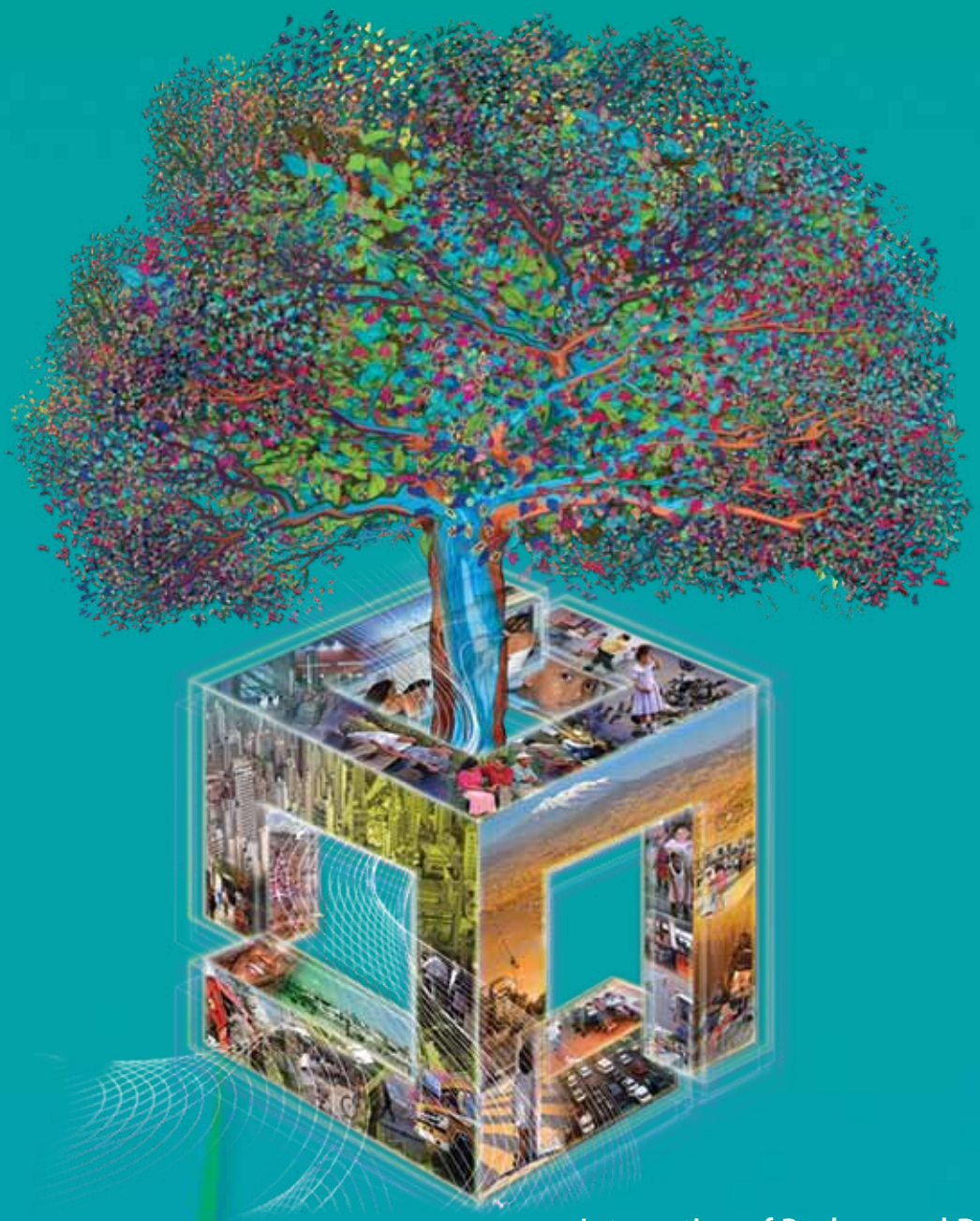

Integration of Background Documents
for the Strategy and Plan of Action

on urban health in the Americas

Pan American Health Organization

Regional Office of the
World Health Organization

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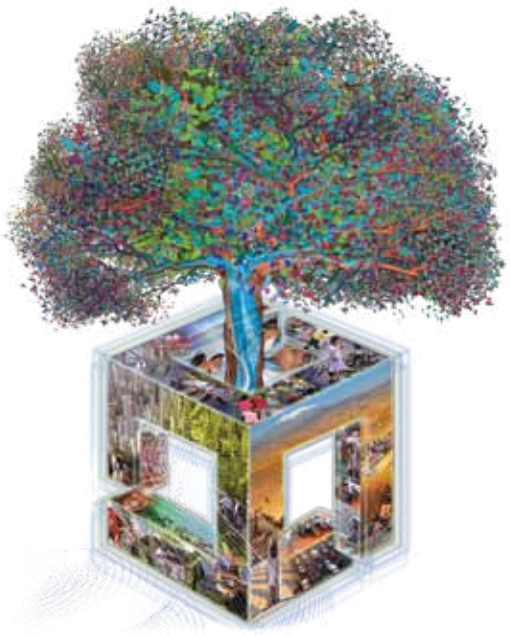


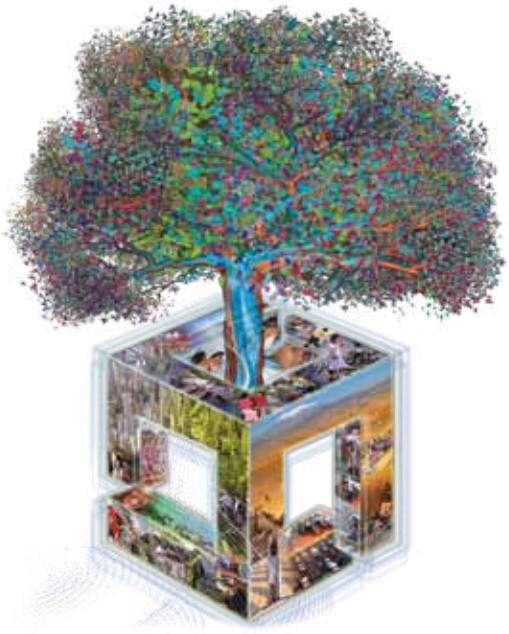
PAN AMERICAN HEALTH ORGANIZATION/WORLD HEALTH ORGANIZATION

Integration of Background Documents
for the Strategy and Plan of Action

on urban health in the Americas

Pan American Health Organization
Regional Office of the World Health Organization

Strategy and Plan of Action on Urban Health in the Americas



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Dr. Mirta Roses Periago
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Introduction

By 2030, three-fifths of the world's population will reside in urban areas. The city environment offers many opportunities to shape economic growth, alleviate poverty, stabilize the population, create environmental sustainability, reduce inequalities and ultimately support the exercise of human rights worldwide[1]. Urban infrastructure affects the health status of the population and can facilitate access to public services such as clean drinking water, sanitation, electricity, transportation, education, health services, communications and public spaces for recreation and sports.

However, if current trends continue, the evidence points to a future with greater inequalities than ever before. The majority of urban dwellers are becoming ever more impoverished relative to the industrialized countries. According to predictions, this future urban shift will be characterized by greater movement of populations toward urban centers; slums will be home to a greater proportion of the world's poor; and cities will expand, with a dramatic impact on the environment and human health[2]. Many factors explain why urbanization is the great challenge for public health in this century. More than 70% of the Region of the America's population is living in urban areas and most of the population growth will be in cities. Unplanned urbanization is a major concern for certain vulnerable populations and is creating a humanitarian crisis. For example, between 43% and 78% of total urban residents are living in slums with no basic public services such as water & sanitation, waste disposal, transportation, energy, health care, education, and no protection from high incidences of communicable diseases, poverty, violence, and mortality. Nevertheless, there are many possibilities for reversing these trends as is demonstrated by numerous municipal governments, nongovernmental organizations, and private providers in the Region that are implementing new policies and programs to achieve better urbanization models that can be

[1] United Nations Population Fund (UNFPA) (2007). State of the World Population 2007. Retrieved from : http//www.unfpa.org/swp/2007/english/introduction.html. Accessed September 14,2010.

[2] Vlahov D, Galea S, Ompad DC. Urbanicity, urbanization, and the urban environment. In S. Galea (ED.), Macrosocial determinants of population health (pp. 53-69). New York, NY: Springer Science: 2007.

models for the world. If the health sector can think and act in a futuristic way to predict these trends and mobilize itself along with other governmental and private sectors, together with the civil society, these predictions can be reversed.

PAHO's Directing Council has maintained a tradition of including a roundtable discussion on the theme for World Health Day (WHD) each year. WHD is celebrated annually on 7 April and marks the founding of the World Health Organization (WHO), but in the PAHO Region activities are carried out throughout the year. Last year's theme was Urbanism and Healthy Living, and so the Ministers of Heath and their delegations addressed this topic during their Directing Council deliberations. Contained in this booklet are the background document and the final report of these roundtable discussions.

Among the recommendations that emerged was for PAHO to develop for the very first time a pioneering Regional Urban Health Strategy and Plan of Action for the countries of the Americas. As a result, a document was discussed with Member States and presented to the Pan American Sanitary Bureau's Directing Council in September 2011. This booklet also contains the Urban Health Strategy, Plan of Action and resolution as approved by the Ministers of Health of the Americas. This ten-year Plan has baseline indicators that need to be collected over the course of the following year, along with recommendations for action to be taken by countries of the Americas and by PAHO.

Countries will now have the responsibility for, among other things, adopting guidelines, tools and methods to promote social participation and reorientation of health services; adjusting surveillance systems to include determinants and indicators related to urban health as well as to document urban health processes and experiences; promote specific health promotion and sustainable development projects that encourage social participation, intersectoral action and/or access to infrastructure, sanitation, education and health services as well as social subsidies; and to report back every two years on the progress they make.

The PAHO Secretariat will have the responsibility for producing and disseminating public health criteria, guidelines, model policies and legal frameworks for urban health planning, services and methods for achieving multisectoral action; collecting and disseminating new information on urban health experiences, lessons learned and best practices; promoting capacity building for urban health planning, implementation, surveillance, and information systems; and supporting Ministries of Health in engaging city and metropolitan authorities and others in important issues outlined in these documents.

We expect that this booklet will be a useful tool for you to mobilize all sectors of government, NGOs and civil society, as well as the private sector on national, regional and municipal levels so that many of the anticipated issues related to urbanization and health can be avoided or ameliorated. It is imperative that action be taken now to prevent or reverse the negative impacts of urbanization on health and to capitalize upon the potential stewardship role of the health sector to make this happen. The future is in your hands. Let's make it a healthy one.

PAHO 51st Directing Council

26–30 September 2011

Resolution CD51.R4

Strategy and Plan of Action on Urban Health

Pan American Health Organization
Regional Office of the World Health Organization

51st DIRECTING COUNCIL
63rd SESSION OF THE REGIONAL COMMITTEE

Washington, D.C., USA, 26-30 September 2011

CD51.R4 (Eng.)
ORIGINAL: ENGLISH

RESOLUTION

CD51.R4

STRATEGY AND PLAN OF ACTION ON URBAN HEALTH

THE 51st DIRECTING COUNCIL,

Having reviewed the *Strategy and Plan of Action on Urban Health* (Document CD51/5);

Recognizing that there are numerous Governing Body mandates dating back to 1992 that highlight the need to address urban health issues and the inequities in health caused by urbanization in the Region, in addition to the opportunity offered by the Health Agenda for the Americas 2008-2017 and the PAHO Strategic Plan 2008-2012;

Recognizing that the urbanization megatrend has rapidly accelerated in the Region and countries have not been able to react and adjust their programs to the wide diversity of cultural, community, family, migration, and socioeconomic challenges posed by this urbanization process;

Having studied the opportunity presented to address many of the most challenging public health problems now confronting the countries in the areas of noncommunicable diseases, injuries, vector-borne and other communicable diseases, and the challenge of tackling the diverse population needs in urban settings, as highlighted in the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases;

Considering that the lack of adequate, systematic consideration of public health criteria in the largely unplanned growth of cities in the Region has resulted in an increase in morbidity and mortality and a widening of the equity gap within cities;

Understanding that, to succeed in advancing public health in the Region, the ministries of health will have to include information in their health surveillance systems that differentiates the gradient of health inequities and their causes and implications for national and city health policies, programs, and services;

Recognizing that achieving urban health is a multisectoral endeavor that involves concerted action to promote physical activity; design safe, effective and accessible public transport options; prevent and reduce injuries; reduce the harmful use of alcohol; and address the particular access and wellness needs of the most vulnerable groups, including children, older persons, and people with special needs;

Further recognizing that countries that adopt this holistic approach, in coordination and synergy with other plans of action, including those of the United Nations specialized agencies, are not only improving the health of their citizens but achieving important environmental and sustainability gains;

Bearing in mind that the implementation of the Strategy and Plan of Action means marshalling a unique combination of stewardship over the health system and its network of services and with the other social actors in urban settings to advocate for and adjust all manner of urban health services that can address the special needs of the social gradient and the heterogeneity of urban populations;

Having requested during the 50th Directing Council that the Pan American Sanitary Bureau prepare a preliminary strategy and plan of action to be presented to the 51st Directing Council,

RESOLVES:

1. To endorse the Strategy and approve the Plan of Action on Urban Health and support its implementation within the context of the specific conditions of each country in order to respond appropriately to the current and future needs and trends in urban health in the Region.

2. To urge the Member States to:

   (a) adopt the guidelines, tools, and methods developed by PASB and the Centers of Excellence to support their intersectoral stewardship role, the promotion of social participation, and health services reorientation;

   (b) support national, subnational, and local health promotion policies and programs, including the strengthening of social participation, with appropriate legal frameworks and financing mechanisms;

   (c) adjust surveillance systems according to national priorities to include determinants and indicators related to urban health, such as gender, age, sexual orientation, socio-economic status, migration conditions, race, ethnicity, indigenous populations, and homelessness and housing conditions;

(d) further the commitment of city and metropolitan authorities to healthy urban planning and development, with consideration of urban health and health equity in national and subnational health policies and plans;

(e) collaborate with city and metropolitan authorities in the development of transport policies and systems that prioritize safe walking, cycling, and public transport; and in urban design regulations and infrastructure that provide for equitable and safe access to recreational physical activity throughout the life course;

(f) assist city and metropolitan authorities with the use of assessment and action tools to address healthy and equitable urban planning and programs more effectively;

(g) raise awareness among key stakeholders and develop social marketing plans and programs;

(h) report back every two years on the progress made, with data for a mid-term evaluation at five years and a final evaluation at ten years;

(i) promote specific health promotion and sustainable development projects in communities, with a focus on vulnerable populations, to encourage social participation and intersectoral action.

3. To request the Director to:

(a) produce and disseminate public health criteria, guidelines, model policies, and legal frameworks for urban health planning, urban health services, and methods for achieving multisectoral action, including health impact assessment, health equity impact assessment, and cross-sector data collection and analysis;

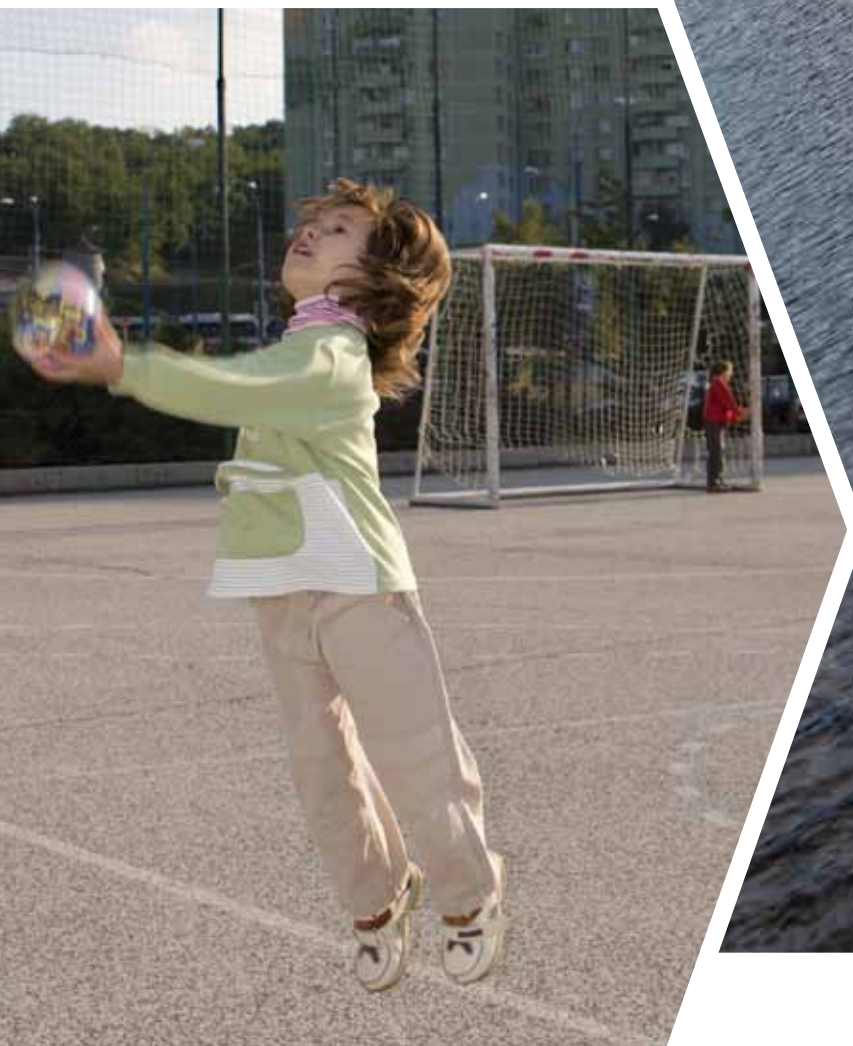
(b) collect and disseminate new information on experiences, lessons learned, and best practices obtained through regional forums, research, observatories, documentation, and the sharing of promising experiences and processes;

(c) further develop health promotion and health determinants approaches into technical cooperation in urban health and Country Cooperation Strategy implementation in the Member States;

(d) promote capacity building for urban health planning and implementation, surveillance, and information systems across the Region;

(e) support ministry of health engagement with city and metropolitan authorities and other relevant sectors, along the lines of the issues itemized in the final report of the roundtable discussions in the 50th Directing Council, the final report of the Urban Health and Health Promotion Forums, and the Global Call to Action on Urbanization and Health.

(Fifth meeting, 28 September 2011)



Pan American Health Organization
Regional Office of the World Health Organization

51st DIRECTING COUNCIL
63rd SESSION OF THE REGIONAL COMMITTEE

Washington, D.C., USA, 26-30 September 2011

Agenda Item 4.2

CD51/5 (Eng.)
27 September 2011
ORIGINAL: ENGLISH

STRATEGY AND PLAN OF ACTION ON URBAN HEALTH

Introduction

1. The health consequences of evolving changes in urban life present enormous challenges for the Region of the Americas. The purpose of this document is to offer guidance on ways for Member States to address urban health issues, particularly those related to health determinants, health promotion, and primary health care. Based on established policies and the agreements reached during the 50th Directing Council, this document first summarizes the information included in the background document for the Council containing the situation analysis. It then outlines a strategy and plan of action to guide the development of multisectoral activities to effectively address the key urban health challenges in the Region of the Americas. Finally, it discusses the implications for action by the Directing Council.

Background

2. Urbanization can have many benefits as well as adverse consequences, for human health and well-being. "Many of the problems of urban poverty are rooted in a complexity of resource and capacity constraints, inadequate government policies at both the central and local levels, and a lack of planning for urban growth and management. Given the high growth projections for most cities in developing countries, the challenges of urban poverty and more broadly of city management will only worsen in many places if not addressed more aggressively"(*1*). Unplanned, unsustainable urban growth puts pressure on basic services, making it difficult for governments to meet the needs of a diverse population with different behaviors and dynamics. Additionally, planning for Gross Domestic Product (GDP) growth instead of for people's well-being has resulted in favoring cars over people, greater development over the protection of natural resources, and the wasteful use of energy. Unplanned urban growth is accompanied by a number of risks, such as those related to environmental, social, and epidemiological factors and disasters (*2*) as well as conditions that affect the safety of the population. The intersectoral action required to confront these risks and their associated determinants has been addressed in three consultative conferences held in 2010 on

Health in All Policies in Adelaide, Chile, and Helsinki. Several resolutions, consultations, and documents on urban health, health promotion, and health determinants are pertinent to this Plan.

3. This Strategy and Plan of Action on Urban Health responds to a number of international and Governing Body mandates:

- The 1992 United Nations Conference on Environment and Development, popularly known as "the Earth Summit"; which issued the report *Protecting and Promoting Human Health Commitments*, whose Chapter 6: Agenda 21 discusses the challenge posed by urban health (*3*).
- Resolutions CD43.R11 (2001) of the 43rd Directing Council of PAHO, on Health Promotion in the Americas, and CD47.R20 (2006), on Health Promotion: Achievements and Aspirations Contained in the Ottawa and Bangkok Charters, both identify the need to work with all sectors of government and civil society to improve health conditions and promote equity.
- Resolution CD47.R1 (2006), Disability: Prevention and Rehabilitation in the Context of the Right to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health and Other Related Rights addresses the rights of persons with disabilities, including equal access to health care, education, housing, and employment.
- Resolution CD40.R6 (1997), Health of Indigenous Peoples, in the context of considering economic, geographic, and cultural barriers and monitoring the inequities experienced by indigenous populations, in accordance with Articles 17.2, 21.1, 23, 24.2, and 29.3 the UN Declaration on the Rights of Indigenous People (2008) *(4)*.
- Resolution WHA62.14 (2009), which considers the Report of the WHO Commission on Social Determinants of Health (2008), highlights the need to address inequities deriving from social determinants, including urbanization and calls for national policies and methods to address them (*5*).
- Documents CD47.18 (2006), Regional Strategy and Plan of Action on Nutrition in Health and Development 2006-2015, and CD47/17, Rev 1, Regional Strategy and Plan of Action on an Integrated Approach to the Prevention and Control of Chronic Diseases, including Diet, Physical Activity, and Health, both consider the urban planning sector to be a key partner in addressing noncommunicable diseases and other health issues.
- Resolution CD48.R11 (2008), Preventing Violence and Injuries and Promoting Safety: A Call for Action in the Region, requested that urban health initiatives be strengthened to help prevent injuries in the Region.
- Resolution WHA57.10 (2004), Road Safety and Health, recognized Resolution WHA27.59 (1974) and considered the *World Report on Road Traffic Injury Prevention* of 2004, calling for intersectoral collaboration to integrate traffic injury prevention mechanisms into public health programs.
- Resolution WHA62.12 (2009) on primary health care (PHC), notes that the WHO *World Health Report 2008* identifies urbanization, along with globalization and the aging of the population, as the

challenge for adapting PHC and calls for the adoption of appropriate local health care delivery models that include health promotion and disease prevention (*6*).

- Resolution CD50.R16 (2010), Health, Human Security, and Well-being, in the understanding that human security is affected inequity, environmental factors and the threat to groups in situation of vulnerability.

4. Ministers of health participating in the 50th Directing Council (2010) (*7*) requested that the Pan American Sanitary Bureau (PASB) prepare a preliminary regional strategy and plan of action on urban health as an outcome of their participation in the urban health roundtable (*8*). They also requested that a resolution be drafted so that after discussion of the preliminary version, the plan can be presented to the delegations for their approval during the 51st Directing Council. This document serves to respond to both of those requests.

5. The roundtable discussion during the 50th Directing Council was followed by the regional forums on urban health and health promotion (October 2010), which yielded a number of the recommendations (*9*) included in this Strategy and Plan of Action. The Global Forum on Urbanization and Health was subsequently held in Kobe, Japan (WHO November 2010), during which WHO-UN HABITAT launched the joint report *Hidden Cities* (2010) revealing how poverty and poor health are linked to urban living (*10*), and a Call to Action on urban health was issued (*11*). Elements from both of these documents have also been included in this Strategy and Plan of Action.

Situation Analysis[1]

6. The world is becoming urbanized at an unprecedented rate posing an enormous challenge to health (*12*): in 1900, 13% of the world's population (220 million people) resided in cities; in 1950, the urban population represented 29.1% (732 million) of the population (*2*). In 2008, the United Nations reported that for the first time in history, more than half the human population is living in urban areas, with that proportion expected to rise to 70% by 2050 (*13*). This trend is of particular concern in the Americas; the Region's urban population has grown by 187% since 1970. The Americas are home to six of the world's largest megacities (São Paulo, Mexico City, New York City, Los Angeles, Buenos Aires, and Rio de Janeiro). The Region of the Americas is the most urbanized in the developing world; 79.4% of the Region's roughly 556 million people live in urban areas, with that proportion expected to rise to 85%. Rapid unplanned urbanization amplifies the impact of climate change (*14*). Urban children are of special concern, and socioeconomically, less privileged children are frequently found playing or even living and working on the streets (*10*). One of the main causes of concern is the fact that 30.8% of the urban population lives in irregular settlements spawned by rapid, unplanned urban growth.

[1] PAHO prepared two background documents in 2010, from which most of the information in this section has been extracted: Roundtable on Urbanism and Healthy Living. Background paper for the debate. CD50/19, Add. I (Eng.) 15 September 2010 (*12*); and *Urban Health Challenges in the Americas*. Reference document prepared for the Second Regional Urban Health Forum, New York, NY, 25-26 October 2010 (*9*).

7. The consequences of population growth and unplanned, uncontrolled urbanization has widened the social gap within cities and produced major poverty belts and slums due to a lack of employment opportunities, housing, security, and environmental protection (*15*). Two-thirds of the people living below the poverty line in Latin America and the Caribbean reside in urban and peri-urban communities. While the relative incidence of urban poverty in the Region fell from 41% in 1990 to 29% in 2007, the number of urban poor rose from 122 million to 127 million during the same time period (*12*). Cities in the Americas have attracted large numbers of indigenous people seeking economic and social opportunities. Mexico's Federal District is currently considered the main indigenous metropolitan area in the Americas (*16*). Cities like Chicago, Guatemala, Lima, Los Angeles, and many others have similar challenges addressing the cultural barriers that these populations face when attempting to gain access to services. Moreover, rapid urbanization has resulted in overcrowding, leading to the creation of slums and unsafe settlements and a lack of basic health and sanitation services, due to barriers to providing adequate infrastructure and essential services (*17*). In the Americas, by the year 2003 it was estimated that 5.1% of the population in the more developed countries was still living in slums, while the figure was 31.9% in the less developed Latin America and Caribbean countries (*18*).

8. Rapid, unplanned, and unsustainable urbanization also has a major impact on health. Conditions in urban settings can exacerbate the prevalence of a variety of vector-borne infectious diseases (*19*) and even neglected diseases (*20*). In the Americas, the infant mortality ratio of the 20% poorest to the 20% richest urban poor is 6:1 (*10*). Chronic noncommunicable diseases account for 74% of disability-adjusted life years (DALYs) lost, and obesity in urban centers is sharply on the rise, with an unprecedented increase in childhood obesity that is particularly alarming. Unhealthy diets and physical inactivity contribute to the rapid increase in childhood obesity. The recent WHO Global Status Report on NCDs 2010 (*21*) reiterates that unplanned urbanization is linked to higher risk of exposure to air pollutants, lack of basic services, more sedentary lifestyles, unhealthy diets, and lower levels of physical activity leading to cardiovascular disease, diabetes and other noncommunicable diseases, which affect the urban poor and the elderly to a greater extent. Information systems are not equipped to clearly differentiate socioeconomic gradients, vulnerable and indigenous populations, or often, even gender differences within cities. Data systems currently lack sufficient disaggregation of data about the impact of urbanization on men and women, ethnic groups, and migrants. In the future, such disaggregation should be available in the Region. The available information, however, supports the strategies proposed below.

9. There are three major contributors to the burden of disease in the Region: violence, alcohol abuse, and tobacco use. Violence in the Americas is concentrated in urban areas and is often clustered in the poorest, most marginalized areas of cities. The WHO *Multi-country Study on Women's Health and Domestic Violence against Women,* which included two countries in the Region, found high rates of violence in a major city in each country: 28% of women in São Paulo**,** Brazil, and 51% of women in Lima, Perú, reported having experienced physical or sexual violence by an intimate partner (*12*). Alcohol consumption is responsible for a heavy disease burden, surpassing global estimates; 5.4% of all deaths and 10% of all DALYs in 2002 were attributed to alcohol consumption, with most of the burden in Central and South America. Globally, men also have far higher rates of total disease burden (DALYs) attributable to alcohol than women—7.4% for men vs. 1.4% for women. Men outnumber women four to one in weekly episodes

of heavy drinking—most probably the reason for their higher death and disability rates. Men also have much lower rates of abstinence compared to women. In the Americas, women are twice as likely to be lifetime abstainers as men. Residence in urban areas has been associated with higher consumption rates (*22*). Lower socioeconomic status and educational levels result in a higher risk of alcohol-related death, disease, and injury—a social determinant that is more significant for men than for women (*23*).

10. In the Americas, as well as the rest of the world, tobacco use is the leading cause of preventable death, responsible for some 1 million deaths in the Region every year (*24*). Of all the chronic diseases, changes in tobacco policy could save more lives more rapidly. Urbanization is a key social determinant for smoking. Tobacco use is associated with low socioeconomic status, whether measured by national income, household or personal income, occupational status, or educational level (*25*). Data from the *World Health Survey 2003* indicate that smoking is most strongly correlated with household income or wealth. As opposed to other Regions of the world where males smoke an average of five times more than females, in the Americas smoking is two times more prevalent among males. In developing countries, smoking rates for men have peaked and have begun to decline, while they continue to rise for females (*26*). In addition, the degree of urbanization has been associated with tobacco use, being higher in more urbanized areas of developing nations, due to the greater exposure of urban populations to aggressive marketing and weak regulatory environments. For example, the ratio between urban and rural tobacco use is 1.8:1 in Mexico (*27*), although rates are starting to decline in most large metropolitan areas (*28*).

11. Traffic injuries are responsible for 142,000 deaths and an estimated 5 million injuries annually in the Americas. Age-adjusted mortality rates from traffic accidents vary widely from country to country, ranging from 4.3 to 21.8 per 100,000 (*12*). In the Americas, while high-income countries exhibit a 20% descending mortality rate, the trend in Latin America has been on the upswing, reaching 40% (*29*); the low-middle income countries in the Region have a 57% higher risk of mortality, with the risk being higher for individuals in the 5-14 age range (250%), as well as for children aged 0-4 (124%). In the developed countries of the Region, automobile crash fatality rates are higher in the lower-level socioeconomic groups (*30*).

12. Because of air pollution, every year in the Americas there may be as many as 93,000 deaths from cardiopulmonary disease, 13,000 deaths from lung cancer, and 58,000 years of life lost due to acute respiratory infections in children under 4 years of age, plus 560,000 DALYs lost (*12*). Studies in the Region have shown that exposure to air pollution is systematically unequally distributed, as demonstrated with children's exposure to exhaust fumes from traffic (*31*) and human exposure to ozone (*32*). For cardiovascular mortality, there is a higher risk ratio of 6-40%, depending on the exposure to exhaust fumes from traffic) (*33*). The serious public health impact of air pollution can be seen not only in terms of disease and death, but lower productivity, missed education, and other missed opportunities for human development as well.

13. In addition to health impacts, social inequalities are exacerbated in cities. While the Region has been making progress in equity, the evidence tends to average out the large inequalities within countries and cities. For example, in 2001, compared to national levels, the city of Buenos Aires, Argentina, was much better off, with lower rates of substandard housing (18.5% vs. 6.4%), unsafe water (21.3% vs. 1.9%) and

people who had not completed primary education (8.6% vs. 4.8%). However, large disparities in health are also found within the city itself: infant mortality ranges from 6.5/1,000 inhabitants in one urban zone to 16/1,000 inhabitants in another part of Greater Buenos Aires (*12*). Disparities also exist among countries: Honduras, Nicaragua, and Paraguay have higher percentages of urban poor: 55% to 63%, a situation far removed from that of Chile, where the figure is 18.5%.

14. The global megatrend towards urbanization is further complicated by problematic social, family, community, intercultural, and gender relations, all of which inequitably affect the health of the population, with particular impact on indigenous and Afro-descendent groups. So far, this dramatic change is not fully addressed in health policies, structures, and services; and it is creating a major disconnect between the population's needs and the health sector's response to them.

15. Urbanization offers significant opportunities for reducing poverty and gender inequality, promoting sustainable development, and advancing the protection of migrants and indigenous populations, while enriching the city culture by the same diversity of populations and improving the quality of life and well-being of the population. The final document from the Follow-up to the Outcome of the Millennium Summit 2010 (*34*), assessing Goal 7 "Ensuring Environmental Sustainability" to address poverty, calls for prioritizing national urban planning strategies with the participation of all stakeholders, promoting equal access for slums dwellers to public services, including health, education, energy, water and sanitation and adequate shelter. This Strategy and Plan of Action builds on examples of programs and policies that have been implemented in selected cities, addressing such topics as air and noise pollution, environmental change, healthy behaviors, healthy settings, spaces for recreation and physical activity, human security, inclusive urbanization, urban infrastructure, and violence. It proposes different options for tackling urban problems and adjusting programs currently under way to consider the social gradient and urban dimension as well as identification of the consequences of not doing anything, highlighting the benefits of urban living as a potential support for health and sustainability. It gives consideration to revising programs and improving the policies currently in place (*35*) to handle the heterogeneity of the urban population appropriately. It makes reference to the Millennium Development Goals; Healthy Municipalities, Cities, and Communities; Health Promoting Schools; PAHO's Cross-cutting Priorities; and other regional and national initiatives.

Proposal

16. The purpose of this Strategy and Plan of Action on Urban Health is to support the ministries of health in order to: (a) strengthen their stewardship role in promoting health in light of the effects of urbanization, (b) adjust health services to meet the specific needs of urban populations, and (c) strengthen the institutional capacity to implement an urban health approach, and (d) advocate for a common goal and shared responsibility.

17. To address the specific needs of the urban population, PAHO's strategy on Stewardship, Health Services, Development of Institutional Capacities and Advocacy for Urban Health (SHEDA) is needed to strengthen ministries of health, using four basic entry points to achieve an integrated, synchronous, regional approach, by making progress in the following areas:

(a) *Assuming Stewardship for Promoting Health*: provide health personnel, city authorities, and key partners from other sectors with the guidance and tools they need to buttress their health- and wellness-promoting activities across the entire social gradient:

- Revitalize the engagement of local authorities and the insights of cities in analyzing and responding to local health conditions using intersectoral and participatory approaches.
- Support the solidarity, partnership, knowledge exchange and identification of leadership and opportunities of cities through the strengthening of Healthy Municipalities / Cities Networks in the Region.
- Update and adjust the current guidelines and instruments for Mayors on Healthy Municipalities, Participatory Planning and Budgeting, and develop new ones to support their intersectoral capabilities.
- Address health and health equity in the policies of other sectors (Health and Health Equity in All Policies).
- Offer guidance on the health priorities to be addressed and guidelines for public health informed urban planning and action to be taken by other sectors.

(b) *Adjusting Health Services*: tailoring them to the needs of urban population, as appropriate, to respond to the dynamic and specific needs of diverse urban populations:

- Implement the primary health care strategy in an innovative manner to improve their accessibility to the different urban populations.
- Go where the people are, considering the specific needs of working mobile families that frequently have few transportation options.
- Address the issue of recently migrating families and indigenous populations and the barriers and difficulties they encounter in accessing adequate health services.
- Consider the size of the population working in the formal and informal sectors of the economy.
- Consider the differential hazards faced in daily living, including drugs, violence, sexual behaviors, among other.
- Include social protection for the entire population, especially the most vulnerable in terms of gender, socioeconomic status, immigration status, and race/ethnicity.

(c) *Capacity building and Policy Development*: design policies and interventions, inform evidence-based decisions, and improve human and financial capacities.

(d) *Advocating for a Common Goal and Shared Responsibility*: in equitable urban population health and well-being, with local and national governments, academia, the private sector, NGOs, and civil society.

THE PLAN OF ACTION ON URBAN HEALTH[2]

Principles

18. To respond to the specific health needs of the urban population in the Region of the Americas, this Plan of Action rests on five guiding principles: equity, sustainability, sustainable development, human security, and good governance.

Expected Results

19. Countries will have:

- An adjusted health system that addresses their urban population's health needs, taking mobility, gender, ethnicity, cultural diversity, and equity into account.
- Adapted their programs to address their social gradient.
- Adopted a coherent approach to promoting health that includes all aspects of government within their cities.
- Made significant improvements in the ability of individuals, families and communities to improve and maintain their health and well-being.

General Objective

20. The general objective of the Plan of Action is to strengthen the organizational capacity and stewardship role of the ministries of health in advocating for sustainable urban growth that puts human beings and communities at the center of planning objectives. It seeks to effectively tackle health inequities and to address the needs and capitalize on the assets of the entire spectrum of urban populations through policies, programs and services for families and communities living and working in urban settings. This requires public health authorities to coordinate their work with non-health sectors, professionals, and institutions directly linked to the planning and governance of urban development matters.

Specific Objectives

21. This is a 10-year Plan (2012-2021) that considers five specific objectives and subsequent activities that will help countries to improve the health of their urban populations and become accountable for the outcomes of related national and city policies and programs; and the Secretariat to adjust its programs and support countries in these initiatives.

[2] At the current time, there is only partial information for fully defining the base lines and targets for some indicators. At the conclusion of the first year of the plan's execution, a review will be conducted to complete the information, and at the same time, this plan will be aligned with the Strategic Objectives and Indicators of the Organization's Strategic Plan 2013-2017.

Specific Objective 1: *Develop urban health policies.*

Indicator

- Number of countries with national development plans and policies at the national and subnational levels, as appropriate, that introduce health and health equity into urban development. (Baseline: 6.[3] Target: 18.[4])

Activities

1.1 Prioritize the integration of health into city, metropolitan, and national policies, encouraging every country in the Region and, in the case of countries with federal systems of government, of states or provinces, to have an explicit urban health policy, strategy, and plan that addresses social determinants and includes the development and maintenance of healthy settings and human security, including safe places for recreation and physical activity.

1.2 Engage and partner with other non-health government sectors and industry, introducing health and health equity into all urban policies, incorporating organizational, legal, and financial mechanisms that will provide coherence across multiple urban health policies and plans, including concrete policies in the areas of sustainable urban growth, balanced land use mix, greater street connectivity and mass transit, the protection of natural resources (agriculture, land, and water), sustainable energy use (with emphasis on recycling mechanisms), the creation of healthy conditions in specific industrial and tourist areas, and the effective assessment and management of inequities, cultural barriers, and health gradients.

1.3 Promote the inclusion of health impact assessments and health equity impact assessments into national, subnational, and local public and private policies, plans, and programs that influence urban development.

Specific Objective 2: *Adjust urban health services to promote health and improve coverage.*

Indicator

- Number of countries with a National Health Plan, and subnational health plan, as appropriate, integrating an urban health equity framework, with consideration of vulnerable groups. (Baseline: 6. Target: 25.)

Activities

2.1 Include within the National Health Plan and, in the case of countries with federal systems of government, of states or provinces, the special consideration required to address the health needs in cities.

[3] Baseline data on this and the remaining indicators is supported by the available information identified from 11 countries.

[4] 10 year targets are developed on the basis of the information available.

2.2 Improve the structure of health services provided to urban populations, promoting their health, giving priority to prevention, and enhancing their effective coverage and social protection according to the social gradient, especially population in vulnerable situations such as slum-dwellers, indigenous populations, and recent migrants. Special consideration should be given to continuing protection for migrants residing outside their home area.

2.3 Adapt public health programs to urban settings, developing and using guidelines that help them explicitly consider the environmental, social, and behavioral risks, cultural diversity, and protective factors of urban populations.

2.4 Introduce health-promoting instruments to develop personal skills and foster community action that strengthens healthy assets, and build protective environments to improve human security among individuals, families, and communities in the urban health context.

Specific Objective 3: *Construct health-promoting normative frameworks and participatory governance strategies.*

Indicator

- Number of countries that apply PAHO's public health guidelines for urban health planning. (Baseline: 3. Target: 18.)

Activities

3.1 Establish a national process to disseminate and apply in cities, public health guidelines and criteria that ensure the institutional and legal foundation for urban and housing planning based on public health criteria, equity, and informed community participation.

3.2 Engage and build community organization and empowerment in the assessment and planning of urban development, especially for slum-dwellers, indigenous populations, and recent migrants.

3.3 Establish explicit organizational settings for the ongoing inclusion and accountability of intersectoral and social actors.

Specific Objective 4: *Expand national and regional networks for healthy urban development.*

Indicator

- Number of countries with national healthy municipalities network applying PAHO's Healthy Municipalities Toolkit in communities with more than 100,000 inhabitants. (Baseline: 5. Target: 24.)

Activities

4.1 Buttress and stress the urban health component in national and regional networks and build upon and through existing regional networks such as the Network of the Americas for Healthy Municipalities, Cities and Communities; Health Promoting Schools; Healthy Housing; Faces, Voices, and Places; and global networks such as Safe Communities.

4.2 Integrate the urban health dimension into sustainable development and climate change initiatives.

4.3 Identify and involve regional players in urbanization, pooling the interests and capacities of other agencies and public health and urban planning professionals.

Specific Objective 5: *Strengthen knowledge, capacity, and awareness to respond to emerging urban health challenges.*

Indicators

- Number of countries with surveillance systems that include indicators for urban health. (Baseline: 4. Target: 15.)
- Number of countries that apply guidelines on assessment and action tools for health impact and/or health equity impact assessments in national or city policies, programs, or projects. (Baseline: 3. Target: 15.)

Activities

5.1 Develop guidelines and indicators for surveillance systems, including urban health determinants and determinants of the differential social distribution of health indicators, including the disaggregation of data by gender, migration conditions, and indigenous populations.

5.2 In synergy with the efforts by the WHO Centre for Health Development, establish a regional mechanism, such as an observatory and regional forums, that systematically mines urban health data, experiences, health service innovations, and best knowledge, policies, and practices, promoting city/metropolis-to-city/metropolis collaboration and interchange within the Region, with special emphasis on improving the documentation on disparities and inequities, slums, indigenous populations, and recent migrants, and working through the modification of their health determinants.

5.3 Establish effective mechanisms for transferring information to bring rigorous, updated knowledge into the design of urban health policies and interventions.

5.4 Build closer ties with academicians and universities, fostering action by collaborating centers, promoting the funding of pertinent research, as identified from observatories and practice related to the impact of urbanization on health and the social gradient.

5.5 Build capacity for urban health action, including the development of human and financial resources for the effective development and negotiation of integrated urban health policies and interventions.

5.6 Apply evidence-based advocacy and social marketing approaches to target specific audiences for the needed changes to improve urban health.

22. This document is intended to cement PAHO's role in anticipating emerging urban health issues and ways of addressing them through multisectoral and multilevel action at the regional, national, and local levels.

Monitoring, Assessment, and Evaluation

23. Derived from the proposed specific objectives, monitoring the Plan and reporting on its progress will refer to changes over time, with the baseline information used to benchmark their progress. It is expected that these elements will serve as a stimulus for countries to begin collecting data where there currently is none and that countries will report with whatever data they have available at the time. Indicators are included with each specific objective that will serve as the basis for this monitoring, assessment and evaluation process.

24. This Plan of Action contributes to the achievements of Strategic Objectives (SO) 3,[5] 6,[6] 7,[7] and 8[8] of the PAHO Strategic Plan.[9] The specific Region-wide Expected Results to which this Plan of Action contributes are detailed in Annex C. The monitoring and assessment of this Plan will be aligned with the Organization's results-based management framework as well as its performance, monitoring and assessment processes. In this regard progress reports will be developed based on information available at the end of a biennium.

25. With a view to determine strengths and weaknesses of the overall implementation, causal factors of successes and failures, and future actions, both a midterm and final evaluation will be conducted.

Action by the Directing Council

26. The Directing Council is requested to examine the Strategy and Plan of Action on Urban Health and consider the possibility of approving the proposed resolution included in Annex A.

[5] SO 3: To prevent and reduce disease, disability and premature death from chronic non-communicable conditions, mental disorders, violence and injuries.

[6] SO 6: To promote health and development, and prevent or reduce risk factors such as use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex, which affect health conditions.

[7] SO 7: To address the underlying social and economic determinants of health through policies and programs that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches.

[8] SO 8: To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health.

[9] For more information please consult the PAHO Strategic Plan.

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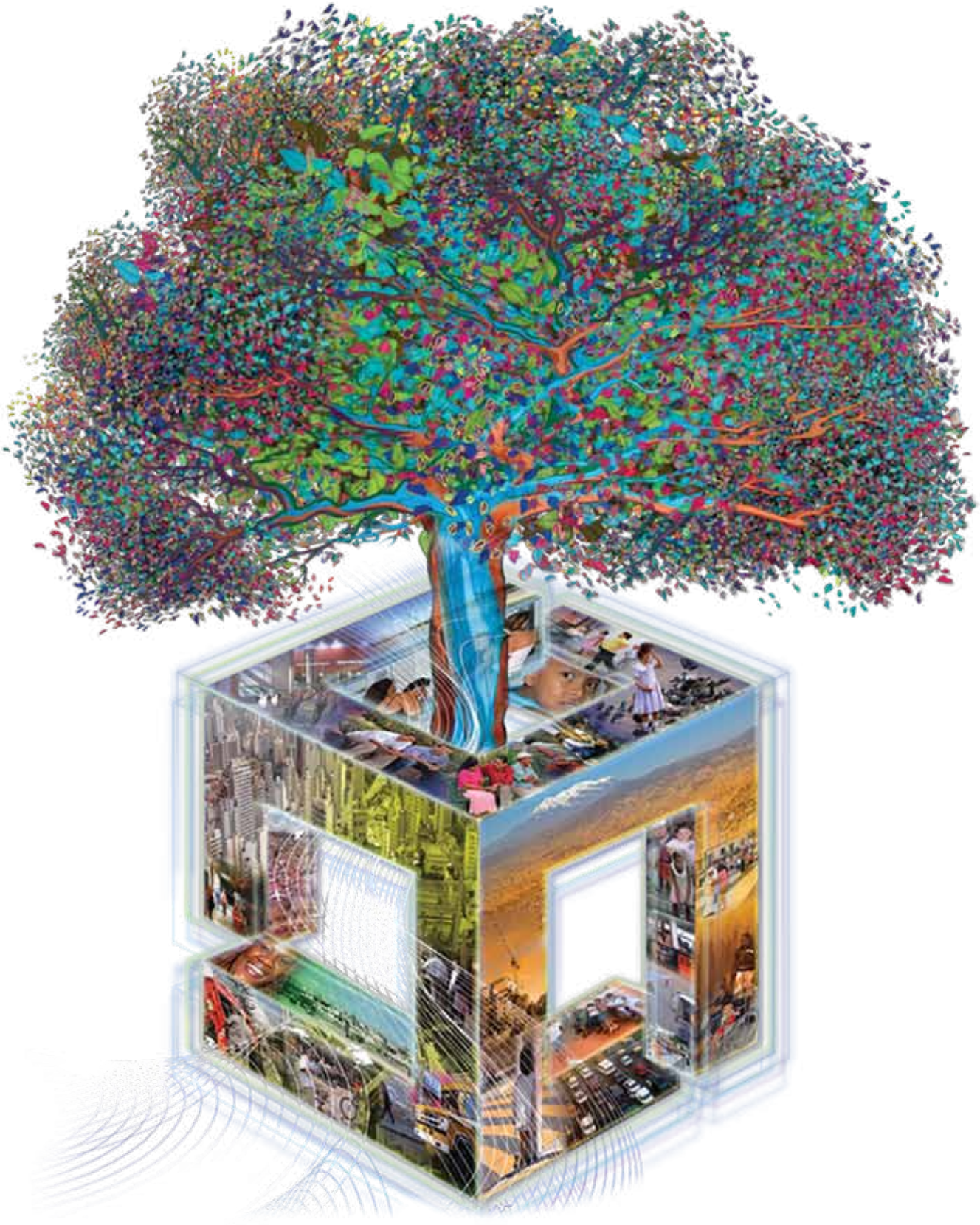


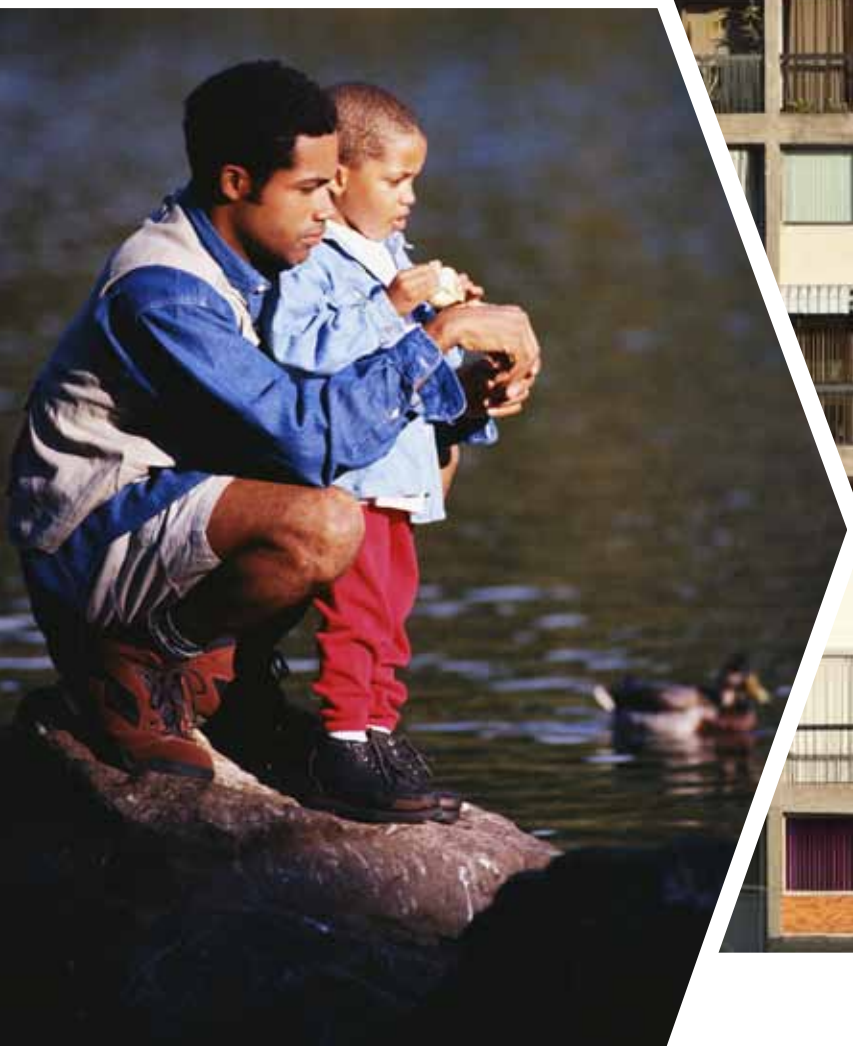
PAHO 50th Directing Council

27 September–1 October 2010

Roundtable on Urbanism and Healthy Living

Add. I: Background Paper for the Debate

Add. II: Final Report



Pan American Health Organization
Regional Office of the World Health Organization

50th DIRECTING COUNCIL
62nd SESSION OF THE REGIONAL COMMITTEE

Washington, D.C., USA, 27 September – 1 October 2010

Provisional Agenda Item 4.15

CD50/19 (Eng.)
26 August 2010
ORIGINAL: SPANISH

ROUNDTABLE ON
URBANISM AND HEALTHY LIVING

Background

1. World Health Day (WHD) is celebrated annually on 7 April, the day which marks the anniversary of the founding of the World Health Organization (WHO). In recent years, a roundtable on the theme of that year's World Health Day is included on the agenda of PAHO's Directing Council. It is an opportunity to draw worldwide attention to a subject of major importance to global health. "Urbanism and Healthy Living" is the theme of WHD this year and will be the topic of the roundtable at the 50th PAHO Directing Council.

2. Improving urban health is a mandate that originated from the Rio 92 meeting. A focus on finding a solution to the problem of urban health can be found in chapter 6 of Agenda 21: Protection and Promotion of Human Health *(1)*. In 2005, the Report of the Secretary-General of the United Nations: "In larger freedom: towards development, security and human rights for all," *(2)* highlights the need for freedom to live without misery in the face of the challenge of urban development: creation of jobs, improvement of slum neighborhoods, and a search for alternatives to prevent the development of such neighborhoods.

Situation in the Region of the Americas

3. By 2030, three-fifths of the world's population will reside in urban areas. Evidence suggests there will be even greater inequality in health in the future. The majority of urban dwellers will live in cities in Asia, Africa, and Latin America. Such cities are becoming ever more impoverished relative to the industrialized countries. It is predicted that this future urban shift will be characterized by greater movement of populations toward urban centers; slums will be home to a greater proportion of the world's poor; and these expanded cities will create a dramatic impact on the environment and human health *(3)*.

4. Since the 1980s, a number of studies have been conducted on urban health or healthy cities *(4-10)*. These studies have evaluated aspects of: health in the world's cities, environmental factors, migration and immigrant health in cities, city health systems and services, equity, local governance, urban policy and planning, social innovations, care for the poor and hungry, and urban violence. The Region of the Americas has the largest economic disparities in the world. Disparities in social, political, climatic, and ethnic conditions also exist, especially in urban settings.

5. Urban health problems cannot be resolved by the public health sector alone. The problems are a consequence of the interaction of many other factors, such as transportation and housing. The health sector can and should lead the dialogue for the development of public policies that will contribute to healthy populations. The urban approach requires going beyond what an individual or a family can achieve. Such urban efforts also require viewing the city as a whole complex of social and environmental determinants of health. It is clearly not sufficient to work in isolation with one sector, one population, or one institution.

PAHO/WHO Collaborative Efforts

6. Since 2003, PAHO has promoted a series of activities in order to establish a common strategy that responds to urban health problems. Profiles of some cities of the Region were prepared and presented at the First Regional Urban Health Meeting in Santiago, Chile in 2004. At the same meeting, the first conceptual document, with the title "The City of Citizens," was presented *(11)*.[1]

7. In collaboration with its partners, PAHO presented a framework document on urban health at the first meeting of the Urban Health Forum in Mexico in 2007 *(12)*.

8. Related to urban health, for years PAHO has been working on health promotion, especially through healthy setting initiatives such as Healthy Municipalities and Health Promoting Schools, among others.

9. PAHO observed World Health Day 2010 by including the WHO *1000 Cities, 1000 Lives* Campaign.[2] PAHO joined WHO and UN-Habitat in drafting the *Global Report on Urbanization and Health*; in the World Urban Youth Assembly, jointly organized in Brazil with UN-Habitat during the 5th World Urban Forum; and in Expo 2010 in Shanghai, China. Moreover, this year PAHO will participate in the Global Forum on Urbanization and Health in Kobe, Japan and prepare a report on the regional urban health situation, to be completed in time for analysis at the second meeting of the Second Regional Forum on Urban Health and the Third Regional Forum on Health Promotion, slated for October.

[1] Document produced for the Pan American Health Organization consultation on urban health, Chile, May 2004.

[2] *1000 Cities, 1000 Lives* is a global initiative coordinated by the WHO Centre in Kobe, Japan, to encourage cities, towns, neighborhoods and individuals to conduct health-promoting activities on or around WHD. For more information, visit: www.paho.org/whd2010.

Attendees

10. Public health officials from Member States attending the Directing Council will be joined by representatives of academia, United Nations agencies, and civil society organizations.

Program Format

11. The roundtable will be of two hours duration and will be organized, as follows:
    - Opening session
    - Discussion panels
    - Presentation of the report during the plenary

Opening session (30 minutes)

- Opening remarks by the President of the Directing Council.
- Presentation on global urban health by Dr. Jacob Kumaresan, Director of the WHO Center in Kobe
- Opening conference on the improvement of the health in cities by a special guest.
- Explanation of the methodology for the discussion panels by Dr. Luiz A. Galvão, Manager of the Sustainable Development and Environmental Health Area, PAHO

Discussion Panels (60 minutes)

12. After the opening session, discussion panels3 representative of each of the subregions and taking language preferences into consideration, will be convened to discuss the pertinent elements of this topic.

13. All panels will discuss the following questions:

1. How to develop relevant intersectoral initiatives to modify health determinants in urban settings?

Consider:

- How to establish a common objective.
- What instruments are required to exercise health sector governance in urban settings.
- What the existing capacities are and the capacities that are needed to achieve it.

[3] Each panel will have a moderator, a motivational speaker, and a rapporteur.

2. ***What role the Ministry of Health's play in planning geared to a healthy future for cities?***

3. ***How should the health services and other relevant sectors act in managing cities to prevent and control the health risks associated with climate change?***

Consider:

- Actions in the medical services themselves.
- Integration of information for identifying the health impact of other policies linked with urban development.
- Competency, capacity, and methodology development.
- Instruments for creating synergies in other sectors relevant to urban development.

4. ***What needs to be done for the Pan American Sanitary Bureau and the Member States to provide support and follow up in this area?***

DISCUSSION GROUPS:

	Discussion Group #1
Moderator:	President of the Directing Council (TBD*)
Rapporteur:	Marilyn Rice, PAHO Adviser
Presentation of the discussion item:	Ministry of Health to be confirmed
Countries:	Antigua and Barbuda, Bahamas, Barbados, Belize, Canada, Dominica, France, Grenada, Guyana, Haiti, Jamaica, the Netherlands, Puerto Rico, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, the United Kingdom of Great Britain and Northern Ireland, and the United States of America
	Discussion Group #2
Moderator:	Directing Council Vice President (TBD)
Rapporteur:	Carlos Santos-Burgoa, PAHO Advisor
Presentation of the discussion item	Ministry of Health to be confirmed
Countries:	Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Portugal, Uruguay, and Venezuela
	Discussion Group #3
Moderator:	Directing Council Vice President (TBD)
Rapporteur:	Carlos Corvalan, PAHO Adviser
Presentation of the discussion item	Ministry of Health to be confirmed
Countries:	Costa Rica, Cuba, Dominican Republic, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, and Spain

* TBD: to be determined.

Presentation of the Report in Plenary Session (30 minutes)

14. The conclusions of the group discussions will be presented at a subsequent plenary session of the Directing Council.

Expected Result

15. The document with the discussions and conclusions will provide additional input and serve as the basis for PAHO to develop a regional plan of action on urban health with clear objectives, outcomes, and indicators for monitoring program implementation.

16. Report on the progress made in health by the countries of the Region, within the context of the United Nations Framework Convention on Climate Change.

Action by the Directing Council

17. The Directing Council is invited to participate in the roundtable and take note of the report and its recommendations, and, moreover, to disseminate its results in other forums.

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Pan American Health Organization
Regional Office of the World Health Organization

50th DIRECTING COUNCIL
62nd SESSION OF THE REGIONAL COMMITTEE

Washington, D.C., USA, 27 September-1 October 2010

Provisional Agenda Item 4.15

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ROUNDTABLE ON
URBANISM AND HEALTHY LIVING
(Background paper for the debate)

Urbanism: A Challenge for Public Health

1. The megatrend toward the integration and demographic growth of cities partly reflects the cultural, economic, and political dynamic of these spaces. The result of this trend is that, since 1975, the population in megacities (cities of over 10 million inhabitants) has tripled; in general, this has also occurred in cities of over 1 million inhabitants *(1)*. The world is becoming urbanized at an unprecedented rate: in 1900 13% of the world's population (220 million people) resided in cities; in 1950, the urban population represented 29.1% (732 million); while in 2005, 49% of the population lived in urban areas, that is, 3,171 million people *(2)*. This trend is very marked in the Americas, the region with the highest degree of urbanization and whose cities are the most crowded in the world. This translates into growth in the number of small, medium, and large cities, and their burgeoning into metropolitan areas and megalopolises. Latin America and the Caribbean (LAC) have undergone an early and rapid transition in comparison with other, similarly developed regions, with the urban population growing from 42% of the total in 1959 to 77% in 2005 *(1)*.

2. The proportion of cities with over 20,000 inhabitants is higher in Latin America than in Europe. In 2010, 79.4% of the population of the Region of the Americas is living in urban areas, and most of the future population growth is expected to take place in cities (*2*). In the Region of the Americas, six of the largest urban areas are megacities, with two in Brazil (São Paulo and Rio de Janeiro), two in the United States (New York and Los Angeles), one in Argentina (Buenos Aires) and one in Mexico (Mexico City). Other major cities are Bogotá (Colombia) and Lima (Peru), each of which has over 8 million inhabitants, followed by Santiago (Chile) and Belo Horizonte (Brazil), with 6 million each (*2*). Although these large cities continue to grow, medium-sized cities in the Region (generally with populations ranging from 2 to 5 million) are currently exhibiting the greatest population growth rates.

3. The socioeconomic and political development of medium-sized cities in the Region is lower than that of large metropolitan centers. A study on poverty and precarious living conditions in the cities of the Region by the Economic Commission for Latin America and the Caribbean (ECLAC) shows that, since 1995, the highest proportion of poor families has been found in medium-sized cities *(3)*. In 2001, 127 million people, representing 33% of the Region's population, lived in poor neighborhoods; that is, 35% of the population of South America and 24% of the population of Central America and the Caribbean *(4)*.

4. Cities attract people because of their potential opportunities to improve people's quality of life and well-being *(2)*. Cities create economies of scale, resulting in the availability of educational services, knowledge, medical care, and food. Moreover, industrial growth offers opportunities for paid employment. The concentration of technology and supplies, as well as professionals, for the delivery of medical services in the Region is very unequal between urban and rural environments. For example, there are 8 to 10 times more physicians in cities than in rural areas *(5)*: in Argentina, the ratio is 10:1; in Paraguay, 16:1; in Nicaragua, 27:1, in Peru, 5.3:1, and Colombia 2.4:1 *(6)*. In Canada, in 2004, only 9.4% of physicians worked in rural areas, where 21.1% of the population resides. In 2005, a Health Department study showed a concentration equivalent to 80% of all physicians and 87% of specialists in cities, where only 59% of the population resides. *(7)* Overall, in the United States of America, the urban-rural ratio for primary care physicians in 2005 was 1.5:1, while that of specialists was 2.4:1 *(8)*. In Mexico a 2005 study showed that in the state of Chiapas, where 54% of the population is rural, there were 0.79 physicians per 1,000 population, while in Mexico City, where 99.5% of the population is urban, the figure was 3.03—that is, a ratio of 3.8:1 *(9)*. A 2002 report published in Uruguay complements the picture *(10)*. Brazil has 6 physicians per 10,000 population in the North region, 8 per 10,000 in the Northeast, and 21 per 10,000 in the Southeast. In Guatemala, the rural-urban ratio is 4:1. In Argentina, the ratio between the city of Buenos Aires and Tierra del Fuego is 10.13:1. Thus, city populations have higher income levels; in 2007, poverty among the rural population in Latin America was 53% higher than among the urban population *(2)*. The majority of people in large cities have access to basic services; people live longer, with average life expectancy now at 75 years. The majority have enough income to purchase durable goods such as televisions and audio equipment, and cities have increasingly built parks and other recreational facilities *(2)*.

5. In LAC, the rapid and unexpected growth process is exceeding the capacity to provide these services, while in the cities the complexity and turbulence of an interdependent and unequal world are becoming exacerbated. Although more services are available in the cities, there is also greater labor market flexibility and lack of job security. In cities, inequalities in access to infrastructure services *(2),* housing, and the economy are intensified. Unexpectedly high urbanization is a serious concern for certain vulnerable populations and is rapidly creating a humanitarian crisis. Thus, this year, 30.8% of the inhabitants of urban areas in Latin America and the Caribbean live in poor neighborhoods lacking basic public services *(2)*. In these neighborhoods, there are no water and sanitation, waste disposal, transportation, energy, health care, or education services, nor is there protection against poverty, violence, injury, or high morbidity and mortality.

6. The "urban" context, which poses so many challenges, also reflects the permeability of societies and the complexity of political agendas, as well as the proliferation of networks and coalitions that have power and influence *(11)*. Urbanization not only differentiates populations in terms of the traditional rural-urban

dichotomy, but also intensifies heterogeneity in the conditions that determine the health status of urban residents, in terms of both their distribution and the dynamics of inequity. These differences are not always seen in the data compiled and used by the ministries of health *(12)*, as they treat the entire population as a homogeneous unit. Where information does not reflect the differences in the population, the response of the health system is not sufficiently adapted to the urban condition and its social gradients, nor is it possible to find appropriate language for interaction with direct stakeholders.

7. Buildings, transportation, energy supply, industry, the demand for food transport, and waste management in cities have a profound impact on the climate. *(13)*. Similarly, the cities of the Americas are exposed to the health implications of factors related to climate, such as hurricanes, disease-transmitting vectors, extreme temperatures, and more. It is calculated that natural disasters related to climate change cost the affected countries around 0.6% of their GDP *(14)*. In some countries, such as Brazil, it has been documented that health facilities consume around 10% of the total of the energy produced in the country *(15)*. As a result, the PAHO White Paper *Protecting Health from the Effects of Climate Change in the Region of the Americas (15)* includes elements of a regional plan, in which the specified actions represent a framework for national plans *(16)*; they include specific recommendations for actions designed to protect urban health. Tackling the complex current and future challenges that urban contexts pose for human and environmental health demands a change in our way of thinking and acting with respect to society's role in urban settings and also a greater understanding of the forces and relations that will shape cities in the long term.

The Burden of Urbanism on Health

8. In cities, population is not distributed uniformly, particularly in the Latin American context (*2*). There are visible differences between residential zones for rich and poor, with well-constructed houses and makeshift dwellings, many of the latter built by the residents themselves. The poor have different levels access to urban services in terms of their affordability and accessibility; potable water is still scarce in three out of four homes in some Latin American countries, and sewage disposal is lacking in 50% of homes *(2)*. Due to the growing number of irregular settlements in the Region, almost 50% of the population of the Region now lives in such settlements *(18)*. The structure and the size of this type of settlement negatively impacts social, family, community, and gender relations; moreover, their tendency to attract migrants has significantly undermined the social support available.

9. The distribution of the immediate health determinants varies considerably among urban populations. These determinants include access to health services and affordable nutritious food; the availability space for physical activity *(20)*; alcohol, tobacco, and illegal drug use; and exposure to toxic chemicals *(19)*. Urban transportation and production conditions lead to changes in air, water, and soil quality *(19)*. Although disaggregated information for the Region is unavailable, roads are clearly less safe in the cities and even worse in smaller towns.

10. Thus, urbanism creates a specific burden for health care services, since they must ensure equity when dealing with chronic noncommunicable diseases, such as cancer, diabetes, respiratory disorders, cardiovascular disease, and mental illness and with diseases resulting from environments conducive to communicable diseases, such as sexually transmitted diseases, HIV/AIDS, dengue, yellow fever, and

tuberculosis. Obesity in LAC is greater in urban areas and areas with higher poverty *(21)*. Urbanism is also a determinant of injuries from traffic accidents, which cause no less than 3.2% of DALYs (disability-adjusted life years) in the Region, and violence. The homicide rate in the Region, 27.5 per 100,000 population, is the highest in the world *(12)*. Its social determinants have been studied, and mortality has been documented at 23 to 62 per 100,000 population in locations marked by medium and high levels of poverty and high population density; this figure is much higher than that of locations with low levels of poverty and high levels of urbanization, with rates from 3.0 to 7.7 per 100,000 population *(22)*. Injuries and violence contribute to the perception of insecurity, which has an impact on mental disorders (anxiety and depression) in individuals and families living in poor urban neighborhoods *(11)*.

The Cost of Urbanism for Health

11. Urban living conditions entail social, financial, and political costs for health systems and families. To address these conditions of urban life, it must be understood that this is a large-scale problem due to the number of people affected and the vulnerability of cities. For example, the impact of air pollution each year costs São Paulo some 28,212 years of healthy life *(23)*; the concentration of people in Mexico City accelerated contagion and the spread of influenza A (H1N1), costing the country almost 0.5% of its GDP *(24)*; floods such as the one in New Orleans, in the United States, and earthquakes, such as those in Port-au-Prince, Haiti, and Chile. The main social and political responsibility to act to protect the population in critical conditions like these rests with the authorities and the health services, which should be at the forefront of every pertinent social and intersectoral response.

The Importance of Influencing the Future of Cities from the Health Sector

12. The environment constructed by human beings defines the health situation. In LAC there is a mix of cities, some very well-established and others where the regularization of irregular settlements is under way; this process implies policy decisions about the construction of new dwellings, basic sanitation, the design of transportation alternatives, energy, waste management, and industrialization. Once infrastructure has been constructed, it is very costly to modify; to a great extent, infrastructure defines the nature and culture of a society, its relations, and its impact on environmental quality and the population's health outcomes.

13. Given the current phase of development in the cities of the Region, there is a great opportunity to develop a design more favorable to population health. Therefore, acting now to help define the future of the city is an investment that will yield results in the short and medium term and can influence the level of well-being, quality of life, functional capacity, and health of the population. Urban planning capacity remains limited throughout the Region. There are only are 27 universities with urban planning programs in all of Latin America, compared with 88 in the United States alone. Ministries of health should play a key role in urban planning activities *(20)*, linking them with public health criteria beyond the traditional geographical distribution of health care services; this link should be structured from its legal foundations up through the implementation stage. Within this context, consideration should be given to the recent guides issued by WHO *(25)*, which include training schemes, financial incentives, regulatory mechanisms, and other nonfinancial mechanisms to encourage rural practice, as well as models to functionally link rural areas

with urban medical services, as is being attempted with the medical services themselves under the direct leadership of the ministries of health, linking specialized services virtually or through medium- and long-term planning methods with the purpose of bringing services closer to the people *(27)*.

The Response within the Health Sector Itself

14. Within the health sector as such, it is necessary to have adequate models for health care services that reflect the resources and challenges posed by urban complexity. Services must be closer to the population, as well as timely, and should be capable of going where the people are, especially when it comes to primary care; staff should be trained to work in urban environments, using appropriate technologies to help reduce inequalities. This is particularly important in the case of poverty mitigation programs *(28)*, health programs for industry, and school and university health services. The models should address issues of social and institutional capacity as well as the health needs of the urban population. Activities for health promotion and the regulation of environmental determinants must also be responsive to urban conditions, as well as to their own environmental impact.

Response of other sectors with respect to health

15. Ministries of health must use their resources to affect health determinants that are driven by other sectors and reduce the greatest burden of disease at its origins. To this end, they exercise their steering role, which includes *(29)* generating information and performing urban health surveillance, developing socioeconomic indicators that reveal differences within cities and with the rest of the nation; producing health guidelines and standards for use in urban planning and development; and incorporating health impact analysis methodologies into the design of urban development policies, programs, and projects. Ministries of health should take advantage of the context of city administrations, which bring multiple sectors together under a mayor or governor, to incorporate needed health perspectives *(30)*.

Next Steps

16. In the roundtable discussion, the ministers of health will have to analyze the opportunity that cities offer for improving the health of the large populations they contain: the benefit can be substantial. This means discussing the elements needed to define urban health policy that can be used to integrate public health criteria into urban planning. Within this steering action the following should be considered: health surveillance systems that differentiate the social status of populations and their degree of urbanization; and innovative health service design and operation, with different models for people and families living in the urban context. For the ministries to exercise their steering role, they will have to consider analyzing the impact of the activities of other sectors on health, and from there undertake integrated action to promote a better quality of life for urban populations. It falls to the Ministry of Health to serve as the catalyst for this multisectoral work, with technical support and relevant standards and guidelines. We hope that the ministers of health will stipulate the need for a regional strategy or plan, to be implemented by the Bureau, that can serve as the framework for future processes and better guide its work.

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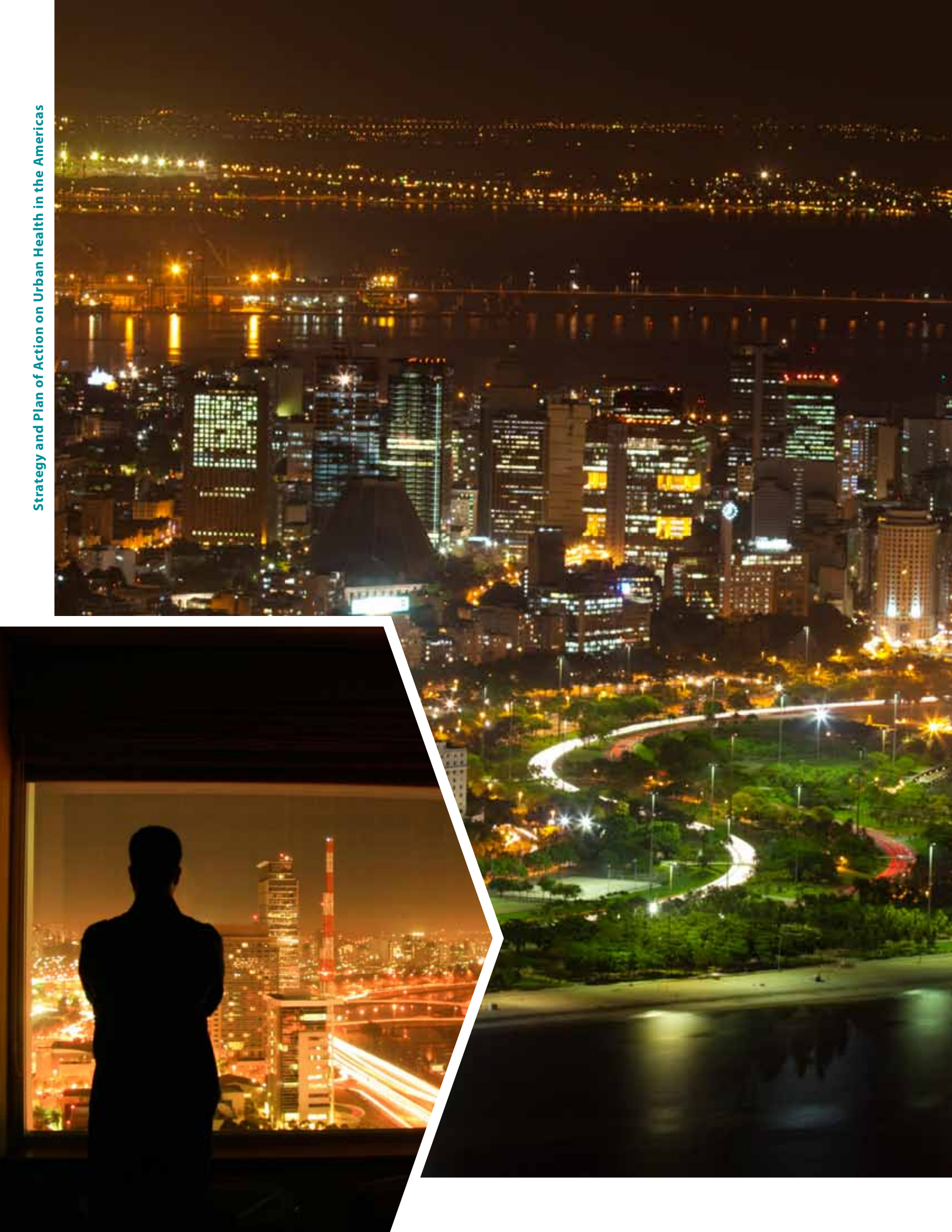

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ROUNDTABLE ON URBANISM AND HEALTHY LIVING

Final Report

Introduction

1. During the 50th Directing Council of the Pan American Health Organization, the Member States participated in a roundtable to determine which activities they should be responsible for and which will require support from the Pan American Sanitary Bureau to implement the work program agreed to on 7 April 2010 during the celebration of World Health Day, whose theme this year was *Urbanism and Healthy Living*.

Summary on the justification for the item

2. The item on urban health is the result of a mandate arising from the 1992 United Nations Conference on Environment and Development, popularly known as the Earth Summit. Chapter 6 of Agenda 21 addresses the challenge posed by urban health. Urban health is a vital issue in the Americas, since 79.4% of the Region's population lives in urban areas. It is well known that Latin America is home to six of the world's largest megacities. One of the main causes of concern is the fact that 30.8% of the urban population lives in irregular settlements spawned by rapid, unplanned urban growth. Inequalities in the social distribution of well-being and resources are far more pronounced in rural areas than in the cities, representing a serious disadvantage for people living in the countryside in comparison with their city brethren. Nevertheless, it should be noted that this inequitable distribution of resources is also found within the cities themselves.

3. The Pan American Health Organization has been tackling this issue for a couple of decades through the Healthy Municipios movement, which is active in the majority of countries in the Region. PAHO has

participated and requested representation of the countries of the Region in the Knowledge Network on Urban Settings of the WHO Commission on Social Determinants of Health, the Global Research Network on Urban Health Equity, and the Roundtable for Urban Living Environment Research, these latter two entities sponsored by the Rockefeller Foundation. It has convened two special meetings to explore the issue of urban health (one in Chile in 2004 and the other in Mexico in 2007); this year it has promoted numerous activities and participated in several of them, especially the observance of World Health Day, which will be followed by the regional forum on urban health in New York and the Global Forum on Urbanization and Health in Kobe, Japan. It is within this context that the delegates of the Member States examined the relevant experiences and evidence, so that the roundtable participants could decide which activities should be adopted.

Summary of the background addendum

4. The health of urban populations poses an enormous challenge, not only because of the global megatrend toward the integration and growth of cities, but also because of the accelerated pace of this phenomenon. This trend has resulted in the growth of small cities and their fusion into large metropolises. There is a concentration of resources in cities with the potential to offer a greater supply of services than rural areas can provide, while at the same time offering more options for improving the quality of life and increasing well-being. Nonetheless, the Region's considerable social inequalities are exacerbated in the cities, where major inequities are found in housing, work, environmental quality, education, access to food, transportation, medical care, water and sanitation services, waste disposal, etc. Problematic social, family, community, and gender relations increase the complexity of the approach to these problems. The economic, industrial and transportation dynamic of cities and consequent energy consumption in themselves leave a significant climate footprint. This translates into major differences that, while evident in practice, are not consistently captured or detected by health information systems, even though they result in a direct burden of chronic disease, injury, violence, mental illness, and reemerging infectious disease that the health services must address and that poses a significant challenge for equitable health service delivery. These factors entail a high social, economic, and organizational cost.

5. To the extent that human settlements are regularized, there is still an opportunity, depending on the growth of the urban population, to influence the planning of new infrastructure and housing construction, the designation of green spaces, areas for social gathering and physical activity, modes of transportation, and other factors that have significant impact on health and the quality of life. The same can be said for the changes that must be made in cities. Hence, the importance of addressing health issues in urban planning. It will also be necessary to adopt a new type of planning for health services, especially primary care services, to make them accessible and useful to the dynamic urban population. It is therefore important to have appropriate models, especially for activities in the Region linked with poverty-reduction plans. In order to meet these objectives, the ministries of health must exercise their steering role and offer guidance to other sectors to ensure the construction of a positive environment for health by making public health criteria and guidelines and health impact assessment part of overall urban planning. In this process, the ministries must serve as a catalyst for including a health impact assessment of the activities of other sectors, making an integrated effort to promote a better quality of life for urban populations.

Results of the discussions on intersectoral initiatives

6. The President of the Directing Council introduced the item to encourage debate, underscoring the need to act in this area and the challenge of influencing the urban impact on urban health caused by climate change The presenters, Drs. Jacob Kumaresan and Dr. Nils Daulaire, discussed the global dimension, the successes achieved, the definition of national and local policies, and the development of methods and instruments that can be shared in the Region. During the roundtable discussions, the delegates of the Member States recognized that the urban dimension and, especially, the elements of equity, are fundamental to meeting the goals in health; this requires a different approach than that employed with health systems and the public health function. Growing inequity only leads to social instability and greater poverty. Health inequities in urban settings are particularly dramatic. Therefore, they must be systematically identified so that they can be addressed. Lack of differentiation conceals the peculiarities of urban heterogeneity and thus limits the efficacy of interventions.

7. Effective instruments and strategies must be identified to strengthen the health sector's links with other sectors in the urban environment, since sectors outside the health sector have a greater ability to affect health determinants in urban populations. However, institutional arrangements have not always been made to ensure that the influence and collaboration of other sectors are both vigorous and effective.

8. In the ministries of health, strategies, methodologies, instruments, and indicators for exercising the steering role and taking action need to be improved. This should begin with changes in information systems so that they distinguish the degree and conditions of urbanization and how they influence the economic and psychosocial situation of individuals and communities. These information systems should produce disaggregated data so that social trends in populations and territories can be discerned and not just averages, permitting mobile populations to be tracked and programs developed to address future needs, providing support not only with information but specific direct operations research that supports planning.

9. In order to move forward, national and local authorities should identify barriers to effective intersectoral action and their existing capabilities, which include their legislative capacity and the capacity to develop competencies to persuade and negotiate with people who do not necessarily have responsibility in the health sector or espouse its principles and values. Efforts should be made to identify the factors critical to success. The health sector will put these into practice based on the scientific evidence at its disposal to provide information that will serve as the foundation for the decisions of other sectors and to try to make urban health part of all public policies in cities.

10. It is necessary to raise awareness in various sectors about the link between the built environment and health through messages geared/targeted to specific key partners (i.e, planners, builders/developers, health sector, community). In order to construct a comprehensive coherent State policy, sector alignment should be sought at the national and supranational level, followed by the subnational and local level. The national and local authorities should identify the key sectors and actors with whom intersectoral collaboration is essential and create mechanisms that will foster the maintenance of those ties and promote the inclusion of important aspects of health in all policies. These actors include mayors as basic counterparts, in addition to

the officials in charge of urban development areas such as transportation, housing, public safety, education, culture, sports, energy, agriculture, tourism, commerce, and civil defense, as well as the financial and private sector and NGOs. Social and intersectoral participation involving the entire population through intersectoral commissions or councils is key.

Results of the discussions on the function of the national and local health authorities in planning

11. The delegates of the Member States noted that urban planning processes represented an opportunity for health and that it was important to get involved in their activities. From the situational standpoint, this is important in the new developments that are emerging in the Region, as well as in the adaptation of urban space, as urban settlements become regularized. The delegates also took the view that, since this occurs principally at the local level, the ministries of health should formulate a policy and invite stakeholders to enlist the active and effective participation of city health officials in urban planning and redesign processes. It is important that the intersectoral coordinating entities of the national government be complemented with entities at the regional or municipal level charged with territorial planning. In order to accomplish this, they need public health guidelines, standards, and criteria to make a realistic, coherent contribution to the work in aspects such as green spaces and their density, quality, and proximity for a healthy social life conducive to physical activity; convenience and safety when walking on the streets; basic hygiene, density, safety, and dignity in housing, schools, and workplaces; environmental and food protection and safety.

12. The roundtable discussed the need for capacity building to promote health impact assessment as an essential element for decision-making by other sectors and for public budget execution. It also discussed the leadership role that the health sector can play to guarantee that these approaches are implemented and, especially, to reduce the source of the disproportionate burden of causes of disease in certain more vulnerable populations. There is no doubt whatsoever that public health criteria should be part of urban planning to ensure that the necessary changes in legislation are made and that health is included in all policies.

13. The roundtable also underscored the general need for training, with a balance between prevention and care. It recommended promoting a holistic approach to the education of health professionals, considering all the factors and determinants of urban and rural health. Moreover, young people must be provided with training in work and life skills.

14. The roundtable also identified the changes needed in the design and structure of health services—especially, primary health services—when they serve urban populations, using criteria that go beyond the geographical distribution of these services. To accomplish this, the barriers that hinder the work of the ministries of health and their existing capacity to reorient the health services must be recognized in order to adapt them to the social, economic, and population dynamic of the cities, bringing services closer to users and achieving adequate coverage. At the same time, it will be necessary to forge sturdy links with rural areas to improve service delivery by bringing services closer to the rural population.

Results of the discussions on health services and their relations with other sectors to prevent and control threats to health from climate change

15. PAHO/WHO and the countries have made great strides in implementing plans of action on climate change and health, creating intersectoral programs that include population vulnerability assessments, surveillance of climate-sensitive diseases, and efforts to raise awareness in the health sector about the importance of climate change and its impact on health.

16. The ministries of health of the Member States have recognized that the very operation of health services (hospitals, laboratories, clinics, and health centers) has a discernible impact on the climate footprint and that a special effort must be made to determine the real magnitude of that impact. Based on this determination, which will be used as the starting point, steps to gradually reduce that footprint should be identified, while taking advantage of the economic incentives that are being offered at the global level to reduce the footprint. Here, it is especially important to make emissions reduction planning and programming an integral part of the environmental management of new and remodeled medical and hospital units and of the procurement of new equipment. If these medical units are considered an integrated system, greater efficacy will be achieved.

17. In the health sector's exercise of its steering role, the key functions are monitoring, research, and the generation of information about the health impact of climate change, especially that portion of the change that has a bearing on the persistence, reemergence, or spread of infectious vector-borne diseases, and also the worsening of the crisis of chronic cardiovascular and respiratory diseases, mental disorders, etc. These considerations should also be addressed in the health impact assessment during the urban planning process. It is also considered important to develop natural disaster preparedness and response plans, strengthen the response of community organizations in this area, and establish policies to control emissions and industrial pollution.

18. Consequently, the ministries of health should determine which competencies, skills, and methodologies need to be developed to detect and control the risks associated with climate change and to become a major player in that global challenge. Thus, they stated that the Sixteenth Session of the Conference of the Parties to the United Nations Framework Convention on Climate Change (COP 16) meeting should acknowledge the contribution of the health services and the need for active involvement by the ministries of health in the prevention and treatment of health problems related to climate change. The health sector is invited to participate in the COP 16, to be held in Cancún, Mexico, in December.

Results of the discussions on the recommendations that the Pan American Sanitary Bureau and Member States will implement

19. The ministries of health examined the need for the Pan American Sanitary Bureau to prepare a preliminary regional strategy and plan of action on urban health that outlines the policies that should be adopted to guide sector activities and the intersectoral steering function in order to adapt the health services and take

effective action in the face of climate change. They requested that a resolution be drafted so that after discussion of the preliminary version, the plan can be presented to 51st Directing Council.

20. They requested the Pan American Sanitary Bureau to increase collaboration with countries, collaborating centers, and other experts so as to develop the tools that the Member States need to exercise their steering role, including:

(a) the adaptation of health/epidemiological surveillance;

(b) health impact assessment;

(c) tools for adapting urban health programs and incorporating the issue of health in all policies, taking the health determinants into account;

(d) monitoring instruments for urban decision-making (e.g., "Urban HEART")

(e) the adaptation or preparation of a package of essential criteria and guidelines for the design of urban settings;

(f) the preparation of criteria and guidelines for adapting health service delivery to urban settings, especially for primary care;

(g) facilitating the sharing of good experiences and lessons learned.

21. At the same time, the Member States will have to make progress in:

(a) studying their legal and organizational structure to include the urban dimension in their internal work;

(b) determining the modifications that should be made in national and local plans and their respective programs of action, so that they include the urban dimension and its elements of equity;

(c) examining their legal and organizational structure in order to include the urban dimension in their intersectoral work;

(d) contributing this information to help formulate the regional strategy;

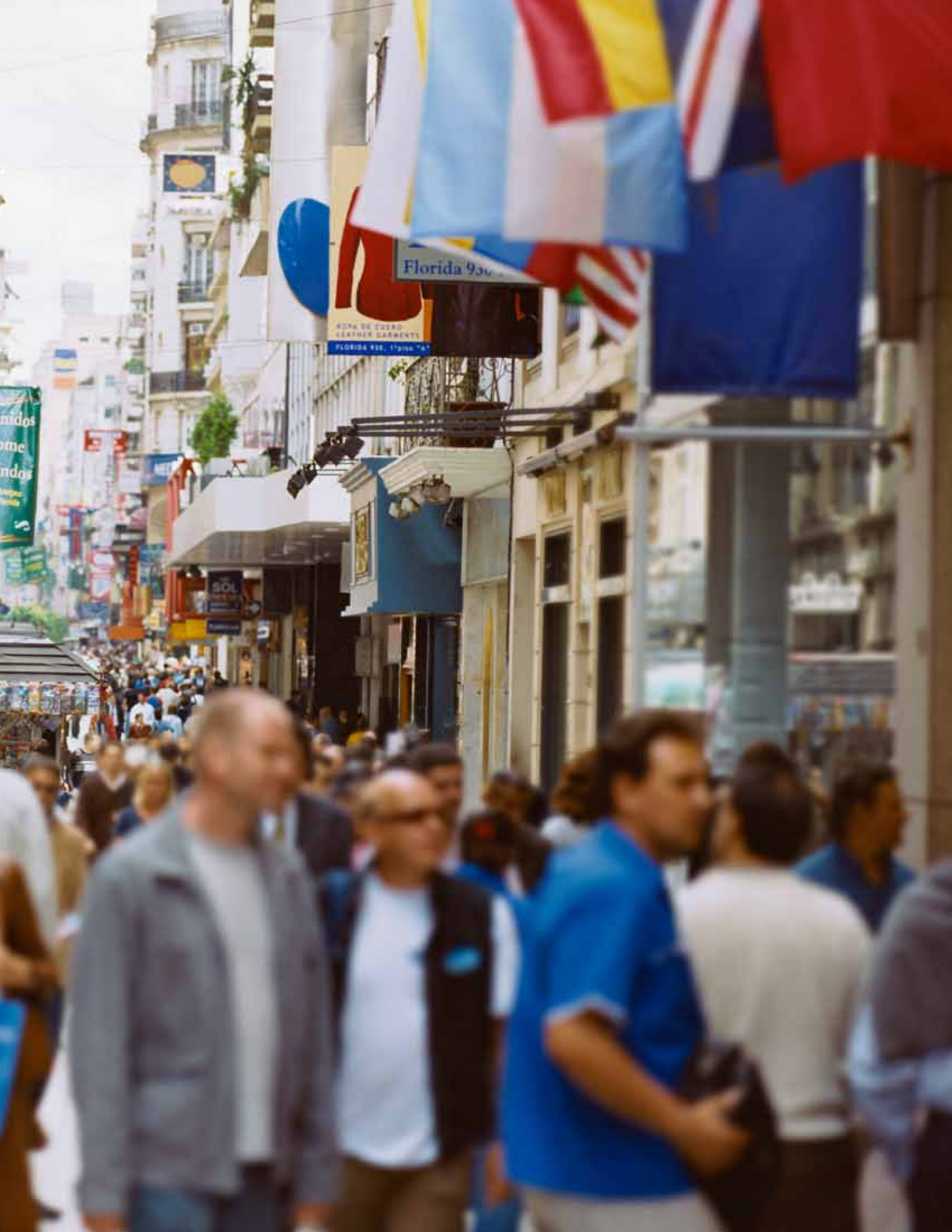
(e) implementing the Healthy Municipalities, Cities, and Communities strategy and promoting interaction among these levels of government in vulnerable urban communities as a mechanism for identifying and acting on the social determinants of health, forging partnerships for intersectoral action and empowering communities to achieve their own well-being;

(f) strengthening health promotion activities within the context of the Ottawa Charter, the Bangkok Charter, and the Nairobi Call to Action, so as to forge partnerships to promote intersectoral collaborative action to address the social determinants of health;

(g) establishing a Health Promotion Fund, using taxes on tobacco and other products for urban health programs that address the social determinants of health.

22. Mexico invites the countries to endorse a regional statement on protecting health from climate change, to be presented at the COP 16 in Mexico.

23. This document includes the results of the work done in the Roundtable. It will be submitted for the consideration of the Directing Council, so that that body can determine what steps to take in the coming months to enable the health sector to effectively meet the public health challenge posed by urbanism.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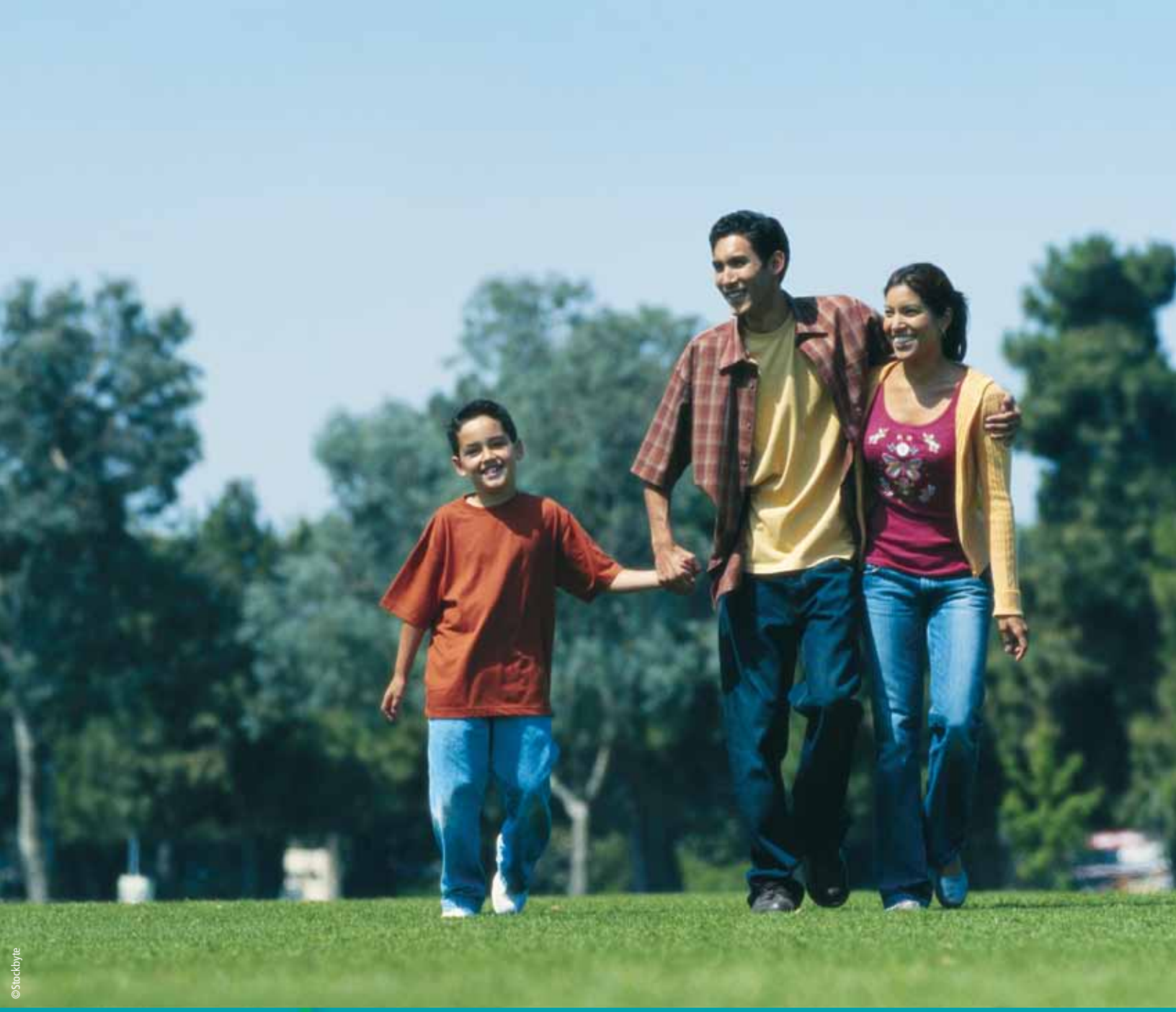

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