

TOWARDS THE HEALTHY CITY : A REFLECTION ON PLANNING FOR HEALTH

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ABSTRACT. Health, in a sense, can be considered an intensely personal matter, strongly governed by behavioural choices and genetics. However, indicators show that at the level of the community or the city, marked disparities exist in morbidity and mortality throughout the world. Clearly, politics, economics and geography also have a bearing on health outcomes, and not just in environments that are obviously extremely hazardous. Health problems can in part be due to a failure to reconcile the impact of the layout and design of urban form with the needs of individuals and communities for space to achieve a healthy existence. This article seeks a greater understanding of how the planning, design and management of cities have a bearing on sustainable development and the health of their citizens. It seeks such an understanding through a consideration of the social and environmental determinants of health and the influence that urban policy has upon the quality or liveability of cities. Lessons are sought from development theory and the move towards more collaborative approaches to health, looking particularly at the WHO Healthy Cities Project, to identify challenges and recommendations for future policy.

Key words: health, wellbeing, sustainable development, urban planning, collaboration, WHO Healthy Cities Project.

ABSTRAK. Kesehatan dapat dikatakan sebagai masalah pribadi, yang biasanya merupakan akibat genetika ataupun pilihan kebiasaan. Namun, indikator-indikator memperlihatkan bahwa pada tingkat masyarakat atau kota tertentu, terdapat kesenjangan dalam morbiditas dan mortalitas di seluruh dunia. Jelasnya, politik, ekonomi dan geografi juga memiliki pengaruh pada luaran kesehatan, tidak hanya pada lingkungan tertentu yang sangat jelas berbahaya. Masalah kesehatan sebagian disebabkan karena adanya kegagalan dari akibat tata ruang dan disain dari "urban form" disesuaikan dengan kebutuhan individu dan komunitas akan ruang untuk mencapai kehidupan yang lebih sehat. Artikel ini bertujuan untuk mencari pemahaman yang lebih besar dari bagaimana perencanaan, disain dan pengelolaan sebuah kota yang memiliki pengaruh pada pembangunan berkelanjutan dan masyarakat yang sehat. Selain itu juga untuk mencari

pemahaman seperti melalui pertimbangan faktor penentu sosial dan lingkungan kesehatan dan pengaruh bahwa kebijakan perkotaan ditentukan oleh kualitas atau kelayakan sebuah kota. Pelajaran dicari dari teori pengembangan dan pergerakan menuju pendekatan yang lebih kolaboratif untuk kesehatan, terutama dengan melihat Proyek Kota Sehat dari WHO, untuk mengidentifikasi tantangan dan rekomendasi bagi kebijakan masa depan.

Kata kunci: kesehatan, pengembangan berkelanjutan, perencanaan kota, kolaborasi, Proyek Kota Sehat WHO

INTRODUCTION

Climate change is having a direct bearing upon access to fertile land, food and water and consequently their prices. Coupled with this, economies that have relied heavily on oil are facing a world where its extraction maybe reaching, or has reached, its peak. As renewed fears over prices serve as reminders of the interconnected nature of the global economy, questions of health equity and social justice continue to have a persistent, worldwide relevance. The urban poor and vulnerable face further difficulties to secure a healthy lifestyle and so the search for more sustainable practices is of paramount importance for the shoring up of resilience within communities (Stern, 2007; Chamberlin, 2009; Connor, 2010). Effective planning, design and implementation of suitable adaptation measures can work towards sustainability and the overcoming of health inequalities or, at the very least, help in avoiding the exacerbation of those problems (Marmot et al., 2010; Wilkinson and Pickett, 2010). The identification of the relationships between health and planning and the study of collaborative working practices for sustainable development are, therefore, considered essential for enhancing health resilience at the local level.

PERSPECTIVE ON HEALTH

Health depends upon the capacity for any individual, family or community to secure basic resources of food and water and a safe place to live, with health problems, traditionally, addressed as they arose, by a professional biomedical response. However, differing models of health began to challenge this view. Beyond basic needs, the part that social and emotional matters played in leading a rich and fulfilling life, began to be more fully acknowledged and so health became more often considered a more multifaceted concept.

Figure 1 illustrates one such attempt to encapsulate the broad spectrum of human experience. A socio-ecological perspective spawned the evolution of a 'New Public Health', within which Antonovsky coined the expression salutogenesis, to describe a perspective that has, as its starting point, the identification of the ingredients of a healthy life for an individual and the ability to cope (Hancock, 1993). Ashton and Seymour (1988) list the determinants of health of a person as: i) genetic endowment, ii) environment, iii) nutrition, iv) occupation and v) lifestyle. Using the analogy of life being like a river, looking further 'upstream' was seen by them as necessary; an understanding of the causes of ill-health, rather than solely dealing with symptoms. An ecological model of health that more holistically acknowledges the multifaceted nature of the determinants of health is illustrated in Figure 2.

In 1946, the World Health Organisation defined a positive model of health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (Barry and Yuill, 2008). The acknowledgement of socio-economic and environmental determinants, however, presents challenges for health research, policy and implementation. People exercise a degree of choice in their behaviours, are genetically different, and have differing ideas of what actually constitutes a good quality of life. Despite this, quality of life perspectives are increasingly recognised at the governmental level; the development of indicators for happiness being an example in Bhutan (Linley et al., 2009; Centre for Bhutan Studies, 2011). Mental wellbeing and a sense of happiness are elusive qualities to quantify. Certain behavioural choices are obviously more risky, however, health is clearly related to mental and emotional factors that are unique to the individual concerned. Linley et al. (2009) usefully categorised well-being into two distinct factors: firstly, subjective well-being based on perceptions of satisfaction with one's life; and secondly, psychological well-being, conceptualised as having six components, namely, a) positive relations with others, b) autonomy, c) environmental mastery, d) self-acceptance, e) purpose in life and f) personal growth. Preparedness and successful negotiation of the opportunities and challenges of everyday life is key. For Dubos, 'Health is the expression of the extent to which the individual and social body maintain in readiness the resources required to meet the exigencies of the future' (Kelly, M.P., Davies, J.K. and Charlton, B.G., 1993).

Greater identification of the linkages between environmental policies and health, then, can aid the quest for sustainability and facilitate psychological benefits through environmental mastery. Not only mental health is at stake, however; certain urban environments can induce obesity through the need for a car to travel to work and/or take children to school,

for example, or because of a lack of convenient access to fresh foods and open space. Socio-economic and environmental determinants, then, can be considered to have a significant impact on both physical and psychological well-being and, whilst there is obviously a great deal of choice in lifestyle that can have a subsequent impact on health outcomes, a focus on individual responsibility can be overplayed.

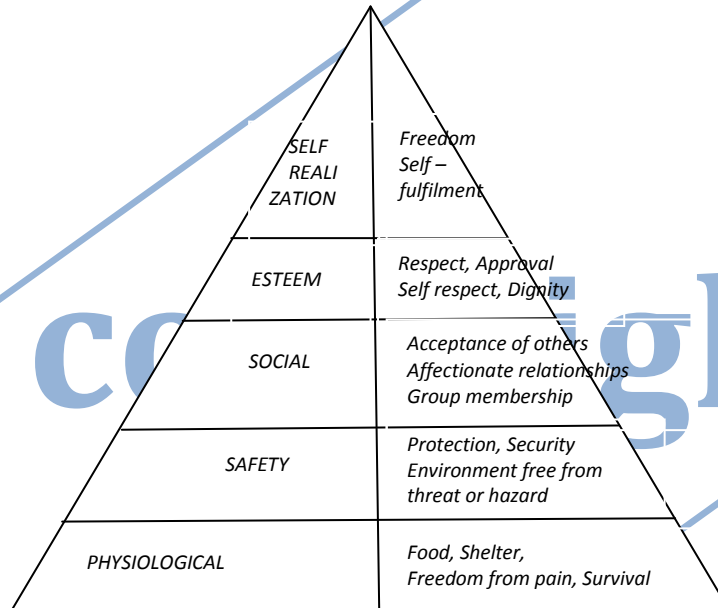


Figure 1. Maslow's hierarchy of needs
Source: Ashton, J. and Seymour, H. (1988)

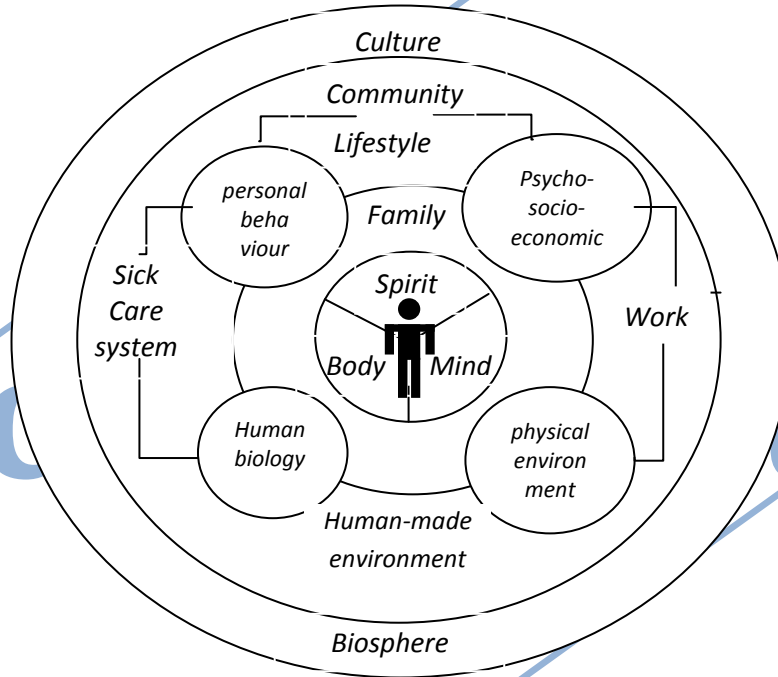


Figure 2. The mandala of health: a model of the human ecosystem
Source: Hancock, 1993

DETERMINANTS OF HEALTH

As well as the genetics of any individual and their access to health services, health determinants can include the physical environment, income and social status, education, gender and social support networks (WHO, 2011a). There are many broad fields of study

from development theory and management theory through to sociology and psychology that can inform a better understanding of the determinants of health, and the degree of human control over them (Barry and Yuill, 2008). Usefully, Kamp et al. (2003) posit the following questions for planners: What is environmental quality?; What is the effect of my (planning and designing) measures/ interventions on the environmental quality and well-being?; Which factors determine environmental quality?; How big is the effect?; Are the factors of equal importance to everyone? These questions raise issues that are both physical and social. Civic leaders, then, need to consider matters that are both scientific, such as engineering, biochemistry and medical science, and artistic, such as persuasion for the political acceptance of shared environmental and health and safety conscious goals and the associated management (see Table 1). A 'critical holism' that attempts an appreciation of the wide variety of influences on human experience seems preferable to a reductionist approach (Dooris, 2005; Pieterse, 2010). Figure 3 shows the interrelationships of a conceptualised sustainable city.

Table 1. Five broad categories of environmental action for assessing the performance of cities (based on Satterthwaite, D., 1999)

- A. Controlling infections and parasitic diseases and the health burden they take on city populations, including reducing city populations' vulnerability to them.
- B. Reducing chemical and physical hazards within the home, workplace and wider society.
- C. Achieving a high quality city environment for all city inhabitants – e.g. open space, and provision for sport and culture.
- D. Minimising the transfer of environmental costs to the inhabitants and ecosystems surrounding the city.
- E. Ensuring progress towards what is referred to its 'sustainable consumption', - i.e. ensuring that the goods and services required to meet everyone's consumption needs are delivered without undermining the environmental capital of nations, the world of future generations.

Obesity, asthma and mental illness are new epidemics facing society. As well as obvious dangers from pollutants or cold and damp, research has shown that access to open space and greenery, can not only afford opportunities for fresher air and exercise; the very sight of it can also enhance a sense of mental wellbeing (Freeman, 1998; Jackson, 2003). The question of equitable access to healthy environments is far from a straightforward one,

however. It has been shown for Glasgow, for example, that deprivation is more differentiated, and access to resources, physically and psychologically, can be also be dependent upon i) the quality of the resource; ii) whether the resource is actually health promoting; iii) whether a resource in a residential neighbourhood would be used; iv) whether there may be symbolic barriers to use; and v) the scale and measure of evaluation of deprivation (Macintyre, MacDonald and Ellaway, 2008). Such insights are clearly relevant to places that have had, or are experiencing, conflict, with the new Peace Bridge in Derry showing how architecture can facilitate community interaction (BBC, 2011).

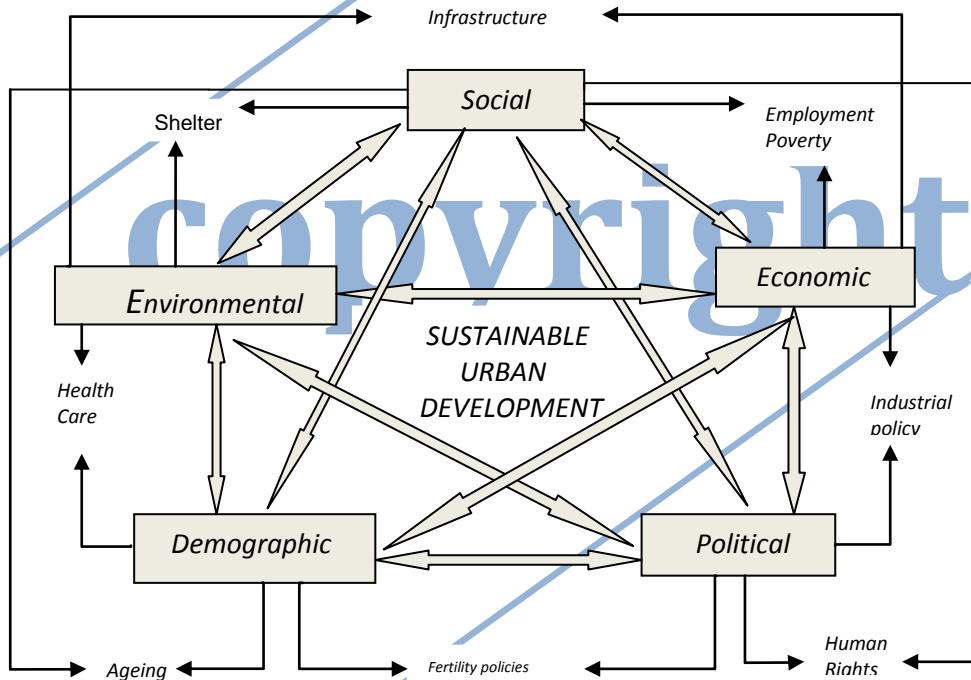


Figure 3. Sustainable urbanisation: main components and indicative issues
Source: Adapted from Drakakis-Smith in Pelling (2003)

MODERN CHALLENGES FOR PLANNING FOR HEALTH

Given that health is such a multi-faceted concept with a wide variety of determinants, a marked improvement in health and health equity is more likely to be effected through a variety of interventions. Dooris (2009) highlighted the tackling of health inequalities through promoting inclusion, and a synergy with other policies and an approach to modern day issues that has an appreciation of complex systems. Kjellstrom and Mercado (2008) presented a broad range of possible interventions for health equity and consider that urban planning can play a key role (see Table 2).

Table 2. Broad Spectrum of potential interventions for health equity
(Source: Kjellstrom and Mercado, 2008)

1. Build social cohesion and trust at all levels
2. Improve the living environment
3. Support healthy housing, neighbourhoods and other local settings
4. Invest in clean air
5. Promote easy access to higher quality food
6. Create safe and healthy workplaces
7. Adopt comprehensive strategies to reduce urban violence and substance abuse
8. Develop more equitable urban health systems
9. Use innovative financing schemes, e.g. cash transfers
10. Hold urban planners accountable for health
11. Address urban sprawl

Planning in both developed and developing economies continues to play a significant role in whether the layout of cities lends itself to healthy environments for all citizens, and in attempting to mitigate and adapt to the threats of climate change. The accommodation of increasing car ownership has, in a sense, sown the seeds of a new public health crisis; not only through creating places that contribute to stress, or obesity (obesogenic

environments), but also through continued damage to the biosphere and global environment through economic expansion. Within planning theory, the ills of the modern city are not necessarily perceived as being due to a slow or inadequate response to socio-economic conditions. As Cherry (1982) points out, if state planning is geared towards achieving state objectives, from a Marxist perspective these objectives can be seen as being geared towards the interest of the dominant class. In a post-WWII neo-liberal economy, planning can be seen as having reflected these interests through the facilitation of the development of space to aid in the accumulation of capital. As such, this can have a differential impact on certain sectors of society, through the creation of an inequitable distribution of unhealthy environments, with the working class and poor bearing the brunt of risk of ill-health through increased commuting times, dangerous roads and isolated, segregated suburban environments, for example. So, for some authors, the planning system can be perceived as having had, as a priority, the facilitation of the demands of capital and, in affecting the land development process, does not overcome the inherent contradiction between private accumulation and collective action (Hall, 2002). The urban planning of cities, therefore, has a strong bearing on the health and wellbeing of its inhabitants through determining the levels of access to resources, be that access to work, ease of movement and transport options, or access to open space, for example. Many factors such as these can have a bearing on the lifestyle and life expectancy of any given individual. An understanding of the relationships between health and environmental circumstances, then, remains of vital importance in both developed and developing economies. Planners need to accept more responsibility for their part in creating unhealthy environments rather than over-reliance on the treatment of illness by health services operated to a biomedical model (Morgan, 2010).

An apparent, renewed convergence exists between public health and planning, with the encouraging of the public away from the use of cars to increased walking and cycling, for example. The concerns of planners to avoid congestion, pollution and crashes and, more recently, to mitigate against climate change, coincide with the concerns of public health to overcome illness associated with lack of activity (Hoehner et al., 2003). Computer networks pose both opportunities and threats; as an aid in the dissemination of health advice and reduction of the need to travel, whilst possibly leading to sedentary and isolated lifestyles (Mitchell, 2000). Circumstances are ripe for the transition of the working practices of public health and planning professionals into more formal collaborative relationships geared towards more synergistic, multi-level interventions.

THE POWER TO SHAPE THE CITY

Urban planning has, seemingly, adopted more communicative and collaborative approaches, in recent decades, as opposed to 'top-down', prescriptive ones (Dale, 2004). A clearer appreciation of the political space that may genuinely be available for individuals and communities for the creation of healthier environments can be gained through an understanding of concepts from the sociology of development, and this can help underpin more informed urban policy.

Agency, capabilities and social capital

The capacity for anyone to meet their needs depends on the state of the wider economy and the societal will to cooperate in the adequate distribution of resources. Amartya Sen has usefully encapsulated this by distinguishing between processes in society and opportunities for the individual, and gives the term 'unfreedom' to an inadequacy in either. For poor people, restricted circumstances lead to a restricted life (Sen, 1999; Yunus, 2010). Externally established conditions, be they physical, economic or political, are described within sociology as structure, and the capacity of an individual to control their circumstances to lead to a particular health outcome, is seen as agency (Barry and Yuill, 2008). This interplay between the dictates of circumstances and the will, ability and opportunity to change circumstances lies at the core of what determines a healthy life.

The distribution of the resources that enable a healthy life is obviously, contentious and at the macro-economic level, within the current neoliberal economy of much of the world, the structure provides riches for some, that enable a healthy prosperous life. However, such wealth can be at the expense of others; a trend that geographer David Harvey has termed accumulation by dispossession (Harvey, 2005). The agency of any individual to make healthy choices can be strongly influenced by that structure through the degree of access to jobs and/or financial credit, education, a healthy environment and good quality housing, for example. Recent financial crises for neo-liberal western economies have exacerbated difficulties, with austerity measures hitting the poorest the hardest (Elliott and Dodd, 2010). Such economic pressure can, of course, impact upon the capacity to maintain healthy lifestyles, thereby increasing the importance of enhancing resilience amongst individuals and communities. The capabilities of an individual to develop resilience against environmental threats are dependent upon physical, emotional and psychological qualities. The capabilities approach was outlined by Sen in his influential book *Development as*

Freedom in 1999 and further work on the approach has been undertaken by Nussbaum, summarised in Table 3 (McGillivray, 2008). For a person to more fully and successfully engage with processes that shape the quality of their social, political and physical environment, it is clear that the more capabilities they have as individuals the more enhanced are the chances of leading a healthy life.

Table 3. Nussbaum's central human functional capabilities
(source: McGillivray, 2008)

Life: being able to live to the end of a human life of normal length; not dying prematurely, or before one's life is so reduced as to be not worth living

Bodily health: being able to have good health, including reproductive health; to be adequately nourished; to have adequate shelter

Bodily integrity: being able to move freely from place to place; having one's bodily boundaries treated as sovereign as such being able to secure against assault, including sexual assault, child sexual abuse, and domestic violence; having opportunities for sexual satisfaction and for choice in matters of reproduction

Senses, imagination, thought: being able to use the senses, to imagine, think and reason – and to do these things in a 'truly human' way, a way informed and cultivated by an adequate education, including, but by no means limited to, literacy and basic mathematical and scientific training

Emotions: being able to have attachments to things and persons outside ourselves; to love those who love and care for us, to grieve at their absence; in general, to love, to grieve, to experience longing, gratitude, and justified anger

Practical reason: being able to form a conception of the good and to engage in critical reflection about the planning of one's own life

Affiliation: being able to live for and towards others, to recognise and show concern for other human beings, to engage in various forms of social interaction; to be able to imagine the situation of another and to have compassion for that situation; to have the capability for both justice and friendship; having the social bases of self-respect and non-humiliation; being able to be treated as a dignified being whose worth is equal to that of others (this entails, at a minimum, protections against discrimination on the basis of race, sex, religion, caste, ethnicity, or national origin)

Other Species: being able to live with concern for and in relation to animals, plants and the world of nature

Play: being able to laugh, to play, to enjoy recreational activities

Control over one's environment: being able to participate effectively in political choices that govern one's life; having the right of political participation, protection of free speech and association; being able to hold property (both land and movable goods), not just formally but in terms of real opportunity; and having property rights on an equal basis with others; having the right to seek employment on an equal basis with others; having the freedom from unwarranted search and seizure.

A key concept in considering the worth of urban policy is the degree to which social capital is improved for local communities. Social capital is a contested term, from institutional attempts to involve the population to more 'organic' forms of community organisation (see Table 4).

Table 4. Definitions of social capital (source: Bridge et al., 2009)

1. features of social life – networks, norms and trust – that enable participants to act together more effectively to pursue shared objectives...Social capital, in short, refers to social connections and the attendant norms and trust.
2. Social capital is seen as the foundation on which social stability and a community's ability to help itself are built; and its absence is thought to be a key factor in neighbourhood decline.
3. the institutions, relationships and norms that shape the quality and quantity of a society's social interactions.
4. networks together with shared norms, values and understandings that facilitate co-operation within or among groups.
5. The term 'social capital' is increasingly used by policy makers as another way of describing 'community', but it is important to recognise that a traditional community is just one of many forms of social capital. Work-based networks, diffuse friendships and shared or mutually acknowledged social values can all be seen as forms of social capital.

The Department for International Development considers there to be five types of capital for achieving 'sustainable livelihoods': social, human, natural, physical and financial (Bridge et al., 2009). Urban policy can be viewed in terms of the degree to which the various types of capital of the disadvantaged are actually served or enhanced.

Collaborative approaches to shaping the environment

For any individual, the capacity and knowledge to shape their environment in order to enhance their health is partly mediated through the degree to which involvement in decision making is welcomed. Also, the move towards collaborative and participatory working practices for urban policy can be considered in terms of whether stakeholders have a genuine impact upon social capital in a way that is beneficial to the poor. The degree to which public involvement in public services is welcomed and facilitated stems partly from developments from the conflict of ideas between the capitalist United States and the state socialism of the Soviet Union. Over the last twenty years, neo-liberal policies have become under renewed attack as there have become growing disparities between rich and poor both across the globe. Recently, an increase in partnership working and policies geared towards social inclusion and collaboration have been posited as a more socially responsible form of providing public services that brought about change in the relationships between the market, state and civil society (Howell and Pearce, 2001).

Greater public involvement in the overall context of a neo-liberal economy, through the use of voluntary labour and the creation of a perceived 'sense of ownership' of the processes that effect civic life, could be seen as a way of staving off more radical challenges to the overall structure. Government policies can be seen as tokenistic if the public are merely informed of a proposed development rather than involved in its design or conception (Arnstein, 1969). Also, the choices of who gets involved in a collaborative programme or project can be unrepresentative and it has been argued that the actual forms of discourse used in collaborative projects can further the maintenance of unequal power relations, if certain sectors of the community are uncomfortable with particular formalities or styles of communication (Fairclough, 2001; Stern and Green, 2008). Collaboration can be considered along the lines of whether it is a betterment administered by outside agencies or empowerment through a degree of community self-determination (Sullivan and Skelcher, 2002). The degree to which collaborative approaches and participatory approaches are a valid use of the agency of the poor, who bear the brunt of the manifest unhealthy environments, is a salient question to consider.

TOWARDS THE HEALTHY CITY

The Healthy Cities project of the World Health Organisation (WHO) has become widely accepted for health promotion and is an opportunity for collaborative empowerment. As

such, a closer look is considered helpful for an appreciation of the challenges faced in working collaboratively to address health and sustainable development challenges (Norris and Pittman, 2000). As the prevailing paradigm of a biomedical and 'victim-blaming' approach to health education came under mounting criticism, the promotion of healthy lifestyles and community participation was accepted, in theory at least, with the WHO Alma-Ata Conference and Declaration on Primary Health Care of 1978 (Davies and Kelly, 1993). Thus began a push towards 'Health for All by 2000', culminating in the Ottawa Charter for Health Promotion and the formal launching of the WHO Healthy Cities project in 1986 which encouraged more effective community involvement. The Healthy Cities project has since become a global network for health promotion at the city level (Kenzer, 1999).

The European arm of the Healthy Cities Network has grown from an initial thirty five cities, for the first phase between 1987-1992, to currently over ninety. Through a series of phases, the WHO has guided networks of the civic leaders of cities in the adoption of policies, multisectorally, that aim to improve health and wellbeing of their populations, through a collaborative approach to health promotion. To join the network, a city's civic leaders prepare a city health profile and a city health development plan to address core priorities, that are renewed every five years. By 1991, participating cities had to have a steering committee of political, business and civil society representatives and a technical committee. The Phases that have been established to date can be seen in Table 5. Hancock (1993) noted that there are three salient features of the Healthy Cities project, namely: that health is considered a positive quality; that an ecological model, that considers the many factors that determine health, is considered preferable; and that a focus is taken on addressing inequalities in health. The current aims stated by WHO for a Healthy City can be seen in Table 6. The Healthy Cities project aims have current political backing through the commitment of civic leaders of European cities to the Zagreb Declaration in 2008. The Declaration outlines the core principles for a consideration of health in all local policies, namely: equity; participation and empowerment; working in partnership; solidarity and friendship; and sustainable development. Further to this, the Declaration outlines new concerns and challenges. These are summarised as i) achieving a reduction in inequality, social exclusion and vulnerability, b) reducing the social and economic costs of noncommunicable and chronic diseases, c) tackling emerging public health threats including climate change, d) achieving a greater understanding of the impacts on health of the built environment to help ensure a stronger link between policies for health and sustainable development.

Table 5. Phases and overall goals of the WHO Healthy Cities project
(source WHO, 2011b)

Phase I (1987-1992)

Goal to introduce new ways of working for health in cities

Phase II (1993-1997)

Emphasis on action through healthy public policy and comprehensive city health planning

Phase III (1998-2002)

Core themes of equity, sustainable development and social development, with a focus on integrated planning for health development

Phase IV (2003-2008)

Emphasis on equity, sustainable development, participatory and democratic governance and tackling the determinants of health. Also a commitment to working on healthy ageing, healthy urban planning, health impact assessment and physical activity and active living

Phase V (2009-2013)

Priority given to health and health equity in all local policies. Core themes are: caring and supportive environments, healthy living, healthy urban design. Phase V is supported by the Zagreb Declaration for Healthy Cities

Challenges for management

The Healthy Cities project is essentially a practical movement to enhance public health, and ultimately to embed a perspective towards health in the wider context of everyday living (Werna et al., 1999). The aims for a healthy city are listed in Table 6. In reflecting upon the experience of the management of the Healthy Cities project, points gleaned from the academic literature are summarised below in terms of issues concerned with i) implementation, ii) research and iii) evaluation.

(i) Implementation

In terms of implementation, Tsourus and Draper (1993) note that a successful healthy cities project depends upon the size of the city and its economy, strategic thinking for improving the involvement of the public, political commitment and accountability and the establishment of multi- sectoral committees. However, there can be a number of barriers and constraints to cooperative and effective new ways of working.

Table 6. Aims for a Healthy City (Source: WHO, 2010c)

1. a clean, safe, physical environment of high quality (including housing quality);
2. an ecosystem that is stable now and sustainable in the long term
3. a strong mutually supportive and non-exploitative community;
4. a high degree of participation in and control by the citizens over the decisions affecting their lives, health and well-being;
5. the meeting of basic needs (food, water, shelter, income, safety and work) for all the city's people;
6. access by the people to a wide variety of experiences and resources with the chance for a wide variety of contact, interaction and communication;
7. a diverse, vital and innovative economy;
8. connectedness with the past with the cultural and biological heritage of city dwellers and with other groups and individuals;
9. a form that is compatible with an enhances the preceding characteristics;
10. an optimum level of appropriate public health and sickness care services, accessible to all;
11. high health status (high levels of positive health and low levels of disease).

Traditional health authorities and local government bureaucracies can resist change to their modus operandi and there can be a failure to find a common 'language' between health services and social services to discuss and evaluate priorities. Berkeley and Springett, (2006) coin the expression 'bureaucratic introversion' to illustrate the difficulties in developing new ways of working for health. It would seem from the literature that questions of successful implementation are of paramount importance, despite over two decades of experience of the Healthy Cities project (de Leeuw, 2009). There can be a diversity of approaches to implementing a healthy cities project, and there can be a variety of approaches within the same country (Flynn, 1993). However, Werna and Harpham (1996) have a checklist of nine general issues that came to light through a study of the implementation of Healthy Cities project in developing countries, these can be found in Table 7.

(ii) Research

Suggested directions for research include reviews of the literature to improve understanding of the debate over environmental justice and quality, a greater appreciation of people's perceptions of the determinants of quality of life, and the development of a 'toolbox' to aid decision-making (Kamp et al, 2003). Tsouros and Draper (1993) have pointed to six areas for which further research is needed: a) to aid in understanding the consequences of disadvantage for greater equity; b) for studies of health down to the city and neighbourhood level as a precondition of political advocacy and action and associated documentation to illustrate the prerequisites of health; c) for the development of new concepts and methodologies for investigation of the impact of urban policy on health; d) to progress organisational theory for improved intersectoral action; e) to improve community participation; f) to improve strategic planning that combines a clear sense of direction with flexibility to changing circumstances.

Table 7. A Checklist for the implementation of Healthy Cities project in developing countries
(source: Werna, E. and Harpham, T., 1996)

- (i) the appropriateness of the institutional organisation of the local authorities;
- (ii) conceptual understanding about the project among the existing institutions (and the project's members);
- (iii) existence of legislation that would make the activities of the project officially legitimate;
- (iv) existence of a public authority with enough power to co-ordinate the process of urban development;
- (v) co-operation between different layers of government;
- (vi) co-ordination/co-operation between the ministries which have agencies operating in the city;
- (vii) the project's office capacity to stimulate and build co-operation and to co-ordinate ongoing activities;
- (viii) the implementation of internationally funded projects in co-ordination with existing activities;
- (ix) the degree of community organisation.

Some commentators note the political nature of research, with Hunt (1993) pointing out that the underprivileged have rarely had the opportunity to influence the topic of the research, and conservative minded and career oriented researchers can also play their part in maintaining health discrepancies through using the study of the poorer sectors of society to further their own careers, and not effectively disseminating the results. Whitehead (1993) also argues that the choice of topics for consideration, the choice of methods of research that are used, and issues over dissemination of results are politically salient considerations. She points out that need for Healthy Cities projects to complement 'professional' insights with participatory research for a more genuine sense of community ownership of the agenda, and for more effective dissemination of the findings of the health research in a broad and timely fashion. Promising signs of innovative approaches to community health research began to immerge in Australia and Scotland in the 1990s (Baum, 1993; McGhee and McEwen, 1993). However, an appreciation of who has control of the nature of the discourse of community initiatives remains a sobering counter to unbridled enthusiasm for their apparent equitable aspirations (Petersen, 1996). Also, for many, social capital is informal in nature, be it the lending of tools, shopping for ill or elderly, baby sitting or even friendly conversations. Faith-based support can also be important (Larsen and Manderson, 1996).

(iii) Evaluation

The complexity of interrelationships between social and environmental determinants presents difficulty for evaluation, with the benefits of health related policy maybe only becoming apparent over the long term (see table 8).

Table 8. Difficulties for evaluation of community based strategies, such as Healthy Cities

(source: Smithies, J. And Adams, L., 1993)

- (i) various actors and interests sometimes opposing each other may be involved
- (ii) the work is developmental and outcomes are unpredictable
- (iii) change takes place constantly
- (iv) process is integral and needs evaluation as much as any outcomes
- (v) evaluation methods should mirror the principles of the approach itself

Takano and Nakamura (2001), in their analysis of Healthy Cities projects, used nine health determinant indices, namely: healthcare resources, preventive health activities, environmental quality, housing, urban clutter, local economy, employment, income and education. Given the more holistic nature of the Healthy Cities approach, further work is required to develop methods of evaluating its success or otherwise, in any particular city, so that lessons can be shared and mistakes avoided (De Leeuw and Skovgaard, 2005). Hancock (1993) pointed out that given the intersectoral working required in a city that adopts the goals of the Healthy Cities project, there is a lack of agreement on the measures to be used to evaluate the success. He considered that each city may have to develop its own set of indicators that are salutogenically oriented. Werna and Harpham (1995) note the benefits of local indicators that can bring out local peculiarities, and international indicators that aid comparison and can be of use in settings where the community may not be prepared for involvement. They also consider that the nature of Healthy Cities projects is such that process indicators for evaluation have increased relevance compared to impact evaluations, however, both can be used together to create a greater understanding of the effectiveness of a project.

The shift from an analysis of illness to one of health and coping with stress requires sophisticated methods for evaluation. Also, changes to policy, through the facilitation of community based initiatives, presents unique difficulties for evaluation as for any individual, there can be differing perceptions of what actually constitutes a successful policy (Kline, 2000). Smithies and Adams have pointed out a number of issues that are faced in the evaluation of community based research and these can be seen in Table 8. Inventive approaches to research began to emerge in the 1990s (Baum, 1993; O'Neill, 1993; McGhee and McEwen, 1993). However, as Kenzer (1999) points out in her useful literature review, there are no set blueprint for evaluation. It has been suggested that the aforementioned issues could be addressed by what are termed 'fourth generation evaluation' and 'theory-based evaluation methods' (Curtice, 1993; Kline, 2000; Gahin, Veleva and Hart, 2003; Dooris, 2005). Clearly, there is scope for improvement in evaluation of health promotion policy to more fully acknowledge stakeholder participation and the processes, definitions and assumptions involved.

CONCLUSION

This article has explored issues surrounding health and sustainable development. Cities throughout the world face huge challenges to secure water supply, adequate sanitation and housing in safe locations (Kjellstrom and Mercado, 2008). Health inequalities exist on a large scale in both developed and developing countries; however, with the political will, they can be overcome (Marmot et al., 2010). Upon reflection, the Healthy Cities project represents an opportunity to find common solutions to complex problems, especially if a focus is shifted, in a new form of praxis, from the study of vulnerability to the study of healthy resilience and how people adapt and thrive (Dooris, 2009; Harpham, 2009). There are however many difficulties to overcome for a more effective linking of the implementation, research and evaluation of health promotion initiatives to provide greater accountability of the researchers and, ultimately to achieve better health outcomes (Kenzer, 1999). With amendments to multi-sectoral and participatory practice, further research into health determinants, and further developments in community based health evaluation, the WHO Healthy Cities project provides a suitable vehicle for a more holistic type of planning (Ashton, 2009).

REFERENCES

- Arnstein, S.R. (1969). ***A Ladder of Citizen Participation***. *Journal of the American Planning Association*. 35:4, 216-224
- Ashton, J.R. (2009). ***From Healthy Towns 1843 to Healthy Cities 2008***. *Public Health* 123 (2009).
- Ashton, J. and Seymour, H. (1988). ***The New Public Health: The Liverpool Experience***. Buckingham: Oxford University Press.
- Ashworth, W. (1954). ***The Genesis of Modern British Town Planning***. London: Routledge & Kegan.
- Paul Barry, A-M. and Yuill, C. (2008). ***Understanding the Sociology of Health: An Introduction***. 2nd edn, London: Sage.
- Baum, F. (1993). ***Noarlunga Healthy Cities Pilot Project: the contribution of research and evaluation*** in Davies, J.K. and Kelly, M.P. (eds) *Healthy Cities: Research & Practice*, London: Routledge.
- BBC. (2011). ***Derry's new 'peace bridge'*** officially opens on Saturday <http://www.bbc.co.uk/news/uk-northern-ireland-foyle-west-13914708> accessed on 11 December 2011

- Berkeley, D., Springett, J. (2006). **From rhetoric to reality: Barriers faced by Health for All Initiatives.** *Social Science & Medicine*. 63. 2006. 179-188.
- Bridge, S., Murtagh, B. And O'Neill, K. (2009). **Understanding the Social Economy and the Third Sector.** Basingstoke: Palgrave Macmillan.
- Cherry, G. (1982). **The Politics Of Town Planning.** London: Longman.
- Curtice, L. (1993). **Strategies and values: research and the WHO Healthy Cities project in Europe** in Davies, J.K. and Kelly, M.P. (eds) *Healthy Cities: Research & Practice*. London: Routledge.
- Dale, R. (2004). **Development Planning: Concepts and tools for planners, managers and facilitators.** London: Zed Books.
- Davies, J.K. and Kelly, M.P. (1993). **Healthy Cities: research and practice** in Davies, J.K. and Kelly, M.P. (eds) *Healthy Cities: Research & Practice*. London: Routledge.
- de Leeuw, E. And Skovgaard, t. (2005). **Utility-driven evidence for healthy cities: Problems with evidence generation and application.** *Social Science & Medicine* 61 (2005). 1331-1341.
- de Leeuw, E. (2009). **Evidence for Healthy Cities: reflections on practice, method and theory.** *Health Promotion International*. Vol.24. No. S1
- Dooris, M. (2005). **Healthy settings: challenges to generating evidence of effectiveness.** *Health Promotion International*. Vol.21. No.1
- Dooris, M. (2009). **Holistic and sustainable health improvement: the contribution of the settings-based approach to health promotion.** *Perspectives in Public Health* 2009. 129:29.
- Flynn, B.C. (1993). **Healthy Cities within the American context** in Davies, J.K. and Kelly, M.P. (eds) *Healthy Cities: Research & Practice*. London: Routledge.
- Freeman, H. (1998). **'Mental Health and the urban environment'** in Cartledge, B. (ed) *Mind Brain and the Environment*. Oxford: Oxford University Press.
- Gahin, R., Veleva, V. And Hart, M. (2003). **'Do indicators help create sustainable communities?'** *Local Environment*. 8:6. 661-666.
- Hancock, T. (1993). **The Healthy City from concept to application: implications for research** in Davies, J.K. and Kelly, M.P. (eds) *Healthy Cities: Research & Practice*. London: Routledge.
- Hoehner, C.M., Brennan, L.K., Brownson, R.C., Handy, S.L., Killingsworth, R. (2003). **Opportunities for Integrating Public Health and Urban Planning Approaches to Promote Active Community Environments.** *American Journal of Health Promotion*. September/October 2003. Vol.18. No.1. 14-20
- Jackson, L.E. (2003). **The relationship of urban design to human health and condition.** *Landscape and Urban Planning*. 64 (2003). 191-200.

- Kamp, I. Leidelmeijer, K., Marsman, G., de Hollander, A. (2003). **Urban Environmental quality and human well-being. Towards a conceptual framework and demarcation of concepts; a literature study.** Landscape and Urban Planning. 65. 2003. 5-18.
- Kelly, M.P., Davies, J.K. and Charlton, B.G. (1993). **Healthy Cities: A modern problem or a post-modern solution** in Davies, J.K. and Kelly, M.P. (eds) *Healthy Cities: Research & Practice*. London: Routledge.
- Kenzer, M. (1999). **Healthy Cities: a guide for the literature.** *Environment and Urbanization*. Vol.11, No.1. April 1999.
- Kjellstrom, T. And Mercado, S. (2008). **Towards action on social determinants for health equity in urban settings.** *Environment and Urbanization* 2008. 20:551
- Kline, E. (2000). **Planning and Creating Eco-cities: indicators as a tool for shaping development and measuring progress.** *Local Environment*. Vol. 5. No.3. 343-350. 2000.
- McGhee, S. And McEwen, J. (1993). **Evaluating the Healthy Cities Project in Drumchapel, Glasgow** in Davies, J.K. and Kelly, M.P. (eds) *Healthy Cities: Research & Practice*. London: Routledge.
- Norris, T. And Pittman, M. (2000). **The Healthy Communities Movement and the Coalition for Healthier Cities and Communities.** *Public Health Reports* (1974). Vol. 115. No. 2/3. Focus on Healthy Communities (Mar-Jun. 2000). pp118-124.
- Petersen, A. (1996). **The 'healthy' city, expertise, and the regulation of space.** *Health & Place*. Vol.2. No.3. pp157-165.1996.
- Smithies, J. and Adams, L. (1993). **Walking the tightrope: issues in evaluation and community participation for Health for All** in Davies, J.K. and Kelly, M.P. (eds) *Healthy Cities: Research & Practice*. London: Routledge.
- Stern, R. and Green, J. (2008). **'A seat at the table? A study of community participation in two Healthy Cities Projects'.** *Critical Public Health*. 18:3. 391-403.
- Takano, T. And Nakamura, K. (2001). **An analysis of health levels and various indicators of urban environments for Healthy Cities projects.** *Journal of Epidemiology and Community Health*. 2001. 55. 263-270.
- Tsouros, A. and Draper, R.A. (1993). **The Healthy Cities project: new developments and research needs** in Davies, J.K. and Kelly, M.P. (eds) *Healthy Cities: Research & Practice*. London: Routledge.
- Werna, E. And Harpham, T. (1995). **The Evaluation of Healthy City Projects in Developing Countries.** *Habitat International*. Vol.19. No.4. pp629-641. 1995

- Werna, E. And Harpham, T. (1996). **The implementation of the Healthy Cities Project in Developing Countries.** *Habitat International*. Vol.20. No.2. pp221-228.
- Werna, E., Harpham, T., Blue, I. And Goldstein, G. (1999). **From Healthy City projects to healthy cities.** *Environment and Urbanization*. Vol.11. No.1. April 1999.
- Whitehead, M. (1993). **The ownership of research** in Davies, J.K. and Kelly, M.P. (eds) *Healthy Cities: Research & Practice*. London: Routledge.
- Wilkinson, R. and Pickett, K. (2010). **The Spirit Level: Why Equality is Better for Everyone.** London: Penguin.
- Yunus, M. (2010). **Building Social Business: The New Kind of Capitalism that Serves Humanity's Most Pressing Needs.** New York: Public Affairs.

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