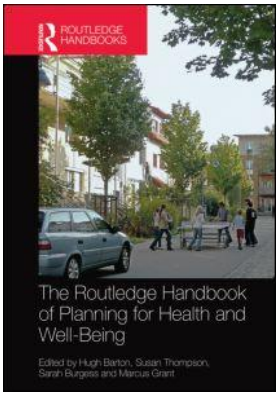

The Routledge Handbook Of Planning For Health And Well-Being

Shaping a sustainable and healthy future

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Urban Inequities, Population Health and Spatial Planning

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URBAN INEQUITIES, POPULATION HEALTH AND SPATIAL PLANNING

Jason Corburn

Introduction: health in cities vs healthy cities

The twenty-first century is the century of the city, as the world's population now lives predominantly in urban areas. Where you live and how that place is governed can determine when and if you get sick, receive medical treatment and die prematurely. City living can be beneficial for human health, since urban areas generally offer greater economic and educational opportunities, medical services, political and gender rights, affordable housing and cultural, political and religious expression. This holds true in both rich and poor cities of the global North and South. Yet, not everyone in cities can take advantage of these socially produced resources and the poor and socially marginalised often experience health inequities, or differences in access to health promoting resources that are unnecessary, avoidable and unfair.

Today, most urban health interventions are focused on bringing social services, primary care, economic opportunities and physical improvements to urban residents or their neighbourhoods. Interventions tend to focus either on people or places, but rarely both at the same time. Interventions are generally conceptualised and led by experts, and focused on one disease, one risk factor, one hazardous exposure, one population group, or one suspected 'cause' of poor health, such as poverty (Corburn 2009). More care, more places offering care, more prevention and more services tend to be intervention targets. This is the *health in cities* approach, and while life has become better for most urban residents using this approach, the strategy has largely failed to address the spatial (and ethnic/racial) inequities in health (EU 2013). In this chapter, I set the context for today's efforts to reconnect policy fields to address rising health inequities, by first exploring some public health and planning history. I then review some of the connections between planning and human health that suggest the built and social environments matter, as well as the governance of cities and places, for understanding the complex ways place gets into our bodies. I close with some approaches for more healthy urban governance that includes an attention to new science and politics in the twenty-first century. This healthy urban governance framework embraces complexity science, uses processes of ecological adaptive management, and emphasises the expertise of city residents as problems solvers and beneficiaries of healthy city planning.

The rise of urban health inequities

Sanitation, germs and spatial segregation

A dominant narrative in the history of urban public health, as set out in the previous chapter, is that sanitary interventions during the nineteenth century arrested epidemics of infectious disease and helped clean-up dirty and unhealthy cities. As nineteenth- and early twentieth-century urban populations increased across Europe and North America, improvements in physical infrastructure, particularly housing, water and sanitation did not keep pace. Buildings were quickly overcrowded as rooms were divided to house more workers and their families. Animal, human and industrial wastes accumulated dramatically in cities without systems for their removal. Common methods of waste disposal in cities, such as cesspools, regularly overflowed and contaminated water supplies and wells. Human and animal waste heaps were infested with flies and vermin, had unbearable odours and, when combined with the thousands of animals brought into the city for slaughter to feed the growing population, were logically seen as the culprit for infectious disease (Duffy 1990). Edwin Chadwick's *Report on the Sanitary Condition of the Labouring Population in Great Britain in 1842*, documenting unsanitary living conditions afflicting the urban poor across Britain, led to the subsequent Royal Commission on the Health of Towns concluding that physical changes to the city were necessary to improve population health and particularly the well-being of the poor.

While the movement for urban sanitation and health gained momentum, others would point to economic and political inequities as the reasons behind inadequate life-supporting infrastructure for the poor. Friedrich Engels would point to economic and social inequalities that he claimed produced the physical squalor and diseases of the poor in *The Conditions of the Working Class in England in 1844* (Engels 1891). After an epidemic of typhus broke out in Upper Silesia, an economically depressed Prussian province inhabited by a large Polish minority, the pathologist Rudolf Virchow was hired to investigate and issue a report. Virchow (1848) concluded, in what would become a classic of social medicine, that eliminating epidemics in the future would not require more palliation but the 'politics of prophylaxis' – unlimited democracy, devolution of decision-making, universal education, disestablishment of the church, taxation reform, and industrial development in the poorest regions. Yet, by 1848, the arguments of Chadwick and the Health of Towns Commission, not Engels, would help to establish the first British Public Health Act.

Sanitary engineers emerged to take a prominent role in city management and governance. The British physician and sanitarian Benjamin Ward Richardson would advocate in 1876 for the utopian vision of *Hygeia: A City of Health*, where he outlined the site selection, street layout, water and sewerage, park system and housing design that together could reduce mortality. Engineers laid claim to having the knowledge for designing healthy water delivery, street networks, and sewer systems – the 'arteries of the city'.

By the end of the nineteenth century and into the early twentieth, modern city planning and public health were using physical interventions to respond to urban public health crises. While planning and public health both addressed sanitation and housing reforms during this time, the driving ideology was physical removal, of both 'environmental miasmas' – garbage, wastewater, slum housing, 'swamp' land, and so forth – and 'undesirable and sick' people. These interventions rarely addressed urban poverty or other social inequalities that also contributed to disease and premature death. As the driving theory of disease causation in public heath shifted from miasma – filth and dirty air – to germ theory, urban health interventions would move even further away from addressing social inequities and instead focus on the cell, or pathogens, as bacteriology took hold.

Germs, labs and city management

Bacteriology stimulated laboratory research that developed vaccines to immunise the poor, rather than clean up their neighbourhoods, workplaces and improve their economic status. Laboratory public health research also treated drinking water, milk and food for disease-carrying microbes. This research led to compulsory vaccinations for school-age children and the chlorination of municipal drinking water supplies. Clearly, these non-specific urban health strategies helped reduce the spread of infectious diseases.

The model of laboratory science seen as producing definitive, apolitical knowledge also contributed to a view of city management during this time. City planners interested in improving health were often confronted with finding ways to pay for politically and economically controversial infrastructure projects that often wouldn't produce results for a decade or more. Planners and engineers turned to the prestige of laboratory science for a model of city management, since in the lab results were often unquestioned as researchers were viewed as neutral and detached from the social context where investigations were taking place, inputs into lab experiments were highly controlled and restricted, and analytic techniques were mechanical and standardised, so that results from a lab anywhere could be applied everywhere. City managers demanded political autonomy in the interest of the city's health, and used new 'efficiency' technologies such as benefit–cost analyses, land use zoning and long-range comprehensive planning, to radically alter urban governance.

A least two urban design schemes from the early twentieth century highlight the laboratory-like claims of city planners, engineers and managers: the Garden City and the Neighbourhood Unit. In Britain, Ebenezer Howard (1965) aimed to integrate a regional perspective with principles from ecology to improve well-being in his Garden City designs. The Garden City, he claimed, could create 'slumless and smokeless' cities and merge the best of the country into the city, while eliminating the features of each that were unhealthy. Clarence Perry (1929) proposed the Neighbourhood Unit in 1922 as a design scheme intended to provide order, liveable scale and health-promoting rationality to urbanisation. The Garden City and the Neighbourhood Unit offered a physical ideal that tended to ignore the often contested, gendered, variegated and value-laden characteristics of cities. By leaving out the distinctive virtues of particular places in a bid for universal applicability, these representations of the city were intended to be credible and capable of being applied regardless of time and place, social and physical geography, or political and administrative organisation – much like results from laboratory science.

Perry's Neighbourhood Unit idea took hold with planners, developers, and the American Public Health Association's (APHA) Committee on the Hygiene of Housing. The APHA Committee adopted the Neighbourhood Unit design scheme as the basis for two reports; one, in 1938, *Basic Principles of Healthful Housing* (APHA 1938), and a second in 1948, *Planning the Neighborhood* (APHA 1948). The *Planning the Neighborhood* guidelines were increasingly used to justify state-sponsored slum clearance in American cities, with municipal public health agencies using the guide as justification for labelling poor neighbourhoods blighted. In the UK in 1944, the Ministry of Health, Central Housing Advisory Committee, published guidelines on the design of dwellings and a *Housing Manual* (commonly referred to as the 'Dudley Report') to guide post-war reconstruction, both of which were based on the design standards of the Neighbourhood Unit and Garden City (Ministry of Health 1944).[1]

Rise of modern planning and razing of unhealthy neighbourhoods

Modern city planning had taken hold by the early 1920s in both Europe and North America, with societies, conferences and new academic training programmes. European zoning, or the

segregation of space by categorising land uses, would emerge as a key tool for planners to separate 'unhealthy' spaces – such as industry – from residences. In the US, neighbourhood health centres also emerged at this time as one way to connect planning and health, since they were one-stop locations in poor, often immigrant urban areas, where ambulatory health services were combined with community participation in development and planning decisions. A federal policy, the Sheppard-Towner Maternity and Infancy Protection Act of 1921, funded a network of community health centres in urban and rural areas.

Federal housing policies, such as urban renewal in North America, encouraged the razing of what were viewed by both planning and public health professionals as blighted, unhealthy neighbourhoods. The idea was to rebuild these neighbourhoods with modern high-rise social housing. However, urban renewal also displaced thousands of urban poor residents, largely African-Americans and new immigrants, from their social and financial networks and is viewed as a key reason why the health of these populations rapidly declined during this period. Federal home-loan policies accompanied urban renewal programmes, but loan guarantees were limited to new single-family homes, giving rise to the American suburb and a subsequent auto-centred development pattern in and around metropolitan regions. Federal highway policies and road-building subsidies also emerged in the 1950s, as national and metropolitan planning was oriented toward road building, not transit, helping entrench an auto-centred development pattern that would come to dominate the landscape for much of the latter half of the twentieth century.

By the mid- to late twentieth century, the driving ideology in public health had shifted again to the biomedical model, which attributes morbidity and mortality to molecular-level pathogens brought about by individual lifestyles, behaviours, hereditary biology or genetics. Urban health interventions shifted to the 'health in cities' approach, aiming to change unhealthy behaviours such as drinking alcohol, smoking tobacco and poor diets (Corburn 2013). Yet, urban health activists continued to challenge medical and planning professionals for why, in the face of rising economic prosperity and advancements in medical technologies, inequalities in health persist for the urban poor and people of colour? The fields of urban public health and city planning were in crisis at the turn of the twenty-first century, as reports from governments around the world and the World Health Organization noted the rise in health inequalities and declining health for some urban populations living in the poorest areas (cf. 'Black Report' (Townsend and Davidson 1980), and 'Targets for health for all' (WHO Regional Office for Europe 1985)).

How twenty-first century urbanisation shapes health

Cities in the twenty-first century are more diverse than their nineteenth-century counterparts in terms of their built environments, social characteristics and governance schemes. Further, the health outcomes that afflict urban dwellers are different than those of 150 years ago; non-communicable diseases are more prevalent as are issues of mental health. Finally, people in cities are living longer, so ageing and associated functional and independence limitations have become core twenty-first-century urban health, design and planning issues. Thus, nineteenth-century urban health solutions focused almost exclusively on physical improvements to the urban environment will be insufficient to address the complex contributors to twenty-first-century urban health inequities. Below, we review some of the complex ways the twenty-first-century city impacts health inequities.

Physical and built environments

The physical environments of cities still matter for health, such as whether there is access to safe and affordable drinking water, sanitation, drainage and garbage collection. Urban air and noise

pollution remain critical health determinants in highly industrialised cities of Europe and Latin America as well as developing cities in China and Sub-Saharan Africa (Harpham 2009). Urban air pollution is linked to up to 1 million premature deaths each year. Over 90 per cent of air pollution in cities in these countries is attributed to vehicle emissions brought about by high numbers of older vehicles coupled with poor vehicle maintenance, inadequate infrastructure and low fuel quality (UNEP 2014). Urban particulate matter is associated with cardiovascular death and asthma. Noise pollution, a common urban nuisance, is associated with hearing impairment, hypertension and ischemic heart disease. Exposure to environmental pathogens in urban air and water can contribute to both infectious (i.e. parasitic, diarrhoeal, intestinal, etc.) and non-infectious diseases.

Pedestrian conflicts with motor vehicles are one of the leading causes of injuries in urban areas. When a new development project includes new housing and commercial activity, pedestrian activity increases and this can lead to an increase in injuries. However, greater pedestrian activity can promote physical activity that reduces heart disease, stroke and mental illness and increase functional status and the longevity of independence among the elderly. Creating new opportunities for pedestrian activity can also improve well-being by increasing the likelihood of social interactions that can reduce feelings of isolation. However, the construction of highways contributes to vehicular air pollution and suburban sprawl, while the lack of or inadequate transport inhibits access to employment and health promoting services, especially for the urban poor. Highways and streets can limit green open space, which can act as a site for physical activity, social interactions, and an urban heat sink, reducing the likelihood of adverse human health impacts from climate change induced urban heat islands.

Social environment and urban health

The physical and social environments of cities frequently interact and cannot be disassociated when trying to understand and improve urban health inequities. The urban social environment includes the institutions that shape the structure and characteristics of relationships and opportunities among people and different population groups within a given community (Healey 1999). Perhaps the most well researched aspect of the social environment that influences health is economic status or class. While debate continues whether absolute or relative poverty matter more for influencing health, there is agreement that being poor in any city increases one's likelihood of a range of health risks across the life-course, from infant mortality and low birth weight, to stunted physical and cognitive development to early on-set chronic illnesses and higher rates of infections (Marmot et al. 2012).

The economic 'environment' also influences well-being. Neighbourhoods with high concentrations of liquor stores also have high rates of addiction. However, local businesses can act as a source for employment and culturally appropriate food and other services. Displacement of local businesses can adversely impact health by altering the availability and affordability of essential goods and services and the type of local employment possibilities. Business displacement can also contribute to physical blight – the tooth-gaped landscape all too common in poor neighbourhoods where widespread property abandonment has taken hold. Property abandonment can adversely influence health by increasing the likelihood of illegal dumping of garbage and hazardous wastes.

The social environment also influences health through a variety of other pathways, including the support of individual or group behaviours that affect health, buffering or enhancing the impact of stressors, and providing access to goods and services that influence health (for example housing, food, informal health care). Limited social supports may predispose persons to poorer coping and adverse health. High levels of social stressors, such as social isolation and violence,

are also known to adversely impact the health of urban residents. In cities, the greater spatial proximity of one's social networks may accentuate their role in shaping individual and population health (Friel et al. 2011).

Perhaps the most crucial social and political force in cities that influences health is spatial segregation. Many cities worldwide are highly segregated with discrimination against certain racial, ethnic, caste or tribal groups often acting as justification. Spatial segregation can have multiple effects, including the enforcement of homogeneity in resources and social network ties and suppressing diversity that may benefit persons of lower socioeconomic status. Persons who live in segregated communities may have disproportionate exposure, susceptibility and response to economic and social deprivation, toxic substances and hazardous conditions. The physical and social factors that influence health in cities are summarised in Figure 3.1.

Health resource	*Urban physical and social influences on health (examples)*
Environmental quality, including noise, air, soil and water pollution	Vehicle emissions exacerbate respiratory disease and increase cardiopulmonary mortality, while indoor allergens exacerbate asthma Chronic noise exposure adversely harms sleep, temperament, hearing and blood pressure, all of which can lead to developmental delays in children Trees and green space remove air pollution from the air and mitigate the urban heat island effect
Access to high quality transit and safe roadways, sidewalks and bicycle lanes	Vehicle/pedestrian injuries are most severe where sidewalks and crosswalks are non-existent Sidewalks and bicycle lanes facilitate physical activity, reducing heart disease, diabetes, obesity, blood pressure, osteoporosis and symptoms of depression. Public transit provides access to employment, education, parks and health care services
Access to quality childcare, education and health care facilities	Quality childcare can build disease immunities and increase likelihood of future educational attainment and earnings Education can enhance health literacy about preventative behaviors and services Timely access to primary health services prevents serious illness
Affordable, safe, stable and socially integrated housing	Crowded and substandard housing conditions increase risks for infections, respiratory disease, fires and stress Unaffordable rents or mortgages result in trade-offs between housing, food and medical care Racial residential segregation limits economic and educational opportunities, concentrates disadvantage and increases social distance between racial/ethnic groups
Access to safe and quality open space, parks, cultural and recreational facilities	Clean and safe parks can increase the frequency of physical activity Cultural activities can promote cross-cultural understanding, decrease violence and enhance social cohesion
Employment providing meaningful, safe and living wage jobs	Higher income is associated with better overall health, reduced mortality and higher emotional stability Unemployment is a source of chronic stress, while job autonomy increases self-esteem

Access to affordable and quality goods and services	Neighbourhood grocery stores support nutritious diets Local financial institutions help families create and maintain wealth
Protection from crime and physical violence	Indirect effects of violence and crime include fear, stress, anxiety and unhealthy coping behaviors, over-eating, smoking and alcohol/drug abuse Fear of crime can force children to stay indoors, increasing exposure to toxic indoor air and allergens, and limiting physical activity outside
Social cohesion and political power	Physical and emotional support buffers stressful situations, prevents isolation, contributes to self-esteem and reduces the risk of early death Stress from severed/lack of social ties/support can contribute to low birth weight, which increases risk of infant death, slow cognitive development, hyperactivity, breathing problems, overweight and heart disease.

Figure 3.1 Urban health resources and risks

Source: Corburn (2009).

Politics, urban governance and health

The physical and social characteristics and dynamics in cities that influence health do not happen randomly or by accident. Cities and metropolitan regions more generally are not shaped by faceless forces of natural succession and competition. Social movements and citizens make urban places through activism, generating economic and cultural opportunities (i.e. markets, community centres, places of worship, etc.), building homes and play spaces, using these spaces in certain ways, maintaining their spaces (or not) and making the environment open and hospitable to others/outsiders (or not). There are real winners and losers in the *political struggles* of place making, and static definitions of physical and social variables rarely captures this dynamic of places. The political processes of urban place making and remaking are what I refer to as 'urban governance'.

The term governance is broadly understood as attentive to the relationships between the overlapping spheres of political, economic and social life, as each aim to influence collective action. Governance is not government, but is inherently about the struggle and conflict between formal institutions and organisations and informal norms and practices.[2] Urban governance includes a complex mix of different contexts, actors, arenas and issues, where struggles over power can be manifested in public discourses or tacit day-to-day routines. An urban governance approach to healthy planning is attentive to both processes and outcomes, and must ask questions such as: what conditions lead to planners using or abusing power, responding to or even resisting market forces, working to empower some groups and dis-empower others, promoting multi-party consensual decision-making discourses or simply rationalising decisions already made? The governance approach views urban planning as a process that includes the shaping of public agendas and attention, available evidence and norms of inquiry, inclusive or exclusive deliberations, and responses (or lack thereof) to bias, discrimination, inequality and a recalcitrant state. An attention to governance moves health equity planning away from only focusing on vulnerable people or places to also include altering the political processes and institutions that work to maintain the social inequities driving urban health inequities.

Toward a twenty-first-century science for healthy city planning

A new urban science for healthy cities ought to capture the combination of physical, social and political forces, and their interactions across space and time. This is what we could call a 'relational' view of healthy place making. A relational view of place is crucial for understanding healthy urban planning because social processes, such as power, inequality and collective action, are often revealed through the construction and reconstruction of the material forms and social meanings of places (Cummins et al. 2007).

Consider the now well-documented idea that social stress can be toxic to the human body, especially when place-based stressors are chronic and cumulative across one's lifetime (McEwen 2007). In toxic stress situations, the constant chemical release of 'fight or flight' hormones does not properly regulate or shut off, and wears away at the immune system as it overworks to manage the hormonal releases, contributing to a host of chronic diseases such as overweight and obesity, diabetes, hypertension, cardiovascular disease, stroke, asthma and other immune-related illnesses. Since populations in many deprived and impoverished areas of cities are likely experiencing multiple 'toxic stressors', planners must be attentive to the physical and social stressors that they may help co-produce, such as institutional responses to poverty and discrimination, housing instability, or neighbourhood exposure to violence. The toxic stress idea suggests that a twenty-first-century science for the healthy city can no longer view a person as, for example, one day an African immigrant, another day born low birth weight, another day raised in a home bearing remnants of lead paint, another day subjected to racial discrimination at work, and still another day living in a racially segregated neighbourhood without a supermarket or access to transport. Just as the body does not neatly partition these experiences – all of which may serve to increase risk of uncontrolled hypertension and related morbidity and premature mortality – the urban planner aiming to improve health in the twenty-first-century city can no longer separate these spheres and sectors in research or practice (Corburn 2013).

We suggest how a relational view of place can differ from a built environment and health view in Figure 3.2. We suggest that geographic scales must explore the interactions between local and global decisions, not just static administrative boundaries. Distance under the relational view ought to include physical and social relations and view populations and places embedded within networks. Importantly, in a relational view of place population groups are not treated as static but rather as dynamic and heterogeneous, so that, for instance, the slum dweller in Nairobi's Kibera settlement is not assumed to be afflicted by the same toxic stressors as their neighbour in an adjacent village or a slum dweller in the Mathare settlement on the other side of town. The biographies of people and the histories of places matter for understanding and acting to improve health in the relational view. Importantly, governance and political power are essential features that are investigated, analysed and incorporated in the relational approach, not 'controlled for' as confounding or ignored in urban health research and practice.

Adaptive urban health science

The discussion here has suggested that cities and urban health are complex 'systems' problems; they have multiple historical and contemporary inputs and no one linear pathway of cause and effect. Adaptive ecosystem management offers a model of scientific research and practice for healthy urban planners (Corburn 2013). Adaptive management acknowledges the failures of linear processes where narrow disciplinary scientists have aimed to develop complex models, predict long-term outcomes and suggest one-time policy standards. Instead, adaptive management begins with an acknowledgement of the inherent complexity and uncertainty within

	Built environment	*Relational view of place*
Geography	Boundaries at specific scale (i.e., census tract); distinct scales	No dichotomy between local and global
Distance	Fixed physical distance	Physical and social location; networks
Populations	Static in time/space; differences between	Contingent and mobile; differences within and between
Resources	Physical and social in specific locations; culturally neutral	Physical and social plus culturally specific meanings assigned to them
Political power	Not addressed	Relations among populations in place and held by institutions that shape places

Figure 3.2 A built environment and relational definition of place

Source: Corburn (2009).

systems, that this complexity demands an iterative, ongoing learning process among a range of expert stakeholders, and policy interventions must be adjusted to reflect newly acquired knowledge (Lee 1999). Another difference between adaptive management and conventional science policy is that adaptive management does not postpone actions until definitive causality is known about a system, but rather emphasises the importance of action in the face of uncertain science and couples these decisions tightly to rigorous monitoring.

The adaptive management approach begins by articulating, often with a range of stakeholders, the overall management objectives. In the case of health and planning, this might be to reduce or eliminate intra-urban health inequities. Second, a baseline model of change for the urban system needs to be described. Again, for urban health inequities, an adaptive urban health approach might begin with the 'toxic stressors' model of cumulative disadvantages. Next, a range of management choices are considered, prioritised, and a monitoring and evaluation strategy is developed for each management strategy. The prioritised strategies are implemented and monitored. An important feature of adaptive management is that the process does not end with decision analysis, but rather results from ongoing monitoring feedback into management processes as a form of social learning. Stakeholders consider the effectiveness of early interventions, learn from monitoring data and adjust decisions based on whether interventions are or are not approaching the original objectives.

Conclusions: prioritising health equity

While far from ideal, adaptive urban health management offers a framework for planners interested in linking research and practice to meet the twenty-first-century challenges of urban health equity. Planners must still do the hard work of getting 'inside' urban neighbourhoods to understand the interactions of physical and social forces that are influencing human health. Yet, the adaptive approach offers a robust model of participatory democracy, since the management team must be comprised of a range of interested stakeholders in order for the process to represent the varieties of expertise necessary to address complex problems. Planners may be ideally suited to facilitate these inclusionary processes, rather than just exert their 'expert' analyses into complex urban health problem solving. As the world continues to urbanise, planners must take

a leading role in offering new models for understanding and improving the place-based characteristics that influence health equity. We have offered some ideas here that aim to prioritise health equity for planning in the twenty-first-century city.

Notes

1 Importantly, the UK housing standards based on the neighbourhood unit were not viewed as unquestionably health promoting. In 1948, Lord Silkin (1948), then Minister of Town and Country Planning, addressed the Town Planning Institute, noting: 'In every plan now it is fashionable to provide neighbourhoods. The assumption is that by dividing up your population into groups of 10,000 to 20,000 and surrounding them by open spaces, railways and main roads you will get nice little communities living happily and sociably together. On what evidence is that based? . . . Do we really get a good life that way? What steps do you take to ensure that people inside these little areas do mix freely together and do all the things one thinks it good for them to do? I would like more thought to be given to the question of neighbourhoods, even to the whole conception of the idea. I have fallen for it myself, but I would like to think it out again.'

2 The United Nations Human Settlements Programme (UN-HABITAT), as part of its 'Inclusive City' declaration in 2000, emphasised the continual struggle and conflicts inherent in urban governance, defining it as: 'the sum of the many ways individuals and institutions, public and private, plan and manage the common affairs of the city. It is a continuing process through which conflicting or diverse interests may be accommodated and cooperative action can be taken. It includes formal institutions as well as informal arrangements and the social capital of citizens' (http://ww2.unhabitat.org/campaigns/governance/docs_pubs.asp#Inclusive%20Cities).

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