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**Routledge Handbook on Cities of the Global South**

# 44. Healthy Cities of/ from the South

**Notes on contributors**

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## 44. Healthy Cities of/ from the South

### INTRODUCTION

In all the debate on theorising cities from and for the South, discussions of health remain relatively silent amid the rush to find adequate explanatory frameworks for a rapidly-changing urban reality. This silence remains despite the fact that the broad cannon of urban studies has actually been remarkably prolific in responding to Robinson's (2006, x) assertion that urban theory has 'excluded many cities and their citizens from their accounts of the excitement and potential of city life' by corralling cities of the South into developmental frameworks, rather than theories of urban modernity. Indeed, while Mcfarlane (2008, 341) has argued that the South still exists as an 'urban shadow' on the 'edges of urban theory', there now seems to be an increasing movement towards making the shadows smaller (Myers, 2011, Roy, 2011, Roy, 2009, Watson, 2009b, Parnell and Robinson, 2012). Inventive work is being undertaken in Urban Studies, but it remains the case, as Pieterse (2008, 1) contends, that contemporary studies of cities of the Global South are bifurcated between those assuming an 'apocalyptic view' and those 'who display an irrepressible optimism about the possibility of solving the myriad problems that beset such cities'. In turn, whether framed by apocalypse or optimism, 'the categorisation of poorer cities through the lens of developmentalism has often meant that they are discursively constructed as "problem"' (McFarlane, 2008, 345). Here, the difference between the two perspectives stems from the degree to which urbanists believe that cities and their residents hold the solutions or represent only their inevitable downfall. In matters of health, this tension points to a critical set of conceptual and policy debates.

Urban health in the Global South is a particularly contentious and pernicious "problem", especially given the paucity of evidence of 'what works' in an era of 'evidence-based policy making' (Macintyre, 2003). This chapter questions the extent to which 'healthy cities' of the Global South are possible as either material outcome or theoretical object of inquiry. In so doing, it aims to elide an apocalyptic and irrepressibly optimistic Urban Studies in a more syncretic vision of the healthy city. This approach is important as accounts of urban health have largely tended to bypass urban theory and vice versa. Indeed, a series of significant interventions on reframing urban planning theory and practice in the light of the importance of 'new dynamics' of the 'stubborn realities' (Watson, 2012, Yiftachel, 2009) of cities of the Global South (see also Watson, 2009a, Watson, 2009b) places health at the temporal and empirical margins of discussion. Here, the relationship between public health and planning is mainly viewed as a past aspiration of the modern, colonial endeavour, with the state now assuming the role of health promoter through regulation, governance and service provision (Watson, 2009b, 2270). Health does not appear on the roll-call of '21st century issues of poverty, inequality, rapid growth and environment' (Watson, 2009a, 153), an oversight which may, in part, be due to the fact that human health has largely be side-lined in discourses of 'urban sustainability' in favour of environmental concerns (Smit and Parnell, 2012, 1). Health geographers have persuasively made the case for the importance of 'place' in health processes, policies and outcomes (Airey, 2003, Cummins et al., 2007, Kearns and Gesler, 1998, Kearns and Moon, 2002, Kearns, 1993), but urban theorists of the Global South should also have much to contribute to this field. This chapter thus offers an initial exploration of how these fields may be brought into productive conversation in ways that tread the line between apocalypse and optimism with criticality and care.

## HEALTH IN THE "URBAN CENTURY"

The recurrent recitation of the percentage of people calling cities their home in this "Urban Century" (Beall and Fox, 2009) should leave us in little doubt as to the location of the most significant pressure points in the pursuit of universal health. However, if we accept that 'urbanization is a major public health challenge for the twenty-first century … [especially] as urbanization itself is a determinant of health' (Kjellstrom and Mercado, 2008, 554), then we must also remember that 'any discussion of urbanisation needs to acknowledge that the practice of dichotomising the world as "urban" and "rural" is problematic' (Vlahov et al., 2011, 799), especially as rural communities become enfolded with an ever-growing peri-urban hinterland. The challenges posed by the unpredictability, magnitude and scale of urbanisation processes reach their apex in the mega-cities of the Global South which are argued to 'embody the most extreme instances of economic injustice, ecological unsustainability, and spatial apartheid ever confronted by humanity' (Dawson and Hayes Edwards, 2004, 6). But, as Robinson's work reminds us, we must move beyond categorisations and hierarchies of cities (see for example Beaverstock *et al's* 1999 roster of Alpha, Beta and Gamma World Cities) to reconsider the spaces in between explanations of modernity and discourses of development that characterise not only emergent mega-cities, but also the increasingly "mega" medium and small cities of the South (Asdar Ali and Rieker, 2008, World Health Organisation, 2008). It is in these multiple urban spaces that the urbanisation of poverty (Ravallion et al., 2007) and the infrastructural burdens of growth are having profound health effects. That said, determining the causal and contributory factors in this urbanisation-driven 'public health challenge' remains methodologically complex, undermining attempts to define what the healthy city might look like, function or aspire to be. The World Health Organisation (WHO) asserts that urban settings themselves are 'social

determinants of health' (see Marmot, 2005), and that the factors driving poor health are at their most acute in the slums that characterise many cities of the Global South. This 'universe of urban slums and shanty towns' (Davis, 2004, 11) is estimated to currently house at least one billion people (World Health Organisation, 2008, 1, Sheuya, 2008). By 2030, Mike Davis suggests that 'at least 2 billion…will exist outside the formal relations of production, in Dickensian conditions or worse, ravaged by emergent diseases and subject to a menu of megadisasters following in the wake of global warming and the exhaustion of urban water supplies' (2004, 13). Importantly, these conditions (hyperbole aside) threaten to unravel the 'urban advantage' long believed to convey better health on urban dwellers in the Global South compared to their rural counterparts due to better education, higher incomes, reduced fertility, improved access to healthcare services, infrastructure and employment opportunities (Dye, 2008).

In terms of *absolute numbers of deaths* in 2008, cardiovascular disease was the biggest global killer claiming 17.33 million lives and cancer the second most significant cause of death (figure 1). By contrast, diarrhoeal diseases caused 2.5 million deaths, HIV/AIDS 1.8 million deaths and malaria 827,000 deaths in 2008. This means that, as figure 2 illustrates, non-communicable or chronic diseases actually accounted for almost 63% of the global mortality burden; communicable (infectious), perinatal and maternal diseases 28% and injuries 9% in 2008. By contrast, the leading global cause of *years of life lost* (YLL) in 2008 (the most recent WHO data) are communicable disease at 48% (figure 3). Non-communicable diseases accounted for 38% of years of life lost and injuries for 14%. This pattern exhibits distinct variations between WHO regions, with 77% of years of life lost in Africa accounted for by communicable disease, in contrast to 72% of years of life lost attributable to non-communicable disease in Europe and 63% in the Western Pacific and 59% in the Americas.

YLL is a measure of premature mortality and indicates that globally, communicable disease and injuries cause more adults and children to die before they reach average life expectancy than non-communicable conditions. In Africa, non-communicable diseases account for only 15% of YLL, reflecting more than anything the age gradient of chronic disease as well as the low life expectancies of much across the continent. The discrepancy between the relative significance that can be attributed to communicable/ non-communicable diseases depending on whether total deaths or YLL are considered, further highlights the epidemiological gaps in our knowledge and understanding of the intricate dynamics of the *global* health burden, let alone the urban health burden. There are massive variations in the burden of disease not merely between the Global North and South, but also between and within countries of the Global South. Such discrepancies are further experienced across urban space, where the same city may have co-existing high rates of both infectious and chronic disease prevalent across different locales and population groups. Even at the scale of a household, a "dual burden" of malnutrition (with its attendant elevated risks of contracting infectious disease) and obesity may increasingly be, if not the norm, then at least an issue of substantial concern for many middle income countries (Doak et al., 2004).

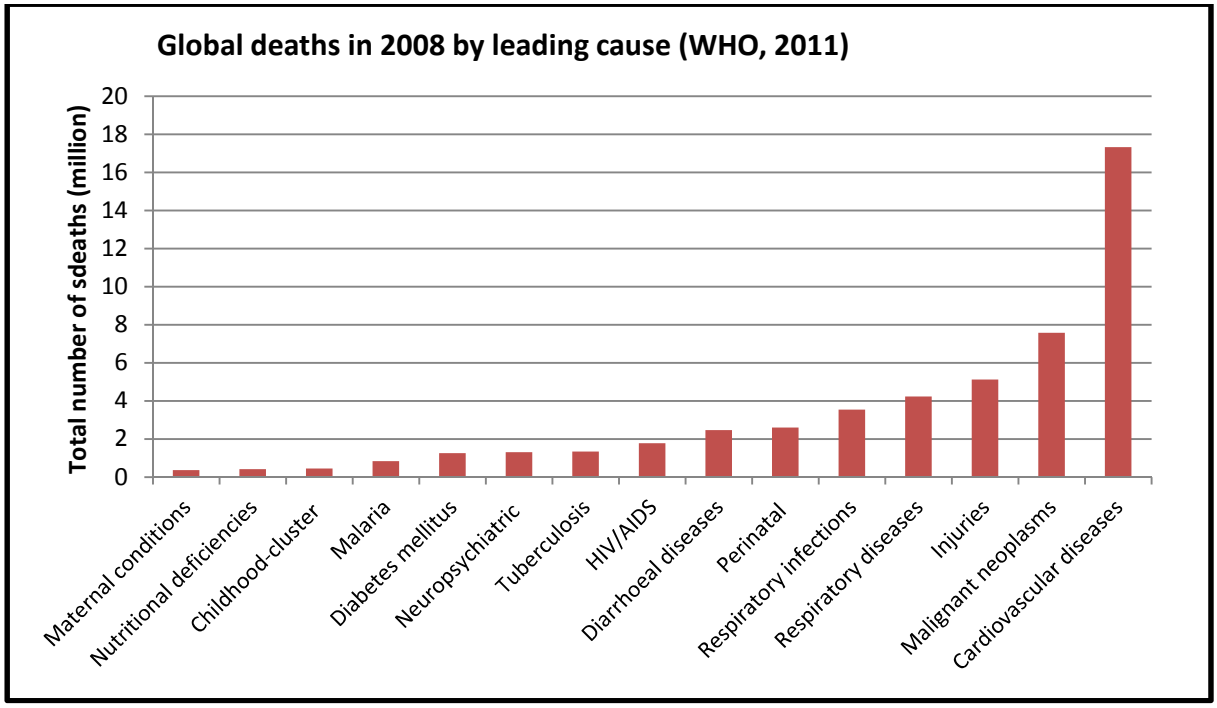


**Figure 1 – Global deaths in 2008 by leading causes (Source data – WHO, 2011)**

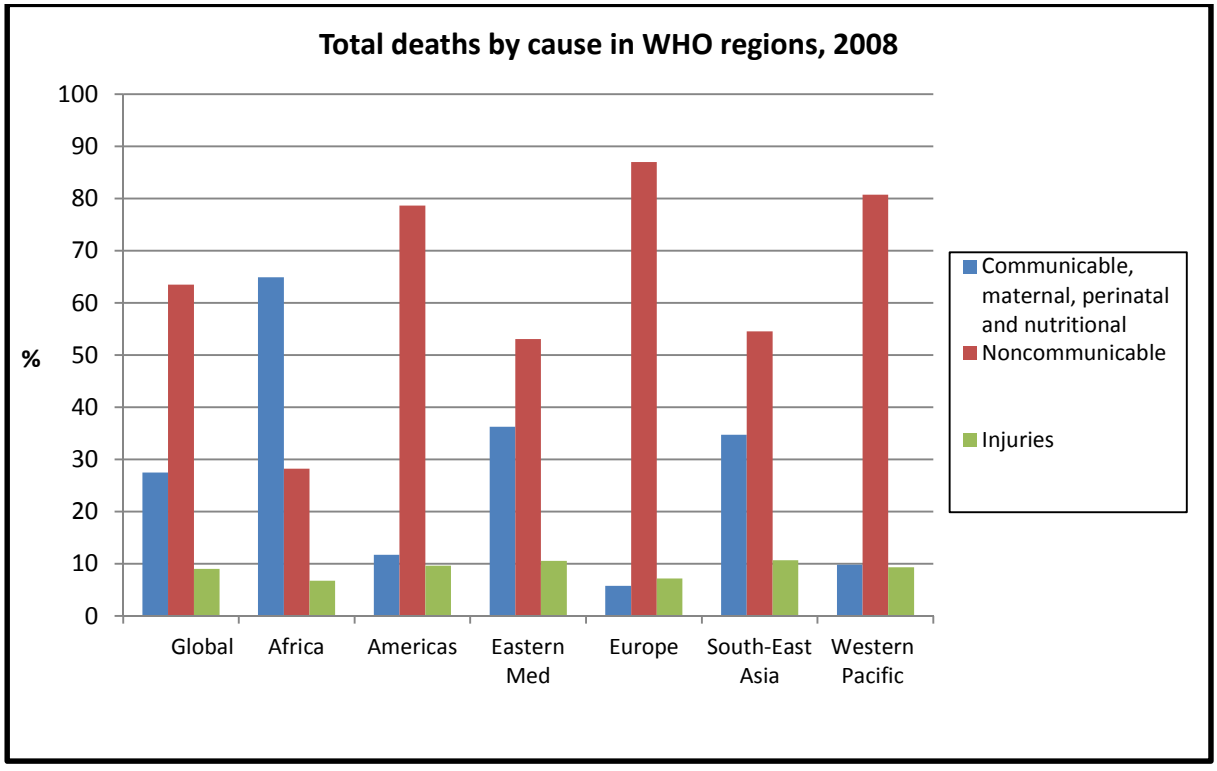


**Figure 2 – Total deaths by cause in WHO regions, 2008 (Source data: WHO, 2011)**

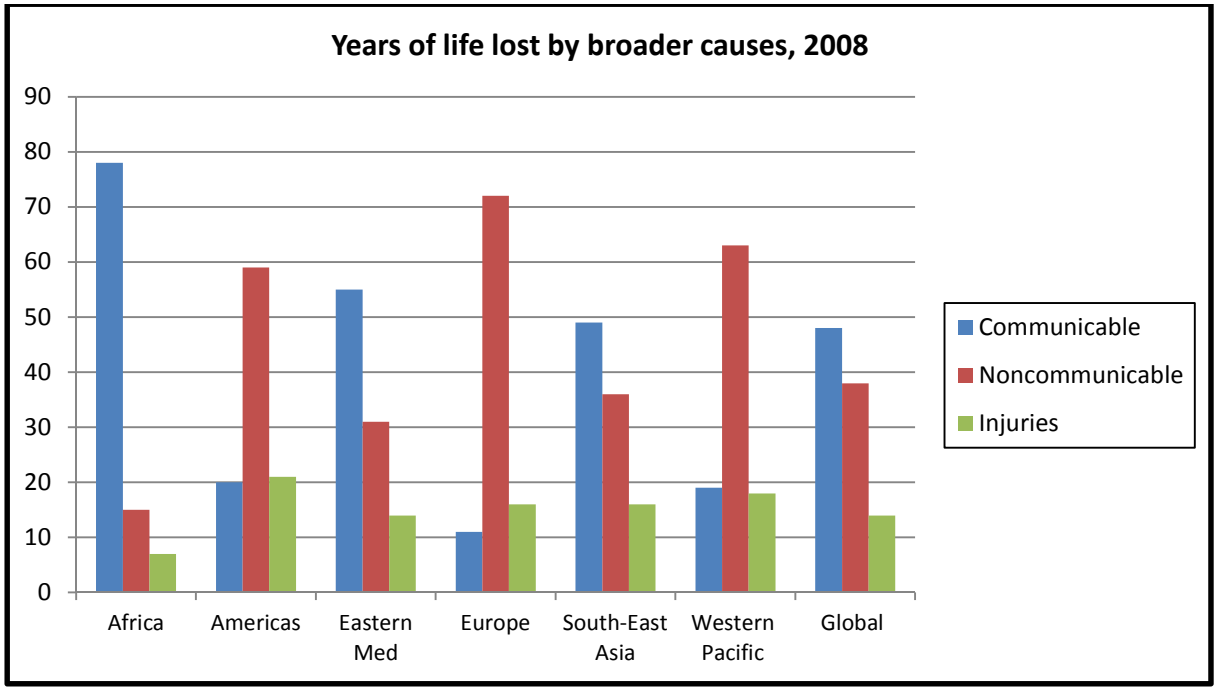


**Figure 3 –Years of life lost by broader causes in 2008 by WHO region (Source data: WHO, 2011)**

With this in mind, one key question that faces the multidisciplinary study of urban health is whether we are currently facing a shift from a previous state of "urban advantage" to one of "urban penalty". The answer to this question is limited by the fact that 'there are no systematic, comparative studies of the health of the urban poor across the continents' (Harpham, 2009, 111), a situation brought into being by the relative paucity of health survey data in many countries and methodological barriers to comparing datasets. Moreover, there are often stark challenges in undertaking urban health research not least as the dynamics of causality, correlation and health outcomes are both incredibly complex and context-specific (Mathee et al., 2009), with questions over the relative contribution of 'composition' (i.e. demographics) or 'context' (i.e. place-based, structural factors) remaining open (Jen et al., 2009, Do and Finch, 2008). Thus epidemiology and urban studies have much to learn from each other, particularly in the pursuit of bringing forth healthy cities. The gross inequalities

characterising many cities of the Global South presents a twin health challenge as 'rich and poor people live in very different epidemiological worlds, even within the same city' (Rydin et al., 2012a, 2079). In this case, the urban poor - who Mike Davis has characteristically referred to as the 'outcast proletariat' (2004, 11) – occupying slum conditions face equal or worse health outcomes than rural dwellers (WHO/UN-HABITAT, 2009, Goebel et al., 2010). By contrast, the urban rich may enjoy significantly longer life expectancies, but may still be disproportionately affected by rising rates of non-communicable disease (Blas and Sivasankara Kurup, 2010) compounded by behavioural risk factors including alcohol consumption, smoking, dietary choices, sedentarism as well as exposure to pollutants. Increasingly, however, non-communicable disease risk is not concentrated solely among the urban rich in the Global South, for as Monteiro *et al* (2004) suggest, that as a country's GDP rises, so too does the risk of obesity amongst the poorest and that, furthermore, this relationship is strongest for women. Thus urban and economic growth present an increased risk of obesity. The complex dynamic between the urban rich and poor in terms of health outcomes is also manifest in the rising rate of road traffic accidents and injuries in the Global South. Poor road infrastructure combines with scant regulation of driving laws and an increasing volume of traffic producing a 'neglected epidemic' across the Global South, but reaching an their highest rates in the low and middle-income countries of Africa and the Middle East (Nantulya and Reich, 2002). Although there is little comparative data, studies suggest that the greatest burden of mortality from road traffic accidents is among pedestrians rather than drivers rich enough to have cars, indicating the disproportionate vulnerability of the urban poor (Ameratunga et al., 2006).

Such a scenario paints a pretty grim picture of health in cities of the Global South. This is compounded by the 'Global Health' enterprise's concentration of political will and financial

resources on infectious, maternal and child health, reflecting the demands of the Millennium Development Goals (United Nations, 2010), rather than the evolving global burden of disease (Koplan et al., 2009). Thus, foreign aid donations and global organisations – e.g. the Bill and Melinda Gates Foundation, the Global Fund, the Global Health Initiative, the Rockefeller Foundation, Bloomburg Initiative, Clinton Foundation etc - that provide the bulk of the Global Health arsenal dispense funds according to priority intervention areas including malaria, HIV/AIDS, Tuberculosis (TB), tobacco control and maternal health. The Gates Foundation, for example, prioritises the development of low-cost, mass-scale technological solutions including vaccinations, nutritional interventions and family planning programmes. The Global Fund prioritises access, affordability and adherence to antiretroviral drugs; TB detection and treatment; and the distribution of insecticide-treated mosquito nets, malaria rapid diagnostic tests and treatment. Many of these organisations also lobby for the reformation of healthcare economics and markets to ensure that the poor in low and middle income countries have access to affordable drugs, as well as for greater health surveillance (i.e. data) capacity. Yet, while 'global health is fashionable', a burgeoning area of foreign policy and a major area of philanthropy (Daar et al., 2007, 1993); the urban is an implicit rather than explicit area of activity, investment and activism (Shetty, 2011). This point is corroborated by Vlahov *et al* in their suggestion that 'International agencies and nation-states have been ignorant of, or in denial about, the increasing vulnerability and consequent impact of urban environments' (2011, 797). It is interesting to note, therefore, that a recent special issue of the *Lancet* on 'Health in Brazil' (Kleinert and Horton, 2011) did not feature any explicitly 'urban' analyses and even a paper on chronic disease referred only to generic processes of 'urbanisation' as a causal factor (Schmidt et al., 2011).

This 'ignorance' or 'denial' on the part of international agencies and nation states has persisted despite significant lobbying efforts to raise urban health up global agendas. For

example, the WHO chose the theme of 'Urbanisation and health' for its 2010 World Health Day's theme, UN-Habitat has invested heavily in its 'State of the World's Cities' research and in 2009 focussed its report solely on 'Urban health inequity and why it matters'. There has been a University College London/ *Lancet* commission report (Rydin et al., 2012a) on 'Healthy Cities', the New York Academy of Medicine has an *International Society for Urban Health* and there have been a series of calls for attention to the 'globalised' (and thus urbanised) risks of non-communicable disease (Beaglehole and Yach, 2003, Yach and Beaglehole, 2004, Yach et al., 2005). On this latter point Beaglehole *et al* (2011, 1438) assert that 'the spread of non-communicable diseases (NCDs) presents a global crisis' which needs to become 'central to the long-term global development agenda'. Thus, there has been a parallel drive (by organisations such as the NCD Alliance) to revise the Millennium Development Goals in line with the complexities of the epidemiological transition in the Global South. The model's logic of a shift in the burden of disease from infectious to chronic has been problematised in many countries (especially in Sub-Saharan Africa) where high rates of infectious and chronic disease not only co-exist, but also act as risk factors for each other (Lopez and Mathers, 2006). In sum, therefore, while Vlahov *et al* have convincingly argued that 'Urban settings are a priority area of focus as they are the platform on which the 21st century mega-trends are played out' (2011, 794) and an array of books have been published in the last two decades arguing for the importance of urban health (Harpham et al., 1988, Harpham and Tanner, 1995, Vlahov et al., 2010, Mitlin and Satterthwaite, 2012) the Global Health endeavour (and therefore significant funding and research) still seems to be lagging behind this stream of thought.

For the Global Health enterprise to take urban health seriously would require a significant reframing of the locus of risk and vulnerability. In their recent *Lancet* Commission report, Yvonne Rydin and colleagues (2012b, 554) contend that healthy communities require eight

amenities: clean water and good sanitation; clean air; clean land; safe homes; secure neighbourhoods; car-independence; green and blue spaces; and healthy facilities. The necessity of these amenities points to the importance of urban planning, management, governance and infrastructural upgrading. In turn, these raise issues of capacity and competence as problems of urban sustainability and human health are compounded by 'relatively rapid population growth combined with high levels of poverty and under resourced and under-capacitated local governments' (Smit and Parnell, 2012, 5). Moreover, while infrastructural issues of inadequate sanitation (water and drainage), pollution (indoor and outdoor), poor housing, and lack of services are most glaring in slum conditions (Sclar et al., 2005); in many cities of the Global South, such concerns also mark the daily lives of all but the most wealthy. These are concerns that have yet to permeate the Global Health rubric. For example, Goebel *et al* (2010, 57) assert that 'housing is one of the basic human needs that have a profound impact on the health, welfare, social attitudes and economic productivity of the individual'. This acknowledgment locates risk and vulnerability in the built environment and suggests that some of the greatest returns in human health would be achieved through environmental upgrading. Put bluntly, the investment by the Gates Foundation, UNICEF and the WHO in, for example, breastfeeding as a low-cost means of improving child and maternal health is laudable. However, its long-term effects on well-being will ultimately be undermined under conditions of food insecurity and inadequate sanitation. A turn to the urban environment as a site of both risk magnification and mitigation demands that we return to the concerns of urbanists of the Global South highlighted at the start of this chapter. In particular, it is important to explore how the city and the urban figure in all the problems to which urban health discursively, materially, physiologically and psychologically makes reference. This task will be the concern of the rest of this chapter.

## THE HEALTHY CITY: APOCALYPSE OR OPTIMISM?

Improving urban health in the Global South is a significant and multidimensional development challenge (Satterthwaite, 2011, Mitlin and Satterthwaite, 2012), especially given the adverse impacts of inequalities. These fall along the socio-economic and demographic 'fault lines' of class, gender, ethnicity, religion, education etc, but are also both cause and consequences of the infrastructural variances patterning cities of the Global South (*ibid*). These conditions combine to produce inequities in health, in which the 'spill-over effects such as crime, violence, the spread of infectious disease as well as alcohol and drug use, affect all of society' (Pearce and Dorling, 2009, 5). While there is agreement that inequalities of all kinds have pernicious effects at a number of spatial scales; this focus raises questions as to the relative impact and importance of the nested and interlaced social determinants of health set out below in figure 4. For, if we concur with de Leeuw (2012a, 3) that 'health is a relative state and highly contextual, driven by individuals, groups and communities that constantly live and create health in in a complex, changing and adaptive physical and social environment', then these processes of 'living' and 'creating' health require us to question the theoretical and empirical state of the Southern city. How, for example, are living and working conditions shaped by the intersections of political economy, the built environment and demographic factors in cities of the South? The ways in which health is dependent on 'many interactions and feedback loops' in the 'complex systems' characterising cities (Rydin et al., 2012a, 2079) means that questioning the 'situatedness' of and multi-scalar nature of health-promoting and constraining practices is essential. Moreover, to do so means grappling with the most appropriate explanatory framework to explain the contemporary urban experience – a process that means balancing apocalypse and optimism in

the hunt for the best ways to ensure that the 'urban advantage' remains possible. As both the poor and middle class swell in the Global South (the latter arguably based on the disenfranchisement of the former), so too will the health challenges of Southern cities (see for example Banerjee and Duflo, 2008, Chua, 2000), especially as behavourial risk factors such as sedentarism and unhealthy diets become globalised (Beaglehole and Yach, 2003). In such conditions, neither apocalypse nor unfettered optimism at the entrepreneurial possibility of the human spirit seem particularly pertinent to the lived reality of an emergent and grossly understudied social phenomenon.

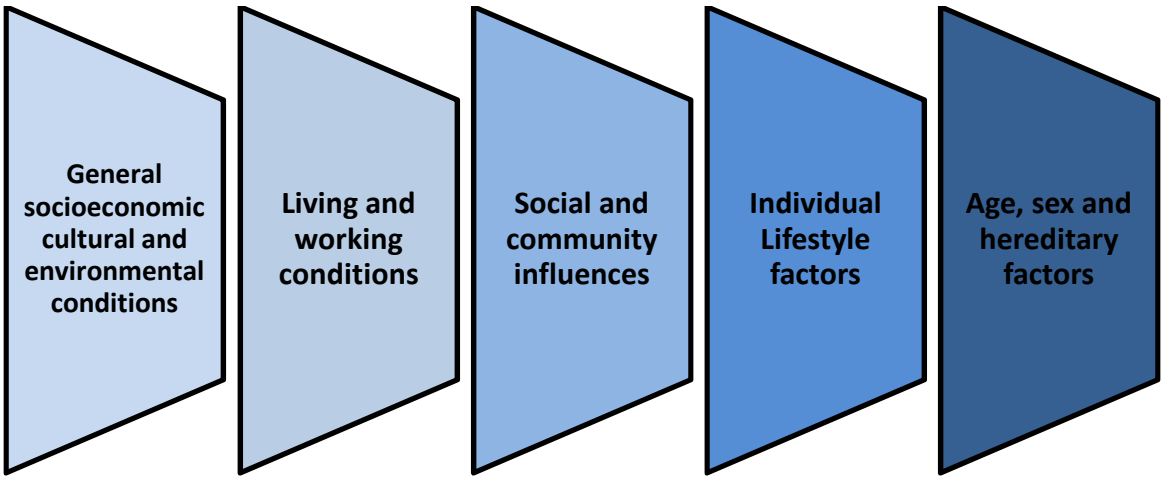


**Figure 4 – Social determinants of health (after Marmot, 2005, WHO/UN-HABITAT, 2009)**

In *Planet of Slums*, Mike Davis (2007) highlights an apocalyptic vision of the city where the huge burden and toll of infectious disease made worse by crumbling infrastructure, the retreat of the middle classes and rich from public infrastructural investment, the dangers of overcrowding, poor environmental conditions and forced resettlement of the urban poor to peripheral locations by rampant speculative development and lax planning laws have produced inherent and uncontrollable risks. He highlights the increasing intra-urban

disparities in health between the rich and poor which have been exacerbated by the erosion of state healthcare provision and the resulting flight of trained healthcare practitioners by neoliberal structural adjustment, chronic underinvestment, the burden of national debt and the entrance of private healthcare providers. Such a situation sets up alternative realities for the rich and poor: the former able to access the privatised means to good health and the latter cut out of even basic healthcare service provision due to a lack of provision and affordability (of services and medication). And, while the rich can afford to barricade themselves in the increasingly common suburban real estate developments or 'privatopias' (McKenzie, 1996) that now ring many cities of the Global South (see Roy, 2011 on Delhi's farmhouses and Calcutta's new towns, and Glasze et al., 2006), they are still vulnerable to the health effects of these aspirational lifestyles. Indeed, the traffic congestion and air pollution that characterises almost all Southern mega-cities (and increasingly medium and small ones) – and that is doubtlessly worsened by suburbanisation and edge-city development - represents one of the most visceral negative externalities of the movement out of poverty, and an inescapable health risk for *all* urban dwellers. A greater emphasis on middle-class lifestyles, pleasure-seeking and risk-taking in the Global South is arguably significant for urban health futures and a central flaw in Davis' consideration of health in *Planet of Slums.* Indeed, he neglects the growing burden of chronic disease that not only marks these middle class enclaves and lifestyles, but is increasingly a new reality for the urban poor in the Global South. Given the rising rate of NCDs in the Global South, it is particularly worrying that , 'NCDs disproportionately affect those who are poor thus increasing inequalities...NCDs also cause poverty' (Beaglehole et al., 2011, 1439).

This side of the urban may be less Dickensian than Davis' vision, but the lived realities and experiences of the middle-classes and slum dwellers and those who fall between these

categories raise questions concerning equitable access to health-promoting environments. In this 'Health for all' narrative, all citizens are important, but it remains crucial to remember that 'the *different worlds* of city dwellers remain in the shadows, and the substantial health challenges of the disadvantaged go overlooked' (WHO/UN-HABITAT, 2009, 33, emphasis added). The nature of these challenges bring us back to the relative importance of environmental and/ or behavioural factors, an area of remarkably little research or evidence. For, as Butala *et al* (2010, 936) note, 'despite the explicit call and need for urban environmental interventions, relatively little research has focussed on health outcomes and infrastructure improvement in urban areas'. In turn, even less is arguably known about how residents in cities of the South make, rationalise and implement health-related behavioural decisions. It is this type of lacuna that AbdouMaliq Simone's 2010 work *City Life* arguably addresses in his concern with understanding urban life as a 'combination of possibility and precariousness' (p.281). He suggests that we should be focussing our theoretical and empirical energies on exploring individual and collective forms of living in the city: the deliberations, calculations and engagements that render urban life both possible and full of possibility – rather than solely the 'misery' that such lives can engender (p. 333). As he asks, 'if we pay attention only to the misery and not to the often complex forms of deliberation, calculation and engagement through which residents try to do more than simply register the factualness of a bare existence, do we not inevitably make those conditions worse?' (*ibid*). While Simone, like the majority of his contemporaries never expressly dwells on health as a vital component of the urban condition, his work is arguably important to the study of healthy cities in its highlighting of choice and agency in everyday life, even (and especially) among the poor. This approach may speak more clearly to the optimistic accounts of urban life in the South, especially among those urban theorists keen to point to the entrepreneurial capacities

of informality and informal settlements (Roy, 2011) despite the failures of the state and private enterprise to provide adequate infrastructure, services and housing.

Such meta-narratives of catastrophe and possibility point, in turn, to vastly different ways of seeing the role of urban regulation. Smit and Parnell's recent work reminds us that achieving advances in health outcomes will 'require good governance', as 'urban management clearly has an essential role to play in making cities healthier and more sustainable' (2012, 5). The need for effective governance, legislation and regulation of both the built environment and individual behaviours however runs counter to the vision of the urban as set forth by Simone. Instead he argues that 'at the heart of city life is the capacity for its different people, spaces, activities and things to interact in ways that exceed any attempt to regulate them. While the absence of regulation is commonly seen as a bad thing, one must first start from the understanding that no form of regulation can keep the city "in line"' (Simone, 2010, 3). The impossibility of regulation here is cast as an entrepeneurial triumph of those faced with the multiple decisions and possibilities that characterise the city of 'intersections' that forms one of his core analytical metaphors. To Simone, the 'ungovernable city' (p. 115) is thus an element of the 'resourcefulness of urban life' under conditions of volatility and uncertainty that produce surprisingly 'substantial thickness to the relations among all the different things and persons that compose urban life' (p. 154). Simone's vision of 'cityness' echoes that of Pieterse (2010) and offers a compelling antidote to the hopelessness put forward by Davis. In many ways, health treads a delicate line between regulation and 'cityness', marking a terrain where individuals needed to invoke their ingenuity and resourcefulness to the achievement of good health, but also require appropriate and enabling regulatory structures in order to ensure their right to health is assured.

If social relations are characterised by an unexpected thickness and complexity, as Simone and others suggest, then what significance does this hold for the individual choice and agency that is seen as a vital discursive component of health policy in the Global North (Herrick, 2011)? Moreover, how does this then chime with accounts of urban health in the Global South in which choice and personal responsibility are frequently neglected, or deemed to be a superfluous to the more pressing concern of human rights? In the South, discourses of choice – even as applied to the middle class – are under-explored in contrast to more paternalistic concerns over the structural violence perpetrated by, for example, unclean water, unsafe housing, insufficient legislation, poor healthcare provision, gender imbalances, food insecurity and poor transport . In sum, it is argued that 'entrenchment in urban slums represents a powerful barrier to health-promoting behaviours, regardless of the particular country in which these slums are housed' (Greif et al., 2011, 956). This makes conceptual advances exploring the 'new' public health's (Petersen, 1997, Petersen and Lupton, 1996) concern with bringing responsible, health-seeking subjects into being across a variety of geographic contexts a theoretical artefact that many would argue has little relevance to huge infrastructural crises facing cities of the Global South. Here, instead, 'the systems approach suggests that the most efficient way to improve health is to improve the environment' (Weeks et al., 2012, 940, see also Rydin et al., 2012a) and, therefore by extension, alter human behaviour. However, in the race to cast cities as 'complex systems' or 'networks', urban spaces and their residents are often disembodied and muted, directly contradicting Simone's vision of cityness and undermining attempts to understand the multiple ways in which cities are *inhabited.* Cityness, in Simone's vision, is a result and reflection of the proliferation of active and reactive choices that are constantly being made and remade. It is important that these are made not just to *survive*, but also to *enjoy* life. Accounts of urban health in the Global South factor out these pleasure-seeking processes, rendering poor urban residents

victims of structural violence. This rhetoric is not limited to the poor, however. In a recent account of the rise of obesity among the Chinese middle class, Hawkes (2008, 155) argues that 'as the agro-food supply chain has grown, the Chinese consumer has begun to eat excessive amounts of fat'. Here causality is framed as emanating directly from a change in the political economy of food, underplaying the role of consumer aspirations, trends, choices and responsibilities play in conditioning health outcomes.

It is also important to note that in a recent editorial on urban health, Satterthwaite (2011) points out that health is underexplored in discussions of the environment and development largely because many of the measures that aim to promote health and wellbeing fall under the remit of governmental agencies other than health (e.g. transport, treasury or social development). In turn, this leads municipal, regional and national governments to afford low priority to addressing the social determinants of health. Harpham has suggested that 'health is not a politically sexy subject' (2009: 114), perhaps due to the complexity inherent in situations where 'urban change is massaged at a multiplicity of pressure points across the city and its institutional scaffolding' (Pieterse, 2008, 10). Not only are these pressure points socially and spatially contingent, but not all are political viable or desirable. The need for strong municipal leadership (Llorca I Ibañez, 2011) in generating healthier cities is doubtlessly vital, and the success of such initiatives often requires suspending the siloed remits and ambitions of government departments in a favour of cross-collaborative efforts that may not offer equal (and measurable) institutional rewards. The importance and nature of governance points to the need for a terrain of generative regulation that enables Simone's vision of the possibility of city life to be brought into being, while still attending to the waves of economic, infrastructural and social crises that characterises Davis' city of slums. Achieving better health for all means acting on the structural vulnerabilities of the poorest, but also the limitations placed on the ability of the middle classes and rich to mitigate the

health risks posed by environmental pollution, the stresses of congestion, the lifestyles brought about by the privatised nature of access to many urban resources, as well, ultimately, as poor decision-making and irresponsible choices Thus, planning and approaches to health must be 'deeply embedded in local institutional structures and cultures *and* closely aligned to the tactics and strategies of survival of poor urban populations' (Watson, 2009a, 187) if they are to make a positive difference.

## CONCLUSION

This chapter provides an initial foray into eliding the urban health literature (largely stemming from public health) with the growing canon calling for urban theory of the Global South. That Urban Studies has largely bypassed questions of health is not, by itself, that surprising. That an urban studies of the Global South has followed suit is perhaps more unexpected, given that many of the questions posed about how cities are inhabited, understood, navigated, negotiated and rationalised invoke questions of health. At the same time, there is growing interest in the field of urban health in which risks – and therefore sites of intervention - are seen to be predominantly (infra)structural. Here less attention is afforded to questions of inhabitation in favour of thinking through how 'better health outcomes can be delivered through interventions in the urban environment' (Rydin et al., 2012a, 2080), quite in contrast to the sociological and salutogenic vision of urban health set out in the WHO *Healthy Cities* remit (de Leeuw, 2012b). Ultimately, at present there is a growing awareness of the need to address poor urban health outcomes in both the Global North and South, but a lack of evidence of effective interventions impedes any progress in doing so. This should prompt two questions: First, if we are lacking in evidence of effective interventions, perhaps we are not framing the question correctly in the first place? Or second, perhaps we are not

making the urgency of the case explicit enough for interventions to be either taken up, let alone evaluated? To make the case most urgently, an apocalyptic vision of the city and its future would no doubt offer the most powerful framing. However, in its concentration on the very poorest, it also holds the potential for the ignoring and thereby distancing (?) the middle class and urban rich from its message, reinforcing the trend towards a retrenchment from collective responsibility and an appreciation of the cumulative impact of individual choices. Similarly, Simone's generative city of intersections speaks to the resourcefulness and resilience of the poor, a reality that many of the urban rich feel and experience as negative externality (e.g. crime, begging, panhandling etc) and would sooner banish than celebrate. Thus, treading the line between apocalypse and optimism, where environmental interventions need to be combined with an appreciation that the poor have agency and choice in the pursuit of health, is essential to ensure that the healthy city is a shared aspiration that can be inhabited by all.

Key words: infectious disease, chronic disease, inequality, middle-class, slums, agency, choice, environment, structure

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