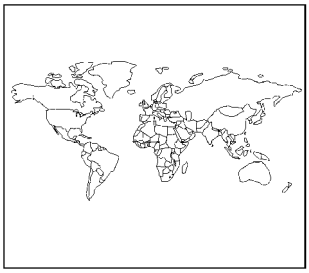

From healthy city projects to healthy cities

Edmundo Werna, Trudy Harpham, Ilona Blue and Greg Goldstein

SUMMARY: *This paper discusses experience to date with the formulation and implementation of Healthy City projects in the South. After describing the origin of the Healthy Cities movement and what constitutes a Healthy City project, it reviews the experience of Healthy City initiatives in Fayoum (Egypt), Quetta (Pakistan) and Campinas (Brazil). It then discusses the roles of three critical stakeholders: international agencies (and how their support should facilitate local action rather than dictate it); local government staff and politicians (and the difficulties in getting their sustained support); and citizens and grassroots organizations. It ends by discussing how the real success of any Healthy City project is when it ceases to be a project, because the system it set up to ensure that health issues are given priority, to involve all stakeholders and to ensure that all sectors recognize that their role in healthy cities becomes part of the structure of local governance.*

I. INTRODUCTION

THIS ARTICLE IS about the Healthy City projects initiative which began in 1987 with World Health Organization (WHO) support. It is a development activity that seeks to put health on the agenda of decision makers in cities, to build a strong lobby for public health at the local level, and to develop a local, participatory approach to dealing with health and environmental problems. Ultimately, the initiative aims to improve the physical, mental, social and environmental well-being of the people who live and work in urban areas.

Most experience of Healthy City projects has been in high-income countries. However, there are a growing number of initiatives in low and middle-income countries and increasing interest from the international community about the nature and direction of Healthy Cities in Africa, Asia, and Latin America and the Caribbean. This interest has been heightened by: Habitat II, the 1996 United Nations Conference on Human Settlements (also called the City Summit) which emphasized action at the local, urban government (municipal) level; the fact that the 1996 World Health Day focused on Healthy Cities; and the increased poverty focus of many bilateral and multilateral aid agencies (e.g. the UK's Department For International Develop-

This paper draws on the authors' recently published book **Healthy City Projects in Developing Countries: An International Approach to Local Problems,** ***Earthscan, London, 1998.***

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1. This was previously known as the Overseas Development Administration (ODA).

2.Werna, E., T. Harpham, I. Blue and G.Goldstein (1998), *Healthy City Projects in Developing*

ment (DFID).[1] In response to such interest, this article aims to give an overview of the evolution of Healthy City projects in low and middle-income countries and to consider their future development.

The article starts with a general explanation of the history, concepts and implementation of Healthy City projects. This is followed by an analysis which focuses on three main dimensions of Healthy City projects that have implications for sustainability, namely, the international dimension (considering that Healthy Cities is an international initiative, sponsored by the WHO); the public sector dimension (considering that its implementation is carried out via local authorities); and the community dimension (considering that Healthy Cities is fundamentally about participatory governance and about improving the well-being of local communities). The article concludes by discussing the implications for the development of Healthy Cities beyond the projects.

Most of the information presented in this paper is drawn from a recently published book which provides further details on the establishment, implementation and evaluation of Healthy City projects in Africa, Asia and Latin America.[2]

II. BACKGROUND TO WHO'S HEALTHY CITY PROJECTS

THE WORLD HEALTH Organization (WHO), from its founding in 1948, has recognized the interaction of physical, mental and social factors in determining health. In 1978 at Alma Ata, WHO launched a major public health movement called "Health for All", based on six principles:

- reduced inequalities in health;
- emphasis on disease prevention;
- intersectoral cooperation including reducing environmental risks;
- community participation;
- emphasis on primary health care in health care systems; and
- international cooperation.

Healthy City projects build on WHO's definition of health and the principles of "Health for All", and have roots in the public health culture of many parts of the world such as the local health systems in Latin America, the "Health Culture" movement in Japan, and the Ottawa Charter for Health Promotion.[3]

In 1986, the European office of WHO proposed a health promotion programme to be known as "Healthy City" projects. The intention of the programme was to devise ways of applying the principles and strategies of Health for All through local action in cities and to put it on the agenda of local government. *The approach is based on the principle that health can be improved by modifying living conditions, namely, the physical environment and the social and economic conditions of everyday life.* This holistic view sees health as the outcome of all the factors and

Countries: An International Approach to Local Problems, Earthscan, London.

3. The Ottawa Charter for Health Promotion enunciated five action areas to improve health: building healthy public policy; creating supportive environments; strengthening community action; developing personal skills; and reorienting health services; for more details see WHO (1986), "Ottawa Charter Health Promotion", *Healthy Promotion* Vol.1, No. 4, pages iii-v.

activities which impact upon the lives of individuals and communities.

In Healthy Cities, attention is given to health opportunities. Though various urban development activities (housing, industry, infrastructure, etc.) can bring health risks if they lack health and environmental safeguards, more importantly, they offer health opportunities. They can enhance health status if health promotion and protection measures are included in their development. For example, in industrial development, safety considerations in factories and workshops, worker training and pollution control should be integral; or in housing development, water and sanitation and garbage services, and basic health care measures should be implemented with community participation.

Healthy City projects support city health authorities and/or local governments in undertaking what may be two new roles:

- Information and analysis - health impacts are monitored, involving the measurement of health status, and an estimation is made of the contribution that various environmental factors are making to health problems. This is then followed by an analysis of health requirements and opportunities in various development sectors that are significant for health.

- Policy and advocacy - specific health policies for each sector are formulated and advocated (e.g. for water, sanitation, local government, education, industry and the workplace).

Ultimately, "A Healthy City is one that is continually creating and improving those physical and social environments and expanding those community resources which enable people to mutually support each other in performing all the functions of life and in developing their maximum potential."[4]

4. Goldstein, G. and I. Kickbusch (1996), "A Healthy City is a Better City", *World Health* No.1, pages 4-6.

Healthy City projects are popular around the world, with more than 1,000 cities or towns adopting them. There are networks of Healthy City projects in all regions of the world, with anglophone, francophone, Spanish-speaking and Arabic-speaking networks linking different continents. Many city leaders, professionals and citizens have taken up the challenge to link up with a network of Healthy Cities in every region of the world and to develop the dimension of city-level work in international public health. On the basis of experience in some 1,000 cities, Healthy City projects were presented to Habitat II, the second UN Conference on Human Settlements in 1996, as an example of best practice in urban management.

III. ORGANIZING A HEALTHY CITY PROJECT

THE WORLD HEALTH Organization has developed a set of guidelines for establishing Healthy City projects[5] that cities and towns which have joined the Healthy Cities movement lately, especially those in low and middle-income countries, have tended to follow. These guidelines indicate that the institutional organiza-

5. WHO (1995), *Building a Healthy City: A Practitioner's Guide – A-Step-by-Step Approach to Implementing Healthy City Projects in Low-Income Countries,* WHO, Geneva, Switzerland.

6. See reference 5.

tion of a Healthy City project should be based on a steering committee, a project office and working groups.[6] The steering committee has representatives of the main stakeholders involved in different aspects of the development of the city or town. It is generally chaired by the mayor and is responsible for the political decisions regarding the activities of a Healthy City project. The project office is the operational arm of a Healthy City project and is generally based within the premises of the local government. The working groups are responsible for the practical activities of a Healthy City project in different sectors of urban development and health, and/or in different areas of the city or town. The implementation of a Healthy City project should follow three basic stages: start-up, organization and implementation. The start-up phase aims to initiate the process, to build wide public support for the project and to start awareness-raising campaigns. During this phase, the project coordinator is appointed and the major groups and organizations in the city that might take part in the project are contacted and encouraged to participate. During the second phase, the institutional organization of the project and the approval of the government authorities are consolidated. Also, the city health plan (sometimes called the municipal health plan or the Healthy City plan of action) is produced. The creation of a city health plan involves various related processes: linking health status to environmental conditions; information-gathering; priority-setting; mobilizing resources; and action planning. The third phase is devoted to the implementation of the city health plan, enhancing participation, evaluation and the setting-up of networks with other Healthy City projects.

Because of the city-specific, process oriented nature of Healthy City projects, it is impossible to draw up a comprehensive list of activities to be undertaken. However, Boxes 1-3 provide some details of key activities by presenting three Healthy City project case studies in Fayoum in Egypt, Quetta in Pakistan and Campinas in Brazil.

Having presented the basic elements of WHO's Healthy City projects, it is now important to consider some specific issues of relevance to projects in low and middle-income countries. Three main dimensions will be discussed in turn: Healthy Cities as an international initiative; Healthy Cities as public administration; and Healthy Cities as popular participation.

Box 1: Fayoum, Egypt

The Fayoum governorate is a densely populated region of closely packed villages and towns with around 2 million inhabitants in a natural depression situated approximately 90 kilometres from Cairo. The main economic activities are related to agricultural production. Many health indicators (for example, infant and child mortality rates and immunization coverage) compare unfavourably with national averages, and Fayoum has various problems related to basic infrastructure and health and social service provision.

The Healthy City project in Fayoum began in 1995 with a workshop at which key

local policy makers presented their views on how activities in their sector influenced health, and on the main problems they felt needed to be addressed. Local elected leaders also attended the workshop and contributed to the discussions on the major health problems in the area. It was decided to focus initially on three specific sites in the hope that Healthy City project activities would then spread to other sites. Following this, existing data related to the city were collected and semi-structured interviews were held with key policy makers, hospital and health centre staff and local leaders (including the leaders of women's groups). In addition, a brief questionnaire was conducted among local women, seeking to understand their health needs and priorities. Focus group discussions were held with staff at various health centres, and health centre and hospital records were analyzed.

On the basis of the information collected and analyzed, a preliminary situation analysis was produced. The following list of priorities was drawn up: health and housing; income generation; sanitation; food safety; healthy animal husbandry; women's participation; youth action; healthy schools; health and safety at work; water; land use planning; health and hygiene education; and upgrading health centres.

From this list, it can be seen that Healthy City projects can address a wide range of problem areas and require inputs from many sectors in local government, the private sector and the community. A second workshop was held in February 1996 and the steering committee decided to select six issues to be tackled first, given available resources: healthy schools; water supply; health and hygiene education; garbage removal and disposal; drainage and sanitation; and income generation. A 1995/96 plan of action was drawn up and it was decided to focus on two issues, healthy schools and on-site sanitation. The plan included details of what was to be done, by whom, by when, for what purpose and with what resources. Implementation of the plan has been quite successful although some aspects still need to be addressed. There has been progress in carrying out a needs assessment of the water, sanitation and solid waste facilities in schools, and school staff have been trained in health and hygiene issues. In addition, surveys have been conducted of on-site sanitation facilities but progress in this aspect has been limited due to a lack of funds.

A second plan of action, incorporating the 1995/96 plan, was devised for 1996/97 and, in this, four issues were identified: health education and promotion; water and waste water; environmental sanitation; and income generation. Working groups were created to address each of the issues. Substantial progress has been made in all four components of the plan although much of this is due to the keen support provided by the local government. In the future, it will be important for the Healthy City project to seek greater participation from the community, local stakeholders and other potential funders.

SOURCE: Harpham, T. and I. Blue (1995), Fayoum *Healthy City Project, Egypt: start-up phase*, WHO consultants' report, May/June; and Werna, E. (1997), *Fayoum Healthy City Project*, Egypt: review of progress, WHO consultant's report, May.

Box 2: Quetta, Pakistan

Quetta is the capital of the province of Balochistan with an estimated population of 1 million. The Quetta Healthy City project began in 1995. During the start-up phase, the Healthy City process was reviewed, a situation analysis was carried out and a list of existing gaps in data and recommendations for action was drawn up. It

was suggested that the following gaps in data needed to be filled: urban development and health for Pakistan, Balochistan and Quetta; the main preventable causes of death in Quetta; housing and health; refugees and migrants; occupational health; education and health conditions in schools; health services; the urban informal sector; and future development options. In addition, priorities for action were identified based on the preliminary information collected from discussions with local institutions and from a limited number of reports. These were: governance and institutional integration; land development and housing; economic development and healthy workplaces; socio-cultural issues; water; sanitation; drainage; solid waste; roads, traffic and transportation; energy; environmental protection; education and healthy schools; health services; and funding opportunities. The list is not in order of priority. It was suggested that the list be reviewed and elaborated upon by the task forces during the preparation of the city health plan.

The next report reviewed the start-up phase and made preparations for the organizational phase of the project. It was suggested that a Quetta profile be prepared "…providing information on the various sectors of activity in the city (for example housing, water, education), their impacts on health, and an inventory of the organizations and resources in each sector." The link between the profile and the Quetta Healthy City plan of action was stressed. Following on from the 14 priority areas identified during the start-up phase of the project, task forces were developed. These were constituted in such a way as to encompass all aspects of urban health and development previously identified. The final choice of task forces was decided upon after a phase of broad consultation within the steering group and with representatives from local organizations. The seven Quetta Healthy City task forces are: environmental health services; housing and land development; roads, transport and energy; economic development; education; social affairs; and health services.

The task forces were formed during a workshop in 1996. They were asked to identify the main problems in their area and make suggestions as to how the problems could be addressed. This exercise will feed directly into the preparation of the Quetta Healthy City plan of action. In addition to the seven main areas of activity, it was suggested that three initial projects should be developed: an environmental health project in one ward; a basic minimum needs project in another ward; and a city-wide project (e.g. curbing air pollution). The idea behind such pioneer projects is that it helps focus Healthy City participants on particular activities while the bulk of the project revolves around planning in the early stages. Implementing small projects at the outset of the Healthy City project is also a way of increasing community awareness and motivation.

By May 1997, progress on the Quetta Healthy City project had been limited mainly due to changes in national, provincial and local government and a change in project coordinator. Although some progress had been made with respect to information gathering, a health and environment profile of Quetta had not been compiled and, as the plan of action depends upon the information in the profile document, it has not been devised. In addition, the task forces created in 1996 had ceased to function effectively. In 1997, a new project coordinator was appointed and, with a relatively stable political situation, progress has been made.

SOURCE: Werna, E. (1995), *Quetta Healthy City Project, Pakistan: start-up phase*, WHO consultant's report, August; Werna, E. (1996), *Quetta Healthy City Project, Pakistan: review of start-up phase and preparation of the organization phase*, WHO consultant's report, May; and Harpham, T. (1977), *Quetta Healthy City Project, Pakistan: report of a visit*, WHO consultant's report, May.

IV. HEALTHY CITIES AS AN INTERNATIONAL INITIATIVE

THIS DIMENSION REPRESENTS a main difference between Healthy City projects in high-income countries and low or middle-income countries. In the former, WHO involvement can be less, due to the advanced (at least in relative terms) capacity of local stakeholders to assimilate the projects. Also, these countries have greater resources with which to implement the projects. WHO faces a different challenge in low and middle-income countries, where cities have few resources to address a great range of problems. This condition does not mean that WHO has to bring in all the extra resources necessary to address all urban health problems within these countries. But it does mean that in such countries, Healthy City projects face different problems from those found in Europe or North America and thus must operate differently. The projects must be *adapted* because they originated in high-income countries.

In addition to these differences, in Africa, Asia and Latin America, the Healthy City projects are encompassed within the "international aid machinery". This fact represents a fundamental distinction from the situation in high-income countries because it entails a specific kind of relationship between the projects and the participating cities. After a number of decades of international aid, a "culture of aid" has been established throughout the South. This has prompted the rise of a specific kind of behaviour within the public sector (and sometimes in the population in general) vis-à-vis international agencies. This behaviour sometimes creates problems, such as public authorities expecting paternalistic support from international agencies, or such agencies being suspected of interfering in internal affairs. No matter how Healthy Cities may in reality differ from other/traditional international projects, local stakeholders and partners in Africa, Asia and Latin America are often not able to make the distinctions from the start. This situation must be taken into account for the sound implementation of Healthy Cities. The remainder of this section will analyze two further issues related to the international nature of Healthy City projects and their presence in low and middle-income countries; first, how to start a participatory process top-down and, second, the place of Healthy City projects among other international initiatives.

A recent encounter between a Mexican local politician and one of the authors of this article illustrates the first issue. Despite the fact that Mexico has a very large number of Healthy City projects (probably the largest in the South) and an active network, the politician criticized the projects for being conceptually - and in practice - contradictory because, on the one hand, they claim popular participation but, on the other, it is a top-down international programme. In his opinion, these two sides are in conflict, reflecting a criticism that has often been made. Such criticism is not only levelled at the Healthy City projects but also at numerous international initiatives which have a participatory ethos. This paper argues against such criticism. First,

there is a difference between "top-down *imposition* of ideas" on the one hand and "*facilitation* of local initiatives" on the other. Healthy Cities aims at the latter, not the former. This paper also argues that, in many circumstances, a good idea or concept can successfully be transferred from one settlement to another. Otherwise, we would still be living in a world of isolated communities which would constantly be reinventing the wheel. The Healthy City projects have such a transfer of knowledge component which does not necessarily clash with local participation. One should still not let "outside" ideas constrain local initiatives. Therefore, in other words, Healthy City projects need to keep a balance between prescribing action for the cities and towns, and starving them of inputs.

Another issue related to the international nature of Healthy City projects is their "place" among other international initiatives. There are many international initiatives which have an integrated/intersectoral approach similar to the approach of the Healthy City projects. Examples include:[7]

- Sustainable Cities Programme (run by UNCHS, the United Nations Centre for Human Settlements);
- Sustainable Cities Initiative (run by USAID, the United States Agency for International Development);
- Metropolitan Environmental Improvement Programme (run by the World Bank);
- CITYNET (run by the Regional Network of Local Authorities for the Management of Human Settlements);
- Private-Public Partnership for the Urban Environment Programme (run by UNDP, the United Nations Development Programme, in association with the Sustainable Project Management Programme and the Massachusetts Institute of Technology);
- The Local Agenda 21 Initiative (run by ICLEI, the International Council for Local Environmental Initiatives).

The existence of multiple initiatives is not necessarily a problem. However, it needs good coordination[8] - particularly when two or more programmes are concomitantly implemented in the same city, which has happened already in Dakar (Senegal), Johannesburg (South Africa) and Madras (India), among others.[9] Such a situation reinforces the need for Healthy City projects to strengthen their character based on a clear focus on health issues. They also need to be flexible enough to be able to adapt to other integrated international programmes. The concomitant implementation of a Healthy City project and the Sustainable Cities Programme in Ibadan (Nigeria), and the synergies created between them constitute a successful experience.

7. UNCHS-UNEP (1996), "Implementing the urban environment agenda", paper prepared for the Global Meeting of Cities and International Programmes, Habitat II, Istanbul, Turkey, 1 June 1996.

8. Werna, E. (1996), "United Nations agencies' urban policies and health", chapter in Atkinson, S. et al. (editors) (1996), *Urban Health Research: Implications for Policy*, CAB International, Wallingford, UK.

9. UNCHS-UNEP (1997), "Implementing the urban environment agenda" in *Environmental Planning and Management (EPM) Source Book* Vol. 1, Nairobi, Kenya.

V. HEALTHY CITIES AS PUBLIC ADMINISTRATION

DESPITE BEING AN international initiative, Healthy Cities is not just "owned" by an international agency and "applied" in a given country. Rather, it is a programme in *partnership* with local stakeholders, with a major objective of promoting good health and preventing health related problems at the local level via a systemic change in urban policies. Such an emphasis in change in policy entails the involvement of - and often transformations within - the public sector. The local government is the leading agency/stakeholder in a Healthy City project. Therefore, public administration is an important dimension.

Experience shows that the internal dynamics of the public sector are a major determinant of success in a Healthy City project in low and middle-income countries. In this regard, two major issues should be highlighted, namely, motivation of the public authorities and motivation of the public agencies' staff.

First, the political backing of local decision makers - especially mayors or their counterparts - is a key element in the implementation of Healthy City projects. Conversely, a number of on-going projects have lost momentum precisely because of changes in local government leadership, particularly when a mayor is succeeded by a political opponent. Unfortunately, the dismantling of established and on-going programmes by an incoming government is common practice in many countries, as, for instance, in the case of the Campinas Healthy City project in Brazil.

Box 3: Campinas, Brazil

With a population of around 1 million, Campinas is the second largest city in the state of São Paulo, situated in the south-east of the country. São Paulo is the richest and most populous state in Brazil and Campinas plays an important role in its industrial, commercial and educational activities. Despite its relative economic success, Campinas displays the intra-urban differentials common throughout Brazil and there are approximately 182 slum areas (*favelas*), found mainly in the peripheral areas of the city, with an estimated 10 per cent of the total population.

A Healthy City project was initiated in Campinas towards the end of 1994, with an agreement between the municipal authorities and WHO. Campinas is divided into four administrative areas, each with an administrator accountable to the mayor. The Healthy City project actors opted for a zonal rather than a sectoral approach and used the existing divisions as the basis for organization. Although action plans were drawn up for all four areas, it was decided to concentrate Healthy City activities in just one of these administrative areas, namely SAR-NORTE (the northern area), in the hope that activities, once established there, would eventually spread to the other areas. Within SAR-NORTE, the district of São Marcos (with a total population of 22,000) was chosen as the focus of the Healthy City project as it was considered one of the most needy areas. A group consisting of local municipal officers, health advisors, representatives from local schools and representatives from the housing associations of the *favelas* was formed. Following this, a rapid appraisal was carried out using interviews with key informants, an analysis of existing documents and

observation. The information collected was then presented at a workshop attended by approximately 450 people including the key informants, advisors, members of local NGOs, municipal officers and the mayor. From all the problems discussed, it was decided to focus on two particular issues: children and adolescents living on the streets; and the lack of infrastructure and sanitation in the *favelas*.

For each of the two problems, a list of causes and possible solutions was developed. In the case of children and adolescents living on the streets, local parents were asked to talk about their understanding of the problems. The possible solutions were linked to specific causes of the problem and included: implementing a programme directed at family relations; implementing a programme for managing income; devising a programme for schools; and creating areas for play and leisure activities.

In the case of the lack of infrastructure and sanitation, it was found that a large majority of people living in the *favelas* did not have sanitation facilities or rubbish collection. In addition, there were several heavily polluted lakes contaminated with schistosomiasis. Solutions suggested included: providing infrastructure for *favelas*; relocating some families to new, planned settlements; implementing environmental education programmes; creating community environmental groups to replant trees and oversee environmental aspects of the community; and clean the lakes.

At present, many of the above-mentioned solutions are in the process of being implemented in São Marcos. However, the original intention of spreading the Healthy City project from São Marcos has yet to be fulfilled and appears to have been delayed due to changes in the municipal administration.

Healthy City projects facing the above problem can be supported by initiatives from outside the public administration system. Active popular participation is probably the best option, as the following section will argue. WHO may also play an important role as, for example, it did in Chittagong (Bangladesh). This project started in 1993 but, one year later, there was a radical political shift in local government. WHO support enabled the new mayor to be briefed on the Healthy City project, thus raising its profile.

One possible solution, with a focus on the public administration system, entails an awareness-raising campaign targeting new politicians, especially mayors-elect. PAHO (the Pan-American Health Organization) is currently discussing such an idea.

A second issue related to the internal dynamics of the public sector is the motivation of public employees. Staff of local government and other public agencies with a stake in urban affairs are often strongly involved in the day-to-day running and decision-making of a Healthy City project - e.g. leading task forces and implementing activities of the city health plan. Therefore, if not well motivated, such staff may jeopardize the implementation of a project. For example, there have been cases where public employees had difficulty incorporating the activities of a Healthy City project into their routine duties. When this happens, Healthy Cities can be regarded as an extra assignment, a fact which

disheartens the responsible public employees. Also, successful projects in the South often entail changes in ways of working. This requires further motivation. A clear design of a Healthy City project backed by steady political support and an awareness-raising campaign targeting public staff may address this issue.

Taking into consideration that public administration is a fundamental dimension of Healthy Cities, a vital question to ask is who will be WHO's main partner in leading the projects in the future? In other words, which public entity in each country and city should be responsible? There are two major candidates: the health sector and the local authorities.

The health sector has the major advantage of being the traditional partner of WHO (i.e. via the national ministries of health). Also, there is, of course, a rationale for involving the health sector in a movement/programme which deals with promoting good health and preventing health related problems. However, the health sector also has a significant disadvantage. Healthy Cities entails policy-making in many fields which are outside the control of public health authorities - such as housing, transport, education and employment.

Local authorities, in turn, have the advantage of being responsible for urban policies in general which, theoretically, enables them to act more effectively against the root causes of a plethora of health problems. They are also represented internationally, through the IULA (International Union of Local Authorities), which means that their support for Healthy Cities can go beyond the local and national domain. But local authorities also have disadvantages, such as the lack of a traditional linkage with health as an issue and with WHO as an organization. Their possible involvement in Healthy City projects as a leading partner may also generate conflict with the public health sector (e.g. with ministries of health) who would not want to lose their position as traditional partners of WHO (also bearing in mind that the secretary-general of WHO is chosen by the ministers of health).

In sum, there is no clear-cut picture about whether the health sector or local authorities should take the lead. Rather than establishing beforehand who should lead the Healthy Cities movement, it would be more appropriate to monitor the implementation of on-going Healthy City projects around the world and identify the natural leaders that emerge from the movement.

VI. HEALTHY CITIES AS POPULAR PARTICIPATION

ALTHOUGH HEALTHY CITIES may be an international initiative as well as a means of conducting public administration, as noted in the previous sections, it is fundamentally about participatory governance. Werna et al.[10] note four issues relating to the sustainability of Healthy Cities, one of them being a "broad range of actors". Within this issue, popular participation may

10. See reference 2.

be the ultimate element which leads to - and supports - sustainability.

The preceding section noted that the success or failure of Healthy City projects in the South has been largely associated with the degree of political support from local decision makers. In most cases, such support still does not fully reflect ideas coming from different sectors of the population. Grassroots propositions by and large exist but many Healthy City projects are still heavily linked to the personal agendas of mayors who have implemented them in the first place. Although WHO and, indeed, many mayors have taken popular participation as a fundamental element of Healthy Cities, in reality its implementation is frequently not a straightforward process. This is particularly true in some low and middle-income countries which have limited experience of popular participation.

Lack of popular participation, however, exacerbates the risk of new governments dismantling established and on-going programmes. It is much easier for a new mayor to set up his/her own personal agenda if there are no pressures from different sections of the population. Therefore, Healthy City projects that do not secure a sound popular basis run a greater risk of being manipulated or even dismantled by an influential politician.

Popular participation may be the ultimate element which leads to - and supports - sustainability in Healthy Cities. Therefore, efforts should be made to support participation as widely as possible in each project. When local communities find a real stake in the project, they will put pressure on any incoming mayor to continue it. Popular participation may even guarantee the sustainability of Healthy Cities beyond the project, an issue which will be analyzed next.

VII. CONCLUSION: FROM HEALTHY CITY PROJECTS TO HEALTHY CITIES BEYOND PROJECTS

THIS FINAL SECTION briefly discusses whether Healthy City projects need to exist indefinitely. The city of Campinas in Brazil is used as a case study to illustrate the discussion. The Campinas Healthy City project experienced difficulties, starting in 1996 with the death of the mayor who initiated the project. He died before the completion of his term in office and the deputy mayor, who took his place, did not show the same enthusiasm for the Healthy City project which, thereafter, lost considerable momentum. At the end of 1996, there were municipal elections and a candidate from an opposition party won. A new mayor took office in 1997, who has not supported the Healthy City project. The Campinas project chose to concentrate action in São Marcos, a low-income region of the city. Therefore, considering the changes in office, what happened to the São Marcos initiative?

Clearly, there has not been any political top-down support following the death of the mayor. However, work already implemented in São Marcos, based on strong popular participation,

was sufficient to motivate the local population to fight for its continuation. The actions of such local groups have been backed by technical staff from local government who worked in the establishment of the São Marcos initiative - the motivation of such staff grew to a point of resisting the demise of the Healthy City project even without direct support from the mayor. In short, the São Marcos initiative has been pushed forward. The Campinas Healthy City project may not exist any more under such a name or label, however, the actions which were established under its umbrella have lived beyond the project itself.

The above anecdote is a small illustration of the fact that the sustainability of Healthy Cities should not necessarily mean the long-term survival of the project. Although Healthy Cities is a WHO initiative, its sustainability should not be understood through the narrow approach usually adopted by international agencies - i.e. that a programme or project should continue to survive, as a programme or project, after the departure of the implementing agency. Healthy City projects have been implemented in cities and towns which need a systemic change in their approach to urban development and health in order to improve the well-being of the citizens. At the initial stages, the project implements a system (office, task forces, committees, plans of action, etc.) clearly distinguishable from the local/existing system of governance. However, as time goes by, it is expected that both systems blend into each other. Therefore, the aim is not to indefinitely maintain the Healthy City projects' institutional organization, plans of action and the like but to move from such a situation to the underpinnings of daily public policy. At this point, the project as such may have ended but Healthy Cities will remain alive.