LITERATURE REVIEW

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Healthy Cities: A Guide to the Literature

SYNOPSIS

The author reviews the literature on attempts by city governments, international agencies, and nongovernmental and community organizations to improve city life around the world through Healthy Cities projects.

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At its core, the Healthy Cities movement is about the connection between urban living conditions and health. The term *health* is used broadly to include not just the physical health but also the mental, social, economic, political, and spiritual health of city dwellers. The central ideas behind the movement are that cities provide a good setting in which to develop action strategies to promote health and that the city has an unmatched potential for producing healthy human beings when attention is paid to the values of city dwellers (Tsouros and Draper, 1993).

The Healthy Cities concept is based on the Health for All policy of the World Health Organization (WHO), which views health policy as a set of processes that raise awareness, mobilize community participation, and develop the roles of local government in public health. Healthy Cities programs address those activities that make up the lives of individuals, households, communities, and cities, gauging health according to the holistic conditions of people's everyday lives (Hancock, 1993).

Definitions of health and of the most appropriate means of ensuring good health in an urban context have been debated since the 19th century, when many European and North American cities witnessed rapid growth, usually underpinned by industrialization. These debates were spurred by the very serious health problems linked to rapid urbanization, which was accompanied by inadequate provisions for water supplies, sanitation, waste collection, pollution control, and housing. These debates have continued as increasing numbers of countries in Latin America, Asia, and Africa have also experienced rapid urban growth.

Throughout the latter half of the 20th century, many ideas and initiatives contributed to the concepts of Healthy Cities projects. At the founding of WHO in 1948, health was defined as "a state of complete physical, social and mental well-being, not merely the absence of disease or infirmity." In subsequent years, WHO, following this definition, promoted health for all by endorsing primary health care and suggesting that action on health must include a strong focus on the prevention of disease and injury as well as adequate provision for water and sanitation.

This commitment to health through the provision of basic services and healthy living environments was an important contribution to the Healthy Cities concept. Another was an explicit recognition of the scale and nature of health problems in urban areas. Throughout the 1970s, international agencies tended to concentrate on poverty in rural areas and the health problems associated with it. That began to change in 1983, when participants at a joint meeting of WHO and the United Nations Children's Fund (UNICEF) on "Primary Health Care in Urban Areas" agreed to study urban health with a special emphasis on countries in the Southern Hemisphere, on "slums and shanty towns," and on low-income, deprived, and at-risk populations. Both organizations faced difficulties in taking on a more explicit urban role as many of their staff and most other international agencies still considered urban dwellers to be privileged in their access to health care and to other basic services (Mitlin and Satterthwaite, 1992; Black, 1996).

The Healthy Cities concept also came to rest on the idea that conventional public health approaches focused on the prevention or treatment of diseases did not adequately address new health risks, including violence and motor vehicle accidents, and key underlying causes of ill health, including poverty (Davies and Kelly, 1993).

Healthy Cities programs first developed in Europe and North America. The concept builds on the work of Thomas McKeown, former professor of social medicine at Birmingham University, who found that the major factors in improving health in the United Kingdom and elsewhere in the 19th and 20th centuries were not advanced medical care and technology but social, environmental, and economic changes, smaller family size, an increase in food supplies, a healthier physical environment, and specific preventive and therapeutic measures (McKeown, 1979). More recently, the writings and conference presentations of Leonard J. Duhl and Trevor Hancock were important in developing the Healthy Cities concept (Duhl, 1986 and 1990; Hancock, 1990).

The concept of the "healthy city" encompasses *technical aspects* related to local-level mobilization of resources, formulation of plans, application of technology, and allocation of resources, and *representational aspects,* which include greater participation by groups outside government and increased transparency and accountability in the workings of local authorities (WHO, 1996a). This literature review includes publications dealing with both aspects. The review divides the literature on Healthy Cities into the following categories: general texts; urban policies and action plans; project initiatives in the developed countries; project initiatives in the developing countries; and evaluations of Healthy Cities programs and networks.

General Work

Three main works offer an overview of Healthy Cities programs around the globe. The first, *Urban Health in Developing Countries: Progress and Prospects*, edited by Trudy Harpham and Marcel Tanner (1995), presents an overview of what particular agencies are doing about urban health in the developing countries. This text focuses on the multisectoral nature of urban health development and includes contributions from implementers, researchers, and writers.

A second book, *Our Cities, Our Future: Policies and Action Plans for Health and Sustainable Development,* edited by Charles Price and Agis Tsouros (1996), focuses on Healthy Cities developments in the Northern Hemisphere, primarily those in the European Healthy Cities Network. In addition to case studies from cities, it offers a review of the *Healthy Municipios* programs in the Caribbean and Latin America as well as keynote speeches presented at the first World Conference in Urban Health and Environment, held in Madrid in July 1998 (See also: **www.mrc.ac.za/uhdbulletin/sep98/worldconference.htm**).

The third book, published in 1998, is *Healthy City Projects in Developing Countries: An International*

Approach to Local Problems, by Edmundo Werna, Trudy Harpham, Ilona Blue, and Greg Goldstein. It describes the different phases of Healthy Cities projects, including planning, implementation, and evaluation, with illustrations drawn from case studies in Quetta, Pakistan; Chittagong, Bangladesh; Fayoum, Egypt; Campinas, Brazil; and Bangkok, Thailand.

In addition to the above texts, the January-February 1996 issue of *World Health*, which focused on Healthy Cities provides an accessible, although brief, look at various initiatives aimed primarily at promoting the Healthy Cities concept in Africa, Asia, North America, South America, and Europe.

URBAN POLICIES AND ACTION PLANS

More governments and aid agencies are beginning to integrate urban and health policies. John Ashton and Howard Seymour's *The New Public Health: The Liverpool Experience* (1988) provides an important introduction to this trend. Based on the authors' experience of developing and participating in a health promotion strategy in Liverpool, England, over a five-year period, *The New Public Health* discusses the importance of policies that promote public participation in improving aspects of ordinary life in order to improve health.

Building a Healthy City: A Practitioners' Guide (WHO, 1995) provides a step-by-step approach for prospective project coordinators and volunteers working on the implementation of a Healthy Cities projects. It also presents overviews of: the framework for WHO's Healthy Cities programs; evaluation methods; and how to develop a local task force, build public support, gain approval from the municipal government, and prepare a municipal health plan. The *Guide* emphasizes looking beyond damaging health hazards and risk factors to the settings where health is maintained, promoted, and created—for instance, through a particular focus on healthy schools.

Joseph Aicher's book *Designing Healthy Cities: Prescriptions, Principles and Practice* (1998) discusses the different physical, biological, chemical, socioeconomic, and psychological factors that influence health and includes many prescriptions and implications for the planning and design of healthier communities.

National and local policies. Agenda 21, the action plan endorsed by governments attending the 1992 United Nations Conference on Environment and Development (also called the Earth Summit) in Rio de Janeiro, initiated the UN's program of action for sustainable development and made explicit the relationships between good environmental policy and social and economic development. The WHO European office's document *City Planning for Health and Sustainable Development* (1992) provides useful background on the connection between Local Agenda 21 and Healthy Cities.

Leonard Duhl's article "Conditions for Healthy Cities: Diversity, Game Boards and Social Entrepreneurs" (1993) analyzes why many attempts at addressing urban problems fail and proposes new ways of understanding cities. He argues in favor of what he calls a "common game board" on which communities and people may work out their differences and suggests that Healthy Cities projects should seek to develop this game board as a method for negotiating and modifying solutions to urban problems.

The second United Nations Conference on Human Settlements (Habitat II) in Istanbul in 1996 addressed the problem of deteriorating urban environments. The Habitat II conference was unique among a series of global conferences organized by the United Nations during the 1970s, 1980s, and 1990s in that it involved local governments from the outset. The Habitat Agenda, the recommendations that governments endorsed at Habitat II, recognized that addressing health problems in cities requires the combined efforts of nongovernmental and community organizations and local authorities, not just medical professionals. For more details, see the document developed by WHO for the Dialogue on Health in Human Settlements at the Habitat II Conference titled *Creating Cities in the Twenty-First Century: Habitat II* (WHO, 1996a).

One of the key issues within the Healthy Cities program is the role of national programs in supporting local level projects. In some countries it has been helpful to establish national or regional Healthy Cities commissions or networks. An example of national support for local health projects appears in Ruwe, Macwan'ge, and Atkinson's contribution to *Urban Health Research in Developing Countries* (1996). Their case study of health care reform in Zambia emphasizes the important role of local districts.

The *Healthy Municipios* projects started in Latin America provide another example of the ways in which the concept of the healthy city has moved from the international and national levels to the more local level. "The PAHO/WHO Experience: Healthy Municipalities in Latin America" by the Pan American Health Organization (1996) provides a good introduction to some of the Latin American *Healthy Municipios* initiatives.

The city of Cienfuegos, Cuba, was the first municipality in Latin America to adopt a "Healthy Municipios" strategy. Alfredo Brito and Dario Espinosa's 1996 paper, "The Global Project of Cienfuegos," argues that existing health promotion and public health programs should be integrated into Healthy Cities projects and that comprehensive health development approaches must include healthy villages and health-promoting schools, workplaces, and hospitals.

Jo Boyden and Pat Holden's *Children of the Cities* (1991) highlights the relationship between health and poverty. Boyden presents a case study of mothers in Port-au-Prince, Haiti, where despite supplementary feeding and other programs, the city government was unable to reduce the infant mortality rate among severely malnourished children. The Healthy Cities program there intervened by providing local mothers with vocational and other forms of training and helping them set up small-scale, local enterprises, while their children received nutrition rehabilitation. Boyden documents how these efforts improved the living conditions of these women and their children.

International networks. WHO promotes networking between Healthy Cities projects, both within regions and between regions or continents. As of the mid-1990s, the Global Cities Network linked more than 650 cities (WHO, 1996b).

In his 1996 paper "Networking for Action on Sustainability and Health," Agis Tsouros emphasizes the need to expand linkages and exchange experience and information between the Northern and Southern Hemispheres, recognizing the process as a two-way exchange. In *Our Cities, Our Future: Policies and Action Plans for Health and Sustainable Development* (1996), Agis Tsouros and Charles Price note that North-South links provide a vehicle for extending mutual understanding of global problems as well as for joint action on sustainable development initiatives.

WHO's document *Technical Discussions on Strategies for Health for All in the Face of Rapid Urbanization* (1991) identifies networks and coalitions established within cities, between cities, and between sectors. It also presents an overview of the concept of networking and outlines the main elements of city networking.

A paper on "Health in a City Environment" by Françoise Barten (1994) describes the Health and Environment in Cities (HEC) program, through which institutional partners from the Northern and Southern Hemispheres collaborate on various projects, including projects addressing the environmental and occupational health hazards of small-scale industries Dar es Salaam, Tanzania); the living and working conditions of scavengers (Jakarta, Indonesia); women-friendly health care (Managua, Nicaragua); determinants of violence (Kingston, Jamaica); and urban health management. HEC includes member institutes from India, the Netherlands, Switzerland, and the United Kingdom.

Two notable Healthy Cities networks have been established in Francophone Africa. The sub-Sahelian African network (created with Canadian assistance) includes eight cities in six different countries, and the Maghreb network (created through Tunisian initiatives) includes 20 cities located in Algeria, Morocco, and Tunisia. The city of Rufisque, Senegal, has developed a successful Healthy Cities project with the help of its twin city, Nantes in France. The two main components of the action plan in Rufisque are environmental improvements and the rehabilitation of hospitals. The Maghreb network has been able to develop projects throughout Tunisia and northwest Africa including Algeria, Libya, and Morocco. The first Maghreb Healthy Cities symposium, held in 1990, brought together representatives from four neighboring countries. Since then, the network has steadily grown and now, in each country, involves the ministries of the interior, housing, environment and land-use planning, social affairs, youth and children, education, and science. Within Tunisia alone, there are more than 5,000 neighborhood committees with a total membership of 35,000 (Girault, 1996).

In 1997, the European Commission began funding a project designed to address issues related to health and human settlements in Latin America and South Africa. This project, coordinated by South Bank University in London, has eight partner institutions and aims to address international, national, and local agencies' concerns about the burden of ill health found among low-income urban populations in Latin America and South Africa. A 1998 workshop in São Paulo brought together the partners, and resulted in a report, "Health and Human Settlements in Latin America," which includes summaries of the major papers presented (South Bank University, 1998). Although the workshop focused primarily on urban health research, it reveals the complexities surrounding urban health and the interests of partners involved in the Latin America/South Africa concerted action plan.

Intersectoral activities. A basic tenet of the Healthy Cities philosophy is that various social sectors collaborate on programs to improve urban conditions. In 1991, WHO institutionalized the idea of intersectoral collabo-

ration by requiring that member cities of the European Healthy Cities program establish two intersectoral committees: one consisting of politicians, business leaders, labor representatives, agency heads from key sectors, community organizations, and churches to provide overall direction and policy orientation for Healthy Cities projects; and another committee of professionals with the expertise and resources to provide advice to the steering committee and implement policy directions (Davies and Kelly, 1993)

The necessity to promote intersectoral cooperation was recognized in the Ottawa Charter, produced at the first International Conference on Health Promotion (Davies and Kelly, 1993), The Charter defined health as "the process of enabling people to increase control over, and to improve, their health," thereby laying the groundwork for WHO's Healthy Cities initiative. The Adelaide Conference in April 1988 expanded on the Ottawa Charter. A document on the "Healthy Cities Fifth Annual Symposium" (WHO, 1991b) and a second, "Making Partners: Intersectoral Action for Health" edited by A.R. Taket (1988), emphasize the need for intersectorality within Healthy Cities projects. To support intersectoral action, the health sector, according to Taket, must win allies and motivate people and groups through methods such as the identification of common goals and through compromise, negotiation, and working together on equal ground. Two of the most important components of intersectoral action, she concludes, are flexibility and communication.

In their paper "The Global Project of Cienfuegos," Alfredo Brito and Dario Espinosa (1996) examines a plan developed in response to the limited ability of the medical sector by itself to meet the city's health needs. That plan brought together intersectoral groups to work together on specific strategies in special target areas. As a result, Cienfuegos developed projects addressing specific issues such as education, communication, environment, food and nutrition, physical exercise, and medical guidelines.

Urban Health In Africa (Atkinson and Merkle, 1993) describes the experience of the Urban Technical Taskforce in Lusaka, Zambia, with intersectoral planning, and also provides case studies from Sokode, Togo, and Dar es Salaam, Tanzania. Lusaka's approach brought together the district health management team, the water and sewerage company, the Ministry of Health, the University of Lusaka Department of Community Medicine, Care International, and additional members from other government ministries This approach is an example of a program seeking to use intersectoral action to improve primary health care, synthesize an urban health master plan, and make intersectoral technical information relevant to urban health development.

Trevor Hancock's "Planning and Creating Healthy and Sustainable Cities: The Challenge for the 21st Century" (Hancock, 1996a) suggests that, to create healthy cities by working intersectorally to develop public health policies, it is necessary to develop a holistic approach to both government and governance and to reject the idea that issues are discrete and independent. The holistic model is premised on the idea that everything within a community, whether it be urban or rural, is connected.

Most local and national governments, especially in the Southern Hemisphere, are not structured for a holistic, multi-sectoral approach. To adopt the holistic approach to urban governance, and beyond this to urban health policy, requires new skills, processes, styles, and structures. In Harpham and Werna 1996 article on "The Idea of Healthy Cities and its Application," the authors show how Healthy Cities projects in Bangkok, Thailand, rallied various sectors around the cause of health and safety in the workplace.

Preventive programs. Since the beginning of the 20th century, there has been a strong emphasis on curative health treatment rather than on the promotion of good health. In the Southern Hemisphere, this approach has sometimes been adopted at the expense of environmental services such as good water supplies, sanitation, housing, and vaccinations against infectious and epidemic diseases. In their book *Children of the Cities* (1991), Jo Boyden and Pat Holden highlights the tendency of the US public to believe that, in order to improve health, even more dramatic advances in medical science and specialist interventions to cure major health problems are necessary. Boyden argues that medical and health policy should not emphasize prevention over cure, but that such a shift cannot be entirely successful until planners and policy makers have a clearer picture of the health problems that exist. To acquire this clearer picture, Boyden proposes a careful recording and analysis of statistics by settlement, district, class, age, and sex (Boyden and Holden, 1991)

UNICEF now supports urban primary health care programs in more than 43 countries. In 1985, it brought together government and nongovernment programs from more than 30 countries for an international workshop on community health care and the urban poor that aimed to address problems such as the coverage and scale of health care. *In the Shadow of the City,* edited by Harpham, Lusty and Vaughan (1988) was based on the papers presented at that workshop.

David Black's "Glasgow: Working Together to Make a Healthier City" (1996) and Price and Tsouros's *Our Cities, Our Future: Policies and Action Plans for Health and Sustainable Development* (1996) also discuss how poverty undercuts many attempts to achieve healthier urban environments. For example, over the past 15 years, actions to improve health in Glasgow (as in most other cities in Europe and North America) have tended to focus on specific diseases such as heart disease, stroke, and cancer and have emphasized individual responsibility for behavior leading to and associated with these diseases. But a disease-specific approach proved inadequate to improve the health of those Glaswegians who live in poverty, leading the authors to conclude that projects must address poverty and the deprivations associated with it, not simply the diseases associated with poverty.

Lapido and Lanizaan's 1994 article, "Community-Based Family Health," discusses Nigeria's Association for Reproductive and Family Health. Implemented in an urban setting, this program seeks to encourage local creativity and innovations in preventive care. For example, the program has explored the use of market traders as agents for promoting health maintenance and family planning in city marketplaces.

Healthy Cities Initiatives in More Industrialized Countries

Most of the literature on Healthy Cities comes from projects implemented in developed countries because these projects have been in existence the longest. The idea for a Healthy Cities project first became explicit in Toronto, Canada, in 1984 during the WHO-sponsored Healthy Toronto 2000 convention held there. A healthy city, as defined by WHO and the Toronto plan, is "one that is continually developing those public policies and creating those physical and social environments which enable its people to mutually support each other in carrying out all functions of life and achieving their full potential" (Healthy Toronto 2000 Subcommittee, 1988).

The report of the Healthy Toronto 2000 subcommittee became a blueprint for the city's Department of Public Health until the year 2000. Like many Healthy Cities reports, this document has limited information on the actual outcomes because Healthy Cities projects are typically long-term, ongoing processes whose success are in part determined by the extent to which they are sustained.

The Canadian cities of Quebec, Sherbrooke, and Montreal have also been working on Healthy Cities projects since the late 1980s. In Quebec, the Network of Healthy Towns and Villages has been so successful that links have been developed with Brazil, Colombia, Mexico, and Senegal. In her article "The Quebec Network," Dupriez (1996) describes the accomplishments of projects in areas such as Rouyn-Noranda in Quebec that were developed in consultation with concerned citizens, plant management, workers unions, municipal authorities, members of local public health networks, and representatives of community groups.

In the US, California was one of the first states with Healthy Cities projects. Nine of California's 23 participating cities have included issues of violence on their Healthy Cities agendas. "Reducing Urban Violence" (Twiss, 1996) discusses actions against violence taking place in eight of these cities. Twiss cites the example of Berkeley, which in 1993 launched a program uniting city residents, merchants, students, property owners, churches, the university, and many others.

Healthy Cities Initiatives in Less Industrialized Countries

Trevor Hancock, one of the architects of the Healthy Cities movement, suggests that the challenge we face in cities is no longer how to understand the links between health, environment, and the economy nor to understand threats to sustainability. The challenge is how to put into practice the things we already know (Hancock, 1990). His point applies especially to the growing Healthy Cities movement in the Southern Hemisphere.

Most of the world's urban population lives in developing countries, where the expansion in urban population has been more rapid than the expansion in basic infrastructure and services. The urban poor often have to cope with the health hazards not only of inadequate water, sanitation, and health care and of poor quality housing but also the health hazards associated with industrial development (Werna, Harpham, Blue, and Goldstein, 1998).

Various books and papers have been important in highlighting the scale and nature of the health problems in urban areas in Africa, Asia, and Latin America and in highlighting how a multisectoral Healthy Cities approach is needed in addressing them. One of the first books was *In the Shadow of the City: Community Health and the Urban Poor* (Harpham, Lusty, and Vaughan, 1988). Tulchin's *Habitat, Health, and Development: A New Way of Looking at Cities in the Third World* (1986) argues that addressing poor housing conditions and inadequate basic services in cities is a pre-condition for improving health.

This theme was elaborated in *The Poor Die Young: Housing and Health in Third World Cities* (Hardoy, Cairncross, and Satterthwaite, 1990) which stresses the scale of the health burden in cities and includes chapters on the importance of interventions in water, sanitation, drainage, housing, and emergency services. *Spotlight on the Cities: Improving Urban Health In Developing Countries* by Tabibzadesh, Rossi-Espagnet, and Maxwell (1989) highlights the scale, nature, and urgency of the predicament of the poor in the Southern Hemisphere and advocates a shift in health care priorities and strategies. Another contribution to this topic is *A Review of Environmental Health Impacts in Developing Country Cities* by Bradley et al. (1991).

Sarah Atkinson's "Guide to the Literature on Urban Health in the Third World" in the October 1993 issue of *Environment and Urbanization* is valuable for its inclusion of literature on the range of health problems, environmental issues, social aspects of health, health services, and urban policy issues affecting the urban poor. A guide to the literature on "Health Inequalities in Urban Areas" by Alison Todd, in the October 1996 issue of *Environment and Urbanization*, focuses on health inequalities in urban areas of the Southern Hemisphere with a few references to the Northern Hemisphere used to illustrate the global nature of the problem of health inequalities within cities.

Urban Health In Africa (Atkinson and Merkle, 1993); *Environment and Health in Developing Countries: An Analysis of Intra-Urban Differentials Using Existing Data* (Stephens, Timaeus, Akerman, et al., 1994); *Our Cities, Our Future* (Price and Tsouros, 1996); the 1996 "Healthy Cities" issue of *World Health* magazine; and *Healthy City Projects in Developing Countries* (Werna, Harpham, Blue, and Goldstein, 1998) discuss Healthy Cities projects in the Eastern Mediterranean, Africa, Southeast Asia, the Americas, and the Western Pacific. A summary of those programs follows.

Sub-Saharan Africa. Healthy Cities projects have been initiated in Cameroon, Congo, Côte d'Ivoire, Ghana, Niger, Nigeria, Senegal, and Tanzania.

In Kampala, Uganda, a drainage repair project has been used as an entry point for primary health and community mobilization in an urban slum. Although not part of WHO's formal Healthy Cities program, it has operated according to some of the key elements of the Healthy Cities concept. For example, the project involved representatives from different organizations and government sectors and called on residents to discuss participatory solutions (Harpham and Tanner, 1995).

Ly et al. (1998) review the achievements of Healthy Towns and Villages actions in three settlements within Dakar, Senegal, using participatory research, and highlight the potential contradictions between the Healthy Cities philosophy and the conventional management culture of local authorities.

Eastern Mediterranean. Countries with Healthy Cities projects in the Eastern Mediterranean region include Cyprus, Egypt, Jordan, Iran, Kuwait, Morocco, Pakistan, Tunisia, and the United Arab Emirates. In Tunisia, most of the common communicable diseases are showing a steady decline, general sanitation is now being improved, and primary health care services are being strengthened (Giroult, 1996).

In 1991, Teheran's 20th municipal district, Kooy-e-Sizda-e-Aban, was formally selected as an experimental area for a Healthy Cities project. The project sought to increase health standards and improve services. To help accomplish these goals, the mayor of Teheran donated a building to serve as a city health center. The city then chose a Healthy City High Council to serve as a steering committee with representatives from the ministries of Health and Medical Education. In his article "Teheran: Success in a Suburb," Salmanmanesh (1996) describes public involvement in the project.

A paper in *Environment and Urbanization* by Werna, Harpham, Blue, and Goldstein (1999) includes a case study of Fayoum in Egypt.

Latin America. Healthy Cities projects have been initiated in Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, the Dominican Republic, Ecuador, Mexico, Nicaragua, Peru, and Venezuela. A case study of the Healthy Cities program in León, Nicaragua, by René Pérez Montiel and Françoise Barten was published in *Environment & Urbanization* (1999). The *Healthy Municipios* project implemented throughout Latin America has encouraged decentralization and building citizenship, and has made it possible to include priority health problems in the political agenda.

In Cali, the second largest city in Colombia, a Healthy Cities project has worked to extend public services such as water, gas, and electricity, low-income housing, an anti-violence program, and universal health coverage. In his article, "Cali: The Right Priorities," Rodrigo Guerrero, a former mayor of the city, describes broad-based efforts to improve urban health in Cali (1993 and 1996). Some of these efforts have drawn on support from the private sector and the Catholic church. One activity was the distribution of oral rehydration salts, which

resulted in a decrease in deaths from diarrhea and a drop in infant mortality rate from 70 per 1,000 live births in 1983 to 26.2 in 1994 (Guerrero, 1996). In addition, vaccination coverage rose to 90% for infants.

Asia. Bangladesh has been host to several Healthy Cities initiatives, including those in Chittagong and Cox Bazar, as Salma Burton's paper (1999) describes.

Little literature exists on Healthy Cities projects in China, Malaysia, Nepal, Thailand, and Vietnam, but one article is worth noting. "Giving the Public Their Say" (Hashim, Kiyu, and Hardin, 1996) describes a Healthy Cities project in Sarawak, Malaysia. Despite rapid industrialization, economic prosperity, and strong Western influences, the residents of Kuching City, the capital of Sarawak, have been able to preserve their rich social and cultural values. In 1994, WHO invited Kuching City to join the Healthy Cities project. To find out what people wanted, a simple, interview-based questionnaire was devised that asked city dwellers and visitors to name the five things they hated most, liked most, and wished for most in the city. The findings were then used to complement the ideas of official policy makers and planners. Some of these findings were surprising for city officials, such as concerns about public transport and an interest in more parks and open spaces and strategic locations for shopping malls.

Evaluations of Healthy Cities Programs and Networks

This section considers the as-yet rather limited body of literature on evaluation of the Healthy Cities concept and specific Healthy Cities projects. Petersen's 1996 article, "The 'Healthy' City: Expertise and the Regulation of Space," critically examines the healthy city as it has been articulated in health promotion literature, policy documents, and program evaluations of the WHO Healthy Cities project and suggests that WHO's methods reflect a modernist belief in the power of science and in rational administrative solutions to problems. Petersen argues that WHO's approach to Healthy Cities reinforces professional dominance and the "search for technical-rational solutions to complex sociopolitical problems." Ly et al. (1998) also discuss what constrains and enhances Healthy Cities–type interventions.

Some literature questions the methods used for evaluating Healthy Cities projects and their application to programs in the Southern Hemisphere. One such method, presented in the document "An Instrument for Evaluating Healthy Communities Projects in Quebec" (Fortin, Groleau, et al., 1992) is based on studies of the Quebec Healthy Cities movement, *Villes et Villages en Santé*.

One of the current debates surrounding the evaluation of Healthy Cities is the use of process versus impact indicators. Process indicators represent the array of activities displayed by the project as well as the project's interaction with the community. Impact, or outcome, indicators include changes in morbidity, mortality, nutritional status, or fertility. A paper on "The Evaluation of Healthy City Projects in Developing Countries" (Werna and Harpham, 1995) addresses the indicator debate and concludes that, as Healthy Cities projects move into the 21st century, evaluation based on process rather than on impact indicators will become increasingly important in the success of the movement.

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www.healthycities.org: This is the website of the International Healthy Cities Foundation. The site includes sections on the Foundation and on the Healthy Cities movement, case studies of cities and communities, a library, and contact lists.

www.who.dk/healthy-cities/: This is the primary WHO Healthy Cities website, providing background

information on the project as well as plans for its future. The site also provides links to other Healthy Cities websites, including city health profiles and city health strategies.

All World Health Organization publications including the journal World Health, *except for those published by the WHO Healthy Cities Project Office in Copenhagen, can be ordered from Distribution and Sales, WHO, 1211 Geneva 27, Switzerland. The address for the WHO Healthy Cities Project Office in Denmark is: Scherfigsveg 8, DK-2100, Copenhagen.*

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