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Twelve Years and Counting: California's Experience with a Statewide Healthy Cities and Communities Program

SYNOPSIS

California Healthy Cities and Communities is the longest running statewide program of its kind in the nation. After providing a brief history, the authors give an overview of the supporting activities and resources the Program provides to Healthy Cities and Communities initiatives throughout California.

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During the 1980s, efforts to improve health focused on changing the behavior of individuals. The public was cautioned to quit smoking, eat low fat diets, exercise more, and adopt other lifestyle changes that medical researchers had proven to lower health risks. Unfortunately, a focus on individual behavior change did not translate into appreciable improvement in the health of Americans, especially those with disproportionate risk for disease, disability, and premature death.

In California, several key leaders in public health and the Healthy Cities movement, drawing on their professional experience as well as research suggesting that people who feel well connected to others tend to enjoy healthier lives, decided that something different was needed to improve the public's health. As the World Health Organization was starting its Healthy Cities campaign in Europe, these leaders decided to bring

the Healthy Cities model to the United States. In 1987, they launched the California Healthy Cities Project.

HISTORY OF CALIFORNIA'S HEALTHY CITIES AND COMMUNITIES PROGRAM

Identifying a starting point. The California Healthy Cities and Communities Program ("the Program") has its origins in the California Healthy Cities Project ("the Project"), which began in 1987. The strategic direction for the Project was shaped by key political, economic, and structural factors and challenges, including:

- An emerging public health interest in focusing on the broad determinants of health, that is, education, income and living conditions, for community health improvement.
- The emergence of the Healthy Cities model, which was largely unknown in the United States and had only recently been initiated in Europe and Canada.
- A need to popularize what *creates* health while simultaneously countering the traditional and prevailing notion equating health with medical care.
- The absence among many local public health departments, which held legal and fiscal responsibility for community health, of organizational relationships, resources, and staff necessary for policy development or expertise in content-specific areas related to health determinants.
- Extremely modest resources for a statewide program—$249,000 for the first 18 months.

Given these factors, the Project's founders decided that the most advantageous initial entry point would be cities. Cities were the level of government closest to the people; they had responsibility and resources for many health determinants such as safety, housing, and economic development; and they had the ability to rally broad constituencies, including the business sector and residents, based on civic pride and a sense of place. Even though there were 447 municipalities in California at the time, they provided a discrete, identifiable audience with whom to start a movement. The League of California Cities, based in Sacramento, the state capital, offered opportunities for partnership.

Initiating the Project. In the late 1980s, California's harsh economic times, combined with the view that health and social services were budgetary "black holes," made many city leaders wary of experimentation. These factors implied a strategy to attract those municipalities for which being at the forefront of change had great appeal.

The initial strategy involved:

- A *competitive* process by which the Project's steering committee would choose 10 cities for a demonstration program. Cities were required to submit applications to the Project that: profiled their city; identified areas for community improvement; detailed staff involvement; described the convening of a broad-based steering committee; detailed a work plan and evaluation process; and demonstrated city council commitment via passage of a supportive resolution. While some technical (and minimal financial) assistance was available once cities were selected, there was no direct funding to implement initiatives.
- Promotion of the Healthy Cities concept and approach in ways that related to municipal functions. The Project sent out more than 3,000 newsletters to political, community, and public health leaders. This literature emphasized improving "community livability" and "quality of life" using familiar examples such as literacy programs, ordinances limiting alcohol use in parks, and the development of master plans.
- Products and services offered by the Project on a continuing and regular basis to all California cities, the public health community, and interested others to raise awareness and garner support.

The Project accepted 10 applicants based on their commitment to innovation, interest in lowering social inequities, and commitment to involvement of various sectors of the community. In 1992, these first 10 participants were designated "Charter Cities"—a title they continue to use proudly—to recognize their pioneering spirit and their willingness to share their experiences with others.

Expanding the Project. As interest grew, the Project shifted from a demonstration phase to accepting applications on a "rolling" basis, with extensive technical assistance provided for proposal development. This approach was more responsive to the organic nature of community development. As additional resources were secured, seed grants were made available. Over the next several years, 33 additional cities participated.

With a solid track record of providing quality services and a decade of success elevating the profile of cities in prevention-oriented programs, policies, and plans, the Project was eager to work more directly with other "lead" organizations, for example, community-based organiza-

tions and other nonprofit groups. In 1998, the Project entered its next major phase with a grant from the California Endowment. With these new resources, grants were made available to 20 qualifying communities that encompass neighborhoods, unincorporated areas, and multi-jurisdictional regions. With this expansion, the Project changed its name to California Healthy Cities *and Communities* (referred to here as "the Program").

Creating an organizational structure. Consistent with the Healthy Communities philosophy, the Program grew through cooperation between public and private entities. When the Project originally began in 1987, the California Department of Health Services (DHS) and the Western Consortium for Public Health had established a partnership to lead in the planning. Later, in 1996, the Center for Civic Partnerships was established to provide an "umbrella" structure for the Project and similar community building efforts designed to reach different constituencies. In 1998, the Center became part of the Public Health Institute, a private nonprofit organization.

Operation of California Healthy Cities and Communities

The Program takes a multi-tiered approach that includes technical assistance, funding, promotion, coordination and collaboration, systems reform, program evaluation, and celebration.

Technical assistance. The goal of the Program's technical assistance services is to help participating cities and communities to develop, implement, and evaluate community-driven programs, policies, and plans for improved quality of life. Site-specific technical assistance is tailored to each community's characteristics—recognizing its assets and challenges—to facilitate the discovery and sustainability of its collective wisdom and power. In addition, the Program facilitates networking and peer-to-peer exchange among communities in order to share resources and institutionalize best practices.

The Program provides the following forms of technical assistance: consultation, educational programs, literature and information, and a resource clearinghouse.

Consultation. The Program provides on-site skill-building consultation to community coalitions on such topics as governance, collaborative planning, systems thinking, and intersectoral coalition building. While technical assistance is often provided on request, the cultivation of positive relationships between Program staff and communities also allows the Program to identify challenges and proactively provide assistance and resources. This approach results in the integration of technical assistance into ongoing local planning and development. For example, the Program staff often receives requests from communities to participate in coalition retreats and vision workshops and for assistance in making presentations to governing bodies.

The Program also helps to facilitate communication within community coalitions. Staff members' facilitative role includes assisting communities to bridge knowledge gaps and cultural understandings among residents, organizations, and institutions and to foster collaborative relationships to develop a collective vision, shared values, and mutual exchange of skills and resources. In this role, the Program also serves as a sounding board for communities, offering an "outsider" perspective that can present and interpret different viewpoints. California's changing demographics challenge communities to embrace ethnic and cultural diversity as part of a commitment to full participation. Program staff members have recommended strategies that are responsive to existing or emerging cultural norms and that engage ethnic communities through inclusive and empowering approaches.

Technical assistance also has a role in monitoring community progress. Program participants submit progress reports and annual work plans. Review of reports and consultation on work plans provides opportunities to assess the integration of the Healthy Cities and Communities model. Program staff members identify local successes and challenges, offer recommendations (including lessons learned from other communities), and assess the use of technical assistance.

Educational programs. The Program also sponsors interactive educational programs to promote learning and the sharing of community-building skills. These include day-long orientation sessions, an annual conference, and regional workshops. Through the exchange of information, resources, and stories, the Program's educational opportunities help participants in their community improvement efforts and broaden their understanding of what it takes to do this work; develop and nurture relationships among participants; and energize and support all those in attendance (including Program staff).

Each educational event models Healthy Cities principles by involving program participants in the planning, implementation, and evaluation. For the annual conference, participants are surveyed on their interest with regard to content, and a planning committee of commu-

nity representatives develops the agenda and conference format and identifies speakers.

The majority of the conference speakers and workshop facilitators are community residents. Meeting "ground rules" are posted, and "jargon police" monitor the use of acronyms and language that can be exclusionary. In the last eight years, attendance at the annual conference has grown more than five-fold, to over 270 participants.

A recent technical assistance survey of participating communities indicated great interest in the areas of: leadership development, Healthy Cities and Communities "basics," sustaining coalitions, inclusive community-building strategies, and using evaluation results for advocacy. Participants also indicated a high level of willingness to be involved in educational sessions as hosts, participants, or facilitators. As a result of this interest and the growth in the number of participating communities, the Program will sponsor regional workshops to provide more accessible opportunities for sharing expertise. These workshops will be hosted by participating communities, will have minimal registration fees, and will offer low-cost meals.

Literature and information. As part of technical assistance, the Program provides participating communities with literature, including a comprehensive resource guide; *Connections*, our quarterly newsletter; and bi-annual mailings of *Highlights*, a bulletin of funding opportunities, best practices, innovative community-building strategies, and useful websites. Additionally, the Program makes available the latest reference materials on various topics, including meeting facilitation, coalition-building, and evaluation. The Program also maintains an electronic mailing list and website.

Resource clearinghouse. Each year, the Program receives hundreds of in-state inquiries and requests for information from throughout the United States and abroad. To respond to these, the Program has developed a wide selection of literature that explains the Healthy Cities and Communities concept and profiles, in a mini-case study format, the background, experiences, and results achieved by program participants. Planning guides have been developed on youth violence prevention, promoting youth development, and tobacco control and sent to thousands of professionals and activists.

The Program provides an important link to practitioners in the community-building field and the Healthy Cities and Communities movement nationally and internationally. For instance, as part of the Coalition for Healthier Cities and Communities, the Program assisted with nationwide dialogues on community-building in 1999–2000.

Funding. The initial funding for the Project was provided through the Preventive Health Services Block Grant from the Centers for Disease Control and Prevention, administered by DHS. This funding has remained at the same level since 1993. In the last few years, additional funding streams have been added to increase local grants, bolster the infrastructure of the state program, conduct a cross-site evaluation, and support special projects, such as conference scholarships and publications. Resource limitations, and a goal of engaging communities that are genuinely committed to Healthy Cities and Communities principles, determine local funding strategies. At first, for the Project's demonstration program, the only financial assistance provided was for travel to Project-sponsored meetings. The Project also had a small reserve for consultant contracts to be used locally. Frequently, however, communities needed resources for implementing the most basic activities of their work plans, for example, community outreach and local promotion.

Since 1993, the Project (and later the Program) has offered cities seed grants of $5,000 to $10,000 per year, based on population size. Typically, these awards have been used to offset costs for student and participant stipends, incentive or promotional items, and evaluation. Awards are granted on a merit basis; the criteria include focus, cohesiveness of work plans, community commitment, and evaluation methodology. Additionally, past performance and organizational integration of the Healthy Cities philosophy are considered for renewal applications. In addition to direct awards from the Program, millions of dollars have been leveraged. For every dollar provided, cities have brought in more than eight dollars. Incalculable in-kind resources have also been generated.

Over time, state health department programs and external organizations have sought assistance from the Project for work on specific health promotion topics. In 1995, the Project began formalizing partnerships that resulted in categorical funding opportunities for participating communities. Over the last four years, approximately 25 awards, averaging $28,000 each, have been given for injury control, food security, cardiovascular and cancer disease prevention, and tobacco control projects. These awards, which have been made available to program participants on a competitive basis, have served as a catalyst for securing or reconfiguring resources.

In 1997, the Program received a small grant from the California Endowment to enhance the work of four

promising participants through one-year implementation grants. In addition, planning grants were made to two "budding" coalitions. The next year, a five-year, $5-million grant from the Endowment allowed the Project to expand into the Program, California Healthy Cities *and Communities*. The key audience for this grant program is communities that are just beginning to coalesce around Healthy Cities and Communities principles and that have disparities in income, educational status, or other demographic variables associated with health status inequities or health risk. Priority is further given to geographically, socially, or culturally isolated communities, including neighborhoods, unincorporated areas, and areas that cross jurisdictional boundaries.

Over a five-year period beginning in 1998, 20 communities will receive planning and implementation grants of $25,000 each. On successful completion of the planning phase, the program will make available implementation grants of up to $50,000 a year for two years. A 50% match is required for each of the implementation grants; the matching requirement is imposed to emphasize the need to plan for sustainability from the beginning.

Promotion. The Program has invested heavily in a multi-pronged information campaign to create a Healthy Cities and Communities movement in the state. Strategies have included enlisting key leaders, including policy makers and administrators from constituency groups the Program wants to reach; formal presentations as well as personal contacts; and widespread distribution of publications.

The language of Healthy Cities and Communities has always been a struggle. The term itself, while appealing and wholesome, is still confused with medical, or sick, care. Even people who understand the model and who may have participated in the Program for years, need the tools and appropriate "everyday language" to describe what this work is about to the community at large and their colleagues. Drawing connections to quality of life issues such as education, the environment, and the economy will often strike a responsive chord.

Enlisting city government officials, including city managers and key department heads, as spokespersons for the Healthy Cities movement has been one of the most effective promotion methods. These people have credibility because they are well-respected and active in their professions and can be vigorous advocates among their peers. The value of these peer-to-peer transactions cannot be overstated because they lend access to a larger audience. Spokespersons for the Program can also "translate" the Healthy Cities message with language familiar to their disciplines.

For example, in one case, a city manager made presentations to state and national audiences and wrote a feature article in the magazine of the International City/County Management Association. He also organized a staff team to visit another Healthy City to learn from its experience. So-called "social entrepreneurs" like this city manager come from a wide variety of fields, including public administration, community services, recreation, public safety, community development, and human services. In the policy making arena, the Program's California Smoke-Free Cities Program worked with city council members who championed the cause of clean indoor air not only in their jurisdictions but also with their counterparts in local and state government.

One of the Program's goals has always been to influence policy making and resource allocations on the part of public and private organizations at the local and state level.

Another strategy for promotion is to go to the venues that attract the audiences we want to reach. Annually, Program staff members make dozens of presentations to community groups and at meetings of elected officials and of professional associations for public health, park and recreation, health care, education, and human services professionals. The Program routinely exhibits at the League of California Cities' annual conference and other meetings.

To further promote the Healthy Cities and Communities message, the Program publishes a quarterly newsletter, *Connections*, which is mailed to more than 6,500 people. At the municipal government level this includes the mayor, council members, city manager, and various department heads in all of California's 473 cities. It is also sent to health officers, administrators, health education directors, and division directors of local public health departments.

Coordination and collaboration. Coordination and collaboration among public, private, and nonprofit groups is the cornerstone of the Healthy Cities and Communities philosophy. The road to collaboration is fraught with

challenges. Turf issues, crossed communications, and conceptual misunderstandings all have the potential to derail rewarding, synergistic efforts. Nonetheless, collaboration has been a key ingredient in much of the Program's success.

To promote the collaboration, the Project decided to locate its office in the state capital. In Sacramento the Project was well positioned to form significant partnerships with DHS programs and with local government associations, policy groups, health care organizations (and their associations), a food security organization, the state recreation society, and the education and faith sectors. Because each sector reaches a different constituency, these relationships allow for cross-pollination that would not otherwise be possible.

One of the most important—and certainly the longest running—collaborations has been with DHS. Beyond funding, this collaboration has included the Program's roots in what was then the Department's Health Promotion Section. Being physically housed within a DHS facility for the first 10 years provided for an exchange of ideas and resources and heightened visibility. Later, when the Program moved to an off-site location in 1998, Program and DHS staff continued to serve on each other's advisory committees and grant review panels, and alert each other to opportunities and resources for communities with which they work.

Working with so-called "good government groups" has enhanced communication with both elected and appointed local government officials. At the state level, Program staff and groups such as the League of California Cities, the Institute for Local Self-Government, and the Local Government Commission have presented at each others' conferences and shared expertise on ad hoc committees and review panels. At the national level, information has been shared with groups such as the National Civic League and the National League of Cities through journal articles, newsletters, and conference presentations.

Local health departments have been critical partners for local initiatives and the Program. Key officials in local health departments attend Program orientations and receive the names and contact information of representatives from cities and communities in their service areas. Local health department staff are routinely invited to Program events and are frequently asked to make presentations, serve on award and grant review panels, and cosponsor programs in their area. All local Healthy Cities and Communities initiatives are encouraged to involve health department representatives in their work, and health officers are notified about any initiatives in their jurisdictions. The Program also regularly sends publications and announcements to health departments.

Finally, mutual support is an important, albeit intangible, aspect of all of these relationships. The Healthy Cities and Communities movement is about people. Emotional and spiritual support and encouragement to continue this work might be the most valuable outcome of collaboration.

Systems reform. One of the Program's goals has always been to influence policy making and resource allocations on the part of public and private organizations at the local and state level. In California, systems reform at the municipal level—which generally has no statutory responsibility for public health—has involved instituting policies and practices that make explicit the city's role and contribution in community health promotion and protection. At the local level, policy initiatives have transformed vacant land, increased access to healthful foods, expanded community gardening, reduced exposure to environmental tobacco smoke, restricted alcohol availability, and improved transportation safety.

At the state level, systems reform may take place *within* and *across* state-level organizations. For example, it is systems reform when a state public health department partners with organizations or develops constituencies outside the traditional public health infrastructure. Likewise, it is systems reform when non-health organizations incorporate Healthy Cities and Communities principles into their missions and operations and when they collaborate across sectors to improve the public's health.

Several California Healthy Cities have made food security a priority. Seed grants have stimulated and supported demonstration programs, which are resulting in cross-sectoral action and policy. Community garden cooperatives and related micro-enterprises have been established. Food policy councils, with representation from multiple sectors, are working to improve summer lunch programs and to promote community gardening through reducing city water fees, organizing a healthy canned food drive, and supporting teachers as they integrate gardening and physical activity into daily classroom routines. The Adopt-a-Lot Program in the City of Escondido takes advantage of an exemplary land use policy to allow residents, neighborhood groups, and organizations to qualify for a special, no-fee permit when they "adopt" public or private vacant land on a temporary basis for recreational use or other community purposes.

New resources have been made available by schools and city governments. In the city of Chula Vista one teacher now works full-time to institute a garden-based school curriculum. The city of Berkeley developed public

use standards for community gardens on city property, providing free water use, fences, and help with installation.

The private sector has been active in the food security arena as well. In the city of West Hollywood, a small, densely populated urban area in greater Los Angeles, positive experiences with school-based community gardens prompted the manager of an apartment complex where one student lives to establish an on-site garden for its residents. The Escondido Downtown Business Association provides same-day reimbursement for farmers who accept food vouchers at their open-air market.

Systems reform benefits tremendously from a comprehensive framework. The city of Pasadena developed a ground-breaking Quality of Life Index to improve planning, policy making, and resource allocation with extensive input from residents, technical panels, and neighborhood groups. The Index identified more than 50 indicators affecting community life—for example, safety, education, substance abuse, recreation, economy, and housing—which are now being monitored. The Index has guided policy development with regard to alcohol availability, infant health, and tobacco control, has assisted city and community agencies in priority-setting and resource development, and was used as the basis for the city's performance-based budget system.

Increasingly, DHS programs have taken a more environmental perspective. Several DHS programs, especially those in the area of chronic disease and injury prevention, now recognize municipalities and Healthy Communities coalitions as major players in advancing prevention objectives and specifically focus on them for local assistance contracts.

For several years, beginning in 1990, the Project worked in a formal partnership with the League of California Cities and Americans for Nonsmokers' Rights to educate and support municipal officials statewide about tobacco control. Before January 1990, only one California city had an ordinance that completely banned smoking in restaurants. Four years later, more than 100 cities had banned smoking in restaurants and almost 90 cities had eliminated smoking in the workplace. This local action provided the foundation for state legislation, which went into effect in 1995, that required smoke-free workplaces and allowed local governments to enact stronger policies.

Senate Bill 697, California's hospital community benefits law, provided a strategic window to integrate the Healthy Communities philosophy into the mission statements and assessment and planning processes of the state's 250 nonprofit hospitals. The Program has partnered with the Office of Statewide Health Planning and Development (OSHPD), which has oversight for this legislated mandate, to coordinate work wherever possible. OSHPD, a freestanding office within DHS, has endorsed the Healthy Communities framework, as have many health care industry and association leaders.

The Association of California Healthcare Districts (ACHD), a membership organization of hospital trustees, physicians, and key staff, is partnering with the Program to involve its members in Healthy Communities work. ACHD's 1997–1998 annual report includes strong recommendations to its membership to get actively involved in Healthy Communities efforts. As a result of this partnership, four health care districts are participants in Healthy Cities and Communities initiatives.

Evaluation. Methods for evaluating progress have changed over time as the Healthy Communities movement has grown. The intensity of early Project activities and limited budgets during the first decade combined with the nascent state-of-the-science of community-based evaluation meant that efforts were directed primarily at site-specific evaluations. Later, the Program developed more sophisticated evaluation methods.

Program participants have always been required to submit work plans with, at minimum, quantifiable process measures and, whenever possible, outcome measures. Revisions to the reporting form over the years have been responsive to feedback from program participants. Reports are due at six-month and year intervals. New resources acquired or leveraged are reported, including in-kind contributions and increases in budget or staff allocations. Participants are also asked to describe the challenges experienced, unanticipated spin-offs, anecdotes, presentations to other communities or groups, and a financial accounting of grant expenditures.

For several years, participants annually self-administered a leadership questionnaire that provided an opportunity to reflect on vision/mission, community participation, city 'buy-in," the representativeness of the steering committee/coalition and its progress, and continuous quality improvement measures. The questionnaire included a checklist of municipal activities, designed by staff in one of the participating cities, to assess (and encourage) the presence of health-promoting policies and programs in areas such as health, the environment, planning and development, public safety, recreation, the city workplace, and city-sponsored events.

In 1997, after critically reviewing the reporting system and its uses for evaluation, the Program hired a consultant who specializes in community-based health promotion programs to review and revise the evaluation system.

Any change to the reporting system needed to take into account the challenges of conducting evaluations at the local level and across sites. These challenges include limited staff time and budget resources, diversity of efforts across communities, and inherent difficulties in using the "community" as the unit of analysis due to confounding factors. (For example, births, deaths, in- and out-migration mean that the "community" changes over time.) The consultant revised the system with substantial input not only from Program staff members but also from staff representatives from the participating cities.

Based on this input, the consultant identified the concepts and sub-concepts that were most important to measure, devised possible measures or surrogate measures for them, linked these measures to elements of the existing data collection and reporting system, and added elements for sub-concepts or concepts for which measures were missing. Now the evaluation includes measures of organizational-level change (for example, adoption of new policies and practices, institutionalization of health-enhancing programs), inter-organizational change (for example, new partnerships, new linkages outside the community), and civic participation (for example, emergence of new leadership, involvement of informal community leadership).

These concepts and sub-concepts fall under three major categories:

- Skill-level increases: ability of the city/community and its partners to facilitate community action;
- Institutionalization/systems reform: the extent to which institutional changes, within and beyond the organizational unit in which the initiative was originally established, have occurred to foster a safer and healthier city; and
- Increases in community competency and capacity: the extent to which exposure to and implementation of the Healthy Cities/Communities model have made a community stronger and more self-sufficient and have encouraged and expanded community participation in identifying concerns and facilitating problem-solving and decision-making.

Evaluation methodologies for the 20 communities receiving planning and implementation grants involve:

- Stratification of communities by location, size, and other community characteristics to enhance data analysis;
- In-depth study of approximately 10 communities, beyond what is available from standard evaluation reports; and
- Use of triangulation for the in-depth studies, using various strategies, including direct observation of events such as coalition meetings, a survey of coalition members, followed by focus groups or interviews in communities to be studied in depth, and a review of documents generated by the community, such as coalition meeting agendas, minutes, and attendance records.

Celebration. Community building and collaboration require hard work and perseverance; it may take years before there is discernible progress. Celebration and recognition are important elements in promoting and sustaining community efforts.

Through its publications and when providing technical assistance, the Program encourages participating cities and communities to regularly celebrate their accomplishments. Participants have devised many ways to celebrate. The city of Tulare, for example, has a "Take Stock in Tulare" program that issues shares of "stock" to resident volunteers for a broad array of non-paid community service activities such as mentoring and house painting. The awards are presented to individuals and groups on a regular basis during city council meetings. The city council in West Hollywood formally acknowledges, with official certificates presented at Council meetings, community members who contribute to Healthy Cities accomplishments.

The Program also offers a recognition program for participating Healthy Cities and Communities. Program staff members make formal presentations of awards, often at city council meetings. To acknowledge specific accomplishments, Awards of Distinction are offered in several categories such as community participation, resource development, and program impact. For cities and communities *not* officially participating in the Program, there is a Special Achievement Awards Program. Communities are eligible for these awards based on successful programs and policies consistent with the Healthy Cities and Communities model. Initiated in 1992, these awards recognize innovative local programs, policies, and plans that take a broad view of health. Applicants are encouraged to convey how planning and implementation has addressed the many factors that improve the health of residents—including employment, culture and recreation, housing, education, environmental preservation, and violence prevention. Applications are judged on several criteria, including innovation, community-based leadership, equity, collaboration, and impact. In the last seven years, 35 communities have been recognized through these awards. To generate maximum local pub-

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licity, awards are presented locally and community celebrations are strongly encouraged.

THE FUTURE: DEVELOPING A STATEWIDE NETWORK

The experience of the Program over the past 12 years leads to three important observations about launching and sustaining a Healthy Communities movement: the need to be inclusive of, and responsive to, communities' interests; the need to clarify the scope and breadth of what constitutes Healthy Communities work; and recognition of the long-term nature of this work. Program participants report that the Healthy Cities and Communities movement provides encouragement, peer and Program staff support, energy to persevere, hope, credibility, and status.

The Program has a goal of growing into a statewide movement encompassing all California collaboratives that are engaged, or interested, in this work. Unfortunately, limited resources and funding restrictions have limited participation in the Program to two major categories: cities prepared to implement local initiatives and collaboratives just coalescing to do Healthy Communities work. As a result, *existing* collaboratives as well as cities interested in this work, that don't apply for funding have no way to officially affiliate with the Program. Statewide, however, there is widespread interest in the movement, as evidenced by the receipt of more than 40 applications on average for the Program's annual Special Achievement Awards.

During the last two years, research has revealed a consensus around the value of a statewide network. The most valued benefits include linkages to like-minded colleagues, the potential to locate/leverage resources, use of the network as a source of information, shared learning around best practices, and the opportunity to demonstrate a commitment to Healthy Cities and Communities principles.

Establishing a California network is high on the Program's agenda for the coming year. Under consideration are: defining levels of participation that match the "readiness" of cities and communities; expanding mechanisms of service delivery, including linkages between "veterans" and newer collaboratives; and expanding computer-based technology.

Healthy Cities and Communities work is by nature long-term, both at the state and local level. It takes years to build the relationships and corresponding trust that allow community efforts to take root and be fruitful. Too often, there is a failure to appreciate how "upstream" this work is, especially when its benefits will not be realized for years or during the terms of political office holders. It is a privilege to have been given this opportunity in California, and we look forward to the expansion of the Healthy Cities and Communities movement in the next millennium. ■