Healthy Cities as a Political Process

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Introduction

Healthy Cities is an endeavour to improve the health of people, in particular the poor, in cities all over the world. This chapter puts the Healthy Cities movement in the context of globalisation and urban development policies[i]. The first section deals with several dimensions of globalisation and their impact on the cities of the South. The second section deals with major physical environmental problems in the cities of developing countries. The current policy paradigm to cope with urban problems is the subject of the next section. Sections four and five focus on the Healthy Cities movement and its spread into the countries of the South. The following sections argue that Healthy Cities initiatives that developed in the South can only be effective when the specific context of developing countries is taken into account. The chapter ends with critical observations about how the concepts of inter-sectoral co-operation and participation were implemented in Healthy Cities. Healthy Cities Programmes must therefore be sensitive to existing inequalities in access to resources and power. This requires knowledge about political processes within the host city or country.

Globalisation and Cities in the South

Today, around three billion people, half of the world's population, live in cities. Their number is fast increasing. In the following decades all future population growth is expected to occur in urban areas. Around 95 per cent of the growth will happen in the cities of the developing world in the South. In 1950 these cities accommodated 286 million people and by 1985 this figure increased to 1.14 billion (WCED 1987). Between 1986 and 1995 this number increased to 2.4 billion, and it is estimated that by 2025 it will be 5 billion (UNCHS, 1996). This tremendous population increase is a matter of great concern for both development scientists and urban policy makers.

The level of urbanisation differs between the regions of the developing world. In Latin-America, similar to most Western countries, around three-quarters of the population live in cities. In most African and Asian countries the urbanised part of the population is still below 40 per cent. Significant proportions of the world's urban population live in small market towns and administrative centres. However, a high proportion of the urban population either inhabit large cities of over one million inhabitants or in *mega-cities* with ten million or more people.

Significant changes to their economies and socio-political make up also requires attention. *Globalisation*, the process of increasing interdependence between places and regions of the world, is transforming cities in the South as much as in the North (Naerssen 2001). In the 'global village' new means of communication, transport and logistics have led to intensive economic, demographic, social and cultural interaction. Castells describes this as a 'world of flows' which characterises our current era. The impact of this is felt throughout all the cities of the South, although to different degrees (Castells 1996-1998, Pacione 2001, pp. 67-87 and 431-446).

Today, transnational companies are constantly searching for new centres of industrial production throughout the world (Dicken 1998). The costs of production, particularly wages, are substantially less in the South compared to the established production sites of the North. This explains the shift of labour-intensive industries to the South. Developing countries no longer merely supply raw material but they produce industrial commodities for the North. Through the creation of Free Trade Zones and Export Processing Zones, developing countries offer platforms for labour-intensive assembly production. Many cities in the South are becoming further integrated in the new world economy, as they re-structure and specialise their economies to suit global demand. In various regions of the South, such as in East Asia and along the U.S.- Mexican border, new industrial cities have emerged. Some cities remain only weakly involved in this international division of labour. There are many examples of such cities in South Asia, the Middle East, Latin America and Sub-Saharan Africa. In these cities employment in the formal sector has barely increased. Instead an extensive informal sector characterises their labour markets.

Globalisation also affects population mobility. It has resulted in phenomenal rural-urban migration within developing countries and unprecedented international migration. International migration is a striking feature of our 'borderless world' and is indispensable for the economies of the North. Population movements from the South to the North dominate patterns of international migration. Some cities, such as Metro Manila, the capital of the Philippines, serve as

platforms for the supply of international labour. The male population typically migrates for unskilled work in factories and the construction industry, whilst the female population migrate to be employed as housemaids, nurses and entertainment workers.

Since colonial times, the cities of the South have been characterised by a contrast between rich and poor. They typically accommodate a small and affluent political and economic elite while the majority of inhabitants have to deal and cope with poverty. Today, in cities that are strongly integrated in the world economy a new middle class has emerged from the need for professionals and skilled personnel in the private sector. The growth of employment opportunities for the middle classes in the private sector has not been reflected within the public sector. A new group of working urban poor has also emerged. Women have entered the secondary sector in great numbers. They are typically involved in the unskilled production work associated with the electronics and clothing industries (See Cedeño and Barten in chapter 3 of this publication). Their low incomes have helped to increase income amongst the poorest of urban households. Nevertheless, in most of these so-called emerging economies, widespread poverty still exists. Massive migration from rural areas has contributed to high urban population growth and the existence of an extensive poor urban working class.

Cities that are integrated into the global economy are relatively well off compared to cities of countries that are not as well integrated in the world economy, such as the cities of Sub-Saharan Africa. The inhabitants of these countries are among the hardest hit by the spread of a free market ideology and the determining influence of institutions such as the World Trade Organisation (WTO), IMF and World Bank. The *Structural Adjustment Programmes* (SAPs) of the World Bank and the IMF are particularly damaging for these national and urban economies. The implementation of a SAP entails cuts to the national budget, especially in subsidised social sectors such as food programmes, education, health and housing. The principle that services are something that should be paid for by all members of society results in a burden for the poor, who find it difficult or impossible to pay. Moreover, the introduction of a SAP usually results in unemployment through redundancies in the public sector and in those parts of the private sector that are not able to cope with international competition. The informal sector usually dominates the labour market in these countries. This sector typically includes people working as street or market vendors, entertainment workers, and workers in small-scale industries and so on.

Social insecurity, job instability and alienation characterise the life of the poor in these cities. This can lead to broken families, homelessness, increases in the numbers of street children, prostitution, drug abuse, alcoholism and violence. Despite these potential risks, urban living

provides an opportunity for the rural poor to cope with poverty. The poor do not passively accept urban problems. The establishment of self-help housing in squatter areas provides confirmation of this. It has been demonstrated that the poor are able to develop mutual networks which support and contribute towards social cohesion and the development of a collective identity in urban poor neighbourhoods (Gilbert and Gugler 1986, Evers and Korff 2000). Such networks provide a basis for establishing *community-based organisations* (CBOs). In many cities of the South, in particular in Latin America, CBOs and *non-governmental organisations* (NGOs) are actively involved in defending the land rights of poor citizens, improving their urban environs and access to urban services (Hordijk 2000, Kaufman and Alfonso 1997). Foreign donor agencies often support them in such efforts. The global networks that have emerged to support these activities also demonstrate the further globalisation of the cities of the South.

Urban Environmental Problems

The cities of the South have to cope with fast changes in the economy and substantial socio-economic disparities within their territories. They also have to cope with severe ecological problems. The Habitat conference in Istanbul (1996) paid explicit attention to the problems of cities in the South. The conference drew attention to the displacement of poverty from rural to urban areas, which resulted from massive inward migration to the cities. The 'urban challenge', as it was called in the WCED's report 'Our Common Future' (1987), was to reach 'sustainable development' by improving both ecological conditions and eradicating poverty. Both are closely interrelated. A lack of safe water and sanitation facilities, indoor and outdoor air pollution, and uncollected solid waste are some of the most pressing problems in poor urban areas (Hardoy et al. 1992, McGranahan et al. 2001, Satterthwaite 1999).

In almost all the cities of the South the provision of safe water and sanitation facilities is a huge problem. Safe water drinking water is in short supply. In coastal cities the extraction of water from wells has lowered groundwater levels and intrusion of water from the sea has led to salinisation. The scale of water contamination is enormous. Most rivers flowing through the cities of the South are essentially large open drains, containing a mixture of raw sewage and untreated industrial effluent. The rivers are so strongly polluted by organic waste that their oxygen content is negligible. In the dry season, when the water does not flow, estuaries can be transformed into huge, black, smelling pools. An insufficient supply of clean water, contamination and inadequate

sanitation cause high rates of water-related disease, such as diarrhoea and schistosomiasis. Water contamination is only one aspect of water related disease. A general lack of water can also affect levels of hygiene and cause infectious skin diseases. Water-related disease also results from the breeding of vectors in water such malaria, filiriasis, yellow fever and dengue fever (McGranahan et al. 2001, pp. 49-57).

Air pollution is another serious problem. It has been estimated that 1.4 billion people live in cities where average annual levels of sulphur dioxide and particulate matter exceed WHO health guidelines. In most urban areas major sources of air pollution include transport, manufacturing industry, and coal or oil-fired power stations. Air pollution in the cities of the South is expected to increase in the near future due to population growth, the expansion of urban economies and vehicle emissions. In a number of large metropolitan areas the problem is aggravated by topography. Often surrounding mountains restrict air circulation. The morning smog in Mexico City is a notorious case in point. Indoor air pollution is also a matter of serious concern due to the extensive use of biomass fuels for heating, cooking and lighting. Coal, kerosene, wood and liquefied petroleum gas are widely used, especially among poorer households. These fuels, when burnt in poorly ventilated houses, have an adverse effect on health. Studies have shown a strong correlation between air pollution and the incidence of respiratory infections, such as chronic coughs. Acute respiratory infection is considered to be the major childhood killer in the world. Tuberculosis accounts for a quarter of all adult deaths (three million deaths each year) and is the largest cause of adult death in the world. It occurs in urban neighbourhoods with high numbers of poorly ventilated houses and intensive social contact, favoured by overcrowding. It is partly related to the spread of HIV/ AIDS. Disposal of solid waste is a third problem area. An estimated 30-50% of the solid waste generated in the urban areas of the South is left uncollected. Refuse heaps build up in streets and open spaces, providing excellent breeding-grounds for rodents, flies and other disease vectors. Children who often play on wasteland, near to, or on rubbish are among the first affected. Solid waste creates major reservoirs of toxic metals in the urban environment. Hazardous industrial waste such as lead poses a particular problem, as it is currently dumped on open land sites with no control or provision to prevent exposure to humans.

The urban poor usually live in slum and squatter areas without proper facilities. These are typically located near polluted rivers and waste dumps. As a consequence, their level of health tends to be considerably worse than that of people who live in the more affluent residential areas. This scenario summarises the findings of several research findings including

international research undertaken by the Stockholm Environmental Institute (SEI). This research compared Accra, Jakarta and Sao Paulo (McGranahan 1991, McGranahan et al. 2001). In Accra, for example, the overall mortality rate for the city was 5.5 per thousand inhabitants. This figure varied from 1.3 in the affluent areas to 23.3 in one of the city's poorest neighbourhoods. Any strategy which seeks to improve the urban environment of cities, the so-called 'Brown Agenda', must take this inequality into account.

Towards a New Urban Development Policy

From the preceding discussion it is clear that urban development policy needs to resolve three challenges: economic restructuring, equity and ecological sustainability. Since the 1990s a new view on urban policy has emerged to support such approaches. This view is consistent with the same neo-liberal agenda that, at least partly, has created the problems that need to be tackled. It comprises of the three interrelated notions of urban governance, community participation and decentralisation (Cheema 1993, Cohen 1996, Devas and Rakodi 1993, McCarney 1996). Programmes such as the Urban Management Programme (the World Bank, UNDP and UNCHS/Habitat), the Metropolitan Environmental Improvement Programme (the World Bank) and the Local Agenda 21 Initiative (ICLEI, the International Council for Local Environmental Initiatives) have used these notions as undisputed starting points. The 1996 United Nations Conference on Human settlements (the 'City Summit' or 'Habitat II') confirmed these principles and also emphasised the need for action at the local (municipal) level.

The United Nations Development Programme (UNDP) defines *governance* as a broad concept that '….encompasses the organisational structures and activities of central, regional and local government; the parliament; the judiciary; and the institutions'. These all represent organisations and individuals that constitute civil society and the private sector. The concept of governance stresses the nature and quality of interactions among social actors and between social actors and the state' (UNDP 1997, p 4). This represents the sharing of decision-making between local state structures, the private sector and the actors of *civil society*.

The application of the concept implies greater opportunity for poor communities to participate in urban development processes and to initiate improvements in their own living conditions. Hence, *community participation* is another key notion of current urban policy. It

requires both the organisation of urban communities and better access to decision-making institutions. The more poor communities are organised, the more likely they are to participate in efforts to improve the urban environment. The benefits for the poorer segments of the population include improved housing and better access to public services. The benefits for governments include cost savings and enhanced sustainability, as it is assumed that the communities themselves will help to maintain public services.

The third concept of urban development policy concerns *decentralisation*. There is a clear tendency to decentralise decision-making and finance from the national to the regional and local (municipal or district) levels. This results in the creation of a local state structure with new and relatively more independent functions. In a centralised system a disproportionate part of the government budget is usually allocated for the capital city. In giving secondary and smaller cities a larger say, they are guaranteed a fairer share of the national budget. In addition, income tends to be generated locally. Furthermore, decentralisation stretches beyond just technical or administrative concerns as it is assumed that local bureaucracy is more accessible at the local level than centralised bureaucracy. A decentralised system will therefore provide more opportunities for community involvement and initiatives.

Today, there are many programmes and projects all over the world that involve local governments in inter-sectoral management and community participation. In practice, there are many problems in implementing these notions in the urban policies of developing countries. A major problem, for example, relates to a lack of financial resources. Cities in the South have limited government budgets at their disposal. For example, while the management costs of an American city can reach 2,000 US dollars per inhabitant, in cities such as Dhaka or Dar es Salaam, this figure is as little as 2 US dollars (UNCHS 1996, pp. 24-5).

More fundamental objections also have to be made. The emergence of the new urban policy is strongly related to the spread and support of representative democracy at a global level. It also fits into the neo-liberal endeavour to limit the role of governments in policy formulation. At all three levels - national, regional and local, governments are not supposed to take a lead in guiding the urban agenda. Instead governments are encouraged to enable urban actors to defend their private interests.

Three major groups of actors are distinguished in the development process. These are the state with its governmental agencies, the private business sector and the civil society represented by *non-governmental organisations* (NGOs) and *community-based organisations* (CBOs). The concept of urban governance implies that where commercial perspectives exist

the actors of the business sector will get an opportunity to be involved, while the civil society has to take responsibility for social and not for profit activities. The task of government is to co-ordinate and mediate where conflicting interests arise. This assumes a 'neutral' government or at least a government which is representative of public opinion. This situation is rare in most developing countries. Moreover, in many cities of the South, the representatives of the civil society are not autonomous but co-opted or controlled by local and national government and increasingly dependent on external funding – and therefore the policy of donors in the North.

The limits of the new urban policy can be demonstrated by the way that NGOs and CBOs usually participate in urban development projects. Although the notion of participation is broadly accepted, in practice it is often limited to consulting the 'target-groups' of the urban poor. Participation is, in itself, a highly instrumental factor in helping to alleviate social exclusion (Abbott 1996). Real participation demands a political process to get people involved, to mobilise their resources (including social capital) and to strengthen their capacity to participate. This process has to occur at several levels, since the organisational capacity of urban community groups depends on the democratic context of a country's national and local governments. Governments themselves can influence the socio–environmental contexts within which independent CBOs and NGOs can be encouraged to support the participation process. The existence of an 'enabling government' is an important prerequisite in supporting participatory processes at the community level. Participatory processes that contribute to the emancipation of poorer segments of populations are still rare in emerging democracies. Unfortunately, in most developing countries it is precisely this socio-political environment that dominates.

The Healthy Cities movement

Health and the environment are closely inter-linked. Health concerns the general wellbeing of individuals both physically and mentally. It is determined by four sets of factors. The influential *Lalonde report* (1974) uses the concept of *health field* composed by the four sets of biology ncluding genetic factors, medical services, lifestyle and environment (Davies and Kelly 1993, p, 128-129). The latter consists of a number of dimensions. It goes without saying that a bad physical environment, for example, dilapidated housing or a lack of sanitary facilities will affect health. The influence that the economic, social, cultural and political realms can have on urban environs is often overlooked or underestimated. Disposable household income, national and local

health policies (redistributive mechanisms) and cultural singularities that stress the importance of hygiene and a healthy lifestyle have a substantial influence over health. This and following sections deal with the role of the Healthy Cities movement in developing initiatives to improve urban environments. It also includes experiences of how the movement has influenced the policy process in order to benefit the health of urban inhabitants.

For a good understanding of Healthy Cities we have to go back to the Health for All conference held in Alma Ata in 1978 under the auspices of the WHO and UNICEF. At this conference a major health movement was launched, called 'Health for All' and six principles for the implementation of public health were formulated which still stand today. The principles are (1) reduced inequalities in health; (2) an emphasis on disease prevention; (3) inter-sectoral co-operation (including reduction of environmental risks); (4) community participation; (5) an emphasis on primary care in health care systems; and (6) international co-operation. The first principle was put forward by participants of the conference through a unanimous acknowledgement that inequalities in health were caused by disparities in income and access to economic and social provisions. The fourth principle is important as it acknowledges that communities need to have a say in improving their health conditions.

The principle of community participation in particular got attention at the First Inter-national Conference on Promotion of Health in Ottawa in 1986. The conference stressed the importance of involving the traditionally 'hard to reach' social groups. In the declaration of the conference, called the *Ottawa Charter for Health Promotion*, health promotion is defined as 'the process of enabling people to increase control over, and to improve their health'. It also states: 'Health promotion works through effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health, at the heart of this process is the empowerment of communities, and the ownership and control of their own endeavours and destiny' (the WHO 1986, quoted by Davies and Kelly 1993, pp. 14 and 56).

The Healthy Cities movement started in the wake of the Ottawa Conference when the European office of the WHO proposed an urban health promotion programme which targeted deprived urban neighbourhoods (Ashton 1992). Healthy Cities focuses on the long standing relationship between urban health and the urban environment. Moreover, its projects attach great value to participatory interventions at community (neighbourhood) level.

Since Healthy Cities is a movement, and its concept spread more or less spontaneously through networking between cities, certain flexibility will be found in the interpretation of

what a Healthy City comprises. In the WHO brochure *Building a Healthy City: a Practitioners Guide*, the aims of a Healthy City Programme (HCP) are stated as follows: ' …..to improve environment and health conditions by raising awareness, and by mobilising community participation through partnerships with local (municipal) agencies and institutions, thereby helping them to deliver effective environmental and health services. A priority objective should be to develop the role of local governments in public health and to encourage them to implement a Health for All policy at city level' (WHO 1995, p. 7). In this citation the improvement of services and local government involvement get special attention. Werna et al also emphasises the role of local government when they refer to Healthy Cities as '….a development activity that seeks to put health on the agenda of decision makers in cities, to build a strong lobby for public health at the local level, and to develop a local participatory approach to dealing with health and environmental problems…..' (1999, p. 28).

However, if one conceives Healthy Cities as a movement which supports the WHO 'Health for All' strategy in urban areas, its ultimate aim is to achieve greater equity in health. Since Healthy Cities are intended to build upon the Ottawa conference, it should be stressed that community involvement is not a mere instrument to reach the health objectives of a local government but should lead to community empowerment. The other features of Healthy Cities, which include inter-sectoral co-operation and the settings approach are designed to serve this aim (Naerssen and Barten 1999). Since the Healthy Cities approach stresses decentralisation of responsibilities to local governments, inter-sectoral co-operation and participatory processes it closely corresponds to, and is in line with, the new urban development policy as analysed earlier. The Healthy Cities approach is specific in the sense that it puts *health* development as central to urban policy development. It particularly addresses the health sector to assume a proactive advocacy role in establishing the urban health agenda by providing information on health and environmental linkages.

First Healthy Cities Initiatives in the South

At the City Summit in Istanbul, Healthy Cities was presented as best practice in urban management. Although most of the approximately one thousand cities which form the Healthy Cities movement were situated in the North, the movement and its networks successfully spread to cities in Africa, Asia, Latin America and the Caribbean. The Healthy Cities concept was well received in the South. The first initiatives were directly linked to the

WHO headquarters in Geneva, and/or cities in the North that were part of the world-wide Healthy Cities network. However, it should be noted that by the early 1980s "healthy city initiatives" were already established at municipal level in the South. These were often established without any explicit reference or recognition to the term "Healthy City" in their title. A clear example is the healthy city process in Leon, Nicaragua (see Montiel and Barten, 1999).

In 1991, during the 44th World Health Assembly in Geneva, discussions were held to consider the problems associated with rapid global urbanisation. It was within this framework that the WHO stimulated interest in the Healthy Cities project between representatives from countries of the South. The WHO wanted to select a number of cities to help spread the programme to developing countries. An example is the Accra Healthy Cities programme. On return from the assembly, the Ghanaian delegation approached the Ministry of Health and the Accra Metropolitan Assembly and Authority to initiate a programme for the Accra Metropolis. After approval from the city council, a request was send to the WHO in Geneva to get Accra selected as a programme city. The initial phase started in 1992 with the technical and financial support of the WHO in Geneva (Blankers 1995, p. 15).

Another example concerns the short-lived Healthy City Project in Johannesburg. The project was established through the business plan of the Health, Housing and Urbanisation Directorate of Johannesburg City Council in 1992. After the business plan was drafted, senior city officials undertook a tour through Europe to assess whether a Healthy City Project was feasible in Johannesburg and to learn more about different experiences of Healthy Cities projects. Delegates from Johannesburg were given the opportunity to visit the headquarters of the WHO in Geneva, a number of cities in Britain, and the cities of Copenhagen, Liege, and St Petersburg. In doing this, links were established with cities of the North prior to Johannesburg's own healthy cities project being implemented. This visit did not imply that Johannesburg's own Healthy Cities project was initiated by the North. According to Mathee et al. (in chapter 4 of this publication), the Healthy Cities idea was well received in Johannesburg because it fitted well with the principles and priorities of the 1994 National Reconstruction and Development Programme which was established by the new ruling party, the African National Congress.

Mendes and Akerman (chapter 6 of this publication) identify two phases in the development of the Healthy Cities movement in Brazil. The first phase began in 1991 with an agreement of technical co-operation between the twin-cities of São Paulo and Toronto.

Experts from Canada attended seminars in Brazil to explain the concept and strategies of the Healthy Cities movement to representatives from Brazilian cities. Exchange programs were arranged between the two countries. Experiences gained from these exchanges were documented and helped to inform the Healthy Cities programme in Brazil.

During the second phase, which started in 1994, contact between Canada and the Pan-American Health Organisation (PAHO) was intensified. This was particularly assisted by a group of consultants from the Pan American Health Organisation (PAHO) who were responsible for assisting new initiatives. A Brazilian Healthy Cities movement was soon established which comprised of ten cities with Healthy Cities concepts on their agendas. The Paraná State Health Authority promoted numerous meetings and actions as an attempt to make the municipalities of the State more receptive to Healthy Cities ideas. The authority promoted the *Saúde Cidade* meeting. Approximately 20 cities from within the state, with the potential to implement Healthy Cities programmes, were invited to this meeting. In 1996, the city of Campinas hosted the First Latin American Congress for Healthy Cities and Communities. This promoted a broad debate about how projects could be implemented**.**

In the cases of Accra, Johannesburg and São Paulo, local governments were actively involved in initiating Healthy Cities programmes. The role of outside foreign donors was more pronounced in the UNDP/WHO Healthy Cities programme, that started in 1995. The programme was to be implemented in the four cities of Cox Bazar (Bangladesh), Quetta (Pakistan), Dar es Salaam (Tanzania) and Managua (Nicaragua), and the administration of Fayoum which included both rural and urban areas (Egypt). In Managua the programme could build on a network of local civil society actors and the WHO was not required to form an institutional framework for Healthy Cities (Barten and Montiel in chapter 7 of this publication). In all other programme areas the WHO took the initiative to form Healthy Cities committees. In initiating networks globally, the WHO gained substantial experience in the steps required to strengthen the Healthy Cities movement at the local level. Based mainly on experiences in Western countries, *Building a Healthy City: a Practitioners' Guide* contains a step by step strategy for institutional development which consisted of three phases.

- Phase 1 concerns the establishment of a Local Task Force, defined as 'a nucleus of several key individuals in the city who have leadership capabilities, the desire to improve health conditions in the city and the ability to stimulate the participation of key actors such as NGOs, community groups, municipal agencies, university and training institutions' (WHO 1995, p.14).

- Phase 2 aims to establish a Partnership Task Force to replace the Local Task Force. This phase includes all stakeholders in the Healthy Cities programme and the appointment of a Healthy Cities co-ordinator with a remit to formulate a Municipal Health Plan (MHP). It is basically a plan of action and a tool to promote discussion and raise awareness.
- Phase 3 involves the implementation of the Municipal Health Plan.

The UNDP/WHO project document for Healthy Cities estimated that the first two phases would both last for six months and the implementation of the MHP would continue for two years. Whether this timetable was realistic depended on the socio-political conditions within the cities involved. In most programme cities it was not realistic and in practice the programme period had to be extended by up to two years. Indonesia presents an example of this step by step development of a Healthy Cities programme. Compared to Johannesburg and cities in Brazil, Indonesia started its Healthy Cities network rather late. The Indonesian national workshop on Healthy Cities was not held until 1997. From 1997 onwards a series of consultation meetings and workshops were held with the support of the WHO. These meetings and workshops helped to establish criterion for becoming a Healthy City and steps to promote Healthy Cities at a local level were intensively discussed. Surjadi and Atrisman (in chapter 5 of this publication) show how these steps were systematically implemented, and that the MHP (in Indonesia called 'Healthy Cities Plan') represented the core of the programme.

A Municipal Health Plan is indeed a major tool for Healthy Cities programmes. It contains local health information, analysis of health and environmental linkages, policy, advocacy, and small scale projects. Another specific tool is the so-called *settings approach*. This approach favours the implementation of Healthy Cities projects in geographically defined areas such as urban districts, neighbourhoods, industrial estates and schools. In conferences and meetings on health promotion the WHO has emphasised the settings approach. It encourages actions to improve the environment in places where people live and work in order to establish 'supportive environs'. Moreover, an advantage of the settings approach is that it facilitates inter-sectoral co-operation and actions in clearly defined areas.

The Accra Healthy Cities project covered the whole of the metropolitan area but, as Blankers remarks, '….it is more or less a compilation of existing plans of related and involved departments and agencies' (1995, p. 28). In the Johannesburg Healthy City Project the potential areas identified for intervention were high density and low-income areas, schools and market places (Mathee et al. in chapter 4 of this publication). In the UNDP/WHO project

document three settings are specifically mentioned: schools, small-scale industrial workplaces and markets. Projects are usually implemented at this level because the low income areas of cities in developing countries are too large to be realistically incorporated . In Managua the neigbourhood and low-income urban districts were also identified as settings to improve living and working conditions (see Barten and Montiel in chapter 7 of this publication)

By 1995 the WHO had already obtained significant experience of Healthy Schools and Healthy Market Places programmes. A Healthy School project might comprise health education, improvement of the school's environment (water facilities, toilets, school playgrounds, and classrooms), parental and pupil participation and school medical services with an emphasis on disease prevention. In the case of a Healthy Market-Place, a project would typically comprise of the establishment of sufficient or improved food storage facilities, solid waste management and the provision of public toilets. A Healthy and Safe Workplace project might include traditional occupational health services, solid waste facilities, education and training and worker representation in industrial management.

In supporting the Healthy Cities movement the WHO was thus promoting ideas about the establishment and the implementation of Healthy Cities programmes. It provided useful guidance that could be applied all over the world. It paid less attention to the different local and national contexts of the countries in the South. This is one of the conclusions that Mendes and Akerman draw from their experiences in Brazil. 'In the context of the wider movement, truly successful Healthy Cities projects are be generated locally and decentralised from national government. However, in poor countries where there are wide gaps in channels of communication between different levels of government (i.e. between regions, cities and people), Healthy Cities should also be pursued as part of a national strategy' (see their contribution in this publication). For Indonesia this conclusion is confirmed by Surjadi and Atrisman (in chapter 5 of this publication).

The Importance of the Political Context

The importance of the national and local political and institutional context became clear during the implementation of the UNDP/WHO Healthy Cities programme for developing countries 1995-1999. As highlighted earlier, in Managua the WHO was able to build on earlier initiatives of community participation and health promotion in workplaces, markets and schools. After the fall of dictator Somoza in Nicaragua, extensive mobilisation of the

population took place by the Sandinistas government between 1979 and 1990. Nicaragua's political history therefore explains the level of active involvement from civil society. The current government embraces the principles of neo-liberalism but the *Partido Frente Sandinista*, the opposition party, is still strong and the idea of popular participation is also favoured by many outside the party. Managua was included in the UNDP/WHO Healthy Cities programme partly because of its experience in community participation in health development.

: 'The Healthy Cities programme was established in July 1995 through a workshop attended by twenty representatives of the municipal government, government agencies, NGOs, CBOs and academic institutions'.] >From the outset, the intention was to build a programme based on local experiences which would form the basis for ongoing activities in urban health development. Thus the relevance of the HC-programme was discussed in the context of existing structures and processes. In April 1997 the *Initiativa Managua Municipio Saludable* (IMMS; Healthy Managua Municipality Initiative) was established. It was based upon consensus between the participating institutions and organisations. The IMMS was conceived as a local initiative that was supported by the LIFE/WHO HC-programme. Also, an IMMS Assembly was established which consisted of 26 organisations from the public sector and civil society.

In August 1997 the IMMS Assembly established a Local Task Force which was composed of representatives from the two main community-based organisations - *Movimiento Comunal* (MCM) and *Juntos Comunitarias de Obras y Progreso* (JCOPS). Other representatives included the local government, the Ministry of Health, five health and environmental NGOs and three representatives from academic institutions. In other words, civil society was strongly represented. Some participants were fundamentally opposed to accommodating the programme's project officer within the municipal government's own offices. To resolve these concerns monthly meetings were organised on a rotational basis in the offices of each of the member organisations. In 1998, a MHP was formulated following two participatory workshops (Barten and Montiel see chapter 7 of this publication).

Managua's case is revealing, as it provides an example of where Healthy Cities could build on the earlier experiences of the actors involved. It was the particular political and historical context of the country that provided the opportunity to bring major actors together. The question of ownership was put on the agenda from the very start, and the active involvement of civil society actors was also encouraged from the beginning. This probably

made the Healthy Cities *Process* in Managua a unique example of bottom up Healthy Cities building.

It is interesting to compare the case of Managua with that of another city within the UNDP/WHO HC-programme, namely Dar es Salaam, the major city of Tanzania with a population estimated at about 3 million. Here, project initiation was slow. One of the reasons was the specific local administrative context. In 1995, the City Council of Dar es Salaam (the city's local government) was notorious for its corruption. Tanzania's central government soon took over and established the Dar es Salaam City Commission under its control. Following this the political climate within which a Healthy Cities programme could be initiated was improved. A 'Consultative Workshop to Formulate a City Health Plan under the 'Dar es Salaam Healthy Cities project' was held in September 1997. The workshop was organised by the Dar es Salaam City Commission in collaboration with the WHO and the Ministry of Health. It received top-level support with a direct input from the Prime Minister's Office. Members of the Dar es Salaam City Commission also took an active role in the discussions. During the three days of the conference around sixty participants discussed the presentations and action plans were formulated in eight working groups. This process set the basis for a Municipal Health Plan.

Despite good attendance at this workshop, civil society and community involvement was weak. Significantly, only a few representatives of the private business sector and NGOs/CBOs attended the Consultative Workshop. This was partly because the WHO's national office in Tanzania put little effort into allowing civil society actors to participate in the programme. Another reason was that civil society was poorly organised in Dar es Salaam. The existing health NGOs were typically concerned with the needs of disabled people or represented charity clubs such as the Rotary and Lions clubs (Cranenburg and Sasse 1995, p. 27). Moreover, there were only a few CBOs that functioned as independent organisations and were organised enough to make their voice heard. In short, civil society in Dar es Salaam was at an embryonic stage, although some progress had been made. Thus it is not surprising that by the end of the programme period, Healthy Cities were still considered as 'one of the international projects of the WHO'. It had not really been rooted as a municipal health approach, sustainability had not been reached and the Healthy Cities programme came to standstill as soon as the WHO's national office stopped receiving financial support from abroad (Naerssen and Barten in chapter 8 of this publication).

In comparing Managua and Dar es Salaam, one can argue that, while maintaining the major objective of implementing Health for All at the local level, the specifically defined tasks differed. In Managua the interests of local government and civil society had to be reconciled during an intensive negotiating process. In Dar es Salaam the major task was to involve actors of the civil society. As these actors of civil society were non-existent outside the 'charity' NGO sector, the Healthy Cities Programme in Dar es Salaam had to focus efforts towards establishing new health NGOs and linking them with CBOs (Naerssen and Barten 1999).

Dar es Salaam and Managua were just two of the UNDP/WHO Healthy Cities initiative programme cities. The overview in the WHO's final report called *Healthy Cities in Action* (2000) shows that experiences in other cities also varied. In both Fayoum and Quetta, where the programme came to a standstill, NGO and CBO involvement was low. In Cox Bazar stakeholder involvement was high between both local government and the actors of civil society.

Intersectoral Co-operation

In the previous section attention was focused on the different local contexts within which civil society operates. Attention was also given to the consequence of this for the various Healthy Cities programmes. Another issue that requires discussion concerns inter-sectoral co-operation. In principle, the creation of healthy urban environments should be the central objective of urban planning. This implies that a Municipal Health Plan should be developed in co-ordination with a general City Plan and be part of it. In practice, it proved to be difficult to establish effective co-operation between the different sectors involved in city planning including transport, education and so.

By 1995 conditions which favoured inter-sectoral co-operation had improved in Dar es Salaam. Conditions were made favourable through the existence of other inter-sectoral programmes such as the innovative World Bank/UNDP/UNCHS Sustainable Dar es Salaam Project (SDP), the Hanna Nassif Squatter Area Project (an ILO/SDP funded project) and the Dar es Salaam UNDP-LIFE programme**.** Despite involvement from different sectors, the WHO's national office in Tanzania wanted to retain overall control. Without an inter-sectorally composed Local Task Force, it is likely that the Healthy Cities project co-ordinator would have been appointed by the WHO's national office and located within its own premises. Although by 1997, the question of inter-sectoral co-operation was still on the

agenda, potential allies were not able to reconcile their different interests. As a result, the integration of the Municipal Health Plan into an all-encompassing environmental plan for Dar es Salaam was never realised (Naerssen and Barten 1999).

In Brazil, only a very small number of cities advanced through phase 2 and 3 of the programme. Difficulties were encountered during phase one, as inter-sectoral co-operation proved difficult to establish in almost all the Healthy Cities projects. Although City Planning should have a central position in Healthy Cities initiatives, the health institutions often dominated the process as they considered themselves as the prime movers in implementing projects. In this respect, Mendes and Akerman (in chapter 6 of this publication) remark that intersectoral co-operation can change the power relations between municipal organisations, the State and the population. Programmes such as Healthy Cities can give power and status to those who initiate the process, usually representatives of the health sector. They cite the development of a Healthy Cities project in São Paulo as an example. Efforts to develop a project in the central region of the city led to the establishment of a 'Local Inter-sectoral Government'. This government was responsible for joint inter-sectoral action between several programs that were established by City Hall. These included projects which dealt with cholera, homelessness and the regeneration of downtown areas. By the end of the process, however, only the health sector (made up of Health Districts) retained an interest and devised a *Healthy Downtown* plan.

It is unfortunate that these vested interests constrain inter-sectoral co-operation. If the Municipal Health Plan is considered as part of the broader physical and environmental planning of the Municipality, the requirement for a *separate* Healthy Cities programme is questionable. Mathee et al. (in chapter 4 of this publication) demonstrate that the introduction of the Healthy Cities initiative in Johannesburg became integrated with other approaches to environmental management, development and health. These included the principles and approache established through Agenda 21 and the Model Communities Programme (MCP) of the International Council for Local Environmental Initiatives (ICLEI). An inter-departmental environmental management committee was formed in 1995 to co-ordinate the Agenda 21/Healthy City programme in Johannesburg and integrate it into the broader environmental management structure of the Council.

As a result, a new metropolitan committee of Planning, Urbanisation and Environmental Management was formed, to facilitate a more holistic and integrated approach to urban planning and the environment. The committee's role was to ensure that the principles

and approaches of Healthy Cities and Agenda 21 were fully integrated into broader urban development plans and incorporated into the overall urban management process. Mathee et al. (in chapter 4 of this publication) rightly suggest that, although the Healthy Cities programme in Johannesburg was short-lived, it established Healthy Cities concepts at the municipal level and health is now considered as an integral part of the planning of the city. The political context in Johannesburg also favoured the process. After *Apartheid* the city started with a 'clean slate' and vested interests were no longer so entrenched. Account should also be taken of the fact that health is often considered at local government level as merely the provision of health services. Healthy Cities have helped to raise awareness about the linkages between health and all its determinants by identifying it as a cross-cutting issue for urban development policy.

Two Streams of Thinking Healthy Cities

In their overview of Healthy Cities programmes in developing countries, Werna et al. (1998) pay attention to the scarcity of financial and other resources compared to cities in the North. Therefore, they argue, local stakeholders have limited capacity to assimilate projects. However, the previous sections show that Healthy Cities programmes not only have to cope with resource issues at the local level, but also at the institutional level. At this level access to finance and knowledge and the power relations between different stakeholders also presents a problem.

Two streams of thinking on Healthy Cities can now be distinguished. The first one focuses on co-operation between the local government and the health sector. In this view the level of community (civil society) involvement is identified as a low priority (Burton 1999; Werna et al. 1998 and 1999). The second stream focuses on the urban poor and attaches more value to the participation of civil society actors and the related question of ownership of the process. The involvement of communities in problem identification, priority setting, resource allocation and implementation and evaluation of activities is considered as central to the Healthy Cities philosophy. This view is put forward by Mendes and Akerman (in chapter 6 of this publication), Montiel and Barten (1999, 2002, chapter 7 and Naerssen and Barten (1999 and chapter 8) who, among others, build upon the earlier ideas of Alma Ata and Ottawa.

This does not mean that participatory approaches fall outside the first stream of thinking. However, in this scenario they are used as a tool that can facilitate programme

implementation.   Healthy Cities programmes were often introduced in developing countries following the implementation of SAP programmes, this led to a new urban management style. Healthy Cities had to fit into the framework of health reforms which included cuts in the health budget and the implementation of more cost efficient health interventions. Thus the notion of participation became accepted as a way to consult the 'target-groups' of the urban poor and to achieve greater efficiency. For this reason target groups are encouraged to be involved in the implementation and maintenance of projects.

Real participation, however, concerns the empowerment of deprived social groups and requires political processes which allow people to have access to decision-making structures and get involved. These are prerequisites for initiating participatory processes at community level. It would be politically naive to expect that this concept of participation could be directly applied to all cities. The national, regional and local policy contexts of cities vary and it would be unrealistic to expect the same kind of participation in Dar es Salaam, Fayoum or Managua. This model of participation at least provides a starting point from which to work towards empowerment of the poor and to help deliver processes that improve their health. One of the basic constraints of real participation is that it presupposes a strong civil society with a diversity of independent NGOs and CBOs. Where a strong civil society exists, Healthy Cities programmes should aim to support the creation and the strengthening of new health NGOs and community organisations.

Success in a Healthy Cities programme can be interpreted differently. The starting point for Healthy Cities is the principle that health is a basic and fundamental right of citizens. The ability of communities to demand this right and to participate in decision-making processes which improve working and living conditions is therefore an important criteria in the assessment of Healthy Cities programmes. This arguably utopian vision can be achievable where financial and technical resources are relatively scarce as it provides a focus and direction for cities to work towards. Although financial resources are scarce the process can help to strengthen participatory processes. In the end, only participatory processes led from the bottom up can lead to sustainable health plans and healthy urban settings.

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[i] **This chapter is based on our experiences as members of an advisory team to the Healthy Cities programme of the UNDP and**

the WHO between 1995 and 2000. The team was made of experts from -(originally) the London School of Hygiene and Tropical Medicine and the Nijmegen Urban Health Group (NUHG) of the Dutch Nijmegen University to which we belong. Secondary sources and other chapters in this book, which are referred to frequently, provide additional information.