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Healthy Cities and Social Reality Indicators: Comparative Lessons From High Income And Lower Middle Income Economies

Indikator Bandar Sihat dan Realiti Sosial: Pengajaran Perbandingan daripada Negara Berpendapatan Tinggi dan Negara Berpendapatan Sederhana Rendah

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ABSTRACT

The implementation of healthy cities varies across countries, shaped by national issues unique to each context and classified according to their respective social realities. As such, the assumption that more developed countries inherently lead in development is not always applicable since each country possesses different levels of national readiness based on social conditions. This study aims to explore the differences in the implementation of global Healthy City initiatives by analyzing national factors rooted in the social realities of each country. Understanding how these social realities shape development prospects offers valuable lessons for international development efforts, including those in Malaysia. Four countries - South Korea, Nepal, China, and South Africa, were selected to represent diverse global cases of Healthy City implementation. The selection was based on geographical location, economic status, prevailing social conditions, and different approaches to healthy city development. This study employed case studies and content analysis of selected written sources, including official documents and academic journals. Data were sourced from databases such as Web of Science, Scopus, and Google Scholar using search terms like "healthy city policy" or "healthy city implementation in [country name]." A total of 24 documents were analyzed to extract insights and processes that reflect the broader phenomenon under investigation. The analysis identified three key national factors, shaped by each country's social realities that influence the formulation and implementation of healthy city initiatives: (1) the vulnerability and burden on the health sector, (2) political dynamics and economic resources, and (3) population characteristics and local social issues. These findings provide a reference for the more effective implementation of healthy cities tailored to the specific needs of communities within different national contexts.

Keywords: Healthy City, social reality, selected countries, differences in implementation, development lessons

ABSTRAK

Pelaksanaan bandar sihat berbeza merentasi negara, dibentuk oleh isu nasional yang unik bagi setiap konteks serta diklasifikasikan mengikut realiti sosial masing-masing. Oleh itu, anggapan bahawa negara yang lebih maju secara semula jadi mendahului dalam pembangunan tidak semestinya terpakai kerana setiap negara mempunyai tahap ketersediaan nasional yang berbeza berdasarkan keadaan sosial. Kajian ini bertujuan meneroka perbezaan dalam pelaksanaan inisiatif Bandar Sihat global dengan menganalisis faktor nasional yang berakar daripada realiti sosial setiap negara. Memahami bagaimana realiti sosial ini membentuk prospek pembangunan menawarkan pelajaran berharga bagi usaha pembangunan antarabangsa, termasuk di Malaysia. Empat negara, iaitu Korea Selatan, Nepal, China, dan Afrika Selatan dipilih untuk mewakili kes global yang pelbagai dalam pelaksanaan Bandar Sihat. Pemilihan ini dibuat berdasarkan lokasi geografi, status ekonomi, keadaan sosial semasa, serta pendekatan berbeza terhadap pembangunan bandar sihat. Kajian ini menggunakan kaedah kajian kes dan analisis kandungan terhadap sumber bertulis terpilih, termasuk dokumen rasmi dan jurnal akademik. Data diperoleh daripada pangkalan data seperti Web

of Science, Scopus, dan Google Scholar menggunakan istilah carian seperti "healthy city policy" atau "healthy city implementation in [nama negara]." Sebanyak 24 dokumen dianalisis untuk mengekstrak pandangan dan proses yang mencerminkan fenomena lebih luas yang sedang dikaji. Analisis mendapati tiga faktor nasional utama, yang dibentuk oleh realiti sosial setiap negara, yang mempengaruhi pelaksanaan inisiatif bandar sihat: (1) kerentanan dan beban terhadap sektor kesihatan, (2) dinamika politik dan sumber ekonomi, dan (3) ciri populasi serta isu sosial tempatan. Dapatan ini menyediakan rujukan bagi pelaksanaan bandar sihat yang lebih berkesan, disesuaikan dengan keperluan khusus komuniti dalam konteks nasional yang berbeza.

Kata kunci: bandar sihat, realiti sosial, negara terpilih, perbandingan, pengajaran pembangunan

INTRODUCTION

The Healthy City Model is a unique form of development because its implementation is determined by national issues specific to each country. These national issues are shaped by social realities, development levels, and economic status within each context (Zaei 2014). This means that the implementation of healthy cities varies from one country to another. Generally, countries are categorized as the Global North or the Global South. The Global North refers to first-world countries primarily located in the Northern Hemisphere, such as Europe and the United States, and developed countries in Asia, such as Japan, South Korea, Singapore, and Taiwan (with exceptions for Australia and New Zealand) (Park 2018; Lee 2016). By contrast, the Global South refers to third-world countries in the tropics and the Southern Hemisphere, such as Africa, Latin America, and parts of developing Asia (UN 2022). The International Monetary Fund (IMF) classifies these countries based on their Gross National Income (GNI) and per capita Gross Domestic Product (GDP), identifying two major groups: high-income economies and low- or lower-middle-income economies (The World Bank 2022). In terms of healthy city implementation, national factors characterized by the unique social realities of each country serve as key indicators influencing how healthy city initiatives are executed (Sharma & Nam 2017). Consequently, the concept of a healthy city (name, definition, and implementation) varies from one country to another.

For instance, in India, there are wellness zones that encompass community wellness centers, sacred spaces for meditation, clinics, hospitals, and hotels (James & Bhatnagar 2019). In China, models include community health centers, wellness towns, and the Luohu model (Xin et al. 2018). In South Africa, wellness hubs serve as referral centers for managing Human Immunodeficiency Virus (HIV) cases (Martinez Perez et al. 2016). Meanwhile, the United States, wellness neighborhoods are designed to foster social support for community well-being (Webster & Sanderson 2012). Although the names and implementation concepts of healthy cities differ from country to country, their ultimate goal remains the same: to holistically enhance the health and well-being of communities (WHO 2015).

Healthy cities aim to improve population health through targeted health promotion initiatives (Dooris & Heritage 2011). This study aims to examine the differences in the global implementation of healthy cities by analyzing national factors shaped by each country's social realities (Sharma & Nam 2017; Acharya et al. 2022). Social realities, in this context, refer to the existing conditions within a country, such as levels of progress or underdevelopment, economic status, poverty, population density and issues, migration, and political tensions. These factors influence national issues and consequently, the dimensions through which healthy city solutions are developed.

Four countries were selected to represent global cases of Healthy City implementation: South Korea, Nepal, China, and South Africa (Heo et al. 2008; Park 2018; Lee 2016; Sharma & Nam 2017). The selection was based on specific criteria, including geographical location, economic status, social realities, and the approach adopted to implement Healthy City models. The findings of this study are important because they provide insights into how globally healthy cities are implemented and the local national issues that shape them. These insights can serve as valuable lessons for global development efforts, including those in Malaysia, particularly for designing an ideal healthy city model (Lim Seng Boon 2020). Ultimately, healthy cities serve as mechanisms to prevent the burden of disease regardless of a country's economic status (WHO 2015).

HEALTHY CITIES AND THE GLOBAL AGENDA

The Healthy Cities initiative was introduced by the World Health Organization (WHO 1986) to improve population health through health promotion and the enhancement of both social and physical environments, particularly in places where people live and work (WHO 1986). This concept was officially introduced at the International Conference on Health Promotion in conjunction with the Ottawa Charter in Canada (WHO 1986). The vision of Healthy Cities is to build cities and communities of peace where all citizens live in harmony, are committed to sustainable development, respect diversity, strive for the highest possible quality of life, and ensure equity and fairness in the distribution of health by promoting and protecting health in all settings (WHO 2015). In the early stages of this initiative, countries in the Western Pacific region, such as Australia, Japan, and New Zealand, were among the most proactive in integrating the Healthy Cities vision into their national development policies (Hisashi 2003; Ashton & Seymour 1988). Their commitment was later followed by Southeast Asian countries, including Cambodia, China, Laos, Mongolia, Korea, the Philippines, Vietnam, and Malaysia (Sharma & Nam 2017; Park 2018). Over time, particularly from 1995 onwards, the initiative expanded its focus to other developing nations such as Bangladesh, Tanzania, Egypt, Nicaragua, and Pakistan, in support of global health development (Harpham et al. 2001; Bapari et al. 2016). This initiative demonstrates that inclusive health and well-being goals have become a new benchmark for international development, especially for developing countries (WHO 2015; Dooris & Heritage 2011).

From the perspective of global healthy city development, it involves the mobilization of collective ideas to observe, understand, and make strategic and ideal decisions aimed at achieving community health and well-being (WHO 1986; WHO 2015). The ultimate goal is to improve health levels and, consequently, the overall quality of life (Dooris & Heritage 2011). To achieve this goal, the World Health Organization (WHO 2015) has outlined eight core principles of the healthy city approach to guide successful implementation (see Figure 1). Meanwhile, the community serves as the central entity that determines and drives the success of healthy city implementation, as its capacity and resources are key indicators in realizing optimal behavioral change toward healthy living (Sharma & Nam 2017; Harpham et al. 2001).

FIGURE 1. Principles of the Healthy City Approach through Health in All Policies (HiAP) and Social Determinants of Health (SDH) Frameworks
Source: WHO (2015)

Based on the WHO narrative, this study concludes that Healthy City is a global initiative that involves affirmative policies within a country related to health promotion and the strengthening of physical and social infrastructure by key stakeholders, namely the community and policymakers, to enhance human health. It emphasizes health literacy and encourages community participation and empowerment through strategic partnerships, specifically intersectoral collaboration between institutions and communities. The ultimate goal is to shift community mindsets toward a culture of healthy living, foster self-initiated and consistent healthy lifestyle practices, promote active community involvement in health-related activities, and improve inclusive access to healthcare facilities to effectively reduce the burden

of disease. Ultimately, every individual should have equal rights and access to health care.

In terms of implementation, there are seven phases of Healthy City development based on the European Healthy City model (see Table 1). This model serves as a guide for the global community to determine the current stage of healthy city development within their respective countries.

TABLE 1. The Phases of National Healthy Cities Networks in The WHO European Region

Phase	Brief content
1988-1992 (I)	Setting up structures
1993-1997 (II)	Advance the healthy cities approach
1998-2002 (III)	Transition from health promotion to integrated city health development plans
2003-2008 (IV)	Overall commitment to health development
2009-2013 (V)	Priority was given to health and health equity in all policies
2014-2018 (VI)	Gives priority to life course approaches in city policies and plans
2019-2025 (VII)	Prioritize the themes presented in the Copenhagen Consensus of Mayors

Source: Kai et al. (2022)

The phases of the Healthy City model represent specific periods in the implementation of the concept, with each phase focusing on a particular dimension (WHO 1986; WHO 2015). In Phase I (1988-1992) of the healthy city implementation, the primary focus was on establishing the basic structure of the healthy city. As a new development model in Europe, the establishment of foundational plans such as functions, promotional approaches, implementation strategies, and evaluation methods was crucial (Ashton & Seymour 1988; Kenzer 1999). For example, in England, health promotion became the foundation of a healthy city structure in Liverpool to improve the health of its 2.5 million residents (Ashton et al. 1986). This is a common feature of any development model in its early stages. Phase II (1993-1997) emphasized the implementation approach for a healthy city, following the strengthening of the basic structural dimensions. This approach was grassroots-oriented and was developed to ensure that the strategies were well-suited to the disease burden in European communities (Kenzer 1999; Hisashi 2003). Phase III (1998-2002) continued to focus on the implementation approach but with a more advanced and large-scale perspective. Health promotion was integrated into the Healthy City Plan to improve its effectiveness. During this phase, intersectoral/interagency collaboration strategies, community consultations, and cross-city or cross-regional coordination were established (Dooris & Heritage 2011). Phase IV (2003-2008) strengthened the health dimension, as every healthy city approach had to significantly improve health levels and, consequently, quality of life (Harpham et al. 2001). Phase V (2009-2013) emphasized social health equity, ensuring that every individual had equal rights related to health opportunities (WHO 2015). Phase VI (2014-2018) focused on the inclusivity of the health sector, requiring every country to ensure that the health sector was "people-centered" and integrated into every city policy (Sharma & Nam 2017). Finally, Phase VII (2019-2025) introduced the global agenda under the theme "Cities for All," emphasizing that the cities in which people live must be safe, inclusive, sustainable, and resilient, as endorsed by the Copenhagen Mayor's Consensus in 2018 (WHO 2018). In conclusion, the overall input from the theme "Healthy Cities and the Global Agenda" provides valuable constructive insights. It offers additional information for researchers to understand the context of global Healthy City implementation, allowing for the selection of an ideal country entity to represent case studies on Healthy City implementation in this research (Sharma & Nam 2017; Acharya et al. 2022).

CASE STUDIES OF HEALTHY CITIES IN SELECTED COUNTRIES AND JUSTIFICATION FOR THEIR SELECTION

Four countries were selected to represent case studies on the global implementation of healthy cities: South Korea, Nepal, China, and South Africa. The selection was based on the following criteria: geographical location, economic status, social realities, and approaches to Healthy City implementation (see Table 2).

TABLE 2. Studied Countries Representing Case Studies on the Implementation of Healthy Cities

Country	Geographical location	Economy status	Social reality	The approach of healthy city development
South Korea	East Asia	High income/advanced economy	Advanced community	City development-based approach
Nepal	South Asia	Lower-middle income	Underdevelopmentpoverty, rapid population growth, and political conflict	Community-based approach
China	East Asia	Upper-middle income	Rapid population growth, health burden, and Gerontological issues	Integration
South Africa	Africa	Upper-middle income	HIV/AIDS, remote locations	Community-based approach

Source: Authors' compilation (2024)

SOUTH KOREA

South Korea is one of the fastest-growing economies in the world. However, in the early stages of its economic growth, it faced challenges similar to those of other developed countries, having gone through a period of hardship, particularly after Japanese colonization in 1945 and the Korean War (1950–1953) (Park 2018; Heo et al. 2008). In the 1950s, South Korea was one of the poorest countries in the world (Park 2018). However, starting in 1962, following a five-year economic development plan focused on industrial sectors, South Korea's economy experienced significant growth (Heo et al. 2008). By 1987, the country had held its first presidential election after nearly 30 years of political conflict, marking improvements in human rights, public policy, electoral systems, and freedom of speech (Park 2018). As a result, South Korea succeeded in reducing poverty by 30% (Lee 2016). This success was driven by income empowerment, capital injections, and the use of new technologies (Heo et al. 2008). In addition, factors such as high national savings rates, strong human capital, proper institutional maintenance, open trade, and sound fiscal management contributed to this success (Park 2018; Lee 2016). Furthermore, aspects such as education and workforce skills were given holistic attention. By the mid-1950s, South Korea's economy had continued to grow, with GDP per capita increasing from $290 in 1960 to $28,384 in 2010 (World Bank 2022). By 2008, South Korea ranked as the 13th largest economy in the world, a remarkable achievement considered unprecedented in world history (KEIA 2015). In terms of GDP, the World Bank reported South Korea's GDP as $100 billion in 1984, rising to $1.41 trillion in 2014. In terms of Gross National Income (GNI) per capita, it increased from $2,360 in 1984 to $27,090 in 2014 (World Bank 2022). South Korea's GDP in terms of purchasing power parity (PPP) was $33,140 in 2013, on par with Spain and Italy (KEIA 2015). By 2023, South Korea had become one of the leading exporters of technology, contributing to its continued economic growth (Park 2018).

Regarding the implementation of healthy cities, the first Healthy City Project in South Korea began in 1998 in Gwacheon, and the second was established in Wonju in 2004 (Sharma & Nam 2017). Wonju was chosen as the second healthy city based on recommendations from the Healthy City Advisory Committee (HCAC), an international committee dedicated to promoting the well-being of urban populations (Sharma & Nam 2017). In the early stages of its development, South Korea set three national guidelines to drive implementation: the Healthy City Act, the Health Impact Assessment Program, and the Korea Healthy City Partnership (KHCP) (Sharma & Nam 2017). The KHCP is a national network for sharing information on Healthy City initiatives in South Korea. In 2005, the Wonju Declaration was formed to empower local authorities to engage citizens in the governance of healthy cities, and Wonju joined the KHCP in 2006 (Sharma & Nam 2017). That same year, a five-year Healthy City Plan (2006–2010) was introduced, focusing on the Tobacco Consumption Tax. In 2020, a new ten-year Healthy City Plan (2011–2022) was launched to further strengthen healthy city implementation (Sharma & Nam 2017). As of 2023, mental health issues have become a major social concern in South Korea, and local Healthy City initiatives have been adapted to address this issue (Sharma & Nam 2017). Emphasizing mental health well-being has made South Korea's Healthy City Model both unique and proactive. Therefore, the selection of South Korea as a case study for Healthy City implementation is appropriate because it represents a high-income economy. From being a poor country in the 1950s, South Korea transformed into one of the most

advanced countries in East Asia through holistic national transformation (Park 2018; Lee 2016). This highlights how the concept of healthy city development in developed countries has evolved from planning to comprehensive implementation. In addition, its implementation is adaptive and aligned with the changing health needs of the population, indirectly validating the dynamic goals of healthy cities designed to be adaptable to societal changes (Sharma & Nam 2017).

NEPAL

Nepal has a lower-middle-income economy, and its population often faces severe poverty (ADB 2013; UN 2022). Since 1996, dedicated efforts have been undertaken to address this issue. As a result of sustained commitment, the percentage of Nepal's population living below the poverty line has significantly decreased from 41.8% in 1996 to 30.9% in 2004, and further to 25.2% in 2011 (Central Bureau of Statistics 2011). From 2014 to 2019, the poverty rate declined from 30.1% to 17.4% (UN 2022). However, disparities between age, caste, disability, education, ethnicity, geography, sex, migration, and wealth remained largely unchanged (Acharya et al. 2022). Furthermore, 44% of the population living in poverty in Nepal consists of children, although they comprise only 35% of the total population (Central Bureau of Statistics 2011). The Central Bureau of Statistics in Nepal reports that one in four people in the country will remain trapped in the cycle of poverty. The cause of this economic imbalance is complex, with political conflict being a key factor (UN 2022). The violence and ongoing political strife between the government and the Nepal Communist Party-Maoists have been significant barriers to national development, despite the signing of the Comprehensive Peace Agreement in 2006 (UN 2022).

Regarding the implementation of healthy cities, Nepal's development of healthy cities is still in the first phase of establishing the structure (WHO 1986; WHO 2015; Sharma & Nam 2017). There are seven phases in the global Healthy Cities framework, as introduced by WHO, with the initial phase beginning in 1988 and the final phase ending in 2025 (WHO 2015). In Nepal, it was only in 2005 that proposals from civil society emerged, calling for the introduction of projects "similar to" healthy cities in major urban areas (ADB 2013). This initiative was supported by the Asian Development Bank to encourage municipalities to create clean and healthy urban development, particularly in Bharatpur, as it is one of the major rapidly developing cities that frequently face issues with clean water supply (ADB 2013). In 2020, the prospects for healthy cities in Nepal were outlined in the Kathmandu Valley Air Quality Management Action Plan (USAID 2022). However, it has not been fully implemented owing to limitations in local administrative capacity (USAID 2022). In other words, the primary focus of healthy city development in the first phase still revolves around meeting the basic living needs of the population rather than creating a comprehensive urban planning vision for the future (Sharma & Nam 2017). For this reason, this study chooses Nepal as a case study for healthy cities from the perspective of lower-middle-income countries, in addition to its proactive healthy city development efforts, despite ongoing socioeconomic challenges (Acharya et al. 2022).

CHINA

China had a population of 1.4 billion in 2022 (East Asian Institute [EAI] 2021). The country's economy grew consistently at an average rate of 8.9% per year from 2010 to 2019. However, following the COVID-19 pandemic in 2021, China's economy grew at a slower pace of 8.1%, although it remained on track, particularly in the production and energy consumption sectors (U.S Energy Information Administration 2022). In 2020, China's production and energy consumption sectors were ranked among the top globally (U.S Energy Information Administration 2022). Nevertheless, the health sector, particularly the burden of disease, has emerged as a major concern in China's healthcare system, encompassing both infectious and non-communicable diseases (NCDs), especially among the elderly (Baokang 2021). According to China's Ministry of Health, 100 million out of 231 million elderly people in China suffer from at least one NCD (Baokang 2021). As a result, 80% of the government's financial allocations are directed toward the health and medical sectors, with 80% of this allocated to large public hospitals and disadvantaged groups (Baokang 2021). This situation arises due to China's large population, which presents significant challenges for the health sector in providing a comprehensive and conducive healthcare system for its people (Baokang 2021).

China has its own Healthy City model. In 2017, Luohu District was designated as a pioneer for the

Healthy City Model in China by the National Health and Family Planning Commission (Xin et al. 2018). Luohu is one of ten districts in the Shenzhen region. It covers an area of 78.36 km² with a population of 1.4 million (Xin et al. 2018). The Luohu model is progressive, as it transforms the healthcare sector comprehensively based on an integrative concept, forming a coalition between experts and the public, and being jointly managed by agencies and citizens (Xin et al. 2018). The goal of its implementation is "…less illness, fewer hospital admissions, lower financial burdens, and better services through the development of a community-based and prevention-oriented integrated care system" (Xin et al. 2018). In terms of organization, the Luohu model is governed by the Luohu Hospital Group (LHG), led by the president. The LHG consists of four main committees - the council, supervisory board, expert committee, and workers' congress, which form the top hierarchy advising the president. The implementation level includes five hospitals, one medical institution, six resource-sharing centers, six administrative centers, and 23 Community Health Stations (CHS). Human resources, finances, assets, and service delivery at CHS are managed by the Community Health Management Center (CHMC), which is accountable to the district hospital. The district hospitals, in turn, report to the president and the four main committees (Xin et al. 2018).

This study selects China as a case study for healthy cities because of its structured and planned approach to healthy city organization, which also represents the perspective of higher-middle-income countries. In China's Healthy City model, the highest level of management serves as policymakers, involving the community at each level of the structure, with the community acting as a planner and evaluator of the implemented programs (Xin et al. 2018). This structure encourages the participation of the community. The Luohu model should be considered a global healthy city model, including for Malaysia (Xin et al. 2018).

SOUTH AFRICA

South Africa is a country in Africa that has experienced better economic growth compared to other countries on the continent (The World Bank 2018). South Africa's GDP grew positively at 1.3% in 2017, 1.4% in 2018, 1.8% in 2019, and 1.9% in 2020 (The World Bank 2018). However, socioeconomic inequality in South Africa remains the highest compared with other African countries, reflecting a significant income gap among its population (The World Bank 2018). This polarization affects the country's political, economic, health, and social systems, including efforts to provide comprehensive basic needs for its people (The World Bank 2018). In the health sector, implementation is not comprehensive due to political instability, economic decline, population growth, geographical distance, and constraints (UNAIDS 2019; HSRC 2021). However, from the perspective of healthy city implementation, the outlook is positive. It operates within communities through wellness hubs (WH) to address HIV (Martinez Perez et al. 2016). In South Africa, WH hubs not only address NCDs, but their primary focus is on tackling HIV and various other sexually transmitted diseases (STDs) (Martinez Perez et al. 2016). This is because STDs, including HIV and Acquired Immunodeficiency Syndrome (AIDS), represent a major burden on the healthcare system and economy in nearly 60 million people in this densely populated country (UNAIDS 2019). South Africa has the highest number of HIV and AIDS cases worldwide, with 7.2 million people affected (UNAIDS 2019). Furthermore, 3.7% of teenagers in the country are living with HIV, with 2.7% aged 10-14 years and 4.9% aged 15-19 years. Among them, adolescent girls aged 15-19 have the highest HIV prevalence in the country (HSRC 2021). The WH model in South Africa was introduced to communities to address this phenomenon. It is based on a community-based approach that aligns with local sociodemographic conditions (Martinez Perez et al. 2016). This study selected South Africa as a case study for healthy cities because of its grassroots, people-centered approach to healthy city initiatives, despite various implementation challenges at the local level. Moreover, the special function of WH in the country has adapted to the disease burden of the local population. This demonstrates that the WH model was modified to suit the specific needs of the local community (Martinez Perez et al. 2016).

METHODOLOGY

This study applied case studies and content analysis as primary research methods to examine the implementation of healthy cities in South Korea, Nepal, China, and South Africa (Yin 2008; Merriam 1998; Patnaik & Pandey 2019). Case studies refer to a methodology used to understand in depth the nature of a social issue or process, such as programs, phenomena, places, individuals,

or organizations, rather than examining the relationships between variables or testing a theory or assumption (Yin 2008). The goal is to construct a comprehensive narrative of the process and social structure (Merriam 1998). Case studies are commonly used across various disciplines, applying interviews and surveys. The disciplines that apply case studies include ethnography (studying human culture), sociology (studying social interactions), history (studying the evolution of institutions and organizations over time), and psychology (studying human thoughts and emotions) (Becker 1970). This means that the primary sources analyzed through the case study method are human subjects, in line with studying the nature of human social issues in depth. However, in certain contexts, sources other than human subjects can be accepted as primary sources for case studies, particularly written sources, especially when related to the implementation of policies in a country (Patnaik & Pandey 2019). This approach is often used in the disciplines of international relations, political science, and policy sociology (Rashidi et al. 2023).

Therefore, this study applies this approach by analyzing selected written sources to summarize the content of Healthy City implementation in the selected countries (Sharma & Nam 2017; Xin et al. 2018; Martinez Perez et al. 2016). These sources include official documents, such as policy papers or reports by international bodies (World Bank 2022; UN 2022; USAID 2022), and academic journals (Bachani et al. 2022; Munjae & Kichan 2020). Content analysis supports the case study method by identifying the key explicit content (images, meanings, or processes) found in written materials (Patnaik & Pandey 2019). The aim is to understand the implicit narrative and, in turn, draw overall conclusions (Yin 2008). Both methodologies, case studies and content analysis, are integrated because they deeply summarize the specific narrative of the social issue being studied from the written materials. In this study, the issue to be explored in-depth is the content of the differences in Healthy City implementation across the selected countries, with the primary focus being the analysis of national factors characterized by the social reality in each respective country (Sharma & Nam 2017; Acharya et al. 2022).

The justification for accepting written sources as case studies is as follows. First, the purpose of the case study methodology is to understand the nature of an issue in depth, including social issues (Yin 2008). The content of the written sources consists of verified facts that have gone through pragmatic production stages (such as policy papers or official reports by international bodies) and facts studied in-depth in the field and through high intellectual evaluation stages (such as academic journals), including related social issues (Rashidi et al. 2023; Munjae et al. 2019). Thus, these sources are certainly valid as primary sources in the case study method to understand the nature of social issues at the local level (Merriam 1998). Moreover, these sources are official documents, such as national policy papers and authoritative academic corpora (UN 2022; WHO 2015). Second, there are academic fields aimed at holistically studying global societies, such as international relations, political science, and policy sociology (Patnaik & Pandey 2019). Therefore, to understand local issues occurring in other countries for academic purposes, much of the input comes from written sources such as journals and policy papers from those countries (Sharma & Nam 2017; Bachani et al. 2022). Hence, the selection of written sources as the primary sources for the case study method is appropriate. Additionally, each of these journals and policy papers resulted from pragmatic case study evaluations conducted in the field (Munjae et al. 2019). Third, there are study subjects whose inputs are primarily available in policy papers and academic journals, such as policy subjects in the field of policy sociology (Rashidi et al. 2023). Therefore, data collection through written sources is important because it minimizes costs in terms of time, money, and effort. Consequently, researchers do not need to travel to the countries being studied, because this information is readily available in electronic databases (Sharma & Nam 2017; UN 2022). This indirectly facilitates academic activity. Therefore, this study affirms written sources as an ideal source for the case study method to understand the nature of the social issues being studied (Yin 2008; Merriam 1998). The application of case studies and content analysis in this study involves two processes: identification and content analysis (Patnaik & Pandey 2019).

IDENTIFICATION

Identification refers to the search for written sources related to the implementation of healthy cities in South Korea, Nepal, China, and South Africa. Three electronic databases were used for this purpose: Web of Science (WOS), Scopus, and Google Scholar. Specific country-based keywords were used (Table 3).

TABLE 3. Electronic Database and Keyword Usage by Selected Country

Electronic database	Keywords by country
WOS	TS (“healthy city policy” OR “healthy city implementation in...[by country]”)
Scopus	TITLE-ABS-KEY (“healthy city policy” OR “healthy city implementation in...[by country]”)
Google scholar	ALL IN TITLE (“healthy city policy” OR “healthy city implementation in...[by country]”)
The total number of final written sources by the selected country	24 written sources

Source: Author (2024)

A wide range of written sources was retrieved from electronic databases. However, after rigorous screening, 24 relevant written sources were selected as units of analysis for this study (see Table 4). The screening process involves several steps. First, any sources whose abstracts focused on the implementation of healthy cities outside of the four designated countries were excluded. Second, publication type was considered; only official documents (such as policy papers and official reports by international organizations) and academic journals were accepted as units of analysis. Third, sources written in languages other than English are excluded. The 24 selected written sources were then used for the next stage of content analysis.

Country	Official Document	Academic Journal
South Korea	i. The Political Economy of South Korea: Economic Growth, Democratization, and Financial Crisis (Heo et al. 2008) ii. Korea’s Economy (KEIA 2015) iii. The Republic of Korea’s Economic Growth and Catch-up: Implications for the People’s Republic of China (Lee 2016) iv. Modern Korean Economy 1984-2008 (Park 2018)	i. Does Health Promotion Program Affect Local Residents’ Emotions? (Munjae, et al. 2019) ii. Effects of The Health Promotion Programs on Happiness (Munjae & Kichan 2020) iii. A Healthy City Project: A Case Study of Wonju City, South Korea and Its Relevance to The Cities In Nepal (Sharma & Nam 2017)
Nepal	i. Nepal Living Standard Survey (2010/11) (Central Bureau of Statistics, Nepal 2011) ii. Nepal Cities: Clean and Healthy Urban Development (ADB 2013) iii. Economic and Social Council: Nepal (UN 2022) iv. Implementation Plan: Municipal Actions for Air Quality in the Kathmandu Valley (USAID 2022)	i. Healthier Cities Through Systems Thinking: Practical Considerations for City Leaders (Bachani et al. 2022) ii. A Healthy City Project: A Case Study of Wonju City, South Korea and Its Relevance to The Cities In Nepal (Sharma & Nam 2017)
China	i. China’s Population Census (EAI 2021) ii. Country Analysis Executive Summary: China (U.S Energy Information Administration 2022)	i. An Overview of the Chinese Healthcare System (Baokang 2021) ii. The Luohu Model: A Template for Integrated Urban Healthcare Systems in China (Xin et al. 2018)
South Africa	i. South Africa: Current Issues, Economy, and U.S Relations (CRSR 2020) ii. Adolescents Living with HIV in South Africa (HSRC 2021) iii. South Africa Economic Update (The World Bank 2018) iv. Communities at the Centre: Defending Rights, Breaking Barriers, Reaching People with HIV Services (UNAIDS 2019)	i. ‘I Know That I Do Have HIV but Nobody Saw Me’: Oral HIV Self-Testing in an Informal Settlement in South Africa (Martinez Perez et al 2016) ii. Management of Employee Wellness in South Africa: Employer, Service Provider and Union Perspectives (Sieberhagen et al. 2011) iii. A Large-Scale Screening Responding to Sporadic Epidemic of COVID-19 in China by an Integrated Health-Care System (Xuru, et al. 2022)
25 written sources		

Source: Authors’ compilation (2024)

CONTENT ANALYSIS

Explicit content analysis (narratives and processes) was conducted on all 24 written sources, which were then categorized into specific themes (see Figure 2 and Table 5). Following this, a comprehensive (implicit) analysis was conducted for the main discussion of the study. This analysis centered on national factors that influence differences in healthy city implementation across countries, shaped by the unique social realities of each nation.

RESULTS

The findings of this study are divided into two categories: (i) a comparison of the goals and concepts of healthy cities, and (ii) a comparison of the implementation of healthy cities among the selected countries.

COMPARISON OF THE GOALS AND CONCEPTS OF HEALTHY CITIES AMONG THE SELECTED COUNTRIES

Each country has its own goals and concept of a healthy city shaped by specific issues and national factors unique to that country (see Figure 2). In turn, these national issues and factors are influenced by the social realities of each nation.

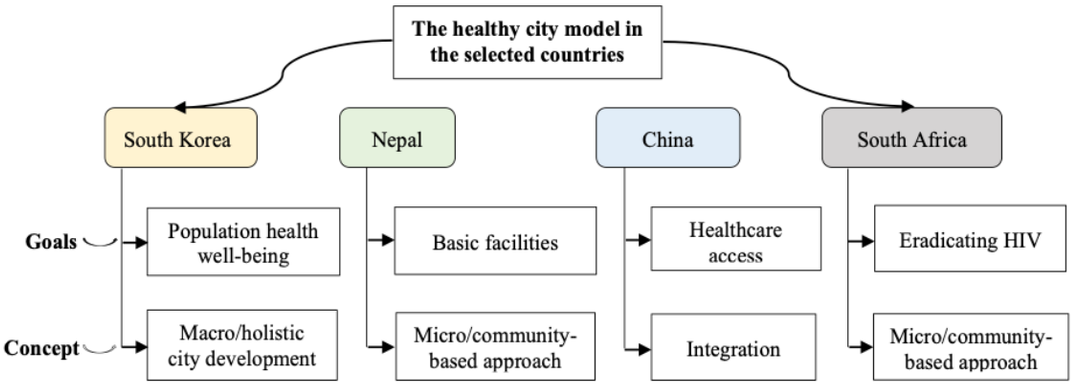

FIGURE 2. Goals and Concepts of Healthy Cities in Selected Countries
Source: Authors' compilation

South Korea conceptualizes healthy cities through a macro-level approach that focuses on a holistic urban development agenda (Figure 2) (Heo et al. 2008 Park 2018). This serves as a forward-thinking national strategy aimed at improving the overall health of the population (Sharma & Nam 2017). This approach responds to health vulnerabilities brought about by rapid development, particularly the rise in NCDs and mental health issues (Munjae et al. 2019). Therefore, progressive policy initiatives have been implemented to address these challenges and enhance public health well-being (Sharma & Nam 2017). In Nepal, the implementation of healthy cities is at the initial stage of the WHO's Global Healthy City Development Framework, specifically the structural setup phase (ADB 2013 UN 2022). At this level, the approach is micro- and people-centered, focusing on building essential public amenities aligned with population needs (Acharya et al. 2022). Examples of a healthy city infrastructure in Nepal include clean water facilities and high-quality healthcare services (Sharma & Nam 2017). In China, provincial authorities have developed an integrated Healthy City model to improve access to healthcare across its vast population (Xin et al. 2018 Baokang 2021). This represents a comprehensive urban development initiative that simultaneously aims to empower remote communities through institutionalized health services tailored to marginalized localities (Xin et al. 2018). The facilities developed under this initiative include hospitals and community health stations in the selected areas (Xin et al. 2018). In South Africa, where HIV remains a national health burden, the Healthy City concept adopts a micro-level approach (Martinez Perez et al. 2016; Sieberhagen et al. 2011). It has been implemented through wellness hubs that address the HIV epidemic (UNAIDS 2019). This demonstrates that the micro-level Healthy City model in South Africa centers on tackling community-level health issues directly (Martinez Perez et al. 2016). Each of the four countries implemented a healthy city model that was distinct and grounded in its own set of national priorities and agendas (WHO 2015).

COMPARISON OF HEALTHY CITY IMPLEMENTATION AMONG SELECTED COUNTRIES

Due to the differing goals and conceptual frameworks of Healthy City initiatives in each country, their implementation practices also vary significantly (as shown in Table 5).

TABLE 5. Comparative Analysis of Healthy City Implementation Among Selected Countries

Country	Goals/ Concept	Implementation approach for healthy cities
South Korea	Population health well-being (Macro/holistic city development)	i. Healthy City Act ii. National healthy city strategic plan iii. Cross-city coordination between healthy cities iv. Research collaboration with universities v. Pedestrian-friendly cities vi. Smart, healthy cities vii. Health tourism viii. Use of tobacco/cigarette tax revenue ix. Medical and sports centers x. Riverside parks xi. Street culture projects xii. Climate change research centers xiii. Neighborhood wellness hubs xiv. Infrastructure and physical facilities for promoting healthy lifestyles
Nepal	Basic facilities (Micro/ community-based approach)	i. Development of clean water supply ii. Environmental cleanliness iii. Employment opportunities iv. Sanitation facilities and wastewater management v. Quality healthcare system vi. Control of vector-borne and waterborne diseases vii. Management of slum settlements viii. Air pollution management ix. Reduction of road accidents x. Management of domestic pollution and solid waste xi. Provision of adequate housing
China	Healthcare access (Integration)	i. Leadership hierarchy through the Luohu Model ii. Luohu Health Application iii. Strengthening the healthcare system (community health centers, hospitals, medical institutions, resource-sharing centers, community health stations) iv. Appointment of health experts (providing general health literacy) v. Appointment of medical experts (personal health literacy) vi. Community care programs (personal healthcare plans) vii. Day care centers (services for drug addiction recovery) viii. Social service centers (personal care for selected patients and the elderly) ix. Subsidies for establishing elderly care homes x. Infrastructure and physical facilities for promoting a healthy lifestyle
South Africa	Eradicating HIV (Micro/ community-based approach)	i. Community wellness hub for HIV cases: • STD screening programs • HIV screening tests • Counseling initiatives for Voluntary Counselling and Testing (VCT) • Antiretroviral treatment or Active Antiretroviral Treatment (AAT) • HIV monitoring ii. Community consultations • Promotion of self-administered HIV test kits • Safe sex programs • Condom and lubricant distribution programs • Voluntary circumcision programs • Prevention of mother-to-child HIV transmission programs • Prevention and treatment programs for Sexually Transmitted Infections (STIs) • Needle exchange programs • Drug programs for HIV treatment • Pre-Exposure Prophylaxis medication programs • Door-to-door interventions • Hypertension and diabetes screening programs • Tuberculosis (TB) awareness programs • Pregnancy test/family planning programs

Source: Adapted from 25 written sources in Table 4 (2024)

Based on Table 5, the implementation of Healthy Cities in each country varies and has its distinct foundation (WHO 2015; Heo et al. 2008). From the perspective of countries that operate healthy cities as a holistic urban development concept, their implementation is proactive and forward-looking (Park 2018 Sharma & Nam 2017). Before the Healthy City concept was developed as a national policy, its authority was established (Heo et al. 2008). Stakeholder consultations were conducted to establish the best possible foundation authority (Sharma & Nam 2017). For example, in South Korea, the National Healthy City Plan and Healthy City Act were drafted as national guidelines, followed by the establishment of Healthy City partnership initiatives and health impact assessment programs (Munjae et al. 2019). This approach aligns with the health issues faced by the population, particularly mental health issues and NCDs (Sharma & Nam 2017). Examples of healthy city initiatives in South Korea include smart healthy cities, pedestrian-friendly cities, riverside parks, neighborhood wellness hubs, infrastructure development to promote healthy lifestyles and the use of tobacco tax revenues to improve healthy cities (Heo et al. 2008; Park 2018).

Nepal represents the implementation of healthy cities that are centered on people, currently in the early phase of the structural setup (ADB 2013 UN 2022; Acharya et al. 2022). At this stage, the focus of implementation is the development of basic infrastructure for the population (Sharma & Nam 2017). Nepal has remained proactive in integrating these initiatives into its national development policies, although implementation has taken some time owing to political and socioeconomic constraints (ADB 2013 UN 2022). Since 2012, the Ministry of Urban Development has been established with a focus on clean water development, urban management, and systematic sewage facilities (Acharya et al. 2022). Subsequently, the Healthy City initiative was incorporated into the Kathmandu Valley Air Quality Management Action Plan 2020 in a more structured direction (UN 2022). All these initiatives are effective in Nepal's Comprehensive National Healthy City Plan (ADB 2013).

In China, the Healthy City Model integrates a coalition of organizations, communities, and urban planning to enhance health access for its large population (Xin et al. 2018; Baokang 2021). In Luohu District, a healthy city is developed based on a coalition between experts and citizens, managed collaboratively between agencies and the public, and implemented based on community feedback (Xin et al. 2018). Examples of healthy city implementation in Luohu include community health centers, hospitals, medical institutions, resource-sharing centers, and community health stations (Baokang 2021; Xin et al. 2018).

In South Africa, the implementation of a healthy city operates within communities through WH to address fundamental health issues (Martinez Perez et al. 2016; Sieberhagen et al. 2011; UNAIDS 2019). South Africa targets a reduction in HIV and AIDS cases, as 7.2 million people in the country are living with HIV/AIDS (UNAIDS 2019). Various grassroots programs have been implemented, such as HIV screening, safe sex, condom and lubricant distribution, voluntary circumcision, needle exchange, and Pre-Exposure Prophylaxis (PrEP) drug programs (Martinez Perez et al. 2016). As a result of these consistent efforts, the prevalence of new HIV/AIDS cases has noticeably declined (Sieberhagen et al. 2011). This demonstrates that a people-centered healthy city approach is significant in the South African context (Martinez Perez et al. 2016). In conclusion, the four healthy city models implemented in the four referenced countries are unique because their implementation is tailored to the needs of each country's society and each has its value-added foundation (WHO 2015).

DISCUSSION: FACTORS CONTRIBUTING TO THE DIFFERENCES IN HEALTHY CITY IMPLEMENTATION BETWEEN SELECTED COUNTRIES

Based on the findings of this study, each country, whether high-income or low-middle-income, has its criteria and objectives for implementing a healthy city, influenced by national factors specific to each country. In summary, there are three national factors, shaped by the social realities, that impact how each nation develops its approach to implementing a healthy city: (i) the vulnerability and burden on the health sector, (ii) political factors and economic resources, and (iii) population factors and local social issues.

VULNERABILITY AND BURDEN OF THE HEALTH SECTOR

Each country has a different level of development, and these differences influence the types of diseases that prevail (WHO 2015 Heo et al. 2008).

Consequently, this affects the development of healthy cities as a mechanism to address these diseases (Sharma & Nam 2017 Park 2018). As a narrative, high-income economies developed earlier, leading to a higher standard of living (Heo et al. 2008). In terms of disease, the shift from underdeveloped to developed changes people's mindset to a new lifestyle, particularly unhealthy habits such as poor eating habits (Sharma & Nam 2017). In the long run, this increases the risk of NCDs such as diabetes and hypertension (WHO 2015; Park 2018). This narrative is referred to as "Western lifestyle diseases," as progress is often associated with the Western way of life, and diseases are a result of that progress (Heo et al. 2008). This means that in high-income countries, the primary diseases affecting the population are NCDs (Sharma & Nam 2017). The situation is different in lower-middle-income countries, where the population suffers from diseases linked to underdevelopment, such as communicable waterborne and vector-borne diseases (ADB 2013; Acharya et al. 2022). This is driven by issues such as poverty, poor sanitation, deprivation, food insecurity, and ecosystem pollution (UN 2022; ADB 2013). Meanwhile, certain diseases exist regardless of a country's economic status, whether developed or underdeveloped, and pose a serious burden on the healthcare system in any country that faces them (UNAIDS 2019; Martinez Perez et al. 2016). One such disease is HIV and AIDS (Sieberhagen et al. 2011; UNAIDS 2019). For example, South Africa is facing a difficult situation, with widespread HIV and AIDS infections, particularly among girls aged 15-19 years (UNAIDS 2019).

Thus, the implementation of healthy cities in each country is influenced by differences in vulnerability and health burdens (WHO 2015). Healthy cities serve as mechanisms for addressing these diseases (Heo et al. 2008). For this reason, the focus of Healthy City implementation varies among the four countries referred to in this study: South Korea (focusing on NCD prevention and mental health issues) (Park 2018; Munjae et al. 2019), Nepal (focusing on preventing infectious diseases) (ADB 2013; Acharya et al. 2022), China (focusing on NCD prevention and gerontology issues) (Xin et al. 2018; Baokang 2021), and South Africa (focusing on HIV STDs and transfusion-related diseases) (Martinez Perez et al. 2016; Sieberhagen et al. 2011; UNAIDS 2019). Therefore, the national context is the most important component in determining the implementation of healthy cities within each community (WHO 2015). This is because each country has comprehensive reports on local health vulnerabilities (Heo et al. 2008). As a result, the actions taken by the four countries to determine the direction of Healthy City implementation in their respective societies are legitimate and valid (Sharma & Nam 2017).

POLITICAL FACTORS AND ECONOMIC RESOURCES

The second factor influencing the differences in the implementation of healthy cities among the four countries referenced (South Korea, Nepal, China and South Africa) was the political system and economic resources (Heo et al. 2008; WHO 2015). In high-income economies, they can realize comprehensive healthy cities because of their robust national resources, such as financial resources, political positions, education systems, human capital, technology, and international networks (Park 2018; Munjae et al. 2019). Policy papers and international conferences are frequently discussed in these countries, exposing societies to various competitive prospects for the implementation of healthy cities (Sharma & Nam 2017). However, for lower-middle-income countries, the focus of development still revolves around improving the basic needs of their populations because of limited national resources (ADB 2013; Acharya et al. 2022). For example, a comparison between South Korea and Nepal shows this contrast (Park 2018; ADB 2013). In South Korea, from 1960 to 2010, Gross Domestic Product (GDP) increased from US$290 to US$28,384, indicating that South Korea's economic position has been strong since the 1980s (Munjae et al. 2019). Meanwhile, in Nepal, even though in 2019, 17.4% of the population still lived below the poverty line, they were burdened by issues such as caste, disability, weaknesses in the education system, ethnicity problems, geographic constraints, population migration, and the unequal distribution of wealth in the country (Acharya et al. 2022; UN 2022). In fact, 44% of the poor population in Nepal consists of children, despite comprising only 35% of the total population (ADB 2013; UN 2022). From a political perspective, violence and conflict between the government and the Communist Party of Nepal-Maoists have been significant obstacles to development in the country, including the implementation of healthy cities, despite signing the 2006 Comprehensive Peace Agreement (Acharya et al. 2022). This situation

highlights why the implementation of healthy cities in high-income countries is more futuristic than that in lower-middle-income countries (Park 2018; Heo et al. 2008). Political and economic factors such as these influence differences in the progress and form of healthy city implementation in each country (Sharma & Nam 2017).

POPULATION FACTORS AND LOCAL SOCIAL ISSUES

The differences in the implementation of healthy cities between countries, whether in high-income or lower-middle-income economies, also depend on population factors and social issues in each country (WHO 2015; Heo et al. 2008). This difference was observed between China and Nepal (Xin et al 2018 Acharya et al 2022). China had a population of 1.4 billion in 2022, with expectations to increase to 1.41 billion by 2035 (Baokang 2021). Due to its large population, the implementation of healthy cities in China focuses on achieving holistic health access (Xin et al. 2018). The implementation spans various regions (Baokang 2021). The health facilities built included community health centers, hospitals, medical institutions, resource-sharing centers, and community health stations (Xin et al. 2018; Baokang 2021). However, the impact of health access goes beyond improving birth rates and life expectancy (WHO 2015). An increase in birth rate has also led to an increase in drug abuse (Xin et al 2018). Consequently, China has adjusted its healthy city implementation to address this issue (Baokang 2021). Various new approaches have been introduced, such as establishing community day care centers (drug addiction rehabilitation services), community care centers (personal healthcare plans), social service centers (personal care for selected patients and the elderly), and subsidies for the establishment of elderly care homes (Xin et al. 2018; Baokang 2021).

Nepal, on the other hand, considers the implementation of healthy cities based on the need to develop a basic infrastructure in densely populated areas (ADB 2013; Acharya et al. 2022). Population density in Nepal is linked to poverty and migration (UN 2022). Poverty leads to migration from rural areas to cities in search of a better life, resulting in a sudden increase in urban population (ADB 2013). In this regard, the five main cities in Nepal have a population density of 6,000 people per square kilometer (Acharya et al. 2022). In Kathmandu alone, there were 19,726 people per square kilometer (UN 2022). The growing population creates problems such as inadequate clean water, health burdens, poverty, crime, domestic waste issues, ecosystem pollution, excessive carbon gas emissions, and poorly managed drainage systems (ADB 2013 Acharya et al 2022). These domestic factors influence the foundation of the implementation of healthy cities in Nepal, with the main focus on micro-development rather than a macro, holistic development approach (Sharma & Nam 2017). This clearly shows that population factors and social issues in a country influence the differences in the implementation of healthy cities across countries (WHO 2015).

LESSONS FOR DEVELOPMENT IN MALAYSIA

The implementation of healthy cities in both high- and lower-middle-income economies serves as a reference for the formation of ideas and structures for healthy city implementation worldwide, including Malaysia (Heo et al. 2008; WHO 2015). Although the concept of healthy cities was introduced in Malaysia in 1994, its implementation has not been impactful (Sharma & Nam 2017). Therefore, the findings of this study provide valuable lessons for development in Malaysia and the world (Park 2018). First, in high-income economies, before the Healthy City initiative was established as a national policy, the legal authority behind the concept was drafted (Munjae et al. 2019). Various stakeholder consultations have been conducted to ensure the establishment of the best legal foundation (Heo et al. 2008). This approach can be adopted in Malaysia, because there is currently a lack of clarity regarding the legal authority of policies in the country (Sharma & Nam 2017). Second, in high-income countries, implementation of healthy cities is continuously monitored through various internal and external evaluation committees established throughout the development process (Park 2018). Monitoring began at the proposal stage and continued until the final assessment, which was followed by periodic audits (Munjae et al. 2019). This cross-audit approach ensures that development projects are completed on schedule and produce high-quality outcomes (Heo et al. 2008). Third, the facilities, programs, and activities conducted through Healthy City initiatives are integrated, in situ, and people-centered, representing an effective Healthy City policy (Park 2018; Munjae et al.

2019). This model can be applied to Malaysia (Heo et al 2008). Fourth, Malaysia should learn from the experiences of lower-middle-income countries, where progress in development results in related downstream impacts (ADB 2013; Acharya et al. 2022). In Nepal, urbanization has led to population density, environmental pollution, poverty, and worsening health issues (UN 2022; ADB 2013). A comprehensive Healthy Cities Act and national strategic plan should be developed to address these global phenomena, including short-, medium-, and long-term mitigation solutions involving all relevant stakeholders (Acharya et al. 2022; UN 2022). Fifth, the focus of most lower-middle-income countries on the basic needs of their citizens often sidesteps larger national development concepts, as observed in Nepal (ADB 2013). Malaysia must ensure that every development in the country is guided by a holistic national policy framework encompassing both small-scale and national concepts, to ensure balanced and inclusive development (Sharma & Nam 2017). Finally, communities serve as the foundation for national development (Park 2018). Communities in high-income economies are key policymakers in healthy cities through regular and collaborative consultations (Heo et al. 2008). Any developmental ideas resulting from these grassroots values will add constructive value to the success of the initiative and minimize conflicts between the people and the government due to differences in aspirations (Munjae et al. 2019). Therefore, it is recommended that local authorities in Malaysia appoint two council members for each authority: one representing the community and the other an expert (someone knowledgeable about health promotion and healthy city planning) (Park 2018; Heo et al. 2008). The findings of this study indirectly provide important guidance for the effective implementation of Healthy City models in Malaysia to address local health issues (Sharma & Nam 2017).

CONCLUSION

The differences in the implementation of healthy cities between countries are determined by national issues in each country and shaped by local social realities, such as vulnerabilities and burdens on the health sector, political factors, economic levels, population factors, and local societal issues (WHO 2015; Heo et al. 2008). Any policy that considers social realities in shaping local development will result in effective development outcomes (Sharma & Nam 2017). This is because these social realities involve real societal issues related to progress, underdevelopment, poverty, population density, migration, political tensions, etc., that occur within a country (Park 2018; ADB 2013). A development policy that analyzes local situations is ideal for meeting the needs of the society in each country (Heo et al. 2008; Munjae et al. 2019). Therefore, comparisons between more advanced countries should not be made (Sharma & Nam 2017). Furthermore, the question of whether development within a country is delayed should not arise as it is constrained by local social reality (WHO 2015). This is because each country has different levels of national readiness (Park 2018; Heo et al. 2008). This finding contributes, to some extent, as a lesson in development for the general public, especially in Malaysia, that to create effective and ideal development, social realities within a community must be taken into account (Sharma & Nam 2017). Moreover, the purpose of development is for people, so their social reality is certainly significant even though it is complex (Heo et al. 2008). In addition, public participation is important because the factors influencing the success of development stem from people's involvement (Park 2018; Munjae et al. 2019). Any policy that arises from inclusive ideas results in a comprehensive implementation (Sharma & Nam 2017). From the perspective of healthy cities, this serves as a guide for formulating sustainable Healthy City policies tailored to the needs of communities in Malaysia (WHO 2015). Health is a key component of sustainable and livable cities as a strategy for reducing the burden of disease (Heo et al. 2008).

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