Policy brief 1: Healthy cities

Definitions and mandate

Globally, more people live in urban areas than in rural settings. While cities offer many opportunities for employment and access to better services (health, education, social protection) that are necessary for good health and human development, cities can also pose unique health risks. In urban slums and smaller informal settlements, overcrowding and lack of access to safe water and sanitation contribute to the spread of infectious diseases such as tuberculosis (TB), for example. Rates of noncommunicable diseases (NCDs), violence, and mental illness are also often higher because of cities' social, built and food environments. Meanwhile, only 12 percent of cities globally reach pollution control targets. With such trends in mind, the World Health Organization (WHO) has identified urbanization as one of the key challenges for public health in the 21st century.[i]

The importance of managing and planning urbanization in a way that advances, rather than holds back, health and health equity will only grow. By 2050, 70 percent of the world's people will live in cities. We must strive to ensure that they are living in *healthy and liveable cities* that are: "continually creating and improving those physical and social environments and expanding those community resources which enable people to mutually support each other in performing all the functions of life and developing to their maximum potential."[ii]

The 2030 Agenda for Sustainable Development places renewed emphasis on just how interconnected our social, economic and environmental ambitions are. Health promotion efforts grounded in a *healthy cities* approach can contribute to achieving the Sustainable Development Goals (SDGs), including **SDG 11: Make cities and human settlements inclusive, safe, resilient and sustainable.** The unique contributions of the successful WHO Healthy Cities programmes/movement have included a strong value-based commitment to innovations at the cutting edge of social determinants of health and Health in All Policies. Today, thousands of cities worldwide are part of the Healthy Cities Network in all WHO regions. This has become an important platform

FROM OTTAWA TO SHANGHAI & THE SUSTAINABLE DEVELOPMENT

Thirty years ago, the Ottawa Charter for Health Promotion recognized the need to enable people to increase control over and to improve their health and well-being by ensuring healthier, sustainable environments where people live, work, study and play. Social justice and equity were highlighted as core foundations for health, and there was agreement that health promotion is not simply the responsibility of the health sector. Subsequent WHO global health promotion conferences have reiterated these elements as key for health promotion.

The 2030 Agenda for Sustainable Development, the world's ambitious and universal "plan of action for people, planet and prosperity", includes 17 Goals, 169 targets and 231 initial indicators. The Agenda offers a new opportunity to involve multiple stakeholders to ensure that all people can fulfil their potential – to live in health and with dignity and equality. With this in mind, the theme of the 9th Global Conference on Health Promotion, "Health Promotion in the Sustainable Development Goals" is both timely and necessary to ensure policy coherence and alignment of agendas for action. The slogan: "Health for All and All for Health" captures the commitment to leave no one behind and to involve all actors in a new global partnership to achieve this transformative Agenda.

for achieving health and sustainable development in many parts of the world, as cities are often at the forefront of innovation with mayors and municipalities spearheading efforts to improve the daily conditions of urban life. A *healthy cities* approach which catalyzes political leadership and participatory governance can be transformational for health and health equity, as well as help mitigate the impacts of environmental degradation, climate change, ageing, migration, growing inequalities and social isolation (Table 1).

Table 1: Links to key SDGs

Healthy cities and the SDGs	
	Healthy cities can ensure access to safe, nutritious and sufficient food by adopting innovative policy measures that improve the food environment through: (1) increased access to healthy options (e.g. green markets); (2) empowering people with clear information to make healthier choices (e.g. calorie labelling at point-of-purchase, graphic labelling); (3) restricting or disincentivising the availability of unhealthy foods and beverages (e.g. economic zoning policies); and (4) helping end malnutrition by targeted delivery of nutrient-dense meals to the poor.
	Urbanization promises efficiencies, better infrastructure, and technology. A healthy cities approach ensures that these efforts give due attention to increasing access to safe drinking water and improved sanitation for large segments of the population, as well as proper waste disposal, pollution management and good hygiene. Informal as well as formal settlements warrant attention for adequate sanitation standards.
	A healthy cities approach views better housing and sanitation, reduced overcrowding and upgraded slums as public health priorities. Substandard housing and sanitation increases the risk of TB and other airborne illnesses, allowing malaria, yellow fever and Zika to flourish, especially where there is stagnant water. Healthy cities also encourage better urban planning to prioritize increased access to safe transport systems, green and public spaces, and emergency responses to natural disasters, which together reduce road traffic deaths, improve air quality, promote physical activity and save lives from disasters.
	Unsustainable consumption and production patterns that harm the environment also harm health, whether through air pollutants, contaminated water supplies or food losses. Healthy cities are, therefore, sustainable cities. They push transnational corporations, and support individuals, to adopt sustainable practices for the health of both the planet and its people.
	A healthy cities approach recognizes that extreme weather events bear significantly on health, through disrupting food supply chains, spreading water borne illness, causing uprooting and migration, and resulting in physical injuries. Healthy cities aim to reduce carbon emissions, thereby improving air quality and promoting physical activity simultaneously (e.g. by replacing cars with walking and cycling). With large segments of the population, including poorer populations, now concentrated in cities, a healthy cities approach is a major pathway toward climate change mitigation.

Healthy cities are peaceful and inclusive. They help eliminate violence by providing safe places for people to live, work and play. They also pioneer the type of effective, transparent and accountable intersectoral governance needed to advance health, achieve universal health coverage, and progress other SDGs. Healthy cities, as a natural place for pro-health social activism to start or gain momentum, also help ensure access to justice for all, including the marginalized and displaced. These are just a few of the reasons why health responses, from WHO's Healthy Cities project to the Urban Health and Justice Initiative to UNAIDS' Fast-Track Cities, have prioritized cities. UNDP's ART initiative helps countries to establish multi-actor, multi-sector and multi-level governance structures and systems to strengthen local governance and development.[iii]

Major health inequities persist across the world, with rates of illness and premature death significantly higher amongst the poorest and most excluded groups. This is true across countries, within countries, and most starkly within cities. As a result, groups least able to deal with the costs of illness are also those most likely to endure them. This is not a matter of chance – the poor and marginalized are more likely to live and work in environments that are harmful to health and have less access to services and amenities. A healthy cities approach can uniquely address this and other injustices. It can advance health and health equity while also advancing other sustainable development goals.

Leadership of mayors and local governments in advancing the SDGs

Cities are increasingly recognized as critical to achieving the SDGs, in part because of their growing share of the world's population, but also because mayors and municipal governments have shown unprecedented leadership in addressing global development challenges. From climate change to addressing HIV, disaster risk reduction to food security, mayors have at times taken bold initiative in responding promptly and efficiently to promote sustainable development. In September 2015, at the sidelines of the SDG Summit, mayors from 40 countries met and declared their commitment to the 2030 Agenda for Sustainable Development[iv] and there have been a number of mayor-led initiatives, including the World Mayors Council on Climate Change, and other initiatives often co-led by foundations and supported by civil society and private sector partners, for example Rockefeller Foundation's 100 Resilient Cities and the C40 Cities Climate Leadership Group.

Of course when urbanization is unplanned or outpaces the capacity of local governments, inequities within cities can widen, with vulnerable communities emerging in the urban periphery.[v] A *healthy cities* approach, which brings human development and health equity to the forefront, can complement more traditional efforts that prioritize economic and environmental sustainability.

Fast-Track Cities: Ending the AIDS Epidemic

Launched on World AIDS Day 2014 in Paris, the Fast-Track Cities initiative is led by mayors and municipal governments from across the globe who have committed to achieve the following targets by 2020: (i) 90 percent of people living with HIV (PLHIV) knowing their HIV status; (ii) 90 percent of PLHIV who know their HIV-positive status on antiretroviral therapy (ART); (iii) 90 percent of PLHIV on ART achieving viral suppression; (iv) the number of new HIV infections reduced to 500,000 globally; and (v) zero discrimination and stigma. Cities have been recognized as key to the HIV response for a range of reasons that bear significantly upon HIV prevention, treatment, care and support. Cities are where large segments of the population increasingly live, account for a large share of the global HIV burden, are in many cases home to severe economic and gender inequalities (SDGs 5 and 10) and offer a strong opportunity for fairer and more inclusive societies (SDG 16). In areas where epidemics are concentrated, cities are home to key populations at higher risk. In more generalized epidemics, progress at city level can be significant enough to bend the epidemic's curve at national level.[vi] The report of the Secretary General on the fast track to ending the AIDS epidemic notes that promotion of a healthy cities approach, amongst other measures such as eliminating poverty (SDG 1) and providing access to social protection (SDGs 1, 3, 5 and 10), is required to "accelerate the response and address the holistic needs of people living with and at risk of HIV throughout their lifetimes" (A/70/811).[vii]

Healthy cities are smoke-free cities

While national comprehensive smoke-free laws are ideal to protect of all of a country's residents from exposure to second-hand tobacco smoke, city leaders, no matter how large or small the populations they govern, have a unique opportunity – and responsibility – to protect their citizens from the illness, premature death and multiple other social and economic harms that result from tobacco smoke.[viii] Dedicated action at the city level to protect populations from exposure to tobacco smoke can also be a catalyst for the entire country to become smoke-free, with city leaders recognized widely for their advocacy and pioneership.

Protection from exposure to tobacco smoke is called for under Article 8 of the WHO Framework Convention on Tobacco Control (WHO FCTC), the strengthened implementation of which features as target 3.a of the SDGs. Reducing people's exposure to second-hand smoke is a cost-effective way to support a range of targets under SDG 3 on health, from NCDs to TB to maternal and child health. It can also advance other objectives across Agenda 2030, for example promoting safe and secure working environments for all workers (SDG 8) and providing universal access to safe, inclusive and accessible green and public spaces (SDG 11).

Almost certainly, every mayor who has embarked on making his or her city smoke-free has had doubts. How realistic is to make all indoor workplaces, public places and public transport free of tobacco smoke? Would such a measure hurt hospitality and tourism in the city? Would workers lose jobs? Would people's rights be affected? Dire predictions often launched by the tobacco industry and its supporters magnify such doubts. Yet, hundreds of cities worldwide – including large cities such as Beijing, Mexico City, New York and São Paulo – have successfully become smoke-free. Their experience is revealing. Political leadership proved to be the buttress against all challenges.

Smoke-free New York – the city's endeavor to become a healthy city with clean air

When on March 30, 2003 Michael Bloomberg, New York's mayor at the time, enacted the Smoke-Free Air Act, controversies began about how the law would kill businesses, lead to job losses and decrease tax revenue. The mayor took leadership and, jointly with New York City's Coalition for a Smoke-Free City, showed the benefits and knocked down the critics. The campaign focused on launching clear messages about the need to equally protect the health of all workers at their workplaces; and proved evidence of public support. One year later, New York City's Departments of Health and Mental Hygiene, Finance and Small Business Services and the City's Economic Development Corporation released a first impact report[ix] revealing an overwhelming compliance, with 97 percent of restaurants and bars being smoke-free – no patrons or workers were observed smoking, no ashtrays were present, and "No Smoking" signs were properly posted. Great support of New Yorkers was evidenced by various polls (e.g. Quinnipiac Poll, October 2003 with 2 to 1 support). Employment in restaurants and bars has risen, business receipts were up 8.7 percent, with all indications that New York City businesses prospered. The city became a safer and healthier place for all of its workers, businesses, tourists and inhabitants – for in one word, everyone.

Good governance for healthy cities programmes

Strong leadership from mayors and other leading authorities is central to a healthy cities approach. However, as experiences and the various phases of WHO's European Healthy Cities Project[x] illustrate, high-level political commitment is but one component, albeit a crucial one, of a larger "whole system" approach to disease prevention. Instituting organizational structures, building the capacity of change agents, devising healthy public policy and comprehensive city planning, adopting a systematic approach to monitoring and assessment, building partnerships, and establishing networks between cities are all integral components of a healthy cities approach. Since 1986 cities in WHO EURO have had the opportunity to make direct connections with WHO through processes of designation (for individual cities) and accreditation (for national networks of Healthy Cities). Through these important processes, cities express political and financial commitment to the Healthy Cities value system, establishing accountability and allowing them to take advantage of the "living laboratory" of evidence and experiences that is the WHO European Healthy Cities Network.[xi] In China and other WPRO cities, similar incentive mechanisms have helped move healthy city programmes forward.

Effective intersectoral coordination is essential. For healthy cities, this often takes the form of an interdisciplinary steering committee or coordination council[xii] that includes representation from health, urban planning, housing, sanitation, environment, and/or transport. While the healthy cities approach holds that "health is the business of all sectors"[xiii], health officials should take a lead role in ensuring that urban development efforts advance, rather than impede, health and health equity. The idea is not for the health sector to "take over" the core competencies of other local agencies or stakeholders[xiv], nor is it to promote healthy cities from a health sector perspective only. Rather, the job for health officials is to support and collaborate with other agencies to develop and implement effective and equitable multisectoral policies, plans and programmes that optimize *co-benefits* for all sectors involved. Effective intersectoral coordination for healthy cities requires that municipal governments understand health threats and map epidemics, measure or estimate the health impacts (positive and negative) of development activities (e.g. through complexity analyses[xv]), implement evidence-backed interventions, and monitor and evaluate impacts on health, health equity and development. Civil society engagement and community empowerment often drive the planning and implementation of healthy cities initiatives.

Local monitoring drives sanitation behaviour change in Maputo, Mozambique[xvi]

A significant portion of Maputo's population lives in unplanned settlements, with poor access to basic services a persistent problem. Poor sanitation in Nhlamankulo Urban District, one of Maputo's most densely populated unplanned settlements (more than 200 persons/ha), is contributing to high rates of diarrheal disease and periodic cholera outbreaks, jeopardizing not just the health of these residents but also those who have access to sewerage or a septic tank.

In February 2010, the Maputo Municipal Council (Mozambique), as part of the multi-donor Water and Sanitation Programme administered by the World Bank, empowered local "block leaders" (each responsible for around 70 households) to gather up-to-date information needed for sanitation planning and management in peri-urban areas. An unintended benefit of the project was that the community leaders, who were widely respected, also persuaded residents to improve the cleanliness and structural state of their sanitation facilities, noting that they would return in two to four weeks to follow up on promises made. At six months, approximately 80 percent of residents had rebuilt, upgraded or improved the hygienic state of their latrines, with the number of latrines in an unsafe state dropping from 29 percent to 14 percent.[xvii] While improving sanitation requires a range of complementary measures, the low cost methodology used in Maputo demonstrates that merely mapping the problem can help to address it, and that community leaders and community residents can both be mobilized to support government-led efforts to make cities healthier.

Moving forward: A plan for the next fifteen years

The Agenda 2030 will require a new way of working, harnessing the considerable synergies across goals. Moreover, taking into account the ambition and broad scope of Agenda 2030, progress will only be achieved through a new ***global partnership*** bringing together a range of stakeholders, as envisioned in Goal 17. With a majority and fast-rising proportion of the world's population now living in urban areas, healthy cities in particular offer a golden opportunity to advance health, health equity, and the SDGs. Making good on this potential requires efforts on the part of multiple stakeholders to strengthen the willingness of mayors and municipal leaders to implement the healthy cities approach, ensure cost-effective mechanisms and interventions that address emerging challenges in cities, and evaluate impacts on health and sustainable development. Examples of roles for stakeholders in applying a healthy cities approach to the SDGs include:

- **Government** – mayors and municipality officials should take a strong leadership role to implement Health in All Policies, to develop structures and mechanisms for healthy cities programmes, to encourage work across sectors to realize win-wins across urban health and related goals, and to continue pioneering innovations while protecting against any industry interference in policymaking (e.g. from food, tobacco, agriculture and/or energy industries).

- **Civil society** – work together to bring different CSO expertise, experiences and capacities to bear in urban planning and ensure that marginalized groups, youth, and women contribute to planning conversations.

- **Media (including social media)** – serve as a critical platform for public dialogue around health and well-being as well as sustainable human development, and create supportive environments for healthy cities.

- **Organizations of the UN system** – support coherence between local and national government policies, and support south-south and triangular co-operation and knowledge exchange on good practices.

- **Community leaders** – promote inclusion in urban living and civic decision making, and support equal access to services and opportunities.

- **Research and academic institutions** – develop and improve methods to evaluate healthy cities programmes, collate and distribute examples of best practice in healthy cities intervention development, and provide evidence of what works, in which contexts, and why.

Cities are arguably the best-known and largest of the settings approaches, which take a "whole system" approach to health and health equity. With Agenda 2030 and the Habitat III process, there is an opportunity to push for integration to ensure that health promotion goes beyond the health sector, and show how it doesn't just advance other sector's primary ambitions but is in fact critical for many. The SDGs will not be achieved if not prioritized and uniquely planned for within the urban areas. Cities present many challenges, but the leadership and commitment that mayors have already shown to improve the lives of their residents in a sustainable and resilient way, offer a promising path forward.

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REFERENCES

[i] WHO and Metropolis. 2014. "Cities for Health." Available at: http://www.who.int/kobe_centre/publications/cities_for_health_final.pdf

[ii] WHO. 1998. "Health Promotion Glossary." Available at: http://www.who.int/healthpromotion/about/HPR%20Glossary%201998.pdf

[iii] UNDP. "ART Initiative: Supporting local development." Available at: http://www.undp.org/content/brussels/en/home/ourwork/democratic-governance-and-peacebuilding/in_depth/UNDP-ART-local-authorities.html

[iv] Sustainable Development Solutions Network and the Global Taskforce of Local and Regional Governments for Post-2015 Development Agenda towards Habitat III. "A Declaration of Cities' Commitment to the 2030 Sustainable Development Agenda." Available at: https://docs.google.com/forms/d/1et01bJ1AmldkCstbNAKuRNwn0azPb1mxWrnFhDx95v4/viewform

[v] WHO and UN Habitat. 2016. "Global Report on Urban Health: Equitable, healthier cities for sustainable development." Available at: http://who.int/kobe_centre/measuring/urban-global-report/ugr_full_report.pdf?ua=1

[vi] See City of Paris, UNAIDS, UN-Habitat and IAPAC. 2014. "Cities Unite to Fast-Track to End the AIDS Epidemic. Event summary: taking action. World AIDS Day 2014." Available at: http://www.unaids.org/sites/default/files/media_asset/2015_Fast_Track_Cities_Paris_Outcomes.pdf

[vii] A/70/811. "On the fast track to ending the AIDS epidemic: Report of the Secretary-General." UNGA, 1 April 2016. Available at: http://sgreport.unaids.org/pdf/20160423_SGreport_HLM_en.pdf

[viii] WHO. 2011. "Making Cities Smoke-free." Available at: http://apps.who.int/iris/bitstream/10665/44773/1/9789241502832_eng.pdf

[ix] New York City Department of Finance, New York City Department of Health & Mental Hygiene, New York City Department of Small Business Services, and New York City Economic Development Corporation. 2004. "The State of Smoke-Free New York City: A One-Year Review." Available at: http://www.tobaccofreekids.org/pressoffice/NYCReport.pdf

[x] WHO Regional Office for Europe. "Healthy Cities." Available at: http://www.euro.who.int/en/health-topics/environment-and-health/urban-health/activities/healthy-cities

[xi] Tsouros, Agis, de Leeuw, Evelyne, and Geoff Green. 2015. "Evaluation of the Fifth Phase (2009-2013) of the WHO European Healthy Cities Network: further sophistication and challenges." *Health Promot Int*, 30 (suppl 1): i1-i2. doi: 10.1093/heapro/dav045

[xii] Werna, Edmundo (author), Harpham, Trudy (ed), Blue, Ilona (ed) and Gary Goldstein (ed). 2014. "Healthy City Projects in Developing Countries: An International Approach to Local Problems." Routledge.

[xiii] WHO Regional Office for Europe. "Healthy Cities." Available at: http://www.euro.who.int/en/health-topics/environment-and-health/urban-health/activities/healthy-cities

[xiv] Werna, Edmundo (author), Harpham, Trudy (ed), Blue, Ilona (ed) and Gary Goldstein (ed). 2014. "Healthy City Projects in Developing Countries: An International Approach to Local Problems." Routledge.

[xv] Rydin, Yvonne et al. 2012. "Shaping cities for health: complexity and the planning of urban environments in the 21st century. *Lancet*, 379 (9831): 2079-2018. doi: http://dx.doi.org/10.1016/S0140-6736(12)60435-8

[xvi] Hawkins, Peter and Odete Muximpua. 2011. "The potential of local monitoring to stimulate sanitation behaviour change in Maputo, Mozambique." ACCESSanitation Case Study. Available at: http://www.sswm.info/sites/default/files/reference_attachments/HAWKINS%20and%20MUXIMPUA%202011%20Maputo%20Mozambique.pdf

[xvii] *Ibid.*