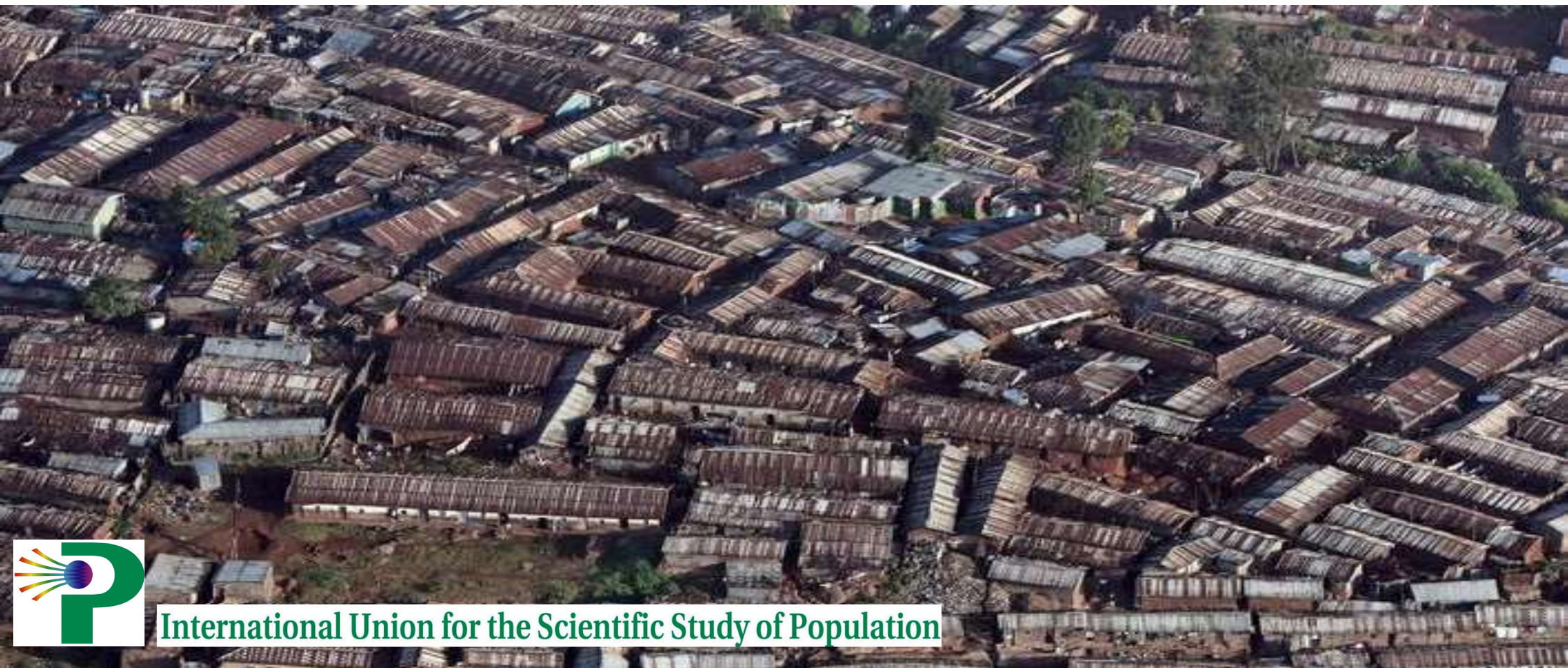# IUSSP Fellowship Candidate Workshop - 2018
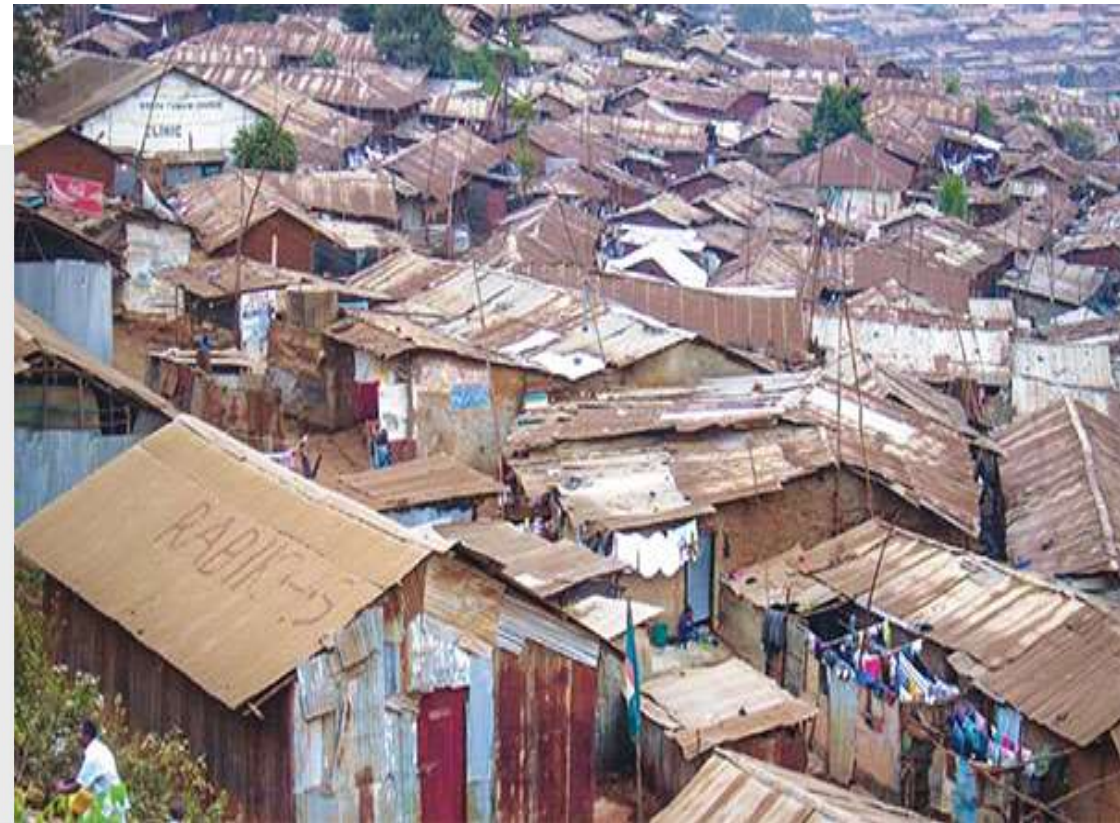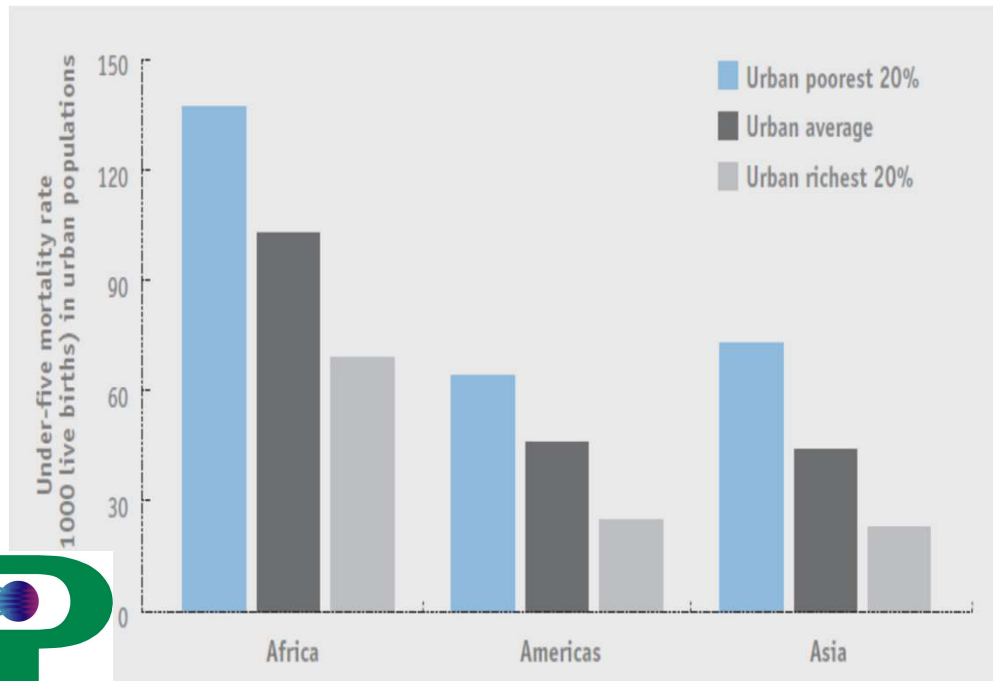# Susan Parnell (Bristol & UCT)

International Union for the Scientific Study of Population

There is an established intra and inter-urban relationship between the how cities work & the burden of disease

Under-five mortality rate in urban areas by region in 42 low- and middle-income countries, 2000-2007 (WHO and UN-Habitat, 2010)

Useful 'stuff' to know about urban development if you are interested in reproductive health in 2018

There are very demanding challenges facing us as <u>urban health thought leaders</u> trying to work within the radical new framing of the 2030 Agenda.

BUT, rather than jump straight to how we can impact the future, I want to spend some time putting the evolution of the current urban health question into perspective, underscoring that:

➢ **How we <u>think</u> about cities and health is important for <u>practice</u>**
➢ **That what we think about cities and health <u>changes over time</u>**
➢ **That this is a <u>strategic moment to rebuild</u> the intellectual relationship between health and cities, which is weaker now than it has been in the past**

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Ideas about designing, building and managing cities change over the period of global urbanisation:

4 big phases, with internal debates, but only 1 phase around the industrial revolution that foregrounds health
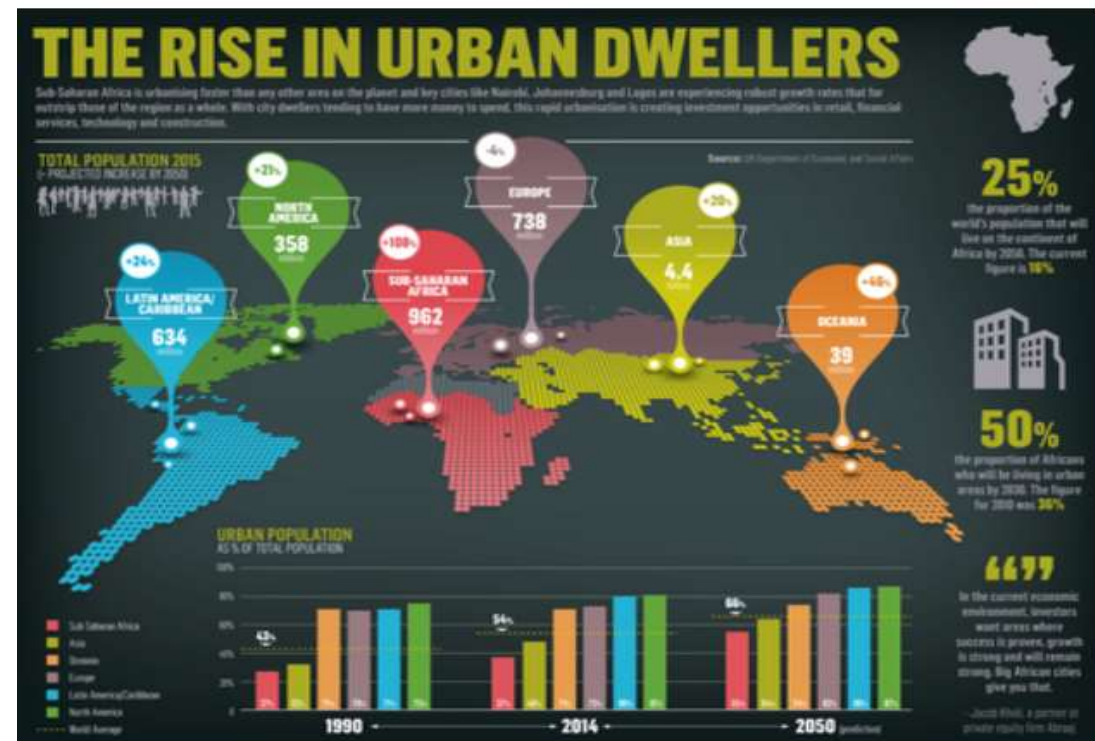
*

HEALTH AND 'THE CITY' HAVE BEEN LARGELY UNCOUPLED FOR ALMOST 100 YEARS!!!

* THE SHIFT TO A MAJORITY URBAN WORLD MAKES IT TIME FOR THAT TO CHANGE

Click to view full size graphic

1. C 19th & early C20th – the dominance of health in the urban planning and practice

Extensive plague and disease in the rapidly expanding cities post industrial revolution meant health professionals dominated the running of cities (Medical Officers of Health), health infused urban law (e.g. building codes and slum legislation) and even lead the way in creating the profession of urban planning - which had public health as its core mandate.

- Health was not only a positive or benign force in cities, as segregation and exclusion were justified in part on grounds of health by the elite (sanitation syndrome)

- In this phase there was furious debate about how best to design cities to improve health

ALERT: lots of old white men here ...but they were/are very influential in the cites they knew and where they lived , REAL QUESTION: are they finally being replaced with new ideas that are pertinent to the present and future cities of the global south?

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Ebenezer Howard (1850-1928)

➢English town planner

➢People and jobs should be relocated from large cities to 'garden cities' in the countryside characterised by radial layouts, interspersed parks, greenbelts and high speed rail connections (the 'New Town Movement')

➢A return to country living in small town environments will promote health, whereas living in modern industrial cities breeds crime, disease and deprivation

Georges- Eugène Haussmann (1809-1891)

o French public administrator (no training in planning/ architecture)

o City beautification through urban renewal and 'slum' clearance and the introduction of parks, squares and boulevards, exemplified by his plan to redevelop Paris (the 'City Beautiful Movement')

o 'Slums' are sites of disease and deprivation and therefore need to be removed to make way for modern amenities

Patrick Geddes (1854- 1932)

❑ Scottish biologist, sociologist, geographer, and planner

❑ Inner-city areas of modern cities should be abandoned in favour of sprawling low-density residential areas characterised by single-detached dwellings, curvilinear street patterns and automobile dependency catering primarily to the middle- class

❑ Urban health is influenced by interactions in socio-ecological systems and requires localised approaches that address the balance between humans and nature

Le Corbusier (1887-1965)

❖ French architect

❖ Mixed-use areas and 'slums' should be demolished to make way for the 'modern city' based on larger tower blocks surrounded by vast open spaces and connected via large arterial corridors (the 'Tower in the Park' model)

❖ Traditional inner-city areas, characterised by dense and heterogeneous built environments and local street networks create disorder, chaos and disease and need to be removed to make way for modern urban form

Frank Lloyd Wright (1867- 1959)

- American Architect

* Inner-city areas of modern cities should be abandoned in favour of sprawling low-density residential areas characterised by single-detached dwellings, curvilinear street patterns and automobile dependency catering primarily to the middle-

* Low densities, segregated land-uses, automobile reliance and homogenous social environments promote health

2. The age of the City Engineer
Mid 20 C – the power of medics is reduced (or do medics leave the city for more powerful health opportunities given the rise of drugs?)

Big changes see the decline in the profile of health as a core concern in urban development – at a critical moment when cities in Europe and the Americas grow rapidly

- Anti biotics … modern health care moves away from environmental controls to individual biomedical interventions

- Cars & Concrete ….the engineers take over designing and running cities and even where there is a welfare state health care is no longer understood as being centrally linked to urban form or urban services.

- Dominance of modern town planning – organized to ensure rationale decisions – at best protecting the pubic good at worst introducing predictability into investment and so serving the elite

As colonialism ended nobody noticed (or cared) much about cities of the south – which were not very large and they do not really form part of the global discussion about health

3. The age of the Management Consultant
By the late C20 (in the west) urban professions from health, engineering or planning give way to strategic planning experts, who take over running cities

- In some parts of the world neo liberalism sees a declining role of the state, partnerships non state providers of urban services. There is a focus on efficiency and cost effectiveness and the ability to pay.
  - Health concerns are almost totally absent, except as part of a commoditized element of wellbeing, and typically urban poverty increases as the burden of disease shifts to NCDs and lifestyle diseases.

- In other parts of the world ideas about the right to the city (e.g. Latin America) or the developmental state (Asia) see an increase in state led action for the urban poor, but the focus is on housing or jobs, not health.

- In China this is the era of the 1 child policy and that, with the opening up of cities that had been rigidly controlled by influx control changed the face of the country (and the world)

- Not withstanding efforts to push a 'healthy cities agenda', globally urban health is privatized, 'traditionalized' or simply not addressed.

- This is the period when you would expect health to refocus on the emerging cities of the global south, but little happens (maybe because the health focus on the developing world goes to HIV/AiDS?)

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Neo-liberalism, not colonialism, occurred in Africa at a critical phase of urban expansion

Percentage of Total Population Residing in Urban Areas
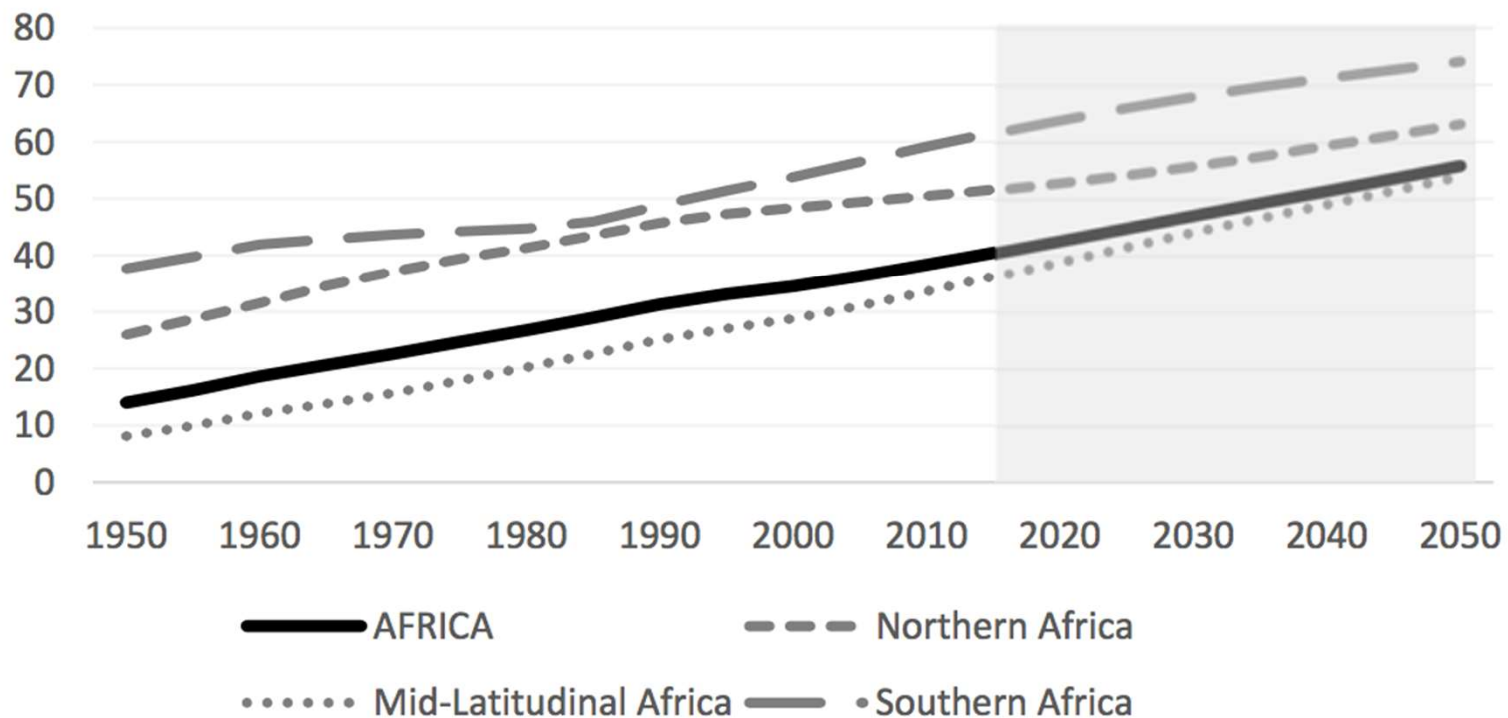
4. The Age of City Data Manager: 'smart cities' and the rise of the power of new technology and social media

- By the C21st revolutions in technology and access to data (by residents, service providers and governments) mean that improvements in urban management in many cities are seen to lie in the realm of new technologies.
  - Smart data apps e.g. for public transport
  - New opportunities for the analysis of data that was once incommensurate (e.g. statistical and geospatial data)
  - Transport, energy, property, banking and retail are all urban sectors that are revolutionized by the tech and big data – BUT REALLY HEATLH

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Share of world's urban population (billions) by region, 1950-2050 (UNDESA, 2015)

Legend: Europe, Asia, Northern America, Africa, Latin America and the Caribbean
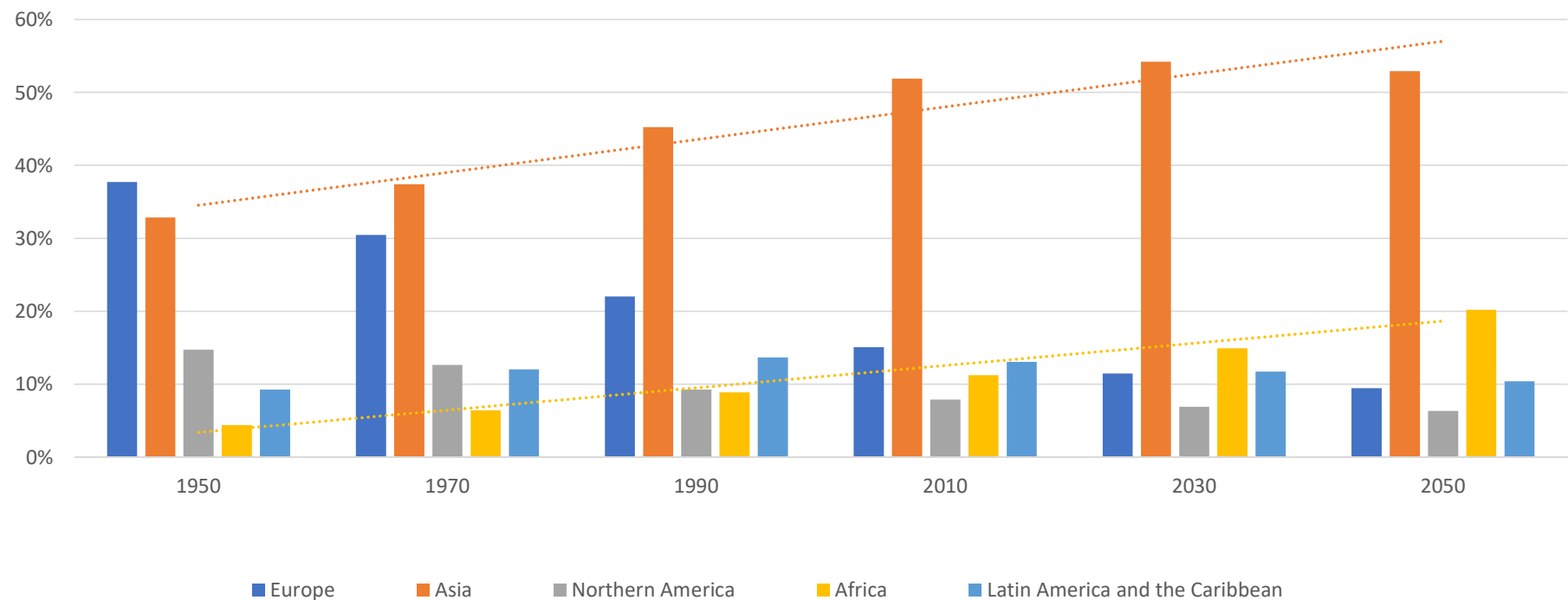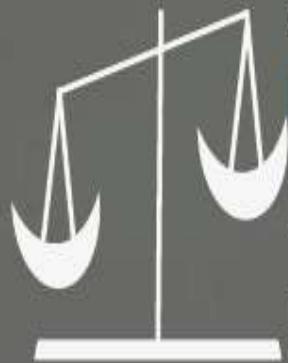
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+ 60 million new urban residents / year

Since 2008, for the first time ever, a majority of the world's population is living in urban areas

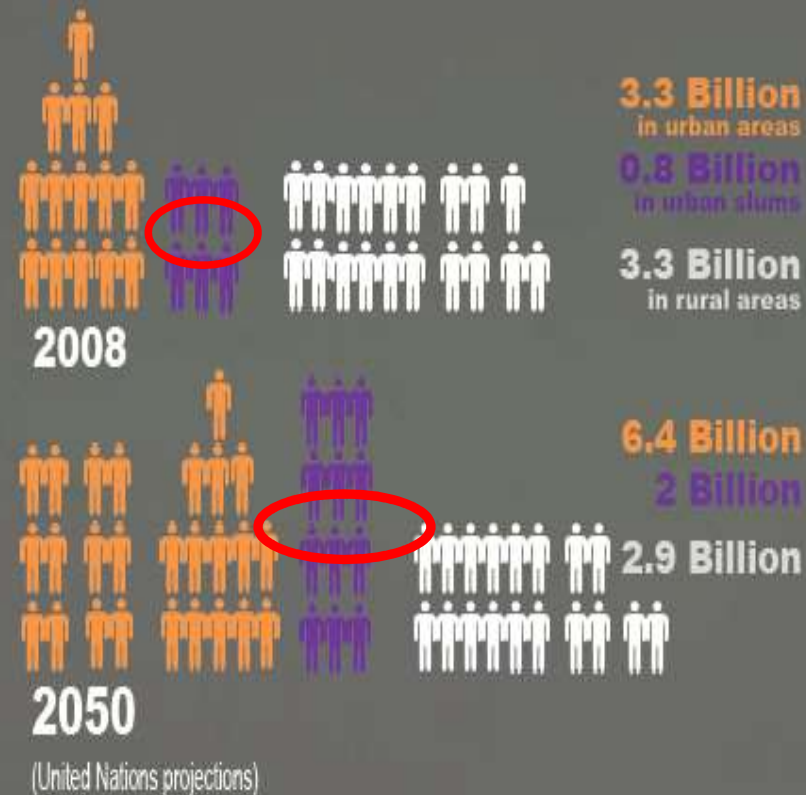One in four people in urban areas lives in **informal settlements** or **slums**

Rapid unplanned urbanization exacerbates

Health Inequities

A lower social or economic status often relates to worse health outcomes

These health inequities can be reduced by a right mix of policies and actions

2008

3.3 Billion
in urban areas

0.8 Billion
in urban slums

3.3 Billion
in rural areas

2050
(United Nations projections)

6.4 Billion

2 Billion

2.9 Billion

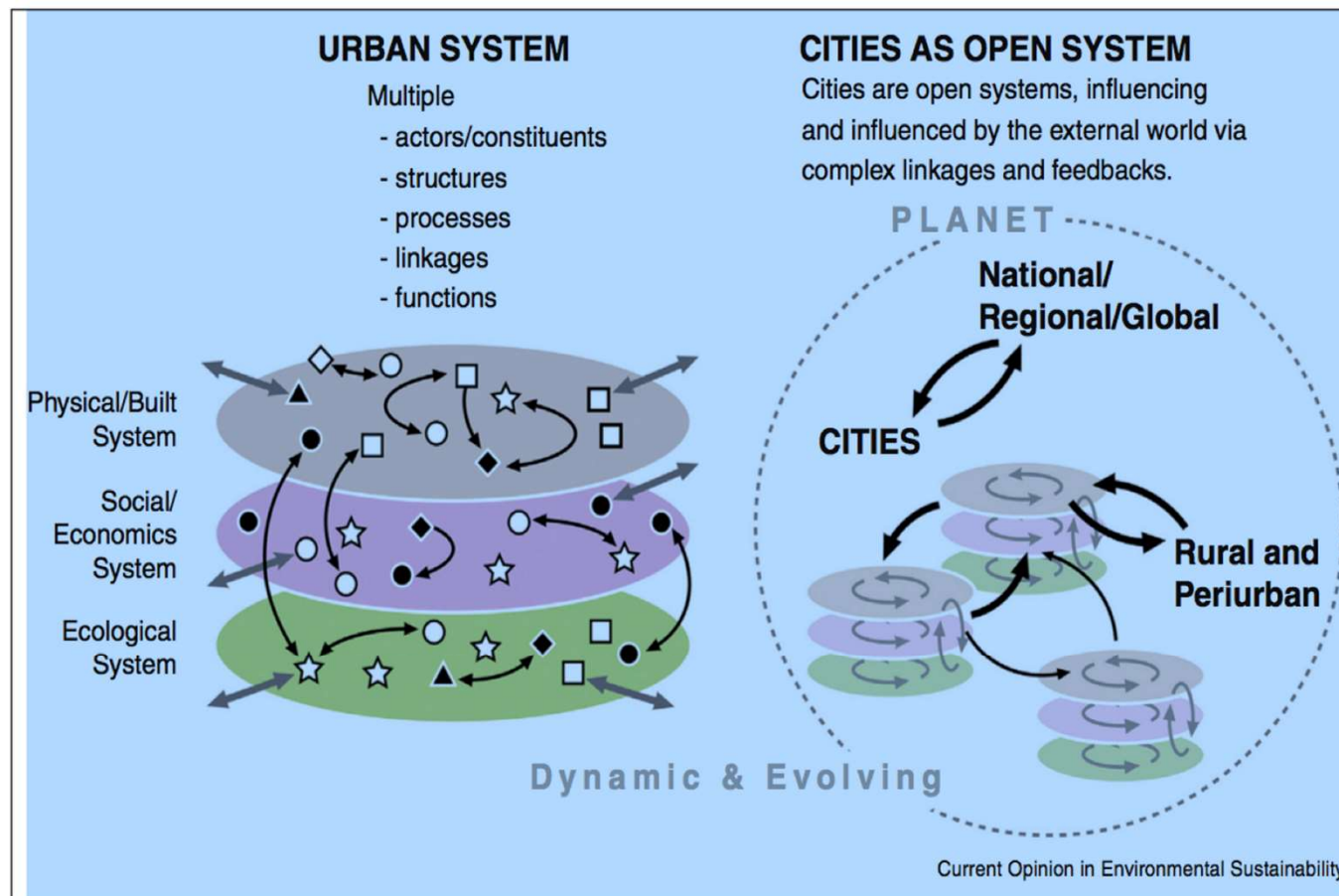International Union for the Scientific Study of Population

5.Fueled by rising urban populations and the 2030 Agenda, debate is re-emerging about the structural relationship between cities and health:

- health as a driver of the global urban system & the urbanisation as a determinant of global health

- health as a cross cutting issue in the SDGs
- urban as key to the health SDGs

11 SUSTAINABLE CITIES AND COMMUNITIES

A key C21st idea rests on the notion of Cities as complex systems (Bai et al, 2016)

URBAN SYSTEM

Multiple
- actors/constituents
- structures
- processes
- linkages
- functions

Physical/Built System

Social/Economics System

Ecological System

Dynamic & Evolving

CITIES AS OPEN SYSTEM

Cities are open systems, influencing and influenced by the external world via complex linkages and feedbacks.

PLANET

National/Regional/Global

CITIES

Rural and Periurban

Current Opinion in Environmental Sustainability

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A systems approach to urban health and wellbeing (Gatzweiler et al, 2018)
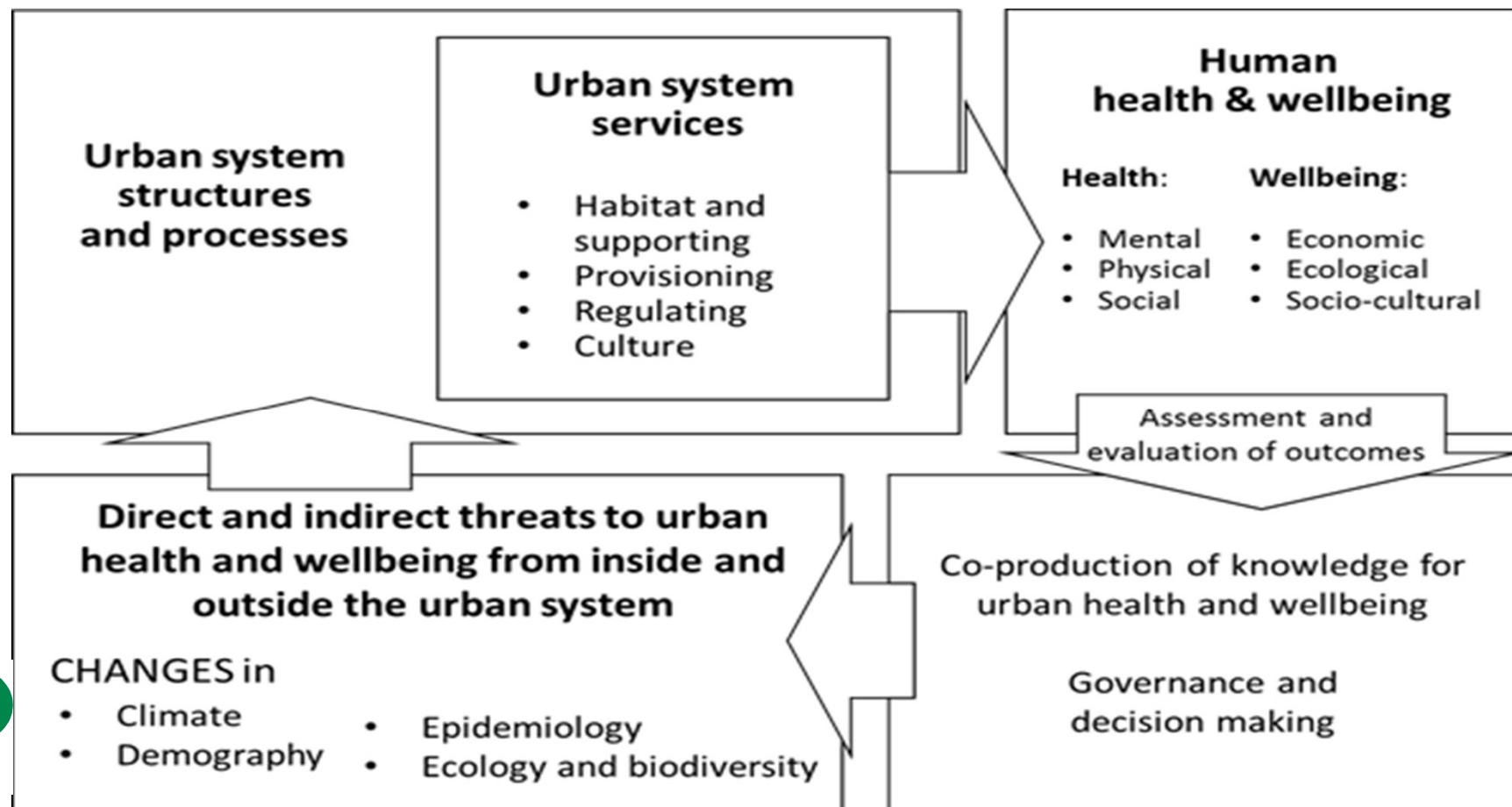
Urban health and complex systems (Glouberman et al., 2006)

- **Gather local information**: The critical importance of local context requires local information to inform interventions. Information must cover both the strengths and weaknesses of the system so that both can be addressed.

- **Respect history**: Complex systems are shaped by their past, and knowledge of their history is required to anticipate their future. This entails understanding the history of the people, communities and institutions involved in interventions.

- **Consider interaction**: Urban health is determined by more than individual biological characteristics; it is determined by interactions between individuals and communities and their social and physical environments.

- **Promote variation**: Various small-scale interventions that are tailored to local contexts offers a better opportunity of finding appropriate and effective solutions to problems in complex systems. Comprehensively planned interventions from the top-down are unlikely to succeed.

- **Conduct selection**: The variety of solutions produced by complex systems undergo a process of selection. Over time, this process will lead to the identification of increasingly effective solutions, but this depends on continuously monitoring and evaluating their performance and selecting the most effective ones.

- **Fine-tune processes**: The dynamic nature of complex systems requires interventions to be continuously refined through a process of selection. The process of intervening in complex systems is therefore iterative.

- **Encourage self-organisation**: Complex systems often produce solutions to problems without formal control or support. Such solutions have been developed by many community-based organisations in under-served areas where formal interventions are largely absent due to either neglect or marginalisation, for example, when unplanned settlements are viewed as 'illegal' and therefore denied services. This type of self-organising activity needs to be actively sought out and supported.

A systems framework for understanding urban health (Rydin et al., 2012)
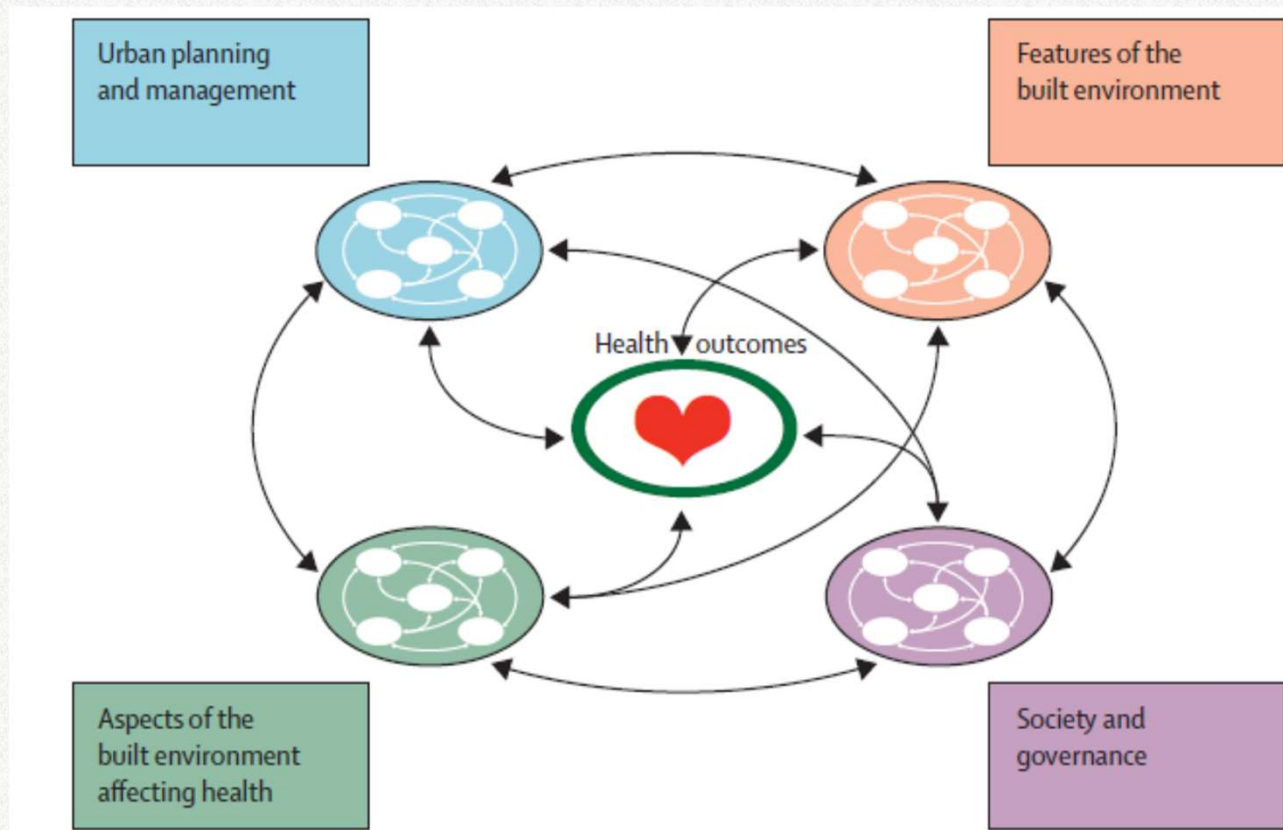
Where does all this leave reproductive health in the era of the SDGs?

NEW IDEAS MEAN NEW PRACTICE

- Change in research methods
- Shift in audience ... not just health policy

- Talk tomorrow ………