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Article

Municipal Health Promotion as Part of Urban Health: A Policy Framework for Action

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Abstract: The link between health, socio-economic status and the living environment is increasingly moving into the focus of public health research and policy. The aim of the European Union's Project "Joint Action Health Equity Europe (JAHEE)" is to enable countries to identify and implement needs-based measures to promote health equity. In one of JAHEE's work packages, focusing on healthy living environments as a strategy to tackle health inequities, a Policy Framework for Action (PFA) has been developed. This article gives an insight into the core contents of the PFA, which are valid beyond the project boundaries for all actors that work at the intersection of community health promotion. The PFA was developed as a consensus document in a participatory process between the members of the work package and an interdisciplinary German team of public health experts. Results from project meetings of the partner countries as well as research findings and recommendations from field experts were incorporated. Reducing health inequalities in public health is a cross-sectional issue that needs to be addressed across all policy areas. The municipality setting is of particular importance in this context, as it offers many starting points and can coordinate between all relevant actors with an overarching strategy.

Keywords: urban health; municipality; health equity; health promotion; policy framework; health in all policies; public health action cycle

1. Introduction

Research findings consistently show that there is a social gradient in health. Many studies document that social inequality is related to poor environmental quality, and inequalities in the environment can be related to health inequalities [1]. Income, education, and occupational class are indicators commonly used to determine individual or family social status and vertical social inequality and access to valuable resources in a society [2].

Five central causal mechanisms behind social inequalities in health have been identified: social stratification, differential exposure, differential vulnerability, differential disease consequences, and disease consequences for the individual and for society [3]. This Policy Framework for Action (PFA) focuses on the influence of the living environmental context on health and health behaviour, an influence shown in numerous studies, often with reference to social gradient [2]. According to the WHO (2017) [4], environmental factors include exposure to hazardous substances in the air, water, soil and food, natural and technological disasters, climate change, occupational hazards, travel, transport and the built environment and access to nature. The environment also includes social factors like social cohesion and social support. There is growing evidence that social inequalities may be linked to worse environmental quality and environmental inequalities may be causally connected with health inequalities [5]. Environmental inequalities are defined as ‘the unequal impact of environmental influences on health and wellbeing’ [6] (p. 3). Socioeconomically deprived communities are more likely to have social and environmental risks to health like poor housing, safety from traffic, fewer green spaces, poorer air quality and higher rates of crime [7]. They are associated with worse health outcomes. The environment can have an impact through biological mechanisms and psychosocial mechanisms [6,8].

Since 2018, the JAHEE project (Joint Action Health Equity Europe) has been implemented as part of the European Union’s third public health programme [9]. The project provides an important opportunity for participating countries to work together to tackle health inequalities, to discover common challenges, and to take greater account of the social determinants of health. The overall objective of JAHEE is to contribute to achieving greater equity in health outcomes across all groups in society in all participating countries and in Europe at large. The JAHEE project is implemented in three steps over a period of four years (2018–2021) in 25 participating countries within different work packages (WP). The WPs represent the different thematic priorities of the project, which are monitoring of health inequalities, healthy living environments, migration and health, access to health services and health in all policies-governance. In a first step, general policy frameworks for action (PFA) were developed within the WP as a working basis for the participating countries. In a second step, the participating countries implemented actions to tackle health inequalities based on needs and different policy contexts to develop and disseminate recommendations for policy and practice, based on the best-practice-examples, in a final step. Figure 1 gives an overview of the WPs within the JAHEE project.

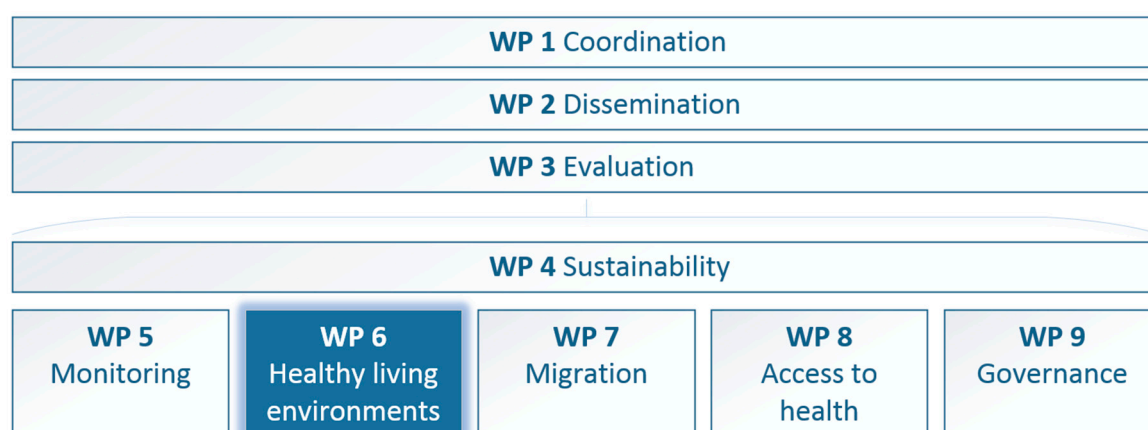


Figure 1. Structure and work packages from Joint Action Health Equity Europe (JAHEE). Own Figure based on JAHEE, 2020.

The PFA was developed within WP 6 “Healthy living environments” as one of the project deliverables and aims to create a common understanding of healthy living environments among stakeholders from different countries. In addition, the communication of the best available knowledge about reasons for and ways to create healthy living environments in a community as an umbrella setting is central.

They cover many different topics and specific target groups, which can have different relevance and characteristics depending on contextual factors and conditions. Therefore, the aim is to enable the countries to identify and implement appropriate measures for their specific needs and conditions. Framework recommendations on ideal processes and quality criteria serve as support in this process.

The aim of this article is to provide an insight into the core aspects of this PFA, which are also valid beyond the project's boundaries. Thus, this article intends to contribute to disseminate the project's findings across disciplinary and national borders and to make it available to all stakeholders working at the intersection of municipal health promotion.

2. Method

The PFA as a consensus document was developed in collaboration with members of WP 6 and other field experts. Based on the discussions and results of the first partners meeting in September 2018, the WP 6 leader drafted the first key points for the PFA.

The further development of the PFA was supported by an interdisciplinary group of six German experts from the fields of public health/health sciences, sociology, health education, social work and urban planning. Their expertise covers social inequality and health, environment and health, setting-based health promotion, quality assurance and evaluation in health promotion and prevention in research as well as in practice. The team of experts conducted a literature search on the different topics of the PFA and extracted its main results. This included a systematic literature analysis of national and international quality criteria in the pubmed and livivo database as well as an unsystematic analysis of current evidence of municipal health promotion, including the current state of research on the Health in All Policies (HiAP) approach.

The following quality assurance instruments for health promotion and prevention focusing on reducing health inequalities were identified and analysed in order to describe and detect central quality criteria that provide the basis for the quality criteria of the PFA: The European Quality Instrument for Health Promotion (EQUIHP) [10], the good practice criteria of the German network Equity in Health [11], the EU Joint Action on Nutrition and Physical Activity (JANPA) [12], the EU Joint Action Chronic Diseases and Promoting Healthy Ageing across the Life Cycle (CHRODIS) [13] and the findings on good practice in the Horizon2020 project Intersectoral Health and Environment Research for Innovation (INHERIT) [14].

The experts involved developed a literature-based proposal for the understanding of healthy living environments and put it up for discussion in the working group. Subsequently, the draft version of the PFA was circulated in an iterative process with two rounds of feedback; first with the field experts and stakeholders of WP 6 and then with the JAHEE Steering Committee. The WP 6 leader (BZgA) coordinated and moderated this complex process.

The development process of the framework was based on a participatory approach, which allowed all participants to be involved from the outset. This allowed all actors involved to define the problem and the approach. Furthermore, the approach reflected the common working philosophy of JAHEE and WP 6, which is characterized by building on the expertise, the different backgrounds and involvement of the different partners.

3. Results

Creating Healthy Living Environments and Actual Evidence of Community Health Promotion and Prevention

The content of WP 6 focuses on the influence of the living environment on health and health behaviour and related possible measures to reduce health inequalities at the local level. The PFA highlights the importance of the municipal setting and the HiAP approach to reduce health inequalities. A decrease in health inequalities can only succeed if all the macro, meso and micro levels are addressed. The macro level is concerned with issues affecting society as a whole (at the political level); at the meso level, the focus is on institutions and social networks, and at the micro level, the focus is on

the individual. However, a systematic and planned approach should always be adopted [15]. One approach, suitable for measures of varying scope and useful on projects at the micro, meso and macro levels, is the Public Health Action Cycle (PHAC). The PHAC represents an ideal process flow, which is therefore not always transferable in all points of a concrete measure or intervention [16,17]. Nevertheless, the value of this model lies in the necessity and significance of its individual process steps and its use in comparing different health promotion measures. The PHAC can be used to identify and analyse different patterns of dealing with health problems and then evaluate their effectiveness and impact on the health equity dimension [17]. The process consisting of the four steps of analysing, planning, implementing, and evaluating can be reasonably supported by the use of quality criteria. The literature review related to the quality criteria yielded 16 criteria. They apply to the four phases and, to a lesser extent, to the overall process of the PHAC. Figure 2 shows the PHAC related to identified quality criteria applied to the individual phases of the cycle resp. spanning all phases.

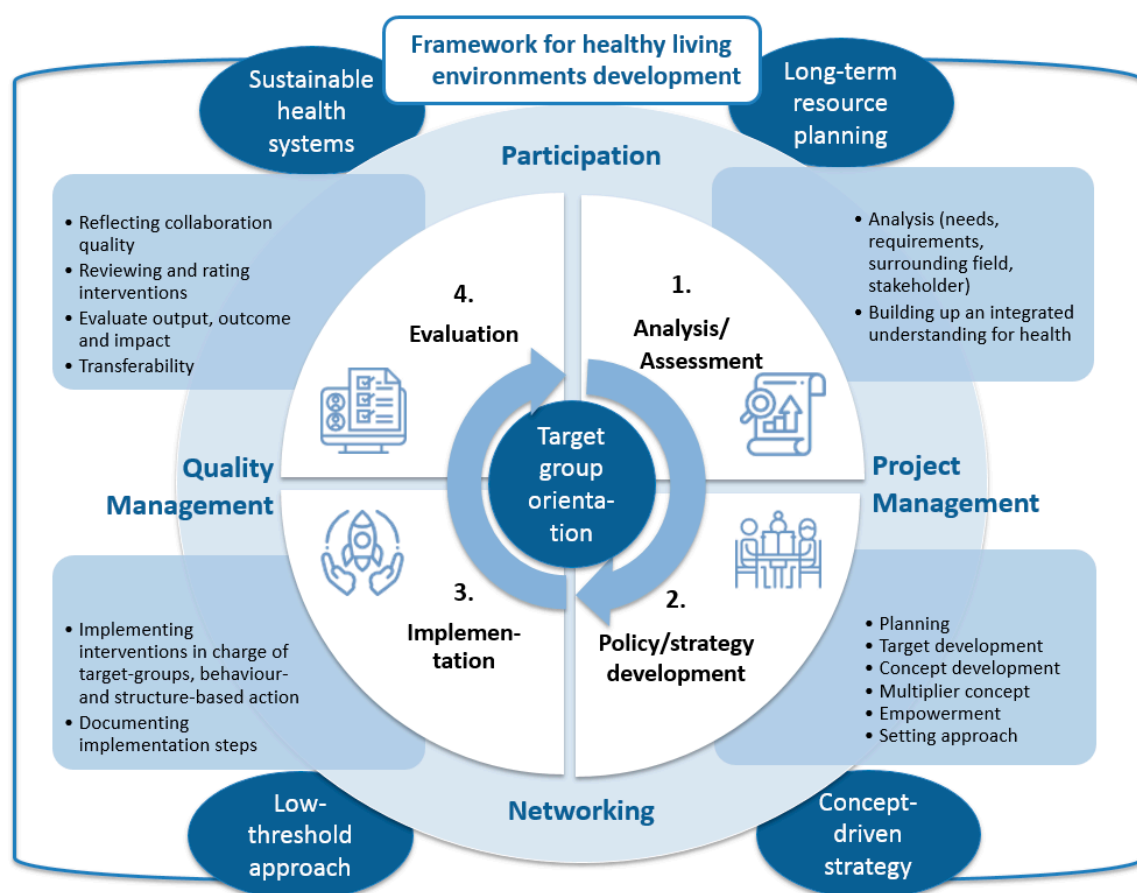


Figure 2. Framework for healthy living environments development: quality criteria identified and applied to the PHAC.

The PHAC originated in political science and was adapted and further developed for health policy actions and processes [16,17]. The action cycle differentiates a health-related intervention into four individual process categories: (1) identification of the fundamental problem to be addressed by the intervention, (2) strategy development in which an intervention suitable for treatment is developed, (3) implementation of the intervention and (4) evaluation of the activities carried out. The 16 central quality criteria for good practice are divided into three categories: fundamental quality criteria for the creation of healthy living environments, process criteria applying to individual PHAC phases and general criteria covering the PHAC.

The influencing factors at the macro and meso levels play a key role as downstream action to tackle risk factors. Accordingly, health inequalities should be seen as a cross-cutting dimension to be taken into account in the development, implementation and evaluation of any activity. This also applies to the social determinants of health (see, e.g., the model of Whitehead and Dahlgren 1991 [18]). Benach et al. (2013) [19] described four scenarios that can contribute to reducing health inequalities:

- Targeted interventions
- Universal policies
- Redistributive policies
- Proportionate universalism (targeted and universal policies)

The healthy living environment approach avoids the individualisation of social problems resulting from social inequality. The creation of healthy living environments is supposed to strengthen individual health in two ways: on the one hand, health-promoting behaviours are improved irrespective of income, origin and educational background [20], and on the other hand, health is promoted by strengthening resilience factors and reducing environmental risk factors. As a result, through the participatory orientation of such measures, people are empowered to influence their living conditions and living environments by themselves. It is of utmost importance to involve particularly vulnerable groups and to apply appropriate methods, as this is not yet well established.

The measures within WP 6 pursue a setting-based approach that is steered from the municipal level. The setting-based approach is one of the core strategies in health promotion and is a central strategy in tackling health inequalities [21]. The municipality represents an umbrella setting, which includes other settings, such as neighborhoods, schools or associations, and provides different access points for interventions. “Municipality” as a term thus describes not only a geographical or political space, but also a social space. This provides resources for health promotion through the possibility of merging and coordinating social networks and through the development of a health-promoting overall policy that allows organizational development in municipal administrations and institutions. The Ottawa Charter (1986) [22] already describes the support of communities and local authorities as a central node for health promotion (in strengthening citizen autonomy and control over the determinants of their own health). Particular attention must be paid to explicitly take into account the individual needs of each municipality.

However, the creation of healthy living environments can only succeed if other areas besides the health sector are involved in the process. This approach, with the main goal of reducing health inequalities, is called Health in All Policies (HiAP) and was coined by the WHO. Since health inequalities are strongly determined by social inequalities, all policies related to social cohesion and the reduction of social disparities, such as labour, social or educational policies, are relevant. An area of relevance at the federal rather than the EU level is spatial planning, with healthy urban development having the potential to reduce health inequalities [23–25].

To reduce the impact of different policy fields on health inequalities, population vulnerability has to be studied rigorously. In various policy areas, such as the environment or urban planning, this is not common or an explicit objective, as all people are considered to be equal. Neither environmental standards nor noise or air action plans consider population vulnerability. The implementation of a population vulnerability principle as an additional guiding principle for (environmental) politics could support the aim of reducing health inequalities through a HiAP approach [26]. The community offers the chance for more health equity, especially if the approach of proportionate universalism is taken into account.

In the following, the central findings with regard to existing evidence of municipal health promotion are summarized in order to substantiate the significance of the municipality for health promotion and to make possible starting points transparent. Although the creation of healthy living environments is generally considered beneficial, it is difficult to provide sufficient empirical evidence of their effectiveness [27]. This is mainly due to the complexity of the approach and the various influencing factors, especially given

that interventions often aim for long-term change. In addition, there are challenges in evaluation designs and methods. Measuring the success of interventions becomes more difficult as the complexity of the intervention increases, since the impact often only becomes visible in the long term and project durations frequently end after one or two years. In the meantime, those affected are exposed to many other social and other environmental factors that can mitigate or change the health-promoting effects. A direct causal link between the health-promoting interventions and the effects on individual health is therefore often not possible.

Evidence of the effects of risk and protection factors offers important starting points for context-oriented and setting-based interventions at the local level. Compared to the epidemiological evidence, there is little but growing evidence of the effects of environmental interventions. For example, the promotion of equal environments can “disrupt the usual transformation of socioeconomic inequalities into inequalities in mental well-being” [28] (p. 80).

Some intervention studies show that the following strategies are of great importance in this context. Potentially effective strategies for designing healthy living environments include capacity building [15], transport and walkability [29,30], green spaces [31], healthy schools and kindergartens [32], municipal planning and control [24,25] and urban planning measures [33]. Especially capacity building within intersectoral cooperation seems to play a major role in creating healthy living environments. Quilling and Kruse (2018) [15] showed in a rapid review that capacity building in particular is of central importance. Fifteen publications (including [34–40]) on the topic of municipal health promotion were included in the content analysis [15]. The programme “Communities That Care” (CTC), for instance, shows evidence on the relevance of capacity building, where capacity building is both one of the main goals and one of the main effects of the interventions. An integral part of the CTC programme is an individual tailoring of measures based on municipal data on specific health problems and risk factors for citizens. In addition, the training of actors and the provision of supporting materials play a central role for capacity-building effects [41].

Transport accounts for 29% of CO₂ emissions. Promoting public transport, road safety and active mobility infrastructures (cycling, walking) can reduce accidents, improve air quality, increase physical activity and facilitate access to community facilities. One central approach to active mobility is the walkability concept. Walkability is understood to mean the ‘movement-friendly’ design of a residential quarter [29]. This includes the existence of good walking, cycling and hiking paths, traffic safety, playgrounds and residential areas, good accessibility to sports facilities, usable green spaces and a stimulating aesthetics of the surroundings [30].

Green environments create the health benefits of staying in nature or in parks and in the countryside [31]. Proven benefits include improved human health, physical activity, self-esteem and reduced short-term sleep duration (associated with obesity) [42]. Green school grounds with open playgrounds, trees and shrubs also improve the quality and quantity of the children’s physical activity [43,44]. Green space interventions were most effective in a dual approach combining physical improvement with social engagement and participation to reach new target groups [45].

Urban planning measures and control— this strategy addresses health inequalities through city administration and planning, including investment in active mobility, environmental and regulatory controls (e.g., alcohol outlet density in deprived communities) [24,25]. In the field of environmental planning, there are a number of environmental standards developed to protect human health. Examples of urban development projects that promote the health of their residents include the redesign of infrastructure to meet the needs of the elderly (Age-Friendly City, City of Unley, Australia) [46], of children (Bendigo in Victoria, Australia, UNICEF City, St. Lukes Anglicare) [47] and women (the Women Work City housing complex in Vienna) [33].

There are various evidence-based approaches for implementing health promotion in the community. The expert opinions also show that municipal health promotion is considered to be of central importance for reducing health inequalities.

4. Conclusions

Reducing health inequalities is a national and international public health priority. In this context, the municipal setting and the HiAP approach are of particular importance. Health is a cross-sectional task that needs to be addressed in all policy areas. The HiAP approach provides an important framework and thus sets the preconditions to promote health equity.

The settings approach is one core strategy of health promotion [22] that can be used to achieve healthy living environments. In this context, it is of particular importance to strengthen context-oriented interventions, which, compared to behavioural interventions, have not received full attention in practice and research. The municipality is of particular importance in this context, because it is—like no other setting—capable of shaping living conditions at different levels. A municipality can be regarded as an ‘umbrella setting’ for a cross-setting strategy, whereby coordinated activities targeting a common overall goal such as improved health in a population group are carried out in a variety of different settings and involving a variety of different stakeholders within a local community [48]. The municipal context offers comprehensive entry points for action, because municipalities address the local political context, local regulations and urban or rural planning and development, which are important contributions to improving living conditions (‘upstreaming’). Health equity not only requires a commitment by society (e.g., political action such as binding intersectoral norms as well as structural and procedural (political) frameworks), but also the willingness and ability (e.g., competencies) of all stakeholders acting on different political levels and in policy areas according to their scope of decision-making.

The local context of each municipality must be taken into account to determine what are the possibilities and needs for interventions, like the population profile, its age structure, the specific institutional infrastructure or geographical, economic and other characteristics which, in sum, mark the needs and requirements for healthy living environments in a municipality. This municipal needs must be accompanied by a willingness on the part of local administration and institutions to play an active part in promoting a healthy living environment. Therefore, both the perspective of the municipality and the perspectives of local stakeholders must be taken into account to decide which measures are appropriate and feasible as first steps.

In principle, the Public Health Action Cycle is a reference point for the implementation of all interventions to improve the health situation in a setting. The more thoroughly and comprehensively the steps of the PHAC are implemented and the more quality criteria are considered, the more likely an intervention will achieve promising practice and good results. The goal of achieving more health equity in the municipality depends on political will and decision-making. It is therefore necessary to develop a well-planned and multilayered strategy that leads to sustainable change. The creation of healthy living environments should be accompanied by a cultural change in the organizations and institutions in the municipality. For this reason, a new awareness of the importance of health and recognition of the responsibility of local government and sectors beyond the health sector has to be promoted.

An evidence base for municipal health promotion is a major challenge. The gold standard in evidence-based medicine is the randomized controlled trial (RCT) used in clinical research to prove the efficacy of a new therapy. However, RCTs are rarely suitable in the case of health promotion because of the significant difference between medical interventions and health promotion interventions. Medical interventions are intended to have a direct, and often visible, effect on physical and psychological illnesses. In health promotion, an intervention is viewed from a fundamentally holistic perspective: ‘Health is the state of complete physical, mental and social well-being’ [49]. Health promotion interventions and primary disease prevention attempt, in a complex way, to influence the health of individuals indirectly through their behaviour and the conditions surrounding them. The complexity of the intervening factors affecting the inhabitants in the local community makes it almost impossible to isolate the effects of individual behavioural interventions, since these usually have an indirect effect and not a direct one. Nevertheless, there is a growing evidence-base available for specific interventions in municipalities, such as for the walkability approach.

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References

1. Policy, S.F.E. Links between noise and air pollution and socioeconomic status. In *In-Depth Report 13 Produced for the European Commission, DG Environment by the Science Communication Unit*; UWE: Bristol, CT, USA, 2016. Available online: <http://ec.europa.eu/science-environment-policy.pdf> (accessed on 6 December 2018).
2. Landrigan, P.J.; Fuller, R.; Acosta, N.J.R.; Adeyi, O.; Arnold, R.G.; Basu, N.; Balde, A.B.; Bertollini, R.; Boseoreilly, S.; Boufford, J.I.M.; et al. The Lancet Commission on pollution and health. *Lancet* **2018**, *391*, 462–512. [CrossRef]
3. Diderichsen, F.; Andersen, I.; Manuel, C.; Andersen, A.N.; Bach, E.; Baadsgaard, M.; Bronnumhansen, H.; Hansen, F.K.; Jeune, B.; Jorgensen, T.; et al. Health Inequality-determinants and policies. *Scand. J. Public Health* **2012**, *40*, 12–105. [CrossRef]
4. Boyce, T.; Brown, C.; World Health Organization (WHO). Engagement and Participation for Health Equity. In *A Core Principle of Health 2020 is Reducing Health Inequities across the Population, Along with the Importance of Participation and Responsiveness, with the Full Engagement of People*; 2017. Available online: <https://tinyurl.com/y74rvwk8> (accessed on 25 March 2020).
5. Cushing, L.; Morellofrosch, R.; Wander, M.; Pastor, M. The haves, the have-nots, and the health of everyone: The relationship between social inequality and environmental quality. *Annu. Rev. Public Health* **2015**, *36*, 193–209. [CrossRef] [PubMed]
6. National Children's Bureau. Environmental Inequalities and Their Impact on the Health Outcomes of Children and Young People. In *Policy and Evidence Briefing*; 2012. Available online: <https://tinyurl.com/y92sxwce> (accessed on 25 March 2020).
7. Marmot, M.; Allen, J.; Goldblatt, P.; Boyce, T.; McNeish, D.; Grady, M.; Geddes, I. *The Marmot review: Fair Society, Healthy Lives. Strategic Review of Health Inequalities in England Post-2010*; The Marmot Review; University College London: London, UK, 2010.
8. Morellofrosch, R.; Zuk, M.; Jerrett, M.; Shamasunder, B.; Kyle, A.D. Understanding the cumulative impacts of inequalities in environmental health: Implications for policy. *Health Aff.* **2011**, *30*, 879–887. [CrossRef] [PubMed]
9. European Union. EU Gesundheitsprogramm. Available online: https://ec.europa.eu/health/funding/programme_de (accessed on 9 July 2020).
10. Tountas, Y.; Dimitrakaki, C.; Bollars, C.; van den Broucke, S.; Kok, H.; Molleman, G. Evaluating quality in health promotion: The EQUIHP. *Arch. Hell. Med.* **2007**, *24*, 75.
11. Gesundheitliche-Chancengleichheit. Good Practice-Kriterien. Available online: <https://www.gesundheitliche-chancengleichheit.de/good-practice-kriterien/> (accessed on 12 July 2020).
12. JANPA. Janpa Toolbox. Available online: <https://janpa-toolbox.eu/> (accessed on 12 July 2020).
13. Chrodis. CHRODIS. Available online: <http://chrodis.eu/> (accessed on 11 July 2020).
14. Inherit. Inherit Model. Available online: <https://www.inherit.eu/project/inherit-model/> (accessed on 10 July 2020).

15. Quilling, E.; Kruse, S. *Evidenzlage Kommunalen Strategien der Prävention und Gesundheitsförderung: Eine Literatur- und Datenbankrecherche (Rapid Review)*; On Behalf of GKV-Spitzenverband: Berlin, Germany, 2018.
16. Rosenbrock, R. Public health as a social innovation. *Gesundheitswesen* **1995**, *57*, 140.
17. Rosenbrock, R.; Gerlinger, T. *Gesundheitspolitik: Eine Systematische Einführung*; Verlag Hans Huber: Bern, Switzerland, 2014.
18. Dahlgren, G.; Whitehead, M. *Policies and Strategies to Promote Social Equity in Health*; Institut for Future Studies: Stockholm, Sweden, 1991.
19. Benach, J.; Malmusi, D.; Yasui, Y.; Martínez, J.M. A new typology of policies to tackle health inequalities and scenarios of impact based on Rose's population approach. *J. Epidemiol. Community Health* **2013**, *67*, 286–291. [\[CrossRef\]](#)
20. Swinburn, B.; Egger, G.; Raza, F. Dissecting obesogenic environments: The development and application of a framework for identifying and prioritizing environmental interventions for obesity. *Prev. Med.* **1999**, *29*, 563–570. [\[CrossRef\]](#)
21. Dahlgren, G.; Whitehead, M. *Levelling up (part 2): A Discussion Paper on European Strategies for Tackling Social Inequities in Health*; WHO Regional Office for Europe: Copenhagen, Denmark, 2006.
22. World Health Organization (WHO). *Ottawa Charter for Health Promotion*; Copenhagen, Denmark, 1986. Available online: http://www.euro.who.int/__data/assets/pdf_file/0004/129532/Ottawa_Charter.pdf (accessed on 25 March 2020).
23. Barton, H.; Grant, M. Urban planning for healthy cities. *J. Urban Health* **2013**, *90*, 129–141. [\[CrossRef\]](#)
24. Baumgart, S.; Köckler, H.; Ritzinger, A.; Rüdiger, A. *Lanung für Gesundheitsfördernde Städte*; Akademie für Raumentwicklung in der Leibniz-Gemeinschaft: Hannover, Germany, 2018.
25. World Health Organization. *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health*; World Health Organization: Geneva, Switzerland, 2008.
26. Köckler, H. *Umweltbezogene Gerechtigkeit: Anforderungen an Eine Zukunftsweisende Stadtplanung*; Peter Lang GmbH, Internationaler Verlag der Wissenschaften: Bern, Switzerland, 2017.
27. Nutbeam, D. Evaluating health promotion—Progress, problems and solutions. *Health Promot. Int.* **1998**, *13*, 27–44. [\[CrossRef\]](#)
28. Mitchell, R.J.; Richardson, E.A.; Shortt, N.K.; Pearce, J.R. Neighborhood environments and socioeconomic inequalities in mental well-being. *Am. J. Prev. Med.* **2015**, *49*, 80–84. [\[CrossRef\]](#)
29. Bucksch, J.; Schneider, S. *Walkability: Das Handbuch zur Bewegungsförderung in der Kommune*; Verlag Hans Huber: Bern, Switzerland, 2014.
30. Galvez, M.P.; Pearl, M.; Yen, I.H. Childhood obesity and the built environment: A review of the literature from 2008–2009. *Curr. Opin. Pediatrics* **2010**, *22*, 202. [\[CrossRef\]](#)
31. Poland, B.; Dooris, M. A green and healthy future: The settings approach to building health, equity and sustainability. *Crit. Public Health* **2010**, *20*, 281–298. [\[CrossRef\]](#)
32. Goldfeld, S.; Oconnor, E.; Oconnor, M.; Sayers, M.; Moore, T.; Kvalsvig, A.; Brinkman, S. The role of preschool in promoting children's healthy development: Evidence from an Australian population cohort. *Early Child. Res. Q.* **2016**, *35*, 40–48. [\[CrossRef\]](#)
33. Foran, C. How to design a city for women. Citylab. Available online: <https://www.citylab.com/transportation/2013/09/how-design-city-women/6739/> (accessed on 28 December 2018).
34. Böhme, C.; Bunge, C.; Preuß, T. Umweltgerechtigkeit in der Stadt—Zur integrierten Betrachtung von Umwelt, Gesundheit, Sozialem und Stadtentwicklung in der kommunalen Praxis. *Umweltpsychologie* **2016**, *20*, 137–157.
35. Große, J.; Menkouo, C.; Grande, G. Nachhaltige Strategien für die stadtteilbezogene Gesundheitsförderung. *Gesundheitswesen* **2015**, *77*, S116–S117. [\[CrossRef\]](#) [\[PubMed\]](#)
36. Hargreaves, M.; Honeycutt, T.; Orfield, C.; Vine, M.; Cabili, C.; Morzuch, M.; Fisher, S.K.; Briefel, R. The Healthy Weight Collaborative: Using learning collaboratives to enhance community-based prevention initiatives addressing childhood obesity. *J. Health Care Poor Underserved* **2013**, *24*, 103–115. [\[CrossRef\]](#) [\[PubMed\]](#)
37. Harris, N.; Sandor, M. Defining sustainable practice in community-based health promotion: A Delphi study of practitioner perspectives. *Health Promot. J. Aust.* **2013**, *24*, 53–60. [\[CrossRef\]](#) [\[PubMed\]](#)
38. Reimann, B.; Böhme, C.; Bär, G. *Mehr Gesundheit im Quartier. Prävention und Gesundheitsförderung in der Stadtteilentwicklung*; Deutsches Institut für Urbanistik: Cologne, Germany, 2010.

39. Rütten, A.; Wolff, A.; Streber, A. Interaktiver Wissenstransfer in der Gesundheitsförderung: Das GESTALT-Projekt. Erste Ergebnisse der Erprobung eines Ansatzes zur nachhaltigen Implementierung evidenzbasierter Bewegungsprogramme. *Gesundheitswesen* **2016**, *78*, 359–366.
40. Steenbakkers, M.; Jansen, M.; Maarse, H.; De Vries, N.K. Challenging Health in All Policies, an action research study in Dutch municipalities. *Health Policy* **2012**, *105*, 288–295. [[CrossRef](#)] [[PubMed](#)]
41. Shapiro, V.B.; Oesterle, S.; Hawkins, J.D. Relating coalition capacity to the adoption of science-based prevention in communities: Evidence from a randomized trial of Communities That Care. *Am. J. Community Psychol.* **2015**, *55*, 1–12. [[CrossRef](#)] [[PubMed](#)]
42. Astell-Burt, T.; Feng, X.; Kolt, G.S. Does access to neighbourhood green space promote a healthy duration of sleep? Novel findings from a cross-sectional study of 259 319 Australians. *BMJ Open* **2013**, *3*. [[CrossRef](#)] [[PubMed](#)]
43. Dymont, J.E.; Bell, A.C.; Lucas, A.J. The relationship between school ground design and intensity of physical activity. *Child. Geogr.* **2009**, *7*, 261–276. [[CrossRef](#)]
44. Larsen, M.; Pedersen, H.S.; Davies, J.; Gulis, G. Assessing public health intervention practices in a Danish municipality: Applying criteria based on the European Community Health Promotion Indicator Development (EUHPID) model. *Scand. J. Public Health* **2013**, *41*, 778–784. [[CrossRef](#)] [[PubMed](#)]
45. World Health Organization (WHO). Urban Green Space and Health: Intervention Impacts and Effectiveness Meeting Report. Bonn, Germany, 20–21 September 2016. Available online: <https://tinyurl.com/y74rvwk8> (accessed on 25 March 2020).
46. WHO. Age-Friendly World. City of Unley. 2020. Available online: <https://extranet.who.int/agefriendlyworld/network/unley/> (accessed on 19 March 2020).
47. Pope, J.; Galvin, L.; Anglicare, B.L. *Making Bendigo a Child Friendly City: A Set of Indicators of Child and Young People's Well-Being to Galvanise Action*; Department of Planning and Community Development & Bendigo: Melbourne, Australia, 2013.
48. Bloch, P.; Toft, U.; Reinbach, H.C.; Clausen, L.T.; Mikkelsen, B.E.; Poulsen, K.; Jensen, B.B. Revitalizing the setting approach—supersettings for sustainable impact in community health promotion. *Int. J. Behav. Nutr. Phys. Act.* **2014**, *11*, 118. [[CrossRef](#)] [[PubMed](#)]
49. *Constitution of the World Health Organization*; WHO: Geneva, Switzerland, 1946.



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