This chapter presents a range of interventions that can be employed to improve the natural and built environment, the social and economic environment, food security and quality, and services and health emergency management. It does not encompass an exhaustive list of everything that can be done, but rather illustrates what is possible.

The chapter describes a range of factors that must be considered in formulating a specific plan to take action against urban health inequities. Above all, information about the particular health inequities within the city should be used as the basis for prioritization and decision-making. Selected interventions should be feasible, sustainable and evidence based. Other considerations include local capacity for implementation, likely impact, acceptability and political support.
Three main approaches to reducing urban health inequities

Multiple strategies can be used to address urban health inequities. Three main approaches are targeting disadvantaged population groups or social classes, narrowing the health gap, and reducing inequities throughout the whole population (Figure 8.1). Most agree that health equity can be achieved best by “levelling up” physical and social conditions for the urban poor and other disadvantaged groups. In reality, though, the three approaches are interdependent and should build on one another. Their relative merits are discussed briefly.

TARGETING DISADVANTAGED GROUPS (A)

This approach focuses on improving the health status of a targeted group, for example the poorest 20% of city dwellers. Within this approach, the health of the urban population as a whole is not taken into consideration. And while this approach may improve the health of the targeted group in absolute terms, it does not necessarily lead to a reduction in health inequities; for example, the health gap between the urban rich and the urban poor may not decrease even as the urban poor are making some health gains (see Box 8.1 on page 92 for an example from Pakistan).

NARROWING THE HEALTH GAP (B)

This approach takes as its starting point the health of disadvantaged groups relative to the rest of the urban population. Action is focused on reducing the gap between the worst-off and the best-off – the extremes of the social scale (see Box 8.2 for an example from East Africa).

REDUCING INEQUITIES THROUGHOUT THE ENTIRE URBAN POPULATION (C)

This approach recognizes that, as shown in Part Two of this report, health status and socioeconomic status are interrelated on a continuum. In other words, health inequities exist not only between the richest and the poorest city dwellers, but also affect the middle classes. Within this approach, the entire urban population is taken into consideration, including middle-income groups. The goal is to reduce the inequities in health by equalizing health opportunities across the socioeconomic spectrum (see Box 8.3 for an example on helmet use).
FIGURE 8.1
THREE MAIN APPROACHES TO REDUCING URBAN HEALTH INEQUITIES*

A. TARGETING DISADVANTAGED GROUPS

B. NARROWING THE HEALTH GAP

C. REDUCING INEQUITIES THROUGHOUT THE ENTIRE URBAN POPULATION

* For illustration purposes only.
Increasing helmet use through legislation is an important evidence-based intervention, especially in low-income countries where motorized two-wheel vehicles are common, and helmet use is low. A recent Cochrane review found that, on average, helmets reduce motorcyclists’ risk of death by 42% and risk of head injury by 69%. Many successful examples of helmet legislation can be found around the world. In Thailand, for example, head injuries decreased by 41% and deaths decreased by 21% following new legislation. In Malaysia, motorcycle deaths were reduced by 30%. Viet Nam experienced similar results after implementing a new helmet law in December 2007 that required all drivers and passengers to wear helmets on all roads at all times, without exceptions or exemptions. By October 2008, there were more than 1400 fewer road traffic fatalities, and more than 2200 fewer serious injuries compared to the same time in 2007.
Choosing priority interventions

Each city must consider a range of factors in deciding priority interventions. The starting point should be a clear assessment of the urban health inequities that exist in the city (see Chapter 7). The choice of interventions must reflect the opinions of city dwellers and the priorities of policy-makers, and be realistically informed about the powers of the intersectoral group to influence health determinants and reduce health inequity. Priority interventions in various areas are presented in Annex C and a specific example of community engagement is provided in Box 8.4 on the next page.

Priorities should be selected in a consensual fashion, taking into account legitimate differences about the pace of change, the most pressing areas for action, and the level of coherence with existing national and regional policies and plans. If, for example, a national government has prioritized and provided local funding for improved sanitation, then the intersectoral group might decide to take advantage of this opportunity and focus its efforts on reducing sanitation-related inequities. In any event, policy-makers and decision-takers should not lose sight of their vision for integrated development.

FEASIBILITY

Interventions must be feasible to implement given available resources – human, financial and organizational capacity. In addition, they should be accepted by the communities who will be affected by their application. Finally, it is important that interventions comply with existing or proposed national policies and priorities, align with the local political agenda and receive support from the local government.

SUSTAINABILITY

Sustainability implies the ongoing availability of adequate resources to continue interventions in the long term. It also means that interventions are meeting the needs of city dwellers without compromising the ability of future generations to reach their full health potential.

EVIDENCE BASED

Whenever possible, local leaders should use the “best available” evidence to inform their choice of interventions. The best available evidence approach is based on the principle that using some evidence, even if it was not produced according to a rigorous study design, is better than using no evidence whatsoever. It acknowledges the gaps in available evidence, yet calls on decision-makers to seek and use the sources of information that are accessible to them.

POPULATION TARGET OF INTERVENTION

As discussed above, most agree that health equity can be achieved best by reducing inequities throughout entire urban populations. Nonetheless, interventions that have a positive influence on general population health might not reach vulnerable groups, thereby potentially increasing health inequities. Interventions to the natural and built environments, for example, will improve health equity only if they are implemented in a way that prioritizes the needs of the disadvantaged. Careful analysis is needed to determine whether priority interventions should be designed to reach only disadvantaged population groups or urban residents as a whole. In any event, the decision should be made based upon the overall objective of reducing health inequities within the city.
LEAD AGENCY FOR IMPLEMENTATION

To what extent the health sector can (or should) take the lead role in implementing the intervention depends in large part on the issue being addressed. In general, the lead role should be assigned to the agency or organization with the greatest responsibility or authority for the topic area. An intervention to improve water quality might be best led by the city’s public utilities department, for example. In other cases, the lead role is most appropriate for the national level of government, or an organization outside government, for example in the case of an intervention located in a private sector workplace, or in a community centre.
Hesti lives with her husband and children in a seaside slum area in North Jakarta. Her husband is a builder who can earn US$ 5.40 a day, but it’s tough when he can’t find work. Then, “I and the children have to shuck shellfish for US$ 1.60 a day. I have back pain from sitting in the same position when I break shellfish. I take traditional herbs to help it.”

Hesti takes care of the local public toilet which was built last year by a charity. It has had a good impact on their life, because it replaced the foul-smelling “hanging toilet” on stilts next to their house. It was so bad that “when it rained,” she recalls, “the excrement would flood into the alleyways and our homes. How would you feel if that happened to you? When we first moved here the smell from the toilet was so bad my children would refuse to eat.”

Now, she gains some income as the keeper of the new public toilet. “I clean it. The charge is 500 rupiah (US$ 0.05), but if people don’t have the money they can still come. I think most people in the community come here now. I don’t make much money from the toilet, but I am very happy that we have this facility.”
Monitoring and evaluation

Monitoring and evaluation are key aspects of taking action. They are crucial for building evidence, refining approaches and sharing achievements and obstacles with others. Close monitoring is required to understand whether the activities outlined in the plan have been completed within the required time frame, whether inputs and outputs for activities have been delivered and whether targets have been attained. Evaluations should be both external and internal, with participation from the community and multiple sectors, and should focus on both processes and outcomes.

A results-sharing mechanism that includes multisectoral partners and the community helps reinforce collaboration and maintain focus on desired equity outcomes. Available and emerging results must be communicated in ways that are understandable and useful to end users.

A full description of monitoring and evaluation methods for urban health inequity interventions is beyond the scope of this report, but additional information sources are provided in Annex B.

CHAPTER SUMMARY

This chapter has provided an overview of three main approaches to take action against urban health inequities. The approaches are to target disadvantaged population groups or social classes; to narrow the health gap between the best-off and the worst-off; and to reduce inequities throughout the entire urban population. Most agree that health equity can be achieved best by levelling up physical and social conditions for the urban poor and other disadvantaged groups. In reality, the three approaches are interdependent and should build on one another. Priority issues vary from city to city; in all cases, chosen interventions should be feasible, sustainable and evidence based. Action can be taken to improve the natural and built environment, the social and economic environment, food security and quality, and services and health emergency management. Examples of interventions from each of these broad categories have been provided within the chapter. Regardless of the chosen interventions, monitoring and evaluation are crucial for understanding their impact.