As shown in Part Two, hidden cities exist everywhere. They can be found within urban centres of the Americas, Europe, Africa and Asia; in rich and poor countries; in small, medium and mega cities. In every corner of the world, certain city dwellers suffer disproportionately from poor health, and these inequities can be traced back to differences in their social and living conditions. At current rates of progress, health-related MDG targets will not be achieved among the urban poor by 2015.

Because urban health inequities exist everywhere, all local and national leaders should consider how to overcome them. This part of the report describes overarching prerequisites for action and gives examples of effective interventions. Local governments are uniquely positioned to tackle health inequities, but must do so in a way that includes other levels of government and communities. They must develop a vision of the future with a strong health dimension, understand the nature and scope of health inequities within their cities, choose priority interventions, and then monitor and evaluate their effects over time.

CONTENTS

Chapter 6. Urban governance for reducing health inequities
Chapter 7. Building an evidence base for action
Chapter 8. Taking action

KEY MESSAGES

- Acting on urban health inequities requires involvement of organized communities and all levels of government – local, provincial and national.
- Solutions often lie beyond the health sector, and require the engagement of many different sectors of government and society.
- Local leaders and governments can and should play a key role in promoting urban health equity.
This chapter describes ways in which different levels of government, nongovernmental organizations, the private sector and the community can work together for good urban governance. Coordination at all levels is essential to reduce health inequities.

At a practical level, good urban governance requires political commitment, vision, institutional change and networks that are working towards similar goals. This chapter describes each of these prerequisites based on the experiences of cities that have already taken action.
The role of local governments

Local governments are diverse in their structure, power, and community representativeness. Yet, they share common roles and responsibilities in implementing pro-equity policy and planning. Motivations for local governments to tackle health inequities vary, too. If there is significant local interest and the political will to address health inequities, actions can be motivated internally. In other cases, national imperatives may influence local governments to translate health equity targets or goals into action at the local level.

Local actions present unique opportunities for partnering with private and non-profit sectors, with civil society or citizens’ groups, or with other public agencies that prove more beneficial than an independent sectoral response. Supporting citizen participation in priority-setting, planning and implementation, and monitoring of health inequities have also been shown to be critical both in terms of facilitating successful action on reducing health inequities and on strengthening social cohesion.

Partnerships: the key to good urban governance

Urban governance is not the sole domain of government, but the combined effort of a multitude of actors, including different levels of government, nongovernmental organizations, the private sector and the community. In the best-managed cities, local governments take a leadership role in combining the talents and powers of all sectors.

To reduce health inequities in urban settings, multiple sectors act in a coordinated fashion on the complex web of health determinants. The specific sectors for involvement will depend on the nature of the health inequity and the organizational arrangement of the government, but typically would include representatives from municipal government departments, national-level ministries, civil society and the private sector.

Vertical partnerships between national, regional and local governments must be complemented by horizontal partnerships of stakeholders within cities. Coherence between national policies and local implementation is crucial for effective urban governance.

Local authorities are often well-positioned to lead the process (see Box 6.1 for an example of local leadership in Kenya). They frequently have influence over land use, building standards, water and sanitation systems, roads and transportation, environmental protection, enactment or enforcement of tobacco use bans, and oversight of occupational health and safety regulations. They may also play a significant role in the provision of a range of human services fundamental to health, such as education, social services, health services, libraries, parks and recreation services, and community development.

In February 2007, Nakuru, Kenya, became the first city in Kenya and in East Africa to ban smoking in public places. The Nakuru Municipal Council enacted a law that prohibits smoking in all buildings frequented by the public, including shopping centres, food courts, retail and wholesale stores, places of public worship, hospitals, colleges, schools, theatres and office buildings. Leadership, political commitment and community participation were crucial for the successful implementation of this policy.

**BOX 6.1 SPOTLIGHT ON NAKURU, KENYA**

In February 2007, Nakuru, Kenya, became the first city in Kenya and in East Africa to ban smoking in public places. The Nakuru Municipal Council enacted a law that prohibits smoking in all buildings frequented by the public, including shopping centres, food courts, retail and wholesale stores, places of public worship, hospitals, colleges, schools, theatres and office buildings. Leadership, political commitment and community participation were crucial for the successful implementation of this policy.
In particular, municipal leaders such as mayors or their equivalents are crucial to leading the effort to reduce health inequities. Their role is not only to address local issues but also broader concerns, including the global challenges of climate change, financial debt and population health. In the United States, for example, more than 1000 mayors have signed the U.S. Conference of Mayors’ Climate Protection Agreement, representing a population of more than 86 million people. In Europe, over 2500 local authorities are committed to the Aalborg Charter, which provides a framework for the delivery of local sustainable development and calls on local authorities to engage in Local Agenda 21 processes. In 2007, European Union ministers adopted the Leipzig Charter, which promotes sustainable European cities and places special emphasis upon deprived urban neighbourhoods within the scope of an integrated urban development policy.

The state/regional and central/national levels of government usually have a less direct impact on the local environment and the local economy. They concentrate on creating a strategic policy framework and facilitating stability, innovation or financial incentives, which are necessary for change. Health service provision is often the responsibility of the regional or national level of government. However, the role of the health sector needs to be flexible. To what extent the health sector can (or should) take the lead role in planning and implementing multisectoral action depends in large part on the issue being addressed.

The private business sector can provide its financing capacity and business expertise to cities by working independently or in partnership with the public sector. Private capital can be attracted by the quality of life in a city and financial incentives.

Community participation in urban governance, from prioritizing issues to evaluating interventions and monitoring the outcomes, is also fundamental. Participation of city dwellers helps ensure that the right issues are being addressed, promotes local ownership and engenders the sustainability of interventions. It also supports the broader agenda of community development and empowerment. Box 6.2 describes how the community was engaged along with many other partners in Barcelona, Spain.
Ashley lives in South London with his mother and attends school at Bacons College. Not long ago, Ashley was overweight. “I was really big before, I wasn’t interested in sports and I ate lots of unhealthy food. I wasn’t doing much at all – I stayed at home or went to school.”

Three years ago, Ashley was encouraged to play basketball by his physical education teacher who also works for a nongovernmental organization that helps children get involved with sports. “Basketball has helped me socialize and it has helped me improve my appearance in school,” he says. “I am also much fitter now. I have more muscle, I am taller and slimmer. I feel much more confident.”

Ashley believes that young people today are not healthy. He notes that there are many more obese people in his generation and that they are not involved in sport. “I’m not sure why that is happening.”

He is glad to have been introduced to basketball and cites the opportunity his school and the local nongovernmental organization gave him by taking him to see games and to meet more people his age. Access to sporting facilities is also helpful. Besides the time he plays on the team at school, he enjoys shooting hoops in his neighborhood where there is a small court outside his apartment block.

“Before, I didn’t use my time very well. Now I enjoy sports, and I eat more fruit and vegetables and less fast food.”
Prerequisites for local action

Local governments are often responsible for addressing many local needs which may exacerbate or diminish health inequities. They can also affect intermediate pathways linking root social and environmental causes to health outcomes and inequities.

Despite variations in governance structure, scale of operation, provision of public spaces enabling debates with their citizenry, and relation to national authorities, local governments share an excellent opportunity to address health inequities. They also have commonalities regarding roles and responsibilities in general, and strategies and interventions in particular.

It is also important to acknowledge the effects of politics on health, as politics may affect population health via policies and interventions, but also via processes like social movements, strikes, and protests. As such, urban health inequities are shaped by mechanisms that go beyond health policies and interventions.

In general, four prerequisites for action can be identified: political commitment, vision, institutional change and networks. They are aimed at changing the ways in which individuals, communities, nongovernmental organizations, the private sector and governments understand and make decisions about health and health equity.

**Political Commitment**

The first prerequisite for sustainable action is political commitment at the highest levels to the values, principles and strategies of health for all urban residents. Lack of political will has been shown to jeopardize multisectoral engagement; actions are sustainable only if there is high-level political interest and support at the outset.

Health is the business of every sector and urban leaders have a convening power to orchestrate the contributions of many actors. The Alma-Ata Declaration on Primary Health Care, the Global Strategy for Health for All, the Ottawa Charter for Health Promotion, and the Bangkok Charter for Health Promotion in a Globalized World are important foundation documents that support this perspective.

To command support and secure needed resources, both the representative and executive arms of local government must be committed to action. One mechanism involves the mayor or equivalent city leader obtaining endorsement from the representative council of the municipality or analogous urban government. Endorsements by other levels of government – potentially including provincial, regional and central governments, depending on the system of governance – are analogously essential for success.

It is also necessary to obtain commitment from key stakeholders within the city. These include leaders of agencies, quasi-governmental organizations, nongovernmental organizations and businesses who have significant influence over the key determinants of health. If, for example, water and sanitation is supplied by a private company and regulated by local or provincial government, then all these stakeholders should be committed before action is taken. If transport infrastructure is supplied by the municipality, and local buses are run by a private company that is partly financed by a grant from the provincial government, then all three stakeholders should be engaged. Communities should also be committed to the process: Box 6.3 on the next page describes how communities were engaged in such a way in the urban slums of Nairobi, Kenya.

**Vision**

A second prerequisite for sustainable action is a city vision with a strong health dimension. Responding to the global trend of decentralization, many city governments now have powers and responsibilities
to define a future characterized by a prosperous local economy, sustainable environment and cohesive social life. Alongside economic prosperity, health should be an integral element of a city’s vision and a core value guiding development. Health is integral to many qualities cities desire, such as good quality of life and a welcoming and liveable environment. It also is related reciprocally to the economy: healthy children are better educated and a healthy workforce is more productive. Finally, health is integral to sustainable development. The city of London in the United Kingdom has recently released its strategy for addressing health inequities; details are described in Box 6.4.

Although an aspirational document is essential, in itself it is insufficient for change. Integrated planning is required to maximize synergies, and health and health equity are required in all local policies.

**INSTITUTIONAL CHANGE**

In the process of preparing for action, many cities discover that their organizational structures and management processes do not serve their present needs (see Box 6.5 for an example from Vancouver, Canada). In these cases, institutional structures, mechanisms and capacities must be developed to

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**BOX 6.3 SPOTLIGHT ON COMMUNITY PARTICIPATION IN THE URBAN SLUMS OF NAIROBI, KENYA**

Since 2005, Jhpiego, an affiliate of Johns Hopkins University, has worked in two Nairobi slums, Korogocho and Viwandani, to ensure increased community participation and improved quality of health services. To this end, Jhpiego uses a participatory approach to help communities and health workers assess their needs, identify problems and develop their own solutions. This approach builds the capacity of local leaders to solve problems, and energizes communities to assert their role in improving health.

Several activities were instrumental in the success of Jhpiego’s work. Community members were engaged in identifying underlying determinants of health by mapping local health dangers. Training was provided to community members on a variety of health issues, including infection prevention and hygiene, HIV, reproductive health and family planning, and maternal and child health. Mechanisms such as regular stakeholder forums were developed to facilitate regular community input into health issues.

Jhpiego’s results demonstrate that poor urban communities can be empowered successfully.

- Trust and respect have improved between health workers and community members, and use of health-care services has increased.
- Communities have been mobilized to address their self-identified health concerns. During one community mapping exercise, participants identified a small grassy area next to a clinic as a health hazard; medical waste discarded there was often scavenged by entrepreneurs or played with by children. Community members and clinic workers cleaned the area and planted a community vegetable garden to support people living with HIV.
- Community technical resources have been developed. A group of trained expert patient trainers (who are engaged to help train health workers in HIV case management) has since registered as a community-based organization called Expert Patients International, whose mission is to educate all people living with HIV on their health rights and to ensure quality HIV care management.

The impact of Jhpiego’s approach has resonated far beyond its original programme objectives. In the immediate aftermath of the disputed 2007 presidential election, young slum dwellers, empowered by Jhpiego’s programmes, served as mediators of peace. Believing in the power of communal resolution, these Jhpiego-trained individuals acted on their own accord to fulfill the tenets of trust and respect they had gained through Jhpiego’s work.
support both near-term change and enduring healthy public policy over the long term.

The traditional departmental silos operating in many local governments are inappropriate because health is everyone’s business. Many potential partners with specific terms of reference – for example, bus operators for transport, schools for education, retailers for the provision of food – do not appreciate their wider impact on health. Inter-sectoral processes and structures are required to engage all these talents, sustain their commitment and maximize their contribution.

Although there is a lack of evidence on what works and what does not work in implementing intersectoral action on health, there is little doubt about its potential for reducing health inequities in urban settings. After analysing experience from 20 countries, a group of experts prepared a set of practical recommendations for policy-makers on how to trigger intersectoral action (Box 6.6).150

**BOX 6.4 SPOTLIGHT ON THE LONDON HEALTH INEQUALITIES STRATEGY**

In 2010, the city of London in the United Kingdom released its Health Inequalities Strategy, which is aimed at reducing significant inequalities within the city in health determinants, health status and life expectancy. The strategy has five core objectives: to empower individuals and communities to improve health and well-being; to improve access to high-quality health and social care services, particularly for Londoners who have poor health outcomes; to reduce income inequality and the negative consequences of relative poverty; to increase the opportunities for people to access the potential benefits of good work and other meaningful activity; and to develop and promote London as a healthy place for all. To ensure the strategy delivers on its aims, the city is producing a series of delivery plans. The First Steps to Delivery plan lists priority actions to 2012 against the strategy’s 30 high-level commitments. These actions are a mixture of long-term campaigns and initiatives to tackle the determinants of the city’s health inequalities, alongside specific initiatives on key health challenges, such as obesity and mental disorders.

**BOX 6.5 SPOTLIGHT ON SUPPORTIVE GOVERNANCE STRUCTURES IN VANCOUVER, CANADA**

To support an intersectoral initiative designed to promote sustainable development in a deprived neighbourhood of Vancouver, partners developed a new governance structure. A policy committee, a management committee, a coordination team and a coordination unit were formed. The policy committee had ultimate responsibility for the initiative, including decision-making and accountability. The management committee was responsible for intergovernmental relations, external communication, monitoring and evaluation, investment decisions and oversight of operational activities. The coordination team was the primary operational committee responsible for implementing the strategic plan. The coordination unit oversaw the day-to-day work of the initiative.

The partnership included federal, provincial and municipal levels of government, as well as the private sector, nongovernmental organizations and community activists. Their initial aim was to establish positive solutions to economic, social and public safety challenges through community development projects in Vancouver’s Downtown Eastside. The area had become Canada’s poorest district, with drug dealing on the main street, crime, street prostitution and homelessness.
and disseminating new ideas and practical solutions to new challenges and perennial problems. They provide support and encouragement, and help sustain key professionals and community representatives through adversity.\textsuperscript{151}

National and international networks facilitate the import and export of evidence and know-how between cities, and they build the legitimacy of cities to address health inequities when health services are the responsibility of national governments.

An example of such networks is Healthy Cities, established in several cities, towns and regions in countries around the world. Some networks are country specific, whereas others are regional. Healthy Cities networks provide an opportunity for WHO to promote the health-for-all policy, provide up-to-date information and tools, and work as a catalyst for action, all at a local level of governance.\textsuperscript{18,152} In this way, the networks

\section*{NETWORKS}

Networks are entities that bring people together and enable collective learning. Through sharing experiences, networks support innovation while helping cities avoid risk and repeating the mistakes of others. As such, networks increase the efficiency of cities and provide the basis for capacity building, change and innovation.

Informal networks often complement formal partnerships, and can operate both within and beyond particular cities. Within a city, informal networks might shadow formal committee structures, sourcing The need for high-level political commitment and adaptation of the policies to the local political, economic, cultural and social contexts was recognized as crucial to success.

\section*{BOX 6.6 \textbf{RECOMMENDATIONS FOR NATIONAL POLICY-MAKERS ON INTERSECTORAL ACTION ON HEALTH}}

1. A shared policy framework between all participating sectors will facilitate the integration of strategies and actions towards a common end. The framework should consider prevailing political, cultural and socioeconomic circumstances, and be supported by strong political commitment.

2. A supportive governance structure for implementing intersectoral action should be established to sustain efforts, utilizing existing organizations where possible. Legislation, institutions, and mandatory reporting are among the tools to strengthen governance for intersectoral action.

3. A capable and accountable health sector is vital to promote and support intersectoral action. The health sector should facilitate the process as appropriate, and be flexible to adapt its role at various stages in the implementation of intersectoral action.

4. Community participation and empowerment in the process of policy-making, from the initial stage of assessment to evaluation of the intervention and monitoring of outcomes, are critical to focus attention on the needs of the people.

5. The concurrence of multiple levels of government on a prioritized and focused set of intersectoral actions is important to success and will help to obtain sufficient funding and human resources.

6. Effective intersectoral action can lead to better public policies. The policies selected for implementation through intersectoral mechanisms have to be robust, feasible, based on the evidence, oriented towards outcomes, applied systematically, sustainable, and appropriately resourced.

7. Assessment, monitoring, evaluation and reporting are required through the whole process. Proper assessment of the problem, its determinants and social, political and cultural context are crucial to frame the issue and benefits to several sectors. Evaluation of the activities should identify the strengths and weaknesses of interventions. Regular monitoring of the health impacts is required to maintain focus on outcomes.
complement WHO’s traditional interactions with national governments.

Local government associations are another example of networks enabling knowledge sharing, lobbying for policy change and working towards the development of inclusive policies to respond to the challenges of urban development. They work in partnership with all levels of government within countries, between regions and globally to encourage multisectoral and intersectoral action. Their outreach potential is particularly strong as they are reliant on peer-to-peer learning and like-minded exchanges.

CHAPTER SUMMARY

This chapter has explained that effective urban governance is not the sole domain of government, but the combined effort of a multitude of actors, including different levels of government, nongovernmental organizations, the private sector and the community. Vertical partnerships between national, regional and local governments must be complemented by horizontal partnerships within cities. Local governments are often well positioned to take the leadership role in combining the talents and powers of all sectors to reduce urban health inequities. Coordination at all levels is essential to reduce health inequities. Prerequisites for action include securing political commitment across a wide range of local leaders, developing a common vision for health and health equity, creating supportive institutional arrangements and connecting with others who can support the work. Political commitment to the values, principles and strategies of health for all urban residents is required at the highest level. A vision of the future with a strong health dimension provides a common basis for multisectoral action. Institutional structures, mechanisms and capacities must support both near-term change and enduring healthy public policy over the long term. Networks at local, national and international levels promote shared learning and innovation. The next step is to conduct an assessment of the urban health inequities that exist in the city in order to build an evidence base for action. This is discussed in the following chapter.
As revealed in Part Two, urban health inequity exists around the world. Yet only few cities and countries have looked for their urban health inequities, and even fewer have done so regularly. This chapter highlights the importance of evidence to understand existing health inequities and their determinants, and how to improve action to overcome them. The importance of disaggregated data is emphasized.

The chapter provides guidance and tools to enable policy-makers and key stakeholders to better understand health inequities in their cities. Two specific tools are profiled within this chapter; Annex A provides a list of additional resources and tools for readers to consider.
The importance of evidence for sustainable and effective action

A variety of interventions and policies have been developed to address urban health, including providing public utilities, increasing neighbourhood security, and the provision of primary health care. Selecting the appropriate intervention is always a challenge. Considering the complexity of the urban environment and the variety of intervention approaches available (for example structural, facility-based and individual), it is vital that policy-makers use available evidence for making decisions regarding the health of urban populations. Evidence-based decision-making is likely to increase the positive aspects and mitigate the negative impacts of urbanization.

A large number of information sources are available to local and national decision-makers, yet they are often underutilized. Moreover, cities are different from one another and may change over time. The complexity and heterogeneity of cities mean that social and environmental determinants of health may vary throughout a particular city. This limits the generalizations that can be drawn about the impact of urbanization on health. For this reason, evidence used in decision-making should be specific to the conditions of the population.

To identify, scale up and adapt programmes and policies that are successful, policy-makers must look at the available evidence in its various forms. The “best available evidence” approach is an alternative to not using any evidence in decision-making. It implies using the evidence that is available, even if it has not been produced according to a rigorous study design. Studies using rigorous evaluation designs are important for informing programmes and policies. Systematic
reviews are also a suitable alternative, as they provide insights into the larger body of evidence. To sum up, sources of data may vary; however, all data are informative and can aid in policy-making.

The importance of disaggregated data

Building an evidence base for action serves multiple purposes. At its most basic level, it enables the identification and monitoring of inequities, high-risk groups and unmet needs. As such, it informs health planning and provides a focus for intersectoral action. Assessments of health inequities can also be used to raise awareness and motivate the public, health professionals and policy-makers to take action.

National-level data from Swaziland illustrate the importance of going beyond national averages when building an evidence base. The left side of Figure 7.1 shows that at the national level in Swaziland, no clear pattern of HIV prevalence among women exists across socioeconomic groups. However, when the data are disaggregated to examine urban areas only, as shown on the right side of the figure, a clear health inequity emerges: poorer urban women are more likely to be infected with HIV than those who are better off.

Once evidence is assembled, it can be organized to identify the population subgroups and health issues that reveal the greatest urban inequities. It also can be used to see how these issues are developing over time, or to compare between cities.

Data considerations

Disaggregated data should be used to examine urban health inequities. Depending on the specific context, data can be disaggregated into male versus female, age groups, geographical areas or locale with the city, and socioeconomic groups.

The process of generating and analysing data should entail minimal cost and should be within the institutional mechanisms of national and local governments. As much as possible, data should be obtained from existing information systems and regular records and reports. Conducting new surveys is not recommended unless there is strong local willingness, capacity and resources to do so.

Data can be sourced from local or national levels. City-specific data have their advantages, in that they can be more specific or detailed at the local level. Nonetheless, efforts should be made to ensure that local data collection and data analysis are done in a standardized fashion, thus enabling city-to-city comparisons. Conversely, national-level
urban data should be collected and organized in a way that enables disaggregation and intra-urban comparisons (Box 7.1). 154

Regardless of the specific source, data should meet high standards of reliability, transparency and completeness. The highest standards of quality should be maintained, including the use of standard sources and indicators that are deemed reliable and valid indicators of the variables in question. Data should adequately represent the population and relevant subpopulations. Data-handling practices should be in accordance with guidelines and other established standards for storage, back-up, transport of information and retrieval. Data analysis should be conducted using well-established statistical tests and methods.

Results revealed a number of urban health inequities. Health indicators among the urban poor were much worse than urban averages, and generally similar to those of rural populations. For example:

- Infant mortality rates were 54.6 among the urban poor, compared with 35.5 among urban non-poor and 41.7 in urban areas overall.
- Only 40% of urban poor children received all recommended vaccinations, comparable to 39% for rural households and much lower than the urban average of 58%.
- Nearly 50% of urban poor children were underweight for their age. This rate was worse than rural areas (46%) and significantly worse than the urban average (33%).
- Nearly 60% of urban poor women aged 15 to 49 years were anaemic, increasing the likelihood of maternal and infant death, premature birth and underweight infants.

This example from India shows how national-level data can be used to unmask urban health inequities. The approach is available to those who are interested in building an evidence base for action when locally disaggregated data are not available.

WHO’s Urban HEART

Urban HEART (Urban Health Equity Assessment and Response Tool) is a tool that can be used to build the evidence base for action. 155 The World Health Organization developed Urban HEART from 2008 to 2009 based on experiences in several cities from 10 countries: Brazil, Indonesia, Islamic Republic of Iran, Kenya, Malaysia, Mexico, Mongolia, Philippines, Sri Lanka and Viet Nam. Their experiences informed and shaped the current version.

Urban HEART offers several advantages to those who want to build an evidence base for action. It is simple and user friendly, and can be used by a wide range of people: local governments; central
government ministries, including health, education and transport; and community groups and civil society organizations. It promotes the use of already-available data, which are then disaggregated into socioeconomic groups, and geographical areas or neighbourhoods. Urban HEART considers health determinants and their interactions in multiple domains of urban life, and encourages policy responses and interventions that will be sustainable in the long term.

Urban HEART has two main components: assessment and response. The assessment component guides users through the process of selecting appropriate indicators to examine health inequities. A common set of core indicators is recommended for all cities (Table 7.1). These indicators are

### Table 7.1: Core Indicators for Urban HEART

<table>
<thead>
<tr>
<th>#</th>
<th>Domain / Indicator</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Outcomes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Infant mortality</td>
<td>The number of infant deaths between birth and exactly one year of age, expressed as a rate per 1000 live births</td>
</tr>
<tr>
<td>2.</td>
<td>Diabetes prevalence and death</td>
<td>Diabetes prevalence and death rates per 100,000 population (age-standardized)</td>
</tr>
<tr>
<td>3.</td>
<td>A. Tuberculosis treatment success</td>
<td>A. Proportion of tuberculosis cases detected and cured under directly observed treatment, short course (DOTS)</td>
</tr>
<tr>
<td>3.</td>
<td>B. Tuberculosis prevalence and death</td>
<td>B. Prevalence and death rates associated with tuberculosis</td>
</tr>
<tr>
<td>4.</td>
<td>Road traffic injuries</td>
<td>Road traffic death rate per 100,000 population</td>
</tr>
<tr>
<td><strong>Physical Environment and Infrastructure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Access to safe water</td>
<td>Percentage of population with sustainable access to an improved water source</td>
</tr>
<tr>
<td>6.</td>
<td>Access to improved sanitation</td>
<td>Percentage of population with access to improved sanitation</td>
</tr>
<tr>
<td><strong>Social and Human Development</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Completion of primary education</td>
<td>Completion of primary education, expressed as a percentage</td>
</tr>
<tr>
<td>8.</td>
<td>Skilled birth attendance</td>
<td>Proportion of births attended by skilled health personnel</td>
</tr>
<tr>
<td>9.</td>
<td>Fully immunized children</td>
<td>Percentage of fully immunized children</td>
</tr>
<tr>
<td>10.</td>
<td>Prevalence of tobacco smoking</td>
<td>Percentage of population who currently smoke cigarettes and other forms of tobacco products</td>
</tr>
<tr>
<td><strong>Economics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Unemployment</td>
<td>Percentage of population who are currently unemployed</td>
</tr>
<tr>
<td><strong>Governance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Government spending on health</td>
<td>Percentage of local government spending allocated to health</td>
</tr>
</tbody>
</table>

limited in number but represent a broad scope of health determinants and health outcomes. Core indicators were selected based on their relevance to urban health equity, availability in pilot sites and comparability. The core indicators are further complemented with strongly recommended and optional indicators, which are adaptable to local circumstances.

To assess equity, data pertaining to each indicator are disaggregated by population group and geographical area. Once the information is collected, it is organized to identify the population subgroups and health issues that reveal the greatest inequities. It is also used to see how issues are developing over time, or to compare between cities. Urban HEART provides tools to help users organize their information in these ways.

The response component of Urban HEART enables users to determine the policies and interventions that will best help them reduce health inequities. Steps involve identifying equity gaps, identifying appropriate response strategies, and then selecting relevant interventions. Using Urban HEART, a team in Parañaque City, Philippines, formulated a response to a pressing health inequity in their city (Box 7.2).

**Box 7.2**

**SPOTLIGHT ON PARAÑAQUE CITY, PHILIPPINES**

Parañaque City, Philippines, used Urban HEART to overcome urban health inequities and improve the quality of health care for pregnant women. Its Urban HEART team, constituted in 2008, was multisectoral and included municipal representatives from the health, housing, planning, budgetary and engineering sectors. Civil society and community groups also participated, and national- and regional-level health representatives joined during the implementation phase. The mayor of Parañaque City played a central role, both in providing leadership and in liaising with a range of sectors and stakeholders. The city, which lies in the southern part of metropolitan Manila, is home to almost 600,000 people and is growing rapidly. It is divided into 16 barangays or administrative areas.

Urban HEART’s assessment component was used to identify the city’s most pressing health inequities. Results revealed that the city had overall shortcomings and substantial inequities between barangays on access to safe water, crime and the percentage of pregnant women giving birth in health facilities. Citywide, almost half of all births were happening at home without a skilled birth attendant. And, among the city’s 16 barangays, one of the poorest had the highest proportion of home deliveries: in San Martín de Porres, 92% of all deliveries were happening at home. Armed with this new information, and with the help of the criteria suggested by the Urban HEART tool, the team decided upon the most feasible and relevant intervention: to establish a birthing facility in San Martín de Porres.

Following approval of the San Martín de Porres council, the facility was opened at the end of 2008. An awareness-raising and advocacy campaign complemented the building’s renovation. Information about the new birthing facility was posted in all deprived areas of San Martín de Porres, and media outreach resulted in wide coverage of the facility’s opening in local and national news outlets. A series of community outreach efforts informed women about the complications and risks of home deliveries, and motivated them to use the new birthing facility. Following the opening of the birthing facility, the number of women using the facility increased in the subsequent months (Figure 7.2). A decrease in the proportion of home deliveries was also witnessed in 2009.

The establishment of the birthing facility stimulated other positive developments. The San Martín de Porres council passed a local resolution discouraging home deliveries in the barangay and pledging full support to the birthing facility. The Parañaque City council approved a new ordinance allowing the city government to set regulations for birthing facilities in the city. Encouraged by the success of San Martín de Porres, leaders in five other barangays are establishing birthing facilities in 2010.
UN-HABITAT’s UrbanInfo

UrbanInfo\textsuperscript{157} is another useful tool for building the evidence base for action. Developed in response to demands from UN-HABITAT’s data users, it is a user-friendly software that runs on the Windows platform and helps users store, present and analyse urban indicators through a variety of presentation tools, such as tables, graphs and maps. UrbanInfo supports both global and user-defined indicators, multiple languages and customized names, logos and graphics.

UrbanInfo has evolved over two versions. The first version was published in 2006 and contained information on several topics, such as housing, demography, communication, energy, economy, education, health, nutrition and gender. The second version provides updated information on these topics and covers new areas, such as disasters, crime, migration, income inequalities and transport. It was designed by UN-HABITAT in collaboration with the United Nations Children’s Fund (UNICEF) and the United Nations Development Group (UNDG), with financial support from the World Bank and other partners.

UrbanInfo is part of UN-HABITAT’s long history of collecting urban indicators and strengthening local and national capacity for monitoring urban development and performance. Its Monitoring Urban Inequities Programme produces the Global Urban Indicators database,\textsuperscript{158} which is updated annually.

**FIGURE 7.2**
**UTILIZATION OF THE NEW BIRTHING FACILITY IN 2009, SAN MARTIN DE PORRES, PARAÑAQUE CITY, PHILIPPINES**

![Graph showing utilization of the new birthing facility in 2009.](image-url)
CHAPTER SUMMARY

Taking action against urban health inequities requires looking at the health status of subgroups of city dwellers according to their socioeconomic status, neighbourhood or other population characteristics. By assembling available information in this way, we can better understand what the health problems are, where they lie and how best to address them. ■ Disaggregating existing national-level health data can uncover urban health inequities. Results can reveal a number of urban health inequities, and this information can build support for action. ■ Tools such as Urban HEART and UrbanInfo can assist with building the evidence base for action. Urban HEART is simple and user friendly, and can be used by a wide range of people to assess and respond to urban health inequities. UrbanInfo is a software that helps users store, analyse and communicate results for an array of urban indicators, both global and user defined. Additional resources and tools are referenced in Annex A. ■ In conclusion, data should meet high standards of reliability, transparency and completeness. As much as possible, data should be obtained from existing information systems and regular records and reports. Depending on the specific context, disaggregated data can be organized by demographic group (gender, age), geographical area or locale with the city, or socioeconomic status (as measured by income or wealth). ■ Following assessment of urban health inequities, next steps are prioritizing and implementing interventions, and monitoring and evaluating results. These are described in the following chapter.
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.

Brazil has one of the highest homicide rates in the world. Between 1980 and 2002 the national homicide rate more than doubled, from 11.4 to 28.4 per 100,000 population. In São Paulo City, the homicide rate more than tripled during the same time period, from 17.5 to 53.9 per 100,000 population.

Jardim Angela is a conglomerate of slums located in the southern region of São Paulo City, with about 250,000 inhabitants. In July 1996, Brazil’s Veja magazine reported an average homicide rate of 111 per 100,000 population, ranking this region as one of the most violent in the world. An integrated community effort of 10 institutions, called Fórum de Defesa da Vida (Life Defence Forum), was created. Parallel to the creation of this alliance, a network of social protection involving civil society was organized, capitalizing on community capacity, social movements and formal and informal health and social services.

This network engaged in a broad range of community interventions, ranging from providing assistance to recently incarcerated children to a collective initiative for rebuilding community spaces. As a result of the investment in community space, abandoned sites such as squares, clubs and schools were rebuilt, providing space for sports, complementary school activities, and alcohol and drug abuse programmes. The community and police also established a coalition aimed at securing community welfare through surveillance of violence, criminality and traffic in illicit drugs. A range of policies and services were also implemented with community input, including closing times for bars, a programme for victims of domestic violence, and health promotion interventions aimed at reducing teen pregnancy.

In 2005, the homicide rates for the city and state of São Paulo were 24 per 100,000 population and 18 per 100,000 population, respectively, reflecting a 51% reduction in homicide for the state. In addition, for 50 consecutive days in the same year, there were no homicides in Jardim Angela. More recently, from January to July 2006, Jardim Angela experienced a more than 50% reduction in reports of muggings, assaults, picking pockets and car thefts compared to previous years.

Jardim Angela represents an example of implementation of integrated efforts towards comprehensive development, attentive to both national and local specificities. A continuous dialogue between civil society and authorities at different levels constitutes a precondition for the success of such initiatives.
Hesti, 47
North Jakarta, Indonesia
IMPROVING SANITATION IN THE NEIGHBOURHOOD

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.
The future of our urban world has yet to be realized, but brings both a price and a promise. To what extent we will pay the price, as opposed to fulfilling the promise, is in our hands.
For the first time in human history, the majority of the world’s population is living in urban areas, and this proportion continues to grow. By 2050, 7 out of 10 people will live in urban areas. Almost all urban population growth will occur in low- and middle-income countries. Some of the fastest-growing cities will double their populations in the next eight years. Urbanization is not inherently positive or negative.

Overall, urbanization has brought countries opportunity, prosperity and health. Urban populations are generally better off than their rural counterparts: they tend to have greater access to social and health services, literacy rates are higher and life expectancy is longer. At the same time, large disparities exist between city dwellers. Rapid, unplanned population growth has strained governments’ capacity to regulate air and water quality, build infrastructure and provide essential services. Globally, one in three urban dwellers now lives in slums or informal settlements. Governments are facing further challenges as they prepare for more and more people living in their cities.

Many cities are facing a triple health threat: infectious diseases exacerbated by poor living conditions; chronic, noncommunicable diseases and conditions fuelled by tobacco use, unhealthy diets and physical inactivity; and injuries (including road traffic accidents) and violence. These are the result of a complex interaction of various urban health determinants, including unhealthy living conditions and insufficient infrastructure and services.
This report has shown the inequitable distribution of these health threats within cities. Families with the lowest incomes in urban areas are most at risk for adverse health outcomes such as child malnutrition and early childhood death, have less access to health services such as skilled birth attendance, and are also disadvantaged in terms of their living conditions, such as access to piped water. Importantly, these inequities exist along a social gradient, also affecting middle-class city dwellers to at least some extent. Disadvantage and disease also cluster within certain neighbourhoods of cities. Beyond socioeconomic status and neighbourhood, some city dwellers have poor health outcomes because of the way societies marginalize and discriminate against them for aspects of their identity they cannot change, such as their age, sex or disability.

These urban inequities have been largely hidden from view, yet exist everywhere – in rich and poor countries, across continents and cultures. No city – large or small, rich or poor, east or west, north or south – has been shown to be immune to the problem. Because urban health inequities exist everywhere, all local and national leaders should consider how to overcome them.

The future of our urban world has yet to be realized, but brings both a price and a promise. To what extent we will pay the price, as opposed to fulfilling the promise, is in our hands.

The price, if we fail to take action, will be the further proliferation of inequity among city dwellers, which will translate into even more avoidable suffering from a range of diseases and health problems. The price will be more efforts to tackle the consequences of heat waves, air pollution, storms, floods and infectious diseases. The price will be the failure of countries to attain the Millennium Development Goals, and indeed, to realize their full economic and human potential.

The promise, on the other hand, is cities that are healthy for all people. Rich and poor, young and old, men and women, migrants and citizens: all will be able to enjoy the highest attainable standard of health.

This promise can be realized by reorienting our conventional approaches. This implies reconnecting the fields of public health and urban planning within a framework of multilevel urban governance. The report illustrates the leadership role that municipal leaders and local governments can play in combining the talents and powers of all sectors. The key to successful action is the involvement of organized communities and all levels of government – local, provincial and national – in a combined and coordinated effort to reduce urban health inequities.

Reducing urban health inequities involves knowing which city dwellers are affected by which health issues, and why. By turning the spotlight on the information in this way, cities will better understand what the problems are, where they lie and how best to address them. Tools such as Urban HEART and UrbanInfo can assist people with building the evidence base for action.

Once the nature and extent of urban health inequities are understood, action can be taken in several areas. Options include interventions to improve the natural and built environment, the social and economic environment, food security and quality, and services and health emergency management. Priority issues will vary from city to city; in all cases, chosen interventions should be feasible, sustainable and evidence based.

We are at a clear turning point in history, in which we are moving towards an increasingly urbanized world. The price and the promise are both possible, and the choice is ours. It is our collective responsibility to ensure that cities are healthy places for all people, both now and in the future. We all have a role to play in making this a reality.
**A role for all: who can do what?**

**MINISTRIES OF HEALTH**

- Become more informed about health determinants, and how urban policy choices influence the health of city dwellers.
- Proactively engage other sectors, including housing, transport, industry, water and sanitation, education, environment, and finance agencies.
- Lead by example: support healthier and more liveable cities.
- Support health and environmental impact assessments for urban plans and policies.

**LOCAL GOVERNMENTS**

- Foster collaboration within local government through forums and dialogue between public health officials and urban planners.
- Partner with nongovernmental and community organizations; establish a mechanism that will give health professionals the opportunity to provide input on planning and transport plans.
- Provide a mechanism for sharing information, across government and with civil society and the community, on the nature of urban health inequities and progress in reducing them.

**CIVIL SOCIETY**

- Ensure that people participate fully in shaping the policies and programmes that affect their lives.
- Include residents of informal settlements in formal processes by establishing groups, associations and federations. Large or small, organizations of the urban poor should come together to identify the social and economic conditions that they face; to find practical solutions to these problems; to struggle against marginalization; and to ensure access to the goods and services to which they are entitled.
- Work with governments on participatory planning and budgeting to allocate a greater portion of the municipal investment budget to priorities determined by neighbourhoods and community groups.

**RESEARCHERS**

Generate and systematize knowledge to address the many existing information gaps, including:

- potential advantages of urbanization and urban growth;
- the inequities of health disaggregated by intra-urban area;
- the effectiveness of proactive approaches to deal with health inequity in cities;
- the importance of involving all citizens in the decisions that affect their habitat and their health.

**URBAN PLANNERS**

- Use zoning and land use regulations as a way to prevent exposure of city dwellers to pollution emissions and hazards from industrial and commercial activities, waste and chemicals, and transport.
- Develop and adopt building practices that protect health among building users.

* The attribution of roles to specific stakeholders is neither an attempt to be exhaustive, nor prescriptive. This report promotes the idea of a “whole of government approach” encompassing all players who impact on urban health equity.
regarding indoor air environment, safety, noise, water, sanitation and waste management, among several other health determinants in urban settings.

- Build compact cities, where dwellers have easy access to green areas, public transport and bicycle paths, as well as health, education and other fundamental social services.

- Incorporate health impact assessment into the consideration of alternative planning choices and policies.

INTERNATIONAL AGENCIES

- Promote and support policies to promote healthy environments.

- Disseminate lessons learnt.

- Support women’s rights, poverty reduction and equity-promoting strategies.

- Encourage policy-makers to generate and use sociodemographic information to make better decisions regarding the urban future.