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Comparison Between Healthy Cities and *Adipura* in Indonesia

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ABSTRACT

Urban health problems are very complex and affected by many factors, ranging from social and economic to environment and living conditions. In the middle of the 1980s, WHO introduced the Healthy Cities concept in Europe as a pilot project in response to a variety of urban problems including health issues. Then, in 1996 in Indonesia, the Ministry of Health and Home Affairs, began to develop Healthy Cities, including establishing a set of indicators to monitor improvements in urban health. However in 1986, ten years before the concept of Healthy Cities was formally recognised by WHO, the Indonesian State Ministry of Environment had developed *Adipura* – a clean cities program. The aims of both these programs are similar but they have a different history and were established by different departments. They also bring with them different policies, indicators and implementation methods. Both the Healthy Cities and *Adipura* programs operate without sufficient coordination to assess their effectiveness. Thus, they seem to be overlapping and competing, potentially leading to inefficient resource use. Based on an extensive literature review and document analysis, this paper compares and reviews the policies and existing indicators used by Healthy Cities and *Adipura*. This analysis has identified that the programs have similar goals in addressing urban problems, but have different agendas and performance indicators and different stakeholders involved in managing them. Therefore, strengthening the partnership between the key players involved in both approaches is an important strategy for improving the health and environmental conditions in Indonesian cities.

Keywords: Healthy Cities, indicators, *Adipura*, Indonesia

INTRODUCTION

Urban health problems are very complex and are affected by many factors, ranging from social and economic to environmental and living conditions [1, 2]. Problems ranging from air pollution, traffic congestion, inadequate health services, inadequate water supply, slum areas up to social and economic problems such as street children and buskers, homelessness, HIV/AIDS, narcotics use and urban poverty occur in both developed countries and developing countries including Indonesia [3]. Urban problems are becoming more complex because urban areas are growing. People moving to urban areas have inherent problems, and urbanisation due to migration from the countryside to the cities has brought additional problems associated with blending of cultures, social structures, values, beliefs, habits and behaviour. Consequently, urban problems are becoming more and more difficult to address [2, 4].

In the middle of the 1980s, in response to a variety of urban problems including health problems, the World Health Organisation (WHO) introduced Healthy Cities in Europe as a pilot project [5]. Since then the Healthy Cities movement has grown and is now a worldwide movement, including in Indonesia [6]. In 1996, the Indonesian government, through the Ministry of Home Affairs (MOHA) and the Ministry of Health (MOH) began to develop Healthy Cities including establishing a set of indicators to monitor improvements in urban health. Although this WHO concept of Healthy Cities has been established in Indonesia since 1996, the implementation of Healthy Cities became most significant after issuing the joint regulation between the Ministry of Home Affairs and the Ministry of Health in 2005. However, around ten years before the formal concept of Healthy Cities was defined, the Indonesian State Ministry of Environment had introduced the *Adipura* program – a clean cities program [7-12].

Healthy Cities and *Adipura* have similarities in objectives, in particular the aspect of clean cities, but they have a different history and were established by different departments. According to the joint regulation between the Ministry of Home Affairs and the Ministry of Health No: 34/2005 and No: 1138/Menkes/ PB/ VIII/2005, the aims of Healthy Cities in Indonesia are to *achieve clean, comfortable, safe and healthy districts/cities to be occupied as a working place for their citizens*. They should do this by implementation of various health programs in conjunction with other sectors, in order to improve facilities and productivity and community income [13]. The aims of the *Adipura* program as mentioned in the regulation of The State Ministry of Environment No. 01/2009 are to encourage districts/cities

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governments and communities in realizing clean and green cities through application of good governance principles in the field of environmental management [12, 14, 15]. In the aspect of achieving a cleaner environment, their aims have similarities but numerous questions remain unanswered - why do they not work together? What kinds of policies, indicators, and implementation methods make it difficult for them to work together? Have the early histories of Healthy Cities and *Adipura* caused them to work independently without enough coordination or effort to assess their program implementation and effectiveness?

This paper aims to compare and review the policies and existing indicators used by the Healthy Cities and *Adipura* programs in Indonesia. Through this appraisal, recommendations will be made to increase the effectiveness and efficiency of resources used for the programs.

METHODS

For this study, six dimensions are used for the comparative review of Healthy Cities and *Adipura* in Indonesia. They are: history of Healthy Cities and Adipura; focus, principles, and legislation; organizational structure; assessment approach and methods; award system; and budgeting. Information needed on these dimensions was obtained from published research papers and government documents. For the Healthy Cities context, the main document used was the national guideline of Healthy Districts/Cities implementation which is the joint regulation between the Ministry of Home Affairs and the Ministry of Health No. 34/2005 and No. 1138/Menkes/PB/VIII/2005 [13] while in the *Adipura* context, the primary document reviewed was the regulation of the State Ministry of Environment No. 01/2009 on Adipura program [14]. Both these main documents are written in the Indonesian language *(bahasa Indonesia)*. Search strategies included key word searches in Bahasa Indonesia such as "kota sehat", "kabupaten sehat", and "Adipura" and in English - such as "Healthy Cities" or "Healthy City"from Google and Google Scholar.

HISTORY OF HEALTHY CITIES AND ADIPURA

The Healthy Cities policy was developed by the Ministry of Home Affairs and the Ministry of Health following the WHO World Health Day theme "Healthy Cities for better life" in 1996. This was the starting point for Indonesia in implementing Healthy Districts/Cities [16]. In October 1998, in Jakarta, the Ministry of Home Affairs launched a Healthy Cities Pilot Project in 6 cities: Cianjur district, Balikpapan city, Bandar Lampung, Pekalongan, Malang, and East Jakarta. Subsequently the central government agreed to develop activities of Healthy Districts /Cities especially in the field of tourism in 8 cities: Anyer Area in Serang District, Batu Raden Area in Banyumas District, Kotagede in Yogyakarta City, Brastagi Tourism Area in Karo District, Senggigi Beach Area in West Lombok District, Bunaken Beach and Coast in Manado City, Tana Toraja District and Nongsa & Marina Area in Batam [11, 13]. Currently, Indonesia has developed 216 Healthy Districts/Cities among 497 districts/cities in Indonesia [17].

In 1986, ten years before the WHO notion of Healthy Cities was conceptualised, the Indonesian State Ministry of Environment developed the *Adipura* Program or clean cities program which focuses on improving the quality of the environment in cities [7, 9, 10]. According to the Java Calender, Adi means having an edge in everything and a lot of new things [18] while Pura (from Sanskrit) that has the meaning of city, fortified city, towered city. According to the Indonesian Ministry of Education, officially *Adipura* means the most clean and beautiful cities. In *bahasa Indonesia* it is called *kota yg terbersih dan terindah* [19]. It differs from the Healthy Cities concept, in which the WHO is the international umbrella, as Adipura does not have any official relationship to WHO or other international agencies. Twelve years after its initial implementation, the *Adipura* program stopped due to the Indonesian internal political crisis (the reformation era). It was re-launched by the State Ministry of Environment in Bali in June 2002 and is still continuing. Since 2002 a further 59 cities have developed an *Adipura* program, and now there are a total of 375 cities in Indonesia that have developed the *Adipura* program.

Some cities have implemented both programs. Adoption of these programs indicates a commitment to achieving beyond the minimum health and environmental legislative standards.

FOCUS, PRINCIPLES AND LEGISLATION

The Healthy Cities and *Adipura* have different program aims, policy documents and regulations. The key words for Healthy Cities are "clean, comfortable, safe and healthy districts/cities" while those for *Adipura* are "clean and green districts/cities". The definitions indicate clearly that there is overlap between *Adipura's* aims and those of Healthy Cities'. To achieve the Healthy Cities' aims eight policies have been established by the Indonesian government:

1. A Healthy District/City is implemented at district/city level gradually, and is begun by prioritizing community programs at sub-district and village level, considering the social, economic and cultural aspects in the areas.
2. A Healthy District/City is implemented with the community as main actors through forming or utilizing City Forums or other names agreed by community and local government and getting resources from related sectors.
3. Each district/city establishes potential areas as "an entry point". Hence, the program starts with simple activities, agreed by the community, and then develops the program in one area or a larger area.

4. A Healthy District/City implementation emphasises more process than output, runs continually, is begun from prioritised activities in one setting and achieves outcomes in a time-frame based on community ability and all stakeholders' support.
5. Agreement on selected Healthy District/City settings and activities as well as types and magnitude of its indicators is established by Healthy District/City Forums together with local government.
6. Local government facilitates selection of community activities including providing the community resources needed.
7. Programs which are not prioritised by community are carried out regularly by each sector and gradually socialised to the community and related sectors through meetings of Healthy District/City Forums.
8. A Healthy District/City implementation is fully funded and implemented by the concerned region and community using the concept of community empowerment, from, by and for community.

On the other hand, the *Adipura* program has four principles which are the basis of policy development, namely:
1. Environmental conservation needs strong political will from decision makers
2. Society needs to demand their right to obtain a good and healthy environment
3. Effective democratic mechanisms that are sensitive to the demands of society are needed, and
4. Governments, both at central and regional levels, need to have the ability to implement good governance in the field of environmental management or good environmental governance [20].

The general difference in these sets of principles is that Healthy Cities is very focussed on community needs and specific process issues, while the *Adipura* principles and process are more broad and less prescriptive.

Although Healthy Cities initiatives were started in 1996 [13], officially the Healthy Cities policy was only well documented in the guideline for the implementation of Healthy Districts/Cities (joint regulation between the Ministry of Health and the Ministry of Home Affairs No. 34/2005 and No. 1138/MOH/PB/VIII/2005, written in *bahasa Indonesia* in 2005. The guideline consists of seven chapters, 19 articles/clauses and two appendices. It contains general provisions; Healthy District/City application (community empowerment, Healthy District/City Forums, and the role of an advisory team); Healthy District/City classification and criteria; assessment; awards; development system; and budgeting. The main guideline only provides general dimensions of Healthy Districts/Cities while the Appendix provides a detailed explanation about Healthy Districts/Cities including a general description; aims and targets; policies and strategies; Healthy District/City application; settings; classification and criteria; indicators; and more details on the evaluation and development system (supervising, advising, coordinating and developing capacities) and funding. In addition, the Appendix also provides an evaluation form for healthy districts/cities consisting of evaluation variables; criteria; and scores[13].

In relation to formal legislation, at the national level there is no specific act regarding Healthy Districts/Cities. However, one Indonesian city, Palopo in South Sulawesi province, has a special Healthy City act *(Peraturan Daerah)*, No. 10/2008[21] developed by the Palopo local government. On the other hand, the latest Adipura document was stipulated by the State Ministry of Environment No. 01/2009. It is a revision of the regulation of the State Ministry of Environment No. 99/2006 and regulation of The Ministry of Environment No. 14/2006. This guideline covers general provisions (terms and definitions); *Adipura* application (including *Adipura* program officer, evaluation system, assessor team, cities classification); development system; sanctions (ethical code for assessor team); funding; and final provisions. As with Healthy Cities, there is no specific national act governing and managing *Adipura*. However, in many cities in Indonesia there is a local act regarding city cleanliness, hygiene and waste management such as the Bontang Local Act No 4/2004 [22]; Balikpapan Local Act No. 10/2004 [23]; Sleman Local Act No. 10/2001 [24]. A number of these regulations support activities relating to Healthy Cities.

ORGANIZATIONAL STRUCTURE

National level

The organisational structure of Healthy Cities differs from *Adipura*. This organisational structure explains the role of each organisational level. Healthy Cities have organisational support at all levels of government in Indonesia: national, provincial and districts/cities level. For example, at the national level, Healthy Cities is the responsibility of two ministries: the Ministry of Home Affairs and the Ministry of Health. Healthy Cities in the Ministry of Home Affairs is the responsibility of the Directorate General for Regional Development while at the Ministry of Health, it is the responsibility of the General Disease for Control and Environmental Health. These two departments have different functions. The Ministry of Health implements and facilitates the Healthy Cities for activities related to health, while the Ministry of Home Affairs supports, encourages, and commands other departments to contribute to Healthy Cities achievement. The Ministry of Home Affairs undertakes general guidance such as providing a Healthy Cities

guide, conducting supervision, improving capacity through training, and giving direction, while the Ministry of Health provides technical guidance on how to implement Healthy Cities including advocating local government.

Provincial and district/city level

At the provincial level, Healthy Cities is managed by the Regional Development Planning Board and the Provincial Health Office. The roles of central and provincial governments are quite similar. The provincial government only provides guidance to districts/cities government implementing Healthy Districts/Cities. Therefore, the real implementation of Healthy Cities is at the local level (districts/cities level). As Healthy Cities implementation is at local government level, the local government plays an important role in achieving it. In the Healthy Cities context, the Head of Regional Development Planning Board at district/city level acts as Head of an Advisory Team *(Tim Pembina)*. The Advisory Team coordinates, integrates, synergizes, and synchronises Healthy Cities programs among governmental bodies and offices in the regional development.

In contrast to Healthy Cities, Adipura does not have any formal organisational structure at the provincial and district/city level. The organisational structure of Adipura is at the national level. However, to help with program implementation, the State Ministry of Environment has divided Indonesia into several regions according to the Environmental Management Centre: the regional office for Sumatera region is in Pekanbaru, Riau; the regional office for Bali and South East Nusa is in Denpasar, Bali; the regional office for Java region is in Condong Catur, East Depok and Sleman, Jogjakarta; the regional office for Sulawesi, Maluku and Papua (SUMAPAPUA) is in Makassar; and the regional office for Kalimantan is in Balikpapan. In general, the roles of the regional offices are to coordinate the implementation of policy and provide technical guidance, to supervise and to monitor the environment in accordance with laws and regulations applicable in each of the regional areas.

EVALUATION: APPROACH AND METHODS

Evaluation is an important part of health management. It is a multistep process that aims to assess to what extent the aims and objectives of program implementation have been achieved. Evaluation can include assessing the level of implementation achieved, the degree of success and identification of a variety of challenges influencing program achievements [25-27].

The assessment of Healthy Cities and *Adipura* differs in the assessment period, choice of indicators, categories, and assessor team. Healthy Cities evaluation is generally carried out in June, July or August every two years. There is no specific period of assessment like a month, a semester, or a year. This differs from the *Adipura* assessment system which is conducted from July in the current year up to June the following year so that the assessment period runs for around one year.

Three kinds of indicators are evaluated in Healthy Cities, namely main indicators, general indicators and specific indicators. The main indicators include literacy rate, and domestic income per capita and Infant Mortality Rate (IMR) per 1000 live births. The general indicators are focussed on process and include the availability of local government support, functioning of the district/city forums; village communication forums, and village working groups. Then, the specific indicators are based on the selected settings. In the Healthy Cities implementation, there are 9 settings established by central government, namely healthy settlement areas and public facilities; traffic facilities areas and transportation services; healthy mining areas; healthy forestry areas; healthy industry and office areas; healthy tourism areas; food and nutrition security; self-reliant healthy community life; and healthy social life. These nine settings can be selected and adopted by local government according to local problems and resources as well as community needs. Each setting has specific and complex indicators. Duplication of the indicators can occur between the Healthy Cities and *Adipura* in certain circumstances.

For example "City A" developed a Healthy Cities program and the "healthy settlement areas and public facilities" setting was selected. Hence it established indicators for clean water, clean river water, individual and public water supply, water disposal, waste management, housing and settlement, gardening and city forest, schools and market management. A number of these indicators are quite similar to the *Adipura* indicators.

For assessment purposes, *Adipura* divides cities into four types according to the population size or other characteristics of the city: metropolitan, large cities, medium cities and small cities [28]. Both physical aspects and non-physical aspects are assessed as part of the assessment program. The physical assessment consists of two types: obligatory assessment and non-obligatory assessment. The obligatory assessment includes settlement areas, urban facilities such as markets, schools, offices, hospitals and parks as well as sanitation facilities (waste management), while the non-obligatory assessment includes transportation facilities and tourist beaches. Further, non-physical assessment consists of three aspects: institution, management and responsiveness. Institution aspects assessed include the availability of law, policy, budget and facilities. Management aspects include planning, implementation and monitoring, and responsiveness aspects including community participation. Therefore, in terms of achieving a healthier environment

"healthy settlement areas and public facilities" is one of the Healthy Cities settings which have similarities with the *Adipura* program. The difference is that 'the healthy settlement areas and public facilities' program is handled by the Department of Public Works and the Regional Environmental Impact Control Board while *Adipura* is managed by the State Department of Environment. Both departments work with little coordination although the goal of Healthy Cities and Adipura is almost the same in the context of this particular setting.

There is a difference in the evaluation step relating to who assesses the districts/cities. The Healthy Cities evaluation is conducted at two levels: provincial and national. For the provincial level, the provincial government selects and determines which districts/cities will be evaluated as healthy districts/cities. This assessment is conducted by a provincial advisory team on behalf of the Governor. This team consists of the provincial government and related institutions' representatives such as the Provincial Regional Development Planning Board, Health Office and university representatives. The results of the Healthy Districts/Cities assessment by the provincial team are submitted by the Governor to the Ministry of Health with a copy to the Ministry of Home Affairs, to be further evaluated at the national level. The national assessor team consists of representatives from the Ministry of Health and the Ministry of Home Affairs and related ministries.

Unlike Healthy Cities, the *Adipura* program has a single evaluation. *Adipura* directly evaluates all districts/cities whether metropolitan; large cities; medium cities; or small cities. The State Ministry of Environment representatives appointed by the State Ministry of Environment and provincial representatives appointed by the governor evaluate those districts/cities. Provincial assessor team members consist of provincial environmental institutions, universities, mass media, NGOs, agencies or board representatives stipulated by the Governor's Decree. The *Adipura* guideline explains in more details the assessor team while the Healthy Cities assessor team is only explained in general (see Table 2 - a summary table on assessment system between Healthy Cities and *Adipura*).

Table 1. Comparison between Healthy Cities and Adipura policy document and regulation

Policy Document and Regulation	Healthy Cities	Adipura
• Title	Guidelines for the implementation of healthy districts/cities (joint regulation between the Ministry of Home Affairs (MOHA) and the Ministry of Health (MOH) No. 34/2005 and No. 1138/Menkes/ PB/ VIII/2005	State Ministry of Environment No. 01/2009 on *Adipura* Program
• Year	2005	2009
• Corporate Author (s)	MOH and MOHA	State Ministry of Environment (SMOE)
• Language	Bahasa Indonesia	Bahasa Indonesia
• Publisher	MOH and MOHA	SMOE.
• Publisher place	Jakarta	Jakarta
• Physical description	69 pages (2 pages for title and table of content; 8 main pages; 38 pages for Appendix I and 21 pages for Appendix II), A4	62 pages, 5 appendixes, A4
• Status of document Act	Guideline • There is no national healthy district/city Act • Palopo City has a local Act *(Perda)* of Healthy Cities	Guideline • There is no national *Adipura* Act • Many cities have a local Act regarding cleanliness and waste management

Table 2. Assessment system comparison between Healthy Cities and Adipura in Indonesia

Assessment System	Healthy Cities	Adipura
Assessment period	There is no specific period of time like a month, a semester, or a year	From July in the running year up to June next year (1 year)
Evaluated indicators	Three indicators: main indicators; general indicators and specific indicators	Physical assessment and non-physical assessment
Categories	There is no specific city classification	Metropolitan, large cities, medium cities, and small cities
By whom	Provincial level • Selection is conducted by provincial advisory team on behalf of Governor • Provincial advisory team consists of the provincial government and related institutions representatives National level • Assessment is conducted by Central Assessor Team that consists of representatives from the MOH, MOHA and related ministries	• State Ministry of Environment representatives appointed by the State Ministry of Environment and • Provincial representatives appointed by the governor, consisting of representatives from provincial environmental institutions, universities, mass media, NGOs, agencies or boards stipulated by governor

AWARD SYSTEM OF HEALTHY CITIES AND ADIPURA

An important part of both approaches is an award system. Such a system builds recognition for the programs and promotes good practice and sharing between participating communities. Awards given for Healthy Cities and *Adipura* are also prestigious for both community and city government. They are proof that the government and people are concerned about their health and the environment. For Healthy Cities, an award system is identified in detail in the joint regulation between the Ministry of Home Affairs and the Ministry of Health. It includes an award name, categories; year the awards are given; by whom; occasion and type of award. The name of a Healthy Cities award is *Swasti Saba*. A *Swasti Saba* is an award given by the central government to the community through Regent(s)/City Mayor(s) who are successful in implementing Healthy Cities. In Sanskrit, Swasti means healthy and prosperous and "Shaba" means city. Thus, "Swasti Saba" means healthy and prosperous city [29].

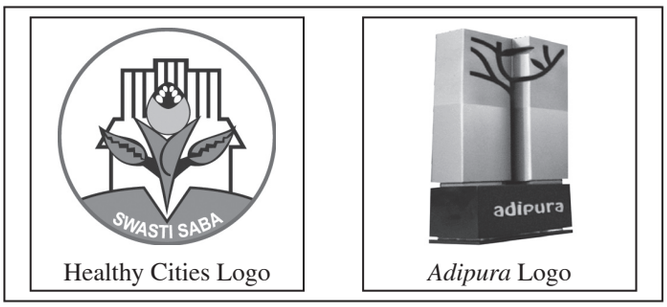

Figure 1. Healthy Cities and *Adipura* logos used in Indonesia

There are three levels of *Swasti Saba: Swasti Saba Padapa* (basic achievement); *Swasti Saba Wiwerda* (middle achievement), and *Swasti Saba Wistara* (high/good achievement). All cities/districts that meet indicators/requirements

established as mentioned before and based on the results of a joint decision between the Ministry of Health and the Ministry of Home Affairs City, Mayors of cities/districts that meet the requirements are invited by the central government to receive an award (certificate) in November every two years in commemoration of National Health Day. The award is given by the Indonesian President, Vice President or The Minister of Health on behalf of the central government.

Similar to Healthy Cities, *Adipura* also has three categories of award according to the level of city cleanliness: Plakat Adipura (basic); Piagam Adipura (middle) and Anugerah Adipura (high). This award is given by the Indonesian President every year in commemoration of Environment Day. The Healthy Cities and *Adipura* Award Logos are illustrated in Figure 1.

BUDGETING OF HEALTHY CITIES AND ADIPURA

The Healthy Cities budgeting is based on the purposes, sources and types of activities. Money is allocated for three kinds of purposes: operational funding, general assistance and technical assistance. The operational funding is charged to the Revenue and Expenditure Budget of Districts/Cities (APBD) in accordance with the selected settings : Healthy settlement areas and public facilities; traffic facilities areas and transportation services; healthy mining areas; healthy forestry areas; healthy industry and office areas; healthy tourism areas; food security and nutrition; healthy self-reliant community life; and healthy social life. Activities relating to general guidance are charged to the State Revenue and Expenditure Budget of the Department of Home Affairs, the Provincial and Districts/Cities Revenue and Expenditure Budget, while technical assistance is charged to the State Revenue and Expenditure Budget of Department of Health, the Provincial and Districts/Cities Revenue and Expenditure Budget.

For the *Adipura* program, the documentation does not make clear the purposes of the budget. Budgeting for *Adipura* is also from the State Revenue and Expenditure; the Provincial Revenue and Expenditure the Districts/Cities Revenue and Expenditure Budget or other sources in accordance with stipulated decrees. Therefore, both healthy districts/cities and *Adipura* budgeting are from the central government allocated in the State Revenue and Expenditure Budget (APBN) either by the Ministry of Health, the Ministry of Home Affairs, the State Ministry of Environment or other related ministries; the Provincial Revenue and Expenditure Budget (APBD); the Districts/Cities Revenue and Expenditure Budget (APBD) or other sources stipulated by decrees or regulation.

Table 3. Comparison between Healthy Cities and Adipura budgeting in Indonesia

Budgeting	Healthy Cities	Adipura
Purposes	• General assistance • Technical assistance • Operational funding	There is no specific explanation
Source	• The State Revenue and Expenditure Budget (APBN) of Department of Home Affairs, the Provincial and District/ City Revenue and Expenditure Budget (APBD) for general guidance • APBN of the Department of Health, the Provincial and District/City Revenue and Expenditure Budget for technical assistance • APBN; the Provincial District/City APBD	• The Revenue and Expenditure Budget of Districts/Cities (APBD) for operational funding • Other sources
Types of activities	Depends on the selected settings	There is no specific explanation

RECOMMENDATIONS AND CONCLUSION

Healthy Cities and *Adipura* are two parallel national policies in Indonesia that have similarities in policy aims and objectives but that are implemented under the governance of different ministries. Both are implemented at the local level across Indonesia. Healthy Cities has a stronger emphasis on process rather than specific health outcomes, and

as part of this emphasis, community engagement and leadership are important aspects of the implementation of Healthy Cities in Indonesia. In contrast, *Adipura* emphasises environmental outcomes more than process and is more government led.

As Healthy Cities covers a range of broad issues, their indicators are tiered: main indicators, general indicators, and specific indicators by settings. However, they really do not emphasise some of the essential problems of the urban environment such as hygiene and sanitation. By contrast, *Adipura* indicators are quite simple and more specific, but they do not really cover social problems and other determinants of health. Both programs have similarities, in particular in the setting of Healthy City, namely Healthy Settlement Areas and Public Facilities. The existence of the joint regulation between the Ministry of Home Affairs and the Ministry of Health and organisational structure at all levels of government system are strong points for Healthy Cities while the assessment system used for the *Adipura* is a good system as it involves assessment of the dimensions over a period of time. However, *Adipura* is better known than Healthy Cities, especially at local government level. Major challenges for urban areas are shortage of resources and lack of community participation. Therefore, in order to create a healthier environment and to improve the effective and efficient use of resources, building partnerships and working together among the Ministry of Health, the Ministry of Home Affairs and the State Ministry of Environment should be strengthened. The Ministry of Home Affairs would be the best department to facilitate this partnership. Strengthening partnerships, should optimise the health and environment benefits to the communities of the cities where the programs are implemented.

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