

WHO CENTRE FOR HEALTH DEVELOPMENT

ANNUAL REPORT



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ANNUAL REPORT 2011

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Message from the Director



WHO/J. Opere

Without doubt, the biggest challenge in 2011 in Japan has been the tragedy of the earthquake, tsunami and the ensuing nuclear concerns of Fukushima. No nation has ever faced such a triple threat over such a short period of time. Such events highlight the important role communities have in responding to and coping with the consequences of disasters.

WHO, including our Centre, provided support to the Tohoku region and to Japan in responding to this unprecedented set of events. WHO has monitored the situation closely since the beginning of the emergency. Related public health risk assessments and recommendations have been issued by WHO. It has also provided technical support to national authorities including our WHO Collaborating Centre partners. Part of the Centre’s response has been to translate and disseminate information in Japanese, which was appreciated by the Ministry of Health, other UN agencies, the Japanese public and diplomatic missions in Tokyo.

Our lives are not only affected by disasters – everyday we must confront and combat silent killers in the form of noncommunicable diseases. In September 2011, a landmark event took place in New York at the United Nations General Assembly (UNGA), where for only the second time in history, a health topic was addressed by Heads of State at the UNGA. Noncommunicable diseases (NCDs) – heart disease, cancer, diabetes, and respiratory diseases – were at the forefront of discussions in the UN High Level Meeting on NCDs, resulting in a commitment by world leaders to respond to this urgent health matter. The UNGA adopted the Political Declaration on Preventing and Controlling NCDs. A series of actions was identified for WHO, including identifying options for multisectoral actions through effective partnership reflecting “whole-of-government” responses. The Centre’s work on intersectoral action has been key to supporting this effort and we will continue to have an important role to coordinate and document such actions in the future.

In the shadow of continued global financial difficulties, a World Conference on Social Determinants of Health, hosted by the Government of Brazil and WHO, was held in October with a resulting Rio Political Declaration. The Conference reminds us of the continued need to address health inequities worldwide, a core element of the Centre’s work.

The Centre’s work around urban health and health equity has yielded concrete products and actions that advance the international agenda to make cities healthier and more equitable. Over the last two years, the Centre developed a tool to measure urban health inequities (Urban HEART) and to identify policy actions to respond to them; produced and published a joint report with UNHABITAT (Hidden Cities); and drafted the Kobe Call to Action. These serve as tangible ways to address the health inequities persistent in all corners of the globe. Through these actions, the Centre helps to ensure that communities around the world adopt healthy public policy choices.

Over the last few months I have enjoyed getting to know better the work of the Centre, its partners, and accomplishments towards fulfilling its vision “Health for all in urban environments”. I am grateful to the Advisory Committee Members and our Japanese partners who support the Centre and enrich its work. As the new Director, I look forward to ensuring that the WHO office in Kobe remains a centre for research excellence, contributes to global health policy and programmatic development, and identifies innovative solutions to key public health issues. The Centre will continue to be a source of innovative policy options for governments and communities, based on evidence, and translated for policy makers.

I would like to thank you for your generous support, especially the support provided by the prefecture of Hyogo, the City of Kobe, along with the Kobe Chamber of Commerce and Kobe Steel, Ltd., without which the work of the Centre would not be possible.

The Annual Report highlights many of the innovative approaches and research the Centre has undertaken in 2011. I welcome you all to read of the achievements made.

Alex Ross
Director, WHO Centre for Health Development



I. TOWARDS REDUCING HEALTH INEQUITIES IN ALL CITIES

The role of WHO Kobe Centre (WKC) to focus on the driving forces of urbanization in health in development has never been more relevant. The 2010 campaign on urbanization and health generated widespread global awareness of the challenges, costs, and promises of urban health as a major contemporary public policy concern. Municipal and national leaders who met at the Global Forum on Urbanization and Health in Kobe (2010) called for action on urban health and health equity (Kobe Call to Action).

Building on this momentum, the focus in 2011 has been on mainstreaming urban health equity. 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. Given the density of population and the critical importance of cities socially, politically and economically, public health actions and increasing multi-sectoral cooperation to find innovative solutions are required to advance health globally.



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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, reduction of risk factors (especially for noncommunicable diseases (NCDs) and in the environment) 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 2011 around the Centre's research focus areas :

- Urban health metrics
- Urban health governance
- Urban health emergency management

A key fundamental driver towards fulfilling the Centre's strategy to mainstream health equity is to scale-up action across the three research areas of work so that urban health is recognized in national policies. Mainstreaming urban health equity requires working across multiple sectors of government, with a wide array of partners, and working across multiple topics and regions within and beyond the World Health Organization. The WHO Centre for Health Development is well positioned to coordinate the efforts and contributions of various stakeholders to ensure this happens.



II. THE INCREASING RELEVANCE OF URBAN HEALTH IN THE GLOBAL POLICY LANDSCAPE

Significant progress has been made towards the goal of mainstreaming urban health in the first year of the strategy for 2011–2015. Building on the Kobe Call to Action in 2010 and the campaign, Ministers of Health from three regions have adopted resolutions for the inclusion of health in urban agendas in national policies in Latin America, Western Pacific and Southeast Asia countries.

Within WHO, the topic of urbanization and health continually gains traction and in 2011, has been recognized for the first time as a health topic in its own right. The Director-General has been involved in fora where cities are featured, and in September commended the efforts of New York City as a model in its role to fight tobacco use at the UN High-Level Meeting on Noncommunicable Diseases.

Increasingly, international and national policy makers are turning to municipal leaders to take action. In June of this year, UN Secretary-General Ban Ki-moon addressed the annual United States Conference of Mayors for the first time and referenced the shared concerns and work being done on energy and the

environment, crime and coexistence, transport and climate change and finding it “good for the health and happiness of citizens.” He continued, “Everywhere I turn, it seems, a mayor is there, front and centre...For me, the message is clear: The road to future peace and progress runs through the world's cities and towns.”

The increasing visibility of the importance municipal leaders play in addressing today's health challenges demonstrates the continuing need to mainstream urban health initiatives with partners, UN agencies, and with multiple levels of government, while focusing on the issue of equity.

The Centre continues to build on mainstreaming urban health equity through its strong partnership with UN-HABITAT, with whom a Memorandum of Understanding was signed this year, outlining concrete actions for the coming years. It will also continue to work with municipal networks such as Metropolis, and the United Conference of Local Governments towards mainstreaming urban health initiatives in their programmes of work at the secretariat level. Collaborative work with WHO has also led to WHO's Regional Office for the Americas launching a new ten year strategy on urban health in November 2011.



WHO/A.Kari

III. GLOBAL CONTEXT OF PUBLIC HEALTH IN 2011 AS IT RELATES TO THE CENTRE'S WORK

UN General Assembly announces historic commitment to fight noncommunicable diseases

Noncommunicable diseases (NCDs) such as diabetes, heart disease and stroke, chronic respiratory disease and cancer together kill some 36 million people each year. Rapid urbanization contributes to increasing behaviour and life style changes that are accelerating the burden of non-communicable diseases.

In September, at a specially convened UN High-Level Meeting, the UN General Assembly adopted the Political Declaration on the Prevention and Control of Noncommunicable Diseases. For the first time, global leaders have reached consensus in the General Assembly on concrete actions to tackle these diseases.

This call to action requests WHO to further develop approaches on how to address the underlying risk factors associated with these diseases, which are now the world's leading killers. NCDs are caused by four main risk factors: tobacco use, physical inactivity, alcohol, and unhealthy diets. As part of the Political Declaration, world leaders agreed that a “whole-of-government” approach is the

way forward to address these four diseases and four risk factors, and in particular to develop and enact broader multi-sectoral actions. Cities have shown remarkable progress in this area, and the Centre will continue to build on its intersectoral action work and to help WHO lead the charge in this critical follow-up to the UN meeting.

Of the 36 million deaths per year from noncommunicable diseases, 9 million deaths are premature. Tobacco use is the most preventable risk factor, effecting all four major diseases. An enormous body of evidence, and the Framework Convention for Tobacco Control treaty, call for reducing tobacco use. One example of concrete action is the Centre's work to develop a model ordinance for Smoke-Free Cities. This suggested model, developed in conjunction with our HQ Tobacco Free Initiative Department, enables municipal leaders to use it as a base when developing their own legislation to ensure smoke-free places can protect people from second-hand smoke. This is just one example of what can be done in the area of tobacco, and how this relates to the whole-of-government approach needed to develop, implement, and enforce policies to improve the health of all people living in cities.



WHO/E. Armada

World emphasis on how social conditions influence health inequities

An individual's health status is largely determined by his or her socioeconomic position. In low-income countries the average life expectancy is 57, while in high-income countries, it is 80. Hosted by WHO and the Government of Brazil, the World Conference on Social Determinants of Health was held in Rio de Janeiro in October 2011, where representatives of over 100 countries worked on tackling the root causes of health inequities.

A precursor to this world meeting, and a strong contributor to achieving this milestone, was the findings from the Commission on Social Determinants of Health. The Centre was the hub of one of nine knowledge networks that contributed to the work of the Commission. It was from this work that recommendations came to develop the Urban Health Equity and Response Tool (Urban HEART).

On 21 October 2011, Member States adopted the Rio Political Declaration, pledging to work towards reducing health inequities by taking action across the five priority areas: (1) governance to tackle the root causes of health inequities; (2) promoting participation through community leadership; (3) the role of the health sector; (4) global action on social determinants by aligning priorities and stakeholders; and (5) measurement and analysis to inform policies on social determinants.

The Declaration pledges to develop public health policies with a particular focus on reducing health inequities. Leaders also pledge to promote the relationship between social determinants and health equity outcomes. Having pioneered the measurement of health inequities in cities, the Centre is well-placed to continue supporting Member States at the national and municipal level in these areas.

The Declaration expresses global political commitment



for the implementation of a 'social determinants of health approach', and it is expected to help build momentum within countries for the development of dedicated national action plans and strategies to reduce health inequities.

These two groundbreaking international meetings in New York and Rio de Janeiro benefited from the work of the Centre, particularly in the area of intersectoral action and its focus on equity issues, both of which the Centre continues to develop and disseminate the essential tools and approaches that national and local decision-makers require. With these in hand, countries, cities and communities can shape, implement, and monitor programs to advance the health of all people.

IV. PROGRESS IN RESEARCH AREAS OF THE CENTRE

A. Urban Health Metrics –measuring is knowing

The importance of measurement for public health and the use of data for decision-making cannot be stressed enough. The Director-General of WHO herself has often stated "What gets measured gets done." This theme has been reiterated in the UN General Assembly Political Declaration on the Prevention and Control of Noncommunicable Diseases and the Rio Political Declaration on the Social Determinants of Health, respectively. The Centre serves as a hub of excellence in research around measuring the health inequities in cities, and equipping national and municipal leaders with the tools and guidance needed to identify health priorities amongst the more vulnerable populations in cities. The primary objectives of the work on urban health metrics at WHO Kobe Centre are (1) to aid city governments in making participatory and evidence-based decisions on addressing health inequities, and (2) to contribute to the global agenda on urban health metrics through cooperation with other international and regional agencies, documentation and dissemination.

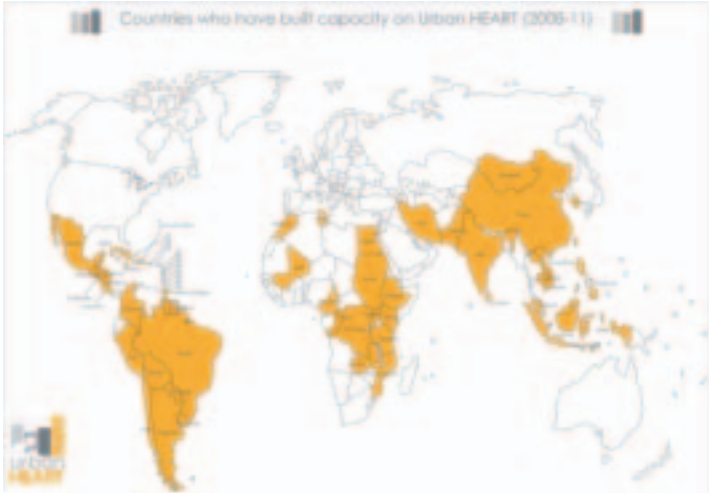
Yet measurement is not sufficient. By linking the Centre's workstreams, we are proposing and assisting cities define policy options to respond to the challenges identified from the process of data collection and analysis. The focus of the Centre's work on health metrics will be on four main areas to achieve those objectives: 1) Urban Health Equity Assessment and Response Tool (Urban HEART); 2) the Global Urban Health Observatory; 3) urban health indicators; and 4) ageing and health.

Key developments and achievements in 2011
More cities measure health inequities using the Centre's Urban HEART than ever before

Urban HEART is a tool that guides local policy-makers and communities through a standardized procedure of gathering evidence and planning effectively for actions to tackle health inequities. The tool was conceptualized in 2007 based on the work of the WHO Commission on Social Determinants of Health, and pilot-tested in 17 cities from 10 countries in 2008–09.

As of October 2011, officials from 47 countries have been trained in the use of Urban HEART (figure 1). Cities in more than 20 countries have initiated the implementation of Urban HEART by 2011. Evaluation of the Urban HEART

Figure 1 Countries who have built capacity on Urban HEART, 2008–11



¹ The 10 pilot countries include Brazil, Indonesia, Islamic Republic of Iran, Kenya, Malaysia, Mexico, Mongolia, Philippines, Sri Lanka and Viet Nam.



process and outcomes are taking place in cities where the tool was pilot-tested and results are expected by early 2012. WHO Kobe Centre has been engaged in training city officials, providing technical support for implementation, and guiding the process of evaluation with our counterpart WHO regional and country offices. Taking on the fight for equity, national and municipal leaders from 21 countries in the Americas vowed to reduce the health inequities in their cities. In a landmark meeting in Colombia in May 2011, municipal officials from these countries attended this capacity-building event to learn how to use the tool to identify the most pressing needs in their cities. Leading by example, leaders from Guarulhos (Brazil) showed its progress using Urban HEART to improve youth employment in three districts of the city. Global work going forward will include documenting, disseminating lessons learned and sharing the types of initiatives cities are taking to reduce the pertinent health inequities identified in their cities.

WHO launches one-stop shop for health data in cities

With urbanization as a leading trend in health issues over the next decade and beyond, the WHO has launched the first-ever global access to urban health data. The past decades have seen increased availability in evidence-based information for national health indicators, but there is a dearth of city level data using globally agreed standards. Urban health data for 45 countries is now available as part of the WHO Global Health Observatory Database. This is a significant milestone to improve urban policies by providing the data needed to formulate evidence-based legislation and regulations around health. This marks the beginning of the long road ahead to provide a statistical view into the lives of people living in cities. But more work is needed for cities to collect that data. The WHO Centre for Health Development serves as the coordinating research centre for global urban health data. Urban health is one of 20 themes contained in the WHO Global Health Observatory. Other themes include women and health, road safety, and noncommunicable diseases.

The Global Health Observatory theme pages provide data and analyses on global health priorities (of which urban health is one). Each theme page provides information on global situation and trends highlights, using core indicators, database views, major publications and links to relevant web pages on the theme.

For example, analysis shows urban under-five mortality rates have improved in 86% of the countries studied (comparing the periods of 1990–1999 and 2000–2007). However, the data also show that differences in health outcomes between the urban rich and urban poor are present in almost all countries. Key urban health indicators such as infant mortality, tobacco consumption, air pollution, access to safe water, and HIV/AIDS can be accessed in the newly launched database. For more information on the urban health observatory: http://www.who.int/gho/urban_health/en/index.html.

In collaboration with WHO regional offices, the WHO Kobe Centre will expand the concept and scope of the information offered by a Global Urban Health Observatory in 2012–13. WKC has further pioneered how cities can organize an urban health observatory. Based on the experience of observatories in Belo Horizonte, Brazil, Barcelona, and London, WKC will further develop guidance and tools for other cities to develop their observatories thereby creating a broader regional and worldwide network. WHO Regional Offices and HQ will be very involved.

Developing composite health indicators to compare the state of cities' health

There has been some success with previous development of indicators to measure the state of health and to have a globally agreed standard measure for comparisons across countries. The UNDP Human Development Index (HDI) is a case in point. It was developed to move beyond comparisons of GDP per capita to capture well-being, and to include criteria beyond income such as education and health at the country level. Similarly, a series of discussion with global partners and municipalities has spurred the

Centre towards developing a composite urban health indicator or an index for cities to use. Ideally, this indicator would take into account several criteria relating to health and its determinants that could assess the state of a city's overall health. While very much a work in progress, in 2011 WKC convened a consultation on urban health metrics during 23–25 February, 2011 with a panel of 16 delegates from across the globe with expertise in research and policy. Based on the recommendations and outcomes of that meeting as well as continuous consultation with experts, WKC is working with partners to develop a composite urban health index as well as an urban health equity index to allow benchmarking across cities, globally. WKC is also contributing to the development of global indicators in two new areas. First, in partnership with the Harvard Humanitarian Initiative, WKC is developing a set of indicators for rapid assessment during disasters and emergencies. Second, WKC is leading the technical expertise to develop global indicators for the WHO Age-Friendly Cities network in partnership with the Public Health Agency of Canada and Nihon Fukushi University, Japan, among others.

Making the healthy choices easy choices for the elderly

WKC is addressing the topic of ageing and health in urban settings given the topic's increasing relevance. At the January 2012 WHO Executive Board (EB) meeting, the EB member states endorsed a resolution introduced by Japan on healthy ageing. The remarkable improvements in life expectancy over the past century are in part due to improvements in public health. For instance, in 1910, the life expectancy for a Chilean female was 33 years; today, a mere century later, it is 82 years. This represents a remarkable gain of almost 50 years of life in one century. This can be seen as a success story for public health policies and for socioeconomic development, but it also challenges society to adapt, in order to maximize the health and functional capacity of older people as well as their social participation and security. Soon, the world will have more older people than children. Within the



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next five years, for the first time in human history, the number of adults aged 65 and over will outnumber children under the age of 5. In Japan, 23% of the population is 65 years or older—the highest proportion of any country in the world.

The Centre works closely with colleagues from around the world to conduct research on age-friendly environments, including the development of indicators for Age-Friendly Cities. Together with leading experts from the University of Tokyo, Kyoto University and Nihon Fukushi University in Japan, and in the Public Health Agency of Canada, WKC is working to address: (a) current evidence on the effectiveness of interventions to promote healthy ageing, (b) methods to evaluate the effectiveness of such interventions, and (c) appropriate indicators to allow benchmarking across cities. An initial set of indicators has been developed through brainstorming and consensus. WKC's prior efforts in this work area, along with its experience with and networks developed for World Health Day 2010 and the Global Forum, will enable the Centre to contribute to the upcoming World Health Day 2012 on Ageing. Further work on how the Centre can uniquely contribute to innovative solutions to ensuring healthy ageing is being developed in cooperation with colleagues in WHO, and partners in Japan and internationally.



B. Urban Health Governance – from knowledge to action

The process of gathering and systematizing evidence to provide guidance to policy-makers on how to promote health equity in urban settings has been the focus of the area of Urban Health Governance. This is a key component to sustain efforts in mainstreaming urban health and health equity and to providing policy options for decision makers (such as following Urban HEART assessments). Projects in three areas were carried out. Initiatives to promote Smoke-free cities and Intersectoral action (ISA) on health, initiated in previous periods, were further developed, emphasizing dissemination of the results; and a new initiative on urban planning was started.

Key developments and achievements in 2011
Equipping municipal leaders to implement smoke-free cities

WHO's knowledge and evidence base of the detrimental effects to health of tobacco use and its key role managing the international treaty - the WHO Framework Convention on Tobacco Control (FCTC) - are paramount in the fight against tobacco. The WHO Framework Convention entered into force for its first 40 Partners on 27 February 2005. To date, 174

countries are parties to the treaty, making it one of the most widely embraced treaties in UN History. Parties agree to increase prices and taxes on tobacco products, ban all forms of direct and indirect tobacco advertising, promotion and sponsorship; establish new packaging and labelling of tobacco products; provide protection from exposure to second-hand smoke; and strengthen legislation to clamp down on tobacco smuggling. The Centre focuses on promoting municipal-level actions concerning Article 8 of the WHO Framework Convention on Tobacco Control which addresses exposure to second hand smoke. The Centre documented how, learning from experience, local legislation can lead to national laws, as was the case in the United Kingdom when the city of Liverpool pioneered smoke-free intervention which became a strong support to national legislation. In 2011, the Centre emphasized dissemination of results of the Centre's research and capacity building for municipal leaders to advance Smoke-free cities to protect people from second-hand smoke. Building on the Centre's model ordinance for smoke-free city legislation in cities and its 12 steps to a smoke-free city, the Centre developed a pilot training programme aimed at local governments to implement these measures. 13 cities in the Western Pacific Region took part in this first-of-its kind workshop



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WHO/F.Armada

targeted specifically to municipal officials. The feedback from these leaders will be incorporated with a view to developing the final training package early next year. The final report of "Making Cities Smoke-free" targeting policy makers was prepared jointly with the Tobacco Free Initiative team in WHO Headquarters, and is used in conjunction with the training. With the Centre's location in Japan, additional research was initiated to further document smoke-free cities initiatives and to evaluate the impact of interventions, with two initiatives focusing on Japan: 1) documenting the experience of Hyogo's smoke-free legislation; and 2) the health impacts of a local street smoking ban ordinance in Kobe City in conjunction with Kobe Pharmaceutical University. In early 2012, Hyogo prefecture will become only the second prefecture in Japan to support legislation to ban smoking in public places, with Kanagawa being the other. While much remains to be done on several fronts, progress is being made. In its efforts to help promote the initiatives of prefectural officials in Hyogo, WKC was pleased to help disseminate findings from its research and background on the WHO FCTC at several events including the World No Tobacco Day Hyogo public forum, joint seminars with Hyogo Tobacco-Free Advocacy and the Hyogo Prefecture

Medical Association; and the "Future of secondhand smoke measures in Japan" organized by the University of Occupational and Environmental Health in Kitakyushu.

World leaders declare multisectoral approach to health a priority at the United Nations High-Level Meeting on noncommunicable diseases

Despite being a widely recognized approach and a priority for WHO, the concept of intersectoral (also called multisectoral) action (ISA) on health remains a challenge for public health. In 2011, world leaders recognized the importance of this component to improve public health at the UN meeting in New York. The Centre's work on ISA was also included in the WHO Global Status Report of Noncommunicable Diseases, in efforts to more widely disseminate the concept of ISA, the findings of the research, and provide good practices of governments adopting this approach. The Centre continues to build on this work. Specifically, the Centre gathered evidence on successful practices and on drawing recommendations throughout 2011. Following an open call of expressions of interest in documenting cases at the city level, case studies focused on the role of local governments in developing and implementing different types of intersectoral policies or interventions and include: (1) the Liverpool Active City



programme; (2) comparative research on the experiences of London and New York with intersectoral child obesity programmes; (3) combating Noncommunicable diseases in Abha City, Saudia Arabia and (4) Varde's (Denmark) approach to make health concerns part of other sectors' routine policy processes. Moreover, in 2011 the Centre published a guidance booklet "Intersectoral Action on Health, A path for policy-makers to implement effective and sustainable action on health", which summarizes a set of recommendations, lessons and approaches to intersectoral action on health as an overall strategy for public policy. Building on these experiences, and serving as a WHO focal point on multisectoral actions to advance action on noncommunicable diseases and their risk factors, the Centre will contribute to synthesizing and disseminating experiences on multisectoral actions and partnering models in 2012. WHO has a number of responsibilities in follow up to the 2011 UN General Assembly Political Declaration on NCDs, including on this topic.

The findings from the studies above and related issues will contribute to the next major milestone event focusing on ISA at the 8th Global Conference on Health Promotion (Helsinki, June 2013).

Building on evidence for urban planning and its influence on health

Closely linked to ISA, a new area of work on linking health approaches to urban planning evolved from an expert consultation held in Kobe in March 2011 with the participation of policy-makers, academics and local government technicians from both public health and architecture/urbanism sectors with expertise on high-income and low-income countries. This consultation resulted in a set of recommendations to WKC on how to develop an agenda on urban planning with a focus on impacting positively on health. In the coming years, the Centre will develop a set of recommendations on Healthy Urban Planning to be implemented by local governments.



WHO/A.Kari

C. Urban Health Emergency Management

A variety of natural disasters confronted the world in 2011 including the Great East Japan Earthquake and its sequelae, earthquakes in Haiti, Chile, Peru and Turkey, and major floods in Thailand and the Philippines, to name a few. They all remind us of the need for preparedness, response, and recovery, particularly affecting the most vulnerable populations as well as urban areas. In 2011, the Centre re-focused its long history of working in emergency preparedness through Urban Health Emergency Management. This area of work builds on the solid past WKC workstream and leadership on Disaster Reduction, Preparedness and Response and WHO's role as the lead for health as part of the Inter-agency Standing Committee that manages humanitarian responses in the UN system. Research and assessment studies conducted as well as contributions to the response to the 11 March 2011 Great East Japan Earthquake are detailed below. The overall goal in the longer term is to create policy recommendations on emergency preparedness for cities, including prioritized work on climate change adaptation for cities. Towards this

end, 2011 focused on the generation of evidence through several research initiatives.

The Centre is equally increasing its partnerships with colleagues in UNOCHA and the UNISDR within Kobe with a shared interest in humanitarian work, as well as to seek additional opportunities globally in working with UN-HABITAT which the Centre already has a Memorandum of Understanding.

Key developments and achievements in 2011
Preparing cities for disease outbreaks

In the area of emergency management, research was initiated this year with the WHO HQ and its Lyon Office on "City preparedness: ASAP (Assessment Status and Action Plan)" with the aim of preparing cities for disease outbreaks. To assist with developing future guidelines on disaster risk reduction in cities, an ongoing review of emergency and humanitarian materials is being conducted in the Eastern Mediterranean Region in the context of community based initiatives.



WHO/M.Kano



Responding to the Great East Japan Earthquake and preparing for future disasters

In close coordination with WHO Headquarters and the WHO Regional Office for the Western Pacific (WPRO), the Centre helped monitor the situation in Japan after the tsunami of 11 March and assess public health risks. Teams from WHO were sent twice to assess recovery efforts and to incorporate lessons learnt in order to help prepare for future events that could strike at any time around the globe. Situation reports, FAQs and daily news updates were made available on WHO HQ and WPRO websites. The Centre translated all relevant documents into Japanese and posted them on its website. Much appreciation was expressed for the readily available documents from the Japanese Ministry of Health, Labor and Welfare, UN agencies, embassies and general public. In its continued work in emergency preparedness and response, the Centre was the location of the most recent efforts by the UN to harmonize the health response in the face of disasters and emergencies. Working with the WHO WPRO in Manila, an operational framework for this region was agreed upon by representatives of member countries and international organizations to coordinate health response efforts in future disasters. This effort is part of a broader WHO responsibility as the global health cluster lead and coordinator under the UN inter-agency humanitarian coordination system.



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Developing guidelines for cities on climate change adaptation

In keeping with the international community's long-term goal to develop climate change adaptation guidelines, the Centre is in the final stages of finalizing two streams of work on health and climate change adaptation. This work supports cities that do not currently have climate change policies in place. The Centre has focused on developing approaches for cities to conduct assessments on how climate change is affecting infectious diseases (both water borne and vector borne) and more broadly on health. In this regard, studies were initiated on climate change and infectious diseases in Mali, Myanmar, Nepal and Sri Lanka. The process and results of the studies are being documented so as to feed into recommendations of how cities can get started in developing plans for climate change adaptation. Also this year, a technical report was published on "Relationship between climate variability and occurrence of diarrhea and cholera: A pilot study using retrospective data from Kolkata, India". These findings will feed into future recommendations. Infectious disease is only a subset of adaptation policy, so a full assessment across all sectors on the effects of climate change will also be needed. Along these lines, climate change vulnerability and adaptation assessments concerning health were completed in Kathmandu, Nepal, and Belo Horizonte, Brazil. A study in La Paz, Bolivia, is currently underway.

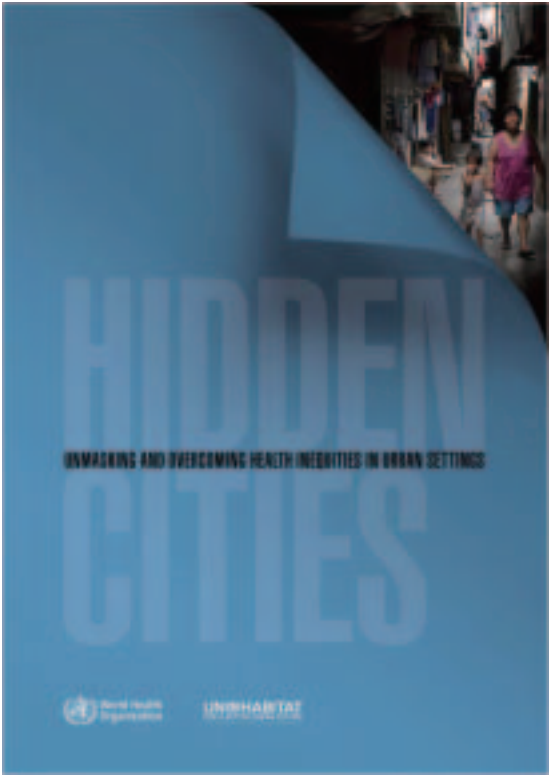
V. PROMOTING THE URBAN HEALTH AGENDA AND THE WHO CENTRE FOR HEALTH DEVELOPMENT

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 2010 Global Forum on Urbanization and Health and the Kobe Call to Action, along with the 2010 Hidden Cities report, set the stage for increasing the profile of the issues. These are critical in the quest to mainstream urban health equity in the global policy landscape. The Centre's research work and development of policy into action is part of this work and are highlighted in the previous sections. Another component of the Centre's work is to influence policy dialogue, research, and agenda-setting at international fora and at events in Japan, where the Centre is located. Research findings are discussed and shared, and lessons learned incorporated. In 2011, the teams of the Centre promoted their work at a multitude of events, summarized below. A full list can be found in Annex 4.

A. Promoting the Centre's work internationally

In 2011, Staff from the Kobe Centre were invited to present research findings, discuss policy issues and share good case examples at 15 international events. Among many highlights:

- At the Humanitarian Action Summit hosted by Harvard University, staff presented the methodology to develop indicators for Urban HEART to spur discussions on how a similar indicator could be used for disaster response. WKC, together with Harvard University and the rest of the working group are now in the process of developing these indicators.
- At the Global Health Metrics and Evaluation Conference in Seattle, co-hosted by the Lancet, the London School of Hygiene & Tropical Medicine and the Harvard School of Public Health, prominent experts in health assessment and measurement convened to discuss innovative tools and methods to improve



global health measurement and evaluation. The Centre was asked to share and present its research on trends in urban health inequalities and its experience in developing Urban HEART.

- Policy and experiences on the Centre's work around social determinants of health formed part of the Western Pacific Regional Meeting on Social Determinants of health in preparation for the World Summit on Social Determinants of Health. Specifically, the Centre shared its findings from the smoke-free cities work, and the Philippines and Viet Nam presented their experience with Urban HEART.
- In the lead up to the UN High-Level Meeting on NCDs, the Western Pacific Regional Office held its consultation in Shanghai, China, on Promoting Healthy Living and Preventing NCDs through Healthy Cities. Through several discussions, WKC's work on urban planning and smoke-free cities was disseminated to city officials from more than 11 countries. The Centre is following up on requests for guidance to help



- implement the recommendations on smoke-free cities.
- At the World Health Summit in Berlin, hosted by the Government of Germany, Centre officer was invited as a panel speaker for the working session on urban environmental public health. This provided a good opportunity to share the Centre's findings on the impact of climate change on urban populations in low income countries, especially on the so-called "hidden cities".
 - One of the only annual international urban health meetings that takes place is the International Conference on Urban Health. This year, in recognition of the Centre's work, staff members were asked to present on eight various topics in the plenary, at workshops, and in multiple side sessions.
 - Over the last several years, the Centre has made progress in the recognition of its work on reducing urban health inequity and is collaborating more and more with multiple partners to help shape the policy landscape in this area.

B. Working with national and local partners in Japan

The Centre continues to work closely with Japanese researchers, government officials, academia, and other partners in Japan. In 2011, staff members from the centre were asked to present at more than 15 meetings in Tokyo, Osaka, Nagoya, Sanda city, and Kobe. The Centre also held four public health forums in Kobe as part of its outreach to the local community on promoting the work of the Centre. Finally, the Centre hosted two large regional meetings in Kobe: Informal Meeting on Disaster Recovery for the Health Sector and the First Regional Health Cluster Forum co-hosted with the WHO Regional Office in the Western Pacific.

Another important component to the Centre's work is hosting interns from universities in Japan and other countries such as France and the United States. In 2011, the Centre hosted 13 interns, conducting research on mental health and equity issues, climate change, health impact assessments, and NCD mortality in Japanese cities. For a full list, see Annex 5.



WHO/I. Opere

VI. CONCLUSIONS AND FUTURE PLANS

In the course of the 2010–2011, the Centre has emphasized the need to address urban health inequities and contribute to ensuring that Urban Health higher on the global agenda.

The 2010 campaign on urbanization and health was coordinated from Kobe and produced several global events and a political commitment to address urban health inequities. The 2010 World Health Day gathered participation from over 1500 cities worldwide raising awareness on the need to address urban health as a matter of public policy; the Global Report on Urbanization and Health (Hidden Cities) -jointly produced with UN-HABITAT- summerized the latest evidence on urban health and health inequities, providing a platform for further evidence gathering; and the Global Forum on Urbanization and Health attended by Dr Margaret Chan, Director-General of WHO, encouraged policy-makers from all levels of government to acknowledge the issues at stake and pledge to tackle urban health inequities.

The Kobe Call to Action, endorsed by the participants to the Global Forum on Urbanization and Health, provides an operational framework highlighting key principles at the heart of WHO Kobe Centre work: evidence gathering on health inequities, technical guidance on appropriate interventions, and on processes such as intersectoral action and community participation. At the same time, the WHO Kobe Centre has been instrumental in defining new standards in urban health measurement through the development of the Urban Health Equity Assessment and Response Tool (Urban HEART), and moved forward towards equipping WHO and its Member States with an Urban Health Observatory.

The 2012–2013 biennium is building on the legacy of the Global Campaign on Urbanization and Health, strengthening research and evidence gathering related to intersectoral action and noncommunicable diseases (NCDs). In the next two years, each area of work of the WHO Kobe Centre will be strengthening its focus: on ISA and examples of NCD local legislation for governance; on metrics and urban observatories for metrics; and on



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disaster resilience analytical frameworks for emergency. Responding to emerging health needs and trends, the Centre will consider how best to leverage its expertise, resources, networks, and convening power to contribute. The landmark adoption by the United Nations General Assembly of the Political Declaration for the Prevention and Control of Noncommunicable Diseases raised the profile of the significant impact NCDs have on societies, economies, and the health of populations, and also the need to control them and their risk factors. It also introduced the need to design "whole-of-government" responses. Related to this, a spotlight on ageing, the life course approach, and Age Friendly Cities, will lead WHO to declaring the theme of World Health Day 2012 (April 7) to be on Ageing. Another major emerging force in advancing health outcomes has been innovation in new research, product development, health care system delivery, and in communication. An underlying core principle of the Kobe Centre's work has been innovation in its research, standard development for metrics, translation of research

into policy, and multi-disciplinary approaches. The Centre has made significant contributions to public health areas that have been under- or unaddressed. These include urban health, ageing, disaster risk reduction, and intersectoral action. In the next 12 months, the Centre will be exploring how it can further capitalize on the knowledge and innovation located here in Kobe and Hyogo to bring about improved benefits in global health. It will also seek to build new bridges with partners in this area of expertise elsewhere in Japan, Asia and beyond. A key need and opportunity will be to address and develop public policy frameworks for technology assessment, selection, financing, and scale-up for the benefit of communities. In 2012, the Centre will undertake a process to update the 2004 WHO Kobe Centre Health and Development Research Framework to account for past lessons learned and - in the context of other WHO offices, local/national/ regional institutions and partnerships - to identify strategic new areas of work for the Centre.



WHO/J. Opere

15th Meeting of the Advisory Committee of the WHO Centre for Health Development, 8–9 November 2011

ANNEXES

- Annex 1 : Recommendations of the Advisory Committee of the WHO Kobe Centre 2011
- Annex 2 : Declaration of the UN High-Level Meeting on Non-communicable Diseases
- Annex 3 : Rio Declaration at the World Conference on Social Determinants of Health
- Annex 4 : WKC presentations and products 2011
- Annex 5 : List of staff and interns 2011

Annex 1:
Recommendations of the Advisory Committee
of the WHO Kobe Centre 2011

Recommendations


In summary, the Advisory Committee recommended that the Centre:

1. build on and sustain the momentum gained in 2010, and nurtured during 2011, in order to mainstream work on urban health equity by building appropriate partnerships and networks to achieve the goal of reducing health inequities in cities, and in particular ensure a thorough follow-up and mainstreaming of the Kobe Call to Action;
2. continue and strengthen its work to support cities and municipalities as laboratories for the adoption and assessment of health and intersectoral policies that can improve health and reduce health inequities, noting the recent UN Political Declaration on the Prevention and Control of Noncommunicable Diseases and Rio Declaration from the World Conference on Social Determinants of Health;
3. carry out the workplan for the 2012–13 biennium within the general framework of the 2011–2015 strategy to reduce health inequities in urban settings relying on an integrated workplan with three core pillars of urban health metrics, urban health governance, and urban health emergency management;
4. develop additional evidence, models, tools and guidelines to promote adoption of urban policies that aim to address health and health equity; and to support efforts to assess and document the impact of such policies;
5. develop a strategy for scaling up Urban HEART and assist cities and municipalities to develop policy and programmatic options based on evidence derived from Urban HEART;
6. strengthen development of urban health observatories; and explore approaches for inter-city

- comparisons and options for developing a global urban health equity index;
7. explore and develop research opportunities for innovative approaches and technologies to support ageing populations, including developing metrics and promotion strategies for Age Friendly Cities;
 8. support WHO HQ and Regional Office efforts to assess and strengthen city preparedness tools to address urban health emergencies for enhanced risk assessment, management and communication;
 9. explore and identify strategic research and convening opportunities for WKC, utilizing its comparative advantages and networks, to advance innovation in health by exploring issues related to balancing protection of public health and equity with the introduction of innovative products, services and approaches;
 10. pursue, in cooperation with the JCC and other partners, a dissemination campaign of WKC's work to increase the Centre's visibility among the local and international community;
 11. continue to expand its network of institutions in Japan and worldwide where there are mutually beneficial areas of work; and continue to engage local scientific institutions in Kobe and Hyogo with a focus on issues that are a priority to the local community;
 12. urge the Kobe Group to continue its support to WKC in the implementation of the 2011–15 strategy;
 13. consider the discussions and observations made by the Advisory Committee in the implementation of the Centre's work.

Annex 2:
Declaration of the UN High-Level Meeting
on Non-communicable Diseases

United Nations



General Assembly

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16 September 2011

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Sixty-sixth session
Agenda item 117
Follow-up to the outcome of the Millennium Summit

Draft resolution submitted by the President of the General Assembly

Political declaration of the High-level Meeting of the
General Assembly on the Prevention and Control of
Non-communicable Diseases

The General Assembly,
Adopts the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases annexed to the present resolution.

Annex

Political Declaration of the High-level Meeting of the
General Assembly on the Prevention and Control of
Non-communicable Diseases

We, Heads of State and Government and representatives of States and Governments, assembled at the United Nations from 19 to 20 September 2011, to address the prevention and control of non-communicable diseases worldwide, with a particular focus on developmental and other challenges and social and economic impacts, particularly for developing countries,

1. Acknowledge that the global burden and threat of non-communicable diseases constitutes one of the major challenges for development in the twenty-first century, which undermines social and economic development throughout the world, and threatens the achievement of internationally agreed development goals;
2. Recognize that non-communicable diseases are a threat to the economies of many Member States, and may lead to increasing inequalities between countries and populations;
3. Recognize the primary role and responsibility of Governments in responding to the challenge of non-communicable diseases and the essential need for the efforts



and engagement of all sectors of society to generate effective responses for the prevention and control of non-communicable diseases;

4. Recognize also the important role of the international community and international cooperation in assisting Member States, particularly developing countries, in complementing national efforts to generate an effective response to non-communicable diseases;

5. Reaffirm the right of everyone to the enjoyment of the highest attainable standard of physical and mental health;

6. Recognize the urgent need for greater measures at global, regional and national levels to prevent and control non-communicable diseases in order to contribute to the full realization of the right of everyone to the highest attainable standard of physical and mental health;

7. Recall the relevant mandates of the United Nations General Assembly, in particular resolutions 64/265 and 65/238;

8. Note with appreciation the World Health Organization (WHO) Framework Convention on Tobacco Control, reaffirm all relevant resolutions and decisions adopted by the World Health Assembly on the prevention and control of non-communicable diseases, and underline the importance for Member States to continue addressing common risk factors for non-communicable diseases through the implementation of the 2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Non-communicable Diseases as well as the Global Strategy on Diet, Physical Activity and Health, and the Global Strategy to Reduce the Harmful Use of Alcohol;

9. Recall the Ministerial Declaration adopted at the 2009 high-level segment of the United Nations Economic and Social Council, which called for urgent action to implement the WHO Global Strategy for the Prevention and Control of Non-communicable Diseases and its related action plan;

10. Take note with appreciation of all the regional initiatives undertaken on the prevention and control of non-communicable diseases, including the Declaration of the Heads of State and Government of the Caribbean Community entitled “Uniting to stop the epidemic of chronic non-communicable diseases”, adopted in September 2007; the Libreville Declaration on Health and Environment in Africa, adopted in August 2008; the statement of the Commonwealth Heads of Government on action to combat non-communicable diseases, adopted in November 2009; the outcome declaration of the Fifth Summit of the Americas adopted in June 2009; the Parma Declaration on Environment and Health, adopted by the Member States in the European Region of WHO in March 2010; the Dubai Declaration on Diabetes and Chronic Non-communicable Diseases in the Middle East and Northern Africa Region, adopted in December 2010, the European Charter on Counteracting Obesity, adopted in November 2006, the Aruban Call for Action on Obesity of June 2011, and the Honiara Communiqué on addressing non-communicable disease challenges in the Pacific region, adopted in July 2011;

11. Take note also with appreciation of the outcomes of the regional multisectoral consultations, including the adoption of Ministerial Declarations, which were held by the World Health Organization in collaboration with Member States, with the support and active participation of regional commissions and other relevant United

Nations agencies and entities, and served to provide inputs to the preparations for the high-level meeting in accordance with resolution 65/238;

12. Welcome the convening of the First Global Ministerial Conference on Healthy Lifestyles and Non-communicable Disease Control, which was organized by the Russian Federation and WHO and held on 28 and 29 April 2011, in Moscow, and the adoption of the Moscow Declaration, and recall resolution 64/11 of the World Health Assembly;

13. Recognize the leading role of the World Health Organization as the primary specialized agency for health, including its roles and functions with regard to health policy in accordance with its mandate, and reaffirm its leadership and coordination role in promoting and monitoring global action against non-communicable diseases in relation to the work of other relevant United Nations agencies, development banks, and other regional and international organizations in addressing non-communicable diseases in a coordinated manner;

A challenge of epidemic proportions and its socio-economic and developmental impacts

14. Note with profound concern that, according to WHO, in 2008, an estimated 36 million of the 57 million global deaths were due to non-communicable diseases, principally cardiovascular diseases, cancers, chronic respiratory diseases and diabetes, including about 9 million before the age of 60, and that nearly 80 per cent of those deaths occurred in developing countries;

15. Note also with profound concern that non-communicable diseases are among the leading causes of preventable morbidity and of related disability;

16. Recognize further that communicable diseases, maternal and perinatal conditions and nutritional deficiencies are currently the most common causes of death in Africa, and note with concern the growing double burden of disease, including in Africa, caused by the rapidly rising incidence of non-communicable diseases, which are projected to become the most common causes of death by 2030;

17. Note further that there is a range of other non-communicable diseases and conditions, for which the risk factors and the need for preventive measures, screening, treatment and care are linked with the four most prominent non-communicable diseases;

18. Recognize that mental and neurological disorders, including Alzheimer’s disease, are an important cause of morbidity and contribute to the global non-communicable disease burden, for which there is a need to provide equitable access to effective programmes and health-care interventions;

19. Recognize that renal, oral and eye diseases pose a major health burden for many countries and that these diseases share common risk factors and can benefit from common responses to non-communicable diseases;

20. Recognize that the most prominent non-communicable diseases are linked to common risk factors, namely tobacco use, harmful use of alcohol, an unhealthy diet, and lack of physical activity;

21. Recognize that the conditions in which people live and their lifestyles influence their health and quality of life, and that poverty, uneven distribution of



wealth, lack of education, rapid urbanization and population ageing, and the economic social, gender, political, behavioural and environmental determinants of health are among the contributing factors to the rising incidence and prevalence of non-communicable diseases;

22. Note with grave concern the vicious cycle whereby non-communicable diseases and their risk factors worsen poverty, while poverty contributes to rising rates of non-communicable diseases, posing a threat to public health and economic and social development;

23. Note with concern that the rapidly growing magnitude of non-communicable diseases affects people of all ages, gender, race and income levels, and further that poor populations and those living in vulnerable situations, in particular in developing countries bear a disproportionate burden and that non-communicable diseases can affect women and men differently;

24. Note with concern the rising levels of obesity in different regions, particularly among children and youth, and note that obesity, an unhealthy diet and physical inactivity have strong linkages with the four main non-communicable diseases, and are associated with higher health costs and reduced productivity;

25. Express deep concern that women bear a disproportionate share of the burden of care-giving and that, in some populations, women tend to be less physically active than men, are more likely to be obese and are taking up smoking at alarming rates;

26. Note also with concern that maternal and child health is inextricably linked with non-communicable diseases and their risk factors, specifically as prenatal malnutrition and low birth weight create a predisposition to obesity, high blood pressure, heart disease and diabetes later in life; and that pregnancy conditions, such as maternal obesity and gestational diabetes, are associated with similar risks in both the mother and her offspring;

27. Note with concern the possible linkages between non-communicable diseases and some communicable diseases, such as HIV/AIDS, and call to integrate, as appropriate, responses for HIV/AIDS and non-communicable diseases and, in this regard, for attention to be given to people living with HIV/AIDS, especially in countries with a high prevalence of HIV/AIDS and in accordance with national priorities;

28. Recognize that smoke exposure from the use of inefficient cooking stoves for indoor cooking or heating contributes to and may exacerbate lung and respiratory conditions, with a disproportionate effect on women and children in poor populations whose households may be dependant on such fuels;

29. Acknowledge also the existence of significant inequalities in the burden of non-communicable diseases and in access to non-communicable disease prevention and control, both between countries, and within countries and communities;

30. Recognize the critical importance of strengthening health systems, including health-care infrastructure, human resources for health, health and social protection systems, particularly in developing countries in order to respond effectively and equitably to the health-care needs of people with non-communicable diseases;

31. Note with grave concern that non-communicable diseases and their risk factors lead to increased burdens on individuals, families and communities, including impoverishment from long-term treatment and care costs, and to a loss of productivity that threatens household income and leads to productivity loss for individuals and their families and to the economies of Member States, making non-communicable diseases a contributing factor to poverty and hunger, which may have a direct impact on the achievement of the internationally agreed development goals, including the Millennium Development Goals;

32. Express deep concern at the ongoing negative impacts of the financial and economic crisis, volatile energy and food prices and ongoing concerns over food security, as well as the increasing challenges posed by climate change and the loss of biodiversity, and their effect on the control and prevention of non-communicable diseases, and emphasize, in this regard, the need for prompt and robust, coordinated and multisectoral efforts to address those impacts, while building on efforts already under way;

Responding to the challenge: a whole-of-government and a whole-of-society effort

33. Recognize that the rising prevalence, morbidity and mortality of non-communicable diseases worldwide can be largely prevented and controlled through collective and multisectoral action by all Member States and other relevant stakeholders at local, national, regional, and global levels, and by raising the priority accorded to non-communicable diseases in development cooperation by enhancing such cooperation in this regard;

34. Recognize that prevention must be the cornerstone of the global response to non-communicable diseases;

35. Recognize also the critical importance of reducing the level of exposure of individuals and populations to the common modifiable risk factors for non-communicable diseases, namely, tobacco use, unhealthy diet, physical inactivity, and the harmful use of alcohol, and their determinants, while at the same time strengthening the capacity of individuals and populations to make healthier choices and follow lifestyle patterns that foster good health;

36. Recognize that effective non-communicable disease prevention and control require leadership and multisectoral approaches for health at the government level, including, as appropriate, health in all policies and whole-of-government approaches across such sectors as health, education, energy, agriculture, sports, transport, communication, urban planning, environment, labour, employment, industry and trade, finance and social and economic development;

37. Acknowledge the contribution and important role played by all relevant stakeholders, including individuals, families, and communities, intergovernmental organizations and religious institutions, civil society, academia, media, voluntary associations, and, where and as appropriate, the private sector and industry, in support of national efforts for non-communicable disease prevention and control, and recognize the need to further support the strengthening of coordination among these stakeholders in order to improve effectiveness of these efforts;

38. Recognize the fundamental conflict of interest between the tobacco industry and public health;



39. Recognize that the incidence and impacts of non-communicable diseases can be largely prevented or reduced with an approach that incorporates evidence-based, affordable, cost-effective, population-wide and multisectoral interventions;

40. Acknowledge that resources devoted to combating the challenges posed by non-communicable diseases at the national, regional and international levels are not commensurate with the magnitude of the problem;

41. Recognize the importance of strengthening local, provincial, national and regional capacities to address and effectively combat non-communicable diseases, particularly in developing countries, and that this may entail increased and sustained human, financial and technical resources;

42. Acknowledge the need to put forward a multisectoral approach for health at all government levels, to address non-communicable disease risk factors and underlying determinants of health comprehensively and decisively;

Non-communicable diseases can be prevented and their impacts significantly reduced, with millions of lives saved and untold suffering avoided. We therefore commit to:

Reduce risk factors and create health-promoting environments

43. Advance the implementation of multisectoral, cost-effective, population-wide interventions in order to reduce the impact of the common non-communicable disease risk factors, namely tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol, through the implementation of relevant international agreements and strategies, and education, legislative, regulatory and fiscal measures, without prejudice to the right of sovereign Nations to determine and establish their taxation policies, other policies, where appropriate, by involving all relevant sectors, civil society and communities as appropriate and by taking the following actions:

(a) Encourage the development of multisectoral public policies that create equitable health-promoting environments that empower individuals, families and communities to make healthy choices and lead healthy lives;

(b) Develop, strengthen and implement, as appropriate, multisectoral public policies and action plans to promote health education and health literacy, including through evidence-based education and information strategies and programmes in and out of schools, and through public awareness campaigns, as important factors in furthering the prevention and control of non-communicable diseases, recognizing that a strong focus on health literacy is at an early stage in many countries;

(c) Accelerate implementation by States parties of the WHO Framework Convention on Tobacco Control, recognizing the full range of measures, including measures to reduce consumption and availability, and encourage countries that have not yet done so to consider acceding to the Framework Convention on Tobacco Control, recognizing that substantially reducing tobacco consumption is an important contribution to reducing non-communicable diseases and can have considerable health benefits for individuals and countries, and that price and tax measures are an effective and important means of reducing tobacco consumption;

(d) Advance the implementation of the WHO Global Strategy on Diet, Physical Activity and Health, including, where appropriate, through the introduction

of policies and actions aimed at promoting healthy diets and increasing physical activity in the entire population, including in all aspects of daily living, such as giving priority to regular and intense physical education classes in schools; urban planning and re-engineering for active transport; the provision of incentives for work-site healthy-lifestyle programmes; and increased availability of safe environments in public parks and recreational spaces to encourage physical activity;

(e) Promote the implementation of the WHO Global Strategy to Reduce the Harmful Use of Alcohol, while recognizing the need to develop appropriate domestic action plans, in consultation with relevant stakeholders, for developing specific policies and programmes, including taking into account the full range of options as identified in the global strategy, as well as raise awareness of the problems caused by the harmful use of alcohol, particularly among young people, and call upon WHO to intensify efforts to assist Member States in this regard;

(f) Promote the implementation of the WHO Set of recommendations on the marketing of foods and non-alcoholic beverages to children, including foods that are high in saturated fats, trans-fatty acids, free sugars, or salt, recognizing that research shows that food advertising to children is extensive, that a significant amount of the marketing is for foods with a high content of fat, sugar or salt and that television advertising influences children's food preferences, purchase requests and consumption patterns, while taking into account the existing legislation and national policies, as appropriate;

(g) Promote the development and initiate the implementation, as appropriate, of cost-effective interventions to reduce salt, sugar and saturated fats, and eliminate industrially produced trans-fats in foods, including through discouraging the production and marketing of foods that contribute to unhealthy diet, while taking into account existing legislation and policies;

(h) Encourage policies that support the production and manufacture of, and facilitate access to, foods that contribute to healthy diet, and provide greater opportunities for utilization of healthy local agricultural products and foods, thus contributing to efforts to cope with the challenges and take advantage of the opportunities posed by globalization and to achieve food security;

(i) Promote, protect and support breastfeeding, including exclusive breastfeeding for about six months from birth, as appropriate, as breastfeeding reduces susceptibility to infections and the risk of undernutrition, promotes infant and young children's growth and development and helps to reduce the risk of developing conditions such as obesity and non-communicable diseases later in life, and, in this regard, strengthen the implementation of the international code of marketing of breast milk substitutes and subsequent relevant World Health Assembly resolutions;

(j) Promote increased access to cost-effective vaccinations to prevent infections associated with cancers, as part of national immunization schedules;

(k) Promote increased access to cost-effective cancer-screening programmes as determined by national situations;

(l) Scale up, where appropriate, a package of proven effective interventions, such as health promotion and primary prevention approaches, and galvanize actions



for the prevention and control of non-communicable diseases through a meaningful multisectoral response, addressing risk factors and determinants of health;

44. With a view to strengthening its contribution to non-communicable disease prevention and control, call upon the private sector, where appropriate, to:

(a) Take measures to implement the WHO set of recommendations to reduce the impact of the marketing of unhealthy foods and non-alcoholic beverages to children, while taking into account existing national legislation and policies;

(b) Consider producing and promoting more food products consistent with a healthy diet, including by reformulating products to provide healthier options that are affordable and accessible and that follow relevant nutrition facts and labelling standards, including information on sugars, salt and fats and, where appropriate, trans-fat content;

(c) Promote and create an enabling environment for healthy behaviours among workers, including by establishing tobacco-free workplaces and safe and healthy working environments through occupational safety and health measures, including, where appropriate, through good corporate practices, workplace wellness programmes and health insurance plans;

(d) Work towards reducing the use of salt in the food industry in order to lower sodium consumption;

(e) Contribute to efforts to improve access and affordability for medicines and technologies in the prevention and control of non-communicable diseases;

Strengthen national policies and health systems

45. Promote, establish or support and strengthen, by 2013, as appropriate, multisectoral national policies and plans for the prevention and control of non-communicable diseases, taking into account, as appropriate, the 2008-2013 WHO Action Plan for the Global Strategy for the Prevention and Control of Non-communicable Diseases, and the objectives contained therein and take steps to implement such policies and plans;

(a) Strengthen and integrate, as appropriate, non-communicable disease policies and programmes into health-planning processes and the national development agenda of each Member State;

(b) Pursue, as appropriate, comprehensive strengthening of health systems that support primary health care, deliver effective, sustainable and coordinated responses and evidence-based, cost-effective, equitable and integrated essential services for addressing non-communicable disease risk factors and for the prevention, treatment and care of non-communicable diseases, acknowledging the importance of promoting patient empowerment, rehabilitation and palliative care for persons with non-communicable diseases, and a life course approach, given the often chronic nature of non-communicable diseases;

(c) According to national priorities, and taking into account domestic circumstances, increase and prioritize budgetary allocations for addressing non-communicable disease risk factors and for surveillance, prevention, early detection, and treatment of non-communicable diseases, and the related care and support including palliative care;

(d) Explore the provision of adequate, predictable and sustained resources, through domestic, bilateral, regional and multilateral channels, including traditional and voluntary innovative financing mechanisms;

(e) Pursue and promote gender-based approaches for the prevention and control of non-communicable diseases founded on data disaggregated by sex and age in an effort to address the critical differences in the risks of morbidity and mortality from non-communicable diseases for women and men;

(f) Promote multisectoral and multi-stakeholder engagement in order to reverse, stop and decrease the rising trends of obesity in child, youth and adult populations respectively;

(g) Recognize where health disparities exist between indigenous peoples and non-indigenous populations in the incidence of non-communicable diseases, and their common risk factors, that these disparities are often linked to historical, economic and social factors, encourage the involvement of indigenous peoples and communities in the development, implementation, and evaluation of non-communicable disease prevention and control policies, plans and programmes, where appropriate, while promoting the development and strengthening of capacities at various levels and recognizing the cultural heritage and traditional knowledge of indigenous peoples and respecting, preserving and promoting, as appropriate, their traditional medicine, including conservation of their vital medicinal plants, animals and minerals;

(h) Recognize further the potential and contribution of traditional and local knowledge and in this regard, respect and preserve, in accordance with national capacities, priorities, relevant legislation and circumstances, the knowledge and safe and effective use of traditional medicine, treatments and practices, appropriately based on the circumstances in each country;

(i) Pursue all necessary efforts to strengthen nationally driven, sustainable, cost-effective and comprehensive responses in all sectors for the prevention of non-communicable diseases, with the full and active participation of people living with these diseases, civil society and the private sector, where appropriate;

(j) Promote the production, training and retention of health workers with a view to facilitating adequate deployment of a skilled health workforce within countries and regions, in accordance with the World Health Organization Global Code of Practice on the International Recruitment of Health Personnel;

(k) Strengthen, as appropriate, information systems for health planning and management, including through the collection, disaggregation, analysis, interpretation, and dissemination of data and the development of population-based national registries and surveys, where appropriate, to facilitate appropriate and timely interventions for the entire population;

(l) According to national priorities, give greater priority to surveillance, early detection, screening, diagnosis and treatment of non-communicable diseases and prevention and control, and to improving the accessibility to the safe, affordable, effective and quality medicines and technologies to diagnose and to treat them; provide sustainable access to medicines and technologies, including through the development and use of evidence-based guidelines for the treatment of non-communicable diseases, and efficient procurement and distribution of



medicines in countries; and strengthen viable financing options and promote the use of affordable medicines, including generics, as well as improved access to preventive, curative, palliative and rehabilitative services, particularly at the community level;

(m) According to country-led prioritization, ensure the scaling-up of effective, evidence-based and cost-effective interventions that demonstrate the potential to treat individuals with non-communicable diseases, protect those at high risk of developing them and reduce risk across populations;

(n) Recognize the importance of universal coverage in national health systems, especially through primary health-care and social protection mechanisms, to provide access to health services for all, in particular, for the poorest segments of the population;

(o) Promote the inclusion of non-communicable disease prevention and control within sexual and reproductive health and maternal and child-health programmes, especially at the primary health-care level, as well as other programmes, as appropriate, and also integrate interventions in these areas into non-communicable disease prevention programmes;

(p) Promote access to comprehensive and cost-effective prevention, treatment and care for the integrated management of non-communicable diseases, including, inter alia, increased access to affordable, safe, effective and quality medicines and diagnostics and other technologies, including through the full use of trade-related aspects of intellectual property rights (TRIPS) flexibilities;

(q) Improve diagnostic services, including by increasing the capacity of and access to laboratory and imaging services with adequate and skilled manpower to deliver such services, and collaborate with the private sector to improve affordability, accessibility and maintenance of diagnostic equipment and technologies;

(r) Encourage alliances and networks that bring together national, regional and global actors, including academic and research institutes, for the development of new medicines, vaccines, diagnostics and technologies, learning from experiences in the field of HIV/AIDS, among others, according to national priorities and strategies;

(s) Strengthen health-care infrastructure, including for procurement, storage and distribution of medicine, in particular transportation and storage networks to facilitate efficient service delivery;

International cooperation, including collaborative partnerships

46. Strengthen international cooperation in support of national, regional, and global plans for the prevention and control of non-communicable diseases, inter alia, through the exchange of best practices in the areas of health promotion, legislation, regulation and health systems strengthening, training of health personnel, development of appropriate health-care infrastructure, diagnostics, and promoting the development, dissemination of appropriate, affordable and sustainable transfer of technology on mutually agreed terms and the production of affordable, safe, effective and quality medicines and vaccines, while recognizing the leading role of WHO as the primary specialized agency for health in that regard;

47. Acknowledge the contribution of aid targeted at the health sector, while recognizing that much more needs to be done. We call for the fulfilment of all official development assistance-related commitments, including the commitments by many developed countries to achieve the target of 0.7 per cent of gross national income for official development assistance by 2015, as well as the commitments contained in the Istanbul Programme of Action for the Least Developed Countries for the Decade 2011-2020, and strongly urge those developed countries that have not yet done so to make additional concrete efforts to fulfil their commitments;

48. Stress the importance of North-South, South-South and triangular cooperation, in the prevention and control of non-communicable diseases to promote at national, regional, and international levels an enabling environment to facilitate healthy lifestyles and choices, bearing in mind that South-South cooperation is not a substitute for, but rather a complement to, North-South cooperation;

49. Promote all possible means to identify and mobilize adequate, predictable and sustained financial resources and the necessary human and technical resources, and to consider support for voluntary, cost-effective, innovative approaches for a long-term financing of non-communicable disease prevention and control, taking into account the Millennium Development Goals;

50. Acknowledge the contribution of international cooperation and assistance in the prevention and control of non-communicable diseases and, in this regard, encourage the continued inclusion of non-communicable diseases in development cooperation agendas and initiatives;

51. Call upon WHO, as the lead United Nations specialized agency for health, and all other relevant United Nations system agencies, funds and programmes, the international financial institutions, development banks, and other key international organizations to work together in a coordinated manner to support national efforts to prevent and control non-communicable diseases and mitigate their impacts;

52. Urge relevant international organizations to continue to provide technical assistance and capacity-building to developing countries, especially to the least developed countries, in the areas of non-communicable disease prevention and control and promotion of access to medicines for all, including through the full use of trade-related aspects of intellectual property rights flexibilities and provisions;

53. Enhance the quality of aid by strengthening national ownership, alignment, harmonization, predictability, mutual accountability and transparency, and results-orientation;

54. Engage non-health actors and key stakeholders, where appropriate, including the private sector and civil society, in collaborative partnerships to promote health and to reduce non-communicable disease risk factors, including through building community capacity in promoting healthy diets and lifestyles;

55. Foster partnerships between Government and civil society, building on the contribution of health-related NGOs and patients' organizations, to support, as appropriate, the provision of services for the prevention and control, treatment, care, including palliative care, of non-communicable diseases;

56. Promote the capacity-building of non-communicable disease-related NGOs at the national and regional levels, in order to realize their full potential as partners in the prevention and control of non-communicable diseases;



Research and development

57. Promote actively national and international investments and strengthen national capacity for quality research and development, for all aspects related to the prevention and control of non-communicable diseases in a sustainable and cost-effective manner, while noting the importance of continuing to incentivize innovation;
58. Promote the use of information and communications technology to improve programme implementation, health outcomes, health promotion, and reporting and surveillance systems and to disseminate, as appropriate, information on affordable, cost-effective, sustainable and quality interventions, best practices and lessons learned in the field of non-communicable diseases;
59. Support and facilitate non-communicable disease-related research and its translation to enhance the knowledge base for ongoing national, regional and global action;

Monitoring and evaluation

60. Strengthen, as appropriate, country-level surveillance and monitoring systems, including surveys that are integrated into existing national health information systems and include monitoring exposure to risk factors, outcomes, social and economic determinants of health, and health system responses, recognizing that such systems are critical in appropriately addressing non-communicable diseases;
61. Call upon WHO, with the full participation of Member States, informed by their national situations, through its existing structures, and in collaboration with United Nations agencies, funds and programmes, and other relevant regional and international organizations, as appropriate, building on continuing efforts to develop before the end of 2012, a comprehensive global monitoring framework, including a set of indicators, capable of application across regional and country settings, including through multisectoral approaches, to monitor trends and to assess progress made in the implementation of national strategies and plans on non-communicable diseases;
62. Call upon WHO, in collaboration with Member States through the governing bodies of WHO, and in collaboration with United Nations agencies, funds and programmes, and other relevant regional and international organizations, as appropriate, building on the work already under way, to prepare recommendations for a set of voluntary global targets for the prevention and control of non-communicable diseases, before the end of 2012;
63. Consider the development of national targets and indicators based on national situations, building on guidance provided by WHO, to focus on efforts to address the impacts of non-communicable diseases, and to assess the progress made in the prevention and control of non-communicable diseases and their risk factors and determinants;

Follow-up

64. Request the Secretary-General, in close collaboration with the Director-General of WHO, and in consultations with Member States, United Nations funds and programmes and other relevant international organizations, to submit by the end

- of 2012 to the General Assembly, at its sixty-seventh session, for consideration by Member States, options for strengthening and facilitating multisectoral action for the prevention and control of non-communicable diseases through effective partnership;
65. Request the Secretary-General, in collaboration with Member States, WHO, and relevant funds, programmes and specialized agencies of the United Nations system to present to the General Assembly at the sixty-eighth session a report on the progress achieved in realizing the commitments made in this Political Declaration, including on the progress of multisectoral action, and the impact on the achievement of the internationally agreed development goals, including the Millennium Development Goals, in preparation for a comprehensive review and assessment in 2014 of the progress achieved in the prevention and control of non-communicable diseases.



Annex 3:
Rio Declaration at the World Conference
on Social Determinants of Health



Rio Political Declaration on Social Determinants of Health

Rio de Janeiro, Brazil, 21 October 2011

1. Invited by the World Health Organization, we, Heads of Government, Ministers and government representatives came together on the 21st day of October 2011 in Rio de Janeiro to express our determination to achieve social and health equity through action on social determinants of health and well-being by a comprehensive intersectoral approach.
2. We understand that health equity is a shared responsibility and requires the engagement of all sectors of government, of all segments of society, and of all members of the international community, in an "all for equity" and "health for all" global action.
3. We underscore the principles and provisions set out in the World Health Organization Constitution and in the 1978 Declaration of Alma-Ata as well as in the 1986 Ottawa Charter and in the series of international health promotion conferences, which reaffirmed the essential value of equity in health and recognized that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition". We recognize that governments have a responsibility for the health of their peoples, which can be fulfilled only by the provision of adequate health and social measures and that national efforts need to be supported by an enabling international environment.
4. We reaffirm that health inequities within and between countries are politically, socially and economically unacceptable, as well as unfair and largely avoidable, and that the promotion of health equity is essential to sustainable development and to a better quality of life and well-being for all, which in turn can contribute to peace and security.
5. We reiterate our determination to take action on social determinants of health as collectively agreed by the World Health Assembly and reflected in resolution WHA62.14 ("Reducing health inequities through action on the social determinants of health"), which notes the three overarching recommendations of the Commission on Social Determinants of Health: to improve daily living conditions; to tackle the inequitable distribution of power, money and resources; and to measure and understand the problem and assess the impact of action.

6. Health inequities arise from the societal conditions in which people are born, grow, live, work and age, referred to as social determinants of health. These include early years' experiences, education, economic status, employment and decent work, housing and environment, and effective systems of preventing and treating ill health. We are convinced that action on these determinants, both for vulnerable groups and the entire population, is essential to create inclusive, equitable, economically productive and healthy societies. Positioning human health and well-being as one of the key features of what constitutes a successful, inclusive and fair society in the 21st century is consistent with our commitment to human rights at national and international levels.

7. Good health requires a universal, comprehensive, equitable, effective, responsive and accessible quality health system. But it is also dependent on the involvement of and dialogue with other sectors and actors, as their performance has significant health impacts. Collaboration in coordinated and intersectoral policy actions has proven to be effective. Health in All Policies, together with intersectoral cooperation and action, is one promising approach to enhance accountability in other sectors for health, as well as the promotion of health equity and more inclusive and productive societies. As collective goals, good health and well-being for all should be given high priority at local, national, regional and international levels.

8. We recognize that we need to do more to accelerate progress in addressing the unequal distribution of health resources as well as conditions damaging to health at all levels. Based on the experiences shared at this Conference, we express our political will to make health equity a national, regional and global goal and to address current challenges, such as eradicating hunger and poverty, ensuring food and nutritional security, access to safe drinking water and sanitation, employment and decent work and social protection, protecting environments and delivering equitable economic growth, through resolute action on social determinants of health across all sectors and at all levels. We also acknowledge that by addressing social determinants we can contribute to the achievement of the Millennium Development Goals.

9. The current global economic and financial crisis urgently requires the adoption of actions to reduce increasing health inequities and prevent worsening of living conditions and the deterioration of universal health care and social protection systems.

10. We acknowledge that action on social determinants of health is called for both within countries and at the global level. We underscore that increasing the ability of global actors, through better global governance, promotion of international cooperation and development, participation in policy-making and monitoring progress, is essential to contribute to national and local efforts on social determinants of health. Action on social determinants of health should be adapted to the national and sub-national contexts of individual countries and regions to take into account different social, cultural and economic systems. Evidence from research and experiences in implementing policies on social determinants of health, however, shows common features of successful action. There are five key action areas critical to addressing health inequities: (i) to adopt better governance for health and development; (ii) promote participation in policy-making and implementation; (iii) to further reorient the health sector towards reducing health inequities; (iv) to strengthen global governance and collaboration; and (v) to monitor progress and increase accountability. Action on social determinants of health therefore means that we, the representatives of Governments, will strive individually and collectively to develop and support policies, strategies, programmes and action plans, which address social determinants of health, with the support of the international community, that include:

11. **To adopt better governance for health and development**

11.1 Acknowledging that governance to address social determinants involves transparent and inclusive decision-making processes that give voice to all groups and sectors involved, and develop policies that perform effectively and reach clear and measurable outcomes, build accountability, and, most crucially, are fair in both policy development processes and results;



11.2 We pledge to:

- (i) Work across different sectors and levels of government, including through, as appropriate, national development strategies, taking into account their contribution to health and health equity and recognizing the leading role of health ministries for advocacy in this regard;
- (ii) Develop policies that are inclusive and take account of the needs of the entire population with specific attention to vulnerable groups and high-risk areas;
- (iii) Support comprehensive programmes of research and surveys to inform policy and action;
- (iv) Promote awareness, consideration and increased accountability of policy-makers for impacts of all policies on health;
- (v) Develop approaches, including effective partnerships, to engage other sectors in order to identify individual and joint roles for improvements in health and reduction of health inequities;
- (vi) Support all sectors in the development of tools and capacities to address social determinants of health at national and international levels;
- (vii) Foster collaboration with the private sector, safeguarding against conflict of interests, to contribute to achieving health through policies and actions on social determinants of health;
- (viii) Implement resolution WHA62.14, which takes note of the recommendations of the final report of the Commission on Social Determinants of Health;
- (ix) Strengthen occupational health safety and health protection and their oversight and encourage the public and private sectors to offer healthy working conditions so as to contribute to promoting health for all;
- (x) Promote and strengthen universal access to social services and social protection floors;
- (xi) Give special attention to gender-related aspects as well as early child development in public policies and social and health services;
- (xii) Promote access to affordable, safe, efficacious and quality medicines, including through the full implementation of the WHO Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property;
- (xiii) Strengthen international cooperation with a view to promoting health equity in all countries through facilitating transfer on mutually agreed terms of expertise, technologies and scientific data in the field of social determinants of health, as well as exchange of good practices for managing intersectoral policy development.

12. ***To promote participation in policy-making and implementation***

12.1 Acknowledging the importance of participatory processes in policy-making and implementation for effective governance to act on social determinants of health;

12.2 We pledge to:

- (i) Promote and enhance inclusive and transparent decision-making, implementation and accountability for health and health governance at all levels, including through enhancing access to information, access to justice and public participation;
- (ii) Empower the role of communities and strengthen civil society contribution to policy-making and implementation by adopting measures to enable their effective participation for the public interest in decision-making;
- (iii) Promote inclusive and transparent governance approaches, which engage early with affected sectors at all levels of governments, as well as support social participation and involve civil society and the private sector, safeguarding against conflict of interests;
- (iv) Consider the particular social determinants resulting in persistent health inequities for indigenous people, in the spirit of the United Nations Declaration on the Rights of Indigenous Peoples, and their specific needs and promote meaningful collaboration with them in the development and delivery of related policies and programmes;
- (v) Consider the contributions and capacities of civil society to take action in advocacy, social mobilization and implementation on social determinants of health;
- (vi) Promote health equity in all countries particularly through the exchange of good practices regarding increased participation in policy development and implementation;
- (vii) Promote the full and effective participation of developed and developing countries in the formulation and implementation of policies and measures to address social determinants of health at the international level.

13. ***To further reorient the health sector towards reducing health inequities***

13.1 Acknowledging that accessibility, availability, acceptability, affordability and quality of health care and public health services are essential to the enjoyment of the highest attainable standard of health, one of the fundamental rights of every human being, and that the health sector should firmly act to reduce health inequities;

13.2 We pledge to:

- (i) Maintain and develop effective public health policies which address the social, economic, environmental and behavioural determinants of health with a particular focus on reducing health inequities;
- (ii) Strengthen health systems towards the provision of equitable universal coverage and promote access to high quality, promotive, preventive, curative and rehabilitative health services throughout the life-cycle, with a particular focus on comprehensive and integrated primary health care;
- (iii) Build, strengthen and maintain public health capacity, including capacity for intersectoral action, on social determinants of health;
- (iv) Build, strengthen and maintain health financing and risk pooling systems that prevent people from becoming impoverished when they seek medical treatment;
- (v) Promote mechanisms for supporting and strengthening community initiatives for health financing and risk pooling systems;



- (vi) Promote changes within the health sector, as appropriate, to provide the capacities and tools to act to reduce health inequities including through collaborative action;
- (vii) Integrate equity, as a priority within health systems, as well as in the design and delivery of health services and public health programmes;
- (viii) Reach out and work across and within all levels and sectors of government by promoting mechanisms for dialogue, problem-solving and health impact assessment with an equity focus to identify and promote policies, programmes, practices and legislative measures that may be instrumental for the goal pursued by this Political Declaration and to adapt or reform those harmful to health and health equity;
- (ix) Exchange good practices and successful experiences with regard to policies, strategies and measures to further reorient the health sector towards reducing health inequities.

14. **To strengthen global governance and collaboration**

14.1 Acknowledging the importance of international cooperation and solidarity for the equitable benefit of all people and the important role the multilateral organizations have in articulating norms and guidelines and identifying good practices for supporting actions on social determinants, and in facilitating access to financial resources and technical cooperation, as well as in reviewing and, where appropriate, strategically modifying policies and practices that have a negative impact on people's health and well-being;

14.2 We pledge to:

- (i) Adopt coherent policy approaches that are based on the right to the enjoyment of the highest attainable standard of health, taking into account the right to development as referred to, inter alia, by the 1993 Vienna Declaration and Programme of Action, that will strengthen the focus on social determinants of health, towards achieving the Millennium Development Goals;
- (ii) Support social protection floors as defined by countries to address their specific needs and the ongoing work on social protection within the United Nations system, including the work of the International Labour Organization;
- (iii) Support national governments, international organizations, nongovernmental entities and others to tackle social determinants of health as well as to strive to ensure that efforts to advance international development goals and objectives to improve health equity are mutually supportive;
- (iv) Accelerate the implementation by the State Parties of the WHO Framework Convention on Tobacco Control (FCTC), recognizing the full range of measures including measures to reduce consumption and availability, and encourage countries that have not yet done so to consider acceding to the FCTC as we recognize that substantially reducing tobacco consumption is an important contribution to addressing social determinants of health and vice versa;
- (v) Take forward the actions set out in the political declaration of the United Nations General Assembly High-Level Meeting on the Prevention and Control Noncommunicable Diseases at local, national and international levels – ensuring a focus on reducing health inequities;
- (vi) Support the leading role of the World Health Organization in global health governance, and in promoting alignment in policies, plans and activities on social determinants of health with its partner United Nations agencies, development banks and other key international organizations, including in joint advocacy, and in facilitating access to the provision of financial and technical assistance to countries and regions;

- (vii) Support the efforts of governments to promote capacity and establish incentives to create a sustainable workforce in health and in other fields, especially in areas of greatest need;
- (viii) Build capacity of national governments to address social determinants of health by facilitating expertise and access to resources through appropriate United Nations agencies' support, particularly the World Health Organization;
- (ix) Foster North-South and South-South cooperation in showcasing initiatives, building capacity and facilitating the transfer of technology on mutually agreed terms for integrated action on health inequities, in line with national priorities and needs, including on health services and pharmaceutical production, as appropriate.

15. **To monitor progress and increase accountability**

15.1 Acknowledging that monitoring of trends in health inequities and of impacts of actions to tackle them is critical to achieving meaningful progress, that information systems should facilitate the establishment of relationships between health outcomes and social stratification variables and that accountability mechanisms to guide policy-making in all sectors are essential, taking into account different national contexts;

15.2 We pledge to:

- (i) Establish, strengthen and maintain monitoring systems that provide disaggregated data to assess inequities in health outcomes as well as in allocations and use of resources;
- (ii) Develop and implement robust, evidence-based, reliable measures of societal well-being, building where possible on existing indicators, standards and programmes and across the social gradient, that go beyond economic growth;
- (iii) To promote research on the relationships between social determinants and health equity outcomes with a particular focus on evaluation of effectiveness of interventions;
- (iv) Systematically share relevant evidence and trends among different sectors to inform policy and action;
- (v) Improve access to the results of monitoring and research for all sectors in society;
- (vi) Assess the impacts of policies on health and other societal goals, and take these into account in policy-making;
- (vii) Use intersectoral mechanisms such as a Health in All Policies approach for addressing inequities and social determinants of health; enhance access to justice and ensure accountability, which can be followed up;
- (viii) Support the leading role of the World Health Organization in its collaboration with other United Nations agencies in strengthening the monitoring of progress in the field of social determinants of health and in providing guidance and support to Member States in implementing a Health in All Policies approach to tackling inequities in health;
- (ix) Support the World Health Organization on the follow-up to the recommendations of the Commission on Information and Accountability for Women's and Children's Health;



- (x) Promote appropriate monitoring systems that take into consideration the role of all relevant stakeholders including civil society, nongovernmental organizations as well as the private sector, with appropriate safeguard against conflict of interests, in the monitoring and evaluation process;
- (xi) Promote health equity in and among countries, monitoring progress at the international level and increasing collective accountability in the field of social determinants of health, particularly through the exchange of good practices in this field;
- (xii) Improve universal access to and use of inclusive information technologies and innovation in key social determinants of health.

16. Call for global action

16.1 We, Heads of Government, Ministers and government representatives, solemnly reaffirm our resolve to take action on social determinants of health to create vibrant, inclusive, equitable, economically productive and healthy societies, and to overcome national, regional and global challenges to sustainable development. We offer our solid support for these common objectives and our determination to achieve them.

16.2 We call upon the World Health Organization, United Nations agencies and other international organizations to advocate for, coordinate and collaborate with us in the implementation of these actions. We recognize that global action on social determinants will need increased capacity and knowledge within the World Health Organization and other multilateral organizations for the development and sharing of norms, standards and good practices. Our common values and responsibilities towards humanity move us to fulfil our pledge to act on social determinants of health. We firmly believe that doing so is not only a moral and a human rights imperative but also indispensable to promote human well-being, peace, prosperity and sustainable development. We call upon the international community to support developing countries in the implementation of these actions through the exchange of best practices, the provision of technical assistance and in facilitating access to financial resources, while reaffirming the provisions of the United Nations Millennium Declaration as well as the Monterrey Consensus of the International Conference on Financing for Development.

16.3 We urge those developed countries which have pledged to achieve the target of 0.7 percent of GNP for official development assistance by 2015, and those developed countries that have not yet done so, to make additional concrete efforts to fulfil their commitments in this regard. We also urge developing countries to build on progress achieved in ensuring that official development assistance is used effectively to help achieve development goals and targets.

16.4 World leaders will soon gather again here in Rio de Janeiro to consider how to meet the challenge of sustainable development laid down twenty years ago. This Political Declaration recognizes the important policies needed to achieve both sustainable development and health equity through acting on social determinants.

16.5 We recommend that the social determinants approach is duly considered in the ongoing reform process of the World Health Organization. We also recommend that the 65th World Health Assembly adopts a resolution endorsing this Political Declaration.

Annex 4:
WKC presentations and products 2011

Publication

An urban health and health equity index: problems, pitfalls, and potential
Attaining Urban Health Equity: A policy brief (Japanese)
Healthy Urban Planning, Report of a Consultation Meeting, 10-11 March 2011, Kobe, Japan
Intersectoral Action on Health: A path for policy-makers to implement effective and sustainable action on health
Making cities smoke-free
Relationship between climate variability and occurrence of diarrhoea and cholera: A pilot study using retrospective data from Kolkata, India
Report of Consultation Meeting on Urban Health Metrics Research, 23-25 February 2011, Kobe, Japan
介護予防プログラムの効果に関する文献レビュー：日本国内の事例を中心に [Systematic Literature Review of the Effectiveness of Programs to Prevent Elderly Persons’ Dependence on Long-Term Care] (Japanese w/ English abstract)
Taking the pulse of an urban world: mechanisms for characterizing urban health and urban health equity
Urban HEART (Japanese)
Urban HEART User Manual (French)
Urban HEART User Manual (Spanish)

Journal

"Kanagawa, Japan’ s Tobacco Control Legislation: a Breakthrough?", co-author, the Asian Pacific Journal of Cancer Prevention, Volume 12, Issue 8, 1909-1916, 2011
"Local Governments and Civil Society Lead Breakthrough for Tobacco Control: Lessons from Chandigarh and Chennai", co-author, Indian Journal of Public Health, Volume 55, Issue 3, Jul-Sep 2011
"Roundtable on Urban Living Environment Research (RULER)", co-author, Journal of Urban Health, Volume 88, Number 5, October 2011
"Street smoking bans in Japan: A hope for smoke-free cities?", co-author, Health Policy, Volume 102, Issue 1, 49-55, September 2011
"Urban Planning, Development and Noncommunicable Diseases", co-author, Planning, Practice and Research, Volume 26, Number 4, 373-391, August 2011



Presentations

Title	Event	WKC Contributors
WHO Kobe Centre's Updates on Urban Risk Reduction Initiatives	8th Meeting, Urban Regional Task Force on Urban Risk Reduction, Kobe, Japan, 13 January	Lapitan, Dr Jostacio M.
WHO Health Policy and Stop Tuberculosis Partnership	Stop Tuberculosis Partnership Japan and Kansai – 1st International Tuberculosis Symposium in Kansai, Osaka, Japan, 15 January	Kumaresan, Dr Jacob
A global perspective on ageing and health	HEM21 Seminar, Kobe, Japan, 2 February	Kano, Dr Megumi
WHO’ s Role in Public Health: Global overview on urban health	Seminar of Nagasaki University Graduate School of Biomedical Sciences, Nagasaki, Japan, 11 February	Kumaresan, Dr Jacob
Urban HEART: a methodology for developing indicators	Harvard Humanitarian Summit, Cambridge, USA, 4-6 March	Prasad, Mr Amit
WHO's Urban Health Equity Assessment and Response Tool. Global Health Metrics & Evaluation Conference: Controversies, Innovation, Accountability	Global Health Metrics & Evaluation Conference: Controversies, Innovation, Accountability, Seattle, USA, 14-16 March	Prasad, Mr Amit Kano, Dr Megumi Kumaresan, Dr Jacob
Global Trends in Urban Health Inequalities		Kano, Dr Megumi Prasad, Mr Amit
Health recovery and development	JICA-IRP Training on Resilient Recovery for Haiti, Kobe, Japan, 16-18 March 2011	Lapitan, Dr Jostacio M.
Six presentations: 1) Introduction to Urban HEART; 2) Build and Inclusive team; 3) Indicators and Benchmarks; 4) Matrix and Monitor; 5) Prioritizing health equity issues 6) Developing a Plan of Action	Urban HEART workshop; Bogota, Colombia, 6-14 May	Prasad, Mr Amit Kimura, Ms Yumi
Aiming for good government: Public policies, equity and mental health	1st International Scientific Forum: Urban suffering, Human rights and Good governance, Milan, Italy, 23-25 May	Garçon, Mr Loïc
Overview of Recovery efforts	Meeting on Disaster Recovery for the Health Sector; Kobe, Japan, 26 May	Pesigan, Dr Arturo
Street smoking bans in Japanese cities	Sanda City Public Forum on Second-Hand Smoke, Sanda city, Japan, 4 June	Kashiwabara, Ms Mina
Assessing and responding to urban health inequalities in the Western Pacific Region	The Western Pacific Regional Meeting on Social Determinants of Health, Manila, Philippines, 6-10 June	Armada, Dr Francisco
Smoke-free cities	2011 World No Tobacco Day Hyogo Forum - WHO Framework Convention on Tobacco Control, Sanda City, Japan, 11 June	Kashiwabara, Ms Mina
Seminar on Urbanization and Health	JICA's International Seminar on Health Systems Management 2011, Tokyo, Japan, 23-25 June	Prasad, Mr Amit
Introduction to Urban HEART	NIPH student lecture, Tokyo, Japan, 23 June	Prasad, Mr Amit
Introduction to Urban HEART	Japan Gerontological Evaluation Study (JAGES) Workshop , Nagoya, Japan, 24 July	Prasad, Mr Amit
WHO's Urban HEART	International Conference on Social Stratification and Health, Tokyo, Japan, 5-8 May	Kano, Dr Megumi
Adaptation of Urban HEART to Japan Gerontological Evaluation Study (JAGES)	Workshop on Developing Benchmarks for Evaluating Japan's Long-term Care Insurance Policy, Nagoya, Japan, 17 August	Kano, Dr Megumi
Two presentations: 1) Urban Planning-an Overview; and 2) 12 Steps to a Smoke-free city	The Western Pacific Regional Meeting on Promoting Healthy Living and Preventing NCDs through Healthy Cities, Shanghai, China, 30 August - 2 September	Armada, Dr Francisco
Climate Change and Health	Southeast Asian Ministers of Education-Tropical Medicine (SEAMEO-TROPMED) Network Policy Forum, Bangkok, Thailand, 7 September	Pesigan, Dr Arturo
Six presentations: 1) Introduction to Urban HEART; 2) Build and Inclusive team; 3) Indicators and Benchmarks; 4) Matrix and Monitor; 5) Prioritizing health equity issues 6) Developing a Plan of Action	Urban HEART workshop, Changchun, China, 15-20 September	Prasad, Mr Amit
Introduction to Urban HEART The Kobe Call to Action	Consensus Meeting on the Kobe Call to Action, Addis Abeba, Ethiopia, 12-18 September	Garçon, Mr Loïc
WHO's research on Social Determinants of Health and Urban HEART	Japan Gerontological Evaluation Study (JAGES) Workshop Group Meeting with MHLW, Tokyo, Japan, 19 September	Kano, Dr Megumi
Plenary: Affecting public policy through partnerships	MOVE 2011 World Congress - International Sports and Culture Association, Paris, France, 19-21 September	Sloate, Ms Lori
WHO Kobe Centre research on smoke-free cities	Symposium on the Future of Second-hand smoke measures in Japan, Kobe Japan, 23 September	Kashiwabara, Ms Mina
Measuring and Monitoring Progress of Age-Friendly Cities	First International Conference on Age-Friendly Cities, Dublin, Ireland, 30 September	Kumaresan, Dr Jacob

Title	Event	WKC Contributors
Assessing health facilities' preparedness for disasters in cities: a case study of two hospitals in Kobe, Japan	31st International Union of Architects/Public Health Group Seminar on Safety and Security in Healthcare Environment, Tokyo, Japan, 2 October	Lapitan, Dr Jostacio M.
Disaster recovery for the health sector	JICA-IRP Training on Resilient Recovery for Haiti, Kobe, Japan, 3-6 October 2011	Pesigan, Dr Arturo
Panel speaker: Urban Environmental public health in low-income countries - health challenges facing urban societies	World Health Summit, Berlin, Germany, 23-26 October	Lapitan, Dr Jostacio M.
Developing Indicators for disaster preparedness in cities	10th International Conference on Urban Health, Belo Horizonte, Brazil, 2-4 November	Prasad, Mr Amit Lapitan, Dr Jostacio M.
Assessing urban health equity in the Greater Ho Chi Minh City (HCMC) Metropolitan Area: an application of the Urban HEART		Prasad, Mr Amit
Socioeconomic inequalities in anxiety and mood disorders in urban areas of nine countries		Kano, Dr Megumi
Trend in noncommunicable disease mortality in the 13 largest cities in Japan, 1999-2009		Kano, Dr Megumi
Plenary: The Importance of Local Data Observatories: Accumulated Experiences		Ross, Mr Alex
Plenary: The Role of International Agencies in Promoting Urban Health Metrics	Joint event: 1st International Symposium on Health Research and Development with the 3rd Symposium of the Western Pacific Region of the World Federation of Public Health Assoc., Bali, Indonesia, 14-20 November	Prasad, Mr Amit Kano, Dr Megumi
Workshop: How can metrics better capture health needs and respond to demand in cities?		
Urban health challenges in the Asia Pacific Region		Prasad, Mr Amit
Six presentations: 1) Introduction to Urban HEART; 2) Build and Inclusive team; 3) Indicators and Benchmarks; 4) Matrix and Monitor; 5) Prioritizing health equity issues 6) Developing a Plan of Action	Western Pacific Regional workshop on Making Your City Smoke-free, Manila, Philippines, 23-25 November	Kashiwabara, Ms Mina Garçon, Mr Loïc
Presentations on: 12 Steps to make a smoke-free city, tobacco control in countries of the Western Pacific region, smoke-free policy	Informal Consultation on Anti-microbial Resistance in Emergencies, Manila, Philippines, 29-30 November	Pesigan, Dr Arturo
Urban Health Emergency and Disaster Management	Founding Conference of the Chinese Society of Disaster Medicine and the First International Summit Forum on Disaster Medicine, Shanghai, China, 7-8 December	Pesigan, Dr Arturo
International Aid Mechanisms: Doing Better	International Symposium on World Trends in Research on Social Determinants of Health, Tokyo, Japan, 23 December	Pesigan, Dr Arturo
Climate Change, Urbanization and Disasters		Pesigan, Dr Arturo
Global efforts to address Social Determinants of Health in Urban Settings		Kano, Dr Megumi

WKC Public Health Forums

Title	Event	WKC Contributors
Smoke-free cities: how to make your city smoke-free	WKC Health Forum: Smoke-free cities, Kobe, Japan, 15 January	Armada, Dr Francisco
Street smoking bans in Japanese cities		Kashiwabara, Ms Mina
Hidden cities: analysing urban health inequity	WKC Health Forum: Urbanization, social disparities and their impact on mental health, Kobe, Japan, 4 March	Kano, Dr Megumi
Responding to Health Emergencies in the Western Pacific Region	WKC Health Forum: Disaster Recovery for the Health Sector, Kobe, Japan, 25 May	Pesigan, Dr Arturo
Risk Reduction and WHO work	WKC Health Forum: Strengthening for disaster resilience, Akashi, Japan, 20 November	Pesigan, Dr Arturo Lapitan, Dr Jostacio M.

Annex 5:
List of staff and interns 2011

Office of the Director

Mr Alex Ross, Director (from 15/10/11)
Dr Jacob Kumaresan, Director (through 1/9/11)
Ms Mina Arai
Mr Richard Bradford
Mr Loïc Garçon
Mr Robert Matiru
Ms Azumi Nishikawa
Ms Keiko Okuda
Ms Lori Sloate
Ms Kumiko Yoshida

Work Programme

Ms Nina Andersen
Dr Francisco Armada
Ms Yoko Inoue
Dr Megumi Kano
Dr Jostacio Lapitan
Dr Arturo Pesigan
Mr Amit Prasad
Ms Riikka Rantala
Ms Merisa Romero
Mr Gerardo Sanchez
Ms Mariko Yokoo

Administration, Information and
Communication Technology

Mr Shunichi Akazawa
Ms Akiko Imai
Ms Geneviève Mermin Martinez
Mr James Opere
Mr Romero Reroma
Ms Miki Sakaguchi
Ms Lihong Su
Ms Junko Takebayashi

Interns

Name	Nationality	Affiliation	WKC Work focus
Ms Yoko Aihara	Japan	University of Yamanashi	Research on mental health and psychosocial support post Great East Japan Earthquake
Ms Jessica Barry	USA	Johns Hopkins School of Public Health	Assist in the organization of an expert consultation meeting on urban health metrics; research on institutional mechanisms in place to quantify, monitor and share information on urban health equity
Ms Claire Boulange	France	Institute for Urban Planning, Grenoble, France	Crime and Physical Activity; Climate change risks
Ms Shiori Eguchi	Japan	University of Tokyo	Review of the success of health impact assessment tools and defining links with Urban HEART
Ms Miyuki Hotta	Japan	Osaka University Graduate School of Medicine	NCD mortality trends in Japan; methods for M&E local interventions to promote healthy ageing
Mr Zhan Qiu Mao	China	Japan National Institution of Public Health (NIPH)	Generate a preliminary evidence base, analysis, conclusions and recommendations regarding the vulnerability and adaptation of health emergency management systems in urban settings to the health impacts of climate change with a focus on floods in 3 Asian cities (Manila, Dhaka and Tokyo)
Ms Kanako Masuno	Japan	University of Tokyo Graduate School of Medicine	Develop inventory of the vulnerability and capacity of health emergency management systems to the health impacts of earthquakes; Conduct a literature review and compile standards, policies, programmes and practices (both national and international) for older persons in urban settings that promote active and healthy ageing
Ms Azusa Matsumoto	Japan	University of Tokyo Graduate School of Economics	Assist in a literature review of English and Japanese literature on methods and metrics to evaluate the effectiveness of interventions to promote active and healthy ageing
Ms Ebelechukwu Mogo	Nigeria	University of Edinburgh, Scotland	Conduct a literature review, including grey literature and official documents on megacities and health in Africa with a focus on documenting examples on the area of health governance; Identify and document some examples of public policies in cities worldwide that have had an impact on health equity through urban planning with a focus on increasing physical activity
Mr Patou Musumari	DRC	Kyoto University Graduate School of Public Health	Smoke-free cities; local intervention in WPRO cities
Ms Nicole Reyes	USA	State University of New York Downstate Medical Center	Physical activity promotion through urban planning ; some ISA-related tasks
Ms Lucy Mimi Wu	USA	School of Public Health, Li Ka Shing Faculty of Medicine, University of Hong Kong	Assist in the Centre' s technical work on developing guidelines and policy recommendations for urban adaptation to climate change; Support the technical team in deriving lessons for policy-making and extracting information from urban climate change and health vulnerability and adaptation assessment
Ms Sakiko Yasuda	Japan	Kyoto University Graduate School of Public Health	Smoke-free cities; legislation in Hyogo Prefecture