

# INDUSTRIALIZED COUNTRIES COMMENTARY



# Healthy cities, healthy children

Leonard Duhl and Trevor Hancock

***Economic development has brought comfort and convenience to many people in the industrialized world, but in its wake are pollution, new health problems, blighted urban landscapes and social isolation. Growing numbers of the dispossessed are also being left on the sidelines as the disparity between rich and poor grows. In an effort to remedy these ills, people from disparate backgrounds in thousands of communities are joining together with government agencies under the Healthy Cities/Healthy Communities banner to improve the quality of life in their towns and cities.***

Life is vastly easier in the industrialized world than it was 150 years ago. Most people live longer, eat more and work less. Many live in private homes and drive to work alone in their own cars. Office workers communicate instantaneously across continents through telephone, fax and e-mail. Industries crank out new goods faster than people can buy them in ever-bigger shopping malls.

But the advantages of modern life are not available to everyone, nor do they come without a price: new kinds of health problems, many caused by our own bad

habits or by the dirty air and water left behind by industries; the loss of parkland as highways devour open space; declining literacy as television beats teachers in the competition for children's attention; cadres of unemployed and homeless people overlooked by the free market system; and sprawling, desolate suburbs where neighbours are strangers and fear of crime isolates people behind locked doors.

Added to these is the disinvestment in services and physical infrastructure over the past 15 years, which has hit urban dwellers—especially poor urban dwellers—the hardest. The cuts

in government spending for social programmes are all the more stark when viewed in the context of a world with a widening gap between rich and poor. The fraying of social safety nets, most severe in the United States, has increased the percentage of children under 6 living in poverty from 20 per cent of US children in 1980 to 24 per cent in 1995. Without addressing these fundamental inequalities, programmes developed to mend worsening urban conditions will be unable to secure long-lasting solutions.

Even when government agencies and private organizations have the economic means and political will to address these ills, the typical approach is fragmented and specialized: A programme is created to fix a problem. A clinic is opened to treat disease, ignoring the fact that good health is much more than the absence of illness. Schools are upgraded, but the curriculum ignores lessons learned on the streets and in the media, which set the patterns for children's beliefs and perceptions.

There is a better way. It is rooted in the simple but revolutionary idea that health is less about medical care than about equitable access to such basic pre-

requisites of health as food, shelter, transportation, clean air and water, education, physical safety and meaningful jobs paying sufficient wages. This way of thinking expands on the idea that no person or family is an island; everyone's life is bound up in the whole community.

## Quality of life

Ask people to imagine their ideal community and what they describe is a modern version of a 19th century European market town: a place that is built to human scale; small and compact yet technologically and ecologically sophisticated; where all the activities of daily life are located within walking distance; where the absence of cars means that children can play safely and people can greet their neighbours while strolling on the sidewalk; and where trees and grass and flowers are plentiful.

The message is obvious: What people want is quality of life. They want their children to be healthy and happy and safe, they want to work close to home at meaningful jobs for which they are fairly compensated, they want to have time for recreation and learning. Most of all, they want

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# INDUSTRIALIZED COUNTRIES

## COMMENTARY

human connections. What people are describing when they talk about their ideal town or city is a healthy community. Not very many exist—yet. But for more than 10 years now, a movement called ‘Healthy Cities/Healthy Communities’ has been helping communities to cure their ills—or better yet, to prevent them.

The movement emerged from the concerns of people in diverse countries about the deterioration of their communities. It was sparked in 1984 by a one-day workshop—Healthy Toronto 2000—organized in conjunction with a conference on healthy public policy. There, staff from the World Health Organization (WHO) recognized an opportunity to put health promotion concepts into practice in Europe. Two years later, Healthy Cities projects were initiated in 11 European cities.

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*Oakland passed a measure requiring that 2.5% of the city budget go to children's needs.*

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Municipalities in at least 50 countries were participating by 1996, when WHO chose Healthy Cities as the theme for its annual World Health Day. To date, participating communities number in the thousands worldwide.

Given current trends, nothing could be more important than an initiative aimed at improving the quality of life and health in cities. By the year 2000, almost half the world's population will live in and around urban areas. In the industrialized countries, growth is increasingly taking place in suburban areas, which puts even more demands on transportation, housing and other services because of the suburbs' dispersion and low population density.

For children, especially in neighbourhoods left behind by economic progress, Healthy Cities/Healthy Communities is a tool for fulfilling the rights pledged in the Convention on the Rights of the Child—among them, the right to health care, to education and to housing, as well as the right to play and to participate in society.

### Creating a healthy city

A healthy city is not a finished product created at one point in time; it is a dynamic place where citizens and government have established relationships and processes that allow them to collaborate in tackling any problems that arise. The healthy city approach calls for collective action, in which all the sectors—local government as well as community, religious and other groups and individual citizens—work together for a common purpose. A healthy city is also sensitive to gender, working to eliminate the discrimination that women face in access to housing, services and jobs.

The role of local government is too often overlooked. Yet in analysing health improvements in the city of Oxford (UK) in the past 200 years, public health physician Jessie Parfitt wrote: “Many would be surprised to learn that the greatest contribution to the health of the nation over the past 150 years was made not by doctors or hospitals but by local government.”

Municipal governments are involved in making decisions about urban planning, public works, housing, fire and police protection, education, public health, transportation and a whole host of other issues that have, cumulatively, far more impact on the well-being of their citizens than do health care services. Ensuring that local officials take health into account in making decisions is an important part of the process of creating healthier cities and communities.

People tend to view needs as endless and resources as few. But resources are greater than anyone at first imagines, and discovering that fact makes people realize how much power they have to address their most pressing problems. Every community has individuals who are ready and willing to contribute their untapped, if not professional, skills—entrepreneurial, political and managerial.

While no city can claim to have achieved the ideal, Horsens (Denmark), one of the first cities in the WHO Europe project, comes close. With initial leadership from local government staff and politicians, this community of 70,000 people has made the healthy city approach integral to its way of working and to municipal decision-making. Representatives from all municipal departments make up a Healthy City Group chaired by a full-time coordinator. At a Healthy City Shop, people come together to work on myriad problems ranging from environmental clean-ups to closer integration of immigrants into the life of the city. So successful is the approach that a joint public/private sector partnership has established a consulting group to advise others on how to create healthier cities.

The Healthy Communities banner is guiding similar efforts in many other cities. In 1990, the City Council and the residents of Parksville (Canada) developed a process to involve all parts of the community in defining a set of shared values and writing a plan based on them. The values statement developed by the citizens of Parksville, a rapidly growing community of 10,000 people in British Columbia, emphasizes environmental quality, maintenance of a small-town atmosphere, economic vitality, equal access to a range of human services and amenities, affordable public transportation and an ongoing forum for citizens to

express opinions on local issues. These values have been integrated into a decision-making checklist that is applied to new construction.

The Healthy Community process has now also been used as the framework for developing a strategic plan for Parksville. This effort resulted in the creation of a ‘Healthy Community Advisory Commission’ and a new organizational design for local government. Five committees, staffed by over 100 volunteers, are working in areas such as economic development, environment, housing, transportation and access for people with disabilities.

### Children's role

Children are a crucial part of a healthy city's life and growth. Without their participation, the community is not fully represented. Too often, lip-service is given to children's needs, but in a healthy city, young people are part of civic life. They express opinions and take part in neighbourhood projects.

In Rouyn-Noranda, a city of 30,000 in Quebec (Canada), 5,000 young people were asked in 1987 to describe what their town would be like in the future if it were more healthy. Their ideas formed the basis of a youth agenda, presented to the City Council, which has helped to shape the city's activities for a number of years.

Among the agenda's initiatives were a programme of activities to highlight accomplishments by young people and steps to reduce emissions of acids and heavy metals from the smelter that is the economic lifeblood of the region. During a community forum in June 1996, a second round of projects was adopted, including plans for neighbourhood justice circles for youth and a strategy to reduce poverty.

Healthy Cities has been active in Oakland, California (US) since 1993. Even before that, the city

worked in partnership with the county administration to promote the health and well-being of its residents. In several Oakland neighbourhoods, the infant death rate used to be as high as in some developing countries—more than 20 deaths per 1,000 live births. Public health officials had undertaken the usual measures: more prenatal care, nutrition programmes, counselling of mothers. But these actions had negligible effect. Community members formed a coalition to work on the problem.

That effort led to the establishment in the early 1990s of a series of coalitions of diverse people addressing issues of education, housing, economic development, security and law enforcement. At one meeting, when the discussion turned to infant mortality, representatives of some coalitions started to leave, because they felt their mandate was unrelated. Persuaded to stay, they began to see that the infant death rate is an issue not just of health but also of poverty, adolescence, education, housing and transportation.

Four years later, the rate in the neighbourhoods had dropped by half, the first decline in 25 years—because people began to address infant deaths not only as a medical problem but also as a community problem. Collaboration between agencies improved and the city won a federal grant aimed at reducing infant mortality. In addition, through the coalition process, the word spread about services that had been available all along, so more pregnant women began to take advantage of them.

Healthy Cities raised awareness among Oakland's residents of the importance of investing in children's well-being. In 1996, Oakland passed a 12-year budget bill appropriating 2.5 per cent of the city's budget to children's needs. Children were a major force in getting this legislation passed,

and they are participating in deciding how to allocate funds.

In Milan (Italy), an Urban Child Project began in 1989, with UNICEF backing, to work on improving the quality of life for children, with an emphasis on their right to participation. A well-to-do city, Milan nonetheless suffers from the range of modern social ills, including poverty, crime and unequal access to community services. Research undertaken when the project began found little coordination among the many institutions dealing with children's issues. Information about young people's needs was disjointed, and there was no systematic monitoring of conditions.

In 1994, Milan established a Council for Child Well-being to oversee plans for children's programmes, monitor fulfilment of child rights and assist in coordinating municipal resources. Two pilot projects were begun in 1995 to help social workers access services more efficiently, renew urban areas and encourage the participation of children and local communities.

Many benefits have resulted. Resources for services were surveyed, resulting in development of

a map, called 'Friendly spaces for us', which was widely distributed. Children, assisted by facilitators, surveyed their neighbourhoods and prepared plans for improving them, complete with designs and models. They have carried out projects to improve parks and courtyards with the help of local artisans and municipal technicians.

More than 3,000 children have participated in Milan's healthy cities' activities, and the project is expanding to three additional neighbourhoods. The total population now benefiting is about 300,000.

Children in Seattle, Washington (US), similarly got involved in improving their environment through Kid's Place. It was initiated in 1983 by a retired paediatrician so that young people would have somewhere to go for recreation other than shopping malls.

The first activity, developed by children with some adult help, was a simple questionnaire asking children about places in their community—the cleanest place, the happiest place, the most unsafe, the most stimulating.

With this survey, the children identified dangerous intersec-

tions, polluted areas, good schools and safe areas—all without an expensive study. They pointed out that public transport did not take them where they wanted to go because it was developed to carry adults to and from work. The Mayor, impressed by their effort, asked them to suggest changes in the bus routes. The routes were changed, the children's needs were met and the buses made more money. Seattle has now developed a city-wide policy for children and youth.

Kid's Place and similar programmes are now active in many cities in Europe, Japan and North America. The results have included new parks and play areas, pedestrian bridges, neighbourhood centres and clinics for adolescents. Young people have won approval for midnight basketball games and have persuaded principals to keep schools open late so they can be used for recreation.

These efforts have in common the participation of citizens in deciding the community's priorities and working to achieve them. A healthy community is dynamic. It has the capacity to change with the times and with the needs of its citizens. But they cannot do it alone. Only when governments join with residents in willing partnership can urban areas become responsive to the needs and rights of all their inhabitants, young and old, poor and rich. These efforts require political will and new forms of democratic and participatory governance reoriented towards social needs.

As we enter the urban millennium, when the majority of the world's children will be born and raised in cities, the health and well-being of young people and of future generations will depend upon our ability to create healthier cities and communities. The progress of nations will thus be closely tied to the progress of cities. ■



*The urban infrastructure of the industrialized countries, particularly in poor areas, is crumbling after 15 years of disinvestment. A neighbourhood full of boarded-up buildings, such as this one in London, is no place for a child.*

Philip Wolmuth/Panos Pictures

### Youth unemployment rate highest in Spain, lowest in Austria and Switzerland

In Spain, more than 40% of young people age 24 and under who are looking for work fail to find it. At the other end of the scale, in Austria and Switzerland, the youth unemployment rate is only 6%.

More than a quarter of the 22 industrialized countries providing information have youth unemployment rates above 20%. In 10 of the countries, female unemployment rates are higher than those of males, while in 8 countries, young men have a harder time finding jobs than young women.

The data include only those young people of a specified age, usually 15 through 24, who are looking for work. A country's youth unemployment rate is the number of youth seeking employment as a percentage of the total number of working and work-seeking youth. In every country, the

youth unemployment rate is higher than the total unemployment rate.

The Convention on the Rights of the Child calls for countries to set minimum ages for employment, regulate conditions of work and protect children from work that threatens their health, education or develop-

#### Youth unemployment rates

Unemployed youth age 24 and below

	% unemployed			% unemployed			
	male	female	total	male	female	total	
Spain	37	51	43	New Zealand	16	14	15
Finland	32	36	34	United Kingdom	16	11	14
Italy	29	39	34	United States	13	11	12
France	26	32	29	Germany	11	9	10
Greece	20	37	28	Netherlands	9	11	10
Belgium	19	27	22	Norway	11	9	10
Sweden	22	22	22	Luxembourg	8	8	8
Ireland	18	16	17	Denmark	6	9	7
Australia	17	16	16	Japan	7	7	7
Canada	19	14	16	Austria	4	7	6
Portugal	13	20	16	Switzerland	6	6	6

Source: Eurostat news release no. 3/97, 1997; OECD, *OECD in Figures*, 1996.

ment (article 32). The International Labour Organization's general minimum age of 15 years (provided this is not less than the age of completion of compulsory schooling) is the most widely used standard.

Youth unemployment results in social and economic trauma at a per-

sonal, community and national level. For young people, work is more than earning an income: It is a critical phase in the transition from dependent childhood to independent adulthood and a source of emotional and social well-being. Although the links between youth employment and crime are tenuous, research affirms the association between unemployment and a decline in psychological health.

While the phenomenon is disturbing, it is not new: 10 years ago, youth unemployment rates varied from 5% to 48% in industrialized countries; today, they vary from 6% to 43%. By seeking solutions to the problem—such as promoting ways to combine education and work—countries can address labour markets' ever increasing demand for higher skills and the best interests of young people.

### Teens at risk: Drinking and bullying

Millions of adolescents in some of the wealthiest countries in the world are seriously affected by alcohol abuse and bullying—behaviours that compromise their health and limit their chances to become successful adults. Both alcohol abuse and bullying, found at high levels in a number of industrialized countries, according to a WHO youth health survey, are associated with alienation from school and home, as well as low academic achievement. Boys are at higher risk than girls.

In the countries surveyed, the highest levels of alcohol abuse among both boys and girls are found in Denmark. Danish girls have the highest levels of all: 67%. Denmark is the only country where girls have a higher rate of alcohol abuse than boys. In 14 countries or regions within countries where 15-year-olds were asked about their experience with alcohol, more than one third of boys reported being drunk two or more times.

Teens who misuse alcohol are

more likely to develop health problems and die prematurely. While the increased risk is partly the result of the direct effects of excessive alcohol consumption—liver disease, depression, road accidents—it is also due to the link between drinking and other high-risk behaviours, such as smoking and violence.

Bullying—which includes physical contact or verbal abuse—is also associated with such high-risk behaviours as drinking to excess and smoking. The variation in the amount of bullying occurring among 15-year-olds is striking. Germany has the highest rates: 86% of boys and 72% of girls reported bullying others at least once in the past school term. In Wales, the rates dropped to 28% of boys and 13% of girls.

More than half of boys and girls in Austria, Belgium (Wallonia), Denmark and Lithuania reported engaging in bullying. The behaviour, however, is considerably less frequent among girls than boys.

#### Alcohol abuse

Percentage of 15-year-old students who had 2 or more episodes of drunkenness

	% male	% female
Denmark	65	67
UK (Wales)	61	59
UK (Scotland)	53	51
Finland	52	50
Austria	46	30
Denmark (Greenland)	46	46
Slovakia	46	20
UK (N. Ireland)	44	36
Canada	39	38
Hungary	37	20
Czech Rep.	36	19
Latvia	35	21
Germany*	34	26
Poland	34	18
Belgium (Flanders)	31	16
Norway	30	29
Belgium (Wallonia)	27	20
Lithuania	27	17
Sweden	27	22
Estonia	26	10
France*	24	13
Spain	23	19
Switzerland	22	13
Russian Fed.*	21	12
Israel	8	6

#### Bullying

Percentage of 15-year-old students who took part in bullying others at least once in the previous school term

	% male	% female
Germany*	86	72
Austria	78	59
Denmark	75	53
Lithuania	73	53
Belgium (Wallonia)	70	56
Denmark (Greenland)	64	40
Estonia	64	32
Belgium (Flanders)	62	34
Israel	57	25
Finland	56	26
Norway	56	19
Latvia	54	36
France*	49	39
Russian Fed.*	46	35
Canada	42	23
Switzerland	42	13
Hungary	40	18
Czech Rep.	39	23
Slovakia	35	16
UK (Scotland)	34	16
Poland	32	14
Sweden	32	12
UK (N. Ireland)	29	10
UK (Wales)	28	13

\* France, Germany and the Russian Fed. are represented only by areas. Source: A. King, B. Wold, C. Tudor-Smith, and Y. Harel, *The Health of Youth: A Cross-National Survey*, WHO Regional Publications, European Series No. 69, 1996. (Surveys undertaken 1993/94.)

# Sharing the wealth? Aid at lowest level in 45 years



UNICEF/93-1994/Prizzoi

Development aid goes far when used to develop skills of local staff. A health worker, her training supported by aid funds, weighs a baby in Benin.

Official development assistance (ODA) from the industrialized countries is in the doldrums, slumping to an average of just 0.27% of their combined GNP, the lowest level since aid statistics were first collected in

1950. The US gave the lowest portion of its GNP for aid: 0.10% in 1995, the latest year for which figures are available. In contrast, Denmark, the Netherlands, Norway and Sweden all allocated more than 0.7% of their

GNP for development assistance, the international target agreed upon in 1969. Denmark tops the list, earmarking 1.04%.

In absolute dollars, Japan gave the most aid (\$14.5 billion), almost double that of the US (\$7.4 billion). The US dropped to fourth place from first place in 1990, when it gave \$11.4 billion in aid. However, together with France and Germany, these four countries accounted for more than three fifths of the total \$59 billion in aid provided by 21 Organisation for Economic Co-operation and Development (OECD) donors in 1995.

On the amount of aid per person, however, Denmark heads the list, giving \$311 per capita. Three countries—Italy, Portugal and the US—gave \$28, the lowest amount per capita.

Though private investments and loans flowing to developing countries have surged, tripling from \$52 billion in 1990 to \$159 billion in 1995, most have gone to a dozen or so emerging

economies, including China, Mexico and the Republic of Korea. The poorest countries, particularly in sub-Saharan Africa, have received hardly any private loans or investment. Aid is crucial for these countries in combating poverty, repaying debt, supporting investment and financing social services.

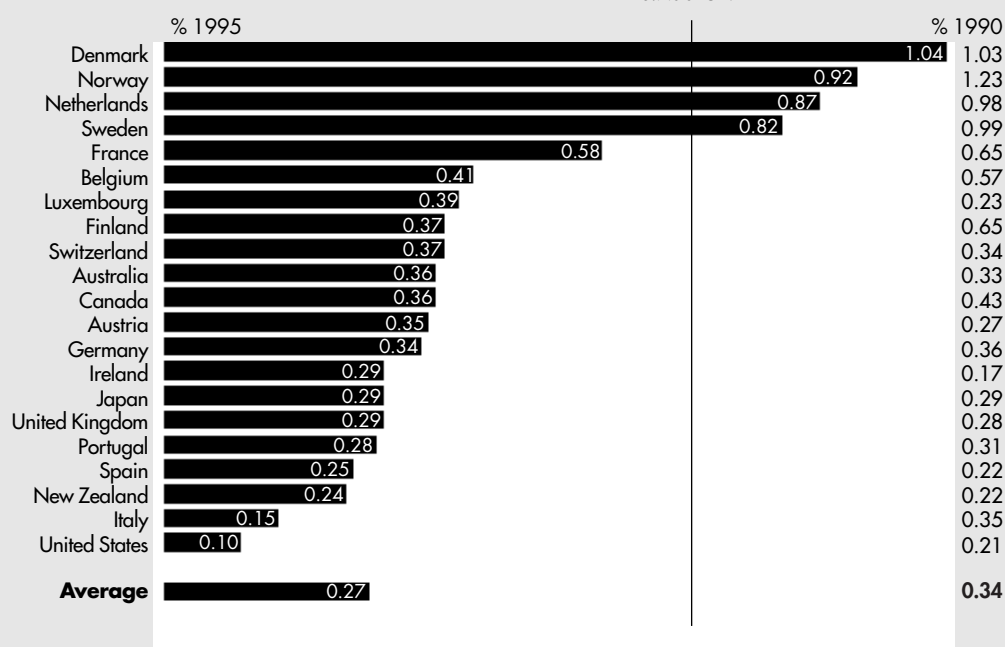
A glimmer of hope in the disquieting aid picture is the evidence of a shift in aid allocations towards social sectors. This trend gains further impetus from the 20/20 initiative, supported by UNDP, UNESCO, UNFPA, UNICEF and WHO.

The initiative calls for allocating 20% of aid and 20% of developing countries' budgets for basic social services—primary health care, including reproductive health and family planning, nutrition, basic education and safe drinking water supply and sanitation. These services are the foundation for sustainable human development.

## Sharing the wealth...or not

ODA as % of donor nations' GNP

Target figure of 0.7% of GNP



## Amounts

	Total aid (\$ billions) 1995	Aid per person (\$) 1995	Change per person (\$) since 1992*
Japan	14.5	116	-5
France	8.4	145	-15
Germany	7.5	92	-9
United States	7.4	28	-18
Netherlands	3.2	208	-2
UK	3.2	54	1
Canada	2.1	70	-14
Sweden	1.7	194	-59
Denmark	1.6	311	8
Italy	1.6	28	-33
Spain	1.3	34	-2
Australia	1.2	67	6
Norway	1.2	287	-8
Switzerland	1.1	151	-59
Belgium	1.0	102	2
Austria	0.8	95	15
Finland	0.4	76	-68
Portugal	0.3	28	-6
Ireland	0.2	43	30
Luxembourg	0.1	160	58
New Zealand	0.1	35	-1

**Total \$58.9 Avg. \$72 -\$13**

Source: OECD, Development Co-operation (1996 Report), 1997.

\*Changes are based on constant prices and exchange rates.