EMPOWERING THE FUTURE OF CITIES: ADDRESSING URBAN HEALTH AND HEALTH EQUITY THROUGH INTERSECTORAL ACTION

Alex Ross, Director, WHO Centre for Health Development Kobe, Japan
Sustainable, liveable, economically productive cities need healthy people!
- Smart, Sustainable, Healthy, Age-Friendly...Cities

Public health and urban planning are historically linked

Urban spaces and design directly affect health of people

Includes health promotion and disease prevention, environmental health, water and sanitation, and health care delivery systems.

Demographic patterns vary: youth, fertility rate, ageing, etc

Equity a key issue.
POLITICAL SUPPORT AND CALLS TO ACTION

- MDGs
- Commission on SDH
- UN Political Declaration for Prevention and Control of NCDs
- WHA Resolution on Ageing
- Kobe Call to Action
- WHO Regional Committee Resolutions on Urbanization & Health
- Rio Declaration on SDH
- Rio+20 Outcomes document
- Health 2020 –EURO
- AFRO Libreville Declaration
  .... to name a few
Joint WHO-Habitat Report in 2010
First report on urbanization and health
Documented equity gaps
Need for constructive policy and programmatic actions
KOBE CALL TO ACTION

Key Principles

1. UNCOVER AND ADDRESS URBAN HEALTH INEQUITIES TO BUILD HEALTHIER CITIES

Understanding urban health begins with knowing which city dwellers are affected by what health issues, and why—making the vulnerable visible so that their situation can be addressed. In this way, municipalities will better understand what the problems are, where they lie, and how best to address them.

This understanding can be enhanced through the use of reliable measurements of health inequities and their determinants within cities, especially those associated with the lack of safe water and adequate sanitation, as well as lifestyle-related noncommunicable diseases and conditions.

2. SHOW LEADERSHIP BY INCLUDING HEALTH IN ALL URBAN POLICIES THROUGH INTERSECTORAL ACTION

Local governments have a major leadership role to play in improving urban health and reducing urban health inequities. They have the capacity to bring together many different areas of government and society in order to bring health and health equity to the heart of the policy-making process.

Essential prerequisites for action to integrate health in urban policies include securing commitments from a wide range of local leaders, developing a common vision for health and health equity, creating supportive institutional arrangements, measuring the health impact of policies and programmes, and connecting with others—including civil society and the private sector—who can support the work.

3. USE EFFECTIVE MECHANISMS FOR COMMUNITY PARTICIPATION IN URBAN POLICY AND PLANNING

Communities need to be actively engaged in the decisions that affect their lives. Communities often know their situation best and what needs to be done. Moreover, communities have a capacity for handling constant change. Local governments are uniquely positioned to tackle health inequities, but must do so in a way that includes other levels of government and specifically communities.

This can be done by enabling citizens’ participation in the urban planning process and through the empowerment of individuals and communities to improve health and well-being.
WHO AND THIS SESSION

- WHO Centre for Health Development (WKC) in Kobe
  - Research on health in development with a focus on how social, economic, environmental and technological determinants impact on health, particularly in the urban setting.
  - Links between health, equity, urban governance, innovation and ageing, climate change and emergency preparedness, with reference to WHO strategic objectives.
- WHO HQ, Regional and Country Offices engaged in urban health issues
  - Key driver to achieve MDGs
  - Healthy Cities; New WHO Europe Health Policy: Health 2020
  - Environmental health
- WKC works with many universities and institutions around the world.
  - This session highlights two such collaborations: (a) Mr Jon Dawson from the UK and (b) Ms Maja Larsen from Denmark.
Information......first step to action

A major WKC contribution
  - Urban HEART

Key local government issue and responsibility

Being applied to ageing populations in Japan
The Urban Health Equity Assessment and Response Tool (Urban HEART) is a user-friendly guide for policy- and decision-makers at national and local levels to:

• identify and analyse inequities in health between people living in various parts of cities, or belonging to different socioeconomic groups within and across cities;

• facilitate decisions on viable and effective strategies, interventions and actions that should be used to reduce inter- and intra-city health inequities.
EXAMPLE OF URBAN HEART ANALYSIS

Access to sanitation

- West Jakarta
- North Jakarta
- Denpasar
- National average

- Poorest 20%
- 2nd quintile
- 3rd quintile
- 4th quintile
- Wealthiest 20%

3 September 2012
<table>
<thead>
<tr>
<th>City</th>
<th>Key Outcomes</th>
</tr>
</thead>
</table>
| **Tehran, Iran**   | • “Tehran, Smoke-Free City”  
                      • Reallocation of city budget to worse-off areas |
| **Paranaque, Philippines** | • Birthing facilities  
                          • Guidelines on maternal and child health |
| **Nakuru, Kenya**  | • Advocacy for new investments in infrastructure  
                          • Street lighting to improve security |
| **Guarulhos, Brazil** | • Increase youth employment  
                            • Improve opportunities for physical activity |
| **Jakarta, Indonesia** | • Improve urban poor access to public services  
                        • Health within urban development plan |
**Country Profile***

<table>
<thead>
<tr>
<th>General</th>
<th>Bangladesh</th>
<th>South Asia regional average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population living in urban areas (%)</td>
<td>26</td>
<td>30</td>
</tr>
<tr>
<td>Gross national income per capita (PPP int. $)</td>
<td>1,550</td>
<td>2,954</td>
</tr>
<tr>
<td>Health expenditure per capita (PPP int. $)</td>
<td>42</td>
<td>98</td>
</tr>
</tbody>
</table>

**Health**

| Life expectancy at birth for both sexes (years) | 66         | 64                         |
| Maternal mortality ratio (per 100,000 live births) | 340        | 290                       |

**Indicators of Health Outcomes**

**Children from the poorest urban quintile are 3 times more likely to die before the age of 5 than children from the wealthiest urban quintile. They are also more likely to die than children from rural areas.**

**Children from the poorest urban quintile are 4 times more likely to be chronically malnourished than children from the wealthiest urban quintile. They are also more likely to be malnourished than children from rural areas.**

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**Background**

As urban populations continue to grow globally, there is an increasing need to focus on urban health. This fact sheet displays data for urban areas in Bangladesh. Further, this fact sheet aims to reveal inequalities in health between different wealth quintiles in urban areas and to compare these to rural averages.

*Data from latest year available from 2005-2009 World Bank Data.
**Data from latest year available from 2003-2009 Demographic Health Survey.
***Data from 2003 World Health Survey.

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**Trends in Key National Indicators***

**Life expectancy at birth**

Life expectancy at birth in Bangladesh has increased from 40 years in 1960 to 66 years in 2008, but is still lower than the global average of 69 years in 2008.

**Under-5 mortality rate**

The proportion of urban population in Bangladesh has increased from 5% in 1960 to 26% in 2005, but is still lower than the global average of 49% in 2005.
## Bangladesh: Urban health profile

### Indicators of Health System Outputs**

<table>
<thead>
<tr>
<th>Antenatal care</th>
<th>1993</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Urban poorest 20%</td>
<td>10%</td>
<td>15%</td>
</tr>
<tr>
<td>2nd quintile</td>
<td>20%</td>
<td>25%</td>
</tr>
<tr>
<td>Middle quintile</td>
<td>30%</td>
<td>35%</td>
</tr>
<tr>
<td>4th quintile</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Urban richest 20%</td>
<td>40%</td>
<td>45%</td>
</tr>
</tbody>
</table>

Coverage of antenatal care has increased among all wealth quintile groups between 1993 and 2007. Inequalities persist despite increased coverage of antenatal care.

### Measles vaccination

<table>
<thead>
<tr>
<th>Measles vaccination</th>
<th>1993</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>80%</td>
<td>90%</td>
</tr>
<tr>
<td>Urban poorest 20%</td>
<td>85%</td>
<td>95%</td>
</tr>
<tr>
<td>2nd quintile</td>
<td>90%</td>
<td>95%</td>
</tr>
<tr>
<td>Middle quintile</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>4th quintile</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>Urban richest 20%</td>
<td>95%</td>
<td>95%</td>
</tr>
</tbody>
</table>

Coverage of measles vaccination has increased among all wealth quintile groups, except the 4th quintile, between 1993 and 2007.

### Indicators of Health Risk Factors

#### Obesity among women**

<table>
<thead>
<tr>
<th>Obesity (%)</th>
<th>1996</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>National average</td>
<td>10%</td>
<td>15%</td>
</tr>
<tr>
<td>Rural average</td>
<td>12%</td>
<td>18%</td>
</tr>
<tr>
<td>Urban average</td>
<td>10%</td>
<td>15%</td>
</tr>
<tr>
<td>Urban poorest 20%</td>
<td>20%</td>
<td>25%</td>
</tr>
<tr>
<td>Urban wealthiest 20%</td>
<td>40%</td>
<td>45%</td>
</tr>
</tbody>
</table>

In 2007, women from the wealthiest urban quintile were more than 12 times likely to be obese than women from the poorest urban quintile.

#### Tobacco consumption***

<table>
<thead>
<tr>
<th>Current daily smoker</th>
<th>1996</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>41%</td>
<td>32%</td>
</tr>
<tr>
<td>Urban</td>
<td>41%</td>
<td>32%</td>
</tr>
</tbody>
</table>

More people are current daily smokers in rural areas compared to urban areas.

### Indicators of Health Determinants**

#### Access to safe water

<table>
<thead>
<tr>
<th>Access to safe water</th>
<th>1993</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>80%</td>
<td>100%</td>
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<td>100%</td>
<td>100%</td>
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</tbody>
</table>

Access to safe water increased in the 2nd poorest quintile between 1993 and 2007. Inequalities in access to safe water have improved in urban areas during this time period.

#### Knowledge of transmission of HIV/AIDS

<table>
<thead>
<tr>
<th>Knowledge about transmission of HIV/AIDS</th>
<th>1996</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>National average</td>
<td>10%</td>
<td>12%</td>
</tr>
<tr>
<td>Rural average</td>
<td>10%</td>
<td>12%</td>
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<td>Urban poorest 20%</td>
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</tr>
</tbody>
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Knowledge on the transmission of HIV/AIDS increased among urban and rural women from 1996 to 2007. Inequalities persist between the urban wealthiest and poorest despite increased knowledge of the transmission of HIV/AIDS.
Identification of equity gaps leads to crafting solutions.

Many health problems and issues require actions from different stakeholders and perspectives.

UN Political Declaration on NCDS calls for “whole of government” and “whole of society” responses.

More realistic approach to solving recurrent challenges.

Lessons from other areas of development.

Urban environment easier to implement such actions.
INTERSECTORSAL ACTION ON HEALTH

A path for policy-makers to implement effective and sustainable action on health
Health and quality of life are determined by a complex net of interrelated social, environmental, and economical factors.

The measures to promote health cannot be confined to health sector alone.

**Strategies of ISA**

1) "Health in All Policies"

2) Integrating a specific health concern into other relevant sector’s policies
WHO: 10 STEPS TO POLICY-MAKERS

- Published in 2011 by the WHO Centre for Health Development in Kobe (WKC)
- Presents a series of steps which policy-makers can take to promote multi-sector health initiatives in national level
- Aims to share lessons and encourage policy-makers to move towards intersectoral action on health
- Relevant to both an issue-centred approach to implementing ISA, and to a general strategy of achieving health in all policies at national level
Viet Nam’s national mandatory helmet law — success of a multisectoral approach

Motorcycle helmets are a well-documented public health and road safety intervention. With its multisectoral approach, Viet Nam provides an excellent example of how intersectoral action can help save lives and improve health.

Road traffic injury in Viet Nam is a leading cause of death and disability, with more than 14,000 deaths and 140,000 injuries reported by the Ministry of Health in 2009. Statistics from 2001 show that an estimated 60% of all road traffic fatalities were in motorcycle riders and passengers. Some degree of motorcycle helmet legislation has been in place since 1995, but few penalties and limited enforcement coverage made it largely ineffective.

In 1997, a multidisciplinary coordination mechanism, the National Traffic Safety Committee (NTSC) with representatives from 15 ministries and agencies including transport, police, health and education was established as an advisory body to the Prime Minister on all transportation safety initiatives. The terms of reference of the NTSC include promotion of international
Alma Ata (1978) and Adelaide (2010) Declarations

Several analyses of international experiences on ISA

Series of expert consultations hosted by WHO:
- Kobe, June 2009
- Helsinki, June 2010
- Global Forum on Urbanization and Health in Kobe, November 2010
EXAMPLES ON ISA

- Viet Nam: National mandatory helmet law
- South Africa: Intersectoral collaboration for mental health
- Liverpool: Active City 2005-2010
- Australia: Experience in governance from the South Australian model on Health in All Policies
- Ghana: Intersectoral collaboration for health in the extractive industries – oil and gas sector
- WHO Framework Convention on Tobacco Control, FCTC: WHO’s intersectoral action mechanisms in tobacco control
STEP 1: SELF-ASSESSMENT

- Assess the health sector’s capabilities, readiness, existing relationships, and participation
- Strengthen the institution by improving staff capacity to interact with other sectors, to address and communicate potential co-benefits, and to contribute the debate with other sectors

Liverpool: the analysis of the local health profile before initiating intersectoral programme to increase levels of physical activity
Achieve a better understanding of other sectors
Establish links and means of communication with them
Conduct a stakeholder and sector analysis
Identify existing intersectoral bodies
Participate in activities led by other sectors
Establish a common information system

Ghana: the conduction of the health impact assessment (HIA) of national oil and gas development plans in order to identify the potential impacts on health, environment etc.
STEP 3: ANALYSE THE AREA OF CONCERN

- Define the area and the intervention needed
- Analyse the context regards to available mechanisms
- Present sector-specific disaggregated data focusing on the impact of other sectors
- Analyse the feasibility of the intervention
- Build your case using disaggregated data

**Viet Nam:** the analysis of statistics illustrating that road traffic injury is a leading cause of death and injury in Viet Nam, and that 60% of the accidents happened with motorcycle
STEP 4: SELECT AN ENGAGEMENT APPROACH

- Gauge the intensity of engagement with other sectors in terms of health impact, health priorities, public policy priorities etc.
- Select the approach:
  1) Issue approach
  2) Sector approach
  3) Opportunistic approach

**FCTC**: the decision to focus on the relations of tobacco and agriculture
STEP 5: DEVELOP AN ENGAGEMENT STRATEGY AND POLICY

- Develop a strategy to involve the relevant sectors. Consider:

  1) Long-term commitment
  2) Time allocation
  3) Supporting champions with tools and guidance
  4) Establishing common points of interest
  5) Identifying strategies agreeable to all parties

**Ghana:** the conduction of Health Impact Assessment that aimed to establish a continuous engagement and communication with potentially affected communities
STEP 6: FOSTER COMMON UNDERSTANDING BETWEEN SECTORS

- Identify a common understanding of the key issues and required actions
- Use a common framework to facilitate a shared understanding of the pathways and key interventions

**Viet Nam**: the negotiations held in the framework of National Traffic Safety Committee in order to set a national law on mandatory use of motorcycle helmets

3 September 2012
STEP 7: STRENGTHEN GOVERNANCE STRUCTURES, POLITICAL WILL AND ACCOUNTABILITY MECHANISMS

- Assess the political route required to adopt the policy
- Develop accountability mechanisms
- Take advantage of the treaties and reporting mechanisms mandated by international agreements to integrate health determinants across sectors

**Australia:** the linking of the HiAP approach to the South Australian Strategic Plan that already provided a cross-government mandate
Enhance participation in the policy development and implementation through:

1) Public consultations and hearings
2) Disseminating information using mass media
3) Web-based tools
4) Facilitating the involvement of NGO’s from different sectors

Liverpool: the cooperation between the Liverpool Strategic Partnership and community-sector organizations
STEP 9: CHOOSE OTHER GOOD PRACTICES TO FOSTER INTERSECTORAL ACTION

- Join other sectors in establishing common policies, programmes or initiatives
- Be an agent in other sectors’ policies, and invite them to be agent in yours
- Provide required expertise
- Provide tools and techniques to include health in the policies of other sectors
- Allocate available resources to contribute to other sectors’ policy implementation
- Share lessons

South Africa: the establishment of a Mental Health Directorate based on the recommendations from the South Africa Mental Health and Poverty Project
Follow closely the implementation of intersectoral action through monitoring and evaluation processes.

Report regularly on the development of policies that protect and promote health.

Liverpool: the verification of the positive effects of the Liverpool Active City programme by two national surveys.
1. Use already identified and prioritized public health issues.

2. A supportive governance structure helps to sustain efforts and ensures integration of strategies.

3. A capable and accountable health sector is vital to promote and support ISA.

4. Establish a common information system with sector-specific data.

5. Policies selected for implementation through intersectoral mechanisms need to be robust.
6. Community participation and empowerment is critical.

7. MDG’s can be used as a mechanism to promote ISA.

8. Context-appropriate application of Health Impact Assessment can help promote ISA.

9. A human rights-based approach can help address the underlying determinants.

10. Assessment, monitoring, evaluation, and reporting are required throughout the process.
Healthy Urban Planning: Joint project with UN-HABITAT

- WKC has initiated a case study project on ISA mechanisms used in middle-sized Asian cities to foster healthy urban planning
- A call for case studies sent in September 2012
- UN-HABITAT is examining African cities

8th Global Conference on Health Promotion in Helsinki, Finland, June 2013: Health in All Policies

- WKC is looking forward to host session(s) on ISA
Most important are real experiences on ISA

Further research led by WKC (examples)

- Intersectoral Action on Health in Urban Settings: Liverpool Active City 2005-2010
- Intersectoral Health Policy in Varde Municipality, Denmark
- A Case Study on Intersectoral Action on Health in Urban Settings: the experience of Abha City, Saudi Arabia
- A Community-based Effort to Work Across Sectors to Reduce Level of Diabetes in Riverlea, Johannesburg, South Africa
THANK YOU!

Alex Ross, Director
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Kobe, Japan

www.who.int/kobe_centre
YOUR CONTRIBUTION

- What is your experience?
- What are the challenges you are facing?
- What would you advise to make it successful?