

Urbanization dynamics and WHO's "healthy city" initiatives in the South-East Asia Region

Surinder Aggarwal* and Abdul Sattar Yoosuf**

Abstract

It is an accepted fact that the fast and skewed urbanization process that is presently taking place in the WHO South-East Asia (SEA) Region is becoming a powerful agent of change and is accompanied with economic opportunities, environmental threats and health challenges. The present paper examines primarily the process of urban dynamics and its health challenges in the SEA Region and how the "healthy city" initiatives have responded to this urban challenge to sustain and promote health in various urban settings and vulnerable communities. We present in brief a review of the "healthy cities" programme in countries of the SEA Region and the constraints in engaging the healthy settings process. Finally, we present a critical analysis of the "healthy city" programme in countries of the SEA Region including (i) strengths and limitations of healthy cities projects in South-East Asia; (ii) lessons learnt, (iii) the way forward; and (iv) the future of the healthy settings movement in a fast urbanizing Region.

Context

For the first time, half the world population now lives in urban areas. By 2030, this is expected to swell to almost five billion.¹ Furthermore, a large share of new urban growth shall be borne by developing countries like China and India and by emerging mega cities like Bangkok (Thailand), Chittagong (Bangladesh), Hyderabad (India) and Yog Jakarta (Indonesia). Ecological imbalance and environmental degradation caused by abuse and overuse of environmental services pose new threats to human health in urbanizing economies.² Mega cities are at an even greater risk of disasters through this global urbanization process.³ Meanwhile, globalization accompanied with liberalization of economies diminishes the hope for more

investments in social sectors, including health. Such a scenario does not mean that cities will be the villains in future. Rather, they will be the places for future employment. Since most cities suffer from bad governance, financial constraints and lack of inclusive city planning, they become "hot spots" of health risks. A development approach embedded in sustainable development, holistic health and good governance can provide us with a protective environment for improved health and an inclusive society. To realize this vision, the healthy city concept promoted by WHO has even more relevance today for the fast-urbanizing developing countries.

Urban dynamics in the South-East Asia Region

The experience of countries in the SEA Region has been similar; the urban population in the Region exceeded 531 million in 2005, which was about 17% of the global and 34% of

* Former Professor of Geography, Delhi University.

** Director, Department of Sustainable Development and Healthy Environments, Regional Office for South-East Asia, World Health Organization, World Health House, 1 P Estate, New Delhi - 110002

Table 1: Selected urban population characteristics in countries of the SEA Region

Country	Urban population ('000)		Urban population (%)		Population growth (%)		Population density (persons/sq km)	
	2005	2025	1990	2007	1990-1995	2000-2005	1990	2007
Indonesia	108 828	178 731	30.6	50.4	4.6	4.1	96	122
Myanmar	14 700	24 720	24.9	31.9	2.4	2.7	59	72
Thailand	20 352	29 063	29.4	32.9	1,7	1.5	106	125
Timor-Leste	278	732	20.8	27.3	4.5	7.1	50	78
Bangladesh	39 351	76 957	19.8	25.9	4.0	3.5	785	1102
Bhutan	197	428	7.2	11.8	1.4	5.7	12	14
India	325 563	538 025	25.5	29.2	2.8	2.4	262	356
Maldives	100	233	25.8	30.5	2.7	3.1	719	1019
Nepal	4 269	10 550	8.9	16.7	6.9	5.4	130	192
Sri Lanka	2 895	3 830	17.2	15.1	0.2	-0.3	261	294
DPR Korea	14 546	17 697	58.4	62.3	1.8	1.0	167	197

Source: UN World Urbanization Prospects : 2007 Revision . <<http://esa.un.org/unup>>

Asian urban population.⁴ The urban population of the Region is expected to reach about 880 million by 2025. The urbanization trends clearly indicate that the Region is urbanizing very fast, cities are getting denser, and the large urban agglomerations are growing faster to comprise a larger share of urban population (Table 1).

The inflow of poor migrants and their settling down in degraded and crowded illegal settings without adequate basic services is the greatest challenge of urban health. The emergence of mega cities with huge slum populations is another disturbing urban phenomenon. Four of the 23 mega cities, including Delhi, Dhaka, Kolkata and Mumbai of the world are located here in the SEA

Region and are home to about 15 million slum dwellers. Rising epidemic situations and the fast spread of communicable diseases are strongly linked to the growing densification process of slums in these cities.

Urban experts view such kind of growth and distribution as a natural phenomenon. Countries in the Western world experienced similar trends while they were urbanizing and industrializing more than a century ago. However, what is important for people's health is not the speed with which urban settlements are growing or how their populations are going to be distributed, but the extent to which effective local response can be developed to promote health, drawing on all possible sectors and utilizing available resources.⁵

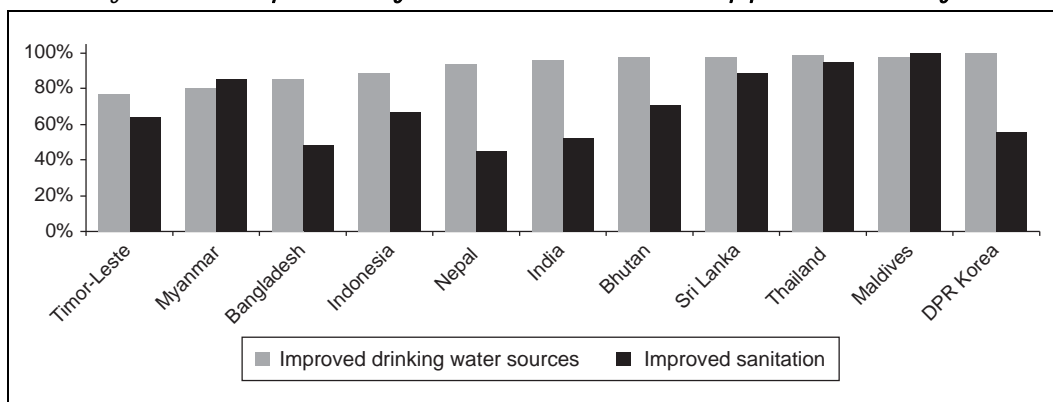
Hyper-urbanization-linked health challenges

With mega urbanization happening in many countries of the Region, most local governments and parastatal institutions have not planned to provide basic amenities, basic health services and affordable housing as they face financial constraints. Compared with other WHO regions, the SEA Region has the lowest level of improvement in sanitation coverage, about 50% (Figure 1).

Access to improved drinking water sources has improved over the years and at least 75% residents now are connected to safe water sources. However, the situation is very

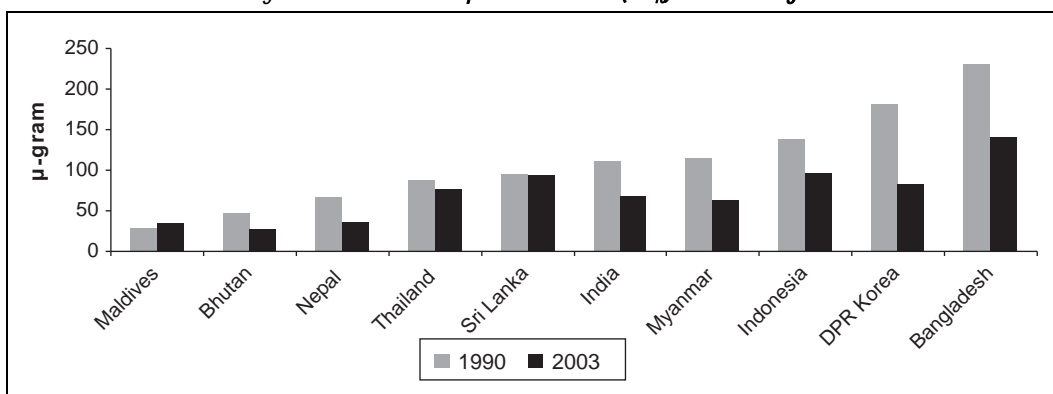
bad in urban slums where regular water supply for long hours is still a dream. Solid waste management, even with low per capita generation, remains a big environmental hazard (land degradation, groundwater pollution and flooding) and a serious health risk. Exposure to biomedical waste and e-waste are emerging as new environmental and health challenges. As a result of greater awareness, many countries have enacted strong policies and legal measures to reduce air pollution levels. These measures have resulted in declining trends in major pollutants like carbon dioxide, sulphur dioxide and nitrogen dioxide, etc. (Figure 2). But still, the pollution levels are much higher than the WHO-recommended limits. Financial

Figure 1: Access to improved drinking water sources and sanitation for urban populations of the SEA Region



Source: WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation(JMP) Report, 2008

Figure 2: Concentration of particulate matter (PM_{10}) in the SEA Region



Source: UNESCAP. Socioeconomic Survey, 2009

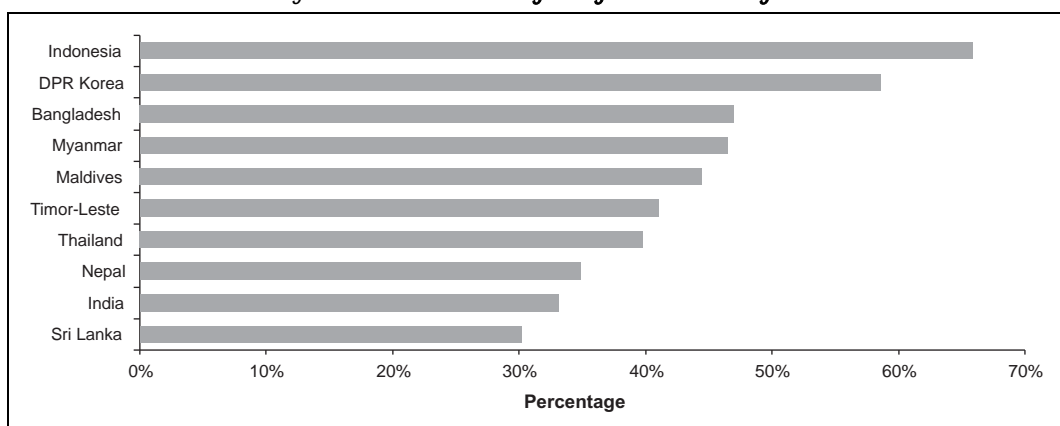
constraints, lack of governance and uncontrolled physical expansion of cities have contributed largely to such environmental and infrastructural damages.

Health risks are getting even worse with the added dimension of climate change impacts including flooding of coastal cities, heat stress and exposure to new disease vectors. Natural and man-made disasters (floods, droughts) are also on the rise and threaten food security. Bangladesh, being a low-lying country and having a long coastline in the Bay of Bengal, is severely affected by frequent cyclones and floods now, and with climate change the impact is getting even worse.

Social support systems in big cities are becoming weak and are leading to social alienation and crime, and to alcohol and drug addiction. Alienation of the youth arising from growing unemployment and withdrawal of the social support system lead them to more substance abuse, alcoholism and tobacco abuse. Heavy smoking among men, and the youth in particular, is prevalent across all countries, except Bhutan (Figure 3). With an intense city mobility and stressful work environments, the area of mental health is another new challenge being faced due to the growing urbanization.

Urbanization is considered a significant social determinant of health as the urban system allows and produces spatial and economic inequalities. The WHO Commission on Social Determinants of Health⁶, Special Issue of the Journal of Urban Health on “Achieving health equity in urban Settings”⁷ and other publications brought out by the WHO Kobe Centre⁸ and the WHO Regional Office for South-East Asia on health inequities⁹ clearly establish social gradients (viz. gender, location, education and ethnicity, etc.) on health indicators like infant mortality; access to health care; and safe water and sanitation. Social, economic and spatial gradients are evident in consumption of goods and services across and within most big cities of the Region. There is a strong social gradient across urban settings in countries of the Region when we relate health indicators like children living in slums and diarrhoea episodes; household wealth and sources of drinking water and housing quality. The Self Employed Women’s Association (SEWA), India, case study conducted by the WHO Regional Office for South-East Asia¹⁰ clearly established that empowerment of poor women could translate into upgradation of slum settlements; deliver primary health-care services at doorsteps of the poor; and provide affordable health insurance towards improved health outcomes.

Figure 3: Prevalence of smoking among men in the SEA Region



Source: UNESCAP Socioeconomic Survey, 2009

Note: Data for Bhutan not available

Therefore, the major question for future is how to ensure that health and environment are not damaged by economic progress and growing urbanization trends. The argument here is not to justify anti-urbanism, but to bring about a balance between the two. It further aims at strengthening the individuals and the city governments to be the actors of change, and at encouraging and enabling the communities to develop lifestyles and environments that support positive health in cities of the future. The “healthy cities” approach of WHO initiated during the late 1980s was an appropriate response to such emerging urban, social and environmental challenges across cities, including countries of the SEA Region

The “healthy city” response

The “healthy city” concept and projects emerged in the Region as a response to deteriorating environmental, social and health conditions associated with urbanization as discussed above. These projects were based on the principles and strategies of health for all and the principles embodied in the Ottawa Charter for health promotion. The “healthy cities” programme (HCP) strategy advocates an inter-sectoral approach to health development that focuses on the environmental, social and economic determinants of health. It aims to bring about a partnership of public, private and voluntary agencies to focus on urban health and to tackle health-related problems within a broad approach. In addition, the HCP aims to build a strong case for public health at the local level and to put health issues onto urban political agendas.

Examples of WHO-facilitated “healthy city” programmes in the SEA Region

The WHO HCP launched in the SEA Region in 1994 covered six cities: Chittagong and Cox’s Bazar (Bangladesh); Bangkok (Thailand); Badulla (Sri Lanka); Kathmandu, Koleshwar

(Nepal); and New Delhi (India). However, the progress in healthy cities development was slow due to unclear concepts among local authorities and lack of coordinated urban infrastructure to support the process. In order to address these issues, several local and regional meetings, and workshops were held to improve HCP implementation. A comprehensive review of HCP in selected Member countries of the Region was conducted in 1998¹¹, and a SEA Region Healthy Cities Framework for Action was subsequently developed in 1999. This same year an opinion survey was also conducted to seek subjective perspectives from related policy-makers, academics and programme managers. By 2002, the number of healthy city projects, with WHO involvement, had increased to 18 cities in 8 countries of the Region, namely Bangladesh, Bhutan, India, Myanmar, Maldives, Nepal, Sri Lanka and Thailand. It is presently estimated that action at the local level is being taken with regard to 40-50 healthy settings in all countries of the Region.

Review of “healthy cities” programme in countries of the SEA Region

The HCP was initiated by cities in Europe and North America since 1986, just after the Ottawa Conference, and the practice has existed now for about 25 years. Developing countries adopted this approach only in the mid-1990s, which means that it has been in operation now for the past fifteen years. However, given the length of time the programme had been in operation in the Region, it was not replicated in various settings and in the degree expected. This was despite sufficient awareness having been generated through a variety of activities including seminars, training workshops, healthy city days, and training programmes. Thus, a need was felt to evaluate the ongoing HCPs in the Region to better understand the constraints and opportunities from ongoing experiences of the past several years and also seek ways to

more effectively chart out a regional healthy-settings future. Process indicators such as political involvement, collaboration, resource mobilization, participation, institutional change, governance and sustainability were used to learn from ongoing initiatives. The strength and sustainability of a healthy city project, in view of many experts, depends largely on the institutionalization of the above-mentioned processes¹².

Constraints in engaging the healthy-settings process

The study revealed many constraints that related to understanding, application and sustainability of the practice. First, the lack of a deeper understanding the concept and practice of healthy settings. The idea of healthy settings seems deceptively simple at the surface, for it masks the complexity of the implementation process where sustainability must be the focus. Any health action carried out in a community does not suffice as an example of a healthy-settings label. Its hallmark must be the synergy between the city health plan, the managerial process, and community involvement for ensuring programme sustainability. In most countries of the Region, with government and community leadership continuously in a state of flux because of inevitable job turnovers in the system, such awareness of the concept is often lost in the change, and needs to be continuously kept up to negate the possibility of this comprehensive process slipping into being just another time-bound project and not a sustainable process.

Second, the internal municipal governance bottlenecks also hinder the progress of the process of healthy settings. Lack of coordinated urban infrastructure responsibilities and related turf issues militate against cooperative engagement among municipal players. Structural issues of internal administration and bureaucracy in local governments, even in the currently

decentralized situations find limitations. The inability and/or lack of opportunities or forums for working together with other sectoral ministries, while not having a forum to deal with common issues, are the constraining factors. While health issues are the common denominator, policies and mechanisms to address these may be available only in a multitude of sectors. This necessitates collaborative approaches within and outside of participating municipal arms.

Third, to bring holism and empowerment into the healthy-settings process requires that the issue of participation of the poor also be addressed. The analysis reveals that there is little evidence of participation by the poor in the healthy-settings process. And because of their absence in the process, the needs of the poor are often neglected in the agenda of the settings programme. Moreover, even if they were present, perhaps there will still be a need for the management to have an egalitarian mindset in order to give the poor the voice to articulate their needs. This is evident from the prevailing situation in the local government that has little interest in promoting the “settings” idea in slum areas because they are considered illegal/unauthorized settlements.

Another limitation is the low priority that the ministries of health (MoH) accord to preventive services and related policies. Also, chronically low budget allocations, weak organizational structures that fail to accommodate comprehensive programming and collaboration, and the lack of civil service requirements for public health expertise in policy-level positions in MoH act as constraints to advancing “healthy settings” programmes. Most ministries are structured along clinical disciplines, curative health care and vertical programmes. Even budget allocation and mandates are devised along these lines. As such, the administrative process for teamwork is limited or hindered. In as much as there is the need to promote the idea of addressing health

comprehensively, there is a critical need to reassess and evaluate the role that ministries of health must play in these present times of promoting sustainable health development, including capacity-building to effectuate such changed positions.

Even with increasing democratic reforms and decentralization in many countries, governance structures that move the system are still in a timewarp. While there is a move towards democratic governance through empowerment at local levels and inclusiveness in decision-making, the central authority still displays bureaucratic and vertical structures. One would hope to see more delegation and teamwork even at the top levels of ministries in governments to complement and facilitate the change towards greater local autonomy. Unfortunately, even the existing dual-purpose or multi-sector-responsibility-mandated ministries are seen to be fragmenting into uni-sector functionaries, thus having to form lateral linkages all over again for needed coordination. An analysis of why this is so is beyond the scope of discussion here, but perhaps not so in the overall context of a healthy settings programme development discourse.

Lessons from the “healthy cities/settings” programme in the SEA Region

Strengths and limitations of “healthy city” projects

The strengths of the Regional Healthy City programme (or more often referred to as the “healthy-settings” process) are those that address, even in a small way, the factors mentioned above. Thus, the more successful settings embody the aspects of preparing a city plan of action; providing strong commitment towards recruiting human resources and sustaining them; creating a strong awareness among decision- and opinion-makers that the benefit of this process; and building institutional structures like working groups and steering committees.

Weaknesses of the programme primarily relate to concerns regarding sustainability. These concerns comprise the lack of enabling conditions such as absence of strong city-level managerial structures to harmonize the public policy on health; inadequate stakeholder involvement; lack of political motivation; and the demand for external programme funds. Overall, smaller settings appear to be more successful than larger ones.

As “healthy settings” are the geographically demarcated physical terrains in our countries, and as many health development actions are presently taking place in our communities, there could be many “healthy settings” type of actions in operation that we do not even know of. The WHO healthy-city process (and thus, healthy settings also) promotes an idea that is timeless and deceptively simple. A plan, a process of management, and involvement of the community, are all that are needed to keep a healthy-setting process moving forward. Leadership commitment is also essential for such continuity.

The way forward: challenges and prospects for the future

As a prospect for the future, the following challenges must be attempted to pursue the vision for sustained success of the HCP. These challenges relate largely to political and administrative expediency.

Experience with several initiatives in the Region that were taken up from scratch with support from WHO shows that the burden of achieving success is on WHO as the initiatives are seen to have been initiated at the behest of WHO, and not because of any real need expressed by the “setting” recipients. The experience with many WHO-initiated healthy city programmes in the Region has been that the programmes were taken up on the basis of requests made by the political leadership of the “setting” rather than by enlightened community groups. WHO has used this

approach of entering the healthy-setting process through the political community since politicians possess the power to elicit community support. Also, politically unaligned people, however committed they may be to strengthen their community, find it very hard to create and develop viable community development programmes. The social organization in many Asian societies dictates that there is almost always the need for having a political base for support – and this comes from elected persons such as the Mayor or a district administrator or an elected legislator. To be realistic, with the kind of prevailing political climate it may be surmised that the really committed elected leaders are indeed hard to find. But when we do find one, the hope for sustainability may be lost unless the programme can move towards institutionalizing the approach.

In the SEA Region, “healthy settings” has been taken up as an organizing concept – one that can put many disparate community development efforts at community level into a coordinated whole. However, challenges abound. Programme managers, administrators, political leaders and even donors favour programme visibility over community development effort. WHO therefore needs to widen such limited vision by going beyond it and educating and convincing the managers and operators of HCPs to derive political, social and economic advantages inherent in such initiatives rather than being satisfied with a limited visibility component alone. Such broadened vision will lead towards the sustainability of the programme.

We view the healthy-settings process as a significant contributor to the widening assumption of intersectoral collaborative practices in both urban and rural settings. It is envisaged that lessons from this process will be increasingly replicated into fully-functioning coordinating mechanisms at the district level of national governance. Based on how WHO and its partners can market the approach through an inclusive process (such as the

Healthy Environments for Children Alliance, revitalization of primary health care, social determinants of health and the Millennium Development Goals (MDGs), it may open the future to a greater cooperative action among donors, businesses and nongovernmental organizations (NGOs) towards an efficient system of health planning and resource allocation — a process we hope can provide a fertile ground for dialogue and comprehensive action on existing and emerging health priorities in countries by having a more conducive means for unfettered interaction among donors and recipients. We hope to see an increasing evidence of this healthy-settings concept being incorporated into national planning processes as a means of looking at health and development issues more comprehensively using an intersectoral development process. This is a very opportune time as political decentralization is taking place in many countries of the Region.

WHO will continue to provide guidance, facilitation and networking support to Member States of the Region as the above process moves forward. It would keep abreast of new developments (both information and expertise) to keep the support most relevant and timely. Networking is very important for exchanging information among partners and learning lessons. It would also promote mutual comparisons and hopefully some competitive spirit that will drive the programme towards greater excellence in implementation. This will enable exchange of people and ideas for making the regional process more dynamic and thus keep the interest for the programme alive. The Regional Office will maintain a regional database that will link all “settings” that may subscribe to it.

WHO will be focusing mainly on those cities where such sense of responsibility and realizations exist (that municipal work is in effect the same as that to be done under the healthy city programme). This will ensure that whatever little funds it has to offer will be put to good use to promote models of good practice

under the “healthy cities” umbrella. WHO also wishes to include its own programmatic priorities as demonstration opportunities where such issues are specified in the “healthy cities” actionplans. One example in Bangladesh is that of food safety training for healthy city programme staff for selected cities. This way WHO is able to show the benefits of the programme in the city itself rather than providing training to people from all over the country but not being able to monitor if the training has indeed been put to effective use. WHO should have its “healthy cities” mandate to bring clinical, social and preventive aspects of health together. Through other programmatic inputs, WHO may also be able to integrate programmes on malaria, diarrhoeal disease control, community health clinics, tuberculosis, children’s environmental health, tobacco, drug abuse and violence, etc. into HCP.

Many Masters in Public Health (MPH) academic programmes in the Region are adopting HCPs as field practice programmes towards planning, management, implementation, monitoring and evaluation of health projects. Lessons in inter-sectoral collaboration and local-level governance may be learnt from studying the working of these community-level initiatives. More effort is needed, however, to incorporate the healthy city concept and its relevance into a variety of public health-related curricula and field practicum.

At the regional level, WHO will implement an HCP coordinators’ training programme for supporting the increasing need to provide the existing HCP with quality managers who understand the process of logical planning, implementing and evaluating programmes.

Effort will be made to advocate the idea of piggy-backing HCP type of actions into the existing community development programmes. This will of course entail a dialogue with protagonists of these programmes (be they NGOs, development agencies and businesses, etc.) and proposing a win-win approach for the partnership.

WHO will also promote institutional changes to the municipal process towards incorporating HCP actions into municipal plans. The lack of such a process has been shown to be the major reason for ineffective management by municipal staff.

Is there a future for the “healthy settings” movement?

All focal points for the Sustainable Health and Healthy Environments programme and staff in the Regional Office agree that there is a bright future for HCP in the SEA Region. However, they all point to the fact that extensive changes are needed to make HCP effective and sustainable as suggested below. The evaluation provides some specific recommendations to strengthen the implementation of the HCP. However, without the support of all parties involved and a willingness to address the problems that HCP faces, communities will miss out on the benefits of a unique community mobilization programme that could positively affect countless individuals in developing countries of the SEA Region.

Actions needed to sustain the HCP

- Adopt small settings with identifiable issues rather than the whole city or a larger area.
- Use SDH approach to identify unhealthy settings and vulnerable groups.
- Involve the poor, women, civil society and private sector as primary stakeholders.
- Institutionalize the “healthy city” programme to give it legitimacy, visibility and sustainability.
- Sustain the political and administrative acceptance of the HCP by integrating it into a healthy public policy.
- Integrate “healthy city” initiatives into other similar community development programmes

- Establish /strengthen networking with other cities or with other similar initiatives within the city.
- Sensitize municipal staff on health issues and build their capacity through training on preparing a health plan, resource mobilization, and implementation of the project.

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