

GLOBAL REPORT
on

URBAN

equitable, healthier cities for sustainable development

HEALTH

EXECUTIVE SUMMARY

INTRODUCTION

From 2016 to 2030, the global community will focus its attention on achieving the 17 Sustainable Development Goals (SDGs) agreed by 193 United Nations (UN) Member States (1). Goal 3 – the “health goal” – of the SDGs includes 13 targets on ensuring healthy lives and promoting well-being for all at all ages. This goal vastly extends the ambitions of the Millennium Development Goals (MDGs) by including targets on maternal and child health, infectious diseases, noncommunicable diseases (NCDs), universal health coverage (UHC) and environmental health. Goal 11 – the “city goal” – consists of 10 targets that aim to make cities inclusive, safe, resilient and sustainable. These 10 targets include a variety of critical issues such as housing, transport, economy and environment that strengthen the physical and social fabric of a city.

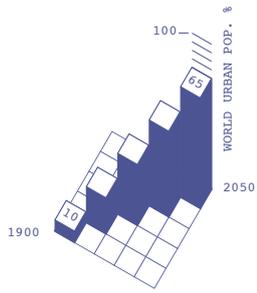
Importantly, this is the first time that cities have been prioritized on the global development agenda. There are two main reasons for this increased interest. First, since 2008, a majority of the world’s population has started living in cities. This proportion is likely to continue rising and it is projected that two in three people will live in cities by 2050 (2). The economic, social and environmental impact of cities will determine quality of life experienced globally in the future. Second, cities are increasingly providing leadership in resolving global development issues such as climate change, public health and food security. Municipal and local governments have the ability to swiftly act on these issues in a responsive manner, and collectively make a significant impact at

national and global levels. For example, mayors from around the world signed the 2014 Paris Declaration in France to achieve United Nations targets on ending the AIDS epidemic by 2020, 10 years earlier than they are expected to be achieved at the national level (3). Similarly, the Compact of Mayors, a coalition of 206 city leaders, pledged to address climate change. They committed to reduce their greenhouse gas emissions through transparent and supportive approaches, to reduce vulnerability and to enhance resilience to climate change.

It is, therefore, no surprise that SDGs 3 and 11 are strongly interlinked. Both goals have explicitly targeted improving road safety and air quality. Target 4 for cities directly links to health by aiming to reduce mortality due to disasters. Additionally, all targets of Goal 11 that aim to improve the living and working conditions of people in cities will support the achievement of the health goal.

The first global report on urban health titled *Hidden cities – unmasking and overcoming health inequities in urban settings* (4) argued that insufficient concern for health equity in cities was hindering achievement of the MDGs. Unlike the MDGs, the SDGs have incorporated equity as a core value of achieving its targets. This report provides a baseline for understanding achievements to date for urban health, delineates key challenges going forward and highlights innovative solutions undertaken by local, national and international stakeholders to aid in the process of pursuing the SDGs.

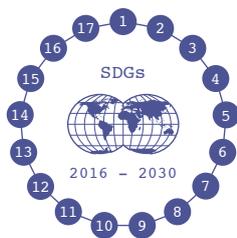
Introduction



Start of the 20th century the world was only 10% urbanized.

6.3B
9.6B

By 2050, 6.3B people, or 65% of the world population will live in urban areas.

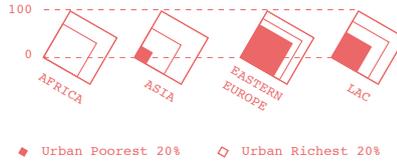


All 17 of the Sustainable Development Goals converge in urban environments, where the success of each is interdependent with one another and with achievements in health.

1 Reduce Health Inequity for Sustainable Development

Health equity remains a persistent problem for residents of all cities

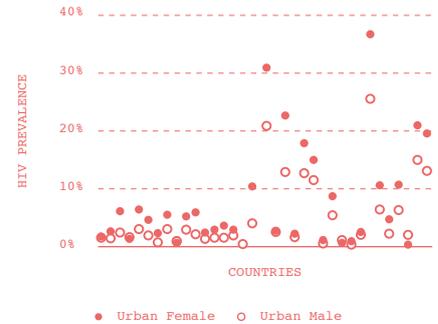
Even with the Millennium Development Goals vulnerable populations in urban areas were left behind.



Common patterns of the urban advantage and intra-urban health inequity, access to piped water is used as an example

3 Leverage the urban advantage to tackle communicable diseases

Cities must play a leadership role in the fight against communicable diseases.



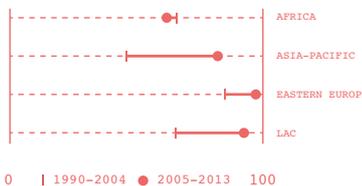
HIV prevalence among general population, by sex and country

Section I Cities free of preventable diseases

2 Advance universal health coverage in cities

Cities will play a major role in demonstrating the feasibility and value of UHC.

The world has experienced some successes in increasing coverage of health services (figure below), but this ultimately masks the exclusion of large numbers of people without the rights or the means to access them.



Antenatal care coverage, by region across two time periods

4 Non-communicable diseases: overcome the new urban epidemic

38 mln

people die every year from NCDs

Non-communicable diseases are emerging as the new urban epidemic. Non-communicable diseases have typically been thought of as diseases of affluence, but they are now killing more people in the developing world than anywhere else, even as they continue to be a growing problem in the developed world.

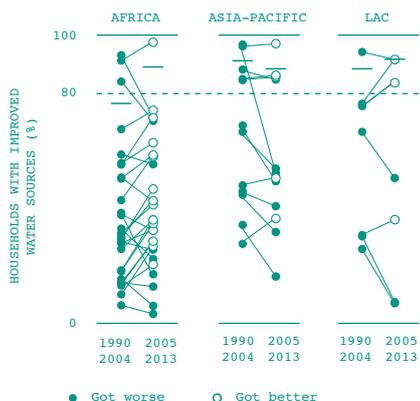
5 Tackle 21st century malnutrition

Cities increasingly face the unprecedented dual challenge of undernutrition and overnutrition.

OVER
UNDER
NUTRITION

6 Provide safe water and sanitation for all

Despite significant global progress, lack of access to safe and sustainable water and sanitation continues to pose an urgent challenge for cities.



► Trends in country level urban prevalence of access to improved water sources, comparing 1990–2004 to 2005–2013

8 Transform urban mobility

Urban transport can be transformed to be healthier, safer and more sustainable.



► Global map of air pollution in cities

12% ONLY

of city populations monitored by WHO are compliant with WHO air quality guidelines.

10 Ensure safety in the city

526.000

people lose their lives to violence every year, 90% of which occurs in countries officially at peace.

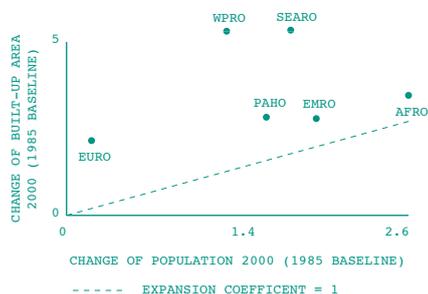
VIOLENCE PEACE

Much of this violence has become concentrated in urban areas.

Section II Cities planned for people

7 Design healthier, more sustainable cities

Cities can be designed and managed in ways that enable healthier behaviour and achieve better health outcomes.



► Urban spatial expansion and population growth

9 Improve health in the home

Targeted housing interventions, greater use of clean energy and improved affordability can help tackle the global challenge of healthy and sustainable urban housing.



By 2025, about one third of the world's urban population will occupy substandard housing or will be so financially stretched by housing costs that they forgo other basic needs.

Section III A renewed focus on urban governance: bringing it all together for health equity

- 1 Participatory decision making.
- 2 Public-private partnership.
- 3 Coordinated policies and actions across multiple sectors to achieve desired outcomes for health equity.

SECTION 1

A VISION FOR HEALTHIER CITIES

CHAPTER 1

Reduce health inequity for sustainable development

ACHIEVING MEANINGFUL PROGRESS IN
HEALTH IN CITIES EVERYWHERE DEPENDS ON
REDUCING HEALTH INEQUITY

Equity is an ethical imperative and an essential principle of the SDGs and the new global health agenda on UHC. The body of new evidence analysed for this report reveals that health equity remains a persistent problem for residents of all

cities. The implications are significant. As the world reflects upon the era of the MDGs, the evidence indicates that vulnerable populations in cities were left behind, constraining progress in global development. As cities continue to grow, urban health inequity will certainly hinder national and global progress towards the new development goals if left unsolved.

The most recent analysis by the World Health Organization (WHO) of 79 low- and middle-income countries (LMICs) showed that, on average, children in the poorest one fifth of urban households are twice as likely to die before their fifth birthday compared to children in the richest fifth (5). Even in higher-income contexts, a study of 16 European cities found evidence of health inequity within all cities, which was strongly associated with socioeconomic deprivation (6). Many factors interact to cause such health inequities, including a person's gender, age, place of residence and migrant status, while poverty is the overriding vulnerability factor. Urban health equity is complex, but as many cities

and countries featured in this report have shown, it is a resolvable problem.

Some countries have successfully narrowed the urban survival gap by accelerating progress among the poorest populations. Ethiopia dramatically reduced the child death rate among the poorest fifth of urban children by over 40% between 2000 and 2011, while there was little to no change among the richest fifth. Several cities featured in the 2015 Save the Children *State of the world's mothers: the urban disadvantage* report (7) also showed major progress in child health equity even under the pressure of significant population growth.

The lack of good city-level data on health and its determinants further compounds the challenges of resolving health equity in cities. However, there is growing demand for an urban data revolution to overcome the challenges of invisibility and inequality as nations work towards sustainable development. A number of local-level initiatives are tackling the systematic lack of data on city populations, especially for the most marginalized people. Innovative approaches are used to more accurately assess not just urban areas in general, but also specifically those people and areas that are often excluded from official surveys. Good subnational data are critical to the achievement of health equity, and to the larger goals of democratization and decentralization. New funding initiatives are now available that can spur cities towards greater investment in comprehensive data gathering to inform local action (8).

Whether for generating data or for making decisions and policies, tackling urban health equity requires the engagement of the whole of society. Breaking down barriers between organizational siloes, and between government and the people, can help ensure that the root causes of health inequity are addressed and that relevant policies and programmes are socially sustainable.

Source: by WHO/Anna Kari





CHAPTER 2

Advance universal health coverage in cities

GREATER ATTENTION TO THE HEALTH NEEDS OF THE URBAN POOR IS ESSENTIAL TO MOVE TOWARDS UNIVERSAL HEALTH COVERAGE

Health is a human right. Access to affordable health care can assist in securing good health for all. UHC is a major step towards reducing inequities in access to health care. The goal of UHC is to ensure that all people and communities receive the quality health services they need, without financial hardship.

Cambodia: Improving hospitals and healthcare helps save lives
Source: by Chhor Sokunthea / World Bank is licensed under CC BY 2.0.
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Perhaps the biggest difficulty for cities in terms of progress on UHC is the growth and heterogeneity of urban populations, their different social, cultural and economic circumstances and backgrounds, and specific subpopulations that are disadvantaged such as those living in slums. Since health systems coverage, including insurance schemes, are mostly the mandate of national governments, this report examines what local authorities and communities can do to make UHC a reality. The good news is that a lot can be achieved locally. For instance, city authorities in Guangzhou, China, increased the scope of their free basic health service provision to registered immigrants without a Guangzhou *Hukou* (a household registration record that entitles holders access to public services in their areas) in 2009. This service reached nearly 13 million people in 2013 and local government funding for the programme

doubled between 2009 and 2015 from US\$ 4 per person/year to US\$ 8 (9).

Local and international NGOs can also play an important role. In Lima, Peru, Socios En Salud (Partners in Health), a non-profit organization, developed a package of health services including TB, HIV, mental health and child development at the community level in Lima's slums where access to health care was limited. Mutual support groups led to particularly good outcomes in both multi-drug resistant TB (MDR-TB) and HIV patients. More than 10 500 people with MDR-TB have been treated in slums around Peru at a very low cost per case, with the highest cure rate in the world, overturning assumptions that treatment of MDR-TB is too expensive and too complicated to succeed in poor communities (10).

Cities will play a major role in demonstrating the feasibility and value of UHC. However, success in increasing coverage of health services over the past decade in urban areas has masked the exclusion of large numbers of people without the rights or the means to access them. Therefore, in the future, cities will have to ensure that the economic and well-being aspirations of billions of people who live in urban areas will not be curbed by restricted opportunities to access quality health care.

CHAPTER 3

Leverage the urban advantage to tackle communicable diseases

CITIES MUST PLAY A LEADERSHIP ROLE IN THE FIGHT AGAINST COMMUNICABLE DISEASE.

Cities are positioned to exercise leadership on altering the course of some of the most devastating infectious diseases of our time. Cities are comparatively well resourced with health workers, financial resources and facilities. The relative population density of cities enables mobility and access at scale for reaching health-care providers, facilities, medicines and more.



Mother comforts baby

Source: by Dominic Chavez/World Bank is licensed under CC BY 2.0. <https://creativecommons.org/licenses/by/2.0/legalcode>

Cities deserve special attention for the control of communicable diseases because they also have features that make them uniquely vulnerable. High population density can cluster people around risk. In cases where there is unsafe water or poor sanitation, even one individual can make entire communities sick. The high human density in cities also heightens the risk of exposure to airborne diseases such as influenza or TB.

Rapid urbanization that outpaces the capacity of local governments creates new vulnerable communities in the urban periphery. These often develop as informal settlements where the combination of poor living conditions, disconnection from public services and infrastructure, and inadequate health service coverage facilitate the transmission of disease. Inequity in cities can facilitate the transmission of disease, even in high-income cities that are hardly growing at all. Cities are heterogeneous places, and they are home to a great many vulnerable people. The tragedy is that the infectious diseases in cities are highly controllable and treatable, and cities are highly capable of taking action to reduce and ultimately eliminate them.

For these reasons and more, cities have become the focus of global ambitions to end the HIV/AIDS and TB epidemics. While the global epidemic may have peaked in the early 2000s, HIV has recently been concentrating more in cities. Analysis conducted by UNAIDS of 200 high-prevalence cities showed that they account for as much as 25% of all people living with HIV, while they only represent 10% of the world's population (3).

TB has also managed to proliferate in some large urban areas, particularly in densely populated, deprived communities. In some larger cities of low-burden, higher-income countries, TB incidence can be several multiples or more of the national average (11). TB continues to be more widespread in large cities in the developing world, where rapid urbanization, poverty and inadequate living conditions exist on a far greater scale without commensurate capacity in the health system to cope.

There can be no doubt that the challenges in rolling back these diseases are significant, but cities and their partners, including WHO, are pushing forward with new initiatives to significantly improve control and treatment. There is still much that can and should be done. Ending deadly disease epidemics such as HIV and TB will depend on cities to control transmission and ensure that those who are already dealing with infections are affordably accessing and adhering to treatment. This will depend on building capacity to identify those who are at risk and those who already live with these diseases. It will also require extending the reach of treatment and prevention for all, particularly for vulnerable people and communities. Importantly, cities must address the social and environmental determinants that contribute to the persistence and spread of communicable diseases

CHAPTER 4

Noncommunicable diseases: overcome the new urban epidemic

NONCOMMUNICABLE DISEASES PRESENT NOT ONLY A THREAT TO HUMAN HEALTH, BUT ALSO HAVE SIGNIFICANT ECONOMIC IMPLICATIONS FOR CITIES

NCDs are emerging as the new urban epidemic. While NCDs are not confined to cities, the city environment is conducive to lifestyles and behaviours that contribute to their development. For example, poor urban planning policies, long commutes and an overreliance on motorized

transport can lead to physical inactivity and difficulty making healthy food choices. Demographic trends such as population ageing can also increase the urban burden of NCDs.

NCDs have typically been thought of as diseases of affluence, but they are now killing more people in the developing world than anywhere else, even as they continue to be a growing problem in the developed world. Cardiovascular disease (CVD) and cancer are now the top two leading causes of death in urban India (12). The urban poor are equally affected by this new penalty of urban living, with slum residents exhibiting a much higher incidence of diabetes and hypertension than the Indian national average. In Kenya as well, deaths due to CVD and injuries significantly increased, while HIV/AIDS mortality declined among the poor in Nairobi between 2003 and 2012 (13). NCDs present not only a threat to human health in cities, but also have significant economic implications, especially in urbanizing economies. The cost of CVD, mental health conditions, chronic respiratory diseases, cancer and diabetes has been estimated at US\$ 27.8 trillion for China and US\$ 6.2 trillion for India for the period 2012–2030 (14).

With low awareness, late presentation and weak health service readiness, there is a need to act at the primary care level to address the impact of NCDs, particularly in LMICs. Integrated health-care delivery systems that provide seamless prevention, early detection, treatment and management of NCDs along with communicable diseases will be essential both at national and local levels. Many of the primary causes and risk factors for NCDs are strongly influenced by different aspects of urban life and environment. Several chapters of this report thus make explicit links to NCDs. The urban food environment, the spatial layout of the city, transportation systems, housing and neighbourhood conditions and safety all play a role in shaping the urban NCD burden, as do other social determinants such as education, employment and income.

In responding to NCDs then, action by the health sector alone is insufficient. Collaboration

across a wide range of sectors is essential. WHO and partners have identified a set of cost-effective “best buy” NCD interventions, including taxation, advertising restrictions and public information, aimed at the risk factors and diseases associated with NCDs (15). Local governments often exercise policy and legislative control over many of these strategies, such as smoke-free legislation and taxation of alcohol. Cities also have the authority to improve the physical environment – housing, sidewalks, parks, roads – to be safer and healthier for all. Thus, cities are poised to exploit the urban advantage to maximum effect to reduce NCD risk factors. Encouraging active participation of multiple stakeholders and critically, the communities themselves, is a necessary component of effective, sustainable solutions.

Source: by WHO/Anna Kari



CHAPTER 5

Tackle 21st century malnutrition

CITIES INCREASINGLY FACE THE UNPRECEDENTED DUAL CHALLENGE OF UNDERNUTRITION AND OVERNUTRITION

Nutrition influences individual health and well-being, as well as many determinants of health such as education and employment, throughout the life course. City environments influence how and what we eat – the quality and quantity of food, its availability, accessibility and consumption patterns. On the one hand, this has led to a concerning trend of rising overnutrition along with the NCD risks associated with it. On the other hand, undernutrition remains a serious concern for those living in deprived urban conditions. Several examples of urban initiatives offer promise that local action can be effective at improving the urban food environment and nutrition outcomes.

Recent analysis by WHO reveals rising rates of overweight and obesity among urban women in LMICs (5). The average prevalence is highest in the Latin America and the Caribbean (LAC) region, where about half of urban women are overweight. Other studies show this growing burden of urban overweight is much greater for those who are poor and less educated (16). At the same time, urban undernutrition is still common in many LMICs. Child stunting, for example, has generally declined in urban areas in recent decades, but the inequity in stunting between children from the poorest and richest urban households has mostly remained unimproved (5). These trends have converged in urban areas to create a perplexing, simultaneous increase of overnutrition and undernutrition (17).

Faced with this challenge, cities have many avenues to tackle the causes of malnutrition.



South View

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While targeted food and nutrition interventions delivered through the health-care system are undoubtedly important, this report casts attention beyond the health sector. Basic urban services, such as water, sanitation and hygiene, can have a major impact on nutrition by reducing episodes of infectious diseases (18). The city layout, services and structures can be designed to promote physical activity and access to healthy foods. Urban agriculture can augment food security, while education and regulation can be used to encourage healthy eating behaviour. Policy coherence and integration can enhance the efficiency and effectiveness of these various interventions. Firm political commitment is also key – and achievable – as demonstrated by city leaders worldwide who have recently committed to developing sustainable urban food systems to strengthen food security in their cities (19,20).

SECTION 2

PLAN CITIES FOR PEOPLE

CHAPTER 6

Provide safe water and sanitation for all

DESPITE SIGNIFICANT GLOBAL PROGRESS, LACK OF ACCESS TO SAFE AND SUSTAINABLE WATER AND SANITATION CONTINUES TO POSE AN URGENT CHALLENGE FOR CITIES.

Clean drinking-water and sanitation are essential to the realization of all human rights (21) and health. They are one of the most important urban services related to poverty alleviation and sustainable development. Providing equitable service, however, is a major challenge in urban

areas due to the size, diversity and instability of the population. The risks of not ensuring these services are high given that the density of cities increases the chance that one source of pollution will affect a great many people.

On average, significant gains in access to safe water and sanitation have been achieved in recent decades, both nationally and at the urban level (22). According to the WHO latest analysis, urban access to improved water sources has exceeded the UHC target of 80% in LMICs in Africa, the Asia-Pacific and LAC (5). However, there are stark inequities in access to water and quality of water, both between and within countries of varying levels of development. Sanitation coverage for urban residents in the world's least developed regions also remains low at less than 50% (22), with high rates of open defecation in several countries among the urban poor (5). Solid waste management, including the removal of human excreta, is a key link in the chain of urban sanitation services that requires more attention.



A number of possible solutions at different scales are available. A recent systematic review found that point-of-use filters in combination with safe water storage is the most effective household-level drinking-water intervention to reduce diarrhoeal disease in LMICs, and at the community-level, high-quality piped water and sewer interventions (23). A novel social programme in Tangier, Morocco, offering in-home connections to the city water system found that low-income families are willing to invest in water connections. Technical assistance for the application process, interest-free loans and social networks (i.e. neighbour effects) enhanced uptake of the programme (24).

Given the systemic nature of water and sanitation services, well-coordinated system-wide solutions are needed to achieve efficiency and effectiveness on a broad scale. Between 2000 and 2012, government ministries, development agencies and civil society have worked together to improve sanitation in urban slums in Kenya with measurable success. The proportion of Nairobi slum households buying water from vendors decreased from 74.8% to 11.4%; in turn, those accessing water through public taps increased from 2.7% to 59.3%. The proportion using flush toilets increased six-fold, while those using pit latrines nearly halved. These improvements were linked to declines in diarrhoeal deaths and under-5 mortality (13,25,26). Such solutions requiring coordination on many levels may be daunting, but are achievable and sustainable, even in resource-limited area

CHAPTER 7

Design healthier, more sustainable cities

CITIES CAN BE DESIGNED AND MANAGED
IN WAYS THAT ENABLE HEALTHIER
BEHAVIOUR AND ACHIEVE BETTER HEALTH
OUTCOMES

The growth of city populations over the last century has forced urban planners and city leaders around the world to cope with significant numbers of new residents. Some cities have not coped well with swelling urban populations manifesting in the growth of informal settlements at the periphery of the city, where they lack city services and infrastructure. In most cases, cities have accommodated their new residents by pushing the boundaries of the city for expansion. These cities occupy increasing volumes of land cover – they stretch and they sprawl as they grow. The problem this presents for planners is that many cities are expanding at rates that exceed their capacity to accommodate the growing population. In a global sample of 120 cities measured during 1990–2000, the geographic extent of the city grew more than twice as fast as the population (27).

In these sprawling cities, the necessities of everyday life for many residents become less accessible. In the absence of density, public transportation for certain communities can be infrequent or non-existent. Hospitals, schools, businesses, city parks and planned public spaces are all more sustainable with human density. With lower density these institutions and infrastructure that make up the very essence of the urban advantage become unsustainable. In these places, urban spaces often become single-use spaces – places where people live, or places where people work,



Los Angeles in a Good Light
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play and access their daily needs, but not both. The correlation between sprawl and ill-health is well documented. For example, a 2014 update to a landmark study of sprawling metropolises confirmed a negative correlation between sprawl, health and economic opportunity across 221 cities and 994 counties in the USA (28).

Cities can be planned for the health of their residents. One of the ways that city design can promote physical activity is through compact, higher-density design. In compact cities, intra-urban distances tend to be shorter – the things people need and the places people need to go are close by. This reduces time spent in a vehicle and lowers travel costs. The lower cost of transport can substantially help low- and middle-income households. Decreased transit time also yields a boost to mental health as well as economic benefits.

Cities should give careful consideration to *how* they should reap the rewards of compactness. The composition of spaces in cities can determine the extent to which high-density living can positively affect health, or not. Mixed land use, together with high-density living, is correlated with increased levels of physical activity (29). Green spaces and recreational areas are key to the composition of mixed land use, giving city residents the opportunity to be physically active and promote mental health. Conversely, if not managed

carefully, compact cities can constrain the housing stock and increase housing prices, and at the extreme, it can lead to unhealthy crowding.

Cities can adapt their current forms and be built for future urban populations to enable healthier living. Healthier urban designs can keep city residents mobile, while keeping them active and eating healthier. They can facilitate residents to spend less time in their vehicles, and more time being productive or improving the quality of their lives. Cities can adapt to enable residents to age well in their communities. They can adapt to the changing climate. These are all achievable, while keeping cities economically dynamic and progressing forward.

CHAPTER 8

Transform urban mobility

URBAN TRANSPORT CAN BE TRANSFORMED TO BE HEALTHIER, SAFER AND MORE SUSTAINABLE

Cities promise to bring people closer to the things they need to live their lives, delivering access and mobility to jobs, food, health-care providers – everything people need, including other people. Mobility and access represent two of the pathways by which cities can deliver the urban advantage for health and prosperity for urban residents. Transportation in the world's cities is increasingly moving towards private motorized transportation. This trend may grant increased mobility and access to many individuals who need it, but it also brings the potential for substantial hazards to health. Increasing use

of motorized transport and urban sprawl are commonly associated with more sedentary behaviour, which is closely associated with the rise of NCDs in cities.

The use of personal motor vehicles in cities contributes significantly to urban air pollution. Monitoring the air quality in 1600 cities in 91 countries in 2014, WHO found that only 12% of the monitored populations were living in cities compliant with air quality guidelines (30). City life exposes residents to relatively higher air pollution levels at close proximity to the source of the pollution. Recent estimates have indicated that as many as 3.3 million people die prematurely every year from exposure to fine particulate matter (31), the type of air pollution that is most strongly associated with motor vehicle exhaust and other forms of combustion. These numbers are on the rise, as deaths attributable to air pollution to which motor vehicles are an important contributor grew by 11% (32).

One of the most tragic consequences of the motorization of urban transport has been the rise of road traffic crashes. Over the last 20 years, the number of deaths attributable to road traffic crashes has increased by 46%, becoming the eighth leading cause of death in the world (32). Without intervention, WHO expects the global burden to exceed 1.9 million deaths and become the seventh leading global cause of death by 2030 (33).

Everyone deserves the right to safe, convenient passage to the places they need to go for their daily needs. It is the role of the city to enable its citizens to do so efficiently and safely. This will depend on cities reducing the number of vehicles on the road and the distances they travel by facilitating mass and active transport alternatives, while ensuring that they are both desirable and practical for users. When people can access what they need on foot or bicycle, or quickly and conveniently by mass transit, operating a motor vehicle becomes a less desirable choice. Planning for transit-oriented development, with multi-use spaces and residences clustered around mass transit options and walkable spaces is ideal. Whether

cities are currently planning new development, or they are locked in to current urban forms, there are cost-effective, proven approaches that reduce car dependence, unclog city streets and create an enabling environment for healthier living.

Healthier urban transport systems further depend on cities making vehicles and roads safer for everyone. Street design can significantly reduce vehicle speeds and reduce injury rates. There are myriad traffic-calming devices that are proven to suppress vehicle speeds, and when built into more comprehensive road safety plans with enforcement of vehicle safety laws, they have been shown to dramatically reduce road traffic fatalities and injury.

Daily Commute

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CHAPTER 9

Improve health in the home

TARGETED HOUSING INTERVENTIONS,
GREATER USE OF CLEAN ENERGY AND
IMPROVED AFFORDABILITY CAN HELP TACKLE
THE GLOBAL CHALLENGE OF HEALTHY AND
SUSTAINABLE URBAN HOUSING

The global challenge of urban housing continues to grow, with a projected need of 1 billion new houses to be provided by 2025 to accommodate 50 million new urban residents per year (34). Lack of quality housing is especially a problem where policies to ensure adequate housing are absent, or where unplanned urban growth has led to the spread of unregulated, substandard housing.

Poor housing, including insufficient access to services such as clean water, sanitation, electricity or security, carries a big health burden. Urban slums are representative of some of the most dire urban housing conditions, and their impact on health is illustrated throughout this report. Even in wealthier parts of the world, recent WHO estimates show that in the WHO European Region, for example, inadequate housing accounts for over 100 000 deaths per year (35). By contrast, good quality housing renders substantial health and social benefits (36).

While new homes should be built to good standards, improvements to existing housing can potentially have the biggest impact as they make up the majority of the total housing stock. Home improvements can effectively improve heating and energy efficiency as well as residents' health and quality of life, especially when interventions target disadvantaged populations who are more likely to occupy substandard homes (37–41). Interventions of a broader scope, such as urban renewal projects, have also met some success, though their effect on



Source: by WHO/Anna Kari

selective (but not necessarily voluntary) in- and out-migration need to be carefully considered.

The use of solid fuels is a major housing-related health risk factor and an environmental pollutant. In 2012, household air pollution was responsible for 4.3 million deaths, making it the largest environmental contributor to ill-health (42). While an estimated 94% of the urban world's homes have electricity (43), recent WHO analysis of LMICs shows that in several countries a great majority of poor urban households still use solid fuels for cooking (5). The best approach is to make cleaner fuels available, affordable, sustainable and desirable, and to encourage their exclusive use in and around the home. In the meantime, improved solid fuel stoves will continue to play a very important part.

In addition to the physical structure of the home, and its indoor and outdoor environments, its affordability is a critical aspect of urban housing and an important determinant of health. Based on current trends, by 2025, about one third of the world's urban population will occupy substandard housing or will be financially stretched by housing costs that they forgo other basic needs (34). Urban housing affordability can be improved through better coordination of housing, transportation and land use and ownership policies. There are also low-cost or cost-neutral strategies for integrating health promotion into the design and amenities of affordable housing developments, which can help reduce health inequities associated with urban housing (44).

CHAPTER 10

Ensure safety in the city

POOR SAFETY AND URBAN VIOLENCE COME AT A SIGNIFICANT COST TO THE HEALTH OF URBAN RESIDENTS AND THE SOCIETIES WHERE THEY LIVE

Approximately 526 000 people lose their lives to violence every year (45), with roughly 90% of these deaths occurring in countries that are officially at peace. Much of this violence has become concentrated in urban areas, even in countries where the population is not substantially urban (46). Across the developing world's cities, 60% of all urban residents are estimated to have been victims of crime (47).

Levels of urban violence vary widely between and within cities, large and small, rich and poor. Evidence implicates social exclusion, poverty, poor educational outcomes and inequality as key risk factors for violence in urban areas (48). Urban environments can be places of profound inequality, where these risk factors can aggregate and cluster in space (49). Rapid urbanization can exacerbate inequalities by straining city governments' ability to deliver basic services that are protective against violence and crime.

In cities, it is often the urban poor who experience much of the crime and violence. Certain communities in cities suffer from an aggregation of risk factors, including poverty and comparatively worse education, infrastructure and other crucial city services. This is particularly acute in informal settlements and slum areas, which often lay beyond the reach of formal city services.

WHO estimates that homicide rates have declined 16% overall since 2000 (50). Consolidating these gains and continuing to reduce the impact

of violence in cities requires that cities commit to understanding the root causes of violence in their communities. In order to do so, cities must develop the capacity to collect and analyse data on violent events. An estimated 60% of all countries do not have usable data on homicide from civil and vital registration systems (50). Where these data do exist, they are often not paired with much-needed complementary data about victims, perpetrators and other circumstantial data. Furthermore, too many violent acts go unreported, particularly those perpetrated against women, children and older adults, making survey-based data critical to understanding the nature of violence. These capacities are important at the national level, and are even more crucial at the local level, where the impact is felt, where the root causes can be observed and where the response must be mounted.

When cities have developed the analytical capacity to understand violence in their environment, local evidence can then drive the design of interventions, ensuring that action is locally relevant, timely and responds to the true nature of the issue. Interventions must be proactive and address not just the proximate causes, such as alcohol abuse or access to firearms, but also the risks that often become entrenched in communities and cities, and can transcend generations. Poor educational outcomes, economic inequality, unemployment and social and physical exclusion are among the many risk factors that can pool in communi-

ties and place people at risk. As the determinants of violence are intersectoral in nature, so must be the response.

Population-based strategies can intercede in “hot spots” and reduce overall levels of violence, but within these hot spots there are individuals for whom life experiences and environments may increase their vulnerability to commit or be the victim of violence. Evidence indicates that there are ways to intervene with vulnerable individuals and vulnerable situations to prevent violence, without incarceration (51). In addition to helping people to make better life choices by enabling them with better opportunities, it is also possible to help people to make better decisions when faced with a dangerous situation. People can be trained to diffuse conflict situations and manage violent impulses.

Reducing violence and improving safety in urban areas is a priority that cuts across issues and silos in cities. It is a challenge that affects the social fabric of the city, its economic vitality and the city’s ability to function and deliver for its citizens. Violence and poor safety present a strikingly high burden of preventable ill-health and mortality for cities and the world, which can be mitigated and prevented. City leaders can do much to intervene, but as with so many health issues in cities, the challenges and the solutions require coordination of a multisectoral response

Metrocable - Línea J

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SECTION 3

A RENEWED FOCUS ON URBAN GOVERNANCE

The primary purpose of this report is to elicit how health and health equity in cities is impacted by a multitude of factors including urban planning, environment, safety, housing, pollution and access to health services, among others, and what can be done to remedy negative impacts and maximize positive health outcomes. City governments are responsible for addressing many local needs. For interventions to be effective, a comprehensive approach is needed where a wide variety of stakeholders are engaged. Members of civil society, the private sector and government play key roles to shape the future of health in cities. Their collective capacities can be harnessed using three key mechanisms, underpinned by strong leadership at the city or urban level.

First is the power of participatory decision-making. 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.

Second is leveraging capacity of a city's resources through public-private partnerships, particularly for urban design. Three main ways in which the private sector can engage are: (i) in a partnership with the public sector on building infrastructure and provision of health-related services; (ii) by investing their comparative advantages in actions that advance health promotion ; and (iii) as a donor/ philanthropist supporting public health initiatives. While recognizing the challenges in

sustaining public-private partnerships in relation to productivity and equity in outcomes, it is time to enhance this relationship within local contexts and rules, as well as in following international guidance and compacts, where applicable (52).

Third, as much of this report shows, coordinated policies and actions across multiple sectors are needed to achieve desired outcomes for health equity. Health in All Policies (HiAP) is an approach to decision-making that recognizes that most public policies have the potential to influence health and health equity, either positively or negatively (53). Truly embedding health equity into policy and decision-making processes across all city government departments requires institutionalization of HiAP and similar multi-sectoral engagement strategies. This needs formal and sustainable structures, processes and resources that enable timely analysis of the health consequences of decisions (54).

Health equity is social justice in health. The global political commitment to the SDGs provides us all a platform to contribute to health equity in cities. The United Nations has estimated a US\$ 2.5 trillion annual investment gap for achieving the SDGs in developing countries (52). This strengthens the imperative to capture the links between the different goals and address them holistically. As cities grapple with 21st century challenges and pledge to improve the health and well-being of their populations, it is critical that the core value of their strategy is *equity*.

MDG Scorecard Summary

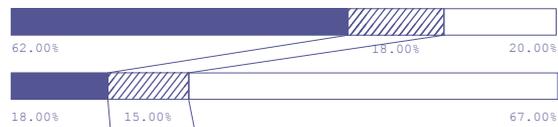
As the Millennium Development Goals [MDGs] have now been replaced by the Sustainable Development Goals [SDGs], we take a look back at how people in urban areas fared with respect to the MDG targets. What follows is a summary of analysis in the Global Report, showing how urban areas performed on the MDGs, as well as the results for the urban poor.

Target 1C

Halve, between 1990 and 2015, the proportion of people who suffer from hunger

Indicator 1.8

Prevalence of underweight children under five years of age

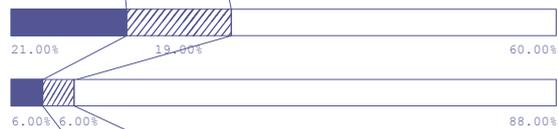


Target 4A

Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate

Indicator 4.1

Under-five mortality rate

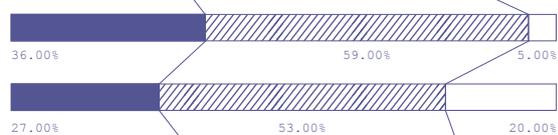


Target 4A

Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate

Indicator 4.3

Proportion of 1 year-old children immunised against measles

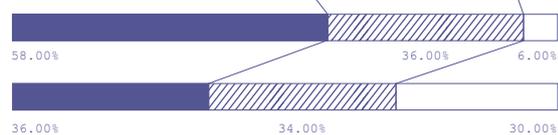


Target 5A

Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

Indicator 5.2

Proportion of births attended by skilled health personnel

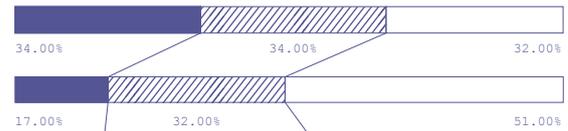


Target 5B

Achieve, by 2015, universal access to reproductive health

Indicator 5.5

Antenatal care coverage (at least four visits)

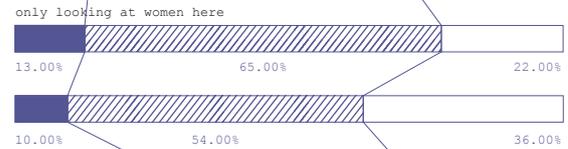


Target 6A

Have halted by 2015 and begun to reverse the spread of HIV/AIDS

Indicator 6.3

Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS

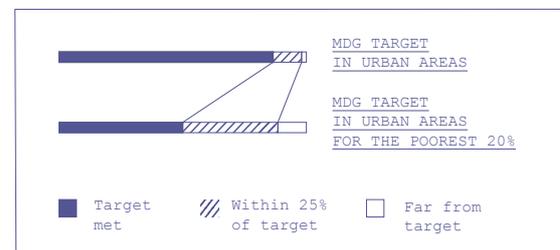
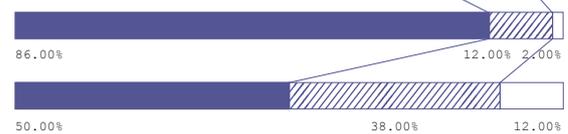


Target 7C

Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation

Indicator 7.8

Proportion of population using an improved drinking water source



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WHO Library Cataloguing-in-Publication Data

Global report on urban health: equitable, healthier cities for sustainable development.

1.Urban Health. 2.Urbanization. 3.Cities. 4.Conservation of Natural Resources I.World Health Organization. II.UN-Habitat.

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GLOBAL REPORT
on

URBAN

equitable, healthier cities for sustainable development

HEALTH

The Sustainable Development Goals, 2016-2030 (SDGs), inclusive of its goals and targets for health and for urban settings, provides an unprecedented opportunity to improve the lives, health, productivity, and wellbeing of all people living in an increasingly urbanized world.

The WHO-UN Habitat Global Report on Urban Health: equitable, healthier cities for sustainable development presents new information and evidence-based multi-sectoral practical solutions to enable cities, countries, and the global health community reduce health inequities, achieve the Sustainable Development Goals (SDGs), and realize universal health coverage (UHC) and the New Urban Agenda. The report reveals the impact of health inequities on achieving health outcomes and outlines options for strengthening health systems and reshaping urban environments, capitalizing on synergy of actions across sectors and co-benefits.



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