Partnerships and participation for urban health

Policy brief
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World Health Organization
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Protecting and promoting people’s health in urban environments is a pressing challenge for national and subnational governments everywhere. In over two-thirds of countries, most people live in cities, and even countries that have yet to reach this threshold are rapidly urbanizing (1). Meanwhile, urban populations continue to increase in absolute and relative terms worldwide – including in slums (or other informal, unplanned, unregistered, or underserviced neighbourhoods), which today are home to more than a billion people (2). While cities typically offer health and economic benefits and a favourable environment for urban health action, they also pose unique risks and challenges. In fact, while they have become healthier places overall, many avoidable health risks, harms, and inequities persist in cities around the world. In part, this is because recent urban health practice has often focused on singular health outcomes, sectoral interventions, or vulnerable groups, without incorporating actions into an overarching, holistic approach. While focused initiatives can, and often do, secure real health gains, they risk missing important
systemic effects arising from the complex nexus of diverse sectors, actors, and environments interacting in urban areas. This can give rise to inefficiencies, unanticipated effects, diminishing returns, and other adverse outcomes. Only through a strategic, multi-sectoral approach, coordinated across national and local governments and rooted in the values of health equity and justice, can decision-makers realize the full potential of cities and secure urban health for all.

Partnerships for urban health

Urban health challenges are typically complex, spanning multiple stakeholders, sectors, and scales, often complicated by persistent patterns of vulnerability and exclusion. As such, urban health cannot be achieved or sustained without effective partnerships that gather and coordinate relevant actors, information, expertise, resources, and authority. These are important in all urban contexts, but especially in slums and informal settlements, which feature the most serious health inequities and often the greatest complexity.

Partnerships are formal or informal working relationships in which two or more parties contribute to a set of common goals. Partnership is also the process by which such parties assemble and make collective decisions about how they will work together. Although those involved contribute differently depending on needs, resources, and norms, ideal partnerships involve a process of co-creation in which all stakeholders are valued, have a legitimate role, share in an understanding of overall purpose, and participate equitably in goal setting and decision-making. Effective partnerships depend on transparent, well-functioning internal working arrangements and mutually developed frameworks of formal or informal rules and accountability.

Designed to improve the lives and wellbeing of urban dwellers, partnerships for urban health are defined by context and available resources and can take on many forms. They may be transient, addressing a single, time-bound issue, or long-term, dealing with a broader, persistent challenge or area of action. They may involve individual decision-makers, sectoral experts, or implementers from the public, private, academic, or civic sectors; government agencies, businesses, universities, or civil society organizations; and citizens or their representatives, including informal and grassroots organizations. Depending on their purpose, urban health partnerships may operate at different levels, with corresponding
partners; for example, partnerships targeting national-level regulation may involve national ministries or political figures, while those focused on local issues are more likely to include city-level public servants or representatives of local communities (including indigenous communities, where relevant). Many partnerships involve stakeholders at multiple levels, and some transcend national boundaries – as with international networks of cities working together on common challenges. Given that urban health emerges from all the interactions of people in cities with their physical, social, and institutional environments, it also depends on many partnerships that do not involve governments at all.

Effective partnerships can not only contribute substantively to urban health goals, but also improve communication, foster buy-in, facilitate effective working arrangements and assignment of responsibilities, help respond to and manage conflicts among stakeholders, and foster critical support and response networks during crises. By providing opportunities for stakeholders to participate in urban health decision-making, partnerships can reinforce individual and community rights. Partnerships that span sectors or scales or types of stakeholders are especially important for addressing complex problems in urban health and health equity, as they can create a framework for integrated action and can highlight underappreciated causal relationships and unanticipated effects, allowing for responsive action. In bringing together different ideas, ways of working, and priorities, partnerships are also a powerful force for innovation.¹

Multistakeholder partnerships for urban health can be challenging to initiate and maintain, given the different priorities, capacities, and ways of working among potential partners. The political nature of some urban challenges with significant health implications (e.g., land use, housing) can pose further barriers for potential partnerships. Governments at all scales should invest in developing the interest and capacity of urban stakeholders to collaborate effectively on urban health issues; actively promote the development of relevant partnerships; support the long-term viability of successful partnerships; and themselves embrace a partnership model, where appropriate, to deliver critical urban health services. They should also ensure that partnerships are not advanced or co-opted as a strategic substitute for more comprehensive health interventions or regulatory frameworks—a particular concern in the context of potentially health-harming industries and vulnerable settings (e.g., schools).

¹ See WHO (2024). Innovation for Urban Health (3).
Participation for urban health

Active participation by a wide range of urban stakeholders is also vital to the effectiveness of urban health action (e.g., rulemaking, planning, and delivery). Participation in this context means the legitimate, transparent, and active involvement of stakeholders in all phases of work, from goal- and priority-setting to decision-making to implementation, monitoring, and evaluation. Effective participation relies on the commitment and capacity of stakeholders both within and beyond the public sector.

Participation serves many purposes: it ensures the representation of relevant interests and groups, supporting improvements in urban health equity and reducing the likelihood that anyone will be left behind; it increases the information and expertise available to guide decision-making and practical action – community members and leaders, for example, often have a better understanding of local health needs and determinants than more remote decision-makers, yet are often excluded from such processes; it creates relationships that support effective communication and the formation of targeted partnerships; and it imparts knowledge about urban health and familiarity with urban health action to diverse stakeholders, increasing their ability to improve their own health and the likelihood that higher-level actions (e.g., policies and interventions) will be broadly taken up and built upon.

To be useful, participation must be legitimate, based on transparent processes, and offer genuine opportunities for all stakeholders to contribute. It should embody a shift from traditional, often passive consultation to active co-creation, with a strong emphasis on contextually relevant procedures for equitable involvement and outcomes. Indeed, deliberate measures to amplify the voices of vulnerable and excluded groups in participatory processes is especially important to achieving urban health, given the imperative of achieving health equity. As with partnerships, participation takes on outsized significance in slums and informal settlements, where residents, often excluded from meaningful decision-making, face unique barriers to improving their own health.
The purpose of this brief

This policy brief reflects and offers guidance on how national and subnational governments\(^2\) can strengthen partnerships and participation for urban health, both independently and in collaboration. It draws on existing international guidelines, academic literature, and insights from a participatory workshop involving experts in research, policy, and practice. The brief is primarily intended for national and subnational decision-makers and their technical staff.

The recommendations and associated supporting actions highlighted below are intended to be complementary and iterative, in line with an integrated, constantly evolving vision for improving urban health. Given substantial variation in needs, capacities, opportunities, and arrangements for supporting partnerships and participation within and across countries, this guidance is not intended to be prescriptive, but rather to serve as a starting point for adaptation to local city and country contexts. Not all items will be immediately or fully implementable everywhere, and sequencing will vary with local conditions. Additional resources which readers may find useful in advancing these recommendations in their work are available on the WHO Urban Health Repository.\(^3\)

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\(^2\) In this brief, “subnational governments” is used to represent a variety of arrangements at various levels; it always includes local and city governments, but the broader term is sometimes used to improve clarity and readability.

Recommendations

Creating and sustaining partnerships to support urban health

1. Adopt a multistakeholder partnership model, where appropriate, to deliver urban health needs

While some challenges may be well addressed through top-down government action, the cross-cutting nature of many urban health issues demands approaches that integrate the contributions of many actors. Governments at national and subnational scales would therefore do well to adopt a multistakeholder partnership model to efficiently serve many urban health needs. Such partnerships, grounded in a whole-of-system approach, may take many forms, including technical cooperation, transdisciplinary research frameworks, and public-private partnerships, among others. They will likewise involve many types of partners, such as traditional health sector actors, international development agencies, communities, civil society organizations, commercial actors, traditional or indigenous authorities, or others, depending on local context and the issues they address. Their success depends on the capacities and resources of both public sector and external partners and on a joint commitment to acting together to achieve urban health.

4 In some cases, multisectoral partnerships will involve multiple government entities spanning a range of sectors and scales and representing different ministries, departments, or jurisdictional authorities. For more on internal governance for urban health, see WHO (2023). Governance and Financing for Urban Health (4).
To build multistakeholder partnerships into government action for urban health:

- Establish an “active, influential, and substantial” high-level\(^5\) structure to explore, establish, and evaluate urban health partnerships involving the public sector (e.g., a multisectoral steering committee with representatives from health and other government sectors, communities, private sector leaders, and academia) (5). This structure should identify key urban health needs that can best be met through multistakeholder partnerships\(^6\); facilitate their establishment; and continuously seek to improve the efficiency and effectiveness of such arrangements.

- Establish mechanisms for other stakeholders to participate in multisectoral partnerships with the public sector; such mechanisms should advance urban health and health equity while fostering transparency, including through processes for identifying and responding to perceived or actual conflicts of interest and open establishment of and reporting on indicators, metrics, and evaluation data.

- Engage in an iterative process of stakeholder mapping\(^7\) and conduct ongoing active engagement to ensure that important stakeholders are incorporated in a strategic approach to urban health. Mapping should include not only actors but the vertical and horizontal relationships among them – including any potential synergies and conflicts – and their needs, priorities, capabilities, norms, and resources. It should cover major stakeholder types (e.g., public, private, and civic sectors, health systems, academia, communities) and extend to key stakeholders outside cities whose actions have important impacts on urban health (e.g., those involved in finance, food and water systems, trade, migration, or other processes involving urban-rural or globalized linkages). To secure equitable outcomes, there should be a concerted effort to identify invisible or underrepresented stakeholders (e.g., the unhoused, slum dwellers, undocumented migrants). Stakeholder mapping should be conducted in line with established conflict of interest criteria.

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5 “High-level” here refers to the broad multisectoral remit and authorities of such a structure, which can nevertheless operate at a national or subnational (e.g., city, metropolitan, or state) scale. At any scale, this structure should aim to be aware of and complement existing organic or bottom-up approaches to multisector partnership for urban health.

6 This will depend on good evidence about the distribution of health outcomes and critical determinants of health in the urban context and on incorporating the insights of key stakeholders. See e.g., WHO (2023). Generating and Working with Evidence for Urban Health (6).

7 Such a process can be useful at national or subnational (e.g., city, metropolitan, or state) scales, and will involve different considerations and stakeholders accordingly.
• Conduct regular training to raise awareness among public officials and civil servants of the value of multistakeholder partnerships, to instill the skills necessary to foster and manage such partnerships, and to empower them to act. In parallel, grow capacities for partnership among civil society, commercial actors, health system institutions, grass roots organizations, and other key stakeholders through education and training on urban health issues and opportunities to participate in co-design and joint problem-solving. Placemaking skills and principles may be especially useful for building and maintaining local partnerships (7).

• Establish incentives for the public sector to engage in partnerships for urban health, potentially including dedicated funding (e.g., national-level funds for cities, city-level funds for sectoral departments) or matching resources. Where proper, and with due consideration for the independence of policymakers and public servants, regulations and key performance indicators for public sector staff can be designed to encourage responsible outreach to stakeholders and exploration of multistakeholder partnerships while managing conflicts of interest.

• Where applicable, involve local universities and research centers in multisectoral partnerships for urban health; academic stakeholders can offer important expertise for synthesizing existing evidence to guide action, gathering new data, deriving insights from implementation, and documenting and evaluating interventions to improve learning, among other things.
Thailand’s Baan Mankong (“secure housing”) programme is a community-driven, partnership-oriented approach to slum upgrading, land tenure, and housing provision which “improved the lives and living conditions of more than 90,000 households in 1,546 communities across Thailand between 2003 and 2011” (8). Emphasizing “close collaboration between poor communities, local governments, professionals, universities and NGOs,” the Community Organization Development Institute (CODI) – Baan Mankong’s implementing agency – aims to secure holistic upgrading of informal communities. By organizing community networks and bringing them into collective engagement with municipalities and other actors, they increase their economic and political power and negotiating leverage, legitimize their projects by providing a legal policy umbrella, and foster social capital by incentivizing internal social support mechanisms. Solutions under the programme differ widely across cities, but include “physical aspects of shelter like housing and infrastructure... [and] human and social aspects like health, welfare, social support systems and well-being...”, encompassing health-relevant “basic infrastructure like walkways, electricity, water supply, drainage and waste management... [as well as] playgrounds, community centers, community gardens and welfare houses which allow the community to look after their own elderly and disabled neighbors.”

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8 CODI. Baan Mankong Urban (https://en.codi.or.th/baan-mankong-urban/)
9 Ibid.
2. Foster an environment that encourages diverse collaboration and supports multistakeholder partnerships

Key stakeholders can transform urban health and health equity for the better by prioritizing effective partnerships and integrated approaches. Yet for this to happen, they need both to be fully aware of the potential advantages and to be supported in overcoming obstacles. Indeed, the capacities, resources, and effort required to initiate and sustain multistakeholder partnerships can constitute significant barriers to collaboration, as can institutional bottlenecks, divergent expectations, and other factors. Shifting political cycles and periodic administrative turnover can also challenge ongoing or emerging partnerships in the absence of institutional commitments. Governments should contribute to an environment conducive to collaboration across sectors, scales, and types of stakeholders. More broadly, they should support the exploration, formation, and viability over time of partnerships for urban health – both those that involve the public sector and those that bring together other relevant urban stakeholders – and share learnings to scale effective partnership across urban settings.

To create a supportive environment for collaboration and partnerships:

- Assign explicit responsibility to national and subnational urban health authorities (within broader urban health plans) for promoting an environment that fosters cross-cutting collaboration and partnerships, including through dedicated institutional structures, rulemaking, and resources.

- Build broad awareness about the interconnected nature of urban health challenges and solutions, a shared language around health determinants, and a common vision for a healthy urban future (e.g., through communications campaigns, targeted outreach, or demonstration projects). These efforts should aim to ensure that everyone understands their agency in co-creating urban health outcomes (e.g., supporting Health-in-all-Policy thinking) and recognizes the potential value of partnerships; they should also build trust by promoting collective understanding of the mandates and missions of different actors and sectors.

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10 These may take different forms, particularly at national versus local scales; for example, urban health plans can be integrated in city-level master plans or national-level economic or development strategies, or in dedicated national strategies for urban health. See WHO (2023) Governance and Financing for Urban Health.
• Create opportunities (e.g., platforms, campaigns, events) for collaboration and partnership formation around urban health. Where feasible, these should reinforce the urban health efforts of existing institutions (e.g., civil society and grass roots organizations, health system actors) and networks (e.g., healthy cities/healthy municipalities, child-friendly cities) at national, regional, and local scales, while bridging “the interests and capacities of... public health and urban planning professionals” (9).

• Make appropriate funding available to urban health-focused partnerships, while managing conflicts of interest to prevent undue influence over agenda-setting. This may include seed funding to encourage exploration and kickstart partnerships; financial support for core functions and capacity-building to equip non-governmental stakeholders (e.g., civil society organizations, community representatives) to partner more effectively; and longer-term funding for multisectoral partnerships that have demonstrated success. Where feasible, connect promising partnerships with potential long-term funders (e.g., development banks, philanthropies, private capital)\(^\text{11}\) to expand the funding base. Widely disseminate funding opportunities among urban stakeholders. Ensure that representatives of vulnerable or excluded groups have access to funding opportunities and that targeted funding is available for interventions that reduce health inequalities and meet their specific health needs, including in slums and informal settlements.

• Develop and disseminate guidance (e.g., educational materials, standards, tools) on establishing, evolving, and maintaining multistakeholder partnerships for urban health and health equity. This should include formulating shared goals and values; defining decision-making and leadership processes and formalizing relationships and contributions; establishing clear conflict management processes; addressing conflicts of interest and upholding ethical standards; ensuring transparency and accountability; evaluation and diffusion of key learnings; and expanding partnerships, planning transitions, and recalibrating to reflect new partners and challenges, among other elements (5).

\(^{11}\) See also WHO (2023). Governance and Financing for Urban Health (4).
The Public Health Agency of Canada’s Multi-sectoral Partnerships to Promote Healthy Living and Prevent Chronic Disease Initiative (MSP) “brings together diverse partners to design, implement and advance innovative approaches for improving population health,” supporting over 30 multi-sectoral partnerships across the country since 2019 (10,11). Administered by the Centre for Chronic Disease Prevention, MSP has focused on primary prevention to achieve healthy living and healthy weights and on addressing common risk factors for chronic diseases. It emphasizes coordinated sets of activities, including for securing healthy environments and promoting healthy behaviour change. Moreover, it “requires the investment of resources (both financial and skill-based) from a variety of sectoral partners including academic, not-for-profit and the private and foundational sectors, both within and outside health,” providing matching funds (11). Funded partnerships have often involved public and private organizations and have led to greater capacities and reach and improved cross-sector engagement and accountability (10).
Participation by non-governmental stakeholders in urban health priority setting and decision-making

1. Standardize a culture of participation in public sector action for urban health

A firm commitment on the part of governments – from national to local – is a prerequisite for broad stakeholder participation in urban health. Formalizing this commitment in governance for urban health (e.g., in priority setting, resource allocation, decision-making, and implementation) paves the way for the development of needed institutional structures and processes. In parallel, nurturing a culture of participation within the public sector and equipping civil servants with relevant skills and knowledge make it more likely that participatory engagement will be productive and inclusive.

To standardize stakeholder participation within urban health action:

- Develop and implement a legal and regulatory framework that engages stakeholders in urban health priority setting and decision-making at all levels, drawing on and aligning with existing institutions and mechanisms where relevant (12). Depending on context, this may include provisions (e.g., laws, regulations, standards, guidelines) for joint decision-making, social participation, participatory budgeting, feedback processes for proposed actions, community consultation, and/or others, accompanied by the institutional structures and resources required for implementation (9). It should provide for external stakeholder engagement on both long-term (i.e., strategic) and short-term (i.e., project) planning and commitments and provide for participation to contribute to whole-of-society, whole-of-government responses for urban health and health equity.

12 While this section “focuses on how to involve” non-governmental stakeholders, many provisions will be relevant for encouraging participation by the diversity of public actors critical to a strategic approach to urban health. For more on establishing a whole-of-government political mandate for urban health, see WHO (2023). Governance and Financing for Urban Health (4).

13 In many contexts, existing laws and policy frameworks have provisions for health-oriented community engagement which have yet to be operationalized. Understanding and addressing the underlying barriers to implementation in these cases is an important step in facilitating participation.
• Develop rules for the supply of timely information about urban health to relevant stakeholders and ensure their application at all levels. These should include, among others, transparency about decisions and decision-making processes (e.g., through public access and freedom-of-information requirements); frequent, regular updates on challenges and progress relative to goals (including clearly established indicators, metrics, and evaluation criteria); complete, up-to-date summary data in easily understood formats (e.g., dashboards, reports) (13); and basic information about urban health. Where relevant, these should be available in multiple languages and accessible formats (e.g., image-based materials, disability-inclusive communications, culturally sensitive messaging).

• At the city scale, conduct local needs assessments and planning with community representatives, potentially including official community councils, local volunteer organizations (e.g., women’s groups, child and adolescent groups, faith-based groups), community leaders, and local health professionals (14). Such processes should stipulate frequency and types of engagement as well as expected intermediate and long-term outcomes. Special arrangements and greater effort will usually be needed to reach excluded groups and under-resourced areas, including slums and informal settlements, and these should be prioritized. Collectively, local needs assessments should inform higher-level (e.g., regional and national) decision-making on urban health.

• Leverage the specialized skills and knowledge of academic and public health institutions, communications and technology specialists, knowledge brokers, community representatives, and other key actors to design and continually improve culturally and contextually appropriate participatory engagement and collective planning processes.

• Provide up-to-date guidance to public sector actors on methods, models, and technologies for engagement, social influence techniques, transdisciplinary research and action frameworks, and other key methods and tools to improve their capacity for and practice of participatory engagement.
The city of Vienna, Austria has identified positive youth participation in public decision-making as a fundamental structural goal, aiming “to put social inclusion of all children and young people living and growing up in Vienna at the heart of policymaking and city administration”\textsuperscript{14} through the Werkstadt Junges Wien program. Over 20,000 children and young people were asked to identify positive features and areas for improvement across all aspects of city life, leading to a Children and Youth Strategy for Vienna that makes a binding commitment to “9 objectives and 193 measures addressing all fields of local policy, and all City of Vienna departments and enterprises.”\textsuperscript{15} Health and wellbeing is one of the nine fundamental objectives, but virtually all are health-related, encompassing themes like Nature and Environment, Space and Place, Mobility and Transport, and Safety and Security. Vienna has also instituted a Children’s and Young People’s Parliament, which deliberates and votes on the allocation of a €1M participatory budget set aside for projects originated by children and youth. By building participation into public sector action, Vienna has taken major strides toward improving urban health for a population that is often without voice.
2. Encourage non-governmental actors to participate in urban health action

Participation is reciprocal, requiring not only openness on the part of government, but the desire and capacity among external (i.e., non-governmental) stakeholders to engage with urban health debates, governance, and activities. Governments at national and subnational scales can encourage this participation by removing barriers, building trust, fostering the knowledge and skills needed to effectively participate, providing arenas and incentives, promoting evidence on the benefits of urban health action, and communicating results. Legitimate participation by representatives of potentially vulnerable or excluded groups and consideration of their needs is imperative for ensuring health equity. Such groups include individuals of all ages, ethnicities, abilities, and genders – especially women, in many contexts – as well as groups that face elevated health risks in urban areas, such as slum-dwellers, indigenous populations, and migrants, among others.

To bring external stakeholders into urban health priority setting and decision-making:

- Encourage buy-in and personal involvement among non-governmental stakeholders by supporting discussion and debate on urban health issues in relevant institutions (e.g., citizens’ assemblies, town halls, business councils, community forums or planning initiatives). Make the case for participation by highlighting local health and health equity challenges and the opportunities for addressing them through a strategic approach to urban health that involves all stakeholders.

- Simplify ordinary participation for external stakeholders by offering frequent, consistent opportunities for engagement in a range of modes and targeting communication effectively, while ensuring that there are mechanisms to demonstrate how feedback has been considered and incorporated into urban health action. Explicit attention should be paid to language issues and the needs of potentially vulnerable or excluded groups. For example, in the context of
local action, offer translation (especially in multilingual communities); foster inclusive dialogue by discouraging technical language and jargon; offer multiple venues and times for physical meetings (e.g., public hearings, issue-oriented dialogues); and provide for online participation and feedback in addition to paper-based or in-person surveys. Working with community leaders can offer pathways to greater participation, particularly in slums or informal settlements.

- Build the capacity of non-governmental stakeholders to access, evaluate, and make use of urban health data, to navigate and understand relevant legislation and regulation (e.g., land rights, human rights, planning consultation guidelines), and to participate in the preparation, implementation, and monitoring of local policies and plans (13,15).

- Offer communities shared control over how urban health funds are used in their area, e.g., through local needs assessment, grants to urban health-focused community groups, or participatory budgeting. This may benefit from incorporating capacity building and knowledge exchange to help community stakeholders understand how their priorities and perceptions relate to those of health professionals and public administrators.

- Make a concerted effort to sustain, scale, and promote effective interventions for urban health and health equity, acknowledging, on the one hand, the potential harms to multisectoral planning, civic trust, and integrity from actions that fail to achieve meaningful engagement or transparency in their aims and impacts, and, on the other, the potential benefits from amplifying well-executed successes.

- Make liberal use of participatory planning tools (e.g., health impact assessment,16 environmental impact assessment, strategic environmental assessment) to gather and consolidate input from urban health stakeholders.

- Ensure that relevant community/neighborhood-led data (e.g., risk and hazard maps) are integrated into urban health strategies, policies, and plans, particularly when setting up neighborhood-level interventions (12,16).

- Recognize community-led efforts to develop local answers for urban health challenges (e.g., local data collection, citizen assemblies, slum mapping initiatives) and support them, including potentially through funding or technical, logistical, or communications resources. Consider offering individual or organizational incentives (e.g., compensation) for participation, in line with principles of transparency, management of conflicts of interest, and equity for excluded and vulnerable groups (17).

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Demonstrate proposed urban health interventions through local pilot projects, allowing communities and other stakeholders to observe implementation, consider potential benefits and impacts, and provide timely feedback.

**HIGHLIGHT**

Star Rating for Schools (SR4S) “is an award-winning evidence-based programme of tools, training and support to measure, manage and communicate the risk children are exposed to on a journey to school.”

Funded by a consortium of commercial actors and global NGOs focusing on road safety, sustainable mobility, and children’s health, it has supported over 1,200 road safety assessments in 70 countries, leading to improved safety for 400,000+ students. The first step in the SR4S model emphasizes positive collaboration among stakeholders encompassing a range of sectors and types; applicants are asked to specify how they will involve local partners. Project participants are provided with extensive supporting materials for education and outreach, undergo focused training on road safety assessment, build connections with schools and neighbouring communities through in-depth engagement, participate in collective priority-setting for an important urban health challenge, and advocate for improvements based on assessed risks. Recent trainings have involved a private-sector emergency services firm and public sector road safety representatives at district and national level in Botswana; automobile club representatives from nine African countries; and youth leaders and a youth education-focused NGO in Cameroon. Various case studies suggest the programme is effective in improving road safety around schools.

A strategic approach to urban health

The recommendations given here for partnerships and participation are intended to be consistent with a strategic approach to urban health, which should be:

**01 Integrative**
- encompassing, involving, and empowering all stakeholders whose actions contribute to urban health;
- raising collective awareness of risks and opportunities;
- creating a shared vision prioritizing collaboration toward unified goals;
- supporting intersectoral connections and joint work;
- fostering coherence in action, diversity in ideas, and grass roots ownership.

**02 Contextualized**
- tailoring solutions to local conditions, culture, and values;
- recognizing that social, environmental, economic, and commercial determinants of health vary widely, as do stakeholders and their needs, priorities, capabilities, norms, and resources;
- using place-based mechanisms to involve local actors in urban health planning, policy, and practice.

**03 Complexity-informed**
- acknowledging the dynamic complexity of cities and their relationships to broader interdependent systems (e.g., climate, global trade);
- recognizing feedbacks among social, environmental, economic, and commercial determinants of health and health outcomes;
- avoiding unintended consequences, managing systemic conflicts, and capitalizing on synergies.
**04 Equity-oriented**
recognizing that populations in situations of vulnerability face heightened health risks, that exclusion exacerbates health inequities, and that these are intersectional and compounding; devoting the effort and resources to rectify injustice and counter the self-perpetuating nature of inequities; leveraging urban health decision-making to prevent and reduce inequities among cities, citizens, neighbourhoods, and population subgroups.

**05 Continuously improving**
regularly updating situational awareness through formal and informal mapping, assessment, monitoring, and evaluation; always seeking a higher level of health based on best information about present conditions and likely futures; swiftly reacting to changing circumstances; constantly learning from local experience, accumulated evidence, and engagement with peers and other stakeholders.

**06 Efficient**
taking advantage of cross-sector and cross-scale synergies and avoiding incoherence; pursuing integrated decision-making where appropriate; repurposing existing assets, resources, and mechanisms to mitigate the administrative and financial costs of new policies or structures; improving return-on-investment where feasible.

**07 Sufficient**
developing and assigning the financial and human resources needed to effectively anticipate, plan for, respond to, and overcome urban health challenges; allocating resources according to needs; investing in capacity building to meet current and future requirements.

**08 Forward-looking**
ensuring that short- and medium-term actions address immediate needs, yield tangible results, and demonstrate progress, while emphasizing long-term planning to lay strong foundations and sustainable mechanisms for healthy futures; recognizing the impact of current actions on future options (e.g., via path dependency and lock-in).
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Central Park, New York, USA. Unsplash / Chanan Greenblat / 2015.