (2009), Preventing childhood obesity through state policy: qualitative assessment of enablers and barriers, in: *Journal of Public Health Policy*, vol. 30, pp S161-S176

[30] The full name of the Rio conference is the 'United Nations Conference on Environment and Development, abbreviated as UNCED. One of the concluding documents of this conference is the Agenda 21, an all-embracing policy programme for a global social change towards sustainable development. This Agenda 21 has a chapter for local administrations in which they were given a decisive role in the implementation of sustainable development. Global social changes can only occur when real people start to change their behaviour in local communities. Local administrations can play a guiding role in this. Moreover, they are closest to the population and they can play an important role in the education and awareness programmes concerning necessary behavioural changes.

towns and municipalities were supported with recommendations on step-by-step plans in which the importance was emphasized of the state analysis of the domestic situation, the creation of a vision, the gradual planning and systematic monitoring, evaluation and adjustment. This uniform support does not alter the fact that in practice, the LA 21 was handled in strongly divergent ways. The SUSCOM research into so-called 'Local Agendas 21' in the administrative practice of towns and municipalities in 12 European countries indicates that there are five implementation models[31]:

- The '*Aalborg' model* is considered to be the ideal model.[32] Quite often there are strong political leaders at work in these towns and municipalities who use the LA21 to improve the local policy cohesion, to enhance the mutual harmony between the town's administrative departments, etc. It is also remarkable that these towns and municipalities have an ambitious population, which is well mobilised by participative processes and shows lots of activities concerning sustainability.
- In the *'paternalistic' model* an 'enlightened' or progressive elite wants to go further in the field of sustainability than the majority of the population. In this respect it is feared that the participative process will weaken the sustainability objectives or slow down the implementation of the necessary policy.
- In the '*integrated one-theme' model* the LA21 is focussed on one single theme which one tries to integrate in all relevant policy fields.
- According to the *'pirate- or external forum'* model a LA21 is used by local activists and NGOs as a strategy in order to mobilise the local population in favour of sustainability, but especially against local administrations, bureaucracy, the Establishment.
- The '*external fragmented' model* is found most frequently in places where a higher authority provides subsidies for certain LA21 activities. In this case the LA21 consists of a fragmented basket of pilot projects concerning for instance composting, road safety, recycling, care for the environment, etc. They remain external projects which last as long as one can appeal to external funds and consequently, they are not directly integrated into the relevant policy fields.

In particular, this study shows us that local political leadership is crucial for the role which local administrations can play in the implementation of local sustainable development. In this study **local political leadership is used with a double meaning**, notably in the sense of 1) the visibility of a "puller" who can show the necessary willingness for action and 2) the advocate or coordinator of a network of actors involved. Strong political leaders with a firm network within civil society are the ideal figures to put LA21 into practice in an effective way. If the political leaders are indeed progressive but lack this network with the social actors, then the implementation of a LA21 will not have as much effect in practice. If there is a local politician who is interested in one particular theme and has a good network on the matter, then it may be possible to gear the relevant policy fields towards this one theme. If the local political leaders show no interest or little or no leadership, then this results in a fragmented approach (in the best case). In that case, also leaders from civil society can rise who use LA21 to be involved in politics and to press the existing politicians hard.

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31 Lafferty W., (ed.) (2001) Sustainable Communities in Europe, Earthscan Publications, London.

32 Aalborg is the town where very soon a broad LA21 was elaborated. On its basis the Aalborg Charter was drawn up. This Charter then had to be signed by all towns and municipalities that wanted to be a member of the European Sustainable Cities and Towns Campaign, which was initiated by – wouldn't you know – an international conference in Aalborg.

The study into the use of an urban monitor for livable and sustainable Flemish towns also revealed a large number of institutional factors which determine the role of local administrations in the implementation of an innovative policy measure or project.[33] This urban monitor has been developed to serve as a scanner for Flemish towns and to show the evolutions of phenomena that are relevant for the livability and sustainability of these towns.[34] In this respect, the study into the implementation of the urban monitor constitutes a surplus value because it offers a detailed and systematically structured inventory of institutional factors that play or can play a role in the ultimate use of this urban monitor by a town council. So, this study defined 41 themes relating to factors which can determine life in Flemish towns in relation to the implementation of an innovative instrument for a strategic state analysis on local society level, as seen from a system approach. Throughout all these themes a number of common themes show up which indicate a number of systematically recurring institutional factors. Certainly in the light of the EEN-study into the role of local administrations in obesity prevention, it is appropriate to dwell on the central factors that have played a role in the use of the urban monitor:

- The urban monitor finds itself in an entity of an *urban organisation with a diversity of subsystems* (departments, sectors, projects, etc.). In everyday practice of these Flemish towns the traditional departments/subsystems (such as public works, e.g.) often have a bigger impact on the urban organisation as a whole than more recent departments (such as the mobility department). Recent modernisations (e.g. concerning 'new public management') or obligations determined by decree (e.g. to create management teams) sometimes lead to changes in the urban organisation, which in turn should lead to more cohesion between subsystems. Nevertheless this diversity between departments and sectors persists.
- The *relation between the political and administrative subsystem* is also a factor which can determine the use of the urban monitor in Flemish towns. Wherever the political and administrative world meet in a strong societal orientation and in the importance of a strategic approach of persistent and complex social problems, there are opportunities for using the urban monitor. In cases where this attitude of concern for social problems and the strategic reflex are hardly present among politicians or leading civil servants, the urban organisation will probably not play an active part in the use of the urban monitor.
- The *internal support and the capacities of the urban organisation and its subsystems* are also an important factor in the use of the urban monitor in certain Flemish town councils. This support is put under pressure by several social developments that also entail growing social expectations. The demand for the use of the urban monitor can put this urban organisation under extra pressure and hence, local administrations apply the brakes.
- The *contribution of the supra-local authority*, in this case the Flemish government, is also an important factor in the use of the urban monitor. In this case the Flemish government provides, at its own costs, the urban monitor with relevant and interpretable data, which strongly increases the user-friendliness for local administrations. The urban monitor is intended for an integrated approach of problems

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[33] Vallet N., De Rynck F., Block T., 'Kijken naar stadsorganisaties in Vlaanderen: kansen, uitdagingen, grenzen en illusies omtrent het gebruik van de stadsmonitor voor Leefbare en Duurzame Vlaamse steden', In: *Praktijkgids Management Lokale Besturen*, Mechelen: Kluwer, October 2005, pp. 273-308

[34] Block T., De Rynck F., Vallet N. en Van Assche J., 'Een omgevingsscanner voor lokale besturen: Stadsmonitor voor leefbare en duurzame Vlaamse steden', In: *Praktijkgids Management Lokale Besturen*, Mechelen: Kluwer, June 2005, p201–248

on a local level. On the other hand, the fact that the Flemish government itself does not succeed in handling mutually connected problems – also on a Flemish level – in a coordinated way and that it fails to establish policy frameworks within which Flemish local administrations must work can curb the use of the urban monitor.

Considering the comparability of administrative processes in the implementation of other innovative projects, such as the EPODE projects for childhood obesity prevention, the above-mentioned study offers us a sample sheet of all possible institutional factors determining the conduct of local administrations. A number of more systematically recurring institutional factors are put forward there, such as the relation between the entire urban organisation and its subsystems, and in particular the relation between the political and administrative level within this urban organisation, next to the internal support of that urban organisation and finally the contribution of the supra-local authority.

In the Netherlands there is some academic literature particularly related to the implementation of health promotion programmes. In 1998 a project on 'working on health promotion in a neighbourhood oriented way' was started in **Rotterdam**'.[35] The Instituut Maatschappelijke Gezondheidszorg [Institute for Social Health Care] of the Erasmus University (iMGZ) was able to evaluate the project. At the beginning of 2000 it was decided to stop the research. The intervention for health promotion did not get off the ground with the necessary intensity that had been expected. The borough administrations, along with the disadvantaged neighbourhoods, put other priorities first. And the presidents of these borough administrations thought that the entire communal health services (CHS) should work in a neighbourhood oriented way. In this context they should function as a helpdesk for answering residents' questions. This role could not be reconciled with a more active and systematic cooperation with the population that was considered by the CHS themselves to be necessary for an effective health promotion. Eventually, a limited number of small-scale health projects, in which a few lifestyle themes were yet mentioned, were discussed with the neighbourhoods. However, the administrative support for the implementation of systematic lifestyle interventions was missing as far as the boroughs of the city of Rotterdam were concerned.[36]

Leadership and operational management of the regional health service and the municipal steering role are the most important factors which determine the administrative establishment of innovation in the regional cooperation in the field of public health care in the Netherlands. These are the lessons learned by Erik Ruland from the doctoral research concerning the '**Hartslag Limburg' [Heartbeat Limburg]** case.[37] This project started in 1998 in all five municipalities of the Maastricht region. It evolved from a meeting of experts of the Nederlandse Hartstichting [Dutch Heart Foundation] in 1994. The experts present at that meeting thought the time ripe for a prevention project which would combine the forces of municipalities, the communal health services (CHS), general practitioners and hospitals. Moreover, the Hartstichting also wanted to support the project financially. Still in that same year the mayor of one of the five municipalities of the Maastricht region organised broad

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35 Haes, W. de, Voorham, A., Mackenbach, J. (2002). Wijkgericht werken aan gezondheidsbevordering in vier achterstandswijken in Rotterdam; opzet, uitgangspunten en beschrijving van het proces. *TSG Tijdschrift voor Gezondheidswetenschappen* 425-430.

36 Voorham, A., Haes, W. de, Mackenbach, J. (2002). Wijkgericht werken aan gezondheidsbevordering in vier achterstandswijken in Rotterdam; leerpunten uit de praktijk. *TSG Tijdschrift voor Gezondheidswetenschappen* 431-435.

37 Ruland, E., Bestuurlijke verankering van innovaties in de openbare gezondheidszorg: lessen uit de casus Hartslag Limburg, Doctoraatsproefschrift aan de Universiteit Maastricht, NIGZ, Woerden, 2008

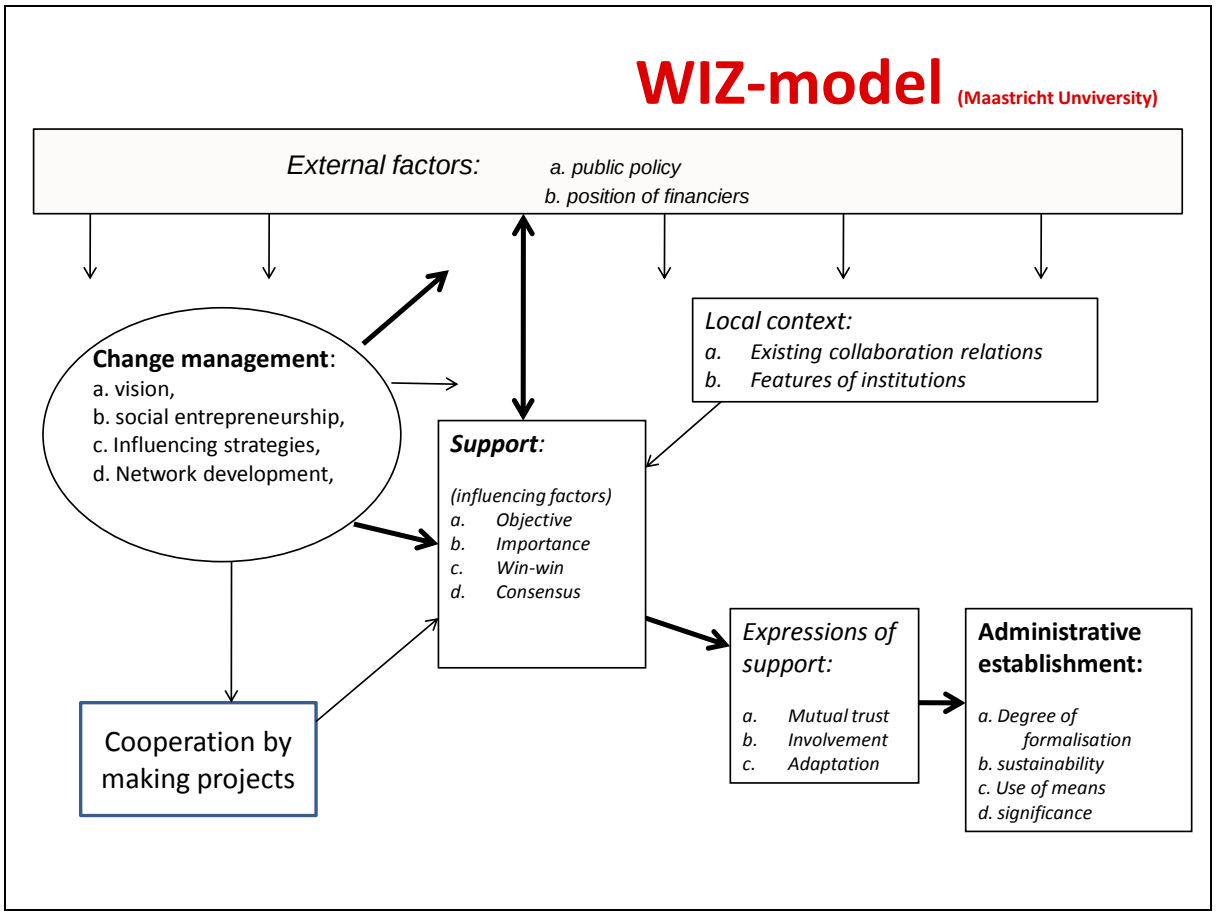
consultation with representatives from the CHS Southern South-Limburg, the regional district, general practitioners, the Maastricht University and the university hospital. There soon seemed to be a consensus about the broad outlines for the prevention of cardiovascular diseases on a regional level. This in turn constituted the basis for the project 'Hartslag Limburg', which is also relevant for the EEN-research because actors and processes on the local administrative level are mostly the same as those that are relevant for other prevention themes.

In his introduction Ruland points out the **unfavourable context** in which the cooperation concerning 'Hartslag Limburg' came into being. Policy documents (from the public health department as well as the RIVM long-term foresight) indicate the necessity to work together (considering the complexity of public health problems), the challenge to combine forces, the priority to work together on the local administrative level, etc. However, the health care inspection points out that the implementation of this cooperation (and direction and coordination) is concretised alarmingly and insufficiently on the municipal level. Municipalities (VNG or Association of Dutch Municipalities) point out a structural shortage of means. Furthermore, the support for health promotion is put more under pressure by two issues. Firstly, the key tasks between municipalities and the CHS are not clarified. The CHS is a decentralised executive professional organisation that should be at the service of the municipalities. In practice therefore, the CHS often assumes the steering role whereas it does not have the legal competences neighter the political support to do so. The municipalities however do have the legal competences, but administrators often refuse to concern themselves with local health promotion. The more so because, secondly, the available scientific evidence for the effectiveness of this local health promotion is limited. [38]

Anyway, people in Limburg were not discouraged and started the 'Hartslag' project. From 1998 onwards an intensive cooperation in the field of health promotion has been achieved in the Southern South-Limburg region. Twelve local partners including municipalities, welfare workers, the CHS, general practitioners, university hospital specialists and a health insurer, worked together to counteract cardiovascular diseases. This cooperation was the subject of the doctoral research. In this research they wanted to examine to which degree management from the CHS could contribute to an administrative establishment of the regional cooperation in the public health care, taking into account the context of the local circumstances and the external climate. To take a closer look at the cooperation in 'Hartslag Limburg' the WIZ-model was used (WIZ stands for Werkgroep Integrale Zorg [Working group Integral Care]).

[38] De Hollander AEM, Hoeymans N, Melse JM, van Oers JAM (eds), Polder JJ, op.cit., pp. 179-181.

Diagram: the WIZ-model (of the Werkgroep Integrale Zorg of the Maastricht University)



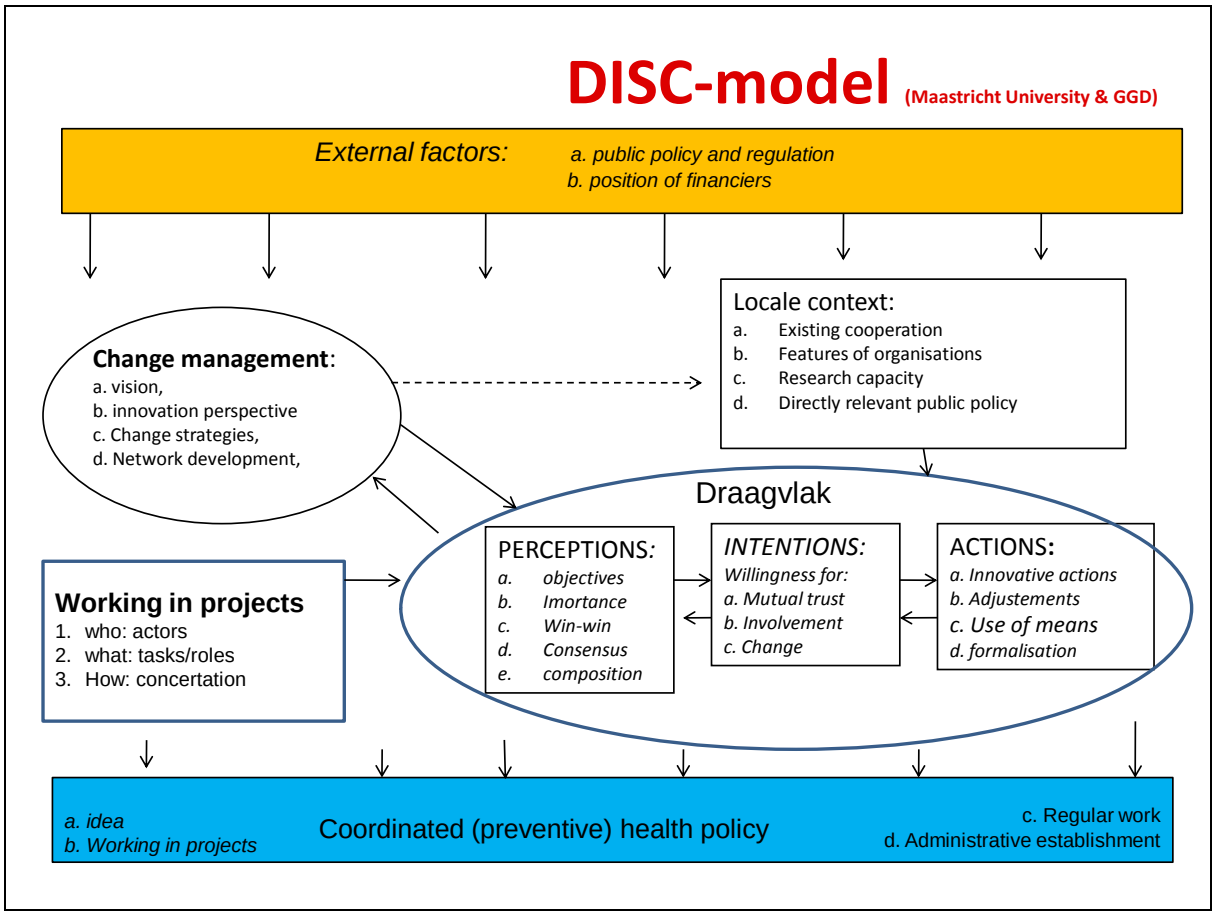
Source: Ruland, a.o., in: TSG – 2003, p53

From the use of this WIZ-model it emerged that it took insufficient account of the effect of the cooperation process (and the accompanying growing and advancing insight) on the – quite often – innovative result of this cooperation.[39] This has led to the **DISC-model** ('Diagnosis of Sustainable Collaboration'). The objective and the key elements have remained. The models are intended to get a better view of the impediments and opportunities for cooperation processes in the integral public health care. In both models, the key elements still relate to external factors, immediate context, management and support. In both models the 'management' element is also specified into a 'necessary combination of project management and change management'. 'Project management bears upon the content and management: realising an organisational structure, an action plan and creating adequate leadership (directing and monitoring). Change management is focussed on the necessary change process: how do people react to change, what is needed to direct this (how to cope with resistance, communication, etc.). Both management aspects are essential for cooperation and they are

[39] Leurs, M., Mur-Veenman, I., Schaalma, H., Vries, N. de. (2003). Integrale samenwerking gaat verder dan de samenwerking tussen professionals: introductie van het DISC-model. *TSG Tijdschrift voor Gezondheidswetenschappen* 2003;81: 369-73.

complementary.' [40] Both models emphasize change management, considering the field of integral public health care to which they need to be applied.

Diagram: the DISC-model (from researchers of the CHS and of the Maastricht university)



Source: Leurs, a.o., in: TSG – 2003, p370

The DISC-model does indeed complete the WIZ-model in a substantial way by recognizing that the result of the cooperation can 'change colour' under the influence of the cooperation process and on the basis of the advancing insight (p371). Certainly when innovations from pilot projects are translated into regular policy and when in addition they are established administratively, the result can differ significantly from the original idea. Both models put the same relation in the centre, notably the relation between 'change management' and the support for it. For putting the element of 'change management' further into practice, both models identify similar elements: vision, innovation perspective or social entrepreneurship[41], influencing or power strategies and network development. Applying change management requires up to date and informal information from different layers within the organisation concerned. In order to organise these information fluxes it is necessary to develop a

[40] Ruland, E., Raak, A. van, Spreeuwenberg, C., Ree, J. van (2003). Managing New Public Health: hoe zijn blijvende preventieve samenwerkingsverbanden te realiseren? Een agenda voor actie en onderzoek. *TSG Tijdschrift voor Gezondheidswetenschappen* 52-55.

[41] In the third generation innovation policy a 'social entrepreneur' brings together bearers of problems, finders of solutions and decision-makers at the right moment. See Larosse, J. (2004), Policy profile: towards a 'third generation' innovation policy in Flanders. Contribution to MONIT-project (TIP-OECD), Work Package 1, Brussels, IWT, 2004.

sufficiently large network, including the necessary **bridging functions** to conquer all kinds of barriers between organisations. In the example of the 'Hartslag'-project these bridging functions are taken on by trained nurses ('health advisors'), health educators (health educators from the CHS), welfare workers and municipal officials. From the **frontline** of the 'Hartslag'-project they gather crucial information for choosing the actions and interventions, and their timing.

On the basis of this in-depth study Ruland concludes that the management of the CHS can contribute substantially to the **administrative establishment** of the innovation in the regional public health care cooperation. Furthermore, he identifies a number of important factors determining the degree to which this administrative establishment is effectively realised. Firstly, the leadership within the CHS (in other words, the management) determines the degree in which prevention is upheld in the conflict of interests with other priorities, especially of a budgetary nature. Secondly, also the steering role of the municipalities involved (as a factor from the local context) determines the degree to which the regional cooperation is established. Amongst other things, the steering role must see to it that the municipal decision-making process is attuned to the professional processes for the implementation of preventive health care. To sum up, this means that the CHS management cannot by itself see to the administrative establishment of the regional public health care cooperation, but depends on the leadership within the CHS and on the steering role of the municipalities.

From the afore-mentioned study it emerged that an integral cooperation in view of preventive health care has (indeed) been adopted. The **most beneficial factors** are external sponsoring (by the Nederlandse Hartstichting [Dutch Heart Foundation], the Grote Stedenbeleid [Metropolitan Policy], etz.), the administrative support (a committee member of the Nederlandse Hartstichting was also mayor of one of the municipalities involved), earlier cooperation between the partners involved (created a basis for trust) and the network management of the CHS. 'The direction or the network management of the CHS provided the mortar between practise, research and policy.'[42] On the basis of the doctoral research, Ruland also adds leadership and steering role of the municipalities involved to these most beneficial factors.

Leadership is often mentioned as an important factor in the implementation of health promotion policy (see Swinburn, Baker and Porter, Ruland, etc.). It is therefore appropriate to dwell on the way in which leaders deal with complex administrative systems. The integral approach of obesity prevention and health promotion is complex, because it usually concerns a programme involving various actors from different sectors. Teisman distinguishes **two types of managing**.[43] *'The first type is concentrated on order. This type of leader wants to stabilise systems and eliminate variations. Everywhere within the public establishment leaders are busy arranging and controlling their systems.'* This requires power and instruments to substantiate this power, such as organisations and institutions, laws, procedures, etc. This kind of leadership is extensively described in literature. The second type of managing pays more heed to context, complexity and the corresponding chaos, but is found less often in literature. According to Teisman, this type of leader wants to let systems evolve

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[42] Ruland, E., Assema, P. van, Ree, J. van, et al. (2006a). Hartslag Limburg: integrale gezondheidsbevordering in buurten, gemeenten, bij huisartsen en in het ziekenhuis; Deel 1. De opbouw: bundeling van praktijk, onderzoek en beleid. *TSG Tijdschrift voor Gezondheidswetenschappen* 84 (2), pp. 83-89.

[43] Teisman, G., (2005), Publiek Management op de grens van chaos en orde. Over leidinggeven en organiseren in complexiteit, Den Haag: SDu Uitgevers.

and will encourage innovations in administrative systems. *'This type is less visibly bound to power. These leaders are competent at making connections. They are spread throughout the administrative system and usually do their connection work independently of their formal position in the organisation involved.'*

The external factors that play a part in cooperation aimed at an integral social health care approach are rather situated in the background of the planned interventions or of those being executed. In this respect, both models pay attention to laws and regulations within the framework of the relevant national policy. Furthermore, also the attitude of financiers plays a not negligible part in the implementation of a coordinated and preventive health policy. 'The cooperation is improved by a stimulating, supporting and thinking along attitude of financiers and a promise of long term financing in order to prevent a personnel exodus'.[44] In this respect we also want to ask attention for the **population's attitude towards the problem of overweight and obesity.** This is an external factor that is not mentioned in these models. Perhaps it can emerge from this EEN-study that this factor does indeed play an important role in the degree in which (local) governments take up their responsibility in developing an integrated and coordinated obesity prevention. Thus, it emerges from a telephone survey among a representative sample of the adult Belgian population that 74% of the overweight or obese respondents think they have a normal weight.[45] This means that three quarters of the adult Belgian consumers have no problem with the fact that he/she – from an objective point of view – suffers from excessive fat deposition. So, the vast majority within Belgian society does not perceive overweight and obesity as a problem. Of the American overweight population (and consequently with obesity), 22% consider their body weight normal.[46] Within the framework of this EEN-study we would therefore like to examine the proposition that the attitude of the population towards overweight and obesity is also a factor that determines to which degree a coherent prevention policy in this field can succeed.

In an increasing part of the administrative literature attention is paid to the role of **frontline workers**. These are people from the government who are responsible in their daily work for providing public services and for involving the real community in these services. Other terms for these people that emerge in literature are 'every day maker' (Bang & Sorensen, 1999) or 'street level bureaucrat'(Lipsky, 1971). An article has very recently appeared which illustrates the key role of frontline workers in the innovation of the local social health care policy. However, they can only fulfil this key role to the degree in which they succeed to reconcile the different policy objectives and discourses of the network organisations involved. So, these frontline workers are expected to handle a strategy in which they keep on providing the public services and at the same time commit themselves to the local communities involved. This article gives us a picture of these frontline workers' strategies by means of stories from community and health workers in disadvantaged urban neighbourhoods of Salford, near Manchester.[47] These stories illustrate how frontline workers proceeded to reconcile policy demands – concerning public health – with worries within the local communities – concerning the fight against financial exclusion – by showing understanding for the micro-context of the people from the neighbourhoods in which they worked. Or as a health worker in Salford puts

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44 Leurs, M, a.o. (2003), p371

45 Vandercammen, M., (2009), De gezondheidsinformatie: Studie van Onderzoeks- en Informatiecentrum van de Verbruikersorganisaties, Brussels: OIVO, September 2009, 40p.

46 Chang, V. W., Christakis, N. A., (2003), Self-perception of weight appropriateness in the United States, American Journal of Preventive Medicine, 24(4), 2003, pp332-339

47 Durose, C., Front-line workers and 'local knowledge': neighbourhood stories in contemporary UK local governance, in: Public Administration Vol. 87, No. 1, 2009 (35-49)

it: *(…) and unless we can do something around tackling those issues (about financial exclusion and low self confidence) we're not going to get them interested in some of the others, like eating better and getting exercise… and doing programmes around things we want them to do to improve their health.'*

The stories also illustrate that their strategy is based upon their **'local knowledge'** or their local reading of the situation. They usually apply a broader social perspective on the health of the neighbourhood people with whom they work together. They see the links between a bad health and financial exclusion, a low level of self-confidence, etc. This broader perspective for looking at health is undermined by the more specific approaches of the higher public health care authorities as they are indicated by the British policy plan, the so-called White Paper on 'Choosing Health'. The central government introduces guidelines and objectives concerning specific health indicators, diet, physical activity, smoking, sexual health and the use of drugs. And sometimes, these central objectives obstruct the work within the neighbourhoods. Particularly since the network partners are also guided by the specific health objectives and consequently are heedless of the social factors which play a role in the public health of these neighbourhood people. So, for the EEN-study we note that also frontline workers have an important role to play in childhood obesity prevention. The degree to which they can reconcile their local knowledge of the obese target groups in the neighbourhoods with the more specific health objectives from supra-local policy plans constitutes an important factor in the success of its prevention.

In real terms of the public health networks frontline workers are not the most powerful partners. Sometimes local administrators as well as health sector representatives or officials from supra-local administrations can have more means of power at their disposal. In order to gain insight in the phenomenon of power within the obesity prevention networks, we can get help from theories on **interdependence or mutual dependence** within networks.[48] Network theories stem from insights on decision-making processes in the seventies. Research from that time made clear that public decision-making took place within some sort of autonomous cooperation between several actors, both from the government and the market and/or the society. Usually, the interdependence of mutual dependence is central in this network approach. Klijn argues that *'analyzing policy processes from a network perspective means that the analyst focuses on the relation between actors, their interdependencies and the way these patterns and interdependencies influence the policy process'*.[49] Hierarchy would be lost in networks, causing the policy (for instance on obesity prevention) to become the result of actions of many actors. According to a growing number of authors, such a decision-making process has become a complex matter because different network actors want to push it into the direction of their objectives. The network actors involved act from different subsystems and are not prepared to simply conform to one of the other subsystems. According to Block the stability stemming from one central actor (with his own supporters, objectives, regulations and logic to act, etc.) is missing and the decisions are the result of the logic of the network with its various actors.

The actors participating in these networks all have their own objectives, but likewise they also depend on each other to achieve these objectives. No actor has sufficient power or steering possibilities to determine the actions of other actors. Interdependence and the lack of a strict

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[48] Block, T., (2009), Besluitvormingsprocessen en beslissingsmacht bij stadsontwikkelingsprojecten, Doctoraal proefschrift Politiek wetenschappen, Universiteit Gent, pp91-95.

[49] Klijn, E.H. (1997), Policy Networks: an overview, in: Kickert, W.J.M, Klijn, E.H., Koppenjan, F.F.M. (eds), Managing Complex Networks, London: Sage, p.30

hierarchy do not mean that all actors involved have the same power. **Power** is usually coupled with the possession or activation of sources of power. Possible sources of power for actors in a decision-making process can be e.g. money, prestige, knowledge, violence, rights, ideology, etc. Block's doctoral research gives a survey of different categories of sources of power. In general we notice that financial means are rather the source of power for private actors, whereas competence and legitimacy pre-eminently constitute the means of power for authorities. Some authors even attribute exclusive sources of power to government actors (in this case the legislative power).[50] In practice sources of power are usually deployed in a combined way. For the most part, the mix of sources of power is then specifically linked to a particular dossier.[51] Because of the unequal possession of sources of power, the relations between network actors are usually considered to be asymmetric. The position of an actor within such a network and the relations with others in that network are to a large degree determinant for the sources of power an actor has. Varying positions of power are a frequent phenomenon and consequently, also coalitions of power vary each time. From the network literature coalitions are considered to be *'semi permanent arrangements among actors pursuing separate but, by and large, convergent or compatible purposes and using their separate actions resources in coordinated strategies'*.[52] The features of such coalitions of power can show huge differences: formal versus informal, single-issue versus multi-issue, long term versus short term, open versus closed, inter-organizational versus intra-organizational, etc. In practice one generally finds a mix of such features.

According to Knoepfel, these different actors in the government policy network always relate to each other in the form of a triangle.[53] On the three poles of this **actors' triangle** one always finds the political-administrative authorities (or public actors who elaborate and implement the public policy), the target groups (or authors of problems) and the final victims (or those who experience the problem). Indirectly, also other private actors can be involved in a government policy, notably the beneficiaries (those who benefit from the handling of the problem) and the injured (whose interests are damaged by the government intervention).

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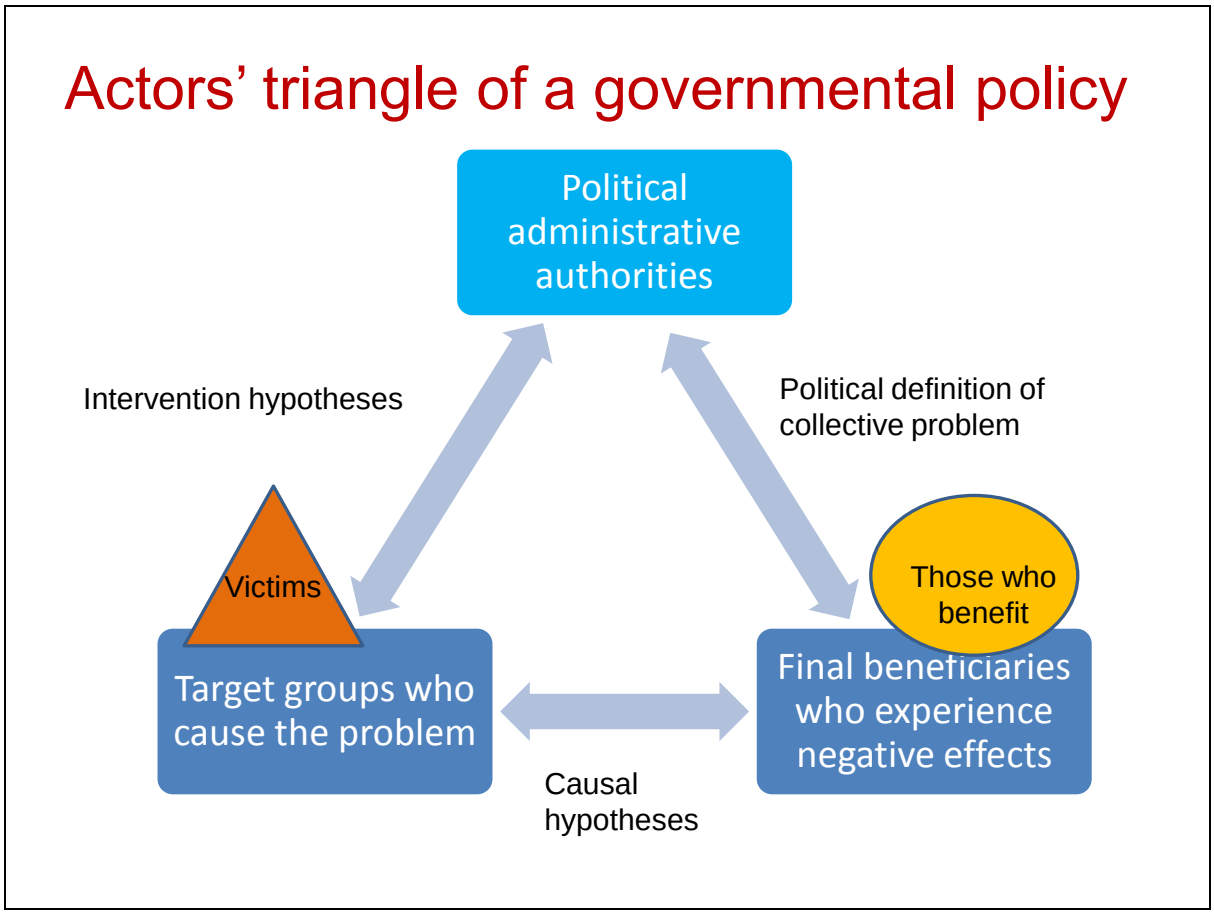
50 Agranoff, R., McGuire, M. (2003), Inside the Matrix: Integrating the Paradigms of Intergovernmental and Network Management, in: International Journal of Public Administration, 2003, 26, 12, pp.1401-1422.

51 Voets, J. (2008), Intergovernmental relations in multi-level arrangements: Collaborative public management in Flanders. Doctoraal proefschrift Instituut voor de Overheid, KULeuven.

52 Scharpf, F.W., (1997), Games real actors play. Actor-centered institutionalism in policy research. Boulder: Westview Press, p55.

53 Knoepfel, P., Larrue, C., Varone, F. (2006), Analyse et pilotage des politiques publiques, Zürich: Verlag Rüegger, 384p

Diagram: actors' triangle of a government policy



Source: Knoepfel, a.o., 2006, p63

In the example of a local prevention policy to counteract childhood obesity, the following picture could be seen in Flemish towns: the town councils, the social service departments, the loco-regional health consultation and organisations, the services of the local social policy and/or district health centres are the public actors. The private actors causing the problem are families with obese children who show the related problem behaviour. These very same obese children are the private actors who, at an advanced age, have more chance of suffering from all kinds of diseases of civilisation. The picture can also be completed by indicating certain food sector companies that can be favoured by a prevention policy in the field of healthy diet because they market healthy food. As a result of the implementation of a prevention policy, also fitness centres and/or producers of sports equipment can benefit, because they encourage people to take sufficient physical exercise. On the other hand, we have companies that continue to produce and distribute high-fat and sugar-rich foods. In time they can be injured by these prevention programmes. This triangular relationship between public and private actors (both authors and victims) can cause the idyllic notion of the local policy as being closest to the citizens and showing the most respect for all interested parties to be adjusted into a more critical approach. In this view, also the local administrative level is an arena in which a struggle for power is fought, with the most dominant local actors trying to shape the policy to their own interests. (Knoepfel, 2006, p331).

Via laws, decrees, regulations and guidelines, the government has a profound effect upon our daily lives and state of health. Research into diseases and health is a source of the scientific foundation of the social health policy. Quite often, however, there is little connection between the quality of the research and the **quality of the laws, decrees, regulations and guidelines** that are deduced from this research. This is argued by a number of researchers from the US.[54] Hence, they ask themselves why they do not see a systematic conversion of the results of scientific studies into government regulations? We will not comment on the fact whether this is the case, but they do indicate factors that are interesting to improve the relation between researchers and policy makers. First of all, they indicate the difference in culture or mentality between scientific and political decision-making. Scientists are mainly occupied with testing specific hypotheses and on this basis they develop their specialised knowledge. Politicians have the responsibility to make decisions in the public interest of the community and in order to do so, they base themselves on questions and input from the 'stakeholders' of society. Ideally, rational decisions are the result of a multi-criteria evaluation, but one in which the weight of the criteria is subjected to a permanent social debate. In his respect, politicians, with the support of their technical and administrative services, must come to the largest possible consensus, so that their electoral capital is not too much affected, or rather progresses, and so that during the next elections they can emerge stronger from the battle. Moreover, in this clash between two cultures all kinds of more punctual factors also play a role, such as poor timing, a lack of unambiguous conclusions of scientific studies, an information overload from various sources, at the same time a lack of relevant data[55] and more specifically a lack of qualitative research whereas researchers continue to produce research results in a quantitative way.

If we can work on these factors, the relation between politicians and researchers could improve. And then the laws, decrees and all kinds of other regulations could be geared more and in a better way to the relevant scientific knowledge. However, within the framework of this study we focus on the existing laws and regulations and search for factors which influence politicians and policy officers to the degree to which they develop an innovative policy, in our case in the field of childhood obesity prevention. In other words, we use the laws and regulations in a certain country or region as data and look at the differences in involvement and activity of local administrations in the field of childhood obesity prevention. To be perfectly clear, we want to state that this EEN-study does not intend to compare national laws and regulations in order to see in which country the insights of scientific research are best translated into preventive health care regulations, and preferably specifically concerning childhood and adolescent obesity. Having said this, it is as much a proposition for further research.

7. To be continued …

From that screening of literature we have learned that public intervention is necessary in order to deal with childhood overweight and obesity and that the local administrative level

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[54] Ross C.B., Royer C., Ewing R., McBride T.D., (2006), Researchers and Policymakers: Travelers in Parallel Universes, in: American Journal of Preventive Medicine, 30(2): 164-172, Elsevier

[55] 'There is a widening sea of data but, in comparison, a desert of information' (May, Mitchell, a.o., 1998). May, A.D., Mitchell, G., Kupiszewska, D., The quantifiable city: the development of a modelling framework for urban sustainability research. In: Schavioni, U. (Ed.), Information systems and processes for civil engineering applications, Luxembourg: European Communities, 1998, p. 124-142.

constitutes the tailpiece of any public intervention in this field. The key task of the (local) government in obesity prevention consists of supporting the target groups (such as children, adolescents, etc.) and the first-level actors (such as parents, schools, sports organisations, associations for a healthy diet, etc.), so that the intended groups start to eat more healthy food and to take more physical exercise. In this respect we also have learned 1) that the (local) government should play four different major parts to show real leadership, and 2) that furthermore various other institutional factors determine to what degree childhood obesity prevention is translated into reality. A summary of the results of the exploration of literature can be found in the first point of this interim report.

In the next phase of the EEN project we will test these insights, coming from the literature, to come to more valid conclusions. We foresee a *testing on two tracks*. In a couple of Flemish cities we want to study the institutional factors that are supposed to influence the role of the city authorities in the implementation of projects on the promotion of healthy diets and physical activity. Beside it, we plan national focus groups with representatives of local governments in a certain number of European countries to describe the impact of some of the crucial institutional factors in the implementation of projects on COP. Last but not least we foresee a validation of both results by means of the input of experts on local politics, public management and implementation theory. About which we will report in due time …