Public Health, Neighbourhood Development, and Participation
This thesis is dedicated to my beloved parents, Margareta and Göran

Man har ingen nytta av att vara unik i en garderob
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Karin Fröding

Public Health, Neighbourhood Development, and Participation

Research and Practice in four Swedish Partnership Cities
Abstract


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Efforts to combat the widespread health disparities are an important challenge in public health and health promotion. A partnership between four Swedish cities was constituted to face this challenge. Within the context of that partnership, the overall aim of this thesis is to study public health strategies and local development work in municipalities and neighbourhoods, with a special emphasis on residents' participation.

Study I analyses strategic public health work, neighbourhood development, and the early implementation phase of the partnership. Interviews, participant observation, and documents were used as data sources. The study shows that a partnership for local public health work can serve as a connecting link for development and learning among stakeholders involved. Formal structures and national support are crucial preconditions for success in neighbourhood development.

Study II analyses what characterizes people who participate in neighbourhood development. A cross-sectional study with a random sample of 1,160 participants from three of the partnership cities was analysed. Citizens who had previous experience of trying to influence policy in the municipality in some way were more likely to be active in neighbourhood development than those who had no such prior experience.

Study III analyses a community-academic partnership and a community-based participatory research process through participant observation. It shows that a community-academic partnership requires an open, equal dialogue, an accepting attitude toward different levels of participation, and a lengthy period of time.

Study IV uses a case-study database to analyse the development processes for achieving sustainable structures in neighbourhood development in the four partnership cities. A partnership has the potential to allocate resources on an area-based level, but in this case few resources remained when the partnership ended.

Keywords: Neighbourhood development, citizen participation, municipality, partnership, community-academic partnership, CBPR, public health, health promotion.
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FÖRORD

Under min doktorandtid har jag fått uppleva så många olika platser, per-
spektiv och möjligheter. Ibland har jag upplevt detta i en salig röra och
därför är jag så oerhört glad och tacksam över att jag inte har varit själv på
denna resa. Det är så många som bidragit till denna avhandling och här vill
jag särskilt nämna några av er.

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Örebro, april 2011

Karin Fröding
ORIGINAl PUBLICATIONS

The present thesis is based on the following studies, which are referred to by their Roman numerals.


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ABBREVIATIONS

PSWD  Partnership for Sustainable Welfare Development
NGO   Non-governmental organisation
CBPR  Community-based participatory research
WHO   World Health Organisation
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INTRODUCTION

People's well-being is largely dependent on their health. Health, in turn, is a resource that arises on a daily basis from complex relationships between a variety of factors at different levels, and it is affected by people's own choices as well as prerequisites in the social surroundings (Baum, 2002, p. 3; Dahlgren & Whitehead, 1991; Marmot & Wilkinson, 2006b). People's personal choices interact with their everyday environment – where they live, work, and play. These living conditions are mainly outside the control of the individual, and are dependent on the social, economic, and physical environment.

Human health as measured by life expectancy has been improving in most populations for many decades (Beaglehole & Bonita, 2009; Swedish National Institute of Public Health, 2010). However, health is not equally distributed. The health inequalities between different groups have rather increased than decreased in recent years (Beaglehole & Bonita, 2009; Graham, 2007; Molarius et al., 2007; Swedish National Institute of Public Health, 2010). Research from Sweden as well as the rest of the world shows important differences depending on people's education, socio-economic status, ethnicity, age, and gender (Galea & Vlahov, 2005; Graham, 2007; Kawachi & Kennedy, 1999; Marmot & Wilkinson, 2006a; Molarius, et al., 2007; Swedish National Institute of Public Health, 2010). There are also geographic health inequalities, and people living in socially and economically poor neighbourhoods generally experience poorer health than the average population.

Over the past hundred years the city has become important as a health promoting setting, as more and more people are moving from the countryside to urban areas (Baum, 2002; Galea & Vlahov, 2005). For the first time in our history, more people live in urban areas than in the countryside (UNFPA, 2007). Urban health factors can be divided into three broad categories that are important for the development of people's health: physical environment, social environment, and access to health and social services (Galea & Vlahov, 2005). What these three categories look like and how they function are dependent on public health policy and practice in a specific nation and municipality.

Local governments are important shapers of public health policy and practice in the city and neighbourhood to create the conditions for reducing inequality and increasing people's health and well-being (Porter, 1999). Social integration programmes targeting poor neighbourhoods have long been high on the agenda in most European countries. Although local government plays a significant role in creating and promoting beneficial condi-
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tions for health, public health issues are embedded in a complex network of policy-making that comprises committed individual and collective actors within different sectors and levels. Often, under the headings of local governance or urban partnership, various forms of coalitions are created to develop common lines of action for the prevention and promotion of public health. Experience indicates that the partnership approach sometimes creates an organizational structure which is open for a very broad set of actors to initiate actions that stimulate citizen participation in the neighbourhood in a way that fosters social trust and long-term, sustainable policy thinking (Andersson, Palander, & Elander, 2002; Lawrence, 2005; Palander, 2006; Stewart, 2003). Evening out health inequalities and improving people’s living conditions requires joint efforts by many different contributors.

One Swedish example of an initiative to improve citizen health and welfare was the Partnership for Sustainable Welfare Development (PSWD). This partnership was formally established on 30 June 2003, with local municipalities and municipal housing companies in four Swedish cities signing up to work for the development of people’s health and welfare in poor neighbourhoods (Eriksson, Järliden, Larsson, & Sandberg, 2010). The ambition was to support and create conditions for getting residents in these neighbourhoods involved in activities aiming at social inclusion (better education, employment, and income) as well as social cohesion (development of network ties and social trust). Among several interesting strategies in the partnership, three in particular were unique at that time in Sweden: 1) the pronounced involvement of the municipal housing companies, 2) the bulk of the partnership costs included in the ordinary municipal budgets and 3) the research strategy “The Healthy City” that followed the partnership longitudinally and tried to integrate theory and practice of public health with multi-disciplinary as well as action oriented research.

The overall aim of the thesis is, within the context of this Swedish partnership for sustainable welfare development, to study public health strategies and local development work in municipalities and neighbourhoods with a special emphasis on residents’ participation in health-promoting efforts in poor neighbourhoods. To do this it has been important to (i) describe and analyse strategic public health work and neighbourhood development work and the early implementation phase of the PSWD (Study I), (ii) analyse what characterizes people who participate in neighbourhood development projects (Study II), (iii) explore a community-academic partnership and a community-based participatory research process (Study III), and (iv) to analyse the development processes for achieving sustainable structures in neighbourhood development in the four partnership munici-
palities (Study IV). To understand the complex and multi-factorial approaches in the neighbourhood and municipal context a multiple methodological approach has been used integrating qualitative and quantitative methodologies. The data sources are interviews, a population survey, participant observations, and documents.

The explorative and integrated approach has partially been dependent on the developmental processes within the partnership and the municipalities, as well as the interaction among the partnership members and the research group, which has shown the importance of practice-based research and development activities as well as the usefulness of case studies. It is of great importance that policy, practice, and research interact to gain knowledge about prerequisites for a healthy development in poor neighbourhoods. As far as I know, this study is unique in having conducted integrated research on the practical work of a municipality cooperation for such long period of time as nearly seven years.
CONCEPTUAL FRAMEWORK

Public health is a dynamic and multidisciplinary field where people work to improve the health and well-being of people in local communities and populations (Beaglehole & Bonita, 2009; Orme, Powell, Taylor, Harrison, & Grey, 2003). There are several definitions of public health. One definition is that public health is “the science and art of promoting health, preventing disease, and prolonging life through the organized efforts of society” (WHO, 1998, p.3), which includes both a preventive and a promotive perspective. The definition is further explained as a “social and political concept aimed at the improving health, prolonging life and improving the quality of life among whole populations through health promotion, disease prevention and other forms of health interventions” (WHO, 1998, p.3).

The field of public health sciences is multi-disciplinary and multi-sectoral in nature. Health promotion is an important part of the public health sciences concerning measures for maintaining or promoting health (WHO, 2009). When developing a health-promoting perspective, the policy document Ottawa Charter for Health Promotion has been crucial (WHO, 1986). Health promotion was defined as “the process of enabling people to increase control over, and to improve their health” (WHO, 1986, p.1), and its key strategies are as follows: (1) building healthy public policy, (2) to create supportive environments, (3) strengthen community action, (4) develop personal skills, and (5) reorient health services. The first four strategies are especially important for this thesis, the first three because they focus on policy and interventions to promote health in environments where people’s health and lifestyles are created and sustained. These three provide a foundation for the fourth strategy, developing personal skills. For people to achieve their fullest health potential it is crucial to acknowledge and address the fact that responsibility is shared between on the one hand individuals making their own choices; and on the other hand between and within all health related sectors in society.

After this brief prologue, which uses public health and health promotion to situate this thesis in its conceptual framework, the following part discusses health inequalities; policy and intervention for a healthy city; public health policy in Sweden; the neighbourhood and neighbourhood development; and citizen participation; before finally presenting the study setting. Following the conceptual framework, the second section describes the four studies included in the thesis. Then, the findings of the studies are presented in the third section. The final, concluding section discusses the findings in relation to earlier research, including implementation of practice.
Public health policy and neighbourhood development

Health inequality

Health problems among urban populations in many parts of the world are generally of another magnitude than in Western European towns and cities (Davis, 2006; UN-Habitat, 2003). In most developing countries, poor sanitary conditions, such as a lack of a clean water supply, and communicable diseases (for example HIV/AIDS, malaria, and tuberculosis) are still major public health problems. Thus, the non-communicable diseases, which are affected by a person’s lifestyle, genetics, or environment, are important public health problems both in developing and developed countries (Beaglehole & Bonita, 2009). In conclusion, public health in various countries exhibits both similarities and differences.

Even if life expectancy has improved in most populations (Beaglehole & Bonita, 2009; Swedish National Institute of Public Health, 2010) human health is not equally distributed (Beaglehole & Bonita, 2009; Galea & Vlahov, 2005; Graham, 2007; Molarius, et al., 2007; Swedish National Institute of Public Health, 2010; WHO, 2008). The great gap between those with the best prerequisites and those who are not so well off is dependent on constitutional factors, such as ethnicity, age, and gender, and non-constitutional factors, such as people’s education, work environment, family situation, and place of residence. These disparities between different groups have consequences for people’s life expectancy, quality of life, and health.

Health inequalities are apparent when comparing geographical areas. In most countries there are poor urban areas that suffer from a multitude of health-related problems such as unemployment, high and rising crime rates, a diminishing sense of security, ethnic conflicts, and neighbourhood decay (Kawachi & Berkman, 2003). Furthermore, the neighbourhood itself has an independent effect on residents’ individual behaviours and health outcomes (Blasius, Friedrichs, & Galster, 2009; Sellström & Bremberg, 2006). The difference in life expectancy between people living in the poorest and the richest areas varies by as much as five, ten, or even fifteen years in post-industrialized countries (Wilkinson, 2005). It is a solid fact that a life with good health is not available to all; it is unequally distributed in Sweden (Molarius, et al., 2007; Swedish National Institute of Public Health, 2010) and other developing and less developed countries (Beaglehole & Bonita, 2009; Galea & Vlahov, 2005; Graham, 2007; WHO, 2008). In fact, some of us will live longer and healthier lives than others, due to individual characteristics and behaviours, and the social,
economic, and physical environment. When discussing health inequalities it is important to address a gender perspective (Sen, George, & Östlin, 2002). Growing economic inequalities reinforce social injustice, forestall health gains, and deny good health to many. Globally there are deep-seated gender biases in health research and policy institutions. It is important to go beyond the gender paradox that women in many countries live longer but report more ill health (Östlin, Danielsson, Diedrichsen, Härenstam, & Lindberg, 2001) and try to understand this complex phenomenon. In particular, female and male vulnerability must be conceptualized to better understand which social environments prove harmful to their health. Moreover, the participation of women and men in health promotion and neighbourhood development is an integrated part.

Inequality in health tends to increase (Beaglehole & Bonita, 2009; Graham, 2007; Molarius, et al., 2007; Swedish National Institute of Public Health, 2010), and some research shows that it is the inequality itself that is the decisive factor underlying a number of key social and health problems. Wilkinson and Pickett point out in their book *The Spirit Level* that communities where the difference between rich and poor is small, and where you can find a more equal distribution of health, are generally better for everyone (Wilkinson & Pickett, 2009). They argue that the degree of inequality in a society affects almost every quality-of-life indicator such as life expectancy, social mobility, crime rate, and much else besides. This suggests that it is better for everyone, including the rich, that inequality be erased. But this conclusion is controversial. The publication of *The Spirit Level* was followed by a heated debate including two newly-published books that claim that the analyses are false and that the book is politically motivated and has a leftist bias (Saunders, 2010; Snowden, 2010). Regardless of whether or not equal societies are generally better, health inequality is a political issue that rhetorically has a worldwide response. Numerous international, national, and municipal policy documents point to the need to eliminate health inequality (see e.g. Partnerskap för Hållbar Välfärdsutveckling, 2010; WHO, 2009, 2011b). One international example is the World Health Organization’s (WHO) Healthy City network.

**Policy and intervention for a healthy city**

To confront the negative effects of inequity and urban segregation on human health, the World Health Organization launched the Healthy Cities Program in 1986, urging towns and cities to introduce public health projects (Ashton, 1992). Building on the core documents *Health for All by the Year 2000* (WHO, 1981) and the *European Targets for Health for All by the Year 2000* (WHO, 1985) the underlying concept of the international
Healthy Cities initiative is a commitment to equity and social justice, and a recognition that, just as powerlessness is a risk factor for disease, empowerment is important for health (Barton & Tsouros, 2000; Curtice, Springett, & Kennedy, 2001; Davis & Kelly, 1993; Wallerstein, 1992). Following Hancock and Duhl (1988, p. 24), a healthy city is a city that is continually creating those physical and social environments and expanding those community resources which enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential.

This means that a city does not have to be well equipped from the beginning. The decision to become a health city, with the commitments this involves, is defined by its important process. This is a process that starts on the basis of the member city’s own context.

The Healthy Cities Program includes a policy package encompassing a broad range of determinants for sustaining urban health (Ashton, 1992). It is a comprehensive package prescribing a high level of political commitment, the formulation and implementation of healthy public policies, the establishment of new institutions, strategic health planning, citizen participation, and a supportive environment. Moreover, the Healthy Cities network aims to assist the member cities to involve themselves in networking within and across nations (Barton & Tsouros, 2000). In practice, five-year phases are introduced that highlight specific themes including a political declaration and a set of strategic goals (WHO, 2011c).

The Healthy Cities network has spread throughout the world. Announced as a worldwide model, the Healthy Cities Program has very diverse national, regional, and local manifestations, and both industrialized and developing nations are taking part in it (Takano, 2002). Thousands of cities worldwide are taking part, and the number of member cities in the European Healthy Cities Network has gone from 34 cities (in Phase I 1987–1992) (Tsouros, 2009) to 83 cities (in Phase V 2009–2013) in 53 countries (WHO, 2011a). The current phase (Phase V 2009–2013) is focused on caring and supportive environments, healthy living, and healthy urban design (WHO, 2011c). In Sweden today, the city of Helsingborg and Stockholm County Council are members of the WHO network. However, several towns and cities are inspired by the Healthy Cities initiative and Sweden has its own National Healthy City network, which includes nine cities (National Healthy Cities network, 2011). Member countries are expected to take the initiative in starting up a national network, which now is a part of the assignment for the Swedish healthy city, Helsingborg (Ristovska & Dethorey, 2010). The Partnership for Sustainable Welfare
Development, another Swedish coalition between four municipalities and municipal housing companies, has also been inspired by the Healthy Cities Program (Eriksson, Järliden, et al., 2010).

However, even if the Healthy City approach has good intentions with regard to developing people’s health and well-being, the most important thing is whether it fulfills its goal. Based on a commission by WHO European Healthy Cities Network, a systematic review of the work of the member cities has been undertaken (Tsouros & Green, 2009). One evaluation of Phase III (1998–2002), including 11 articles, was published in a supplement to the research journal Health Promotion International. A second evaluation is planned in Journal of Urban Health, evaluating phase IV (2003–2008), however this has not yet been published.

Many different aspects of the European Healthy Cities program have been examined in Phase III in the supplement presented in Health Promotion International and success factors as well as difficulties are presented. At the strategic level, several studies point out health as a motivator for developing interdepartmental and interagency cooperation and for putting health on the agenda in many different sectors (Barton, Grant, Mitcham, & Tsourou, 2009; Green, Acres, Price, & Tsouros, 2009). For example, the proposal for the member cities to produce a healthy city development plan (a strategic document giving directions to municipalities and partner agencies) has had some positive effects. It was found that many cities found the process to be of primary importance; the plan itself was of secondary importance (Green, Acres, et al., 2009). In the same study it was also suggested that the cities constitute “a powerful force for health development”, indicating that the process of creating city health development plans was central for communicating the importance of health and putting it high on municipal departments’ and partner agencies’ agendas (Green, Acres, et al., 2009, p. i78). In addition, the Healthy Cities program has also provided legitimacy to the taking of local action (Tsouros, 2009). Turning to another core principle in the Healthy City Program, citizen participation, it is found that citizens take part in local governance in the member cities (Heritage & Dooris, 2009). However, improvements are still needed. Instead of including a variety of voices, many cities rely on the viewpoints of members of large NGOs. Furthermore, even if citizen participation is asked for there is a lack of feedback after consultation.

One important step toward reducing health inequality and tackling the social polarization has been to shift from “downstream” policies to more “upstream” policies (Green, Acres, et al., 2009; Ritsatakis, 2009). However, it has been noted that many member cities mainly receive support for vulnerable groups (downstream policies) (Ritsatakis, 2009) while there is a
lack of “accounting of the causal relationship between upstream interventions and downstream health outcomes” (Green, Acres, et al., 2009, p. i79). This means that even if there are some positive effects for people’s health, downstream policies cannot affect the fundamental causes of urban social or ethnic polarization (Andersson, Brämå, & Holmqvist, 2010; Palander, 2006; Ritsatakis, 2009).

Another challenge is the difficulty of evaluating the health impact of such a comprehensive social-political context which is influenced by and constantly changing due to external factors such as shifting political and economic priorities (De Leeuw, 2009) and that the lessons that could be learned from the Healthy Cities may be dependent on the local context (Lawrence & Fudge, 2009). The wide range of countries and cities included in the European Healthy Cities Network have different governance systems, are at different stages of development, and have different available resources. That is why the complex context has to be met by solid facts and systematic and relevant evidence (De Leeuw, 2009; Tsouros, 2009).

More and more cities are joining the Healthy Cities Network (Tsouros, 2009) and the last word has probably not been said about its work. However, the most important thing is not necessarily to be a member city but to draw lessons from current experience. The recent work (phases IV and V) has a clear focus on research and development that did not really exist in the previous phases (Tsouros, 2009). To build strategies and methods upon research and solid facts is vital. Another key element that is important to maintain and further develop is citizen engagement and participation. Using relevant research methods as a foundation for increasing citizen participation could be a strong and powerful tool for the future. If the network loses the trust of the citizen and becomes a kind of “society for mutual (strategic) admiration” it may not be long lasting.

**Public health policy in Sweden**

To understand Swedish public health policy and its implications it is important to understand Sweden’s integrative central-local government system. Compared to other countries, Sweden has a unique system where the municipalities have substantial financial, constitutional, legal, political, and professional resources at their disposal (Elander & Montin, 1990; Granberg, 2008). Municipal power is exercised within a framework – strongly legitimized by the state, as symbolized by its mention in the open-
ing paragraph of the Constitution\(^1\) – in which a set of laws regulate local
government’s relations to central government and to the citizens. Local
government is responsible for extensive welfare functions that cover essen-
tial societal issues affecting people’s daily lives such as health, education,
pre-school child care, and elderly care, as well as water and sewage infra-
structure. The local public health board, the public health coordinator, and
the municipal administration are those who are primarily responsibility at
the local level for the practical achievement of public health (Swedish
National Institute of Public Health, 2011a). All in all, the 290 munici-
palities [kommuner], the 18 county councils [landsting], and the two regions
[regionförbund] are together responsible for providing a considerable pro-
portion of public services, corresponding to about 2/3 of public expendi-
tures. Among municipalities, county councils, and regions, there are no
hierarchical relations since they all have their own self-governing local
authorities with responsibility for different activities\(^2\) (Swedish Association
of Local Authorities and Regions, 2009).

The political system of Sweden is thoroughly permeated by party polit-
tics, and the central–local dimension is a common thread in the thinking
and actions of the near 50,000 elected local and regional representatives of
all the parties,\(^3\) sometimes provoking internal conflicts, especially in times
of financial strain. This means that local politics is not just a reflection of
national politics, as is underlined by the existence of the Swedish Associa-
tion of Local Authorities and Regions, which functions as a representative,
spokesman, and political resource for municipalities, county councils, and
regions (Swedish Association of Local Authorities and Regions, 2011a).
When it comes to public health work, its assignment is to support member
unicipalities in their health-promotion and preventive efforts (Swedish
Association of Local Authorities and Regions, 2011c). The Swedish Associa-
tion of Local Authorities and Regions is a powerful actor not to be by-

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\(^1\) Article one of the Basic Principles of the form of government reads: “All public power in
Sweden proceeds from the people. Swedish democracy is founded on the free formation of
opinion and on universal and equal suffrage. It shall be realised through a representative
and parliamentary polity and through local self-government. Public power shall be exer-
cised under the law.” (Swedish Government, 2011).

\(^2\) Gotland municipality is the only exception, also having the responsibilities and tasks
normally associated with a county council.

\(^3\) This means that one per cent of the adult Swedish population holds a political assign-
ment in a county council or municipality. In the county council assemblies, 7 per cent are
women and 53 per cent are men; and in local government councils, 42 per cent of
the councillors are women and 58 per cent are men (Swedish Association of Local
Authorities and Regions, 2011b).
passed by the central government when preparing decisions on all matters affecting local and regional governments.

Public health policy is a central part of the Swedish welfare system and is guided by the ideals of human rights and equality for all people in society. To work for a welfare society means to reduce injustices and to close the health gap between different social groups in terms of gender, age, and ethnicity. Sweden is one of the countries with the highest taxes in the world, but also one where people’s welfare is comparatively well covered “from the cradle to the grave”; such things as health care, schools, and elderly care are more or less free of charge. Many actors in society contribute to maintaining the welfare system. Although welfare provision is still mainly a public responsibility, reforms from the 1990s and onwards have re-introduced a variety of private actors as welfare service providers, especially in the areas of child care, elderly care, health care, and education. Services in these areas are carried out both by private, for-profit companies and by non-profit organizations.

Public health is an interdisciplinary field overlapping and involving many policy areas. The overarching aim of Swedish public health policy is to “create social conditions that will ensure good health, on equal terms, for the entire population” (Swedish National Institute of Public Health, 2011b). In attempting to reduce the welfare gap between different groups, the Swedish National Institute of Public Health plays a crucial role as a

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4 However, the declared universality of coverage is not without exceptions. Swedish law is restrictive when it comes to health care for undocumented and hidden persons, for which the country was strongly criticized in a recent UNHRC (UN Human Rights Council) report (Hunt, 2007), and for this reason a number of faith-based and other non-governmental organizations provide health care to these people. Emergency care is offered to everyone residing in Sweden, but non-life-threatening conditions are not covered by public funds for those without legal residency. The vast majority of medical staff works for the county or regional governments. However, after working hours some are involved in volunteer programs to provide care for non-official residents (Läkare i världen, 2011). The government has announced a change making it possible for undocumented people to receive health care. However, a final decision by the parliament in that direction will probably await until spring 2012 (Dagens Nyheter, 2011-03-02).

5 There is a strong tendency that large for-profit companies like Care, Carema, and Capio are taking over parts of social welfare (schools, social services, and health care), basically financed by tax money. Notably, most of these firms are “private equity firms” [riskkapitalbolag] buying and selling established companies in order to make profits, paradoxically with very little risk, as they buy with a combination of borrowed money and fund capital (Brink, Ergon, Gustavsson, & Werne, 2009; Werne, 2010).
national expert agency for the development and distribution of evidence-based strategies and methods in the field of public health. The institute collaborates with different organizations and national agencies, e.g. the Swedish Association of Local Authorities and Regions.

In early 2002, the Swedish Government declared its intention to improve public health by strengthening health promotion and disease prevention initiatives and reduce differences in health between various population groups. The proposal was developed by the Swedish National Committee for Public Health, a process-oriented parliamentary investigation appointed in 1997 (Swedish National Committee for Public Health, 2001). A large group of experts and researchers were involved in the process and 19 different expert-produced reports were published (Wall, Persson, & Weinéh, 2009). This culminated in 11 target areas in a government bill passed by the Swedish parliament (Proposition 2002/03:35, 2002): (1) participation and influence in society; (2) economic and social prerequisites; (3) conditions during childhood and adolescence; (4) health in working life; (5) environments and products; (6) health-promoting health services; (7) protection against communicable diseases; (8) sexuality and reproductive health; (9) physical activity; (10) eating habits and food; and (11) tobacco, alcohol, illicit drugs, doping, and gambling. Notably, the starting point is neither health conditions, diseases, nor risks, but rather health determinants such as living conditions and lifestyle factors with a special emphasis on reducing health inequalities. This is largely a reflection of social-democratic and social-liberal ambitions.

Profound changes in the social welfare system were initiated in 2006, including changes in national public health policy. In 2008 the new Swedish government\textsuperscript{6} presented a public health bill stressing the need for stronger individual responsibility for prevention and health promotion (Larsson & Hågglund, 2008). The new bill presented five particularly important public health areas: parental support, prevention of suicides, diet and physical activity, a stronger civil society, and tobacco prevention. In addition, earmarked economic resources were allocated to these topics. Compared to the former bill, with its focus on public responsibility, the new bill displays

\textsuperscript{6} The four parties in the coalition government are the Conservative Party [Moderaterna], the Liberal Party [Folkpartiet], the Centre Party [Centerpartiet], and the Christian Democratic Party [Kristdemokraterna], the first of which is the largest and also holds the office of prime minister. The Swedish Riksdag election in September 2010 resulted in a situation where the governing four-party coalition does not have a decisive majority of their own but has to secure that support of at least one of the other parties, most likely by seeking an issue-by-issue working majority (Elander & Fridolfsson, 2011).
an individual-centred approach. Public health efforts are now declared to be shared jointly by the public, for-profit providers, NGOs, and the individual. This is an important observation to keep in mind when studying the development of public health policy and practice in municipalities and neighbourhood development work.

Local and regional public health policies and programs are mainly based on the national target areas. Political responsibility resides at different levels and in different sectors. This means that all public agencies and authorities whose operations and tasks affect public health should also take into account the effects of their work on public health; i.e., there should be a kind of mainstreaming of public health efforts. Findings from the monitoring and evaluation of the national public health objectives are reported to the government every four years in a public health policy report produced by the National Institute of Public Health (Hogstedt, Lundgren, Moberg, Pettersson, & Ågren, 2004). The fact that public health policy cuts across many policy areas is a challenge that presents potential opportunities as well as risks. For example, how will health-based arguments influence sectors that do not normally consider the health impacts of their activities? To summarize, in the official political rhetoric, public health is considered an essential condition for social development in a broad sense. Initiatives to improve public health are declared to be included as an integral part of work to promote long-term, sustainable growth and welfare in Sweden.

**Participation and neighbourhood development in practice**

Neighbourhoods of a city differ in terms of unemployment, income, ethnicity, health, and other social and economic factors (Andersson, 1998; Molarius et al., 2009; Molarius, et al., 2007; Stewart, 2003; Vranken, De Decker, & Van Nieuwenhuyze, 2003). Compared to owners of single-family homes, people who live in multi-family, rented dwellings in large peripheral housing estates, in Sweden often called Million-Program Areas [miljonprogramsområden], are generally worse off in terms of most poverty indicators. On the other hand, one should keep in mind that there are large differences between these areas, depending on their function and position in the housing market, their particular composition of residents, and a number of other characteristics related to the history and context of each neighbourhood (Rowlands, Musterd, & Van Kempen, 2009). It is also true that areas may have received an undeservedly bad reputation based on judgments by media, researchers, and other outsiders, and residents may experience that they have found their ideal accommodation.
In the thesis the expression “the neighbourhood” [bostadsområdet] refers to a geographic location consisting mostly of peripheral large housing estates with rental apartments. Different concepts are used to label these neighbourhoods, which are variously described as disadvantaged, deprived, distressed, segregated, vulnerable, or poor neighbourhoods. Roughly corresponding terms in Swedish are utsatta, segregerade, marginaliserade or fattiga bostadsområden. In the thesis, the expression “poor neighbourhoods” is consistently used, with the exception of Study I, where “deprived neighbourhoods” is used.

The neighbourhood – A health promoting setting

There are different settings in people’s lives that have importance for their health and well-being. One of these settings is the neighbourhood, which functions as a starting point and a resource for the daily life. This means that even if one’s individual choice of lifestyle and health behaviour is a crucial determinant of health (Baum, 2002; Dahlgren & Whitehead, 1991; Marmot & Wilkinson, 2006b) the neighbourhood has the potential to function either in a protective and supportive, or conversely, in a harmful and disadvantaging way (Blasius, et al., 2009; Macintyre & Ellaway, 2003; Sellström & Bremberg, 2006; Swedish National Board of Health and Welfare, 2010). There are different views on what causes poverty and social exclusion and whether the “neighbourhood effects” exist or not (Burgers & Vranken, 2004). This research area is studied within several scientific disciplines, and even though this research is well documented there are diverging opinions depending on different theoretical perspectives and the studied outcomes. However, there seems to be consensus among researchers that social interaction in a neighbourhood is an important health determinant (for a review see Swedish National Board of Health and Welfare, 2010). The patterns of social interaction in a neighbourhood, which are linked to factors such as norms and values, social capital, and social participation, can have an impact on residents’ possibilities to live a healthy life (Macintyre & Ellaway, 2003). Research in Western European countries and the USA confirms the presence of neighbourhood effects, e.g. that the absolute proportion of disadvantaged persons (in terms of income and/or being recipients of social-benefits/social-housing), ethnic minority concentrations, and collective efficacy, are common and significant predictors of negative effects in terms of delinquency, perceptions, attitudes, and other socio-psychological outcomes (Blasius, et al., 2009). Neighbourhood effects are also dependent on gender, race/ethnicity, and the degree to which individuals spend time within specific types of neighbourhoods. Other health aspects linked to the neighbourhood are the design of the
physical environment as well as the pattern of social interaction in the neighbourhood. Physical activity seems to be influenced by the neighbourhood design; i.e., if the neighbourhood is designed so as to encourage physical activity more people also become more physically active (Sallis et al., 2009).

Even if there is some diversity of opinion among researchers, the household mix of a neighbourhood seems to matter, and may be used by policy makers and those who are planning specific programmes to reduce the neighbourhood effects (Blasius, et al., 2009). Some important aspects to take into account are as follows: (1) it is important that policy makers state what kind of mix (income, ethnicity, etc.) they want the programme to reach; (2) neighbourhoods that are defined by the municipal administration can exhibit large internal variation; and (3) it is important to mix the disadvantaged into strong neighbourhoods and not the opposite, because the absolute proportion of a disadvantaged group in a neighbourhood predicts the negative neighbourhood effects. Consequently, it seems like place and health are interdependent and inseparable, and that a supportive environment is vital for people's health. However, mixing poor and well-off residents is not a blueprint for success, as there is also a risk that a well-functioning, although poor, neighbourhood may disintegrate with an uncritical application of such a strategy. In a recent editorial (Bolt, Phillips, & Van Kempen, 2010) two main conclusions are drawn. First, although a wide array of desegregation and mixing policies can be found across Europe, they have failed to bring about a significant drop in the level of ethnic segregation. Segregation by social class also remains fairly resistant to policy interventions. Second, mixing policies often not only fails to meet the expectations of policy makers, but can also lead to negative effects, such as the breakup of communities and constraints on housing choice.

**Neighbourhood development**

Concepts like urban renewal and urban development are commonly defined and used broadly as including physical, financial, and social interventions to improve the situation in an entire city or larger areas in a city. It concerns a large number of actors and interests, more or less in conflict with each other. It may take the form of a slow, continuous process at the macro level while at the micro level manifesting itself as a series of swift, discontinuous projects being implemented simultaneously and with little coordination from above (Elander, 1997; Priemus & Metzelaar, 1992). Narrowing the perspective to the neighbourhood level, the term renewal is generally used for physical and social renovations in a particular neighbourhood or housing estate. Community development is another
concept that often refers to a geographical area, even though it may sometimes rather refer to intervention in relation to a group of people that have something in common without necessarily being located in the same neighbourhood (Labonte, 2005). In this thesis, area-based development initiatives and efforts are referred to as *neighbourhood development*, which underlines the focus on distinct geographical areas and the importance that interventions lead to actual development, i.e. do not just alleviate symptoms.

In public health interventions, neighbourhood development is a strategy for developing people’s health and reducing health inequalities and it is a common and established strategies to empower people living in neighbourhoods (Tones & Green, 2004). It is common that national, regional, and local programmes are combined. A variety of action is included, and these development programmes may contain physical renewal as well as individually focused interventions (Burgers & Vranken, 2004; Foulter, 2010; Palander, 2006; Vranken, et al., 2003). Renewals of housing blocks, the neighbourhood centre, open spaces, public gardens, and playgrounds, as well as attempts to mobilize firms to create new jobs and organize training and access to jobs, have been made. Measures aiming to empower residents have been taken in education, culture, health promotion, and other fields. Even though the overall aim is similar, different strategies are implemented due to the local context and “the eye of the beholder”, i.e. politicians, planners, community development workers, and residents who may also play an active part in planning and implementation.

There are many different strategies with the potential to develop a healthy neighbourhood. Some initiatives to reduce health inequalities and empower neighbourhoods have had positive effects. Research on the national programme in the UK, Health Action Zones, shows that local interventions can successfully increase citizen participation and influence in the neighbourhood (Sullivan, Judge, & Sewel, 2004). This is of importance as participation is a significant health determinant (for a review see Liljeborg, 2005). Neighbourhood development could be one important means for people to increase their social capital (Eriksson, Dahlgren, Janlert, Weinhehll, & Emmelin, 2010; Vranken, et al., 2003) as well as tackle social injustice and achieve empowerment and equity for all residents in the area (Green & Tones, 2010). Physical neighbourhood renewal has also been shown to positively impact community health, as shown in improved mental health and reduced smoking (Blackman, Harvey, Lawrence, & Simon, 2001). A recently published review of health impacts of housing improvements shows positive results in terms of improvements of overall health in general, and respiratory and mental health in particular.
In a study based on the Swedish Metropolitan development initiative, area-based policies show some positive effects on neighbourhood residents (Palander, 2006). First, they enhance the possibilities for residents to participate in developing their own neighbourhood, i.e. to create networks and build a social infrastructure. Second, an area-based initiative may also help improve the image of badly reputed neighbourhoods, thus counteracting the stigmatization commonly connected with such areas. Third, although geographical demarcation is a limitation when the basic causes of social problems are located outside the neighbourhood, there are several cases that suggest that area-based policies may create job opportunities, increase language skills of immigrants, and improve social conditions in various respects.

However, even if there are examples of positive health effects of neighbourhood development, they are dependent on careful targeting of the specific intervention (Thomson, et al., 2009). It is also difficult to ascribe the effects to one single intervention, as there are often other initiatives simultaneously underway to achieve common goals (Sullivan, et al., 2004). One review (Thomson, et al., 2009) as well as several research studies also indicate that the impact of an intervention is strongly related to the local context (Blackman, et al., 2001; Lahti Edmark, 2002; Sullivan, et al., 2004). For this reason, it is difficult to make generalizations. Paradoxically, however, a local area-based strategy may sometimes contribute to stigmatization; i.e. by being selected as an area with severe problems, a particular neighbourhood may become even more stigmatized (Andersson, 2006; O'Dwyer, Baum, Kavanagh, & Macdougall, 2007; Palander, 2006). Furthermore, if area-based intervention aims to change the fundamental causes of urban social or ethnic polarization, research shows that this is not really possible (Andersson, Brämå, et al., 2010; Palander, 2006; Vranken, et al., 2003). In this respect there is a need for general welfare redistribution programmes at a national level (Andersson, 2006; Andersson, Brämå, et al., 2010). Research suggests that to gain the best effect in neighbourhood development, the policies should target marginalized individuals, thereby helping them integrate into society (Andersson, Brämå, et al., 2010).

To conclude, this somehow disparate and confusing set of evidence is mainly a result of the difficulties involved in trying to measure a causal relation between neighbourhood development and health outcomes. Considering the comprehensive and complex social-political contexts of a
neighbourhood, we will probably never succeed in isolating the effects of
area-based interventions upon residents’ health, as they are constantly in-
fluenced both by external factors and characteristics and habits related to
each individual (De Leeuw, 2009). The fact that context-dependent studies
are not capable of doing this, however, paradoxically constitutes a reason
to concentrate even more on the context in studies linking research and
action to each other: “If we want evidence-based practice, we need more
practice-based evidence” (Green & Glasgow, 2006, p. 126).

**Partnership as a public health strategy**
The forming of partnerships/alliances/collaborations by decision-makers on
all levels has become an important strategy not primarily for health promo-
tion but for urban renewal and neighbourhood development in a broad
sense. Thus, during the 1990s, national urban development programmes
became commonplace all over Europe (Andersson, 2006; Ashton, 1992;
Palander, 2006; Vranken, et al., 2003). Two examples from the UK are
Health Action Zones and New Deal for Community Initiatives (Stewart,
2003). Swedish examples are *Blommanpengarna* 1995–1998 [“the Blom-
man money”; the name alluding to immigration minister Leif Blomberg
who was the initiator of this neighbourhood development program] and
*Storstadssatsningen* 1999–2005 [the Swedish Metropolitan Policy]
(Andersson, 2004).

Partnership is often defined very broadly as any coalition of different ac-
tors working for a common goal, and sometimes more narrowly following
strict rules to be followed by the partners. In line with the broad approach
WHO defines a partnership for health promotion as “a voluntary agree-
ment between two or more partners to work cooperatively towards a set of
for Sustainable Welfare Development is an example of a coalition between
municipalities and municipal housing companies working for the develop-
ment and renewal of poor neighbourhoods without any formal links to the
national public health policy (Eriksson, Järliden, et al., 2010).

It has often been declared that the partnership approach is something of
a universal tool for best practice, and that co-operation, built on mutual
trust between and among citizens and professionals will contribute to insti-
tutional capacity-building, efficiency, and sustainability. Though heavily
researched during the last decade, the impact of the partnership approach
on people’s health has not been conclusively determined. Arguments given
in favour of the partnership approach in governance include its synergetic
potential, the spreading of risks among the participants, and the increase in
financial resources for all partners (Elander, 2002). In a large comprehen-
sive study of 63 partnerships, the synergy effect was shown to be closely related to leadership effectiveness and partnership efficiency (Weiss, Anderson, & Lasker, 2002). However, whether these perceived synergies will also be realized in any particular case is, of course, not predictable and depends on many factors (Dowling, Powell, & Glendinning, 2004). Smith et al. (2009) mention six factors for a partnership to become a success: (i) a high level of engagement and commitment, (ii) joint agreement on the aim, (iii) high levels of trust, reciprocity, and respect, (iv) adequate management and leadership, (v) satisfactory accountability arrangements, and (vi) financial and other resources in the environment. However, three systematic reviews focusing on partnership and its relation to increased health show that there is little or no evidence for this positive relation (Dowling, et al., 2004; Green, Price, Lipp, & Priestley, 2009; Smith, et al., 2009). This could partly be due to the fact that it is difficult to ascribe health improvements to the partnership initiative (Smith, et al., 2009). Nevertheless, even if there is no clear evidence of partnerships being positively related to health, a self-assessment study revealed positive outcomes. Two-thirds of the stakeholders involved in the WHO Healthy Cities initiative reported the impact of the partnership work as successful (G. Green, et al., 2009). There were also indications that the partnerships created in connection with the Healthy City project would be sustainable over time.

**Citizen participation in neighbourhood development**

Participation is loudly praised by international agencies as well as national and local governments, and taken into account in policy documents and the implementation of area-based interventions. To say that a given activity includes citizen participation is to say something positive, and citizen participation in decision-making, planning, and implementation is important from several points of view. First, from the point of view of individual health, participation in neighbourhood development is vital, and as it commonly includes social interaction with other people it may share in the latter’s positive effects on physical, mental, and self-reported health (Berkman & Glass, 2000). Second, the empowerment of people is a strong reason for collective participation in neighbourhood development (Vranken, et al., 2003), and also has a positive correlation to health (Eriksson, Dahlgren, et al., 2010; Vranken, et al., 2003). Thus, to let more or less powerless residents be a part of decision-making may be a way to empower them, although there is also a risk of disappointment and apathy in the event that this participation does not lead to tangible results in the implementation process. Third, it may enhance the possibilities to make the area-based programs efficient and effective (Burgers & Vranken, 2004;
Tones & Green, 2004), and increase the chances of an implementation being successful (Klijn & Koppenjan, 2000; Yamauchi & Purcell, 2009). From this perspective, it is the people who live in the neighbourhood that can deliver the complete needs assessment. The fourth and final rationale for residents’ participation in this context is that it promotes democracy, although this view is not uncontested. In political science and related social sciences there is quite a variety of opinions on the virtues of citizen participation, and these controversies may also be of relevance when applying the topic to neighbourhood participation (Amnå, 2010). The growing number of attempts to involve participants in decision-making in various arenas in society could be one effect of the decline in election participation as seen all over Europe (Van Beckhoven, Van Boxmeer, & Szemző, 2009). However, a large number of participants (quantity) is not a guarantee for the quality and efficiency of participation, and there may also be well-founded reasons for not participating, either because of trust in representative structures (e.g. local government), or, conversely, distrust (“nobody will listen to my/our voice anyhow”).

Thus, although neighbourhood development policies for citizen participation may have a number of virtues, there are also some concerns. Participation is often invited from above, after the real decisions have already been taken or proposals are so well prepared that there is little room left for residents to have any influence. Furthermore, in many cases, funding from the EU and/or national governments comes with the requirement to involve citizens, which puts local authorities under pressure, sometimes with the result that their inviting citizens is just a token gesture (Burgers & Vranken, 2004). The local authorities could also be under time pressure and want to start the initiative as soon as possible. Then, the result could be that the obligation of citizen participation makes the public meetings rather distant and fairly uninviting.

Contextual as well as individual factors have been shown to have an impact on whether or not citizens participate in neighbourhood development. A recently published comparative study of citizen participation in urban regeneration processes in three European countries shows that cultural factors such as legislation and norms are vital for people’s participation (Van Beckhoven, et al., 2009). This includes the impact of the political system in a country. Consequently, although the involvement of citizens in policy-making is growing, there are large variations between countries and between cities within the same country. Three individual key factors for participation in neighbourhood development are people’s socio-demographic background, their behaviour, and their perceptions. People who have a strong socio-demographic background are more likely to par-
participate in neighbourhood development then those who are not as well off (Agger & Larsen, 2009; Matarrita-Cascante & Luloff, 2008). Higher educational level (Matarrita-Cascante & Luloff, 2008), higher incomes (Burgers & Vranken, 2004; Matarrita-Cascante & Luloff, 2008), and ethnicity (Öresjö, Andersson, Holmqvist, Pettersson, & Siwertsson, 2004), appear to be predictive factors for participation. People’s *behaviour* has been shown to interact with participation in neighbourhood development. Residents who frequently talk with their neighbours (Matarrita-Cascante & Luloff, 2008) and those who already take part in other local activities (Matarrita-Cascante & Luloff, 2008; Öresjö, et al., 2004) tend to be more involved than others in neighbourhood development. Furthermore, those who have lived longer in an area are more likely to participate than newcomers (Matarrita-Cascante & Luloff, 2008; Wandersman, Florin, Friedmann, & Meier, 1987). Finally, recent research also shows that if a citizen thinks others will participate s/he is more likely to participate (Foster-Fishman, Pierce, & Van Egeren, 2009).

In the argumentation about what can cause a citizen to participate or not, it is also interesting to look at potential participants. Amnå (2010) has identified six more or less co-existing, dynamic motives for an individual to shift from latent (potential) to manifest (active) political participation. The first motive is obligation (“one ought to”). For example, this can be seen as a key for the norm (in Sweden as well as in many other countries) that one ought to vote in general elections. The other five motives are importance (“I have to”), ability (“I can”), demand (“I am needed”), effectiveness (“it works”), and meaningfulness (“it’s rewarding”) and, according to Amnå, these imply a more comprehensive participation. These results indicate that given the right circumstances, anyone may be willing to participate in politics and civic matters in a broad sense. To capture these potentially active citizens Amnå has invented the label “stand-by citizens”. Furthermore, he makes the important point that a resident’s life includes both an active and a passive part; no one is simply active or passive.

The importance of local circumstances for people’s willingness to participate makes drawing general conclusions difficult. In other words, there is no shortcut for creating citizen participation in a specific neighbourhood. On the positive side, this creates some opportunities; after all, given the right circumstances anyone may become a participant. However, this can only be known through in-depth scrutiny of the social life of a neighbourhood. Thus, to let people have a voice in identifying and analysing their own environment can give them an important kind of knowledge that may foster participation and induce social change as well as contribute to research.
Community-based participatory research

Except from participating in neighbourhood development another form can be to participate in a community-based participatory research (CBPR) project. This approach is especially used in poor communities or neighbourhoods where people need to build up skills, capacity, knowledge, and power towards health equity (Israel, Schulz, Parker, & Becker, 1998; Wallerstein & Duran, 2006). It is important to point out that a CBPR project is not basically a research project, it is a social change project, thus with research as a method to achieve these broader goals (Stoecker, 2003).

In CBPR scientific professionals and members of specific community work together as equal partners in the development, implementation, and dissemination of research that is relevant to the community (Israel, Eng, Schulz, & Parker, 2005). In a CBPR process the “degrees of collaboration vary along a continuum” (Patton, 2002, p. 269), and at one end there is the researcher who has completely control over the process often together with professional, and at the other end there is the collaboration with people in the setting being studied. The ideal way is that lay people, in shared responsibility with professionals and researchers, are a part in all phases of the research process from designing the inquiry to report the result and make the possible change (Cornwall & Jewkes, 1995; Israel, et al., 1998). However, in practice, the level of activities of participants and researchers may vary through the process (Biggs, 1989; Cornwall & Jewkes, 1995), (1995) and are depended on the specific context and the participating individuals (Israel, Shulz, Parker, & Becker, 2003). Finally, “the challenges notwithstanding, community-based research offers a means to reduce the gap between theory, research, and practice that has been problematic in the field” (Israel, et al., 1998, p. 194).

The study setting

The Partnership for Sustainable Welfare Development

In the mid-1990s two networks were established, one directed at larger municipalities and the other at middle-sized municipalities in Sweden. Both networks were initiated and supported by the Swedish National Institute of Public Health, and the main aim was to support the development of public health initiatives in the municipalities (Eriksson, 1996). According to an evaluation study (Gurevitsch, 2001) some positive effects can be discerned in the cooperating municipalities. For instance, the networks supported the development of local public health efforts, and many municipalities initiated new health promotion projects. One positive effect was the creation of meeting places for sharing strategic and practical experience between poli-
ticians and practitioners. However, the report also shows that there were large differences between the municipalities in terms of citizen involvement, and it was accordingly a great challenge for the network to improve the opportunities for political participation.

The mandate for the Swedish National Institute of Public Health was changed after an external evaluation (SOU, 2000). More emphasis was put on being a national centre of excellence within the field of public health including developing and conveying knowledge to central government and its agencies and on monitoring and coordinating the implementation of the national public health policy. Initially the support for activities at the local and regional levels was reduced. Therefore the networks were dissolved in 2001. However, a new network for larger municipalities was proposed by politicians, practitioners, and researchers from Örebro municipality. Drawing upon experiences from the earlier networks, the initiators proposed a special focus on poor neighbourhoods and new alliances (Eriksson, 2002). An opening conference was held in Örebro in November 2001, giving birth to a partnership called the Partnership for Sustainable Welfare Development (PSWD), a collaboration that came to comprise the four municipalities Örebro, Helsingborg, Västerås, and Norrköping. This was also the starting point for a research and action collaboration in which researchers at the Örebro County Council and Örebro University became scientifically involved in the partnership and developed a research program. The Swedish Research Council for Environment, Agricultural Sciences, and Spatial Planning (FORMAS) supported the Healthy City research program including the involved research team. The present thesis is a result of this activity and is integrating research within the PSWD, stretching from 2003 to the end of 2009.

Initially, the Swedish National Institute of Public Health granted the PSWD ≈66,000 Euro (600,000 SEK) to plan and undertake research and development (R&D) activities (Eriksson, Elander, & Montin, 2010). In 2003, the local authorities (municipal commissioners [kommunälrad] and municipal chief executives [kommundirektörer]) together with the municipal housing companies (managing directors) in each respective city formally signed a three-year partnership agreement for sustainable welfare development. The overall aim was to work for the improvement of citizen health and welfare, with health, housing, economics, and education as key areas. The stated objectives of the PSWD were:

- to contribute to sustainable welfare development in poor areas;
- to develop strategic efforts for participation, influence, and health through cooperation between a broad range of interests and actors within and around the neighbourhood;
• to promote collaboration between the local, the municipal, and the national government levels;
• to promote learning and knowledge development through joint research and development; and
• to disseminate experiences and knowledge about sustainable welfare development.

For the period 2006–2009, when a new partnership agreement was signed, new and/or strengthened collaborations were pointed out as important to meet the need for:
• Increased employment
• Reduced segregation
• New meeting places

Throughout the years the work within the partnership has been focused on an exchange of experiences, knowledge distribution, and method development. The setting for the work was one neighbourhood in each city. The neighbourhoods were chosen locally and had a welfare profile (in terms of employment and unemployment rates, disposable income, and health) that was lower than the municipal average.

The PSWD consisted of three partnership committees (Bengtsson, Järliden, Larsson, & Sandberg, 2010): (1) the political governing committee [ledningsgrupper], including politicians, municipal chief executives, managing directors at the municipal housing companies, and the Healthy City research team; (2) the collaborating committee [samordnargrupper], including public health coordinators, and researchers from the Healthy City research team; and (3) the neighbourhood collaborating committee [arbetsgrupper för erfarenhetsutbyte], including local community development workers, representatives from both the municipality and the municipal housing company, and the Healthy City research team. In addition, representatives from three national partners, the Swedish National Institute of Public Health, the Swedish Association of Local Authorities and Regions, and the Swedish Association of Municipal Housing Companies were regular participants in the first two groups. Besides these partnership committees, temporary working groups have been assembled for certain tasks, such as the working group of indicators [arbetsgruppen för indika-

7 This group included several statisticians, one public health coordinator, one community development worker from a municipality and one from a municipal housing company, together with a researcher from the Healthy City research team. In addition, the Integration Office [Integrationsverket] participated before it was shut down. Based on official statistics and different citizen surveys, various indicators for neighbourhood development were analysed.
torer], and collegial peer review\(^8\) [kollegial granskning]. In addition, annual knowledge and development days were held, combining research and practice by the partnership participants as well as from outside the group. Furthermore, annual and thematic meetings with the political governing committee took place.

There was a yearly municipal fee of \(\approx 5,500\) Euro (50,000 SEK) for membership in the partnership, and the municipalities were also obligated to allocate personnel resources to the different committees and partnership activities. However, even if there were obligations in the partnership, the local activities performed in the neighbourhoods were controlled by each municipality individually without the direct influence of the PSWD. The local activities and neighbourhood development work were mainly a result of the local policy and plans together with agreements between different local actors (the municipality, municipal and private housing companies, NGOs, and residents).

**Four Swedish municipalities**

Four municipalities were included in the PSWD: Helsingborg, Norrköping, Västerås, and Örebro. All four rank among Sweden’s top ten in population size, ranging between 126,000 and 135,000 inhabitants. The four selected neighbourhoods are Dalhem in Helsingborg, Hageby in Norrköping, Pettersberg in Västerås, and Baronbackarna in Örebro. The arguments for choosing to work with these specific neighbourhoods were similar in the different cities, and concerned the differences between the neighbourhoods and the municipal averages for several measures (Table 1).

---

\(^8\) Collegial peer reviews were held in two rounds among the four selected neighbourhoods, including participants from the neighbourhood collaborating committee and local stakeholders.
Table 1. Demographic data for the four housing estates selected as target areas by the PSWD (Fröding, Eriksson, & Elander, 2008).

<table>
<thead>
<tr>
<th></th>
<th>Employment Rate (%)</th>
<th>Unemployment Rate (%)</th>
<th>Disposable income per family (SEK thousands)</th>
<th>Post-secondary Education (%)</th>
<th>Sickness Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Age 20-64</td>
<td>Age above 20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helsingborg</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Municipality average</td>
<td>72</td>
<td>4.5</td>
<td>271</td>
<td>33</td>
<td>43</td>
</tr>
<tr>
<td>Norrköping</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Municipality average</td>
<td>71</td>
<td>6.0</td>
<td>223</td>
<td>28</td>
<td>47</td>
</tr>
<tr>
<td>Västerås</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Municipality average</td>
<td>74</td>
<td>5.0</td>
<td>245</td>
<td>36</td>
<td>40</td>
</tr>
<tr>
<td>Örebro</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Municipality average</td>
<td>74</td>
<td>4.9</td>
<td>222</td>
<td>31</td>
<td>40</td>
</tr>
</tbody>
</table>

*a Disposable income means money left for consumption after deduction of taxes and tax-free transfers such as child support. Notably, however, in the case of Helsingborg the figure shows total income from work.

*b The figures of Jakobsberg-Pettersberg contain of two different neighbourhoods. A private owned housing area (Jakobsberg) and the targeted deprived neighbourhood in PSWD (Pettersberg).
The Healthy City research program

Developing and sharing knowledge was one of the main aims of the PSWD. The key actors for the development of the ongoing network for public health in municipalities were a key politician, the public health coordinator in one of the partnership municipalities, and a public health researcher who at that time worked at the Swedish National Institute of Public Health as director of research. He left the institute and started to work at the Department of Community Medicine and Public Health, Örebro County Council, and as professor at Örebro University. This group of people initiated the establishment of the PSWD (Andersson, Eriksson, & Järlieden, 2010).

A research seminar on public health and urban development became the starting point for a multi-year research collaboration, which included a planning grant as well as a four-year research grant from a national research council. This was based on the belief that it is beneficial to integrate research on the new public health into research in sustainable urban development as well as into urban research in a broader sense, something that was lacking at Swedish universities in the early 2000s. This was achieved by means of a collaboration between researchers from the well-established multi-disciplinary Centre for Urban and Regional Studies and researchers in Public Health Sciences at the Örebro University and the Department of Community Medicine and Public Health at the County Council. The research programme was called The Healthy City – Social Inclusion, Urban Governance and Sustainable Welfare Development (Eriksson, Elander, et al., 2010). This programme studied the healthy city using everyday life and urban governance as complementary perspectives in addressing social integration, urban governance, and housing in relation to health and welfare development. Both structural and policy analysis were included in the program, which uses position in time (1994–2004), space, and social structures (i.e. gender, ethnicity, social class) as crucial perspectives in the different studies.

The research programme has been successfully implemented, and has resulted in a number of different publications. The structural analysis, using population surveys, includes studies of self-reported health (Molarius, et al., 2007), mental health (Molarius, et al., 2009), social capital (Lindén-Bostrom, Persson, & Eriksson, 2010), and prescription-drug use (Johnell et al., 2006; Johnell, Lindström, Sundquist, Eriksson, & Merlo, 2006) among large samples of the population in the mid-Sweden region. Official statistics and statistical databases have been used in studies of the welfare development in the four partnership cities (Axelsson et al., 2010; Sedelius,
Moreover, an analysis of a population survey on local democracy distributed in 2004 was completed in three of the partnership cities (Sedelius & Eriksson, 2010; Sedelius, et al., 2008).

Analyses of the development of policies, collaboration, and practice have been undertaken in the partnership municipalities as well as in the selected neighbourhoods. This has resulted in a series of publications (see Eriksson, Larsson, Järliden & Sandberg 2010) as well as presentations at different national and international conferences (see Appendix 1). Moreover, the author of this thesis and a fellow doctoral candidate, both have been active members of the Health City research group.

Starting in spring 2003, and for nearly a year, the author of this thesis held a full-time position as a coordinator. However, in February 2004 this arrangement changed to became part-time, 20%, as the author was hired as a doctoral student at Örebro University. Her duties in the PSWD consisted mainly of being an administrative secretary and assisting with research initiatives. Since the mid 2008, the author has not been employed by the partnership. The present thesis is a result of this integrated research and practice, and focuses on some aspects of the complex and challenging development of a partnership for sustainable welfare development, neighbourhoods, and participation.
AIMS
The overall aim is, within the context of a partnership for sustainable welfare development, to study public health strategies and local development work in municipalities and neighbourhoods with a special emphasis on residents’ participation for a healthy development in poor neighbourhoods.

The specific aims are:

- to describe and analyse strategic public health work and neighbourhood development work in four Swedish cities and to describe and analyse the policy formulation and early implementation phase of a partnership for sustainable welfare development (Study I),
- to analyse what characterizes people who participate in neighbourhood development (Study II),
- to carry out an in-depth exploration of a community-academic partnership and a CBPR process within a poor neighbourhood in Sweden (Study III),
- to analyse the development processes for achieving sustainable structures in neighbourhood development in four partnership municipalities (Study IV).
MATERIALS AND METHOD

To study municipalities and neighbourhoods within the context of a partnership for sustainable welfare development, and with a special emphasis on participation, a multiple-methodological approach has been used. Qualitative and quantitative methodologies have been employed in parallel in seeking to understand the complex and multi-factorial context. A brief overview of the empirical materials now follows.

The empirical materials were gathered in four middle-size municipalities in Sweden: Helsingborg, Norrköping, Västerås, and Örebro; all of which are members of the Partnership for Sustainable Welfare Development (PSWD). One neighbourhood in each city was selected as the target area for developing the residents’ health. These are: Dalhem in Helsingborg, Hageby in Norrköping, Pettersberg in Västerås, and Baronbackarna in Örebro.

Two of the studies (I and IV) included all four municipalities and neighbourhoods as well as the PSWD. Study I was done to analyse the strategic public health work and neighbourhood development work in the four Swedish cities as well as the early implementation phase of the PSWD. A mixed-method design was used based on interviews, document analysis, and participant observation. Study IV examined the development processes for achieving sustainable structures in neighbourhood development in the four partnership municipalities. The concluding analysis of this longitudinal study was performed in the final phase of the PSWD based on a case study database that included data sources such as interviews, participant observation, documents, and a questionnaire.

In studies II and III the data collection was not conducted in all cities. Norrköping, Västerås, and Örebro decided to take part in a democracy survey in 2004, while Helsingborg did not. The original questionnaire data from the democracy survey was used when analysing what characterizes people who participate in neighbourhood development projects (Study II). In Study III, participant observation, during 2007–2009, was used to perform in-depth exploration of a community-academic partnership and a CBPR process within one of the partnership neighbourhoods. An overview of the thesis and the four studies is given in Table 2.
Table 2. Overview of the thesis. Aims, design, participants, data sources, and analysis of the four studies included in the thesis.

<table>
<thead>
<tr>
<th>Study</th>
<th>Aims</th>
<th>Design</th>
<th>Participants</th>
<th>Data source</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>To describe and analyse strategic public health work and neighbourhood development work and PSWD</td>
<td>Qualitative, mixed-method design</td>
<td>Purposive sample of city coordinators (n=4) and community development workers (n=4) from four cities</td>
<td>Interviews, policy document, participant observation</td>
<td>Content analysis of the interviews and in-depth analysis of multiple data sources</td>
</tr>
<tr>
<td>II</td>
<td>To analyse what characterizes people who participate in neighbourhood development</td>
<td>Quantitative cross-sectional design</td>
<td>Random sample of community members from three cities (n=1,160)</td>
<td>Mailed questionnaire</td>
<td>Factor analysis, crude odds ratios, logistic regression</td>
</tr>
<tr>
<td>III</td>
<td>To explore a community-academic partnership and a CBPR process</td>
<td>Qualitative ethnographic design</td>
<td>Purposive sample of civil servants (n=3) and citizens from one neighbourhood</td>
<td>Participant observation, field notes, tape recorded meetings</td>
<td>Thematic analysis of field notes</td>
</tr>
<tr>
<td>IV</td>
<td>To analyse development processes for achieving sustainable structures in neighbourhood development</td>
<td>Qualitative, embedded single-case design</td>
<td>Purposive sample of politicians, civil servants, and citizens from four cities (n=50). Random sample of residents from one neighbourhood (n=18) and three municipalities (n=1,160)</td>
<td>Case-study database; interviews, policy document, participant observation, questionnaire</td>
<td>Parallel and integrated mixed data analysis</td>
</tr>
</tbody>
</table>
Study I

Participants

Between June and December 2003 eight key players in the PSWD were recruited as participants in Study I. One strategic public health coordinator from each municipality participating in the PSWD and one community development worker from each selected neighbourhood were targeted. They were selected for their involvement in the PSWD, and their position within and knowledge of strategic public health and neighbourhood development. Of the four participants representing the neighbourhood development work, one was from a municipal organization, one from a provider organization, and two were from municipal housing companies. At that time all four had a coordinating role in the neighbourhood development work.

Data collection

Semi-structured interviews were the primary data source. The respondents were first informed about the study at regular PSWD meetings. The presentation was given at two meetings, one for the public health coordinators and one for the community development workers. A follow-up e-mail was then sent explaining the aim and overall questions of the study, asking whether they were willing to participate, and making it clear that they were free to break off their participation at any time. Everyone who was asked agreed to participate. The interviews were conducted at participants’ workplaces in their home municipalities; they lasted between 40 minutes and 1 hour, and were tape recorded and transcribed verbatim.

Two different semi-structured interview guides were prepared. The one intended for the strategic public health coordinators contained questions about municipal public health strategies, political support, organization and resources, local development work, possibilities and problems with the PSWD, and the respondents’ function in the municipality. The interview guide aimed at community development workers included questions about neighbourhood development work and the future, goals and objectives, determinants of success, and their function in the local arena. The different content areas included optional follow-up questions such as “Can you give an example?”, “Can you explain further?”, or “Is there anything more you wish to add?”, which could be used depending on how the interview was proceeding. The entire interview guide can be provided on request.

Participant observations at a large number of meetings with various constellations of local politicians, civil servants, private employees, and citizens
have been going on since the beginning of the partnership in 2003. The observations were conducted by me as a participant observer, however, I had dual roles in the PSWD, both as participant observer and as an administrative secretary. This means that I was taking part in the meetings, writing notes (official minutes and informal notes) at the same time as I observed the proceedings. I listened, talked, discussed, and made suggestions, but I had no mandate in the decision-making. This is similar to what Holmila (2008) calls a “researcher-as-technical advisor”, which means that the research participation “has a clear intention to support the community in ‘finding its own way’ as a means of increasing local ownership of the community project, thus creating natural tensions between researcher knowledge of effective strategies and community preferences” (Holmila, p. 417). With regard to my participation in the PSWD and Study I, this means that for the most part I have made statements in accordance with the situation and the knowledge I possessed at that moment. However, the responsibility for the strategies and implementation ultimately rested with the decision-makers, i.e. those who signed the partnership agreement.

The participant observation also comprised informal conversations with most of the representatives from each party involved in the PSWD. The conversations took place “on the spot”, e.g. at lunch in connection with meetings, and could last from a few minutes up to several hours. Relevant information about the municipalities and/or local neighbourhood development that could be important for promoting learning and disseminating experiences in the PSWD was added in the official minutes or my own informal notes.

Both participant observation and documents were sources of data about the work and process of the public health and local development activities. This means that I was looking in the official minutes, in my own notes, and in documents for information that could give an overview as well as a deeper understanding of the interviewees’ narratives of the strategic and local work in the municipalities and in the PSWD. As an example, in the interviews, the community development workers were asked about different strategies for the local work, and as a complement, official documents describing the work were read and visits were made to the neighbourhoods.

The documents included political and planning documents, reports, and evaluations, and were obtained from the respondents and different websites of the municipalities, municipal housing companies, and local voluntary associations.

Official minutes were taken at every meeting, often by me as administrative secretary; and the time, place, and participants at the meeting, as well
as the time and place of the next meeting, were recorded. An individual report from the participants and discussion about the strategic and local development work, decisions taken, what has been done in the partnership, and tasks to be undertaken after the meeting were central elements of the meetings, regardless of who was present. When no official minutes were available, or as a complement to the minutes, notes were written. In addition, the meetings were alternated, resulting in visits to the participating cities and neighbourhoods.

Study II

Participants
The sample of Study II consists of 2,400 randomly chosen citizens over 18 years of age living in Örebro, Västerås, or Norrköping (800 individuals in each city). Of the total sample, 1,160 responded (response rate 48%). The sample was taken from two sampling frames. One sampling frame consisted of 1,200 (400 from each city) randomly chosen individuals. Their response rate was 52%, as 628 questionnaires were returned. In addition, a second sampling frame consisted of all the residents, except those in sample one, in three specifically selected neighbourhoods with ongoing neighbourhood development activities. This second sample also consisted of 1,200 (400 from each neighbourhood) randomly chosen residents. Their response rate was somewhat lower; 532 people answered the questionnaire, giving a response rate of 44%. In Study II all these 1,160 individuals will be used in answering the research questions. Table 3 shows the descriptive statistics for the participants in Study II.
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Table 3. Descriptive statistics for the participants in study II and by sampling frame from the municipalities and selected neighbourhoods.

<table>
<thead>
<tr>
<th></th>
<th>Sampling frame in study II (n=1160)</th>
<th>Sampling frame from municipalities (n=628)</th>
<th>Sampling frame from selected neighbourhoods (n=532)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td>Percentage (n)</td>
<td>Percentage (n)</td>
<td>Percentage (n)</td>
</tr>
<tr>
<td>Man</td>
<td>49 (1160)</td>
<td>50 (628)</td>
<td>47.0 (532)</td>
</tr>
<tr>
<td>Woman</td>
<td>51</td>
<td>50</td>
<td>53.0</td>
</tr>
<tr>
<td><strong>Age group</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65–</td>
<td>19 (1160)</td>
<td>17 (628)</td>
<td>22.6 (532)</td>
</tr>
<tr>
<td>49–64</td>
<td>33</td>
<td>35</td>
<td>29.7</td>
</tr>
<tr>
<td>33–48</td>
<td>26</td>
<td>28</td>
<td>24.1</td>
</tr>
<tr>
<td>18–32</td>
<td>22</td>
<td>20</td>
<td>23.7</td>
</tr>
<tr>
<td><strong>Native country</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nordic countries</td>
<td>84 (1152)</td>
<td>87 (625)</td>
<td>80.5 (527)</td>
</tr>
<tr>
<td>Outside Nordic countries</td>
<td>16</td>
<td>13</td>
<td>19.5</td>
</tr>
<tr>
<td><strong>Years in the municipality</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11–</td>
<td>78 (1111)</td>
<td>82 (607)</td>
<td>73 (504)</td>
</tr>
<tr>
<td>0–10</td>
<td>22</td>
<td>18</td>
<td>27</td>
</tr>
<tr>
<td><strong>Education level</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compulsory school</td>
<td>28 (1141)</td>
<td>26 (616)</td>
<td>29.7 (525)</td>
</tr>
<tr>
<td>Upper-secondary school</td>
<td>38</td>
<td>39</td>
<td>37.1</td>
</tr>
<tr>
<td>University</td>
<td>34</td>
<td>35</td>
<td>33.1</td>
</tr>
<tr>
<td><strong>Employment status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pensioner</td>
<td>25 (1122)</td>
<td>22 (607)</td>
<td>29 (515)</td>
</tr>
<tr>
<td>Employed/own business</td>
<td>52</td>
<td>58</td>
<td>45</td>
</tr>
<tr>
<td>Student</td>
<td>10</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>Unemployed/long-term sick-leave</td>
<td>13</td>
<td>11</td>
<td>15</td>
</tr>
<tr>
<td><strong>Annual income (SEK)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–120 000</td>
<td>16</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td>120 001–250 000</td>
<td>45</td>
<td>44</td>
<td>45</td>
</tr>
<tr>
<td>250 001–400 000</td>
<td>20</td>
<td>23</td>
<td>16</td>
</tr>
<tr>
<td>400 001 –</td>
<td>5</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Don’t want to say/Don’t know</td>
<td>14</td>
<td>11</td>
<td>18</td>
</tr>
<tr>
<td><strong>Family situation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>26</td>
<td>23</td>
<td>30</td>
</tr>
<tr>
<td>Single with children</td>
<td>8</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Couple without children</td>
<td>34</td>
<td>35</td>
<td>32</td>
</tr>
<tr>
<td>Couple with children</td>
<td>32</td>
<td>36</td>
<td>28</td>
</tr>
</tbody>
</table>

An analysis of similarities between participants and non-participants in the entire survey (6,106 respondents in 27 municipalities) was made for the representatives of two groups: persons who voted in the 2002 election and foreign-born persons (Swedish Association of Local Authorities & The Swedish Association of Regions, 2004). The analysis reveals that while only 80 per cent of eligible voters voted in the general election in 2002, in the questionnaire 91 per cent of the respondents reported having voted. There is thus a certain degree of over-representation of individuals reporting having voted among those who responded to the questionnaire. Fur-
thermore, the representation of foreign-born persons is satisfactory in most participating municipalities, and the proportion of foreigners who answered the survey corresponds fairly well with the total proportion of foreigners in each municipality (this includes Norrköping, Västerås and Örebro). In addition, an analysis of similarities between participants and non-participants in this particular study sample has been performed (Sedelius & Eriksson, 2010). This results of this analysis displayed similarities with the former analysis. Of the respondents who had answered this questionnaire, 87 percent had voted in the last election, and between 79–83 percent on average in the three municipalities. However, in this study sample there was a minor overrepresentation of people born in foreign countries (20 percent compared to 12–16 percent).

Data collection
In November 2003, the Swedish Association of Local Authorities and the Swedish Association of Regions sent out an invitation to all municipalities in Sweden to take part in a democracy survey on citizen participation and influence. Of Sweden’s 290 municipalities, 27 municipalities decided to participate, including Norrköping, Västerås, and Örebro.

The questionnaire was prepared in working meetings by the Swedish Association of Local Authorities and the Swedish Association of Regions in cooperation with the project’s participating municipalities. Numerous research reports and studies in the field were read through. The questions were selected on the basis of the municipalities’ interests. Almost every question had been tested and validated by researchers in earlier investigations.

The questionnaire sent out in 2004 included questions about citizens’ political confidence, trust in municipal politicians and in other citizens, political agenda, civic duty, political equality, and the municipality as a participatory arena. Included in the questionnaire were also sociodemographic factors. In the measures section below, a detailed presentation of the questions included in Study II is presented.

Norrköping, Västerås, and Örebro engaged the Swedish research agency Temo to send out the questionnaire and to collect the answers. In addition, these three cities chose to expand the survey in three selected neighbourhoods (Hageby, Pettersberg, and Baronbackarna, also included in the PSWD) and finance it through the PSWD. The selected citizens received the

\footnote{The Swedish Association of Local Authorities and the Swedish Association of Regions were merged in 2007 into the Swedish Association of Local Authorities and Regions.}
questionnaire by mail to their home address and were informed about the study by a cover letter describing the study procedure. By returning the questionnaire they gave their informed consent. Two reminders were sent out. Temo delivered the original data from these three cities and selected neighbourhoods for separate and comparable analysis.

**Measures**
A key question measured participation in neighbourhood development: “Have you in the last two years tried to influence policy in the municipality where you live by participating in neighbourhood development (neighbourhood improvement association / local development group)?”

The respondents were classified according to their choice of three alternatives: “Yes” (participants); “No, but I would consider it” (potential participants); and “No, I would never do so” (permanent non-participants), which is used as the main focus in this study. Socio-demographic factors, perception factors, and behaviour factors are then used as measures characterizing people who participate in neighbourhood development.

**Socio-demographic factors**
Respondents’ socio-demographic background was measured by eight factors: sex, age, native country, numbers of years living in the municipality, education, employment status, annual income, and family situation. These factors are presented in detail in Table 3.

**Perception factors**
The factor of perceived civic duty consisted of three questions: “How strongly do you agree with the following statements: As a citizen in a municipality, you should:

a) Take collective responsibility for those who are worse off;
b) Take the initiative and not expect society to solve all problems;
c) Take an active part in trying to influence political decisions.”

Two statements measured perceived generalized trust. The question was: “How do you perceive people in your surroundings?

a) I feel solidarity with the people in my neighbourhood;
b) I think you can trust the people who live in this municipality.”

The response alternatives for civic duty and generalized trust were dichotomized into disagreement (strongly disagree, disagree, and don’t know) and agreement (agree and fully agree). In the analysis, the answers were divided into a high level of trust (at least two cases of agreement) or a low level of trust (one or no cases of agreement).
Five questions regarding perceived ability to act were converted into one indicator. The question was: “How do you perceive yourself and your possibilities to participate in society?

a) I’m interested in societal issues within my municipality;
b) If I try to influence policies in my municipality it gives results;
c) I would consider working for my neighbourhood without compensation;
d) I know where to go if I want to influence a decision;
e) I feel comfortable expressing my opinions publicly.”

For ability to act, the response alternatives were divided into a high level of ability to act (three cases of agreement or more) or a low level of ability to act (two or fewer cases of agreement).

**Behavioural factors**

Five questions concerning active engagement were used: “Have you in the last two years tried to influence policy in the municipality where you live, by:

a) Contacting a politician;
b) Contacting a municipal employee;
c) Taking part in a meeting with local politicians;
d) Submitting a citizen proposal;
e) Participating in focus groups.”

The response alternatives were “Yes”, “No, but I would consider it”, and “No, never”. Those respondents who answered “yes” two or more times were accorded a high level of active engagement and the others a low level of active engagement.

A single question measured political discussion with neighbours: “How often do you discuss social issues with neighbours?” The responses were dichotomized into a high level of political discussion (at least once a month) and a low level of political discussion (less often / once or twice a year, or never).

The entire questionnaire can be provided upon request.

**Study III**

**Participants**

The community-based participatory research (CBPR) group who comprised the participants in Study III consisted of six persons, three females and three males, who can be described as follows: a middle-aged male resident, a middle-aged female resident, a retired male resident, a female municipal community development worker, a male community development...
worker at the municipal housing company, and a female researcher/participant observer (the author of this thesis). All were Swedish-born except for the middle-aged male resident who had recently immigrated to Sweden. The researcher, together with the professional stakeholders who worked with neighbourhood development in the selected area, made up the group initiating the CBPR process. The three residents lived in the neighbourhood and were hand-picked through the professional stakeholders’ contacts. The stakeholders and the researcher agreed to try to select residents with different ages, sexes, and ethnic backgrounds, who might provide different perspectives that could be important when conducting a research process aiming to develop the neighbourhood. Furthermore, social competence was considered important (Svensson & Aagaard Nielsen, 2006) as the residents were going to take part in interview situations, listening and asking questions, and inviting the participants to contribute. However, the group constellation changed over time. One stakeholder and two residents could not be a part of the entire journey, and as a result one new stakeholder was added. For several different reasons there were only four participants at the end of the process, two professional stakeholders, one lay stakeholder, and the researcher, all females.

Data collection
A CBPR process was performed in a selected neighbourhood located in one of the municipalities in the PSWD. The initiative arose during discussions in the PSWD, but a local partnership between the municipality and the municipal housing company took the final decision to go through with a CBPR process. An ethnographic design with fieldwork was chosen to explore the community-academic partnership and the CBPR process. Ethnography can be used in a range of settings and is useful for studying problems defined and dealt with by human groups (Wills & Anderson, 2010). Participant observation is a common and appropriate data collection method when studying a setting and/or group for a long period of time (DeWalt & DeWalt, 2002; Hughes, 2007; Wills & Anderson, 2010). In relation to this study, two years of participant observation and fieldwork were conducted at 26 meetings ranging over 84 hours in a CBPR group in a selected neighbourhood between April 2007 and April 2009. In addition, numerous phone calls and informal conversations with the group members took place, together with visits to the neighbourhood. At the beginning of the participatory process, when all stakeholders were in place, all were informed about the practical procedure as well as the fact that the group process was going to be studied. They all consented to the group meetings being digitally recorded.
My part in the CBPR process was two-fold. I was a participant observer, observing the process, as well as a participant in the CBPR group with the responsibility to move the CBPR forward, such as by providing training in each new phase of the research process. During the participant observations I endeavoured to participate, interact, observe, discuss, and ask questions at every meeting and every new phase of the process to achieve an understanding of the community-academic partnership and the CBPR process. The observations were focused on how the process proceeded, what the discussions were like, who was active, what was important or unimportant to the participants, and the interaction between the participants (Patton, 2002). The writings contained both tacit and explicit information, as is common in participant observations (DeWalt & DeWalt, 2002).

The participant observation resulted in field notes consisting of official minutes of meetings and unofficial notes. The official minutes were mainly an important source of data on the practical process and consisted of the time, place, and members present at the meeting; decisions taken; what was done before and during the meeting; and tasks to be done after the meeting. The unofficial notes consisted of field notes of observations. These minutes were e-mailed to the group members as well as to interested members in the PSWD. Descriptions of the practical actions appear in the unofficial notes as well as in the official minutes, but the text was deepened by, for example, clarifying who made proposals and what the responses were. Furthermore, descriptions of how the process proceeded, what the discussions were like, who was active, and what was important or unimportant to the group members were also made (Patton, 2002). Official minutes and unofficial notes were mainly taken directly after the observed meetings. As a participant in the working process and because of the importance of being mentally present, I found it necessary to focus on the proceedings without writing; therefore only brief notes to aid memory were taken down during the meeting sessions.

Informal conversations were also a data source that became a part of the unofficial notes. They often took place “on the spot” in connection with CBPR meetings and lasted a few minutes up to an hour, or on some special occasions, like when dining together, the conversations lasted a couple of hours. The focus was mainly on what the members in the group thought about the process and the interaction in the group. In addition, numerous unplanned phone calls with the group members also took place, mainly to give practical advice about carrying out the research, such as using the digital recorder, transcribing the interviews, writing text in the report, etc. Nevertheless, the calls also yielded information about the working group
process and stakeholders’ participation in it. In addition, a report was jointly produced within the CBPR group as part of the planned feedback to the neighbourhood and other interested parties. Therefore, at the end of the two years of work, intensive discussions about strengths and limitations of the working process took place. Finally, this material and the conclusions included in the report were read through and validated by all group members (Fröding, Larsson, Wentzel, & Österdahl, 2009). To gain even more insight and understanding, the researcher visited the surroundings in the selected neighbourhood as well as visiting the homes of lay stakeholders several times. If something new came up at the visits, it was added to the unofficial notes.

**Study IV**

Participants

All four municipalities and the four selected neighbourhoods that participated in the PSWD were included in Study IV. The municipalities and neighbourhoods are treated as units of a single case, which is the PSWD. Participants were key politicians, chief executive officers, chief executives, public health coordinators, managers, and community development workers. They were selected for their involvement in the PSWD. Others in the sample are persons with various central functions in the local community development activities in the selected neighbourhoods, representing the church, volunteer organizations, and private companies. Residents were also interviewed. Several were respondents in an interview situation and/or a part of a participant observation situation.

Data collection

To obtain a comprehensive picture of the development processes for achieving sustainable structures in neighbourhood development in the four partnership municipalities, several different kinds of methods for gathering data have been used in parallel to build up the database of this case study (Patton, 2002; Yin, 2009). The database includes nine in-depth analyses, interviews, participatory observations at a large number of meetings with different constellations of participants, as well as solicited and unsolicited documents collected during the period 2003–2009. Parts of this data have been used in various previous analyses conducted by members of the Healthy City research team (at least one author of this study is included in each of the nine in-depth studies), resulting in separate reports and scientific publications. However, in this case study, more process-related data is used to give insights into political support, local alliances, and citizen par-
Participation as means to create sustainable structures in neighbourhood development.

The nine in-depth studies included in the database included different sources of data; interviews, participant observations, documents, and a questionnaire (Table 4).

Table 4. Data sources for the nine in-depth studies.

<table>
<thead>
<tr>
<th>In-depth Studies</th>
<th>Interview</th>
<th>Questionnaire</th>
<th>Participant Observation</th>
<th>Documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (2003)</td>
<td>8</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>3 (2005)</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>5 (2006)</td>
<td>29</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>6 (2007)</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 (2007–9)</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>8 (2007–9)</td>
<td>18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 (2009)</td>
<td>5</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

First interviews have been conducted. All in all, 68 interviews were done (in-depth study five includes an analysis of the same 29 interviews as in in-depth study four). Four rounds of semi-structured interviews have been carried out. The first in 2003 (8 interviews with public health coordinators and community development workers) and the second in 2006 (29 interviews with politicians, chief executive officers, chief executives, public health coordinators, managers, community development workers, and other central persons in neighbourhood development). The third was done in 2007 (8 interviews with chief executive officers, chief executives, public health coordinators, managers, and community development workers), and the final set of data was collected in 2007–2008 (18 interviews with residents). In addition, five telephone interviews were conducted in late 2009 and early 2010. All interviews were taped or digitally recorded and transcribed verbatim except for the five telephone interviews in in-depth study nine where notes were taken during the interview. All these interview guides contained one or several of the theoretical concepts analysed in this study.
A large number of *participant observations* were conducted as the research team was highly involved in the PSWD during the entire period 2003–2009. All in all, 125 events were attended by one or several of the authors of Study IV. The participant observations took place at meetings with different constellations of participants (Table 5). Some of these were annual meetings between politicians, civil servants, and local actors from the four municipalities and others were working or planning meetings under more everyday circumstances. The partnerships cities have taken turns hosting the meetings in the PSWD. This has been especially important with regard to the meetings in the collaboration group as it has meant that the research team has visited each municipality and the local neighbourhoods many times. This has given even more insight and understanding of the municipal and neighbourhood development process.

The participant observations have involved both observing and interacting with municipal representatives at the meetings. On most occasions the participant observers have functioned as “researcher-as-technical-advisor” (Holmila, Holder, Andreasson, Baklien, & Rossow, 2008), which means that the research participation has been consultative in the sense of trying to provide knowledge based on research that can be appropriate for decision-making. On some occasions the function was more that of “researcher-as-designer” (Holmila, et al., 2008), such as interacting and designing collegial reviews (in-depth studies 3 and 7) and community-based participatory research (in-depth study 8).

Table 5. Overview of participant observations.

<table>
<thead>
<tr>
<th>Year</th>
<th>Coordinator Collaborating Committee</th>
<th>Neighbourhood Collaborating Committee</th>
<th>Political Governing Committee</th>
<th>Annual Partnership Conference</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2004</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2005</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>2006</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2007</td>
<td>6</td>
<td>31</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>2008</td>
<td>5</td>
<td>20</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2009</td>
<td>5</td>
<td>10</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>37</strong></td>
<td><strong>71</strong></td>
<td><strong>10</strong></td>
<td><strong>7</strong></td>
</tr>
</tbody>
</table>
Apart from the formal meetings, the participant observations have also included informal conversations with most of the representatives from each municipality. The conversations often took place “on the spot,” for example at dinners in connection with meetings, and could last from a few minutes up to several hours. The focus of these discussions varied, but commonly they revolved around different aspects of the members’ thoughts about the neighbourhood development process and the interaction within the partnership. Additionally, numerous unplanned phone calls with members also occurred, for example when the need arose to clarify some factual detail when conducting an analysis.

Another usual data source in case studies is documents of different kinds (Patton, 2002). Documents could be helpful for several reasons; to provide background information and/or details of a context; to verify information that might be mentioned in an interview; and to highlight new questions that could be important in understanding the complexity of a specific case. In this study, official documents such as policy documents, reports, and evaluations related to the four municipalities and the PSWD have been an important data source. These documents were mainly obtained from the municipalities, neighbourhoods, universities, and municipal housing companies. In addition, documents in the form of official minutes of PSWD meetings were used. Most of these were written by one of the authors of the study (the author of this thesis) who also functioned as an administrative secretary in the PSWD 2003–2008. The official minutes were a source of data on the developmental processes and complemented the more detailed in-depth processes. The official minutes included the date, place, and participants at the meeting, decisions made during the meeting, what had been done since the last meeting, and any tasks that it was decided should be done after the current meeting.

Data analysis
Several methods for analysing data have been used in the thesis, both qualitative and quantitative. Qualitative analysis can be used with interview transcripts, diaries, documents, observation-based field notes, or case studies (Patton, 2002). Study I uses a qualitative mixed-method design and includes interviews as well as participant observations and documents. Every data source has its own advantages and disadvantages, and when trying to capture a comprehensive and multifaceted effort, like municipalities’ and neighbourhoods’ interventions for public health, it can be favourable to combine several data sources (Patton, 2002; Tritter, 2007; Yin, 2009). At first, qualitative content analysis was used when analysing the interviews in Study I. This is an appropriate method to use for text analysis...
in interviews (see e.g. Graneheim & Lundman, 2004; Kondracki, Wellman, & Amundson, 2002; Patton, 2002) and it aims to condense the text, code it, and find common categories or themes. In addition, by using a combination of data sources, such as participant observation and documents, the analysis from the interviews was complemented, validated, and cross-checked.

For the quantitative analysis in Study II, logistic regression analysis has been used. This is a powerful method that is appropriate when, as in Study II, the dependent variable is categorical (Hosmer & Lemeshow, 2000). Furthermore, to analyse the internal validity of the four categories (perceived civic duty, perceived generalized trust, perceived ability to act, and active engagement) a factor analysis was appropriate using principal component analysis and varimax rotations with Kaiser normalization (Mulaik, 1972).

In Study III, qualitative analysis was again used in exploring a CBPR process. When studying real-world factors by being there, experiencing, and participating, a thematic analysis is an appropriate method for analysing observation-based field notes (Baxter, 1991; Hughes, 2007; Liamputtong & Serry, 2010). The thematic analysis was performed by carefully reading and rereading the data material to look for repeated patterns, and searching across data to try to identify themes (Braun & Clarke, 2006; Liamputtong & Serry, 2010).

For Study IV, an embedded single-case study was deemed to be the most appropriate methodology when analysing the development processes for achieving sustainable structures in neighbourhood development in four municipalities during the years 2003–2009. A case study is an ideal methodology when a holistic, real-life event as well as an in-depth investigation are needed (Yin, 2009). A single-case study is especially appropriate when studying a unique case. In relation to this study, the single case, the PSWD, is by its very nature different from other partnership organizations. As such, the case-study methodology allows phenomena to be studied “in-depth” as well as holistically, when trying to understand complex social phenomena. In doing so, details become visible that otherwise would be overlooked if another methodology was chosen, e.g. a survey. A single-case study is also appropriate when studying a longitudinal case. With the partnership as a node for mutual learning and coordination, the municipalities’ (i.e. also the embedded units of the single case) development processes were studied during nearly seven years. The longitudinal approach also made it possible to ask new follow-up questions that emerged during the work, something that is not possible to the same extent when the data is collected at one point in time.
Study I
A qualitative mixed-method design was chosen, as interviews, participant observation, and documents are included as data sources in Study I. First, content analysis similar to that of Graneheim and Lundman (2004) was used when analysing the interviews. The analytical work began with reading through all interviews in order to become familiar with the text. At the beginning, the interviews with the strategic coordinators were kept separate from those with the local development workers. In the analysis the material was condensed and units of meaning relevant to the research question were identified. This was finished by checking the condensation to minimize the risk of distortion of the original content. The meaning units were thereafter coded into five different categories, such as formal structures for public health, supportive national strategies, neighbourhood development, and different views on the PSWD.

After that, the documents, official minutes, and informal notes were read through several times to look for similarities and differences to try to get as comprehensive a picture as possible. After the analysis was completed there was one inconsistency between the documents and the interview information from one of the respondents. This was kept as an open question until the co-authors scrutinized the analysis and consensus as to the categories was reached. This resulted in the inconsistent interview response being given less emphasis than the information in the documents and minutes. Next, each participant received a copy of the final analysis for verification and validity check. A few minor and one major correction were made. The major correction was due to the inconsistent finding, and the respondent provided an explanation and presented new documents to support the statement; this led to a change in the result.

Moreover, the formal structure for public health was analysed with a set of criteria for acquiring membership in the WHO Healthy Cities Program (Swedish National Healthy Cities Network, 2007). The criteria concerned public health resources, whether there was: political program for health development, an appointed coordinator; an office and administrative resources; politicians with special responsibility; and systematic follow-ups. All data material was read through looking for supportive or unsupportive information for answering yes or no. With regard to one criteria, “politicians with special responsibility”, Helsingborg municipality differed a great deal from the other municipalities by just answering yes or no; as a consequence, the strong political support in Helsingborg municipality was chosen to be presented in the findings.

Study II
A factor analysis was used to analyse the internal validity of the four concepts: perceived civic duty, perceived generalized trust, perceived ability to act, and active engagement. The factor analysis showed that the four concepts were distinguishable from each other.

A theoretical model for analysing the relative importance of socio-demographic factors, perception factors, and behavioural factors for explaining participation in neighbourhood development was prepared (Figure 1). For each of the three models, three research questions were addressed including participants in neighbourhood development (ND): (1) participants compared to non-participants (including permanent non-participants and potential participants); (2) participants compared to permanent non-participants; and (3) participants compared to potential participants. The first model includes socio-demographic factors, the second model adds perception factors, and the third model also includes behavioural factors. Using SPSS Package 14.0, crude odds ratios and confidence intervals were calculated to get the relative importance of the different factors for different aspects of participation. Thereafter, a stepwise (first model 1, then model 2, and finally model 3) binary logistic regression analysis was applied. A 95% confidence interval (CI) will be given for the odds ratios (OR).
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Figure 1. Theoretical model for analysing what characterizes participants in neighbourhood development.

Study III
Data collection and analysis began at the same time as the CBPR group got underway. It is a common strategy in field work (see e.g. DeWalt & DeWalt, 2002; Patton, 2002; Hughes), “to recording and tracking analytical insights that occur during the data collection are a part of the field work and the beginning of qualitative analysis” (Patton, 2002, p.436). Likewise in this case, themes for coding the data developed both during and after the data collection. Ideas or hunches about preliminary themes in the process was sensed, although, a final analysis was made after data collection ended (Hughes).
A qualitative thematic analysis were used similar to Braun and Clarke (2006). After data collection, field notes were read through several times, to get familiar with the text. At first, the reading were chronological (meeting 1-26) looking for recurrent patterns in the practical process. A timeline and identification of eight preliminary phases of the process were uncovered. The analysis proceeded by rereading the material looking for themes where different presumptions and statements were compared. The texts were condensed and cross-checked. At this way a coding for six tentative themes occurred, i.e. levels of activity, individual situation, commitments, expectations, consensus, and power and authority. Each theme was tested how it could be interpreted and understood in relation to each other and to the text. Digital records were only used in the analysis when clarifying the text, i.e. at two occasions. To validate the result one of the co-authors did an additional analysis, independently of my analysis, which resulted in a few minor corrections.

**Study IV**
In the analysis of Study IV three theoretical concepts were used: political support, alliances, and citizen participation. These concepts helped us to focus our attention on certain data and ignore others (Yin, 2009). The analysis of the case study database began by focusing on one concept and one city at a time. After an initial complete reading, a rereading took place looking for political support, alliances, and citizen participation related to neighbourhood development in each city. Data was extracted and orchestrated into the theoretical concepts. The data analysis involved a comprehensive process of moving between the original data sources and the results of the in-depth studies as well as discussions between the authors to refine the data analysis. The results were tested and revised by all authors after a preliminary analysis. To ensure trustworthiness the discussions among the authors were one way. Another important way was the verification and validity check done by the participants in the PSWD who read through the final analysis (Merriam, 2009; Yin, 2009).
FINDINGS

Public health strategies and local development work (Study I)
The aim of the first study was to describe and analyse strategic public health work and neighbourhood development in the four Swedish municipalities and the early implementation phase of their collaboration in the PSWD (Partnership for Sustainable Welfare Development). Eight interviews, participant observations, and documents provided the data used for analysis.

Political support and formal structure for public health
The interviews with the coordinators, together with our own observations and document analysis, give some clues about the political support and formal structures of the municipalities. The study finds ample evidence that public health is rhetorically high on the policy agenda in all four city councils. The local governments’ public health work is extensive and diversified, with tentacles spreading out to different policy areas like Local Agenda 21, integration, and crime-prevention activities. In the initial stage of the PSWD period, all of them fulfil the criteria for membership in the Swedish National Healthy Cities Network. This means that each of the four municipalities has (i) a political program for health development; (ii) an appointed coordinator; (iii) an office and administrative resources; (iv) politicians specifically responsible for the issues; and, (v) systematic follow-up. Thus, the political support and involvement levels are high in all the municipalities and very high in Helsingborg, which is probably due to their membership in the WHO Healthy Cities network which includes a high degree of political commitment.

The result showed that one crucial aspect of the rapid development of local health initiatives was the Swedish national public health objectives, developed in 2003. This is because local government has given more priority to public health, and because those planners and coordinators have also become more prominent on the overall municipal policy agenda. Furthermore, the process itself has had an impact on the understanding of the vast challenges facing public health and the interaction between hereditary factors and the environment. Backed up by the executive board, public health objectives should be a cross-sector effort, and many civil servants are vividly communicating public health questions. Yet, there are some concerns among the respondents. Public health is a broad, multidimensional concept that can easily be given a purely rhetorical content, especially in times of financial stress.
Neighbourhood development

The neighbourhood development work in the four neighbourhoods showed some similarities and some differences. The main objective is similar: to develop and strengthen healthy neighbourhoods and inhabitants and to encourage people to participate. In practice, the focus of the neighbourhood-oriented work is primarily on social activities and less on physical measures. Even though discussions about large-scale physical renewal had begun in Västerås/Pettersberg (rebuilding the neighbourhood school) and Helsingborg/Dalhem (rebuilding the neighbourhood centre) high priority is given to attempts to create meeting places in the neighbourhoods, with a special emphasis on children and youth activities. Priority also goes to attempts to mobilize and coordinate the individual residents and volunteer organizations represented in the neighbourhood.

Although they are all very similar overall, there are local variations in the details of implementation, due to situational factors in each case. For instance, while the city itself is the employer in Örebro/Baronbackarna, this function is shared with the municipal housing companies in Helsingborg/Dalhem and Västerås/Pettersberg. In Norrköping/Hageby this role is assumed by the local association Your New Hageby (Ditt Nya Hageby), which is financed by the municipality, several housing companies, and the Swedish Church, and includes a broad range of local actors. In practice, the function of the community development workers is quite similar; they are local coordinators and operate as bridge-builders between the residents, local NGOs, the municipal housing company, and the city administration.

The findings reveal that the public health work in the neighbourhoods is in different phases, due to the neighbourhood development activities in two of the neighbourhoods having just started (Helsingborg/Dalhem and Västerås/Pettersberg), but in the others (Norrköping/Hageby and Örebro/Baronbackarna) having been going on for several years. However, both coordinators and process leaders seem to agree about which qualities are needed for future success: extra economic resources, comprehensive and long-term planning, and residents' participation and influence.

Early implementation phase of a partnership

In this study we also analysed the early implementation phase of the PSWD. One clear aspect was that the role of the partnership as a node for mutual learning and coordination was held in high esteem both by coordinators and community development workers. Furthermore, there were great expectations for the future. The presence of the university researcher and the research programme are reported to give an opportunity for public health work to become based on scientific as well as professional knowl-
edge. When working with residents in a neighbourhood, the respondents expressed that the choice of a research approach is important, and it can help provide insight into, for example, research ethics and the methods applied.

Although the municipal actors have great confidence in the PSWD, there are some misgivings about the future. The PSWD is dependent on valid results as well as tangible neighbourhood development in the residential area. The respondents view the value of the PSWD in terms of “getting something practical out of it”. The early implementation phase of the PSWD conclusively reveals high expectations on the part of the public health coordinator and community development workers that the PSWD, including its research activities, will contribute to positive development for the health and welfare of neighbourhood residents.

Prior experience of participation (Study II)

The aim of the second study was to analyse what characterizes people who participate in neighbourhood development, by analysing participants compared to (1) non-participants; (2) permanent non-participants; and (3) potential participants. The answers from 1,160 questionnaires collected from people in three Swedish cities and one neighbourhood in each city were used. Presented below are the findings from the three research questions, and unless otherwise stated, only the findings in the last Model (Model 3) are presented.

The first research question measured what characterizes the participants in neighbourhood development as compared to non-participants. When socio-demographic factors, perception factors, and behaviour factors were included, participants in neighbourhood development were 5.3 (CI 3.0–9.4) times as likely to have a high level of active engagement and 1.8 (CI 1.0–3.2) times as likely to have frequent political discussions with neighbours then non-participants. Native country was significant when measuring only socio-demographic factors (Model 1), and together with perception factors (Model 2), as well as in Model 3 when behaviour factors were included (OR 0.2; CI 0.1–1.0). Thus, it seems that people who participate in neighbourhood development are characterized by displaying a higher level of active engagement than those who have not participated in neighbourhood development. Furthermore, it is less likely for people born outside the Nordic countries to be participants in neighbourhood development.

When analysing the two most disparate groups (the second research question), participants vs. permanent non-participants in neighbourhood development, the results were more disparate. Almost all perception factors
and all behaviour factors were significant, but no socio-demographic factor was significant. Having a strong idea of what citizenship involves (perceived civic duty) (OR 3.5; CI 1.3–10.0), being optimistic about one’s possibilities to participate in society (perceived ability to act) (OR 2.9; CI 1.4–5.8), being active and socially engaged (active engagement) (OR 8.3; CI 4.0–17.3), and having frequent political discussions with neighbours (OR 2.9; CI 1.5–5.5) were all important factors in determining what differentiates participants and permanent non-participants in neighbourhood development.

The last research question measured what characterizes the participants in neighbourhood development as compared to potential participants. The potential participants were those who had responded “No, but I could consider it” to the question whether they had participated in neighbourhood development. When all factors were included, people who participated in neighbourhood development had an overall higher level of active engagement (OR 4.3; CI 2.4–7.8) than potential participants.

In summary, the main findings of Study II show that when all factors were included (Model 3), the most important single factor for predicting participation in neighbourhood development was active engagement during the last two years. Citizens who have tried to influence policy in the municipality in some way, such as by contacting a politician or submitting a citizen proposal, are more likely to be active in neighbourhood development than non-participants. It does not matter if you have high or low education or income levels; as long as you display a pattern of socially engaged behaviour, you are more likely to participate in neighbourhood development. Among socio-demographic factors, it was only people born outside the Nordic countries who showed less participation in neighbourhood development; however, that was only when comparing participants with non-participants.

Community-academic partnership and a CBPR process (Study III)

The aim of the third study was to carry out an in-depth exploration of a community-academic partnership and the CBPR process within one of the selected neighbourhoods in the PSWD. The community-academic partnership included a researcher, several professional stakeholders, and several residents. By using participatory observation and meeting process-notes from 26 meetings spanning 84 hours from April 2007 to April 2009, a comprehensive set of data was sought.

Within the eight different phases, it was possible to outline varying levels of activity on the part of the researcher, professional stakeholders, and lay
stakeholders. These various levels are shown in Table 6 using a grading from no Xs for no activity to three Xs for the highest level of activity.

Table 6. Different phases and levels of activity among the members of the CBPR group, graded from zero Xs for no activity to three Xs for the highest level of activity.

<table>
<thead>
<tr>
<th>Level of activity</th>
<th>Phase</th>
<th>Researcher</th>
<th>Prof stakeholders</th>
<th>Lay stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparatory</td>
<td>XXX</td>
<td>X</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>Recruitment</td>
<td>X</td>
<td>XXX</td>
<td>XXX</td>
<td>X</td>
</tr>
<tr>
<td>Mobilization/</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>Knowledge-learning</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interview guide</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>Planning/composing</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>interviews</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Analysis</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>Writing a report</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>Feedback</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
</tbody>
</table>

The top-down initiative from the PSWD to conduct a CBPR process and the required application for ethical review led to a high level of activity of the researcher in the preparatory phase and less activity by the professional stakeholders. Naturally, no activity was seen from the residents as they had not yet been recruited. In the recruitment phase the professional stakeholders were the most active parties. The researcher and the first two recruited residents (lay stakeholders) were involved, but had low activity in this phase. After the first two phases, the results showed that there was the same high level of active engagement among the lay and professional stakeholders and the researcher. In the group process it was also important that everyone displayed the same level of engagement.

The group members’ individual situation was something that came up naturally on the agenda at the beginning of the process. The members described their different situations in life as well as the condition they were in. This theme only reappeared when a physical issue or life event called for it. For the theme commitments, those with jobs in particular mentioned that they did not want this process to be too time-consuming. Expectations was another theme that came up, especially in the two first phases (before the lay stakeholders were recruited); what the stakeholders expected of the researcher and vice versa were both important. Furthermore, throughout
the process there were mutual expectations within the group with regard to joint commitments. For example, in the most independent working period, when conducting interviews, some were not as engaged as others. There was irritation in the group until the problem was openly discussed. It seemed that the group considered it important that everyone displayed the same level of engagement.

At the beginning of the CBPR process, the participants made a commitment that every stage in the process should involve all partners and that it was acceptable to express diverging opinions during the CBPR process. At the end of the discussions, it was also important that the members search for a shared understanding, consensus. When evaluating the group process, it was stated that the participants wanted the process to take the time it needed. This was especially visible when writing the interview guide. This implies that letting the community-academic partnership process take the time it needs is one way to unmask power and authority.

To summarize, the analysis of the CBPR process found eight different phases of the working process; preparatory work, recruitment, mobilization/knowledge-learning, interview guide, planning/composing interviews, analysis, reporting, and feedback. During the process, several issues emerged, all which can be important in creating the joint sense of commitment and democratic dialogue that is vital in a community-academic partnership. The findings of Study IV suggest at least four lessons: (1) accepting different levels of participation in different phases; (2) openly discussing individual situations, personal commitments, and mutual expectations; (3) unmasking power and authority among those involved in the participatory process; and (4) allowing the work to take the time it needs, with consensus as a watchword.

Towards sustainable structures for neighbourhood development? (Study IV)

In the fourth and final study, the municipalities of Helsingborg, Norrköping, Västerås, and Örebro were all included. By using three core elements of the PSWD, political support, multi-actor alliances, and citizen participation, the development processes for achieving sustainable structures in neighbourhood development were analysed in these municipalities. This longitudinal study, lasting from 2003 to 2009, performed its concluding analysis in the final phase of the PSWD based on a generated case-study database. The case-study database includes nine in-depth studies with interviews (n=68), participant observations (n=125), a survey (n=1,160), and documents.
Political support, local alliances, and citizen participation are important building blocks for a sustainable neighbourhood development work. From the start of the partnership until about halfway through (2006) a clear political and local commitment can be seen in all partnership cities with regard to development efforts in the neighbourhoods. Political support seems to be a means to reach the target, ensuring a consistent approach and allocation of resources. However, this is mainly during the intervention period; when the formal partnership collaboration ends the political support and the resources for neighbourhood development have either been withdrawn or restructured. In this case the municipal allocations for neighbourhood development decline or are completely withdrawn in favour of similar ventures in other neighbourhoods in the municipality, which makes the project’s contribution to the creation of sustainable structures doubtful. For example, the parties who have held management positions in Örebro have been positive to the neighbourhood development work in the selected area until the 2006 election, when changes in the political majority took place. Then, the community development worker was centralized and the group which had been assigned to provide feedback to the political level was eliminated. In all municipalities the shrinking of financial or personnel resources is a sign of a decrease in political support for the neighbourhood development in the selected areas. However, at the same time other areas in the municipalities have emerged as important and are now prioritized, which implies that political support is constant but shifted focus.

At the local level the alliances in each municipality have been working more or less closely with neighbourhood development. The results of the partnership period indicate that local alliances have the best chance of forming sustainable structures when, as in Västerås, they clearly involve the strategic as well as the local level. Even though the neighbourhood development project in Västerås was formally ended in December 2009 the two-part alliance agreed on a division of responsibility to try to maintain the neighbourhood work. Thus, although the project has formally ended, some of the working groups are still active. Meeting are also still held in the project governing committee, though not as frequently as during the PSWD, and there is also commitment to maintain contact and support with the local working groups, comprising a mix of stakeholders and citizens, which were established as part of the project. In conclusion, the alliance continues at both the strategic and operational levels even though the forms it takes are not the same as they were during the PSWD.

At the beginning of the PSWD, the member municipalities strongly expressed the importance of citizen participation in neighbourhood develop-
ment work. However, the residents' degree of engagement in the planning and implementation of the activities has differed between the neighbourhoods. The overall picture in Norrköping is one of citizens participating in the planning as well as the carrying out of the neighbourhood development work. With an NGO leading the activities, the local work has achieved the most significant degree of citizen participation of the four neighbourhoods. The strategy has a clearly stated bottom-up perspective, with citizen involvement in the planning as well as in the operational work. At the end of the PSWD, the financial resources from the municipality were drastically cut and the community development worker had to be withdrawn. However, in this case volunteers seem to have ensured some kind of stability, as a number of these were standing by ready to take over at least some of the duties previously performed by the employed community development worker. None of the selected neighbourhoods in Helsingborg, Västerås, or Örebro have had the same extent of citizen participation. Örebro comes closest to Norrköping, as its citizen engagement has taken the form of various NGOs, depending on the issue at hand, participating to greater or lesser degree in various stages of the planning processes. In Örebro, Västerås, and Helsingborg, the citizen participation has been partly involved in carrying out activities, but not in the planning phase. To sum up, citizen participation seems to generate a kind of foundation for sustainability of neighbourhood development, at least as long as there are volunteers willing to take over the tasks of a project.

To summarize, the findings suggest that the political support in the four partnership municipalities is constant but shifted focus. Alliances have the best chance of forming sustainable structures when they involve both the strategic and the operational level. Similarly, have citizen participation has the possibility to create a basis for a sustainable structure able to continue despite reduced municipal support.

Summary of the main findings

The main findings presented in the thesis are as follows:

- In the early implementation phase of the PSWD, public health was rhetorically high on the policy agenda in all four municipalities. They also had formal structures that were important for health development, such as a political program; a designated coordinator; an office and administrative resources; politicians specifically responsible for the issues; and, systematic follow-up.
• The Swedish national public health objectives were crucial for the rapid development of public health initiatives in the four municipalities.
• The role of the partnership as a node for mutual learning and coordination was held in high esteem by coordinators and community development workers in the early implementation phase.
• The neighbourhood development efforts in all four neighbourhoods were built upon the same main objectives and the same criteria for success, however, the means to reach the target were different.
• Citizens who had previous experience of trying to influence policy in the municipality in some way, such as by contacting a politician or submitting a citizen proposal, were more likely to be active in neighbourhood development than those who had no such prior experience.
• Among socio-demographic factors, it was only people born outside the Nordic countries who showed less participation in neighbourhood development when comparing participants with non-participants.
• To create a joint sense of commitment and democratic dialogue in a community-academic partnership in a CBPR process it is important to (1) accept different levels of participation in different phases; (2) openly discuss individual situations, personal commitments, and mutual expectations; (3) unmask power and authority among those involved in the participatory process; and (4) allow the work to take the time it needs, with consensus as a watchword.
• During the PSWD period, political support, local alliances, and citizen participation were important building blocks for neighbourhood development.
• When the PSWD ended, there were few sustainable structures for neighbourhood development remaining. Political support for neighbourhood development was constant but shifted focus, in the studied neighbourhoods it had declined or been withdrawn in favour of similar ventures in other neighbourhoods in the municipality. Citizen participation seems to have provided a foundation for a sustainable structure able to continue despite reduced municipal support. In addition, it seems as if alliances have the best chance of forming sustainable structures when they involve the strategic as well as the local level in neighbourhood development.
DISCUSSION

As we enter the 21 century there is a need for a holistic approach to health. To increase people’s well-being and health and decrease the worldwide health inequalities in society is a multifarious challenge. Building up partnership cooperation between different actors; involving citizens in decision-making, planning, and implementation; and engaging in neighbourhood development are important activities in this respect. The complex socio-political contexts of neighbourhoods are constantly influenced by both structural characteristics and individual life stories and habits. It is a huge research challenge to isolate the effects of area-based interventions upon residents’ health, which is precisely why it is so important to include different interactive research, linking research to action. The ambition of this thesis is to make a contribution to the knowledge development within the field of public health and health promotion. This is done by taking a holistic and interactive approach within the context of a partnership for sustainable welfare development, highlighting public health strategies and local development work in municipalities and neighbourhoods, with a special emphasis on residents’ participation.

Partnership and a sustainable development in the neighbourhood

Building on a joint initiative and lessons learned from earlier partnership experiences, and integrating the existing research, the Partnership for Sustainable Welfare Development (PSWD) took its first steps in 2003. The stated aim of the PSWD was to improve the health and welfare of people in poor neighbourhoods through the exchange of experience, distribution of knowledge, and development of methods. The partnership cooperation had a relatively small budget and relied on the active involvement of committed people. As suggested in Study I, there were high expectations that the partnership collaboration would function as a node for mutual learning and coordination. Study I presents the partnership in its introductory phase when there was considerable political support not only for the partnership as such, but also for public health in general in the municipalities and neighbourhoods. Study IV shows that the political support for neighbourhood development for the most part remained high during the partnership years. Although political support is one of several crucial factors for ensuring quality of health promotion interventions (Bollars, Kok, Van den Broucke, & Molleman, 2005; Haglund, Jansson, Pettersson, & Tillgren, 1998; Pettersson, 2007), another crucial factor is the need for long-term thinking. As shown in Study IV, the political support for neighbourhood development was constant but shifted focus, moving from one neighbour-
hazard to another, and there was a lack of post-project planning in the studied neighbourhoods. Thus, there was not enough political support to contribute to a sustainable structure for neighbourhood development.

Like any partnership, the PSWD was influenced by the actual conditions and by changes in the political and socio-economic climate. Although the local elections in 2006 resulted in new political majorities in all municipalities except one (in Norrköping the same majority continued with the addition of the Green Party in the left coalition), all partners decided to prolong the project for a new three-year period. The fact that the partnership held on for so long was a promising condition for success. However, even if nearly seven years is a long time in this swiftly changing context, one should keep in mind that the nature of the projects within both the PSWD and most of the neighbourhood development projects does not allow for post-project success. As indicated in Study IV, long-term institutional commitment by the municipalities seems to be lacking.

Local partnerships or alliances between a municipality and a municipal housing company are dependent on long-term joint-working capacity (Leipzig Charter, 2007). As shown in Study IV, alliances have the best chance of forming sustainable structures in neighbourhood development when they involve people at the strategic as well as the operational level in joint efforts. A disconnect between these two levels is harmful, as demonstrated in recent research on the Netherlands, as it may cause fragmentation between partnership levels in terms of policy, time, and space, as well as disrupting the ability to make decisions (Kokx, 2010). Furthermore, the fact that it is difficult to ascribe health outcomes to a partnership initiative (Smith, et al., 2009) may create diverse opinions about the future survival of the partnership. The cultural differences between municipalities and municipal housing companies made the local work tricky but also stimulating. The “sluggishness” described by the municipal housing companies with regard to investing in neighbourhood development was an effect of differing possibilities to allocate resources quickly. With a more efficient joint-working capacity between the strategic and operational level in the local area, like the one in Västerås, the local alliance has a greater potential to create a neighbourhood that is both more healthy and sustainable.

**Citizen participation**

When studying what characterizes people who participate in neighbourhood development, prior experience of trying to influence policy in a municipality was the single most important factor. This result was in line with previous research showing that there are always at least some exceptionally engaged citizens (Matarrita-Cascante & Luloff, 2008). However, in other
respects the results of Study II did not correspond with earlier research showing the impact of socio-demographic factors, such as higher income (Burgers & Vranken, 2004) or higher education level (Matarrita-Cascante & Luloff, 2008). Notably, our research showed that as long as you display a pattern of socially engaged behaviour, it does not matter if you have high or low education or income level. In line with Putnam (2000), personal engagement has a positive correlation to social capital. Most dimensions of social capital, such as social norms, trust, and networking, increase with use, but decrease if they remain dormant. With regard to Study II, this implies that it was not surprising that people with an activist background are those who are most active in neighbourhood development. It is also possible that the right conditions, as described by Amnå (2010), were fulfilled to motivate the majority of people to participate. To succeed in recruiting people who have not been active before, it is thus important to stimulate residents’ competencies and options in different forms of participation. This should not only be an obligation for community development workers but also an assignment for policy-makers and planners. In light of the generally low response rate in surveys of poor neighbourhoods (Thomson, Petticrew, & Morrison, 2001) this is also important when trying to strengthen participation in research. Promoting CBPR can be one tool for strengthening the voice of inhabitants in poor neighbourhoods.

Citizen participation also includes a discussion about society’s role in fostering participation, implying that your first experience of trying to influence policy in a municipality can be of great importance; if you fail you may not try again. Societal prerequisites for citizen involvement and participation are vital because participation has been shown to have a positive impact on people’s health (Berkman, Glass, Brissette, & Seeman, 2000; Liljeberg, 2005; Parry, Laburn-Pearl, Orford, & Dalton, 2004). As an arena for everyday life, the neighbourhood has the potential to host an area-based development initiative, support and encourage citizen participation and, ultimately, community and individual empowerment (Burgers & Vranken, 2004). Here the community development worker has an important function as a bridge-builder between practice and policy, and could also support residents in trying to have an impact on their own environment (Lahti Edmark, 2002). As shown in Study IV, at the end of the partnership period the resources for neighbourhood development were withdrawn, which also caused a lack of community development workers working full-time with coordinating functions. There were various reasons for this. For example, in the targeted area in Norrköping, where a local NGO was responsible for neighbourhood development, municipal and other financial resources were withdrawn, and the community develop-
ment worker could no longer be employed. At present, the chairman of the NGO, with the assistance of a few committed residents, holds the duties. As positive as this may seem, two things can be noted. First, the willingness or ability of a small number of individuals involved in activities may cease, which can have rapid and huge consequences of the work. Second, the loss of the community development worker jeopardizes the broad neighbourhood development focus, as it increases the risk that priorities based on narrow self-interest will take over.

Even if the search for participating residents is crucial and may provide an opportunity for increasing people’s empowerment, there is always a risk that participation will not be followed by due implementation. As participation can vary along a continuum (Patton, 2002), it is important at the beginning of a process to openly discuss what to expect of each other and where the power is situated, as indicated in Study III.

**Community-academic partnerships for practice-based evidence**

When it comes to the community-academic partnership in the CBPR process analysed in Study III, two issues will be highlighted. The first one is related to the *time dimension*. This study pointed out the value of letting the process take time. This was important in every phase of the process, but especially when writing the interview guide. The result implies that the time dimension was crucial in terms of creating open and fair conditions for a democratic dialogue, thus unmasking power and authority. Unless there is agreement between all participants on this matter, the entire approach falls apart and will just be a waste of time for everyone concerned. Other research has identified this problem, showing that when a CBPR project was under time pressure, the academic and practical aims collided and “the dialogue within the project team became obstructed leading to a return to the traditional routine of applied research and the accompanying power relationships, with implications for the learning in and about the project” (Jacobs, 2010, p. 367). Creating relationships takes time (Ospina et al., 2004) and time is shown to be necessary to establish a trustful relationship (for a review see Israel, et al., 1998). To create a sense of joint commitment, Study III advocates openly discussing individual situations, commitments, and expectations. Openness and honesty (Grant, Nelson, & Mitchell, 2008), as well as acceptance of expressing and making use of diverging opinions (Christopher, Watts, McCormick, & Young, 2008) have been shown to be important in creating trustful relationships. However, when arguing the importance of having enough time, it is also unavoidable to bring up the fact that time also was a challenge in Study III.
The professional stakeholders in particular perceived the process as time-consuming, taking time from other work commitments.

Also crucial is the researchers’ commitment to developing a fruitful long-term relationship between all participants in the CBPR process (Buchanan, 1996). In line with this, Study III showed that everyone included in the partnership demanded a joint commitment, and that it was important that everyone displayed the same level of activity. Again, letting the process take time is a key lesson for creating a transparent CBPR process that can unmask power and authority.

The second issue is action. Action is a vital part of CBPR, as the goal is to effect social change in the community (see for example Israel, et al., 1998; Stoecker, 2009). However, one problem is that many CBPR projects do not result in any action at all (Stoecker, 2009), but are more like “talk shops”. This was also partly a problem in the CBPR group presented in Study III. Eager discussions of a possible joint commitment for action were not translated into planning for action. Two years later, when we were writing the information report, we discussed different strategies for joint action but this met with no response from the representatives of the two doers with resources, i.e. the municipality and the public housing company. Only minor joint activities were carried out. The key lesson is that unless the partners with financial and professional resources are prepared to use their powers, the CBPR process comes to a halt before any important neighbourhood changes can take place. It is crucial that funders, managers, or others that are involved behind the scenes are well informed and prepared to take their responsibility for implementing ideas that can lead to social change.

The design, process, and result of the CBPR project are appropriate for local community-academic partnerships with the goal of increasing participation as a means of improving people’s health and well-being in poor neighbourhoods. It can be concluded that there ought to be more community-academic partnerships with regard to practice-based local projects. The research component of broad partnerships, as in PSWD, could also have been further strengthened by developing a closer academic-community partnership. Such an increased involvement of researchers in the partnership would require additional funding, as the university has limited resources to allocate to this type of research. There is great potential in such alliances to develop practice-based evidence (Green & Glasgow, 2006). This type of research is sorely needed in complex context-bound environments where many different factors influence the outcomes (De Leeuw, 2009).
Methodological considerations

During the course of the PSWD, including the collection and analysis of the research material, there were several important things to take into consideration. This section includes both a reflection over the integration of research and practice in the partnership as well as methodological and ethical considerations.

Integrating research and practice

One such consideration emerges due to the research collaboration within the partnership, which has both limitations and strengths. When following a process over time, the researcher becomes a part of the reality being studied, and it could be difficult to remain impartial, and one may fail to see things clearly. The research programme has taken several decisions to avoid this. One method used to avoid bias is that the results and analysis of every study have been validated by several people from the research team, and another is that the respondents (Studies I and IV) and the participants (Study III) in the studies have discussed preliminary results (Merriam, 2009; Yin, 2009). The discussions with the respondents never changed the interpretations of the findings, nevertheless, they often yielded new insights. In addition, inside knowledge of the process and prolonged engagement with the PSWD may strengthen the internal validity and trustworthiness of a study (Patton, 2002; Swanborn, 2010; Teddlie & Tashakkori, 2009). The partnership itself has also helped sustain impartiality by rotating the locations of the annual conferences, the political governing committee meetings, and the various workshops.

The need for the research and the research questions were regularly discussed with members of the PSWD, and the director of the research programme as well as the author of this thesis participated in the meetings of the collaborating committee. Moreover, the research activities and results were always presented at the annual meetings of the political governing committee. The research team designed the studies after discussions with the other partners in the PSWD. The public health activities and the neighbourhood development work in the four different municipalities and selected neighbourhoods were decided, financed, and implemented by these four partners respectively. The following is an example of the interaction between the research team and the partnership. The municipalities were dissatisfied with the generally low response rates to the surveys. They were also concerned about the difficulty of motivating people in the neighbourhoods to get involved. The members in the PSWD were in need of more knowledge about different aspects of the neighbourhood as a place to live. One suggestion from the Healthy City research team was to implement a
The complex political and social environment of a neighbourhood as well as a city is context-dependent (Blackman, et al., 2001; De Leeuw, 2009; Lahti Edmark, 2002; Sullivan, et al., 2004; Thomson, et al., 2009), which makes it vital to link research and practice. In 2006 when a new agreement in the PSWD was to be signed, the objectives of the partnership were reconsidered. As a reaction to problems in the labour market, employment was highlighted as an important issue, which triggered intensified discussion within the partnership. This illustrates what has been confirmed in other research as well, that flexibility with regard to the organization and target objectives is important when facing new insights caused by changes in society (Brulin & Svensson, 2011). As demonstrated in this thesis, and in related research, there is a need to build structures for learning and feedback at all levels as well as to integrate research, practice, and action.

In the context of cooperation between the research and the partnership there have been some challenges. One challenge is the desire for solutions that can be directly applied to the residential area. While there are guidelines and factors known to make success more likely, there is no perfect recipe that fits all residential areas. Several studies indicate that the impact of an intervention is strongly related to the local context (Blackman, et al., 2001; Lahti Edmark, 2002; Sullivan, et al., 2004). Positive results are therefore not achievable without some fine-tuning of a strategy or intervention. Integrative research can support the development of the implementation process through knowledge and methods, but there is no quick-fix. Communication is a tricky issue in this respect (Bradbury & Reason, 2003), however a partnership between politicians, strategists, local practitioners, residents, and researchers has a greater chance to succeed if they discuss the goals of the partnership and their mutual expectations from the very outset of the implementation (Thompson, Story, & Butler, 2003).

**Ethical considerations**

One basic ethical principle that we aimed to follow when studying the four partnership cities is autonomy, which includes confidentiality, informed consent, self-decision, respect for privacy, and openness (Dahlgren, Emmelin, & Winkvist, 2007). In Study I, when we were analysing public health at the strategic and neighbourhood level while also undertaking an initial exploration of the partnership, we could not fully ensure confidenci-
ally to the interviewees. The limited number of members in the partnership and the fact that few had the same role (e.g. public health coordinators) made it difficult. That is why it was especially important (1) to ensure confidentiality as much as we could (for example by handling the information carefully when writing), (2) to openly discuss the issue with the interviewee, (3) to inform them repeatedly that their participation was voluntary and they had the right to call it off at any time, and (4) to let the interviewees verify and validate preliminary results and final analyses. From a practitioner’s point of view not having full confidentiality was never stated to be a problem. The practitioners thought they were public persons and the questions were not indiscreet. In addition, letting the interviewees verify the results was also beneficial for the validity and trustworthiness of the study (Merriam, 2009; Yin, 2009).

When it comes to informed consent, it was especially important because the researcher followed and interacted with the partnership by means of participant observations. Participant observation was a method used for collecting data in three of the studies included in this thesis, Studies I, III, and IV. The Healthy City research team followed and took notes on both tacit and explicit information, as is usual in participant observations (DeWalt & DeWalt, 2002; Patton, 2002). All members in the PSWD as well as in the CBPR group were clearly informed about our/my role as a participant observer. Still, having been observed for such a long time it might have been easy for them at times to forget that they were subject of a research project. The verification of the results and analysis was in this respect especially important. In Study III the meetings were digitally recorded which may have helped to remind the participants that they were in a research situation. Nevertheless, the strength of the participatory method lies in building up trustful relationships, and the research material in this thesis would be far the poorer without the everyday sharing of “insider” insights and information (DeWalt & DeWalt, 2002).

Implications
The findings of the thesis have implications for the fields of public health and health promotion. These implications concern policy, practice, and the research community. To begin with, the implications for politicians, planners, and managers are as follows:

- Use partnerships as a tool for learning and knowledge development.
• Create firm, long-term institutional commitments in the neighbourhood to preserve and strengthen the sustainability of neighbourhood development.

• Stimulate resident participation, and in doing so openly discuss expectations, responsibilities, and the relations of power.

• Public health issues and interventions need to be constantly reconsidered if positive long-term effects for people’s health and well-being are to occur.

Secondly, there are implications for practitioners:

• The practitioners need to be aware that socio-demographic background factors have less impact than active engagement. That is why it is so important to strengthen the options and competencies of the citizens through different forms of participation in health and neighbourhood development, thus extending the group of participants.

• Promoting a CBPR process can be one tool to strengthen the voice of inhabitants in poor neighbourhoods as well as to develop knowledge and action.

• In a community-academic partnership it is important to accept different levels of participation in different phases; openly discuss individual situations, personal commitments, and mutual expectations; and let the process take the time it needs, as these are key factors in creating a democratic dialogue, and thereby unmasking power and authority.

Thirdly, the findings of this thesis also have some implications for the research community:

• Participatory research such as a CBPR approach with joint commitments in community-academic partnerships is a powerful tool to bridge the gap between research and practice to create a platform for a solid evidence-based practice.

• Research is made more accessible and actionable for non-academics.
Further research
Citizen participation in decision-making and activities in neighbourhood development is a complex issue. The context-dependent and individual psycho-social mechanisms need to be further researched. To complement cross-sectional studies with qualitative personal interviews on participation is an important step towards achieving a dynamic interplay between different elements in the learning process of citizen participation.

The methods developed within the partnership were primarily peer review and CBPR. This thesis has focused on the community-academic partnership in one CBPR project. It was optional for the municipalities to develop a CBPR process in their target neighbourhoods, with the result that only one out of four did so. Further research could deepen the knowledge about the community-academic interaction and the working process by comparing different CBPR projects in similar areas at the same point in time.

The healthy city is a multi-disciplinary research area and there is a need to further explore how different disciplines can nurture each other in the effort to achieve healthier cities and neighbourhoods.
CONCLUSIONS

The main conclusion to be drawn from this thesis is that a partnership for sustainable welfare development has the potential to allocate resources for learning and development in public health both on a strategic as well as an area-based level. However, political support, alliances, and citizen participation are needed if the resources are to be sustained. A firm, long-term institutional commitment by the municipality is in this respect crucial.

There are challenges that arise as a result of participation in neighbourhood development and there are different reasons why people choose to participate or not to do so. The most important factor seems to be prior experience of participation when trying to influence policy in the municipality where they live.

There are a number of important issues that need to be taken into consideration when implementing a CBPR approach in a neighbourhood. The need for a joint sense of commitment and a democratic dialogue is crucial and there are four key conditions for this to happen. First, it is necessary to accept the different levels of participation in different phases, even if the gold standard is joint-commitment in every phase of the process. Second, it is also important to openly discuss personal commitments and mutual expectations. Third, any inequitable distribution of power between the participants has to be acknowledged and taken into consideration throughout the process. Fourth, allowing the work to take the time it needs is important in order to fulfil the other conditions.

Last, there is a need for a long-term commitment to joint efforts on the part of everyone involved in promoting and increasing people’s health and well-being. Much is being done, but much more remains to be done if the widespread health inequalities are to be reduced.
SUMMARY IN SWEDISH

Det finns betydande skillnader i hälsa beroende på utbildning, socioekonomisk status, etnicitet, ålder och kön och det har konsekvenser för människors livslängd, livskvalitet och hälsa. Ojämlikheter i hälsa blir särskilt tydliga när man jämför olika geografiska områden, där vissa områden har hög koncentration av fattiga och socialt utslagna människor med dålig hälsa, arbetslöshet och låg utbildning. Att vidta åtgärder mot de utbredda hälsoskillnaderna som finns mellan människor med vitt skilda förutsättningar är en viktig utmaning för hälsofrämjande arbete. En strategi för att minska skillnader i hälsa mellan människor är att arbeta med områdesutveckling i prioriterade bostadsområden.


Avhandlingens första studie syftar till att beskriva och analysera strategiskt folkhälsoarbete och lokalt områdesutvecklingsarbetet i fyra svenska kommuner samt den tidiga implementeringsfasen av Partnerskap för Hållbar Välfärdsutveckling. Datamaterialet består av dokumenterade intervjuer med folkhälsoamordnare och områdesutvecklare, deltagande observationer och skriftliga dokument. Resultatet visar att det redan i början av partnerskapsperioden fanns formella strukturer för folkhälsoarbete i kommunen, till exempel ett folkhälspolitiskt program, en utsedd samordnare, ett kontor och administrativa resurser samt politiker med särskilt ansvar för folkhälsofrågor. I uppbygandet av de formella strukturerna var också de svenska nationella folkhälsoområdena ett viktigt underlag. Vad gäller det lokala bostadsområdes arbete kan det ta sig olika uttryck även om målet är det samma. I partnerskapet fanns också tidigt höga förväntningar
att det skulle fungera som en sammanhållande kraft för ömsesidigt lärande och en positiv utveckling av prioriterade bostadsområden.

Avhandlingens andra studie syftar till att analysera vad som karaktärisera människor som deltar i områdesutveckling. Boende från tre av partnerskapstidernas svarade på en enkät och resultatet visade på att människor som försökt påverka politiken i kommunen på olika sätt i större utsträckning deltar i områdesutveckling. Denna påverkan kan ske genom att kontakta en politiker eller lämna in ett medborgarförslag. Högst engagemang och aktivt deltagande var oberoende av individens sociodemografiska faktorer såsom utbildning eller inkomstnivå. Det var endast personer födda utanför Norden som i mindre utsträckning deltog i områdesutveckling.


delen av områdesutveckling. Medborgarnas deltagande verkar också utgöra en viss hållbar struktur för områdesutveckling, trots minskat politiskt stöd och resurser.

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APPENDIX 1


Publications in the series
Örebro Studies in Care Sciences*


* Seriens namn var tidigare (nr 1–24) ”Örebro Studies in Caring Sciences”.

Doktorsavhandling/Doctoral thesis with focus on Nursing.

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Doktorsavhandling/Doctoral thesis.

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Doktorsavhandling/Doctoral thesis with focus on Nursing.

Doktorsavhandling/Doctoral thesis with focus on Nursing.

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Doktorsavhandling/Doctoral thesis.