LEVERAGING MULTI-LEVEL GOVERNANCE APPROACHES TO PROMOTE HEALTH EQUITY

A GUIDE

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A GUIDE: LEVERAGING MULTI-LEVEL GOVERNANCE APPROACHES TO PROMOTE HEALTH EQUITY

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LIST OF ACRONYMS

CEPA	United Nations Committee of Experts on Public Administration
COVID-19	Coronavirus SARS-CoV2 Disease 2019
HEART	Health Equity Assessment and Response Tool (WHO)
ILO	International Labour Organization
LAT	Local Action Teams
LEP	Local Enterprise Partnership.
LHIN	Local Health Integration Network, Toronto
LSP	Local Strategic Partnerships
MLG	Multi-Level Governance
MSEPs	Multi-Stakeholder Engagement Processes
PPPs	Public-Private Partnerships
PPPPs	Public-Private-People Partnerships
SARS	Severe Acute Respiratory Syndrome
SDGs	Sustainable Development Goals
SME	Small and Medium-Size Enterprise
UHC	Universal Health Coverage
UN	United Nations
UNDP	United Nations Development Programme
UN-Habitat	United Nations Human Settlements Programme
WHO	World Health Organization

EXECUTIVE SUMMARY

The COVID-19 pandemic is disproportionally affecting the poor, minorities, and a broad range of vulnerable populations due to its inequitable spread in areas of dense population and high prevalence of chronic conditions or poor access to high quality public health and medical care. Reducing health inequities is important because health is a key determinant for development and is a fundamental human right; its progressive realization will eliminate the inequality in opportunities to enjoy life and pursue life plans that result from differences in health status (such as disease or disability). United Nations agencies such as the World Health Organization have been advancing health equity at the local, national and international levels through tools such as the WHO Health Equity Monitor which provides evidence on existing health inequalities and avails tools and resources for health inequality monitoring.[1] UN-Habitat is also a key player in this field. In collaboration with WHO, it has provided normative evidence to suggest that good urban and territorial planning is a central component of communicable and noncommunicable disease reduction and management responses.[2] Despite these efforts, challenges in redressing health inequity still persist due to weak governance structures resulting from fragmented decision-making among different urban actors (national, regional and local governments, private sector, civil society and the community).

Governance plays a vital role in the planning, finance, and management of urban areas. However, failure to agree on shared development visions in many urban areas has hindered cooperation, even when actors share common objectives. Limited capacity and legitimacy of government agencies, weak performance and accountability mechanisms and the immaturity of political institutions can undermine urban governance and result in pervasive clientelist relations and corrupt practices. Furthermore, the COVID-19 pandemic has not only demonstrated the urgent need of cities to have effective emergency preparedness plans and health crisis policies, but also the importance of establishing mechanisms, platforms and institutional settings for coordination across government institutions and multi-stakeholder collaboration to successfully introduce and implement emergency and recovery measures.[3]

UN-Habitat has developed this guide to promote an understanding of how to improve horizontal and vertical linkages among different level of governments and the non-state actors (private sector, civil society, community groups, among others). This guide will also showcase ways in which institutional frameworks can leverage inter-sectoral coordination for future health crisis preparedness and monitor and evaluate impacts on health to promote health equity and sustainable development.

1 https://www.who.int/data/gho/data/themes/health-equity

2 UN-Habitat and WHO (2020). Integrating Health in Urban and Territorial Planning: A Sourcebook for Urban Leaders, Health and Planning Professionals. https://unhabitat.org/sites/default/files/2020/05/1-final_highres_20002_integrating_health_in_urban_and_territorial_planning_a_sourcebook.pdf

3 WHO (2021). Advancing Health Emergency Preparedness in Cities and Urban Settings in COVID-19 and Beyond.

This guide will:

a. discuss ways in which urban actors can create multi-level governance systems, institutions and decision-making mechanisms that put peoples' needs at the centre, especially the poor and vulnerable groups to achieve transformative impact; facilitate effective accountability; underscore meaningful participation and transparent decision-making;

b. expound on how governments at all levels can incorporate a "health" lens to ensure preparedness and health equity drawing lessons from the current COVID-19 pandemic, for instance, establishing effective inter-sectoral coordination mechanisms to understand health threats, map epidemics and implement evidence-based public health interventions through the use of data and digital technologies, among others.

This guide is useful for governments at all levels, sectoral institutions, non-state, and community actors.

INTRODUCTION

Source: WHO - https://www.who.int/features/factfiles/health_inequities/en/

Disasters can strike quickly, without warning and with devastating social, cultural, economic, and environmental consequences. According to United Nations statistics, since 1994, 4.4 billion people have been affected by disasters, which have claimed 1.3 million lives and cost USD 2 trillion in economic losses.[4] People and governments need to be prepared for the eventuality of a disaster happening as signified by the term "emergency preparedness" which has been defined as:

a programme of long-term development activities whose goals are to strengthen the overall capacity and capability of a country to manage efficiently all types of emergency and to bring about an orderly transition from relief through recovery and back to sustainable development.[5]

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4   UNDP, *A Call for Action: Disaster Risk Reduction Makes Development Sustainable* (UNDP 2014). https://issuu.com/undp/docs/undp_cpr_cta_20140901/3

5   WHO, 'Environmental Health in Emergencies' https://www.who.int/environmental_health_emergencies/preparedness/en/

The COVID-19 pandemic is the defining global health crisis of our time and the greatest challenge countries have faced since the Second World War.[6] Since its emergence in Asia late 2019, the virus has spread to every continent on the planet. Cases are rising daily, with each country racing to slow the spread of the disease by testing and treating patients, carrying out contact tracing, limiting travel, quarantining citizens, cancelling public events, and closing public facilities such as stadiums and schools.

Countries have been forced to act decisively to prepare, respond, and recover. Crucially, the pandemic has exposed the fragility of public health systems, many of which have lacked capacity to cope with the outbreak. According to United Nations data, for every 10,000 people, developed countries have 55 hospital beds, more than 30 doctors and 81 nurses.[7] For the same number of people in a developing country, there are 7 beds, 2.5 doctors and 6 nurses.[8] A well-functioning health system is built on trained and motivated health workers, a well-maintained infrastructure, and a reliable supply of medicines and technologies, backed by adequate funding, strong health plans and evidence-based policies.[9] While the development and approval of safe and effective vaccines less than a year after the emergence of COVID-19 is a remarkable achievement, some continents such as Africa are in danger of being left behind. Early 2021 has seen 40 million COVID-19 vaccine doses administered in 50 mostly high-income countries.

However, in Africa, the vaccine roll out has been slow. To bridge this gap, 47 African countries have joined the COVAX facility[10], which aims to ensure equitable access to safe and effective COVID-19 vaccines globally. Across Africa, the aim is to vaccinate at least 20 percent of the population by providing up to 600 million doses by the end of 2021. The first phase of 90 million doses was to support African countries to immunize the 3 per cent of the African population most in need of protection, including health workers and other vulnerable groups.[11] This demonstrates that a long period will be needed, for the world's population to be fully vaccinated.
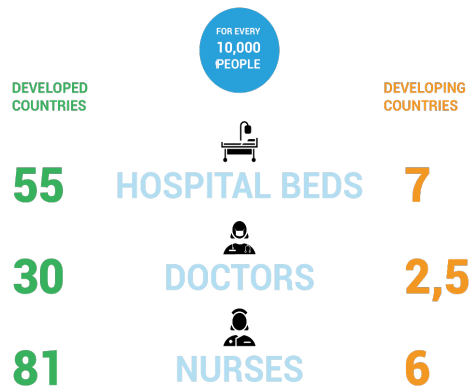
Source: UN-Habitat 2021

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6 UNDP, 'COVID-19 Pandemic: Humanity Needs Leadership and Solidarity to Defeat the Coronavirus' https://www.undp.org/content/undp/en/home/coronavirus.html

7 UNDP, 'Coronavirus vs. Inequality' https://feature.undp.org/coronavirus-vs-inequality/

8 Ibid.

9 WHO, 'Health Systems' https://www.who.int/healthsystems/topics/equity/en/

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10 This stands for COVID-19 Vaccines Global Access, which is co-led by Gavi, the Vaccine Alliance, the Coalition for Epidemic Preparedness Innovations, and the World Health Organisation.

11 https://www.afro.who.int/health-topics/coronavirus-covid-19/vaccines

COVID-19 is much more than a health crisis as it has exposed deep-rooted social and economic inequalities especially in urban areas and among the urban poor.[12] The 'shutdown' measures in urban areas have had far-reaching economic impacts on vulnerable groups, as the majority of them have lost their means of livelihood.

The International Labour Organization (ILO) reports that in India alone, more than 400 million people are at risk of sliding into poverty because they are forced to rely on informal work.[13] In Africa, where small and medium-sized enterprises (SMEs) are the economic lifeline and drivers of growth.

SMEs in cities are highly vulnerable to the impact of systemic shocks, especially in terms of employment, since they account for 80 per cent of all occupations on the continent.[14]

The risks are compounded by a likely spike in the cost of living due to disruptions in supply chains, threatening the livelihoods and social welfare of millions of Africans who depend on small businesses for their daily survival. The informal sector is also hardest hit by containment measures, notably manufacturing, hospitality and food services, as well as trading.

Additionally, due to the structural and social aspects of many slum environments, efforts to prevent the spread of the virus, such as hand washing, self-isolation, natural ventilation and physical distancing have proved impractical. At the same time, the health impacts of COVID-19 in slums have been intensified by poor access to health services in those settings. Informal settlers infected with the virus, or those requiring medical attention for other conditions, are struggling to seek accessible and quality health care and are being turned away due to lack of resources.[15]

These socio-economic inequalities are significant drawbacks to the achievement of the Sustainable Development Goals (SDGs), particularly:

SDG 3: Ensure healthy lives and promote wellbeing for all at all ages;

SDG 11: Make cities and human settlements inclusive, safe, resilient, and sustainable;

SDG 16: Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels.

12   UN Secretary-General's Policy Brief: COVID-19 in an Urban World (2020) https://unhabitat.org/un-secretary-general%E2%80%99s-policy-brief-on-covid-19-in-an-urban-world

13   UNDP. 'Coronavirus vs. Inequality' https://feature.undp.org/coronavirus-vs-inequality/

14   UN-Habitat (2020), Impacts and Perspectives of COVID-19 Responses in African Cities.

15   UN-Habitat, 'Key Messages on COVID-19 and Informal Settlements' https://unhabitat.org/key-messages-on-covid-19-and-informal-settlements

This guide aims to provide knowledge and resources on the multi-level governance strategies and tools that government at all levels can use for emergency health preparedness and the achievement of health equity. These objectives resonate with the SDGs' overarching principle of leaving no one behind and its moral imperative of social justice (equal distribution of wealth, opportunities, and privileges within a society).

The first part of this guide focusses on multi-level governance to promote an understanding of how governments at all levels can improve horizontal linkages among different levels of government, and vertical linkages between governments and non-state actors (private sector, civil society, community groups, among others).

The second part discusses mechanisms to eliminate health inequities, the effects of corruption in achieving universal health coverage and the importance of health equity indicators to capture the social determinants of health (e.g. housing, basic services, employment among others) that often drive outcomes, including institutional practices and policy decisions made outside the health care and medical sectors.

The final section showcases ways in which governments at all levels can collaborate effectively and incorporate a 'health lens', drawing lessons from the current COVID-19 pandemic to support vulnerable groups, understand health threats, map epidemics and implement evidence-based public health interventions through use of data and digital technologies.

UN-Habitat works in over 90 countries to promote transformative change in cities and human settlements through knowledge, policy advice, technical assistance, and collaborative action. This guide provides support to Member States and local authorities to improve the vertical and horizontal linkages between government institutions and among non-state actors, and to promote health equity in governance at all levels (national, regional and local) for sustainable urban development.

MULTI-LEVEL GOVERNANCE

What is Multi-Level Governance?

Governance has been defined in many ways. For this guide, governance refers to the process through which state and non-state actors interact to design and implement policies within a given set of formal and informal rules that shape and are shaped by power.[16] It involves the structures and processes that are designed to ensure accountability, transparency, responsiveness, rule of law, stability, equity and inclusiveness, empowerment, and broad-based participation. Governance also represents the norms, values and rules of the game through which public affairs are managed.[17] Strong multi-level governance frameworks characterized by coherence and coordination between different levels of governments and the involvement of all urban stakeholders are crucial to achieving health equity.

In 2018, the United Nations Committee of Experts on Public Administration developed basic principles of effective governance for sustainable development which apply to all public institutions, including the administration of executive and legislative organs, the security and justice sectors, independent constitutional bodies and state corporations. The principles are elaborated and concretized through a selection of commonly used strategies and related practices.[18] **(See Table 1 below)**.

16   World Bank (2017). Governance and the Law, . https://www.worldbank.org/en/publication/wdr2017

17   UNESCO. 'Concept of Governance' http://www.ibe.unesco.org/en/geqaf/technical-notes/concept-governance

18   UN CEPA, 'Principles of Effective Governance for Sustainable Development' (2018) https://publicadministration.un.org/Portals/1/Images/CEPA/Principles_of_effective_governance_english.pdf

TABLE 1. Principles of Effective Governance for Sustainable Development.

	PRINCIPLE		COMMONLY USED STRATEGIES
Effectiveness	Competence	To perform their functions effectively, institutions are to have sufficient expertise, resources and tools to deal adequately with the mandates under their authority	Promotion of a professional public sector workforce Strategic human resources management Leadership development and training of civil servants Performance management Results-based management Financial management and control Efficient and fair revenue administration Investment in e-government
	Sound policymaking	To achieve their intended results, public policies are to be coherent with one another and founded on true or well-established grounds, in full accordance with fact, reason and good sense	Strategic planning and foresight Regulatory impact analysis Promotion of coherent policymaking Strengthening national statistical systems Monitoring and evaluation systems Science-policy interface
	Collaboration	To address problems of common interest, institutions at all levels of government and in all sectors should work together and jointly with non-State actors towards the same end, purpose and effect	Risk management frameworks Data sharing Centre of government coordination under the Head of State or Government Collaboration, coordination, integration and dialogue across levels of government and functional areas Raising awareness of the Sustainable Development Goals Network-based governance Multi-stakeholder partnerships

Accountability	Integrity	To serve in the public interest, civil servants are to discharge their official duties honestly, fairly and in a manner consistent with soundness of moral principle	Promotion of anti-corruption policies, practices and bodies Codes of conduct for public officials Competitive public procurement Elimination of bribery and trading in influence Conflict of interest policies Whistle-blower protection Provision of adequate remuneration and equitable pay scales for public servants
	Transparency	To ensure accountability and enable public scrutiny, institutions are to be open and candid in the execution of their functions and promote access to information, subject only to the specific and limited exceptions as are provided by law	Proactive disclosure of information Budget transparency Open government data Registries of beneficial ownership Lobby registries
	Independent oversight	To retain trust in government, oversight agencies are to act according to strictly professional considerations and apart from and unaffected by others	Promotion of the independence of regulatory agencies Arrangements for review of administrative decisions by courts or other bodies Independent audit Respect for legality
Inclusiveness	Leaving no one behind	To ensure that all human beings can fulfil their potential in dignity and equality, public policies are to consider the needs and aspirations of all segments of society, including the poorest and most vulnerable and those subject to discrimination	Promotion of equitable fiscal and monetary policy Promotion of social equity Data disaggregation Systematic follow-up and review

Non-discrimination	To respect, protect and promote human rights and fundamental freedoms for all, access to public service is to be provided on general terms of equality, without distinction of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, disability or other status	Promotion of public sector workforce diversity Prohibition of discrimination in public service delivery Multilingual service delivery Accessibility standards Cultural audit of institutions Universal birth registration Gender-responsive budgeting
Participation	To have an effective State, all significant political groups should be actively involved in matters that directly affect them and have a chance to influence policy	Free and fair elections Regulatory process of public consultation Multi-stakeholder forums Participatory budgeting Community-driven development
Subsidiarity	To promote government that is responsive to the needs and aspirations of all people, central authorities should perform only those tasks which cannot be performed effectively at a more intermediate or local level	Fiscal federalism Strengthening urban governance Strengthening municipal finance and local finance systems Enhancement of local capacity for prevention, adaptation and mitigation of external shocks
Intergenerational equity	To promote prosperity and quality of life for all, institutions should construct administrative acts that balance the short-term needs of today's generation with the longer-term needs of future generations	Multilevel governance Sustainable development impact assessment Long-term public debt management Long-term territorial planning and spatial development Ecosystem management.

Source : CEPA (2018)

Multi-level governance (MLG) has emerged from a paradigm shift in governmental and public management approaches that strive for broad consultative processes and mechanisms for vertical and horizontal coordination among and between a diverse range of actors and levels of government. This involves both the formal and informal institutions as well as the public, private and social sectors.

Thus, multi-level governance can be defined as the arrangements for making binding decisions that engage a multiplicity of politically independent but otherwise interdependent institutional actors (private, public and social) at different territorial levels and that does not assign exclusive policy competence or assert a stable hierarchy of political authority to any level.[19] To achieve such collective action, each actor plays a key role in the process:

a. **National governments:** Co-design or co-create programmes and regulations with key stakeholders (local government, private sector, civil society and citizens) in which broad cross-cutting instruments are developed to serve common goals; reflect common policy targets and priorities defined by lower levels of government (sub-national and neighbourhoods) in national policy documents. Fiscal and jurisdictional decentralization should be promoted by national governments to allow lower level governments to implement policies with a territorial approach.

b. **Subnational governments (provincial/regional/metropolitan)**: Develop territorial strategies that address economic, social and environmental challenges in an integrative way; boost regional competitiveness while promoting sustainable development; develop regional infrastructures and facilities for an adequate provision of basic services; encourage metropolitan and urban-rural cooperation to advance balanced territorial development, optimize policy actions and maximise results.

c. **Local governments**: Develop plans and other strategic documents to operationalise urban development encouraging citizen participation; set up adequate institutional structures for integrating urban development policies; define sectoral and geographical actions/projects in cooperation with lower (neighbourhood) and higher (regional and metropolitan) levels; secure public services provision; analyse policy outcomes to strengthen what works and change what does not; develop and operationalise participatory instruments to guarantee inclusivity and maintain democracy.

19 Schmitter, P (2004). "Neofunctionalism" in A. Wiener and T. Diez (eds), European Integration Theory (OUP) OECD (2005). *Building Competitive Regions: Strategies and Governance*.

d. **Neighbourhoods:** Communities and citizens should clearly identify their most pressing and urgent needs; initiate local actions , participate in the creation of national and regional policies, as well as define objectives and contribute towards their implementation; develop innovative instruments to communicate directly with governments; promote and maintain social cohesion. Effective engagement with vulnerable groups through full information sharing, co-designing and co-creating some specific health service to address their unique needs. At its core, community engagement enables changes in behaviour, environments, policies, programmes, and practices within communities.

e. **Private sector**: Provide goods and services; secure adequate job conditions prioritizing the right balance between professional and personal life; boost economic development; include sustainable practices within corporative policies; contribute with public services provision through public-private-people-partnerships; implement philanthropic initiatives addressing the needs of vulnerable communities and territories.

f. **Civil society:** NGOs and the third sector must encourage the participation of excluded groups or residents who do not actively participate in decision-making; bridge the gap between governments and citizens through participative mechanisms; defend the rule of law, respect for human rights and equal access to justice for all; promote collective action and common development visions.

The New Urban Agenda and Sustainable Development Goals (SDGs):

In 2016, the third United Nations Conference on Housing and Sustainable Urban Development, Habitat III, adopted the New Urban Agenda, a framework for sustainable management of cities which appreciates the role of multi-level urban governance in sustainable and inclusive cities. It calls for stronger coordination and cooperation among national, subnational and local governments, including through multi-level consultation mechanisms and by clear definition of mandates; coherence between goals and measures of sectoral policies at different levels of administration; and strong metropolitan governance based on functional territories rather than administrative borders.

The New Urban Agenda also emphasizes the participation of all urban residents in urban governance by encouraging collaboration among local governments, communities, civil societies and the private sector in infrastructure and basic services provision as well as urban and territorial policy and planning processes.[20] The 2030 Agenda for Sustainable Development pushes for going beyond "governance as usual" to reach the Sustainable Development Goals (SDGs). It is worth noting that the 17 SDGs can only be achieved through effective governance frameworks at all international, national, and territorial levels.

20 Paragraphs 87, 88, 90, 91 and 92 of the New Urban Agenda.

In particular, SDG16 has specific targets that contain ingredients for multi-level governance, including: promote the rule of law at the national and international levels and ensure equal access to justice for all; substantially reduce corruption and bribery in all their forms; develop effective, accountable and transparent institutions at all levels; ensure responsive, inclusive, participatory and representative decision-making at all levels; and ensure public access to information and protect fundamental freedoms in accordance with national legislation and international agreements.

The 18th World Winter Cities Association for Mayors Conference on Green Development in 2018, Shenyang, China. Source: Shenyang Municipal Government https://www.prnewswire.com/news-releases/41-cities-reunite-in-shenyang-discussing-green-development-at-the-18th-world-winter-cities-association-for-mayors-conference-300712747.html

Why Multi-Level Governance?

Traditional forms of governing (i.e. top-down hierarchical approaches) have exposed significant limitations and urban governments face an increasing number and complexity of challenges. Population growth and economic, social and cultural globalisation, have led to more economic competition and pressure on national and local institutional structures to guarantee all inhabitants access to the necessities of urban life, including adequate shelter, security of land tenure, safe water, sanitation, a clean environment, health, education and nutrition, employment, public safety and mobility. Indeed, cities have welcomed 1.5 billion more people in the last 20 years making these area more densely populated, socially complex, and geographically extensive.[21]

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21 UN-Habitat. (2020b). Governance Assessment Framework for Metropolitan, Territorial and Regional Management. Nairobi.

A critical factor influencing whether cities are governed in a sustainable, inclusive, and equitable manner is the way in which local institutions operate and whose interests they represent. Thus, cities need to break away from compartmentalised approaches and to integrate formerly fragmented policy actions by considering the spatial, economic, and social dimensions of urban development.

Multi-level governance is an approach that will help them to integrate all these dynamics, activities, and services and has been advanced as the governance model that supports inclusivity since it embodies the principles of coordination, cooperation, participation, integration and 'leave no one and no place behind' which can be easily connected through cross-cutting policy instruments. These are discussed in more detail below:

A. **Coordination**: Multi-level governance demands horizontal coordination across all levels of government as well as multi-stakeholder engagement between governments and non-state actors (private sector, civil society, community groups among others). Multi-stakeholder engagement processes (MSEPs) are structured processes to develop partnerships and networks amongst different stakeholders. The inclusive and participatory nature of the processes promotes a greater sense of ownership over its outcomes, and consequently, strengthens its sustainability.[22] Measuring the impacts of MSEPs can be done at both the qualitative and quantitative levels although it can be challenging due to the number of stakeholders and the divergence of their perspectives, knowledge and experience levels. Multi-stakeholder benchmarking has been designed to respond to these complex problems by clarifying ambiguities and complexities. Indicators for documenting and understanding change in stakeholder attitude aim to decrease divisiveness and polarization of opinions. The benchmarking is a continuous process that uses multiple methods to establish quantitative data, which is used alongside qualitative data to engender an understanding of complex social issues.[23]

The issues addressed in the benchmarking include:

- Socio–economic information – through identification and surveys of stakeholders using quantitative and qualitative questions such as the percentage of social services delivered, number of community trainings etc.

- Qualitative research – conducted with focus groups from those surveyed to validate the results.

- Defining and sharing best practice goals within the groups.

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22 UNDP (2006). *Multi-Stakeholder Engagement Processes: A UNDP Capacity Development Resource.* https://www.undp.org/content/dam/aplaws/publication/en/publications/capacity-development/drivers-of-change/accountability/multi-stakeholder-engagement-processes/Engagement-Processes-cp7.pdf

23 Ibid.

Some of the instruments for coordination include:

ii.   **Integrated Local Action Plans** - Local action plans developed at the neighbourhood level need to be communicated to the higher level to define actions and ensure consistency with common objectives set at higher levels. Local action plans do not have a rigid definition and can refer to any topic and field that contributes to fulfilling the needs of citizens and that provides participatory solutions for challenges faced by local communities; plans may be specific urban projects like neighbourhood regeneration, a specific plan to combat climate change at the city level, or the creation of local employment. They should provide creative, pragmatic and precise solutions based on the results of transnational exchanges **(See example at Box 1)**.

BOX 1.   Programme for Developing Local Plans for Social Inclusion in Catalonia, Spain

In 2006, the Department of Social Action and Citizenship of *the Generalitat de Cataluña* introduced a Programme for Developing Local Plans for Social Inclusion. One of its operational objectives is to boost, stimulate and generate resources for drawing up plans for inclusion at the local level. The Programme for Developing Local Plans for Social Inclusion is an inter-administrative cooperation programme intended to realise these Local Plans. It develops the governing principles for action in the area of social inclusion as established in the Plan. Its coordination was assigned to the Catalan Institute of Social Assistance and Services. The Local Plans for Social Inclusion are implemented through the local administration and in co-operation with other relevant actors in the area. These plans seem to be a mix of existing projects and new initiatives; the most innovative part is that they are integrated into a common framework. Lessons learnt through a peer review concerned the role of national plans (as a favourable context for local plans), the importance of the local context and political support, the need for guidance, indicators and monitoring and for local institutional support and third sector participation.

Source: Tasan-Kok, T. and Vranken, J. (2011). Handbook for Multilevel Urban Governance in Europe. https://www.researchgate.net/publication/261549364_Handbook_for_Multilevel_Urban_Governance_in_Europe

iii.   **Local Strategic Partnerships** - A local strategic partnership (LSP) is a partnership which brings together organisations from the public, private, community and voluntary sectors in a local authority area. The key objective of the LSP is to improve the quality of life in that area. Because an LSP is locally based, the community is well placed to influence its decision-making. This provides the community with the opportunity to have a say on the services that should be provided to meet its needs. The local action teams (LAT) are designed in LSPs to define effective community-led projects, aiming to adopt a proactive multiagency approach, working and engaging with the public on key issues with the aim of improving the quality of life of individuals

and communities in their localities. To promote partnerships between various sets of actors at different levels of governance, it is crucial to build efficient LATs at the neighbourhood level. These can be composed of elected people, practitioners and community organisers who are able to activate different stakeholders around sustainable local action plans. Governments at all levels should strongly support the development of such integrated LATs, since they generate sustainable added values at the city and regional levels and relate them to other, larger scales. In general, the failure of sustainable development strategies is linked to the inadequacies of the LATs rather than to a lack of funds[24] **(see example at Box 2)**.

BOX 2. **East Riding (Yorkshire) Local Strategic Partnerships and Local Action Teams**

The East Riding Local Strategic Partnership (LSP) was founded in 2001. It comprises partner organizations from the public, private, voluntary and community sectors to develop and deliver a plan for the continued sustainable development of the area. Through this jointly developed sustainable community plan, partners work together for the benefit of all East Riding residents and visitors, both now and in the future. The LSP consists of a board and four action groups, all of which are comprised of wide-ranging networks designed to achieve the objectives set out in the plan.

The LSP supports the strategic aims of the regional spatial strategy and is supported by the local spatial planning objectives being set out within the emerging local development framework which will inform local planning, infrastructure development and investment decisions until 2026. The delivery mechanism for the plan is a local area agreement.

The East Riding LSP Board is responsible for overall partnership policy and decision-making. The four action groups are as follows:

- Sustainable Communities and Transport Action Group

- Children and Young People Action Group

- Healthier Communities and Older People Action Group

- Safer and Stronger Communities Action Group

Source: Tasan-Kok, T. and Vranken, J. (2011). Handbook for Multilevel Urban Governance in Europe. https://www.researchgate.net/publication/261549364_Handbook_for_Multilevel_Urban_Governance_in_Europe

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24 Tasan-Kok, T. and Vranken, J. (2011). Handbook for Multilevel Urban Governance in Europe. https://www.researchgate.net/publication/261549364_Handbook_for_Multilevel_Urban_Governance_in_Europe

B. Multi-Party Contracts/PPPs - Public-private partnerships (PPPs) involve collaboration between a government agency and a private-sector entity that can be used to finance, build and operate projects. A city government, for example, might be heavily indebted and unable to undertake a capital-intensive building project, but a private enterprise might be interested in funding its construction in exchange for part of operating profits once the project is complete. PPPs are typically found in transport and municipal or environmental infrastructure and public service accommodations. PPPs often have contract periods of 25 to 30 years or longer. PPPs also require payments from the public sector or users over the project's lifetime. Although public works and services may be paid for through a fee from the public authority's revenue budget, such as with hospital projects, concessions may involve the right to direct users' payments, for example, with toll highways. In such cases, payments are based on actual usage of the service. When wastewater treatment is involved, payment is made with fees collected from users. Despite its many advantages, PPPs are often criticised for blurring the lines between legitimate public purposes and private for-profit activity, and for perceived exploitation of the public due to self-dealing and rent seeking that may occur.[25] To overcome this criticism, the concept of the public—private—people partnership (4P) is emerging to highlight the need for involving the general public in the process. The 4P process framework embraces the bottom-up participative strategies which make public engagement clearly visible for infrastructure planning and policy making. With this newly developed framework and associated engagement strategies, decision-making power can shift from policy makers to the citizens through proactive engagement. **(see example at Box 3)**.

BOX 3.   Leeds City Region Local Enterprise Partnership (LEP)

Eleven local authorities in the Leeds region have been working closely with a range of business sectors and partners to develop an outline proposal which reflects the needs of the city region businesses and of the economy. A Leeds City Region LEP was drawn up based on current city region arrangements and it proposes taking on further responsibilities for strategy, funding, investment, planning and commissioning of economic development and regeneration activities.

On 11 September 2006, the Leeds City Region local authority leaders approved the City Region Development Programme, which translated the LEP's vision into a plan of action. A business-led Leeds City Region LEP Board was established, which is responsible for developing the LEP business plan. Furthermore, the Leeds City Region Partnership team will frequently host business engagement events across the city region to inform, engage and discuss community proposals with the residents.

The key expectations for establishing a LEP are defined as: support from business (engagement of local businesses and SMEs), economic geography (functional economic linkages and strategy),

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25 Ibid. See also, https://www.investopedia.com/terms/p/public-private-partnerships.asp

local authority support. Moreover, the national government announced that the Regional Growth Fund will provide funding for successful LEPs that will help to create private sectors jobs and reduce dependence on public sector jobs.

The Leeds partnership comprises the members of the business-led board that leads the LEP. These board members include councillors from the different communities in Leeds. The private sector board members include high-ranking, private sector officials from enterprises like the Leeds Bradford Airport, private sector infrastructure companies, the University of York, and some banks. Members of civil society organizations are included in the process to ensure the needs of Leeds residents are adequately considered by the LEPs.

Source: Tasan-Kok, T. and Vranken, J. (2011). Handbook for Multilevel Urban Governance in Europe. https://www.researchgate.net/publication/261549364_Handbook_for_Multilevel_Urban_ Governance_in_Europe

B. **Cooperation**: Cooperation allows multiple domains such as employment, housing, education, health and culture to be integrated and implemented through inter-departmental programmes and projects. Inter-municipal and metropolitan cooperation mechanisms make the case for cooperation. These arrangements have recently emerged from continuous transformations of urban and territorial dynamics, especially metropolisation processes in both developing and developed countries. Metropolises are connected urban, peri-urban, and rural territories which do not operate in isolation and have strong territorial interdependencies varying in economic, social and environmental aspects. Managing these interdependencies in an integrated way enables citizens to access urban goods and services without jurisdictional constraints. Metropolitan governance supports the quest to leave no one and no place behind since it aims for balanced territorial development that facilitates housing, work, health, education and other fundamental socio-economic rights without the limitations of administrative boundaries **(See examples in Box 4)**.

BOX 4. **Inspiring Best Practices on Metropolitan Cooperation**

Metropolitan governance has been achieved in different ways around the world. The cases below from Valle de Aburrá in Colombia; San Salvador in El Salvador; Montreal in Canada; Barcelona in Spain; Johannesburg in South Africa; and Singapore, show how metropolises can successfully introduce mechanisms for inter-municipal cooperation and joint decision-making.

The inter-municipal cooperation mechanisms such as those of the Barcelona Metropolitan Area (AMB) made up of 36 municipalities, the Montreal Metropolitan Community (CMM) with 82 municipalities or the Metropolitan Area of Valle de Aburrá (AMVA) with 10 municipalities, exemplify how associative schemes optimize territorial management, the provision of services and the implementation of projects that go beyond their municipal boundaries, without decreasing political-administrative or jurisdictional autonomies.

Decision-making bodies like the Council of Mayors of the Metropolitan Area of San Salvador, the Metropolitan Council, Portfolio Clusters and Committees, Mayoral Committee, and Executive Team, in Johannesburg; and the Parliament, Cabinet, Community Development Councils and Town Councils in Singapore, show how different configurations of governing bodies have been set for regulating metropolitan institutions while achieving horizontal and vertical cooperation and representing local interests and priorities.

Source: UN-Habitat, Governance Assessment Framework for Metropolitan, Territorial and Regional Management (UN-Habitat 2020b). https://unhabitat.org/sites/default/files/2020/10/gaf-mtr.pdf

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C. **Participation**: For processes to be truly participatory, they should reflect the requirement for "***active, free and meaningful***" participation under the United Nations Declaration on the Right to Development. This involves transparent decision-making whereby individuals affected by administrative decisions are allowed and encouraged to know not only the basic facts and figures, but also the mechanisms and processes behind such administrative transactions. It is the duty of civil servants, managers and trustees to act visibly, predictably and understandably. The right to information is a condition for meaningful participation in the different functions of society. In the urban context, the New Urban Agenda encourages participatory approaches at all stages of the urban and territorial policy and planning processes (including conceptualisation, design, budgeting, implementation, evaluation and review). Existing forms of participation, such as participatory budgeting, citizen-based monitoring, self-enumeration and co-planning, have primarily emerged in Asian, African and Latin American countries to create new spaces for interaction between civil society and state organisations **(see example on Box 5)**.

BOX 5.   Participatory Budgeting in India (City of Pune)

Participatory budgeting, an alternative to traditional budgeting styles, allows people to deliberate and negotiate over the distribution of public resources.

In 2005, Pune became the first Indian city to successfully implement participatory budgeting. Every August, the city's municipal corporation publishes an advertisement and invites suggestions from its people for civic works to be included in the forthcoming municipal budgets. People have a month to submit their proposals on the 'Citizen Suggestion Form' available online and at the ward office. Next, the proposals are sent to the *prabhag samiti*, made up of elected representatives of the locality.

The *samiti* approves the suggestions and sends the updated list to the accounts department of the corporation for scrutiny. The accounts department looks at the financial feasibility and sends a final list which is then included in the city budget. The regulations mandate that the individual projects cannot cost more than INR 5 lakh (USD 6,677) and that each of the 76 *prabhags* (divisions) in the city can allocate a maximum of INR 50 lakh (USD 66,782).

People can demand works on pavements, streetlights, bus stands, public toilets, water, parks, signage, roads, traffic lights, public parking, garbage management, drainage etc. Civil society played a crucial role in popularizing the initiative. In 2010, non-profits Janwani and the Centre for Environment Education distributed story-format booklets to sensitize people and carried out over 100 workshops.

Impact: In 2007-08, the budgetary allocation was INR 17.62 crore (USD 2,353,411), which reached INR 37.5 crore (USD 5,009,451) in 2014-15. Even the total number of suggestions increased from 600 in 2012-13 to 4,645 in 2014-15. The 846 works approved in 2014-15 were for roads (34 per cent), electricity (20 per cent), buildings (15 per cent), drainage (14 per cent), slum redevelopment (13 per cent) and water (4 per cent).

Source: Our Pune, Our Budget http://ourpuneourbudget.in/

At the same time, e-participation has become a common method used by governments across the world as part of their e-government toolbox. Definitions of e-participation found in academic and practitioner literature vary, but most of them revolve around the basic concept of using information and communication technologies (ICTs) to engage citizens in decision-making and public service delivery.[26]

26 David Le Blanc (2020). 'E-participation: A Quick Overview of Recent Qualitative Trends'. UNDESA.

In responding to the health emergency, governments have put in place new tools, such as dedicated COVID-19 information portals, hackathons, e-services for supply of medical goods, virtual medical appointments, self-diagnosis apps and e-permits for curfews. Innovative e-participation mechanisms for COVID-19 include online dashboards in Canada and Australia to share information and track emergency responses.

In Estonia, a community engagement app allowed local governments to directly interact with their constituents, including through sharing COVID-19 information, posting photos and videos and even organising virtual events. In Croatia, a "virtual doctor" is powered by artificial intelligence and developed by technology firms in cooperation with epidemiologists.[27]

What are the Challenges facing Multi-Level Governance Arrangements?

Some of the main challenges that hinder multi-level governance include: conflicting interests and competing aims of stakeholders; budgetary allocations, fragmented decision-making and institutional solutions; shifting aims and goals of actors; bureaucracy/organisational hierarchies; corruption and inadequate accountability; low capacity to achieve common visions of development; policy implementation and decision-making based on personal priorities or particular political agendas, among others. All these challenges are characterised by the *collective action problem*.[28]

The collective action problem is a representation of the processes that involve agreeing on public actions and policies that truly respond to the needs of the majority, including cooperation motivated by consensus, interaction and trust between different actors. Collective action demands civic commitment as an essential component of social capital, trust and cooperation as the basis for the social fabric and the association between citizens and institutions (formal and informal) for the achievement of the common good.

According to the collective action problem, cooperation is more easily consolidated in small rather than large groups, since their preferences and motivations will be easier to articulate. This suggests that multi-level governance should start with arrangements that serve specific and concrete public policy objectives and, after being consolidated, receive progressively more powers, responsibilities and functions.

For academics like Cante, the collective action problem is reduced in its simplest version to the *free riders*.[29] Non-cooperation is the preferred option by most governments, institutions, groups and individuals, which could be because the actors do not have access to collective goods or services or because they do not have collective purposes, or despite having collective purposes, they prefer not to bear the costs of cooperation, but to enjoy its benefits for free.

Integrating collective actions between different levels of government and sectoral institutions has allowed countries to effectively respond to the COVID-19 pandemic **(See Box 6)**.

Embedding collective action and overcoming the most common challenges of multilevel governance entails[30]:

27 https://www.un.org/development/desa/publications/publication/2020-united-nations-e-government-survey

28 Olson, M. (1965). *The Logic of Collective Action.*.

29 Cante, F. (2007). *Collective Action, Meta-preferences and Emotions.*

30 Adapted from Roth, D. (2015). *Public Policies* (2015) and Kingdon, J. W. (2003). Agendas, *Alternatives and Public Policies*. Longman.

i.   **Recognising common problems and their policy spaces**: Public policies can be delimited by the scale of the problems that must be solved, or by the space in which the institutions or actors that will deal with said problems act. Defining the policy space is useful to filter relevant information for analysis, find appropriate solutions to problems and forecast the feasibility of a solution, considering the impact it will have on the actors and their cooperation mechanisms.

ii. **Promoting deliberation and public debate to find solutions**: It is necessary to develop negotiation processes to reach agreements that address common problems. Each actor's role in these processes is decisive for success with correct delimitation of the contribution to the legitimacy, cohesion and organisation of the debate, and in turn, its chances of success. A satisfactory process of deliberation and debate will result in the inclusion of public problems in the political agenda, obeying the principles of collective well-being and social order, as well as guaranteeing shared responsibility among all the actors that interact within the policy space.

iii. **Including problems and solutions on the political agenda**: Once common problems have been identified and debated, and possible solutions identified, they should be put on the political agenda. The correct inscription at the political agenda of multiple actors will ensure that multi-level governance arrangements are legitimate, sustainable over time and a priority for decision-making.

BOX 6.   **Multi-level Governance as an Effective Response during the COVID-19 Pandemic**

Achieving vertical cooperation among different levels of governments and horizontal cooperation between local governments and sectoral authorities has been key in addressing the pandemic. For instance, in Cameroon, the mayors of Metropolitan Douala have united to collectively implement several campaigns and measures led by the Minister of Public Health and other national sectoral institutions. In Mexico, the Mexico City Government and 13 of its 16 municipalities collaborated to implement a new "***Market, Community, Food, and Supply***" initiative to support families and microenterprises; in Ecuador, the Mayor of Metropolitan Quito appointed the Metropolitan Company for Integral Solid Waste Management to activate a collaborative protocol of funeral service in coordination with other national institutions.

In other countries, multi-level governance arrangements were enabled by legal emergency measures. In Spain, under the state of emergency, the Conference of Presidents was established, a multi-lateral cooperation body composed of the national government and the governments of the autonomous communities (sub-national level). This became the operative instrument for multi-level dialogue and facilitates communicating containment measures and coordinating resources based on territorial needs.

Inter-sectoral collaboration was also key for prevention. That is the case in Singapore, where a multi-agency taskforce chaired by the Ministers of Health and National Development and with representation across the entire public service, including the sectors of trade, education and communications, was settled even before the first case was reported.

In cases where inter-jurisdictional cooperation mechanisms such as metropolitan governance, inter-sectoral programmes, urban-rural arrangements, or multi-level government instances were in place, measures have been implemented to rapidly contribute to an effective response. Where there was competition among levels of governments, fragmentation of the political scene and dysfunction, institutional conflicts and legal disputes over responsibilities were more frequent.

Source: UN-Habitat (2020a). "Policy, Legal and Governance Responses to Covid-19". In UN-Habitat Cities and Pandemic Report.

HEALTH EQUITY

What is Health Equity?

Equity is the absence of avoidable, unfair or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification.[31] '*Health equity*' or '*equity in health*' implies that everyone should have a fair opportunity to attain their full health potential without being disadvantaged.[32]

Indeed, the right to health is a human right that is well-established in international law. It is recognised in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights and in other international and regional human rights treaties such as the Convention on the Rights of the Child and the African Charter on Human and Peoples' Rights.[33]

According to these instruments, everyone has the right to the highest attainable standard of physical and mental health, which includes **access to all medical services, sanitation, adequate food, decent housing, healthy working conditions, and a clean environment.[34]**

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31 WHO, 'Health Equity' https://www.who.int/topics/health_equity/en/

32 Ibid.

33 Article 25, 12, 24 and 16 respectively.

34 World Health Organisation (2017). *Advancing the Right to Health: The Vital Role of Law.*

In 2000, the substantive obligations embodied within the right to health were clarified by the United Nations Committee on Economic, Social and Cultural Rights in General Comment 14.[35] This General Comment explains that the right to health is an inclusive right that extends beyond health care to the underlying determinants of health, including access to safe and potable water, adequate sanitation, an adequate supply of safe food and nutrition, housing, healthy occupational and environmental conditions, access to health-related education and information, including on sexual and reproductive health, and freedom from discrimination.

The committee also explained that the right to health does not create an entitlement to be healthy, nor does it hold states responsible for all the potential causes of poor health, including genetic susceptibility or an individual's choice to adopt an unhealthy lifestyle.[36] Nonetheless, the obligation to respect, protect and fulfil the right to health puts health on the agenda of every government, and provides a mandate for them to institute legislative and administrative actions that are necessary, across all the relevant sectors of government, to create the conditions in which members of the population can realise the highest attainable standard of health.

In some countries, the right to health has been recognised in national constitutions. For example, in Article 6 of the **Constitution of the Federal Republic of Brazil**, health is designated as a social right. This is further reinforced by Article 196, which states:

"Health is the right of all persons and the duty of the State and is guaranteed by means of social and economic policies aimed at reducing the risk of illness and other hazards and at universal and equal access to all actions and services for the promotion, protection and recovery of health."[37]

Such an explicit and broad recognition of the right to health in domestic legal frameworks is a step in the right direction. However, full realisation of this right has often been a challenge in practice. Communicable diseases such as malaria, HIV/AIDS and tuberculosis disproportionately affect the world's poorest populations, and in many cases are compounded and exacerbated by other inequalities and inequities, including gender, age, sexual orientation or gender identity and migration status. While data collection systems are often ill-equipped to capture all relevant data on these groups, reports show that these populations have higher mortality and morbidity rates due to non-communicable diseases such as cancer, cardiovascular diseases and chronic respiratory disease.

These populations may also be the subject of laws and policies that further compound their marginalisation and make it harder for them to access healthcare services, treatment, rehabilitation and other rights to health.[38]

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35 OHCHR. 'Committee on Economic, Social and Cultural Rights General Comment No. 14: The Right to the Highest Attainable Standard of Health' https://www.refworld.org/pdfid/4538838d0.pdf

36 Ibid.

37 For more information, see UN-Habitat (2020c. *Human Rights, Rule of Law and the New Urban Agenda*. https://unhabitat.org/sites/default/files/2020/07/human_rights_rule_of_law_and_new_urban_agenda_un-habitat_2020.pdf

38 WHO (2017). 'Human Rights and Health: Key Facts'. https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health.

To eliminate health inequities, the principles of **availability, accessibility, acceptability** and **quality**, which are the core elements of the right to health, provide guidance to governments at all levels as they make decisions about the goals, resources, focus and scale of public health reform initiatives[39]:

a.   Availability

Refers to the need for a sufficient quantity of functioning public health and health care facilities, goods and services, as well as programmes for all. Availability can be measured through analysis of disaggregated data to different and multiple stratifies, including by age, sex, location and socio-economic status, and qualitative surveys to understand coverage gaps and health workforce coverage.

b.   Accessibility

Requires that health facilities, goods and services must be accessible to everyone. Accessibility has four overlapping dimensions:

- non-discrimination
- physical accessibility
- economical accessibility (affordability)
- information accessibility

Assessing accessibility may require analysis of barriers, physical, financial or otherwise, that exist and how they may affect the most vulnerable. It may necessitate a call for the establishment or application of clear norms and standards in both law and policy to address these barriers, as well as robust monitoring systems of health-related information and whether this information is reaching all populations.

c.   Acceptability

Relates to respect for medical ethics, cultural appropriateness and sensitivity to gender. Acceptability requires that health facilities, goods, services and programmes are people-centred and cater for the specific needs of diverse population groups and in accordance with international standards of medical ethics for confidentiality and informed consent.

39 Ibid.

d. Quality

Facilities, goods and services must be scientifically and medically approved. Quality is a key component of universal health coverage (UHC) and includes the experience as well as the perception of health care. Quality health services should be:

- **Safe** - avoiding injuries to people for whom the care is intended

- **Effective** - providing evidence-based healthcare services to those who need them

- **People-centred** - providing care that responds to individual preferences, needs and values

- **Timely** - reducing waiting times and sometimes harmful delays

- **Equitable** - providing care that does not vary in quality on account of gender, ethnicity, geographic location and socio-economic status

- **Integrated** - providing care that makes available the full range of health services throughout the life course

- **Efficient** - maximising the benefit of available resources and avoiding waste.

Health inequity therefore entails a failure to avoid or overcome inequalities that infringe on fairness and human rights norms. Reducing health inequities is important because health is a fundamental human right; its progressive realisation will eliminate inequalities that result from differences in health status (such as disease or disability) and will increase the opportunity to enjoy life and pursue one's life plans.

A common characteristic of groups that experience health inequities, such as poor or marginalised people, racial and ethnic minorities, and women, is the lack of political, social or economic power. Thus, to be effective and sustainable, interventions that aim to redress inequities must typically go beyond remedying a particular health inequality and help empower the group in question through systemic changes, such as law reform or changes in economic or social relationships.[40]

40 WHO, 'Health Systems' https://www.who.int/healthsystems/topics/equity/en/

BOX 7.   Mainstreaming Health Equity in Norway

Norway has a long history related to inter-sectoral action for health and well-being, which has been implemented at different levels of governments and supported by a range of tools and mechanisms. Gender, equity and human rights are cross-cutting themes in this work. For indicators, data is disaggregated according to socio-economic variables and gender. Data is also collected for vulnerable groups. The White Paper 20 (2006–2007), National strategy to Reduce Social Inequalities in Health, highlighted public health policy as a cross-sectoral issue and first launched the cross-sectoral reporting system. The document recommended that cross-sectoral tools should be adopted to support efforts to reduce health inequities, including establishing a review and reporting system to monitor developments in the work on reducing social inequalities in health. The reporting system is a feedback mechanism for inter-sectoral indicators on determinants/progress across sectors that constitutes a basis for further policy development. The White Paper 34 (2012–2013), Public Health Report – Good Health, a Common Responsibility, reinforced the need for collective action on health and established a national system for the follow-up of public health policies. To support this work, different sectors have collaborated to create indicators across sectors (e.g. annual monitoring of change in national health-care equity) to inform policy and legal reforms in the Public Health Act. The inter-sectoral collaboration has strengthened the focus on socio-economic indicators and thereby stimulated the equity agenda across governments at all levels.

Source: WHO (2018). *Multisectoral and Intersectoral Action for Improved Health and Well-Being for All: Governance for a Sustainable Future*. http://www.euro.who.int/__data/assets/pdf_file/0005/371435/multisectoral-report-h1720-eng.pdf?ua=1

Is Corruption the Main Threat to Achieving Universal Health Coverage?

Corruption is a universal phenomenon that cuts across nations, cultures, races and classes of people in both developed and developing countries. It is a multi-dimensional concept that has moral, ethical, religious and legal connotations. Given that it is a complex phenomenon, it can take various forms which makes it difficult to define in concrete terms.

However, it can be described as an illegal act, which involves inducement or undue influence of people either in the public setting or the private sphere to act contrary to the existing rules and regulations which normally guide a particular process.[41]

41 UNODC, 'Corruption and Bad Governance' https://www.unodc.org/e4j/en/anti-corruption/module-2/key-issues/corruption-and-bad-governance.html#:~:text=Violations%20of%20the%20principles%20of,of%20law%20and%20economic%20development.

The concepts of corruption and good governance have a two-way causal relationship with each other. If good governance principles and structures are not in place, there is greater opportunity for corruption. Corruption, in turn, can prevent good governance principles and structures from being put in place or enforced. Violations of the principles of transparency, accountability and rule of law appear to be most closely associated with corruption.

Corruption in the health sector can make the difference between life and death. It has severe consequences for **access, quality, equity, and efficiency** of health services and is an obstacle to the long-term goal of achieving universal health coverage. An estimated USD 500 billion in public health spending is lost globally to corruption every year.[42] To achieve universal health coverage, an additional USD 370 billion per year would be needed until 2030, with international development funding required to cover USD 17 billion to USD 35 billion.[43]

By this logic, the funds lost to corruption in the health sector globally could essentially fill the implementation gap for achieving universal health coverage. Indeed, WHO has identified good governance as a 'critical element' in the efforts to achieve this.[44]

Access to health services can be seriously affected by demands for informal payments or bribes in exchange for services that citizens are entitled to receive for free. The incidence of bribes in direct interactions between citizens and health service providers varies widely, from 1 per cent to 51 per cent at global level, with higher levels in Africa, Central and Eastern Europe, and the Middle East/North Africa, and lower levels in Western Europe and the Americas.[45] Theft, embezzlement and bribery also affect access to needed medicines, equipment and supplies. For example, in Togo, a government audit discovered that a third of the anti-malarial medicines provided by the Global Fund to Fight AIDS, Tuberculosis and Malaria, worth over USD 1 million, had been stolen.[46]

Quality of care can be severely compromised by bribes, kickback schemes and fraud. Patients may be charged for diagnostics and treatments that are fake or substandard or were not performed at all. Additional problems include kickback-driven referrals and unnecessary procedures. A study by WHO found that 6.2 million unnecessary caesarean sections are performed worldwide every year, 2 million of them in China alone.[47] Good-quality medicines may be unavailable due to drug theft, stockouts or extortion. Profiteers use corrupt schemes to avoid government regulation of drugs.

42 Hussmann, K, (2020) 'Health Sector Corruption: Practical Recommendations for Donors' *U4 Anti-Corruption Resource Centre*. https://www.u4.no/publications/health-sector-corruption

43 Bruckner, T, *The Ignored Pandemic: How Corruption in Healthcare Service Delivery Threatens Universal Health Coverage* (Transparency International Health Initiative 2019).

44 WHO, 'Universal Health Coverage, Webpage' https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)

45 Transparency International, Global Corruption Barometer, 2013.

46 Bruckner, T (2019).

47 WHO, (2018) 'Public Spending on Health: A Closer Look at Global Trends' *WHO/HIS/HGF/HFWorkingPaper/18.3*

Globally, 10 per cent of all drugs are believed to be fake, while in some African countries the figure can amount to 50 per cent.[48] Counterfeit drugs can lead to severe illness and death, and to the spread of drug-resistant viral or bacterial strains within and across countries.

The effect of corruption on *equity* is a great concern. Families fall into deeper poverty when they are forced to sell assets or go into debt to pay bribes for health services that they should have received without charge. Evidence shows that bribes are regressive, imposing a major burden on poorer households. In Peru, the poorest households spend 15 per cent of per capita income on informal payments in general. Economic shock from illness was the most common cause of falling into poverty in Vietnam, affecting 3 million people in 2010.[49]

Corruption has enormous effects on the *efficiency* of the health sector, especially the availability and use of scarce resources. Globally, an estimated 7 per cent of health spending, amounting to more than USD 500 billion per year, is lost to corruption and fraud.[50] Even in developed countries, the losses are high, estimated at up to 10 per cent of public health expenditure in Germany, EUR 56 billion annually in Europe, and USD 75 billion in the United States for Medicare and Medicaid payments alone.

The British Centre for Counter Fraud Studies found that *"since 2008, losses as a result of corruption have increased by 25 per cent worldwide and even by 37 per cent for the National Health Service in the UK*."[51]

Aggregated estimates for developing countries are scarce, but the following examples help illustrate severe efficiency losses. A study of 64 countries found that corruption lowered public spending on education, health and social protection. In Chad, local regions received only a third of centrally allocated resources; in Cambodia, 5 to 10 per cent of the health budget was lost at the central level; in Tanzania, local or district councils diverted up to 41 per cent of centrally disbursed funds; and in Uganda, up to two-thirds of official user fees were pocketed by health staff.[52] Corruption and lack of transparency also affects drug pricing. In Vietnam, health facilities paid eight times and patients 46 times the international reference price for certain brand-name drugs, and 2 or 11 times respectively for generics; meanwhile, drug costs constitute 50 per cent of the Vietnamese public health budget.[53]

48 Ozawa, S., Evans, D., Bessias, S., et al., (2018) 'Prevalence and Estimated Economic Burden of Substandard and Falsified Medicines in Low- and Middle-Income Countries: A Systematic Review and Meta-Analysis. JAMA Network Open 1(4).

49 Lewis, M. and Pettersson, G. (2009), 'Governance in Health Care Delivery: Raising Performance' *World Bank Policy Research Working Paper 5074.*

50 Bruckner (2019).

51 Sommersguter-Reichmann, M., Wild, C., and Stepan, A. et al., (2018), 'Individual and Institutional Corruption in European and US Healthcare: Overview and Link of Various Corruption Typologies, *Applied Health Economics and Health Policy* 16: 289–302.

52 Delavallade, C. (2006). 'Corruption and Distribution of Public Spending in Developing Countries' *Journal of Economics and Finance* 30: pp.222–239.

53 Vian, T., et al, 'Confronting Corruption in the Health Sector in Vietnam: Patterns and Prospects' *Health and Development Discussion Paper 14.* Center for Global Health and Development, Boston University

An array of tools and initiatives have become available for diagnosis of corruption in the health sector. These tools help define the problem and generate buy-in for anti-corruption measures; they also help practitioners and policymakers to agree on goals and targets and monitor improvement (or deterioration) over time. Some assessment tools focus specifically on experiences or perceptions of corruption and on sectoral risks, while others look more broadly at how the health sector is governed. Some focus on specific areas or sub-sectors within health, such as drugs or human resources. Also, some general international surveys of corruption include assessments of the health sector. The main tools are listed below:

a. Transparency International Corruption Perceptions Index;

b. World Bank Worldwide Governance Indicators (Control of Corruption);

c. World Justice Project Rule of Law Index;

d. Transparency International Global Corruption Barometer;

e. WHO Good Governance for Medicines Assessment Methodology; and

f. Household surveys (e.g., World Bank Living Standards Measurement Studies; Demographic and Health Surveys).

However, most of these tools do not assess high-level corruption in the health sector, that is, at the level of ministers, other high-ranking health authorities at national and subnational levels, or hospital managers. This gap, both in practice and in the literature, needs to be addressed if corruption in health systems is to be tackled seriously and strategically.

Towards Healthier and More Equitable Cities

Over half of the world's population lives in cities and almost all population growth in the foreseeable future is expected to occur in urban areas, especially in regions such as Africa, Asia-Pacific, and Latin America and the Caribbean.[54] Well-planned and managed urbanisation can generate wealth, maximising the benefits of economies of scale and agglomeration, allowing for integrated territorial development and connecting rural and urban areas.

However, around 1 billion people in the world live in slum conditions which have unsafe water supplies, poor sanitation and inadequate infrastructures.[55] Rapidly growing new cities and increasingly segregated older cities in both developed and developing societies are contributing to health inequalities.

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54 UN DESA, 'World Urbanization Prospects' (2018) https://population.un.org/wup/

55 UN-Habitat (2016). Slum Almanac 2015-2016: *Tracking Improvements in the Lives of Slum dwellers.* https://unhabitat.org/sites/default/files/documents/2019-05/slum_almanac_2015-2016_psup.pdf

An example of the health inequalities in urban settings is the strong gradient in infant and child mortality rates in Nairobi, Kenya; rates in the slums are more than three times higher than the city average and possibly ten or more times higher than in the wealthier parts of the city.[56]

Other data from Africa shows that these mortality rates among the urban poor are, on average, almost as high as the rates among the rural poor, while among the richer urban groups the rates are the lowest.[57] Consequently, SDG 3 on good health and well-being is closely linked to the targets of SDG 11 on sustainable cities and communities.

Source: Community members in Mathare slum, Nairobi, Kenya during COVID-19 - May 2020. @UN-Habitat/Kirsten Milhahn

Urbanisation can be a positive determinant of health in appropriate circumstances. Social systems based on democracy and strong equity policies have been successful in creating more equitable urban areas in several countries. However, quantitative evidence of health inequalities is rarely available and measuring the forces that contribute to urban health is one challenge for promoting healthier and more equitable cities.

Burden of disease estimates have tended to focus on the whole world or specific geographic regions. This data can mask intra-city differences and global data may not be relevant to inform national or municipal policy making. Public health has developed metrics for single pathogenic exposures or risk factors, but these measures often ignore both community assets that promote health equity and the cumulative impacts on health from exposure to multiple urban environmental, economic and social stressors.

56 WHO (2008). *Our Cities, Our Health, Our Future: Acting on Social Determinants for Health Equity in Urban Settings.*

57 Ibid.

Recognising these population health challenges, in 2008, the UN Commission on Social Determinants of Health called for *"health equity to become a marker of good government performance"* and for the United Nations to *"adopt health equity as a core global development goal and use a social determinants of health indicators framework to monitor progress"*.[58]

In 2011, the World Social Determinants of Health Conference and the Pan-American Health Organization's Urban Health Strategy called for the development of new urban health equity indicators that track the drivers of health inequities across place and time, particularly within a city neighbourhood.[59]

The complexity of cities and the varied forces that contribute to inequity in urban neighbourhoods demand dynamism in the indicator development processes.

The drafting, measuring, tracking and reporting of indicators can be viewed not as a technical process for experts alone, but rather as an opportunity to develop new participatory health policy making, through governance processes that shape what issues are deemed important for promoting health equity and which institutions are responsible for action **(see Box 8)**.

BOX 8. How Indicators Act as a Form of Healthy Urban Governance:

- Identifying and framing what counts as a health policy issue.

- Generating, or contributing to, the evidentiary standards that underwrite health equity issues.

- Constituting some social actors as "experts", by deciding who gets to participate in defining indicators.

- Grappling with different knowledge claims as the weight and importance of indicators is debated.

- Highlighting the importance of public accountability and transparency of data in the way indicators are reported and shared with various stakeholders.

Source: Corburn, Jasonand Cohen, Alison (2012), 'Why We Need Urban Health Equity Indicators: Integrating Science, Policy, and Community' *PLOS Medicine*

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58 WHO (2008). Commission for Social Determinants of Health, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*. https://apps.who.int/iris/bitstream/han-dle/10665/43943/9789241563703_eng.pdf;jsession-id=EBB4203729ED82DA4F58B4505BAE703A?sequence=1

59 Corburn, Jason and Cohen Alison. (2012). 'Why We Need Urban Health Equity Indicators: Integrating Science, Policy and Community'. *PLOS Medicine.*

The literature on health equity indicators suggests that they should do more than capture health outcomes, but also the determinants of health that often drive outcomes, including institutional practices and policy decisions made outside the health care and medical sectors. Thus, effective urban health equity indicators ought to highlight associations between determinants and health impacts, use data that are verifiable and easily accessible, and be shared in a clear and compelling way to a range of interested stakeholders.[60]

The WHO's Urban Health Equity Assessment and Response Tool (HEART) recognises the importance of governance measures for tracking urban equity.[61] It measures some aspects of governance related to health equity and includes indicators such as government spending on health and education, voter participation, percentage of population completing primary education, and the proportion of the population covered by health and other insurance.[62] The tool suggests that indicator processes themselves, not just the measures, can act as opportunities for crafting new equitable urban governance for health.

While this is an emerging idea for city health management, ecologists and others have used an iterative governance process called **adaptive management** to steward complex ecosystems, such as forests, wetlands and fisheries.[63]

Adaptive management begins with an acknowledgement of the inherent complexity and uncertainty within systems, that this complexity demands an iterative, ongoing learning process among a range of expert stakeholders, and that policy interventions must be adjusted to reflect newly acquired knowledge.

Adaptive management does not postpone actions until definitive causality is known about a system, but rather emphasises the importance of action in the face of uncertain science and tightly integrates decisions to rigorous monitoring.

The process itself is one where a broad group of stakeholders, from scientists to policy makers to users of a resource, work together to generate evidence, make decisions, monitor the progress of those decisions and make ongoing adjustments to decisions as new information emerges from monitoring.

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60   Ibid.

61   WHO (2012). *Urban HEART : Urban Health Equity Assessment and Response Tool.*.https://apps.who.int/iris/handle/10665/79060

62   Ibid.

63   Coburn, Jason and Cohen, Alison (2012). 'Why We Need Urban Health Equity Indicators: Integrating Science, Policy and Community'. *PLOS Medicine.*

TABLE 2. Example of Urban Health Equity Indicators.

EQUITY CATEGORY	INDICATORS	EXAMPLE MEASURES FROM RICHMOND, CALIFORNIA, US	EXAMPLE MEASURES FROM MATHARE SLUMS, NAIROBI, KENYA
Living Conditions	Housing	Percentage of eligible residents receiving housing subsidies.	Percentage of residents in savings programme for housing.
		Number of rehabilitated, formerly foreclosed/vacant housing properties.	Ratio of structure owners to tenants.
	Water, sanitation & food	Ratio of eligible persons to number receiving food support.	Self-reports of food insecurity.
		Self-reports of food insecurity.	Percentage of households with in-home water & toilet service.
			Number of new electricity connections installed by utility company.
	Environment	Percentage of households reporting air pollution or noise-altered sleep, concentration, or work/school performance.	Number of infrastructure projects launched to secure housing on steep slopes & in flood areas.
			Number of non-charcoals burning cook-stoves sold at subsidised cost.

	Safety	Perception of safety, especially at night.	Self-reports of safety & violence from women.
		Percentage participating in community policing/cease-fire activities.	
	Transportation	Public spending on bus and rail transport as ratio of highway spending.	Public spending on transport.
Economic services	Primary health care	Percentage of adults who did not seek medical care because of the cost.	Percentage of free clinics offering maternal and childhood care using in-home community health workers.
		Number of new community health workers at clinics & other providers.	
	Mental/ substance care	Percentage of county budget funding for formerly incarcerated community members to receive counselling & care.	Percentage of international health research budgets spent on mental health services/ interventions.
	Education	Percentage of subsidised enrolment in youth after school programmes.	Percentage of families receiving free day care.
	Employment	Percentage of local employers offering living wage jobs, paid sick days & health care/insurance.	Percentage of local residents hired to work on government and internationally funded contracts in the past year.

	Wealth access	Number of new business permits issued by the city.	Ratio of slum dwellers' new bank accounts to all new accounts by local banks in past year.
		Amount of Community Reinvestment Act funds spent in the city.	
Governance & inclusion	Community participation	Number of community members & local organisation representatives elected or appointed to the city and county boards & commissions.	Percentage of residents participating in community-based organisation.
	Government responsiveness	Percentage of public works complaints responded to within 30 days or less	Number of meetings held in community by Nairobi's city council and water & power company addressing ongoing infrastructure, housing & health issues.
		Percentage of public participation processes that are held at convenient times and provide transport & language translation.	
	Recognition of minority groups (women)	Percentage of residents reporting experiences of gender or ethnic discrimination in school, government relations, police interaction or workplace.	Number of women given land rights/housing tenure by city council.
	Health status	Self-rated health	Self-rated health
	Art/cultural expression	Per-capita funding for the arts	Percentage of youth and adults participating in cultural programmes.

Indicator processes can be limited by unavailability of data and the cost of obtaining locally specific information. Very few cities collect data on the social determinants of health at the neighbourhood scale and those that do rarely keep these data in one publicly accessible location.

However, advances in smart technology are creating new opportunities for tracking and reporting different types of urban health equity data. In Toronto, Canada, the Health Ministry has created the Toronto Central Local Health Integration Network (LHIN), which aims to bring together multiple community actors and government agencies to improve health for the urban poor and tracks progress using indicators of equity.[64]

In Rio de Janeiro, Brazil, the Centre for Health Promotion is a network of over 150 civil society organisations working to promote health equity and, among other tasks, gathers data on the social determinants of health equity in Rio's favelas.[65] In Belo Horizonte, Brazil, an urban health observatory conducts participatory research and maintains data on population- and place-based health equity issues.[66]

The Indian non-governmental organisation, Urban Health Resource Centre, works with the urban poor to improve health equity and helped shape India's National Urban Health Mission, which will document many determinants of health in cites.[67] In San Francisco, California, the public health department maintains a health equity-oriented publicly available database called the Healthy Development Measurement Tool.[68]

64 Toronto Central Local Health Integration Network (LHIN) website, http://www.torontocentrallhin.on.ca

65 Centre for Health Promotion (CEDAPS) website, http://www.cedaps.org.br

66 Belo Horizonte Observatory for Urban Health (OSUBH) website, http://www.medicina.ufmg.br/osubh

67 India Ministry of Health (2011) National Urban Health Mission, http://mohfw.nic.in/NRHM/Documents/Urban_Health/UH_Framework_Final.pdf

68 San Francisco Department of Public Health (2011), 'The Healthy Development Measurement Tool' http://www.thehdmt.org

BOX 9. **Summary Points**

- As the urban population of the world increases and adds new stressors on infrastructure, institutions and exacerbates economic and social inequalities, public health and other social disciplines must find new ways to address urban health equity.

- Urban indicator processes focused on health equity can promote new modes of healthy urban governance, where the formal functions of government combine with science and social movements to define a healthy community and direct policy action.

- An inter-related set of urban health equity indicators that capture the social determinants of health (e.g. housing, basic services, employment, among others), including community assets, and track policy decisions can help inform efforts to promote greater urban health equity.

- Adaptive management, a strategy used globally by scientists, policymakers and civil society groups to manage complex ecological resources, is a potential model for developing and implementing urban health equity indicators.

- Urban health equity indicators are lacking and needed within cities of both developed and developing countries, but universal sets of indicators may be less useful than context-specific measures accountable to local needs.

MULTI-LEVEL GOVERNANCE AND HEALTH EQUITY – WHAT NEEDS TO BE DONE?

Strong leadership from mayors and other leaders is central to a healthy cities approach. However, as experiences and the various phases of development projects illustrate, high-level political commitment is but one component (albeit a crucial one) of a larger "whole-of-government and whole-of-society" approach to disease prevention. The COVID-19 pandemic has demonstrated that the integral components of a healthy cities approach are: strong vertical and horizontal institutional coordination; building partnerships and establishing networks between cities; mainstreaming inclusion and supporting vulnerable groups; and adopting smart and systematic approaches to health monitoring and assessment.[69]

Vertical and Horizontal Institutional Coordination

Effective inter-sectoral coordination is essential for healthy cities. This often takes the form of an inter-disciplinary steering committee or coordination council that includes representation from health, urban planning, housing, sanitation, environment and transport. In some regions like Africa, during the COVID-19 pandemic, several national governments established institutional structures to coordinate actions both vertically between different levels of government and horizontally between sectoral institutions and ministries.

For example, in South Africa, inter-governmental associations such as the South African Local Government Association have been used to disseminate information, support its member municipalities and advocate for their interests in discussions with the national government.[70] Other notable cooperative efforts are, for example, food delivery by the Ugandan Government and distribution by local authorities.[71]

In Latin America, the Chilean Government established a social committee for COVID-19 (*Mesa social por* COVID-19) formed by representatives of municipal associations (mayors), government authorities, academics and professionals from the health sector. The committee meets twice a week to help strengthen the COVID-19 Action Plan.[72] In Europe, the Spain Conference of Presidents is a multi-lateral cooperation body between the Government of the Nation and the respective Governments of the Autonomous Communities. It has become the operative instrument for multi-level dialogue and facilitates communicating containment measures and coordinating resources based on territorial needs.[73]

69 UN-Habitat and WHO (2020). *Integrating Health in Urban and Territorial Planning: A Sourcebook for Urban Leaders, Health and Planning Professionals.* https://unhabitat.org/integrating-health-in-urban-and-territorial-planning-a-sourcebook-for-urban-leaders-health-and

70 https://www.gov.za/about-government/government-system/local-government

71 UN-Habitat (2020). *Impacts and Perspectives of Covid-19 Responses in African Cities.*

72 Government of Chile (2020), Action Plan Covid-19, https://www.gob.cl/coronavirus/plandeaccion/

73 OECD (2020). '*The Territorial Impacts of Covid-19: Managing the Crisis across Levels of Government*'. http://www.oecd.org/coronavirus/policy-responses/the-territorial-impact-of-covid-19-managing-the-crisis-across-levels-of-government-d3e314e1/#section-d1e2125

Ideally, health officials should take a leading role in ensuring that urban development efforts advance, rather than impede, health and health equity. The idea is not for the health sector to "take over" the core competencies of other local agencies or stakeholders, nor is it to promote healthy cities from a health sector perspective only. Rather, the job for health officials is to support and collaborate with other agencies to develop and implement effective and equitable multi-sectoral policies, plans and programmes that optimise co-benefits for all sectors involved.[74]

Coordination and cooperation also promote coherence and efficiency of interventions and reduces the likelihood of institutional conflicts.

Data sharing between municipalities, metropolises and regions is also necessary for pandemic and health response planning for effective interventions and monitoring of relief. For instance, in Latvia, eight municipalities have established strong common working relations during the ongoing pandemic to better deal not only with COVID-19 but also its aftermath. Due to their joint efforts and by sharing supplies among each other, South Kurzeme's municipalities have managed to provide free protective equipment to older people in the region.[75] However, replicating such interventions is challenging for informal settlements as data is normally non-existent, but community participation methods could bridge this gap **(see Box 10)**.

BOX 10.   **Community-Based Monitoring and the Improvement of Local Sanitation Standards in Maputo, Mozambique**

In 2010, the Maputo Municipal Council (Mozambique) initiated a system of community-based sanitation monitoring in order to gain up-to-date information to support the planning and management of sanitation in peri-urban areas. In the pilot project in Nlhamankulo Urban District, neighbourhood leaders used monitoring at the community level as a powerful tool to mobilize households in informal settlements to upgrade and improve the cleanliness of their self-built latrines. An unintended outcome of the information gathering process was halving the number of unsafe latrines.

Local community leaders (block leaders) were recruited to undertake the monitoring of local water and sanitation facilities. To improve the quality of the data collated and the effectiveness of the initiative, discussions were held to ascertain the characteristics of the various water and sanitation options in use locally. Following the initial discussions, block leaders observed a lack of clarity about acceptable standards for sanitation.

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74 Werna, E. (2014). *Healthy City Projects in Developing Countries: An International Approach to Local Problems.* Routledge.

75 Stoyanov, A. (2020). '*Pandemic Brings Latvian Municipalities Closer Together*'. https://www.themayor.eu/en/pandemic-brings-latvian-municipalities-closer-together

Digital photographs showing the wide range of sanitation systems/ solutions adopted by residents of each neighbourhood were used to inform a debate as to what constitutes safe sanitation and adequate service levels, which specifically incorporated the users' perceptions. This methodology provides an entry point for sanitation upgrading as it is pro-poor, cost effective, based on local/ existing structures and mainstreams the need for improved water, sanitation and hygiene facilities and practices.

Source: Hawkins, P. and Odete, M. (2011). 'The Potential of Local Monitoring to Stimulate Sanitation Behaviour Change in Maputo, Mozambique."https://sswm.info/sites/default/files/reference_attachments/HAWKINS%20and%20MUXIMPUA%202011%20Maputo%20Mozambique.pdf

Non-governmental organisations, community-based organisations, faith-based organisations and civil society have always played a crucial role in sustainable development, particularly in Africa, including of issues such as poverty reduction and provision of goods and services such as food, health care and education. With the advent of COVID-19, these actors have been cast into a prominent role in helping communities deal with the pandemic. For example, in Kigali, Rwanda, and Freetown, Sierra Leone, handwashing stations have been set up and community groups are involved in the distribution of these services and resources. In Nairobi (Kibera), Kenya, a community-based enterprise (Shofco) is producing hand sanitisers, masks and protective gear and reinvesting the proceeds into support for contact tracing, isolation and treatment of patients.[76]

Non-state actors are also bridging service provision gaps and promoting some sense of normalcy for local communities under COVID-19 restrictions. In Kenya, the Wheels for Life initiative assists pregnant women to access medical care during the curfew period by providing free medical advice and transport to health facilities through a toll-free line.[77] In other parts of the world, such as the US, residents of Los Angeles have made hand-washing stations for homeless people living in a depressed area known as Skid Row which are installed and maintained by a local community centre.[78]

Supporting Vulnerable Groups

During an acute crisis, identifying target beneficiaries is not simply about dividing the population into two groups of needy and not needy. Given the wide diversity of populations occupying urban areas, there is also a wide spectrum of vulnerabilities.

While categorising vulnerability or segregating vulnerability is theoretically and operationally precarious, humanitarian practice must identify and prioritise target individuals and groups for assistance on a timescale (immediate to delayed) and on a substantive scale (amount and type of aid needed).

76 See https://www.shofco.org/covid-19/

77 See Wheels For Life Initiative by Kenya Healthcare Federation, https://ncdak.org/wheels-for-life-initiative-by-khf/

78 UN-Habitat, 'Housing is Both a Prevention and Cure for COVID-19' https://unhabitat.org/housing-is-both-a-prevention-cure-for-covid-19

Policy and practice should aim to identify and differentiate these varying degrees or types of vulnerability for effective targeting with limited resources.[79]

Women, the elderly, youth, children, persons with disabilities, indigenous populations, refugees, migrants and minorities become more vulnerable in emergencies due to factors such as limited access to effective surveillance and early-warning systems.[80] In Sweden, at the very start of the pandemic, information from the Public Health Agency of Sweden was not translated and was incomprehensible to the migrant population.[81]

Once information on the COVID-19 impact was available, it became clear that many of the deceased, as well as those who were overrepresented in hospitals in the Stockholm region, were originally migrants and inhabited socio-economically marginalised geographic areas. Contrastingly, the city of Ioannina in Greece has paid particular attention to the need for raising awareness about prevention and response to COVID-19 among migrants, refugees and asylum seekers in urban settings and in the refugee camps.

Police vehicles disseminate key information daily in recorded messages in native languages of the migrant population within the neighbourhoods or in the refugee camp. The local radio also provides information to migrants in native languages.[82]

In Italy, the city of Reggio Emilia translates all information into the main migrant languages and maintains daily contacts with the most vulnerable groups via a WhatsApp group moderated by the Intercultural Centre Mondinsieme.[83] Buenos Aires in Argentina launched a public campaign aimed at disseminating legal information regarding COVID-19 for vulnerable groups such as people living in slums, people with disabilities, children and women (mostly focusing on sexual health).[84] Therefore, governments at all levels should tailor their emergency prevention communication strategies for gender, language and local culture to protect the most vulnerable.

Additionally, mainstreaming vulnerability support at all levels of governments is essential. In the US, the 2020 Coronavirus Aid, Relief, and Economic Security Act provides fast and direct economic assistance for low-income families. The assistance package includes USD 4 billion for Emergency Solutions Grants to help local governments and homeless providers to take action to reduce the risk of spread of COVID-19 in the homeless community and those at risk of homelessness.[85]

79 Oxfam (2016). 'What are the Practices to Identify and Prioritize Vulnerable Populations Affected by Urban Humanitarian Emergencies?'. https://oxfamilibrary.openrepository.com/bitstream/handle/10546/620190/rr-identify-prioritize-vulnerable-populations-urban-310117-en.pdf;jsessionid=AB9F4AD6A5698FF084E3510CC6A99877?sequence=7

80 UN Women (2020). 'COVID-19: How to Include Marginalized and Vulnerable People in Risk Communication and Community Engagement.

81 https://www.news-medical.net/news/20201216/Swedish-strategy-overlooked-migrantse28099-way-of-life-during-pandemic.aspx

82 UN-Habitat. (2020a). "Policy, Legal and Governance Responses to COVID-19" in UN-Habitat Cities and Pandemic Report.

83 Ibid.

84 https://acij.org.ar/covid19yderechos/

85 See https://home.treasury.gov/policy-issues/cares

There is an additional USD 65 million for the Housing Opportunities for Persons With AIDS programme that provides support for this particular vulnerable population; a USD 5 billion in supplemental funds for the Community Development Block Grant to fill the gaps not covered by other sources, with a particular focus on serving low and middle-income households, and an additional USD 200 million allocated to Indian Housing Block Grant for indigenous tribes with the greatest need.[86]

In the United Kingdom, the Welsh Government pledged GBP10 million to local councils for emergency homeless housing by block booking empty lodging like hotels and student dormitories. In Spain, while there were no tourists in Barcelona, the city agreed with the Association of Barcelona Tourist Apartments to allocate 200 apartments for emergency housing for vulnerable families, homeless people and those affected by domestic violence. National and local governments have also worked with the private sector to tackle housing issues. For example, Singaporean firms, with government backing, provided accommodation for Malaysian workers who had been commuting to Singapore daily.[87]

However, once economies started to open, most of these approaches became unsustainable, and many cities struggled to find shelter for their vulnerable residents. COVID-19 has brought into sharp relief the housing paradox; in a time when people are in desperate need for shelter - apartments and houses sit empty.
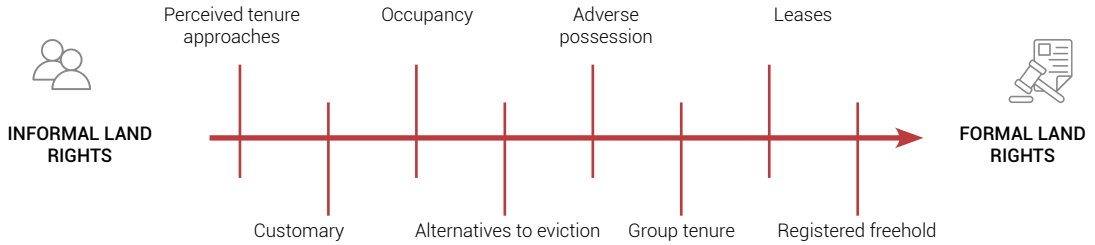
Governments at all levels need to take proactive steps to address the collective right to adequate shelter. Moving away from individual and capitalistic land tenure systems, may yet again point the way forward for housing and land policy in a post-COVID-19 world. UN-Habitat advocates for the 'continuum of land rights' concept as one of the ways to improve security of tenure by recognising several forms of land tenure. These range from informal rights on one end of the spectrum to formal rights on the other. In between, there are occupancy rights, customary, leasehold and group tenure rights, whereby registered freehold is not a special form of tenure but only one among many **(see Figure 1)**.[88]

Indeed, the Hillside Villa Tenants Association in Los Angeles's Chinatown, US, is encouraging the city to use eminent domain to take over their expiring affordable housing development. They are explicitly making the argument that the overlapping health and economic crises would not so easily induce an eviction crisis if there were more robust public and non-speculative community ownership of land.[89]

86 Ibid.
87 UN-Habitat, 'Housing is Both a Prevention and Cure for COVID-19' https://unhabitat.org/housing-is-both-a-prevention-cure-for-covid-19.

88 UN-Habitat Global Land Tool Network, 'Continuum of Land Rights' https://mirror.gltn.net/index.php/land-tools/gltn-land-tools/continuum-of-land-rights
89 See https://spectrumnews1.com/ca/la-west/news/2020/04/17/tenants-of-hillside-villa-in-chinatown-push-for-eminent-domain
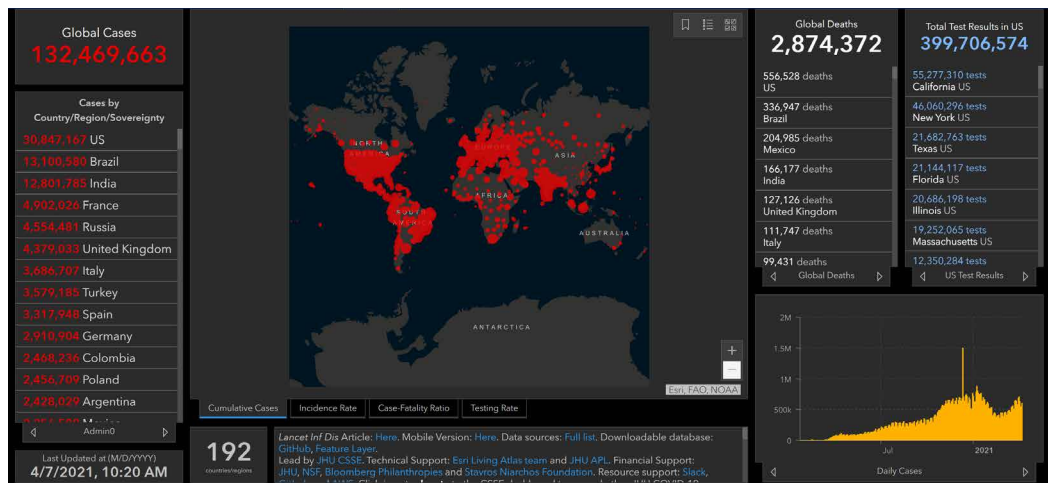
FIGURE 1. Continuum of Land Rights.

Applying Smart Technology

Real-time maps, mobile apps and other frontier technologies are being used by decision-makers to manage and control urban life in real-time. In the context of health, disease surveillance is a map-centric activity, with geographic information system technology being used to collect, analyse and share key data **(see Figure 2)**.

FIGURE 2. The US Johns Hopkins Coronavirus Resource Centre (CRC) is a continuously updated source of COVID-19 data and expert guidance.

Leading health organisations such as WHO and governments have consistently relied on mapping and spatial analysis to manage disease outbreaks.

For instance, in Hong Kong, the Severe Acute Respiratory Syndrome (SARS) map team used the department of health updates to geocode case information against Hong Kong street and building databases.

The map presented information on suspected, actual, and recovered SARS cases. Residents and visitors to Hong Kong could easily check the website to see which buildings in their neighbourhoods had, or were suspected of having, residents infected by the disease and which had been cleared. This helped alleviate the fear and concern due to a lack of information that had disrupted lives during the early days of the outbreak.[90] The sophistication of health maps to track disease has progressed a great deal. The WHO Novel Coronavirus COVID-19 Situation Dashboard provides a proof point, as this interactive map-based tool provides visualisations of cases by date and frequency, maps the number of cases at both a country and regional scale, and shows statistics of confirmed cases and deaths.[91]

The COVID-19 crisis has accelerated the digitalisation of public administration and public services delivery in regions, cities and rural areas. Regional and local governments are increasingly mobilising digital tools to track and stop the spread of the coronavirus. A more expanded use of digital tools for tracking and information purposes in the pandemic scenario has served a twofold objective: (a) to inform decision-makers, adopt adequate measures and contain the pandemic; and (b) to communicate with citizens transparently and strengthen trust; a key element for the population to comply with containment measures. Many jurisdictions have developed specific websites to disseminate information on the crisis' development, communicating daily, for example, the number of cases and new measures adopted.

Even when there is no dedicated website, most cities and regions around the world provide information about the pandemic situation on their own website, and provide links to their Ministry of Health's website, their country's national COVID-19 platform, or to the WHO website. The realisation of the potential benefits of digitalisation in this matter depends crucially on the relevance, quality and user-friendliness of the information being generated by the digital systems and made available to the public. To ensure good and efficient use, it is important to involve key stakeholders (community-based organisations and other groups of users of public services) early in the process of designing these systems.

African countries have already used technology to deal with the pandemic. In Nigeria, the "COVID-19 Triage Tool" assists residents to self-assess their coronavirus risk category while in South Africa, Senegal and Cameroon, the governments use social media to answer common queries about COVID-19 myths, symptoms and treatment.[92] In Uganda, an app (Market Garden) has been developed to enable market vendors to safely sell and deliver fruits and vegetables to their customers.[93] In other regions such as Asia, South Korea has developed and operated the COVID-19 Smart Management System to support epidemiological investigation. This system is based on the country's smart city data hub technologies for collecting and processing a large volume of urban data.

90 See https://www.esri.com/about/newsroom/blog/maps-that-mitigate-epidemics/

91 See https://covid19.who.int/

92 Kim Harrsibery (2020). 'Here's how Africans are Using Tech to Combat the Coronavirus Pandemic'. *World Economic Forum*. https://www.weforum.org/agenda/2020/04/africa-technology-coronavirus-covid19-innovation-mobile-tech-pandemic

93 Ibid.

South Korea has implemented this system for a wide range of statistics analysis to backtrack the movements of infected people, identify transmission routes, or locate an infection source in a large-scale outbreak. The location data of the infected people before they were diagnosed is collected from mobile base stations, credit card transactions and other technologic means, within the permitted range under the **Infectious Disease Control and Prevention Act (2009)**. With full consideration of privacy, information deemed necessary is provided anonymously to the public so that people themselves can check whether they have crossed paths with the infected people and get tested if necessary.[94]

However, digitalisation poses significant challenges for regional and local governments, and the capacity to deal with digitalisation challenges varies widely. In many low- and middle-income countries, an increasing amount of personal health information is being collected. The collection of personal health information is necessary to develop longitudinal medical records and to monitor and evaluate the use, cost, outcome and impact of health services at facility, sub-national and national levels.

As troves of data are generated by a wide array of digital devices and networked systems, there is a risk of improper use. Millions of urban residents are leaving digital footprints and data shadows without any control or even knowledge of their use.

Coupled with data security concerns and the vulnerability of computing systems to hacking, crashing and viruses, a large amount of personal information is at risk of misuse. If personal health information is not held confidentially and securely, individuals with communicable or non-communicable diseases may be reluctant to use preventive or therapeutic health services due to fear of being stigmatised or discriminated against. Some data usages have already caused controversy and been labelled as discriminatory. These include the use of data by both public and private institutions to monitor and predict behaviour based on personal and demographic profiles, especially those living in informal settlements.[95]

National governments should quickly develop sound regulations on data property and use. While in many countries the legal framework does not provide enough individual data protection, international regional blocs are stepping up. For instance, the European Commission has developed guidelines and a toolbox for developing COVID-19 and pandemic-related apps aiming to safeguard personal data **(see Box 11)**.

94 OECD (2020). 'The Territorial Impacts of COVID-19: Managing the Crisis across Levels of Government.' http://www.oecd.org/coronavirus/policy-responses/the-territorial-impact-of-covid-19-managing-the-crisis-across-levels-of-government-d3e314e1/#section-d1e2125

95 Edith Rameriz, "The Privacy Challenges of Big Data: A View From the Lifeguard's Chair" (2013) Technology Policy Institute Aspen Forum.

BOX 11. Main Prerequisites for the Development of Coronavirus/Pandemic Apps – European Commission

1. **The role of national health authorities**: It must be clearly established from the start who is accountable for compliance with EU personal data protection rules. Given the high sensitivity of the data and the ultimate purpose of the apps, the Commission sees this as a role for national health authorities, who would in turn be responsible for ensuring General Data Protection Regulation (GDPR), 2018 compliance in their use of data collected, including providing individuals with all necessary information related to the processing of their personal data.

2. **Users remain in full control of their personal data**: The installation of an app on a user's device should be voluntary; a user should be able to give their consent to each functionality of an app separately. If proximity data is used, it should be stored on an individual's device and only shared with the user's consent; users should be able to exercise their rights under the GDPR.

3. **Limited use of personal data**: An app should adhere to the principle of data minimization, which requires that only personal data that is relevant and limited to the purpose in question can be processed. The Commission considers location data not necessary for the purpose of contact tracing and advises not to use location data in this context.

4. **Strict limits on data storage**: Personal data should not be kept for longer than necessary. Timelines should be based on medical relevance as well as the realistic duration for necessary administrative steps to be taken.

5. **Security of data**: Data should be stored on an individual's device and encrypted.

6. **Ensuring the accuracy of the data processed**: It is a requirement under EU personal data protection rules that any personal data processed by a third party must be accurate. To ensure maximum accuracy, which is also essential for the efficiency of contact tracing apps, technology such as Bluetooth should be used to provide a more precise assessment of individuals' contact with one another.

7. **Involvement of national data protection authorities**: Data protection authorities should be fully involved and consulted in the development of an app and should be tasked with reviewing the deployment of an app..

Source: European Commission, 'Coronavirus: Guidance to Ensure Full Data Protection Standards of apps Fighting the Pandemic' (2020) https://ec.europa.eu/commission/presscorner/detail/en/IP_20_669

Additionally, the current crisis may widen these disparities, as many subnational governments were not necessarily prepared to go digital. In more remote and rural regions, digitalisation is also likely to be particularly challenging if adequate IT infrastructure is lacking. Today, while more than 50 per cent of the world's population is online, there are still 3.6 billion people without affordable access to the internet.[96] Among the world's 47 least developed countries, more than 80 per cent of the population is still offline.[97] Regional differences in the percentage of households with broadband access are strongly pronounced both in countries with a high ICT penetration, such as France, Israel, the US and New Zealand, and countries with low average ICT access such as Mexico or Turkey. In the US, for example, nearly 25 per cent of 15 year olds with disadvantaged backgrounds have no access to a computer.[98] At the same time, the gender gap in connectivity continues to widen.

Only 2 per cent of women in Latin America and the Caribbean and in East Asia and the Pacific own a mobile phone with Internet access.[99] Worldwide, some 327 million fewer women than men have a smartphone and can access the mobile internet.[100]

This gender gap in connectivity hampers women's access to important health care-related information, including about specific medical treatments or prophylaxis. Such access is also important to improve maternal health care as it can reduce the risks and costs of early pregnancy pregnancy.[101]

This inequality gap risks being accentuated as some municipalities do not have the capacities to follow the digital transition in the short and medium term. To reduce this risk, local initiatives, policies and partnerships can be harnessed to tackle the digital divide.[102] **(see Box 12)**.

96 UN-Habitat Flagship Programme, 'People-Focussed Smart Cities' https://unhabitat.org/sites/default/files/2020/01/fp2-people-focused_smart_cities_v261119.pdf
97 Ibid.
98 OECD (2018). *OECD Regions and Cities at a Glance: 2018.* https://dx.doi.org/10.1787/reg_cit_glance-2018-en

99 The UN-Habitat Flagship Programme on People-Centred Smart Cities - https://unhabitat.org/sites/default/files/2021/01/fp2-people-centered_smart_cities_04052020.pdf
100 Ibid.
101 OECD (2018). '*Bridging the Digital Gender Divide: Include, Upskill, Innovate*'. http://www.oecd.org/digital/bridging-the-digital-gender-divide.pdf
102 De Mello, L. and Ter-Minassian, T. (2020). 'Digitalization Challenges and Opportunities for Subnational Governments'. *OECD Working Papers on Fiscal Federalism*, No. 31 https://dx.doi.org/10.1787/9582594a-en

BOX 12. **Bridging the Digital Divide in Lincoln, Nebraska, US – Conduit System**

The **City of Lincoln** and **ALLO Communications,** a Nebraska-based Internet service provider (ISP), has reached the end of the deployment phase of their partnership aimed at building fiber out to every home and business in the city of about 285,000 people. To expand the fiber network, ALLO has leased access to Lincoln's extensive conduit system, which hastened the buildout and lowered costs.

Lincoln began its conduit project in 2012, taking advantage of downtown redevelopment to deploy conduit along public Rights-of-Way. As of 2016, the city had spent approximately USD 1.2 million on building and maintaining the 300-mile-long conduit network. To bring better connectivity to Lincoln residents and businesses, the city leases access to the conduit system to private ISPs to deploy fiber networks. In return for access to the conduit, private companies pay fees and abide by the city's **Broadband Franchise Ordinance**, which stipulates providers must follow network neutrality principles, in addition to other policies, designed for the public good. Lincoln also requires companies to make any conduit that they add on to the existing network available to all other ISPs in the system.

ALLO offers voice and video services in addition to internet access, and residents can subscribe to the following three tiers:

- 20 Mbps symmetrical - USD 45/month

- 300 Mbps symmetrical - USD 70/month

- 1 Gbps symmetrical - USD 99/month

The city's conduit network and partnership with ALLO have produced notable benefits for Lincoln. Residents and businesses now have access to fast, affordable, reliable gigabit connectivity as well as access to high-quality broadband from more providers than before. The conduit leases are also bringing in revenue to the city. It is estimated that the city will be receiving more than USD 2 million annually in fees by 2018.

Source: Kienbaum, Katie. (2019). 'Citywide Fiber Network Nears Completion in Lincoln, Nebraska, Due to Municipal Conduit'. https://muninetworks.org/content/citywide-fiber-network-nears-completion-lincoln-nebraska-due-municipal-conduit

Finally, the digital divide is prevalent in telehealth (the use of electronic information and communication technologies in healthcare) which has seen overwhelming growth during the COVID-19 pandemic.

Along with increased use, telehealth has expanded beyond live video technologies, including remote patient monitoring, mobile health, asynchronous and emerging technologies.

However, advances in the field must not exacerbate existing social and health disparities. According to the Pew Research Centre, Americans with disabilities experience critical access barriers due to technologies unable to accommodate their physical needs and disparate socioeconomic challenges that result in a dramatic decrease in likelihood of going online.[103] Major stakeholders in the technology sector have only just begun to realise and learn from the experiences of people with disabilities and their innovation has accelerated as a result.

For instance, even in their most recent stages, smart-home assistant devices like Amazon's Alexa and the Google Assistant have generated vastly increased independence and opportunities for people with disabilities.[104] Powerful collaborations are essential in creating equity in technological innovation and adoption, and it is imperative that technology innovators of all kinds seize on this intersection of need, demand and opportunity.

103 Kimberly, Noel and Brooke, Ellison (2020). 'Inclusive Innovation in Telehealth' 86 *NPJ Digital Medicine*

104 Ibid.

KEY REFLECTIONS

Health equity demands that everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential. Additionally, for public health interventions to be effective and sustainable, they must go beyond remedying a specific health inequality and should improve people's socio-economic status using an inter-related set of urban health equity indicators that capture the social determinants of health (e.g. housing, basic services, employment among others). This approach will enhance the efforts towards creating healthier and equitable urban spaces.

Corruption in the health sector is an obstacle to the long-term goal of achieving universal health care with severe consequences for access, quality, equity and efficiency of health services. An estimated USD 500 billion in public health spending is lost globally to corruption every year. To achieve universal health coverage, an additional USD 370 billion per year would be needed until 2030, with international development funding required to cover between USD 17 billion and USD 35 billion. An array of tools and initiatives are available to diagnose corruption in the health sector, but for this issue to be tackled seriously and strategically, high-level corruption at the level of ministers, other high-ranking health authorities at national and subnational levels, or hospital managers needs to be addressed.

Multi-level governance, through the lens of the COVID-19 pandemic, has emerged as an integral component towards achieving healthy and equitable urban spaces as it calls for vertical and horizontal institutional coordination; building partnerships and establishing networks between cities; mainstreaming inclusion and supporting vulnerable groups as well as adopting smart technologies and systematic approaches for health preparedness and early response. Multi-level governance has also been key for maximising results for COVID-19 emergency response and recovery measures. Inter-jurisdictional cooperation mechanisms such as metropolitan governance, inter-sectoral programmes or multi-stakeholder arrangements have ensured quick action reaching a rapid response to the pandemic. However, situations where competition among levels of governments, fragmentation of the political scene and dysfunction, frequent institutional conflicts and legal disputes over responsibilities are prevalent, urgent emergency responses are delayed. Frameworks such as public–private–people partnerships are useful multi-level governance tools to involve private actors and the public in a joint process. This bottom-up participation strategy, where decision-making power is not only exercised by state actors but is spread across the community and non-state actors through proactive engagement, has been instrumental in Kenya where the Ministry of Health, the Kenya HealthCare Federation and the Kenya Private Sector Alliance have entered into a partnership agreement to support a coordinated response to COVID-19. This framework has allowed the negotiation and inclusion of COVID-19 testing and treatment services within health benefits packages, reducing the high costs of services for ordinary citizens. Also, given that the private sector provides over 40 per cent of healthcare services, this partnership has enabled healthcare services and COVID-19 public awareness campaigns to reach remote areas.

Governments at all levels and societies have demonstrated a remarkable level of responsiveness, cooperation and adaptability to the COVID-19 pandemic. Effective responses depend on a high level of cooperation and trust between government, health professionals and scientists, the public sector and the private sector. Trust from citizens is also fundamental to ensure the responses and measures are properly implemented. Some recommendations based on the examples of successful COVID-19 pandemic responses to facilitate the governance of cities include establishing local working groups and committees, comprised of local leaders and community representatives to develop and implement strategies based on geographical areas in cities. These strategies could address home care, self-isolation, movement control, closure of high-risk public spaces, support for vulnerable people and communication.

The communities' role is paramount in governance. Indeed, in some urban areas, top-down control measures may be perceived as being used to further oppress and marginalise residents or to reduce political opposition.

The feasibility of these measures is also important. If COVID-19 control regulations are impractical and out of touch with people's reality, patterns of avoidance and repression risk being repeated. Information sharing and clear guidance are needed. This builds trust and mutual understanding. Communication is a key pillar in the management of any health crisis. Since women, the elderly, youth, children, people with disabilities, indigenous populations, refugees, migrants and minorities are more vulnerable in emergencies due to limited surveillance and early-warning systems, governments at all levels should tailor their emergency prevention communication strategies for gender, language and culture to protect these vulnerable groups.

COVID-19 offers an opportunity to reshape urban governance, making it more inclusive and effective. The pandemic calls on governments at all levels to rethink the balance of power between formal and informal institutions in managing emergencies. The power of local communities and civil society, as demonstrated during this crisis, is a real asset in urban governance.

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