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Centre for Health Development

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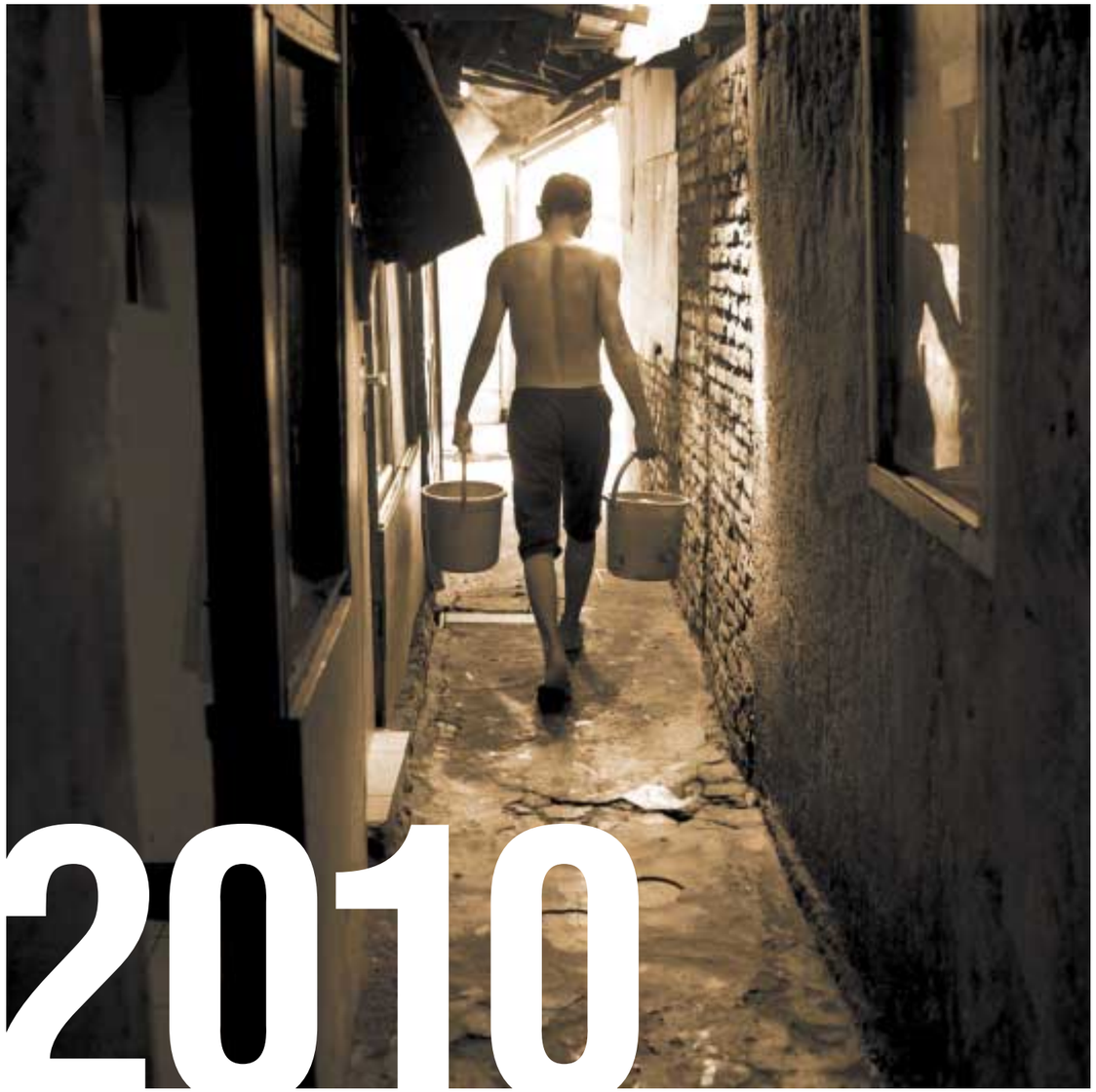
WHO CENTRE FOR HEALTH DEVELOPMENT

ANNUAL REPORT



2010

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Table of contents

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Message from the Director

It has been a remarkable year for urbanization and health. While many advances were made to address health in cities, disasters such as the earthquake in Haiti and the floods in Pakistan remind us of the importance of making cities resilient, pointing to the crucial role that communities and municipal leaders can have in the well-being of over half the world's population.

Cities are increasingly under the spotlight. The World Expo in Shanghai, China with its theme of Better City, Better Life, showcased the innovations being used to improve city life. However, the trends of urbanization and its impact on health are less well known. We at the Centre strongly believe that the conditions in cities will be among the most important global health issues of the 21st century. Urban data is generally consolidated and presented as averages: average income level, average life expectancy, average prevalence of a disease, and average deaths from preventable causes. But averages mask the health vulnerabilities of the young and old, of the rich and poor and of those living in less well-off neighbourhoods. This is why we continue to advocate, research, and reach out to develop sound policies for all urban residents and translate them into action.

This year, the Centre embarked on a year-long campaign to increase awareness, rally political support and action, and develop recommendations and tools to improve health in cities. I am pleased to share with you the results of this campaign and our continued efforts in the fight to address the unfair disparities that exist in cities and for the people who are living in them.

For the first time in the history of WHO, the global World Health Day campaign was led and coordinated by an office outside of Headquarters. Through the Centre's concerted efforts with partners and communities worldwide, over 1500 cities participated under the theme, "Urban health matters." Here in Kobe, city officials promoted the theme for four weeks, culminating in a two-day health promotion event.

Cities can be planned, designed, and administered in ways that promote health and protect people. The Centre remains committed to developing tools and guidance to assist national and municipal leaders. This year, Urban HEART (Health Equity Assessment and Response Tool) was officially published and is now being adopted by cities worldwide. The Smoke Free Cities project resulted in recommendations on 12 steps cities can take to make them smoke-free and a model ordinance to adopt smoke-free laws.

The Global Forum on Urbanization and Health held in Kobe convened representatives from over 80 countries, including over 50 mayors, ministers, and governors. It was a huge opportunity for the city of Kobe to share its vast experience and highlight its successes on the world stage. Leaders from around the world were energized by the potential opportunities to address urban health issues and endorsed the Kobe Call to Action, a clear path for the future.

We are excited by the foundation of the Centre's research over the past years and the prospects of following up the actions laid out in 2010 in the years to come. None of this would have been possible without the enormous support the Centre receives from the Kobe Group, and I would like to personally thank them for their unwavering commitment.

Dr Jacob Kumaresan
Director, WHO Centre for Health Development

I. THE LEADING ROLE OF WHO KOBE CENTRE

Urbanization is increasing worldwide, in a steady trend likely to continue. In 2007, the world's population living in cities surpassed 50% for the first time in history, and this proportion is growing. By 2030, six humans out of ten will be city dwellers, and by 2050, seven in ten. The effect of this phenomenon on population health and welfare needs to be understood and factored in as an actionable determinant that can be positively influenced through adequate public policy actions and strategies.

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WHO/SEARO

As a research institute dedicated to urbanization and health with a focus on equity, the Centre takes the lead role in conducting research on the consequences of social, economic, and environmental change and its implications for health policies in urban settings.

Recognizing the environmental, social, and political factors that determine the health outcomes of urban dwellers is the most important step towards action. These linkages are increasingly being revealed and feature high on the political agenda, as reflected by the 2010 Shanghai World Expo theme "Better City, Better Life" and the focus of 2010 World Health Day with its theme "Urban health matters". WHO is taking a lead role in raising awareness of the health impacts associated with urbanization, promoting partnerships to spur action by countries and cities, generating evidence to help manage rapid urbanization strategically and proposing interventions and strategies to reduce health inequities in urban settings.

WHO stand at the 2010 Shanghai World Expo

LVS Exhibition Service (Shanghai)

II. REDUCING URBAN HEALTH INEQUITY

Due to the trends of urbanization, and the profound shift of people living in cities in many cases, city resources and infrastructure are overburdened, limiting the access of vulnerable populations to adequate nutrition, health care services, safe environments and other factors conducive to good health and well-being. This, as part of a complex array of social determinants of health contributes to health inequity, a difference in health that is socially produced and unfair. In response, leaders across the globe are taking steps to improve urban health and health equity as a matter of human rights and justice, as well as to ensure the environmental, social, cultural and economic vitality of their cities.

Urban health inequities are detrimental to all city dwellers. Disease outbreaks, social unrest, crime and violence are but a few ways that urban health inequities affect everyone. These threats can spread easily beyond a single neighbourhood or district to endanger all citizens and taint a city's reputation.

By taking action to reduce health inequities, cities and the people who live in them can enjoy numerous benefits such as attractive investments to the private sector, social cohesion, reduced violence and crime, as well as the inherent health benefits enjoyed by all groups of city residents, despite income, age, gender, or location of residence in the city.

Significant progress was made in 2010 around the Centre's research focusing on:

- Health equity assessment and response
- Urban health governance research
- Climate change and urban health

A. Health equity assessment and response

The Urban Health Equity Assessment and Response Tool (Urban HEART) for local policy-makers and communities to gather evidence and plan effective actions to tackle health inequities, was published in 2010. Pilot tested in 17 cities of 10 countries during 2008–09, it is one of the Centre's guiding resources for policy-makers to take action to reduce urban health inequities. The assessment component of the tool guides users through the process of selecting appropriate indicators using existing data to examine health inequities. The response component enables users to determine the policies and interventions that will best help them to reduce health inequities in their cities.

Achievements

Publication of Urban HEART: Feedback from the pilot sites and technical advice from experts around the globe contributed to the finalization of the tool, which was officially published in September 2010. It is now being translated into French, Spanish, Japanese and Chinese. An accompanying User Manual has been developed to provide step-by-step instructions on how to implement Urban HEART. In 2010, five workshops were conducted in four of the WHO Regions (one in Africa, one in the Eastern Mediterranean, one in the Americas, two in the Western Pacific) to train local officials and other community representatives in applying Urban HEART. A trainer's manual was developed to standardize the workshops and to assist the facilitators.

Putting Urban HEART to use: As a result of these efforts to scale up Urban HEART, several new cities and countries are adopting the tool, thus galvanizing city governments and communities to identify and take action on health inequities. Policy-makers from cities that piloted Urban HEART in 2008–2009 are also increasingly recognizing the impact of applying the tool. For example, in Parañaque (Manila), Philippines, facility-based childbirths increased from 9% to 65% in disadvantaged areas between 2008 and 2010. Based on this, and similar experiences from other cities, a national policy in the Philippines with respect to City-Wide Investment Plans recommends the use of Urban HEART as a planning and monitoring tool by cities to address health inequities. In 2011, the Centre is assisting city officials to evaluate the process and

outcomes of implementing Urban HEART. Based on feedback from experts and city officials, WKC will conduct research on policy uptake and health equity impact assessments in the next biennium.

Support to Urban HEART

To support the implementation of Urban HEART in coming years, WHO Kobe Centre will:

- Scale-up implementation to new countries and cities through WHO Regional Offices
- Provide technical assistance to support Urban HEART implementation
- Develop additional resources, such as a user manual and interactive website
- Develop measurements and methods for impact assessment

To download Urban HEART go to: www.who.or.jp/urbanheart.html

B. Urban health governance research

Health Governance is a broad area for research. In this field, the Centre focuses on gathering evidence to develop recommendations to policy-makers on how to promote health equity in urban settings. A combined approach was followed in 2010: on the one hand, a strategy of promoting intersectoral action (ISA) for health was developed, and on the other, a specific issue relevant for the health of city dwellers was addressed (preventing people's exposure to secondhand smoke).

Achievements

Intersectoral Action: An expert consultation on ISA was held in Helsinki in September 2010 with the participation of policy-makers (including current and former health ministers), academics, public health practitioners, and WHO staff from more than 12 countries. This consultation resulted in the recommendations to policy-makers on how to trigger intersectoral action on health. These recommendations were then shared and vetted with over 20 national and municipal leaders at the Global Forum on Urbanization and Health held in Kobe in November.

Intersectoral action on health (ISA)

During the Global Forum a special consultation with ministers, governors and mayors focusing on Intersectoral Action on Health (ISA) was conducted. The objective was to review and discuss draft guidelines for policy-makers on how to implement intersectoral action on health. The issues raised will feed into the development of a practical set of guidelines on ISA for policy-makers. The main messages from the meeting were:

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- Intersectoral action on health, especially in urban settings, plays a key role in effectively addressing the social determinants of health and ensuring health equity among city dwellers.
- The municipal level provides an important opportunity for intersectoral action, where mayors as an integrated part of their work provide an arena for coordination between sectors.
- The promotion of co-benefits and increasing the awareness of other sectors on how their actions and decisions may contribute to health is important for the health sector to prioritize.
- Political leadership and commitment at all levels of government to using a multisectoral approach is critical for successful intersectoral action on health.

Building upon this experience, WKC will continue the work in this area, particularly addressing: a) promotion of physical activity in urban settings; and b) urban planning as a tool for the promotion of health equity in cities. Successful experiences will continue to be documented in order to draw lessons for policy-makers.

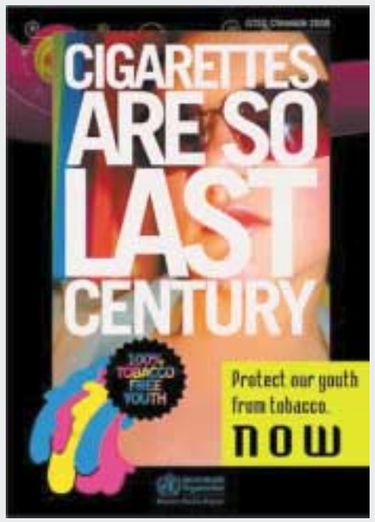
Smoke Free Cities: The final research phase of the Smoke Free Cities project was carried out during 2010, resulting in recommendations to policy-makers ("Twelve Steps" to a Smoke-Free City) and a model ordinance to protect citizenry from exposure to secondhand smoke (see Annex 2). The recommendations were disseminated during the Global Forum on Urbanization and Health (Kobe, November 2010) and in several other fora. This project has provided a framework of action for developing policy guidance in other areas of health governance.

"Twelve Steps" to a Smoke-Free City

The "Twelve steps" provide essential tips on what needs to happen to make your city smoke-free. These steps may occur in a different order than listed, or may occur simultaneously.

Chandigarh/ Hemant Gosaml

1. **Set up a planning and implementation committee** chaired by the local health authority. Include leading civil society organizations (these could be health, consumer, educational, environmental, religious, or civic associations), relevant enforcement authorities, key stakeholders in other government ministries (for example, labour and business), and leading employer and employee associations.
2. **Become an expert.** Learn everything you can about how other jurisdictions have gone smoke-free.
3. **Involve local legislative experts,** guided by international best practice, to draft effective legislation.
4. **Study several potential legal scenarios,** including legal actions by the tobacco industry, and prepare beforehand potential responses to them.
5. **Recruit political champions** to introduce and promote the legislation.
6. **Invite the participation of civil society organizations** to build support among their memberships, political leaders, and the media, and to help counter tobacco industry tactics in a timely manner.
7. **Work with evaluation and monitoring experts** to identify and carry out the baseline studies needed (eg. public opinion, air quality monitoring) to compare the impact of the law, pre- and post-implementation.
8. **Engage with media and communications experts** to develop and disseminate messages to promote the legislation to the public. This should be a combination of earned media through news releases and media interviews and events, and paid messages broadcast through mass media (such as television, radio, billboards). Media strategies should include responding to false arguments from tobacco companies and their allies.
9. **Work closely with enforcement authorities** to design an enforcement plan, including training for inspectors, a clear protocol for inspections, and resources to allow for regular inspections, particularly during the first few months after the law comes into force.
10. **Develop and disseminate guidelines,** signs and other information to employers and businesses who will be responsible for ensuring compliance before the implementation date for the legislation is known.
11. **Celebrate the implementation day** with media events, volunteers on the streets to promote implementation, and inspectors educating establishments about the law. This should be a celebratory occasion!
12. **Ensure maintenance of the law** by monitoring compliance, public opinion, indoor air quality, health of workers, economic impact, and disseminating this information in a timely matter to the media and to political leaders.



C. Climate change and urban health

Climate-related health risks are greatest for the urban poor, especially where they lack adequate shelter or access to health services. Research on climate change impacts and adaptation for health in urban areas was conducted in 2010 as a continuation of the work in the previous biennium. Research included climate impacts on vector-borne diseases, water-borne diseases and heat waves, the assessment of climate change vulnerability and adaptation in cities, and health co-benefits research.

Local evidence of climate impacts as well as city vulnerability and adaptation assessments will provide important lessons for policy-makers on how to deal with climate change impacts in an effective and equitable way, with the goal of urban disaster risk reduction and climate change-resilient cities.

The Centre worked with officials from various cities to develop plans and consider the co-benefits of mitigating and adapting to climate change. Examples include the health co-benefits of urban energy policies in Shanghai and a draft plan for public health preparedness and response to heat waves for Hyogo Prefecture. The Centre is currently supporting further studies on climate change and urban health in South-East Asian Region countries.

Capacity building: The prototype training workshop manual for city officials on the health impacts of climate change was reviewed and updated. The Centre produced the second edition of the training manual, now available on WHO/HQ and WKC websites, with inputs from the Fourth Assessment Report of the Intergovernmental Panel on Climate Change and WHO.

WHO/Azumi Nishikawa

WHO/A Kari

WHO/A Kari

Achievements

Climate change research: In 2010, research protocols were completed on the links between climate and infectious disease. An additional protocol on assessing health vulnerability to climate change in cities was also conducted. These two protocols will make it possible for city officials and programme implementers to conduct research and take necessary actions to identify and measure risks attributable to climate change and establish countermeasures to reduce risks and cope with the eventuality of health impacts from climate change.

III. ADVOCATING FOR URBAN HEALTH EQUITY

A. Building and sustaining partnerships globally to address urban health

One of the main functions of the Centre is to advocate for urban health equity and generate commitment from national and municipal leaders, urban health experts, communities, and other relevant partners to take action. The year 2010 was a landmark year with the aim to increase global visibility of the issue. This was largely achieved as reflected by the number of partners committed to work on the issue, the number of cities globally participating in World Health Day, and the increased mention of health in cities in international media. This was made possible through completion of planned global milestones in 2010 on urban health – the World Health Day campaign, the release of a joint report with UN-HABITAT, the organization of the Global Forum with national and municipal leaders, and the endorsement of the Kobe Call to Action reflecting the commitment of representatives from over 80 countries to take measures to reduce urban health inequities.

The Centre served as the global secretariat for the year-long campaign and marked the first time in the Organization's history that this was undertaken by an office outside of Headquarters.

To increase the visibility of the urbanization and health issue in the global arena and promote action, the Centre continued to work with other UN agencies, partners and municipal and national leaders.

Some of the milestones for 2010 included:

- Ongoing collaboration with UN-HABITAT on urbanization trends and unmasking urban health inequities. This included the production of the WHO/UN-HABITAT global report, *Hidden Cities*, in November.
- Galvanizing support from WHO Regional and Country Offices for the 2010 campaign.
- Working with civil society movements such as Walk and Bike for Life and World Streets to help secure mayoral support for urban health initiatives.
- Engaging local government networks such as the Alliance for Healthy Cities, Metropolis, Eurocities, and European New Towns Platform (ENTP) to develop a sustainable joint agenda on health and to collaborate with the Centre to mainstream urban health equity in their work programmes.
- Strengthening and promoting a network of researchers on urban health by favouring exchanges, sharing expertise, and promoting practical use of research findings.

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B. World Health Day campaign 2010

World Health Day 2010 served as a starting point to raise global awareness on urbanization and health. Cities were encouraged to work across multiple sectors with a wide range of partners to have a lasting impact on health.

Five calls to action were made globally by WHO to build healthy urban areas:

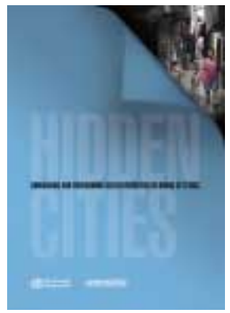
1. Promote urban planning for healthy behaviours and safety.
2. Improve urban living conditions.
3. Ensure participatory urban governance.
4. Build inclusive cities that are accessible and age-friendly.
5. Make urban areas resilient to emergencies and disasters.

Over 1500 cities, towns and urban areas in 137 countries participated in World Health Day events, from the sponsoring of national programmes to promote healthy and sustainable cities in China, to cities opening up hundreds of kilometers of streets worldwide to physical activities. To promote the messages and disseminate recommended actions, many information products were delivered for World Health Day 2010, including a toolkit for event organizers in six languages; *Why urban health matters*, a booklet with background on the issues of urbanization and health, and a short film that highlighted five calls to action. Crucial to the campaign was development of the interactive campaign map, which was launched on the World Health Day 2010 website in February to provide a window on the cities signing up and their events.

Around the globe, World Health Day 2010 and its "Urban health matters" theme were covered extensively with hundreds of articles in print and electronic media, including a series of reports on CNN and a Financial Times special supplement dedicated to this theme. Events involving national and municipal partners helped to reveal champion municipal leaders and successful examples of the actions taken to improve the health of urban residents.


WHO/A Kari

C. "Hidden Cities" – a joint report by WHO and UN-HABITAT



The global report "Hidden Cities: Unmasking and overcoming health inequities in urban settings" is one important component of the overall WHO and UN-HABITAT strategy to strengthen the response of the local, national and global health communities to reduce health inequities in an increasingly urbanized world.

The report exposes the extent to which the urban poor suffer disproportionately from a wide range of diseases and health problems, which can be traced back to inequalities in their social, economic and living conditions. It also provides evidence-based information and tools to help municipal and health authorities tackle health inequities in their cities.

The report was compiled with input from over 150 experts – academics, WHO and UN-HABITAT staff, researchers, field personnel and policy-makers – and was vetted through a rigorous peer-review process. The report was launched on 17 November and widely distributed through print, media, and WHO and UN-HABITAT websites.

D. The WHO Global Forum on Urbanization and Health and the Kobe Call to Action

From 15–17 November, over 300 influential policy-makers from 81 countries such as ministers, governors, mayors, national authorities, civil society and other key stakeholders across multiple sectors met in Kobe and forged a way forward to address urban health issues. The Forum culminated in the endorsement of the Kobe Call to Action, which captures the essence of the discussions and conclusions of the Forum, and is a statement by and for national and local leaders to address health and health equity in cities (see Annex 3).

E. Community outreach

The Centre continues to work closely with the local community to promote urban health and collaborate on projects.

Some highlights of the 2010 activities include:

- Participation of 20 Japanese cities in World Health Day events.
- Display of World Health Day flags along Flower Road in Kobe for the month of April, as well as a weekend of events in Kobe (24–25 April) including a six-kilometre walk and health seminar. Local television captured these activities.
- Collaboration with Hyogo Prefecture in the response to the H1N1 outbreak beginning in April 2009. WKC continued to post weekly global updates from WHO in Japanese and English on its website in 2010.
- Ongoing lectures to the local community on communicable diseases by WHO experts and consultants.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IV. EXECUTIVE MANAGEMENT AND INFRASTRUCTURE SUPPORT

A. Mainstreaming urban health equity

In light of WKC's 2006–2010 accomplishments, especially its strengthened leadership in the field of urban health, a process was followed this year to update the strategic direction for the next five years. This included a series of consultations and one expert review with the participation of other WHO colleagues and external advisors (February). Taking into consideration World Health Day 2010 calls to action and current WHO priorities (attaining the MDGs, climate change and health, and strengthening health systems), the strategy for 2011–2015 was developed.

This strategy reflects the overall goal of reducing health inequity in urban settings, by providing a framework of context-specific, cross-sectoral, feasible, and evidence-based interventions on the determinants of health in the development of urban policies and plans at national and local levels:

Vision: Health for all in urban environments.

Mission: Promoting and leading urban health research to assess trends and build evidence for policy-makers to achieve urban health equity.

The overall strategy is based on an approach to mainstreaming urban health equity that builds on the success of existing initiatives without replacing them, yet seeks to consolidate and harmonize these initiatives and ensures that the equity dimension is consistently considered. The approach is based on three fundamental pillars: 1) urban health metrics, 2) urban health governance; and 3) urban health emergency management. The approach is supported by the cross-cutting core activities of research, capacity building and advocacy.

WHO/HQ

WHO/HQ

B. Hyogo/Kobe partnership

While the Centre draws on a wide range of expertise and engages with partners from multiple disciplines all over the world, implementing its work would not be possible without the support, guidance and technical expertise of the Japanese community. WKC will continue to work towards reinforcing existing partnerships and developing new ones to build strategic links with Japanese research institutions and to further increase awareness of WHO, the Centre and its work.

In 2010, a joint evaluation was conducted with the Kobe Group and through this process, an agreed plan of action for local activities was developed for 2011–2015, focusing on the areas of research (i.e. joint research with local institutions and linking local and overseas research institutions), advocacy (seminars by WHO experts, publicity events) and information sharing (e.g. health emergency management, guidance on global and local health issues).

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C. Information and communication technology and administration

Administrative support and state-of-the-art information and communication technology were provided for effective implementation of the Centre's workplan in 2010. The Global Management System (GSM), WHO's enterprise resource planning system, introduced in 2008 and integrating a new accounting standard adapted by the UN system, continues to stabilize and improve. Modern web and telecommunications technologies have also been actively leveraged. Security measures were significantly updated to comply with global standards and best practices. As the Centre expands its research and programmatic focus on urban health equity, systematic support and modern approaches from information and communication technology and administration are essential to reach the goal of reducing urban health inequities.

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V. CONCLUSIONS AND FUTURE PLANS

In 2010, WHO Kobe Centre has strengthened its position globally to advocate and lead efforts towards urban health equity. It has raised the profile of the topic through advocacy, communication strategies and events. The Centre has also generated evidence on urban health equity, analysed relevant best practices in governance, and provided tools to assist decision-makers in the implementation of policies and programmes to confront urban health inequities.

In the next five years the Centre will focus on mainstreaming urban health equity. In 2011, there will be a scaling up of Urban HEART, promoting and enabling capacity building and providing technical support as necessary. Policy guidance will be provided to municipal leaders, based on best practices derived from Health Governance Research; for example, recommendations to trigger ISA, and promoting physical activity in cities. The Centre will work towards enabling cities to cope effectively and equitably with the health impacts of disasters and climate change, by developing tools and capacity to assess vulnerability and to strengthen health systems.

In conclusion, the achievements of past years and the campaign on urbanization and health in 2010 provide the foundation for the Centre's strategy during the next five years. WKC will continue to promote urban health and health equity, linking to the broader work of WHO and the general UN system, thereby facilitating progress towards the Millennium Development Goals by embedding public health policies in urban development.

WHO/A Kari

Villa Carlos Paz/Carlos Federico

ANNEXES

Annex 1:
ADVISORY COMMITTEE OF THE WHO KOBE CENTRE 2010

The flexibility of its research programme is a specific trait of WKC that allows periodic updates and adjustments to the Centre's research agenda. In order to ascertain the scientific soundness of the research agenda, particularly since it involves a complex inter-sector health programme, an Advisory Committee supports the Centre. The Advisory Committee of the WHO Centre for Health Development (ACWKC) held its 14th meeting on 17 November 2010 and reached the following conclusions and recommendations.

Conclusions

The Advisory Committee congratulated the Director and WKC staff on the impact it made in the past year towards the goal of improving urban health equity. The Committee appreciated the leadership provided by WKC as secretariat of the 2010 WHO Campaign on Urbanization and Health and the achievement of three major milestones: World Health Day, Global Forum, and the launch of the joint WHO/UN-HABITAT report on urbanization and health. Together these achievements provided the impetus to get urban health on the agenda of several Member States, as reflected in the outcomes of at least three WHO Regional Committee Meetings and the endorsement of the Kobe Call to Action by municipal and national leaders attending the Global Forum. Furthermore, the work of the Centre particularly on intersectoral action may feed into the planned 2011 high-level political meetings such as the Summit on NCDs at the UN General Assembly in September and the World Conference on Social Determinants of Health in Rio de Janeiro in October. The Committee also acknowledged the consistent support provided by the Kobe Group and encouraged the Centre to continue to support and contribute to local public health concerns and partnership activities. The Committee commended the Centre's commitment to sustain the momentum gained in 2010 and agreed to advocate and support the Centre in implementing its 2011–2015 strategy to mainstream urban health equity.

Recommendations

In summary, the Advisory Committee recommended that the Centre:

1. implement the 2011-15 strategy of Mainstreaming Urban Health Equity with the collaboration of WHO regional offices and relevant departments;

2. carry out the workplan for the 2010-11 biennium within the general framework of the 2011–2015 strategy based on the three core pillars of urban health metrics, urban health governance, and urban health emergency management;

3. develop additional evidence, tools and guidelines to assess the impact of urban policies on health equity, and to document the benefits to health of intersectoral action;

4. build on and sustain the momentum gained in 2010 toward improving urban health equity to build appropriate partnerships and networks to achieve the goal of reducing health inequities in cities;

5. pursue local activities as agreed with the WKC Cooperating Committee to increase the visibility of the Centre;

6. continue to mainstream urban health equity in the work of WHO regional offices and departments;

7. urge the Kobe Group to continue its support to WKC in the implementation of the 2011–15 strategy.

Annex 2:
MODEL ORDINANCE FOR A SMOKE FREE CITY

A common request of those developing smoke-free legislation is, "Do you have an example or model we can use?" There are no perfectly drafted smoke-free laws and ordinances that can be used as simple models. Many laws have been amended in ways that make them difficult to read. They contain twists, turns, and exemptions that have been inserted as political compromises. Or they include best practice language for some things while omitting other key elements. This is true even in those jurisdictions commonly cited as best practice examples. The text provided below draws on the best elements of laws from many jurisdictions, and from the WHO Framework Convention on Tobacco Control Guidelines on implementation of Article 8. It offers clear language as a starting point for municipalities to work with.

The [name of Municipality] Smoke-Free Workplace and public place ordinance

1. *Purpose.* The purpose of this Ordinance is to protect the residents of [Name of Municipality] from the harmful effects of exposure to tobacco smoke in workplaces and public places.

The purpose and preamble of the ordinance establish that the goal of the ordinance is to protect public health. The city's relevant legal and health bases for regulation should be provided here.

2. *Rationale.* Whereas... .

(a) The Constitution of [Name of Country] guarantees the right to [life] [any other relevant rights]
(b) Exposure to tobacco smoke has been recognized by the World Health Organization and other respected health authorities to cause death and serious disease in non-smokers;
(c) There is no known safe level of exposure to tobacco smoke; and
(d) International guidelines advise that the only way to adequately protect the public from exposure to tobacco smoke is to eliminate the source of smoke;

3. *Definitions.* For the purposes of this ordinance, the following definitions apply:

(a) Enclosed means
  i. Having a ceiling or roof or a cover that functions (whether temporarily or
  ii. permanently) as a ceiling or roof; or being enclosed by one curved wall, or on two or more sides by walls, or enclosures that function (whether temporarily or permanently) as walls, whether or not they contain doors, windows or other openings.

This definition of "enclosed" is meant to include covered patios, and makes it difficult for establishments to construct or remodel portions of their premises to permit smoking.

(b) *Person in charge of an establishment or vehicle* means an employer, owner, manager, or other person with permanent or temporary authority over the operation of an establishment or of a vehicle.
(c) *Public place* means any place accessible to the general public or a place for collective use, regardless of ownership or right to access. It includes, but is not limited to:
  i. offices and all areas of office buildings, whether private or public;
  ii. health institutions, whether private or public;
  iii. educational institutions, whether private or public;
  iv. government buildings;
  v. retail shops and shopping malls;

Workplaces and public places are defined broadly. A list of places that are considered workplaces and public places can be provided for clarity, but does not limit the definition to those places.

vi. hospitality and catering facilities, including pubs, restaurants, hotels, and karaoke;
vii. manufacturing or processing plants;
viii. all public areas in multiple unit dwellings, including lobbies, elevators and stairwells.
ix. [add other places as appropriate to your jurisdiction.]

(d) *Smoke-free place* means any place where smoking is prohibited under this Ordinance.

(e) *Smoking* means the inhalation and exhalation of tobacco smoke or being in possession or control of an ignited tobacco product.

(f) *Workplace* means any place used by people in the course of their employment or work, whether the work is done for compensation or on a voluntary basis. A work place includes, but is not limited to:
i. offices and all areas of office buildings, whether private or public;
ii. health institutions, whether private or public;
iii. educational institutions, whether private or public;
iv. government buildings;
v. retail shops and shopping malls;
vi. hospitality and catering facilities, including pubs, restaurants, hotels, and karaoke;
vii. manufacturing or processing plants;
viii. [add other places as appropriate to your jurisdiction.]

This is the critical clause that prohibits smoking in defined places. It is broad, and also extends the non-smoking area beyond enclosed places. Whatever outdoor distance is specified, it should be practical for most enclosed spaces while also reducing smoke drifting from outdoors to indoors.

What's missing? Smoking rooms. This is how it should be!

4. *Prohibition of smoking in enclosed workplaces and public places.*
Smoking is prohibited in all enclosed public places and workplaces in [Name of Municipality] and within [specified distance] of any entryway, window, or air intake of an enclosed public place or workplace.

Prohibition of smoking outdoors is recommended only if you know there is a reasonably high level of support for taking this step. Initially, you might find you have support for prohibiting smoking in an outdoor area popular with children and families (such as a local sports stadium).

5. *Prohibition of smoking in specified non-enclosed or outdoor areas.* Smoking is prohibited in municipal parks, beaches, playgrounds, and public stadia, even in areas of those places that are not enclosed.

6. *Duty of compliance.*
(a) The person in charge of an establishment or a vehicle required to be smoke-free under this Ordinance shall be responsible for ensuring compliance in their establishment, including:
i. Taking reasonable steps to ensure that no person smokes in an establishment where smoking is prohibited. Reasonable steps include:
a. Requesting a person who is smoking to extinguish the tobacco product immediately or to leave the premises or vehicle.
b. If the person refuses to extinguish the tobacco product or to leave, refusing service to that person and contacting the appropriate enforcement authority to report the violation.
ii. Ensuring that ashtrays or other receptacles designed for smoking products are not present in smoke-free places.
iii. Ensuring that the signs required under Schedule 1* are posted in accordance with the Schedule.

(b) No employer shall take any action against an employee for seeking enforcement of this Ordinance or acting in accordance with the requirements under this Ordinance.

This sets out the specific actions and duties for which employers and businesses are responsible.

* Available upon request

7. *Penalties and fines.*
(a) Persons violating provisions of this Ordinance are subject to the fixed monetary penalties listed in Schedule 2*.
(b) A person who commits or continues an offence under this Ordinance on more than one day is liable to be convicted for a separate offence for each day on which the offence is committed or continued.

Penalties should be high enough to provide a deterrent and therefore should be proportionally higher for businesses than for individuals. In cases where penalties are set in other legislation and may not be sufficiently high to deter violations, consider adding a provision permitting license suspension for successive violations, or disciplinary action for government employees.

8. *Enforcement authority and inspections.*
(a) The following persons shall have authority to enforce the provisions of this Ordinance: [list appropriate categories of persons - for example, "Public Health Inspectors as defined in the Public Health Act"]
(b) The [Head of municipal health authority] may designate an additional class or classes of inspectors for the purposes of enforcing this Ordinance.
(c) An inspector authorized under subsection (a) may
i. enter and inspect any public place or workplace designated as smoke-free under section 4 during reasonable hours;
ii. request any person for information relevant to the inspection
iii. [if possible in the municipality's legal system] issue on-the-spot fines based on evidence of a violation.
(d) No person shall hinder in any way the performance of the duties of an inspector, mislead them by concealment or false statements, or refuse to provide them with any information or document to which they are entitled under this Ordinance, or destroy any such information or document.

Enforcement provisions will vary widely based on the legal traditions of the municipality. Some jurisdictions may require much more detailed language regarding enforcement powers and inspection procedures. This is a suggestion for minimum language, which can be elaborated further as needed either in the ordinance itself or in a regulation.

9. [if possible in the municipality's legal system] *Public complaints.*
The public shall be authorized to report violations or suspected violations of the Ordinance to the appropriate inspection agency. The [Name of relevant local authority] will establish a toll-free telephone number to be displayed on signs, and advertised on the [Name of local health authority] web site.

Explicit statement of powers to issue regulations or other relevant legal instruments will more easily allow the municipality to close unforeseen loopholes, or to clarify other issues that are hindering implementation. For example, additional categories of inspectors could be named, or definitions clarified.

10. *Regulations.* The [head of municipal authority] may issue regulations to further the effective implementation of this ordinance.

11. *Reporting.* The [head of municipal authority] shall issue and publish an annual report on compliance with this Ordinance.

12. *Entry into force.* This ordinance shall enter into force 90 days following its publication in [name of official municipal government publication].

Entry into force of 90 days – or three months – after publication of the law or regulation should provide sufficient time to prepare for implementation.
A longer implementation period invites delays, loss of momentum, and opportunities for the tobacco industry to weaken the law.

* Available upon request


WHO/Francisco Armada

WHO/Francisco Armada


The main Commitee for awareness of smoking hazards in Holy city of Makkah

Annex 3:
THE KOBE CALL TO ACTION

Key Principles

We, government leaders, city mayors and other participants at the Global Forum on Urbanization and Health, recognize the importance of the following three key principles for the development of urban health policies:

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

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

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

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

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

Essential prerequisites for action to integrate health in urban policies include securing commitments from a wide range of local leaders, developing a common vision for health and health equity, creating supportive

WHO/WKC

institutional arrangements, measuring the health impact of policies and programmes, and connecting with others—including civil society and the private sector—who can support the work.

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

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

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

We, government leaders, city mayors and other participants at the Global Forum on Urbanization and Health in Kobe, Japan

COMMIT TO:

- Promote health and health equity in cities;
- Develop ongoing systems for regular and sustainable collection and analysis of disaggregated data;
- Integrate health into all public policies (for example, education, water and sanitation, housing, tobacco use, transportation and road safety, physical activity, healthy diets, and mental health) through the use of intersectoral action in order to have a positive impact on health equity;
- Systematize the use of health equity assessment tools to identify and respond to inequities, and to assess the impact on health of urban policies and programmes;
- Utilize urban planning processes to create and build upon opportunities that address health inequities;
- Invigorate mechanisms for the informed participation of citizenry in local decision-making;
- Promote health literacy to support people in living healthier lives.

REQUEST ALL LOCAL GOVERNMENTS TO:

- Follow up on these commitments to improve urban health and health equity.

REQUEST CIVIL SOCIETY TO:

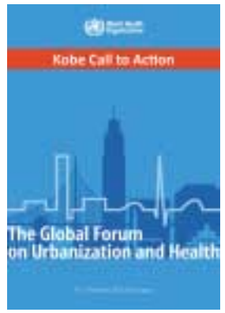
- Support and be actively engaged in the implementation of these commitments.

REQUEST ALL NATIONAL GOVERNMENTS TO:

- Integrate health and health equity into all urban public policies;
- Make all data relevant for health equity and impact assessment accessible across all levels of government;
- Develop supportive institutional arrangements to enable local governments to tackle urban health inequities through intersectoral action;
- Engage their Heads of State in supporting recommendations related to the integration of urban health equity considerations in the high level meeting on noncommunicable diseases at the UN General Assembly in September 2011;
- Support urban leadership in addressing Primary Health Care, urban health and health equity.

REQUEST THE WORLD HEALTH ORGANIZATION (WHO), THE UNITED NATIONS HUMAN SETTLEMENTS PROGRAMME (UN-HABITAT) AND OTHER UN AGENCIES TO:

- Coordinate efforts, generate evidence and favour intersectoral policies and actions on urban health and health equity;
- Promote the integration of urban health and health equity in the agenda, policies and plans of action of municipal networks and civil society organizations;
- Develop tools and processes designed to empower communities in local decision–making and tackle urban health inequities;
- Provide technical assistance and support capacity-building among Member States and local governments with the aim of improving urban health and reducing urban health inequities and the negative impacts on health of urban policies and programmes;
- Encourage the support of Healthy City networks and similar networks as effective mechanisms for promoting political commitment and action at the local level for healthy and sustainable development.



To download this document, go to: www.who.or.jp

Annex 4:
WKC SCIENTIFIC PRODUCTS, 2010

Technical reports

Evaluation of the Effects of Climatic Factors on the Occurrence of Diarrheal Diseases and Malaria: A Pilot Retrospective Study in Jhapa District, Nepal
Hidden Cities: Unmasking and overcoming health inequities in urban settings (jointly published with UN-HABITAT)
Urban HEART: Urban Health Equity and Response Tool
Why Urban Health Matters

Public presentations

Title	Event	WKC contributors
An overview of WHO and WKC activities	Visit from School of Nursing, University of Kindaihimeji, 19 January	Bradford, Mr Richard
Utility of an Urban Health Index	3rd meeting of the GRNUHE (Global Research Network on Urban Health Equity), Bellagio, Italy, 2-4 March	Prasad, Mr Amit
Health impact of climate change and the role of epidemiology	SEA Regional Conference on Epidemiology, New Delhi, 8-10 March	Kumaresan, Dr Jacob
A global perspective on urbanization and health	WPRO World Health Day celebrations, Manila, 8 March	Lapitan, Dr Jostacio
World Health Day Global Launch	World Health Day, Geneva, 7 April	Kumaresan, Dr Jacob
The Urban Health Equity Assessment and Response Tool – Urban HEART	5th International Academic Conference on Environmental and Occupational Medicine, Dujiangyan, Chengdu, China, 7-10 April	Kano, Dr Megumi
Climate Change, Public Health and WHO-Lagos State Collaboration	Second Lagos Summit on Climate Change, 4-7 May 2010	Kumaresan, Dr Jacob
Why urban health matters	2010 Mini Forum on Urbanization and Health, Kobe, 21 May	Sloate, Ms Lori
Urbanization and health: an overview of our research	2010 Mini Forum on Urbanization and Health, Kobe, 21 May	Kano, Dr Megumi
Research and analysis activities at WKC	2010 Mini Forum on Urbanization and Health, Kobe, 21 May	Prasad, Mr Amit and Dr Megumi Kano
Health challenges in cities	European Commission's Conference "Healthy Cities", Shanghai, China (during the Shanghai EXPO), 4 June	Kumaresan, Dr Jacob
WKC's work on ISA	Workshop for Authors - Inter-sectoral governance for Health in All Policies, Brussels, 7-8 June 2010	Armada, Dr Francisco
Megacities and health	International Conference on Emerging Infectious Diseases 2010 (ICEID 2010), Atlanta, 10-14 July	Prasad, Mr Amit
Urbanization and Health: challenges and promises	Seminar on Capitol Hill, "Improving Health Outcomes for the Slum Dwellers and the Urban Poor", Washington DC, 20 July	Kumaresan, Dr Jacob
Healthier People in Healthier Environments	Training Course for Future Health Leaders Development, Tokyo, 29 July	Kumaresan, Dr Jacob
Cities and health	Together with the UN Seminar, Tokyo, 27 August	Kano, Dr Megumi
WKC's research on the health impacts of climate change in urban settings	Research Network for Health Effects of Climate Change and Air Pollution in the East Asian Countries, Seoul, 31 August	Lapitan, Dr Jostacio
WHO's role and activities	Development of Coordinators for Disaster Nursing for Middle East and Asian Countries, Kobe, 9 September	Lapitan, Dr Jostacio
Urbanization and Health	Forum "WHO and Japan", Osaka, 15 September	Kumaresan, Dr Jacob
WKC's main areas of work	2010 Board Meeting of Metropolis, Barcelona, 6 October 2010	Armada, Dr Francisco
Urban Health Lessons from Megacities	Working session: "Megacities: Opportunities and Challenges for Health", World Health Summit, Berlin, 10-11 October	Armada, Dr Francisco
An introduction to Urban HEART	4th Global Conference of the Alliance for Healthy Cities, Mayors Meeting, Gangnam-gu, Seoul, 27 October	Kano, Dr Megumi
Health in All Urban Policies	9th International Conference on Urban Health, New York, 27-29 October	Armada, Dr Francisco
Global Overview of Urban Health: Challenges and Promises	9th International Conference on Urban Health, New York, 27-29 October	Kumaresan, Dr Jacob
Urban HEART	WKC Seminar and workshop at the 9th International Conference on Urban Health, New York, 27-29 October	Prasad, Mr Amit
WHO's campaign on urbanization and health	4th Meeting of Public Health Associations in Asia, Tokyo, 28 October	Lapitan, Dr Jostacio
Addressing urban health inequities: challenges and solutions	Symposium on Interactive Health Sciences Education within developing countries – Graduate school of education leads the way, Kobe, 19 November	Kumaresan, Dr Jacob

Annex 5:
LIST OF STAFF, 2010

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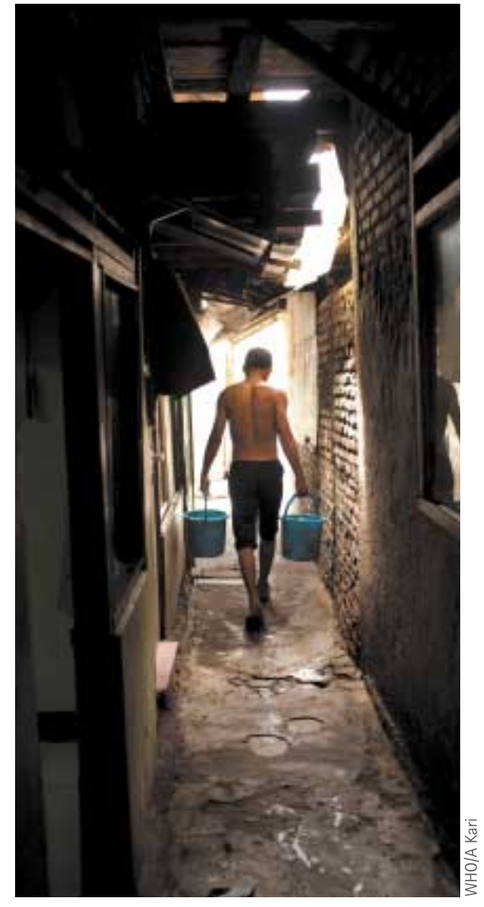

WHO/A Kari