Regional Network for Equity in Health in east and southern Africa

DISCUSSION Paper NO. 117

Pathways to urban health equity

Report of multi-method research in east and southern Africa

R Loewenson, M Masotya
Training and Research Support Centre

Working with Harare and Lusaka youth, Civic Forum on Human Development and Lusaka District Health Office for the participatory validation

In the Regional Network for Equity in Health in East and Southern Africa (EQUINET)

EQUINET DISCUSSION PAPER 117

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With support from IDRC (Canada)

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EXECUTIVE SUMMARY

By 2050, urban populations in Africa will increase to 62%. The World Health Organization (WHO) and UN-Habitat in their 2010 report 'Hidden Cities' note that this growth in the urban population constitutes one of the most important global health issues of the 21st century. In 2016-2018, Training and Research Support Centre (TARSC) in the Regional Network for Equity in Health in East and Southern Africa (EQUINET) explored the social distribution of health in urban areas and the opportunities for and practices promoting urban health and well-being. It focused on youth 15-24 years of age as an important group for both current and future well-being.

The paper synthesises and reports evidence from a programme of work that unfolded iteratively over two years. The work involved desk reviews of published literature and analysis of data from international databases for east and southern African countries, and international evidence on practices supporting urban well-being in areas prioritised by urban youth. The findings were subject to cycles of participatory review and validation by young people from diverse urban settings and socio-economic groups in Harare and Lusaka. These methods were applied with an intention to draw on different disciplines, concepts and variables from different sectors and on the lived experience and perceptions of the youth directly affected by different urban conditions.

Separate publications produced in the project give more detail on particular methods, and findings and are cited in this paper. A series of dissemination and dialogue activities have been carried out with youth, local authority and policy actors, supported by shorter briefs and technical reports.

The literature review reported in *Section 3* suggested that a policy perception of an urban advantage is no longer valid for many health outcomes and determinants in ESA countries. A focus on urban –rural differentials thus seems to be no longer sufficient for addressing inequalities in health, especially those emerging from disadvantage and rising poverty *within* urban areas. The evidence from literature, data sets and the participatory validation by youth suggest a co-existence within the same broad locality of wealth and social insecurity; an inequality in benefit from urban ideas, technology, goods and services, with deficits for many in basic needs. An increasingly literate, educated and connected population co-exists with social abuse and exclusion and a still unrealised potential for participation of many urban communities in local government decision-making.

The paper suggests that our currently dominant approach of understanding health equity in relation to the distribution of morbidity and various deficits in immediate determinants of health appears to be necessary but not sufficient to understand, explain and proactively advance health equity in urban areas. This is particularly so for young people, when biomedical approaches and health services focus on disease, so that youth may appear to be in 'good health' in these terms, but face a number of physical, mental and social challenges that have both immediate and long-term effects.

In contrast, holistic, integrated and affirmative approaches are argued to have the potential to overcome such deficits and to address and rebalance the multiple social, economic and environmental determinants of these different health outcomes. Recent 'health in all policies' approaches seek to address this by embedding health in the work of other sectors. However, the outcomes may still be motivated, perceived, defined and measured in terms of reducing immediate risks to *ill health* and morbidity, limiting other sectors' ownership of these outcomes and implemented as technical solutions with limited bottom-up participation. A focus on individual measures for particular sectors, while necessary, may not adequately encourage the cross-sectoral collaboration needed for sustained and significant changes for urban health.

In *Section 4*, the paper proposes 'wellbeing' as a concept that has value in integrating, exploring and acting on the psychosocial, social, time use, political, material, economic, service, governance and ecological determinants of health equity in urban areas. While explicitly referred to in the first principle of the WHO Constitution, the concept is not 'owned' by any particular sector, and avoids the siloing of outcomes. Its focus reaches beyond the control of negative outcomes to the promotion of positive strategies and assets at individual and collective levels. It integrates both objective and subjective dimensions and the current

and future consequences that develop cumulatively over time. Urban youth found it to be a more accessible concept, not (yet) owned or mystified by a technical community, enabling us to put the youth at the centre of assessment, taking into account their lived experience and perceptions as active participants.

The available data from across ESA countries presented in *Section 5* highlight that in contrast to other regions, there is limited inclusion of many of these parameters of well-being in data collected across the region and that the data are predominantly focused on negative indicators. We propose identifying and measuring across ESA countries both risks and assets in the psychosocial, social, time use, political, material, economic, service, governance and ecological indicators of well-being, drawing as relevant on measures already used in other regions. The additional evidence provided directly by affected communities in the youth participatory validation highlighted the value of complementing such quantitative data with participatory, qualitative assessments and with the voice of those directly affected, particularly for within-area assessment and planning.

A 'healthy city' has been defined as one that enables people to have equitable access to economic opportunities and services, that empowers people to achieve their potential and that nurtures natural environments. The paper presents a range of approaches being applied in urban areas internationally that have addressed these features, focusing on the priorities identified by the Harare and Lusaka youth. The paper presents their common features with examples in *Section 7*. They cover a range of measures, such as for shelter, urban agriculture, improved urban environments, clean energy, but also approaches that engage and support the social assets within urban areas.

What would this imply for urban primary health care (PHC)? Comprehensive PHC is argued to connect with a holistic understanding of wellbeing. It can be an entry point for the collaborative roles and participatory practices needed. Beyond the essential health care made universally accessible to individuals and families in urban communities, a wellbeing promoting urban PHC has a role in:

1. **Facilitating recognition, visibility and voice of active residents**, generating recognition of people's conditions in participatory and asset based approaches, including as a contributor to wider urban democracy. For urban primary care services, it means knowing and enrolling the catchment population; integrating individual, family and community mental, physical and social health services and reaching into community settings in place-based approaches.
2. **Addressing different dimensions of wellbeing, including psychosocial dimensions,** co-locating services in public spaces, and investing in public health, prevention and promotion measures, using tools such as health and social impact assessment and participatory budgeting to connect health with other dimensions of and interventions for wellbeing.
3. **Embedding ideas, innovation and collaborative advantage**, to nurture new, collaborative practice, shifting from top-down approaches to approaches that engage the community and primary care levels as knowledge *producers* (and not just knowledge implementers).
4. **Stimulating and building relationships, trust and collaboration**, across the social groups, authorities, services, personnel and community leaders. The urban youth in this work pointed to the potential for PHC practice to support this through: health authorities participating in local council dialogue and youth forums on programmes and budgets; bringing community voice and evidence into health decision making, especially for groups not usually heard; using online media and working with young people as a voice, watchdog and social advocate for health.
5. **Using online and social media**, providing access to Wi-Fi in public spaces and online sites for people to report issues, get information and provide feedback; for online surveys; for crowdfunding; to generate and model ideas and to facilitate accountability on key services.
6. **Bringing investment and using innovative financing approaches**, with adequate domestic funding of primary care as the most pro-poor level of the health system without cost barriers at point of care; and acting as advocate and lever for other innovative financing approaches for health-promoting interventions, including through crowdfunding, public seed funding, innovation challenge competitions and 'matchmaking' private funders with specific groups.

1. INTRODUCTION: A LENS ON URBAN HEALTH INEQUALITIES

By 2050, urban populations will increase to 62% in Africa. The World Health Organisation (WHO) and UN Habitat in their 2010 report "Hidden Cities" note that this growth in the urban population constitutes one of the most important global health issues of the 21st century. Cities concentrate opportunities, jobs and services, but they also concentrate risks and hazards for health (WHO and UN Habitat 2010). How fairly are these risks and opportunities distributed across different population groups and generations? How well are African cities promoting current and future wellbeing? How far are health systems responding to and planning for these changes?

Training and Research Support Centre (TARSC) as cluster lead of the 'Equity Watch' work in the Regional Network for Equity in Health in east and southern Africa (EQUINET), in follow-up to the findings of the 2012 Regional Equity Watch and the country Equity Watch reports (EQUINET 2012), explored in 2016-2018 diverse forms of evidence and views on these questions in east and southern Africa (ESA). This was implemented through a multi-methods approach to gather and analyse available evidence and reported experience on inequalities in health and its determinants *within* urban areas, covering the multiple conditions that exist across urban areas as a whole, rather than the poorest settings only. The work explores the current and possible responses to these inequalities from the health sector or through the health-promoting interventions of other sectors and communities.

This work aims to build a holistic understanding of *the social distribution of health in urban areas and the responses and actions that promote urban health equity.*

This implies, beyond the distribution of morbidity and mortality and its determinants, understanding the *distribution of opportunities for and practices promoting health and wellbeing. It suggests integrating diverse perspectives, disciplines and sectors* to reach this understanding of wellbeing and integrating *many forms of evidence* beyond 'measured' indicators, with a specific role for participatory validation by those more directly involved and affected.

It aims to identify the implications for how we frame urban primary health care, and for the *wider policies and responses that affect urban health equity.*

This is a wide lens. In line with findings of the literature review, reported later in the paper, we focus the analysis on youth (15-24 years of age) as an important group for urban health equity, not only in relation to the current distribution of opportunities for wellbeing, but also in relation to responses that define future urban life. This paper synthesises evidence from and reports on a programme of work that unfolded iteratively over two years. Separate publications give more detail on particular elements of the work and are cited in this text. A series of dissemination and dialogue activities have been carried out with youth, local authorities and policy actors, supported by shorter briefs and technical reports.

This paper presents:

- In **Section 2**, a summary of the methods and their limitations.
- In **Section 3**, the findings from the literature review on **urban inequalities in health in ESA.**
- In **Section 4, the holistic and transdisciplinary paradigms** and **areas of focus** arising from the evidence that informed the exploration of health and wellbeing promoting responses.
- In **Section 5,** a summary of analysis of **indicators in the ESA region for measuring wellbeing.**
- In **Section 6,** the priorities identified by Harare and Lusaka youth on urban health and wellbeing.
- In **Section 7, approaches for improved wellbeing in other settings** and youth reflections on how they could be applied in their cities.
- In **Section 8**, the **learning and insights** across the body of the work and the implications for action on urban health equity and on urban PHC in the ESA region.

2. METHODS

The work was done in stages, using iterative cycles of desk review and compilation of diverse forms of secondary evidence from ESA countries and internationally, interacting with cycles of participatory review and validation by young people from diverse settings, particularly in Harare. The methods used responded to an intention to draw on different disciplines, integrating multiple concepts and variables from different sectors but also lived experience and perceptions of the youth directly affected by different urban conditions.

We recognised that exploring urban health equity involves multifactorial issues and complex systems, and that holistic responses call for transdisciplinary methods that, beyond collaboration across the concepts and terminologies of different disciplines, co-design new knowledge around shared concepts (Bai et al., 2012). An approach that begins with or involves the lived experience of those directly affected could encourage such approaches, as people do not express their lived experience within sectoral silos (Loewenson et al., 2014). An iterative approach enabled participatory and collaborative methods, engaging stakeholders in review of evidence and analysis.

The multi-methods applied, outlined here and detailed in separately published reports, thus included desk review of published literature, assessment of indicators of wellbeing, internet searches of practices, participatory validation with different groups of urban youth and stakeholder dialogue. Beyond the specific methods, the work aimed to be aspirational, affirmative and intervention oriented, drawing learning also from local innovation and integrating diverse forms of evidence and insights from published literature, internet media and community knowledge and practice. A grounded thematic approach captured key themes emerging from the evidence, drawing themes from the evidence rather than applying a rigid framework to the evidence.

2.1 The desk reviews

In August 2015, an annotated bibliography was compiled from a review of published papers on the pattern of and responses to urban inequalities in health in ESA countries. As inclusion criteria, English language papers post-2005 were included that covered urban or peri-urban areas, addressed inequalities in health, healthcare and their determinants and actions on these by health and other sectors, covering ESA countries individually and as a region. An online search of papers in English language post-2005 accessed from Google, Google Scholar, PubMed, MEDLINE and other online libraries found 1,060 papers. The full search terms are outlined in Loewenson and Masotya (2015). An initial review of the abstracts relative to the inclusion criteria identified 90 papers for review and a further 15 papers from snowballing. The papers included were produced in an annotated bibliography (Loewenson and Masotya, 2015). Notably only a quarter of papers sourced discussed interventions to address inequalities and few discussed community responses to urban inequalities in health. The published evidence mainly came from two countries, Kenya and South Africa, and from ad hoc surveys. This raises caution on interpreting trends found, given the more limited evidence from lower income countries, from community driven interventions and the limited qualitative evidence.

A follow-up search and review was implemented in 2016 on holistic paradigms, that is paradigms that integrate equity and its multiple determinants, that take a multifactorial and cross-sectoral approach, focusing on both risks and assets, as explained in *Section 4*. These paradigms and their methods for exploring urban health were reviewed to identify conceptual approaches. This section presents an overview of holistic paradigms for this, particularly those seeking to overcome the fragmentation of determinants and sectoral inputs that influence health, and that seek to advance health, rather than simply control disease Fifty two papers in English and Spanish were sourced from online searches of the same libraries as noted for the annotated bibliography. A further seven papers were sourced by snowballing and 23 papers sourced on the indicators being used in measurement of wellbeing in these approaches. The papers were reviewed to identify the methods applied and to compile a matrix of indicators for the different dimensions of wellbeing for quantitative analysis.

2.2 Analysis of indicators

In 2016 we implemented a search of online publications using relevant keywords in the Google search engine and combined this with snowballing from literature found in the search on holistic models and in the literature cited in the findings of the Google search (Loewenson and Masotya, 2018). The twelve frameworks found are further described in the paper as are the features of indicators used for different dimensions of wellbeing within these different frameworks. We searched for online data on the identified indicators, or close proxies for them, for ESA countries. The data were included if they were available for all ESA countries, even if only at national level and one point in time.

We also searched for available data over more than one point in time post-2000 and that disaggregated urban areas and youth. The international database sites searched were: UN- HABITAT, UNESCO, UNICEF, Millennium Development Goal indicators, UNDP, UN FAO, UNdata explorer; WHO country-specific urban health profiles, World Health Statistics and the Global Health Observatory); wellbeing indicators sites (Better Life Index, Gross National Happiness, Happy Planet Index, Quality of Life Indicators); and the Demographic Health Survey Program STATcompiler. Every attempt was made to collect most recent data as well as the closest previous time point, or period.

Data specific to youth or aggregated by residence (urban/rural) were limited, and many relevant indicators collected in OECD countries were not available in ESA countries. Indicators for measurement of the Sustainable Development Goals (SDGs) may lead to new evidence being gathered across all ESA countries.

2.3 Participatory validation with urban youth

In the participatory validation, and noting the focus for this work on urban youth as identified from the literature review, TARSC co-operated with youth from different suburbs in Harare and the Civic Forum on Human Development (CFHD), a national civil society organization working on urban development. The evidence from other sources was reviewed in several stages and used to identify thematic priorities for future document review or evidence gathering. These validation cycles involved groups directly affected by urban youth wellbeing in ESA, primarily groups of young people from different socio-economic conditions in Harare with some inclusion of youth from different conditions in Lusaka and stakeholders in the two cities.

The protocol, urban areas and socio-economic groups for inclusion in the participatory validation were discussed with a pilot group of six young people from different socioeconomic areas of Harare and with the CFHD. In this process, reported in detail in TARSC and CFHD (2018), six different levels of socio-economic security were identified as representing a spectrum of key socio-economic groups in the city with higher levels of youth populations, viz:

- At higher levels of security: (1) Youth living in Northern (low density, higher income) suburbs, and (2) Youth in formal employment (although noting that these too may be insecure).
- At medium levels of security: (3) Youth in tertiary education.
- At lowest levels of security: (4) Young people in Epworth, an informal settlement in Harare (5) Unemployed youth, and (6) Youth in informal jobs.

While other types of youth are found in the city, these six socio-economic groups are a reasonable representation of the city and the spectrum within which the majority of youth are found. The paper explicitly focuses on youth and so does not deliberately seek to extrapolate findings to other demographic groups, although the insights and conclusions may have wider relevance.

Meaningful participation in the methods used for the participatory validation process implies a total number of fewer than 40 people for the six groups above combined. Six youth were thus included in each of the six socio-economic groups, purposively selected by CFHD from each of the identified areas, except for the Northern suburbs where there were 5 youth (35 total).

While this is a limited number, the homogeneity within socio-economic groups and the measures for both collective validation and identification of exceptions applied suggest that it is adequate for its purpose as the review, validation and addition from a youth lens on the findings from the multiple other methods used. Youth from two social groups (unemployed, informal employment) largely came from high density suburbs outside Epworth and the Northern suburbs, while some in formal employment and tertiary education did also live in Northern suburbs. There was otherwise limited overlap in the groups. Nearly half (15) of the youth were female. The same socio-economic groups were identified as relevant for Lusaka and the same methods used for purposive selection, detailed in LDHO, TARSC and CFHD (2018). The same comment on limitations and relevance raised for Harare also apply to Lusaka.

Several stages of participatory validation were implemented in Harare, each involving the same people in these same six groups, with details reported in TARSC and CFHD (2018):

1. In August 2016, with each of the six groups separately, on perceptions on health and wellbeing and the dimensions, determinants and priority areas of wellbeing, comparing determinants and priority areas of wellbeing raised in document review with those raised by young people from different settings.
2. In March 2017 the findings were discussed with all six groups in one meeting to interpret the consistent and different findings across the six groups and explore what promoters or risks different groups of youth can influence and how; and how these issues are being tackled in other cities globally, including by young people.
3. In May 2017 the findings from internet searches were discussed with all youth combined to identify the implications for urban primary health care and for urban planning. There was some loss to follow up of youth in the formally employed, informally employed and unemployed youth, mainly due to work related issues. Except for the formally employed, there were still sufficient in each group to input their views in the overall discussions.

These meetings used a mix of participatory methods for the validation: including group discussions, card sorting, ranking and scoring, line-ups on areas for debate, social maps, Margolis wheel, with written briefs of evidence reviewed and video presentation of approaches used in other countries. These participatory methods are described in Loewenson et al. (2014), and further details on the methods in each meeting provided in TARSC and CFHD (2018).

2.4 Sourcing innovations on priority areas of urban wellbeing

Internet searches were implemented in 2017 of multimedia evidence on how other countries and communities are improving areas of urban health and wellbeing that were found to be important for ESA and for addressing social inequalities from the literature review, the analysis of wellbeing indicators and the participatory validation with the youth. The areas searched were:

a. On shelter/social conditions, including access to shelter, slum upgrading and secure community environments for young people, reducing air pollution and promoting use of clean fuels.
b. On education, including support for access to education at all levels and youth participation in shaping education curricula and systems.
c. On the creative and green economy, including its role in youth employment, and the role of online resources and resource recycling activities.
d. On participating in government decision-making by youth at local and national levels, and networking between youth to build solidarity across different social groups of youth in the city.
e. On urban agriculture, healthy food markets and diet.
f. On job and enterprise creation, including measures to support this for youth.
g. On protection of time for leisure and social life, especially in women.

In early 2017 TARSC gathered secondary level multimedia evidence from internet searches of English and Spanish materials post-2000 from Google, Google Scholar, institutional, civil society websites and other search engines on innovations for the improvement of wellbeing within these nine areas drawing on publications, websites, blogs, visual and audio/video evidence, with any information on measurement of outcomes and parameters and data.

Evidence was gathered and produced in case studies on practices and innovations in cities globally, including in Africa, including their involvement of or benefits to youth and more marginalised groups, and their measures to address social or health inequalities and improve wellbeing. The methods and case studies are in Loewenson and Masotya (2017), separately published as an 'ideas book'.

2.5 Thematic analysis of the findings

A manual content analysis was implemented triangulating evidence across all the findings from the different methods above to identify the common themes emerging on:

a. Common and different understandings, perceptions and measures for urban health and wellbeing, particularly as relevant to urban youth;

b. The distribution and drivers of health and wellbeing in urban youth in ESA and priority areas for intervention for improved urban health and wellbeing;

c. Features of approaches and assets for improved health and wellbeing in urban youth and the implications for primary health care in urban areas and for urban health.

Through separate publications and briefs made available online, and provided in forums in Harare and Lusaka, the findings from the thematic analysis were subject to review. A two day meeting in Lusaka convened by the Lusaka District Health Office (LDHO) in June 2018 involved young people in Lusaka living in low density, medium income suburbs; in formal employment; in tertiary education; in informal employment and in informal settlements and unemployed youth on their perceptions of health and wellbeing, the drivers of wellbeing in their areas, the approaches and practices that are and could be implemented to improve their wellbeing and the implications for urban services, including for health systems, reviewing also the findings from the work outlined above. The findings were also reviewed in a dialogue with local authorities and key health and urban officials in Lusaka (LDHO, TARSC, CFHD, 2018).

Explaining the results at the Lusaka meeting, Zambia, TARSC 2018

3. DOCUMENTED URBAN HEALTH INEQUALITIES IN ESA COUNTRIES

The annotated bibliography and desk review outlined in *Section 2.1* presented and analysed evidence from 105 published papers on patterns of and responses to urban inequalities in health in ESA countries (Loewenson and Masotya, 2015). The findings and many references that informed the review are reported in more detail in that publication. This section provides a summary of the key themes found in the review and selected references from it.

The review identified that for ESA countries, while urbanisation is associated with rising and often conspicuous wealth in some groups and with increasing levels of public access to online information and social media, it also involves many dimensions of urban stress, often in close proximity to wealth, ie:

a. Poor living conditions for many urban residents, including substandard and overcrowded housing, water, sanitation systems, unhealthy cooking fuels and technologies, ground water contamination and solid waste, air and water pollution; traffic and related injury (Jenkins et al., 2015; Karanja et al., 2010; Prasad et al., 2015; Kulabako et al., 2010; Nyemba et al., 2010; Mudege and Zulu 2011; Musingafi et al., 2014; Bailis et al., 2005; Chalya et al., 2010; Govender, 2011; Hopewell and Graham, 2014).

b. Employment and income insecurity, with high shares of income spent on high priced food and other basic needs; consumption of poor quality food and harmful use of alcohol, tobacco and other drugs (Chesire et al., 2008; Mkupasi, 2008; dos Santos et al., 2014; Schram et al., 2013; Oyebode et al., 2015; Loewenson and Masotya, 2015).

c. Within conditions of social insecurity, crime and different forms of violence, co-existing with isolation, exclusion and power imbalances across different age and social groups and interactions with institutions (Garenne 2010; Fotso et al., 2007; Vearey et al., 2010; Mutowo et al., 2014; Loewenson and Masotya, 2015).

The review found that while health services are generally available and geographically accessible, there are cost, quality and acceptability barriers that lead to inverse care, with poorest groups using services less (Bandason 2008; Chuma et al., 2007; Fotso et al., 2009; 2013; Soura et al., 2015; Ntambue et al., 2012; Scheffler et al., 2015; Loewenson et al., 2012; Zyaambo et al, 2012). This is disrupting the continuity of care necessary for common chronic and reproductive health conditions (Saifodine et al., 2013; Kolling et al., 2010; Mberu et al., 2014). These gaps could however be closed through how services are organized and delivered.

The literature points to broad trends, but it includes less evidence on social inequalities in health *within* urban areas in ESA countries. Much of the published evidence on *within* urban area inequalities comes from demographic surveillance sites located in two settings only: Nairobi urban 'slums' and South Africa, where household data are more available (Loewenson and Masotya, 2015). From these demographic surveillance sites and from ad hoc surveys, while mother's education and wealth are commonly measured determinants of *within* urban area health inequalities, other social features were also found to be associated, including:

a. High mobility and different waves of *inward migration*, with greater insecurity, weaker social support and higher HIV risk noted in more recent migrants into cities;

b. Different *forms of residency,* not only in terms of informal settlements but also for groups living in informal housing and 'backyard shacks' or as lodgers in formal areas;

c. Living in *different areas in the city,* both for those living in peripheries and slums, and in high density suburbs historically sited in less healthy environments, where residents face new risks of epidemic disease from failed water systems and use of shallow wells;

d. *Different age groups and stages of the life-course*, including in terms of the sexual and reproductive, dietary, social and environmental risks faced by adolescents transitioning to adulthood, the risk of chronic conditions in adults and the physical and social risks of elderly people; and

e. *Different levels of formal recognition*, with those in informal settlements and employment often excluded from service and infrastructure investment (Loewenson and Masotya, 2015).

The picture presented in the literature is not a coherent one- it is rather a series of fragments of different and often disconnected facets of risk, health and care within urban areas. There is limited direct voice of those experiencing the changes. There is also very limited report of the features of urbanisation that *promote* wellbeing. Some papers point to these in the role of:

- urban agriculture in supporting food security (Boischio et al., 2006);
- schools and other facilities in promoting sports and other health promoting facilities for children (Kulabako et al., 2010; dos Santos et al., 2014);
- community health workers and supportive families enabling service uptake (Bryant et al., 2012; Bradley and Puoane 2007; Nsibande 2013);
- Increased levels of social power and autonomy in women supporting improved reproductive health (Mendenhall and Norris 2015).

Urban agriculture… near a dumpsite, Harare, SuSanA Secretariat 2011

However, evidence of the distribution of these health-promoting influences is limited within the different features of migrancy, residency, zones, age groups and formal recognition noted above.

This social distribution of health outcomes implies a need for health services and health promoting responses that are appropriate and accessible to the wide diversity of people serviced, across different areas, residences, gender, stages of life, wealth, time since migration, employment security, social power and inclusion in ways that tap into the resources, capacities and assets that exist within urban areas, and that build coherence and continuity with communities and with other sectors.

The literature was more focused, however, on the challenges than on the solutions. While this was the case, some papers reported practices that were health promoting, in:

- Regulating practices harmful to health (Matzopoulos et al., 2014).
- Appropriate technologies for urban agriculture, food security and energy (Boischio et al., 2006).
- Addressing deficits in sanitation and safe water (Van Wyk 2009; Kulabako et al., 2010).
- Using solar power for water disinfection, rainwater harvesting, cooking technologies and in
- The outreach into communities of social and other services (Kirimi 2011; Pridmore et al., 2015; Loewenson and Masotya, 2015).

In the health sector, the papers confirmed the relevance of primary health care and community-based approaches, including those involving community health workers (CHWs), participatory assessments and social media. The papers pointed to urban sites that merit greater attention in promoting public health, such as market places. The documented health interventions suggested, however, that there are weak links between primary care services and urban public health. Generally, it appeared that there are 'sectoral silos', with limited collaborative interaction or measures to build synergies across sectors. Some approaches also segmented poorer groups in small risk pools in community-based schemes, without confronting the wider imbalances in resources, power, or in sectoral practices and planning (Loewenson and Masotya, 2015).

Local councils were commonly documented to be facilitators of co-ordinated responses, and public sector (state) investment was reported to play a key role in levering community-oriented private sector innovation (Loewenson and Masotya, 2015). The papers indicate the importance of an adequately resourced public health capacity in the state to encourage and ensure the role of other sectors, including in terms of the legal obligations in public health and other laws. They also point to the need for *public health laws* to be updated to take into account urban realities and to achieve a better balance between competing goals that both affect health such as between ensuring safe microbial levels in waste water used in urban agriculture and ensuring adequate food.

Many of the papers recommended *community involvement* in policy and actions to address these urban health determinants (Loewenson and Masotya, 2015). However, few papers presented interventions that implemented and tested these recommendations, with almost no exploration of the *community assets, capacities, roles and perceptions* that inform, shape and sustain health actions, or their impact on social cohesion, solidarity, segmentation and exclusion across cities (Loewenson and Masotya, 2015). The paucity of papers on this, at least in the published health literature, suggests the need for further exploration of the health assets in urban communities, and the health promoting (and harming) ways communities are addressing the drivers raised earlier of social inequality in urban health. Such assets may include the peer-to-peer, informal support networks, information sharing and connectedness gained through social media and socially grounded approaches to promoting health.

Generally, the literature appears to chase, lag behind or miss the rapid, diverse and multifactorial changes taking place in urban areas. Participatory approaches that include the direct voice of those experiencing urban life could help to address this gap, such as with adolescents in transition to adulthood from different parts of the city; different strata of market women; informal producers; recent migrants; or lodgers/ backyard dwellers. Many of these groups are not geographically circumscribed. They are found in and interact with many parts of the city and not just the poorest localities. The literature review suggests a focus on urban youth for this voice, not only for their exposure to urban health risks, but as critical social assets for addressing those risks.

Source School building South Africa, Creative commons

4. HOLISTIC APPROACHES TO ADDRESSING URBAN HEALTH EQUITY

4.1 Holistic paradigms for urban health

The literature review suggests that a multifactorial and cross-sectoral approach, that not only focuses on risks but also on assets, may be important to tackle the social inequalities in health in urban areas. This section presents an overview of holistic paradigms for this, particularly those that seek to overcome the fragmentation of determinants and sectoral inputs that influence health, and that seek to advance health, rather than simply control disease.

Cities encompass inequalities in wealth, resources and consumption that generate challenges to public health, wellbeing and environments. The diversity of material, social and ecological deficits outlined in the last section lead to differing experiences for different social groups, including in their health. As one response, the UN Habitat proposes 'inclusive cities' to overcome this separation of living spaces, opportunities and access to quality services for rich and poor and to strengthen social inclusion in local governance (UN Habitat, 2015).

Others challenge the development discourse further. Argentinian author Atilio Boron (2015) notes that some states and social movements have rejected a linear notion of development driven by technical imperatives, particularly given the significant structural asymmetries, social deficits and inequality in the global economy. Responding to this is not simply about 'closing gaps' but about identifying alternative relationships between society, economy and environment/nature to address universal rights and strengthen human capacities, to build a more harmonious relationship with nature, to balance the liberating qualities of work and leisure, to reconstruct the public sector; and to build a democracy that is "representative, participative and deliberative in a democratic, pluralist and secular state" (Boron 2015, online).

This resonates with views of grassroots movements that have integrated local knowledge and ways of thinking about equity in these debates. For example, the 'Ecological Swaraj' in India, expresses a link between local culture and a response to current challenges to build "a holistic vision of human wellbeing that encompasses physical, material, socio-cultural, intellectual, and spiritual dimensions"… that…"... puts collectives and communities at the center of governance and the economy. Based on the twin fulcrums of ecological sustainability and human equity, the paradigm offers a systemic approach to social transformation, resting on political, economic, socio-cultural and ecological pillars…" (Kothari 2014:1).

These approaches provide a more holistic thinking about how to address social deficits that integrate principles of mutual care and reciprocity for society and for the environment. For example, this is found in Eco-ubuntu in South Africa (Tutu, undated) and in Bhutan's focus on Gross National Happiness (GNH) (GNH Centre Bhutan, 2016).

These paradigms assess the development of a society by the complementary and reinforcing interaction of psychological, physical, spiritual and ecological wellbeing, envisaging community vitality and wellbeing as something that "cannot exist while others suffer", that also comes from "living in harmony with nature, and realizing our innate wisdom..." (GNH Centre Bhutan, 2016: online).

Durban, Markus Spring, 2015

At state and constitutional levels, this holistic approach to thinking about equity is found in the 'Buen Vivir' paradigm, being applied in several Latin American countries. It seeks to depart from "development alternatives" that provide only partial adjustments to major challenges to wellbeing. Buen vivir, a term in Spanish, can be translated as 'living well', but has a wider distinctive meaning in Latin America. It is a holistic approach that seeks to challenge drivers of social deficits and inequality.

Drawing on contributions from indigenous cultures, social movements and political institutions and making linkages between multiple knowledge systems, Buen Vivir critiques the equation of progress in contemporary development with economic growth, when this is at the cost of intense exploitation of nature and significant social inequality. It focuses on basic needs, wellbeing and quality of life (material, social and spiritual) of the individual and community and integrates social rights of current and future generations, as a collective or common good and in a balance with nature (Gudynas 2011a,b).

It thus raises the importance not only of human beings, but of life as a whole, in which a citizen not only has rights, but also obligations and responsibilities. Material life is just one part of life, and cannot just be reduced to the accumulation of things and objects. The paradigm in application thus seeks to transform production towards creating wellbeing, jobs and value added and to generate wealth in a manner that does not sacrifice the wealth or health of future generations (Perez, 2012). It positions politics, rather than economics, at the centre of development strategies, with the approaches constructed for each historical, social and environmental context.

Dar es Salaam, Imke Stahlmann, 2011

These paradigms suggest changing the question somewhat in addressing urban health equity. Asking the question as "what are the determinants of health in urban areas (and how can the health sector intervene on them)?" implies a linear, deterministic focus, placing health as a singular consequence of segmented economic and other determinants that have their own competing goals and outcomes.

Applying more holistic paradigms, such as those outlined above suggest that 'wellbeing' may be a more feasible entry point for exploring and acting in a more integrated manner on the multiple urban imbalances and asymmetries that lead to social inequalities in the opportunities for health. Rather than individual risk – health relationships the question shifts to what balance (or rebalancing) of material, social and natural environments would produce wellbeing for individuals and communities.

It would be important to explore how different groups perceive and experience this question. Within areas, it may point not only to negative 'risks' but also to the capacities, innovations and interactions that make people more aware of and confident in their capacity to produce change. Across areas it may identify shared perceptions of wellbeing and the solidarity driven, city wide approaches that respond to them.

4.2 How is wellbeing assessed within these paradigms?

Some effort has been made internationally to identify dimensions of wellbeing in such holistic paradigms that may be used to assess and review progress, in quantitative, qualitative and participatory approaches. The searches described in *Section 2.2* identified twelve frameworks that include such dimensions and measures of wellbeing summarised in *Table 1* overleaf.

Table 1: Frameworks and measures identified for measuring wellbeing

Framework	Brief description
Buen Vivir (Ecuador, Bolivia) Deneulin S (2012)	Focuses on basic needs, wellbeing and quality of life (material, social and spiritual) of the individual and community, of current and future generations, as a collective or common good and in a balance with nature.
Bhutan's Gross National Happiness (GNH) index (2016)	Includes non-economic aspects of wellbeing such as psychological/physical health, education, time use, cultural diversity and resilience, good governance, community vitality, ecological diversity and resilience, and living standards.
The Happy Planet Index HPI (2016a,b); NEF (2012)	An index from 0-100 of human wellbeing and environmental impact that incorporates ecological footprint, life satisfaction and life expectancy. It ranks 151 countries on the index with the 2012 report the third round of such ranking.
Sarkozy Commission Stiglitz et al., (2009)	The 2009 Commission on the Measurement of Economic Performance and Social Progress recommended measures focused on wellbeing, including the distribution of income and consumption; quality of life (QoL) indicators; people's life evaluations, experiences, and priorities; and of sustainability; including environmental aspects.
OECD indicators of wellbeing, CIW, (2018); McGregor (2015)	Applies the Sarkozy Commission measures in several OECD countries using surveys to identify measures prioritised by citizens. The Canadian Index of Wellbeing (CIW) for example reports annually on community vitality; democratic engagement; education; environment; health; leisure and culture; living standard and time use.
Better Life Initiative OECD (2013), Pantisano et al. (2014)	Launched in 2011 by the Organization for Economic Co-operation and Development (OECD), the Better Life Initiative identifies indicators of objective and subjective aspects of natural, economic, human, and social capital dimensions of wellbeing. It involves citizens in the debate on its construction.
Eurostat 8+1 quality of life framework Eurostat (2015)	Measures wellbeing through simultaneous assessment (given trade-offs between them) of: living conditions; productive activities; health; education; leisure and social interactions; economy, safety; governance and basic rights; natural environment.
The Genuine Wealth Model Anielski M (2012)	A tool for communities to inventory the assets that align with their values and contribute most to the wellbeing of current and future generations, focused on: people, relationships, natural resources, infrastructure, and money.
The Citizen Observatory of New Indicators of Quality of Life (UrbanQol)	The European Commission Joint Research Centre (combining official data with sensor network and citizen-generated data) propose wellbeing dimensions focused on urban mobility, active citizenship, air quality, and noise, and suggested possible data sources and indicators for each of these areas.
QoL in urban Europe EEA (2009)	Reports evidence from EU cities projects on urban environment, democratic participation, cultural participation, social issues, and economic challenges.
Genuine Progress Indicator (GPI) Centre for Education Research and Innovation (2001)	Portrays progress in terms of factors that affect and sustain quality of life, integrating the value of consumption, income distribution, household work, parenting, higher education, volunteer work, services of consumer durables, highways; costs of crime, unemployment, consumer durables, commuting, household pollution abatement, automobile accidents, water, air and noise pollution; loss of leisure time, wetlands, farmland, forest area, depletion of ozone and non-renewable energy; carbon dioxide emissions; net capital investment and foreign borrowing.
UN Sustainable development goals (SDGs) UN (2016b)	Particularly SDG 11: Make cities and human settlements inclusive, safe, resilient and sustainable. Includes access to housing, transport and basic services and to safe, inclusive and accessible, green and public spaces; inclusive, sustainable urbanisation and participatory, integrated and sustainable human settlement planning and management; reducing adverse environmental impact of cities from poor air quality, municipal and waste management; supporting links between urban, peri-urban and rural areas and building sustainable and resilient buildings utilising local materials.

The table indicates that a number of these frameworks gather a range of indicators to prepare a picture of society, economy and environment as an indicator of progress. Others develop composite indicators that combine them or address the weighting between them. Some, such as the Better Life initiative, involve citizens in the dialogue on the construction of the parameter.

Across the twelve frameworks, there is relatively common agreement on the inclusion of social, material and ecological dimensions, viz:

- *Social and political:* psychological/physical health, life expectancy; education, spiritual and cultural diversity and resilience; relationships; leisure and social interactions; good governance, active citizenship; community vitality, democratic engagement; basic rights;

- *Material:* living standards; sustainable and resilient buildings utilising local materials; distribution of income and consumption; material conditions; productive or main activity; economic and physical safety; value of household work and parenting; value of higher education; value of volunteer work; cost of commuting; net capital investment; net foreign borrowing;
- *Ecological:* ecological diversity and resilience, ecological footprint; proximity to dangerous levels of environmental damage; natural environment; air quality; noise; loss of: wetlands, farmland, forest areas; depletion of non-renewable energy resources; carbon dioxide emissions damage; cost of ozone depletion; accessible, green and public spaces; social and economic costs of disasters; and
- *Other:* time use, life satisfaction; people's life evaluations, experiences, and priorities; urban mobility.

Details of the specific parameters identified in each of the frameworks for measuring different dimensions of wellbeing are reported in Loewenson and Mastoya (2018). *Table 2* below presents the dimensions of wellbeing and parameters measured that are consistently included in these diverse frameworks. Their application in different approaches and different countries globally suggests the potential relevance in applying a similarly holistic, multidisciplinary paradigm to urban health equity in the ESA region. The next section explores the extent to which this focus on wellbeing and these indicators are already included in regional databases and analyses, generally, and as a measure of social progress within and across urban settings in the region.

Table 2: Summary of key parameters identified for the different dimensions of wellbeing

Dimension	Potential measures
Psychosocial, spiritual, cultural	Perceptions of dignity, life satisfaction and meaning; access to health, education, social protection and social and cultural assets for wellbeing.
Physical health	Self-reported health status, healthy days, long-term disability and life expectancy.
Education, knowledge and culture	Capacities; national identity based on diverse identities and cultures; years of education; participation in life-long learning and integration of indigenous wisdom.
Quality of life, living conditions, services	Perceived material comfort; population density; access to housing, clean water, quality green spaces, transport and walk-about neighbourhoods; commuting time and bike-sharing scheme.
Time use	Relative time spent on: work, leisure, care and sleep. Time spent at sporting or cultural events and time volunteering.
Governance, citizenship, participation	Perception of government functions; public services; social participation/trust in government decisions; support networks; voter turnout; political party membership; civil society and cultural participation.
Economy	Perception of solidarity and financial security; distribution of h/hold income/ consumption; long-term employment; public finance; leadership and domestic resource control.
Ecology	Perceptions of quality of environment; ecological diversity; air quality; water quality; environmental damage level; ecological footprint (as in the happy planet index).
Integration across dimensions	Gross National Happiness index; Better Life Index; Happy Planet Index; 8+1 quality of life framework.

Nairobi city market graffiti, Daniel Koßmann 2014

5. MEASURING PROGRESS IN WELLBEING IN THE ESA REGION

5.1 Measures of dimensions of wellbeing

As outlined in Section 2.2, we explored data in several online databases with comparable data *across* ESA countries to assess their inclusion of the measures of wellbeing shown in *Table 2*, generally and for urban areas and youth. Where data were available across ESA countries we examined the distribution of and trends in these dimensions of wellbeing. We did not include data that were only measures in individual ad hoc surveys or a few selected countries. This section summarises the findings. Detailed information and tabulations of data are presented in a separately published report (Loewenson and Masotya, 2018).

There is limited measurement of **psychosocial, spiritual and cultural** dimensions of wellbeing in the ESA region. Indeed ESA countries largely measure the opposite of wellbeing, such as suicide, homicide and violence against women (See *Table 3*). We found limited urban data, limited time trends and no disaggregation for youth. As an indicator of support from services, the share of urban pregnant women with four ANC visits did not differ much from national averages in most countries. There was no correlation between happiness and other psychosocial indicators. Paradoxically, some countries with higher happiness rankings, such as South Africa and Namibia, also have higher levels of homicide and suicide.

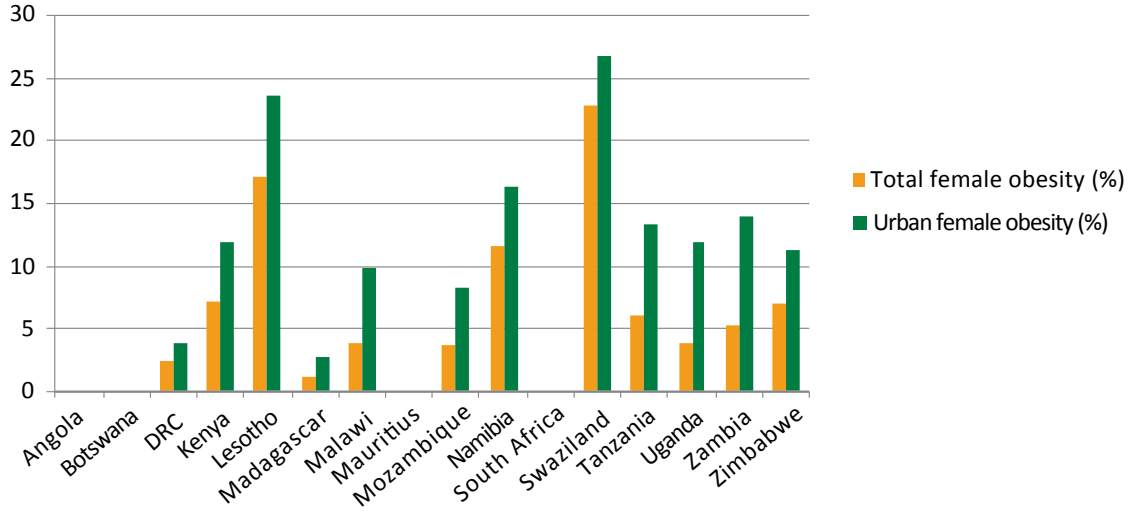
There are data on measures of **physical health** in ESA countries, including for life expectancy, healthy life expectancy, food deficits, under-nutrition and female obesity, (see full data set in Loewenson and Masotya, 2015). Healthy life expectancy rose in all ESA countries between 2000 and 2015. ESA countries do not, however measure self-reported health as is done in OECD countries and again the indicators are biased towards negative outcomes. For example, *healthy* life expectancy is assessed by taking into account years lived in less than full health due to disease and/or injury; food security is assessed through under-nutrition and food deficit.

Table 3: Data on psychosocial, spiritual, cultural dimensions of wellbeing, ESA countries

Indicator / Country	Happiness ranking out of 157 (i) 2013-15	Suicide rate/ 100 000 (ii) 2012	ANC 4th visit coverage % (iii) 2006-2013		Homicide related mortality/ 100 000 (ii) 2012	Mobile phone subscribers/ 100 people (iv) 2014	Internet users / 100 people	
			Total	Urban			2005	2014
Angola	141	10.6	na	na	10.7	63.5	1.1	21.3
Botswana	137	3.2	73.3	na	12.4	167.3	3.3	18.5
(DRC)	125	8.0	48.0	60.0	13.3	53.5	0.2	3.0
Kenya	122	10.8	57.6	58.8	7.4	73.8	3.1	43.4
Lesotho	na	5.4	74.4	80.8	37.5	101.9	2.6	11.0
Madagascar	148	7.3	51.1	68.9	8.1	38.2	0.6	3.7
Malawi	132	8.6	44.7	47.1	2.0	30.5	0.4	5.8
Mauritius	66	8.5	na	na	2.7	132.3	15.2	41.4
Mozambique	na	17.3	50.6	58.1	3.4	69.7	0.9	5.9
Namibia	113	2.0	62.5	72.6	19.7	113.8	4.0	14.8
South Africa	116	2.7	87.1	75.0	35.7	149.7	7.5	49.0
Swaziland	na	5.3	76.1	79.7	19.4	72.3	3.7	27.1
Tanzania	149	15.1	42.8	52.2	8.0	62.8	1.7	4.9
Uganda	145	11.9	47.6	55.7	12.0	52.4	1.1	17.7
Zambia	106	9.6	55.5	56.1	10.5	67.3	2.9	17.3
Zimbabwe	131	16.6	70.1	64.1	15.1	80.8	8.0	19.9

Sources: (i) Helliwell et al., 2016 (ii) WHO 2016a (iii) WHO, 2016a,b, and 1998 data for urban South Africa; (iv) UNDP, 2016; (v) UNSD, 2016. na=not available; DRC= Democratic Republic of Congo

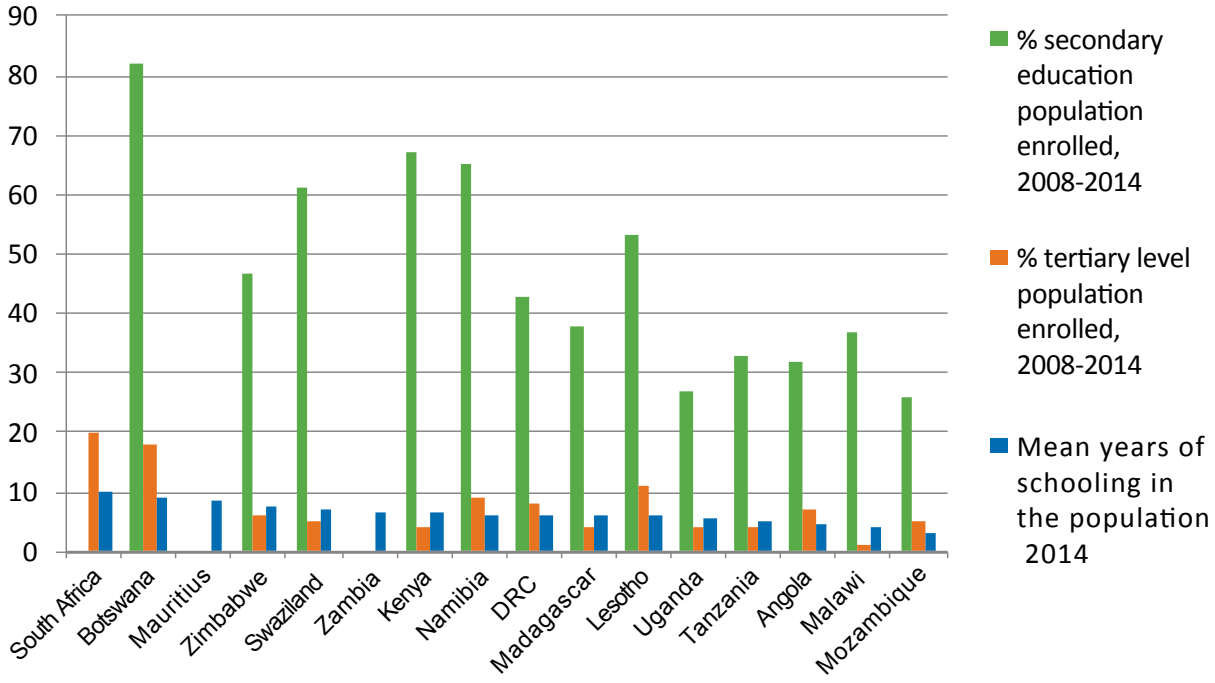
Figure 1: Urban vs. national data on female obesity 2003-2010



Source: Authors, from WB, 2016

The data suggest a strong correspondence between the food deficit and under-nutrition data. While the food deficit fell between 2000 and 2015 in most countries, it rose in Namibia, Swaziland and Zambia (UNSD, 2016; WHO, 2016a; WB, 2016; UNDP, 2016). Demographic and health survey data in ESA countries point to an association between urban poverty and under-nutrition, as reported in Loewenson and Masotya (2015). While time trends are available for these indicators, none disaggregate for youth and we only found an urban disaggregation for the prevalence of female obesity (*Figure 1*). Female obesity in urban areas was markedly higher than national levels in ESA countries (WB, 2016). There is no evident direct or inverse correlation between obesity and the level of food deficit, suggesting that a mix of factors – such as food quality and diet – may be driving the pattern in specific groups in urban areas.

Figure 2: Secondary, tertiary and total education in ESA countries



Source: Authors, from UNDP, 2016

In relation to **education, knowledge and culture,** there are no indicators measuring cultural diversity or integration of indigenous wisdom in ESA countries, although there is some intention in the SDGs to collect related evidence. The primary focus has thus been on indicators of formal education enrolment or completion, and not on quality of this measure.

Many of these indicators relate directly to young people, including youth literacy, but cross-country data are not available by urban/ rural residence (see tabulations in Loewenson and Masotya, 2018). Youth literacy levels vary across ESA countries by 34% points, highest in South Africa and lowest in Madagascar, with gender disparities generally, but not always, wider in countries with lower levels of youth literacy (UNESCO, 2016; UNDP, 2016). There is wide variation in total years of schooling, with South Africa having three times the level of Mozambique (UNDP, 2016) (see *Figure 2*). The low levels and wide differentials in secondary education and even lower levels of tertiary education indicate the disadvantage many youth in the region face in progressing on this dimension of wellbeing.

In relation to **quality of life, living conditions and services,** ESA countries measure the share of the urban population living in slums, as well as indicators for urban vs. national access to improved drinking water and sanitation. They do not measure the remaining indicators for this dimension, such as quality green spaces; transport; walk-about neighbour-hoods; or commuting time (see *Table 4)*. There is an intention in the SDGs to measure access to public transport and access to public spaces. There is no disaggregation of data for youth. The annual rate of urbanisation is projected to decline after 2013 compared to 1990-2013 levels for 7 ESA countries, although it will remain high (>3.5%) in nine countries (See *Table 4*).

Table 4: Data on quality of living conditions, ESA countries

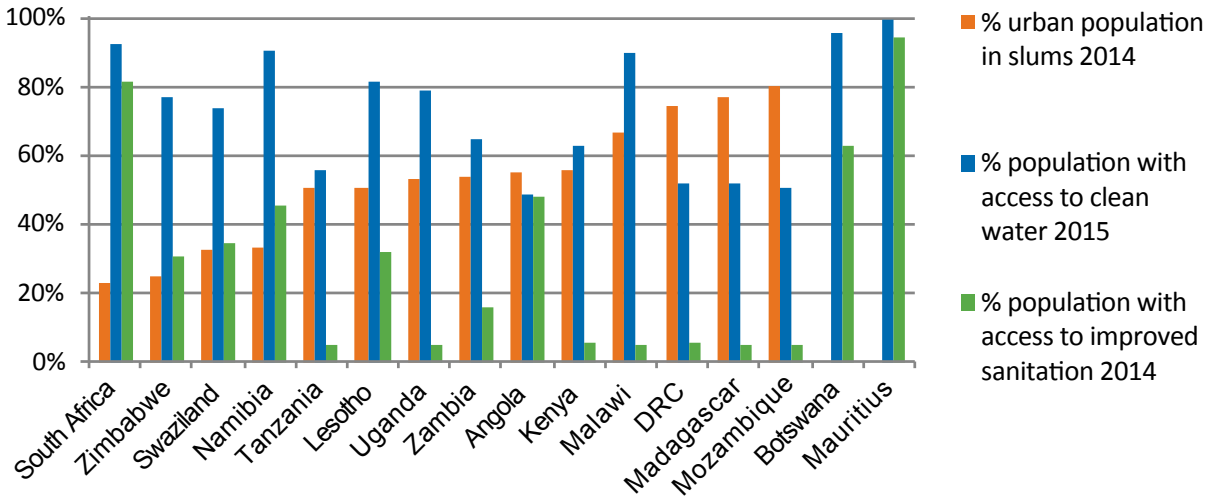
Indicator	Average annual % urban population growth (i)		% Urban pop in slums (ii)	% Pop with access to clean water (iii) 2015		<5 yr deaths/ 100000 due to poor living conditions (b)	% Pop with access to improved sanitation (iii)
Country	1990-2013	2013-2030	2014	National	Urban	2004 (iv)	2014
Angola	5.39	4.29	55.5	49	75	1266	48
Botswana	2.98	1.40	na	96	99	341	63
DRC (a)	4.18	3.67	74.8	52	81	786	6
Kenya	4.47	4.02	56.0	63	82	362	6
Lesotho	3.88	2.69	50.8	82	95	44	32
Madagascar	4.55	4.24	77.2	52	82	540	5
Malawi	3.79	4.17	66.7	90	96	617	5
Mauritius	0.31	0.21	na	100	100	7	95
Mozambique	3.83	3.50	80.3	51	81	388	5
Namibia	4.20	3.26	33.2	91	98	21	46
South Africa	2.45	1.22	23.0	93	100	104	82
Swaziland	1.30	1.58	32.7	74	94	252	35
Tanzania	4.91	4.73	50.7	56	77	322	5
Uganda	4.76	5.16	53.6	79	96	427	5
Zambia	2.75	4.27	54.0	65	86	503	16
Zimbabwe	1.83	2.32	25.1	77	97	256	31

(a) Democratic Republic of Congo; (b) poor water/ sanitation and hygiene na = not available;

Sources: (i) UNICEF, 2016; (ii) UN Habitat UNSD, 2016; (iii) UN, 2016a; (iii) WB, 2016; (iv) UNDP, 2016.

A large share of the urban population lives in slums, highest in DRC, Madagascar, Malawi and Mozambique. However, this may not be a good indicator of density, as in many countries people crowd as lodgers and tenants *within* formal housing areas. Urban areas generally have higher access to improved water sources than national averages, but this may not be the case for all urban residents. Ordering by share in slums, *Figure 3* overleaf shows that countries with high shares living in slums have reduced access to safe water and sanitation, but that the opposite does not hold. Those in formal settlements may also face challenges in access, including when these services do not function.

Figure 3: Living conditions, ESA countries



Source: Authors, from UN Habitat and UNSD, 2016; UN, 2016a

In relation to **time use,** there were no data for all ESA countries on the relative time spent on work, leisure, care and sleep, at sporting or cultural events, or time spent volunteering. Charmes (2015) reports on surveys of time use in various countries globally. For the African countries included, women were found to have less time than men to devote to social life and leisure, although the author notes that this is 'a gap that tends to diminish in urban areas'. (Charmes 2015:28). Women also spent more time working, in unpaid work and in care-giving activities than men did.

The dimension of **governance, citizenship, participation and community** includes various measures of perception and performance of public services; and participation in socio-cultural, civil and political processes (see *Table 2*). ESA countries had data on health and education service delivery and expenditure, some disaggregated by urban-rural area (See *Table 5*). *Table 5* shows that access to a skilled provider for deliveries is higher than national levels in urban areas across all ESA countries.

Table 5: Selected indicators of health and education services, ESA countries

Indicator	Assistance in delivery by a skilled provider (i) 2006-2014		% Govt expenditure on health (ii)	% Govt expenditure on education (ii)
Country	**National**	**Urban**	**2014**	**2000-2013**
Angola	55.4	82.0	5.0	5.3
Botswana	78.4	94.6	8.8	na
DRC (a)	80.7	94.3	11.1	16.8
Kenya	64.5	83.9	12.8	23.1
Lesotho	80.3	89.4	13.1	19.2
Madagascar	43.3	81.8	10.2	14.0
Malawi	73.4	85.4	16.8	20.4
Mauritius	na	na	10.0	14.8
Mozambique	56.2	80.6	8.8	19.0
Namibia	88.9	95.5	13.9	21.9
South Africa	85.5	94.5	14.2	19.2
Swaziland	75.1	89.0	16.6	18.7
Tanzania	47.2	79.9	12.3	17.3
Uganda	59.5	89.6	11.0	11.8
Zambia	67.1	90.6	11.3	8.4
Zimbabwe	65.0	84.4	8.5	na

(a) Democratic Republic of Congo, na = not available;

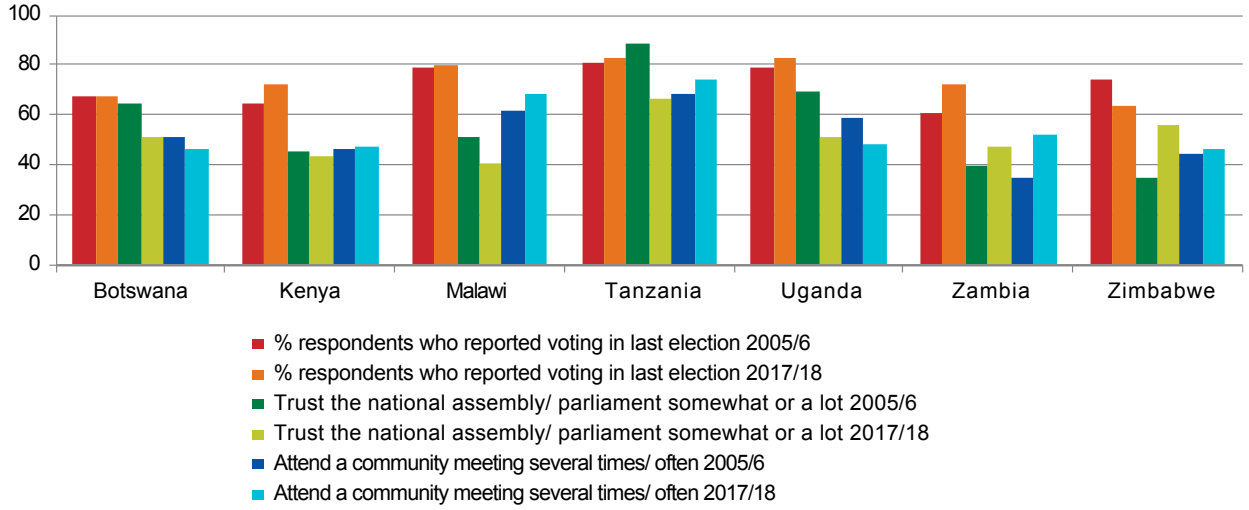
Sources: (i) country demographic and health surveys 2006-2014, except Botswana (1988) and South Africa (1998); definitions may have varied between countries; (ii) WB, 2016.

While this suggests better urban coverage, given that coverage is not universal, it is not clear which groups are not accessing these services and why. African leaders committed to 15% of total government expenditure on health as a signal of prioritisation for the sector. The data indicate that this has not generally been achieved. Health remains relatively underfunded in many ESA countries (EQUINET, 2012). The levels of expenditure on education are higher, but enrolment statistics, discussed earlier, suggest that education services and resources are more concentrated at primary school level and that access falls away at secondary and tertiary levels, affecting young people's life chances.

Data on the share of the population serviced by municipal waste collection services are collected in four countries – Kenya (40% 1999); Madagascar (18% 2007), Mauritius (98% 2009) and Zambia (20% 2005). What is less available is within area data, to show how access varies for the different urban social groups. The Afrobarometer surveys provide sample survey data for selected ESA countries on political participation and perceptions of public institutions, although not for all countries, or for time trend analysis (Afrobarometer, 2008).

Available data indicate relatively high levels of reported voting, stable across time, wide variations in reported trust in the national assembly and in civic participation across ESA countries for which data were available. In some countries (Botswana, Kenya, Malawi) these indicators have been relatively stable over time, while for others (Zambia and Zimbabwe) they have shown significant changes (Loewenson and Masotya, 2018 and *Figure 4*).

Figure 4: Time trends in governance and participation, selected ESA countries, 2005-2018



Source: Afrobarometer, 2018.

For the **economic** dimension, most ESA countries had data on shares of total income held by the lowest 20%, on the share of people below the national poverty line, and on tax revenue as a share of GDP. Of importance for this work, neither urban poverty nor poverty in youth were disaggregated in the databases (see *Table 6*). ESA countries do not collect evidence on positive measures (reported perceptions of financial security; long-term employment; or levels of domestic resource control).

The data indicated a wide variation in poverty in ESA countries, although with more than half the population below the national poverty line in 9 of the 16 countries. There was no clear trend across time in the indicators, with high variability across ESA countries. For example the level of tax revenue in GDP, and thus funds for public spending on services and investments that support equity, had no evident relationship with poverty levels, suggesting that other factors, such as the quality of spending, employment levels and social conditions also matter in this.

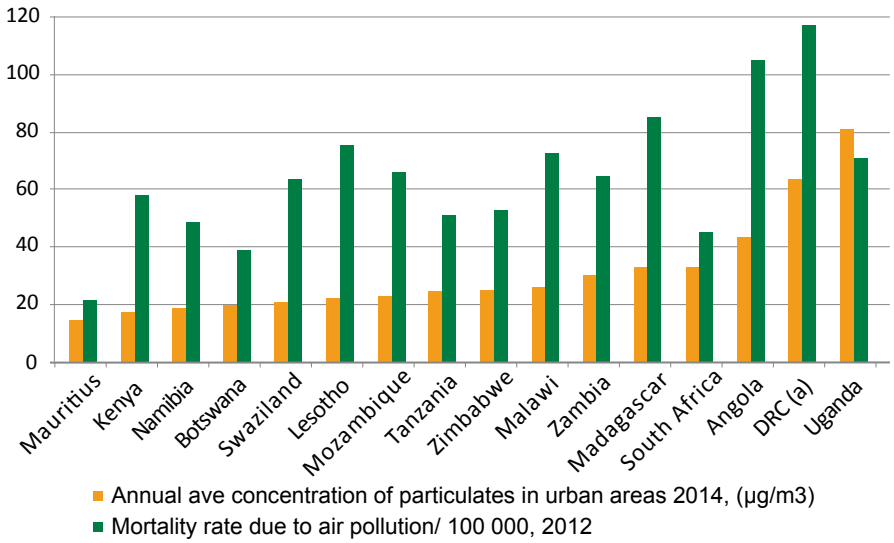
Table 6: Selected indicators of economic wellbeing, ESA countries

Indicator	Income shares of total income held by the lowest 20% (i)		% pop below the national poverty line (i)	% Youth unemployed (ii)	Tax revenue as % GDP (iii)
Country	**2000-2002**	**2008-2012**	**2004-2014**	**2014**	**2005-2013**
Angola	3.2	5.4	na	na	18.8
Botswana	2.3	2.8	na	36.0	27.1
DRC (a)	na	5.5	63.6	na	8.4
Kenya	na	na	45.9	na	15.9
Lesotho	3.0	2.8	57.1	34.4	58.7
Madagascar	4.9	6.5	75.3	2.6	10.1
Malawi	na	5.5	50.7	8.6	na
Mauritius	na	7.4	na	23.2	19.0
Mozambique	5.4	5.2	54.7	39.3	20.8
Namibia	na	3.3	28.7	56.2	23.1
South Africa	5.4	2.5	53.8	51.4	26.5
Swaziland	3.1	4.0	63.0	na	na
Tanzania	6.8	7.4	28.2	5.8	16.1
Uganda	5.9	6.1	19.5	2.6	13.0
Zambia	6.1	3.8	60.5	15.2	16.0
Zimbabwe	na	na	72.3	8.7	na

(a) Democratic Republic of Congo, na = not available; *Sources:* (i) UNSD, 2016; (ii) UN 2016a (iii) UNDP, 2016.

The dimension of **ecology** is relatively well monitored. There are data on the level of biodiversity, the share of terrestrial and marine areas that are protected, air quality in urban areas, mortality levels due to air pollution; natural resource depletion; CO2 emissions and proportion of population with primary reliance on clean fuels. This is a relatively rich dataset on ecological wellbeing (presented in more detail in Loewenson and Mastoya 2018). However, it is not disaggregated to provide urban data and the data are for more recent years, limiting trend analysis.

Figure 5: Air pollution and pollution related mortality in ESA countries



Source: Authors, from UN, 2016a; WHO, 2016a

There is wide variation in these ecological indicators across ESA countries. They generally indicate worryingly low levels of biodiversity potential and relatively high levels of urban pollutants. Seven ESA countries had particulate levels above the 25 µg/m3 standard. *Figure 5* shows the strong association between air pollution and related mortality levels, indicating the growing health risk for urban communities. Of concern, given this, is the low share of the population that uses clean fuels, below 20% of the population in eight ESA countries (Loewenson and Mastoya 2018).

5.2 Integrated measures of wellbeing

Various integrated indicators of wellbeing bring some of these measures together (*Table 7*). Of these, only the Happy Planet Index (HPI) and the Happy Planet Wellbeing Index (HPWI) are reported in ESA countries, and the inequality adjusted human development index (HDI) measures some areas of wellbeing. There were no clear relationships between the HPWI and specific wellbeing indicators. The findings suggest that these combined indexes may have limited value in building an understanding of the multifactorial nature of urban wellbeing.

Table 7: Integrated indicators of wellbeing, ESA countries

Indicator	Happy Planet Wellbeing Index (i) (b)	Happy Planet Index (i) (c)	Inequality adjusted HDI (ii) (d)
Country	**2016**	**2016**	**2014**
Angola	na	na	0.335
Botswana	4.8	16.6	0.431
DRC (a)	3.9	18.8	0.276
Kenya	4.5	24.2	0.377
Lesotho	4.9	16.7	0.320
Madagascar	na	na	0.372
Malawi	4.3	22.1	0.299
Mauritius	5.5	27.4	0.666
Mozambique	5.0	23.7	0.273
Namibia	4.7	21.6	0.354
South Africa	5.1	15.9	0.428
Swaziland	4.9	15.5	0.354
Tanzania	4.0	22.1	0.379
Uganda	4.3	19.4	0.337
Zambia	5.0	25.2	0.384
Zimbabwe	5.0	22.1	0.371

(a) Democratic Republic of Congo, na = not available; (b) Wellbeing (Happy Planet Index) Wellbeing: How satisfied the residents of each country say they feel with life overall, on a scale from zero to ten, based on data collected as part of the Gallup World Poll; (c) Happy Planet Index: measure of wellbeing x life expectancy x inequity of outcomes divided by ecological footprint; (d) The IHDI combines a country's average achievements in health, education and income with how those achievements are distributed among country's population by 'discounting' each dimension's average value according to its level of inequality. *Sources:* (i) HPI, 2016; (ii) UNDP, 2016.

5.3 Limitations in the disaggregated assessment of wellbeing in ESA countries

As indicated by the summary of the findings in *Table 8* below, ESA countries face a challenge if they seek to track progress in the multiple dimensions of wellbeing or to build an understanding from the quantitative data gathered. There are no data across the sixteen ESA countries for many measures of a more holistic approach to wellbeing. The indicators that are measured are more commonly those of negative rather than positive wellbeing outcomes. This turns the focus away from the assets in society. It points out where the problems are, but not the progress in achievement of positive or affirmative goals. Yet health is not only the absence of the problem (disease), but is the attainment of (mental, physical and social) wellbeing. Where data do exist, the definitions may vary across countries and the evidence is poorly disaggregated to show separately the position in urban areas or in specific social groups. While it is possible to assess inequalities quantitatively for a limited range of indicators collected in household surveys, it would be incorrect to equate these indicators with the range of factors affecting the distribution of urban wellbeing,

Finally and importantly, the subjective views of people on their life satisfaction do not always match such measured data. Nor can a holistic view of the many dimensions of wellbeing be coherently captured in composite indicators. As others have suggested, quantitative 'number' may be a less successful way of building this holistic picture of the interaction between what are already complex features of wellbeing, or show where the priorities and deficits are (Saisana, 2004).

Qualitative evidence may thus provide a richer understanding of wellbeing. This calls for local work and capacities to gather and use a mix of methods and evidence in planning for urban wellbeing, including the direct evidence from people's lived experience to interpret, validate, add to, or even challenge quantitative data. This is perhaps even more important in ESA countries, where, as shown in this report, the datasets are more limited and exclude many indicators of wellbeing that have relevance to urban health equity. The next sections report on the evidence raised in the subsequent stages of appreciative inquiry and participatory validation in this work.

Table 8. Availability of data on different dimensions of wellbeing, ESA countries

Area of wellbeing	Parameters for which		Level to which indicator has		
	ESA data exist	No ESA data exist	ESA data	Urban data	Youth data
Psychosocial; spiritual; cultural	Access to health, education; social protection; social assets for wellbeing; happiness	Perceptions of dignity; life satisfaction and meaning; cultural assets for wellbeing	Moderate	Weak	None
Physical health	Healthy days; long-term disability; life expectancy, food security	Self-reported health status; long-term disability	Fair	Weak	None
Education; knowledge and culture	Years of education; participation in life-long learning	Capacities; national identity based on diverse identities and cultures; integration of indigenous wisdom	Moderate	None	Weak
Quality of life, needs; living conditions; services	Density; access to housing; clean water; sanitation	Perceived material comfort; quality green spaces; access to transport; walk-about neighbourhoods; commuting time; bike-sharing scheme	Weak	Weak	None
Time use	Relative time spent on: work; leisure, care, learning	Time spent on sleep. Time spent at sporting or cultural events; Time volunteering	Moderate	None	None
Governance; citizenship; participation; community	Public services	Perception of govt functions; social participation/trust in govt decisions; support network; voter turnout; political party member-ship; civil society participation; cultural participation	Moderate	Very weak	None
Economy	Distribution of h/hold income/ consumption; (youth employment); public finance	Perception of solidarity, financial security; long-term employment; domestic resource control	Fair	None	Weak
Ecology	Perceptions of quality of environment	Ecological diversity; air quality; water quality; environmental damage level; ecological footprint	Good	Weak	None
Integration across dimensions	Gross National Happiness index; Better Life Index; 8+1 quality of life framework	Happy Planet Index; Human and gender development index	Moderate	None	None

6. PRIORITIES FOR AND RESPONSES TO WELLBEING IN URBAN YOUTH

This section presents the findings of the iterative stages of participatory validation with youth from six different social groups in Harare and six different groups of youth in Lusaka, as described in Section 2.3. Separate reports provide detail on the participatory methods used and the discussions and evidence, including visual evidence for each stage presented here (TARSC, CFHD 2018; LDHO, TARSC, CFHD 2018). This paper presents a summary of a rich body of information. While this loses some details of the young people's stories, the paper nevertheless captures key points and insights from the participatory process.

6.1. Understanding of and priorities in health and wellbeing

All six groups of young people in Harare and Lusaka had a more narrow definition of health than of wellbeing. In both cities, they said that *health* refers more to physical and mental wellbeing and absence of disease and has been identified with the medical profession and services, As noted by Lusaka youth "…being in a good physical state, care of our bodies".

Wellbeing was seen to incorporate many other psycho-social, economic, environmental features in young people's daily lives, as raised in Lusaka "… having a good and quality state of living, and all the necessities of life". In Harare and Lusaka the areas identified with wellbeing included education, cultural choice, living conditions and environments (especially shelter, water and sanitation), adequate and balanced food and diets, secure jobs and incomes, having a balance of time between work, leisure and family and participating in government decisions. Even in contexts of economic insecurity, young people in Harare reflected that these often-ignored aspects are important for their current and future wellbeing.

In the discussion in both cities it was noted that improving wellbeing calls for more than health services, but also calls for health services and communities to advocate for improvements in these other conditions that affect health.

There were debates between the youth within and across the groups: How relevant is culture, and whose culture? Does wellbeing rely more on the ability to get a secure job or the ability to create one's own employment by starting enterprises? "Green spaces support social interactions and mental wellbeing, but we don't have time to take advantage of them". How much time should people have to invest in participating in government decisions?

The separate group sessions held in Harare provided evidence of variations in the perceptions of different social groups. The groups with higher levels of income security, as outlined in *Section 2.1*, gave more emphasis to personal features, such as self-determination, self-esteem and a positive mental attitude. Unemployed youth emphasised enterpreneurship over secure jobs and youth from Epworth, an informal settlement, emphasised shelter as the most critical priority.

Clearly their socio-economic context youth makes certain issues more immediate for them. At the same time, all six Harare groups saw having secure incomes, education, participation in government decisions and shelter as very important for their wellbeing, suggesting that these concerns are shared and city-wide amongst youth.

In both Harare and Lusaka, similar priority dimensions were identified for their *current* wellbeing in the ranking and scoring, shown in *Table 9.* Mental wellbeing was prioritised in both cities, with young people facing stress from their situations and relying on peers, rather than services for support.

Table 9: Harare and Lusaka youth priorities in health and wellbeing

Most important for your wellbeing now		Most important for youth in 10 years time	
Harare youth	Lusaka youth	Harare youth	Lusaka youth
a. Secure jobs and incomes / entrepreneurship b. Education c. Participatory democracy (*) d. Living conditions e. Positive mental attitude	a. Secure jobs and incomes / entrepreneurship b. Education c. Participatory democracy d. Social and mental wellbeing e. Living conditions	a. Economy/ incomes/ entrepreneurship b. Education c. Shelter d. Participatory democracy e. Green spaces f. Positive mental attitude	a. Participatory democracy b. Environment c. Economy / jobs / entrepreneurship d. Education e. Time use f. Living conditions

(*) refers to participation in local and central government decisions

However, youth in the two cities differed somewhat in their thinking about the way their cities were generating or solving challenges for the future. In Harare, youth, especially those from the more insecure situations of informal settlements and unemployment, envisaged that as the city grew, it would become more competitive and overcrowded, demanding even more on young people's capacities for innovation and entrepreneurship. Housing would become even more difficult to access.

Informal market in Harare, The Advocacy project 2018, under creative commons license

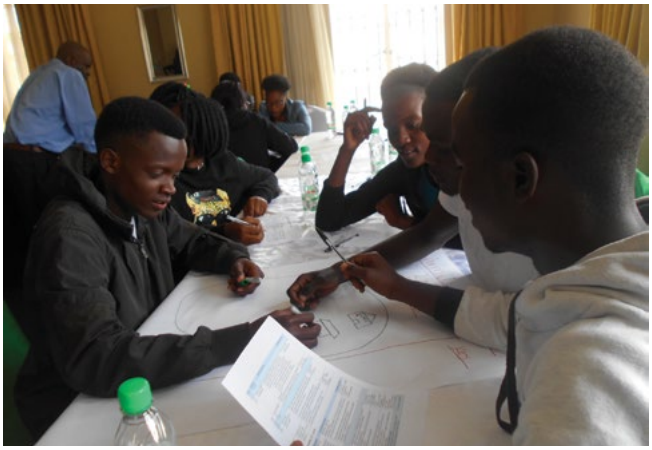
The view gave a sense of a diminishing, rather than an increasing level of social solidarity with urban population growth. In Lusaka, the youth saw the same urban crowding as threatening and adding pressure to the natural resources, such water and green spaces, and that this would increasingly affect wellbeing.

In both cities addressing these issues implies planning at local and central government levels. However, in both cities although the youth felt that it was *their* health and wellbeing that would be affected by the current urban planning, they perceived that they could not easily access these planning processes or that their views were not taken seriously. In both cities, education was seen as one potential vehicle for reaching and integrating young people in such dialogue on urban planning.

6.2 Social mapping of the contributors to health and wellbeing

In both Harare and Lusaka, within their social subgroups, the youth drew social maps of their own home areas or the city centre, with the features of their environments and activities that are promoting (in red) or harming (in green) health and wellbeing.

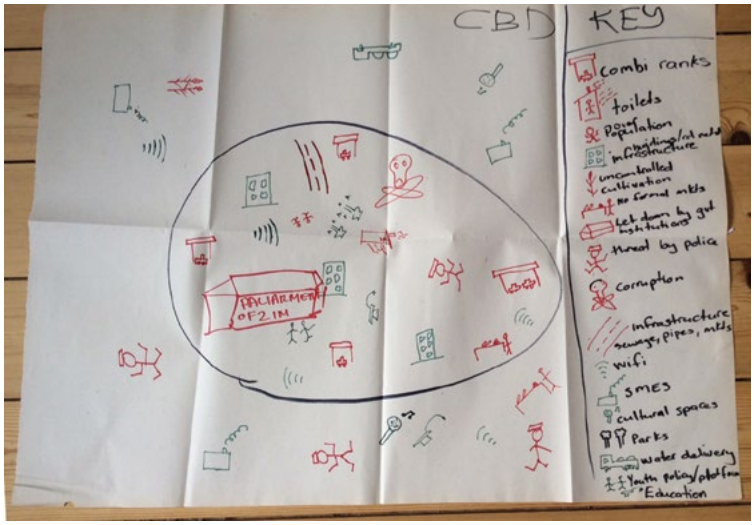
The separate reports of these two urban processes in TARSC and CFHD (2018) and LDHO, TARSC and CFHD (2018) present all the visual social maps and the discussion on them in some detail. An example of the social maps is shown overleaf.



Drawing the social maps in Lusaka, S Zimbeva, 2018

This section summarises the common and different features of factors affecting health and wellbeing identified in the social maps.

There were common features across all the Harare social maps enabling or impeding health and wellbeing.



Social map by youth from Northern suburbs, Harare. TARSC, 2016

- Many **schools** were present, as a positive factor. However, the schools were also noted to have few places, to be costly and to not always provide quality or relevant education. Informal schools may improve access, but may also lead to poor education for those attending them. As education is important, the groups felt that the state should subsidise access as a duty and avoid the privatisation of education. Interestingly health services were not commonly raised in Harare.
- All areas had **social infrastructures** such as churches, cultural and leisure activities and sites, and for the university, library, computers, lecture theatres and sports fields. Epworth youth noted for example the growth in religious and cultural activities, with street theatre and a 'pasa pasa' music festival in their area. However, while these activities could provide economic opportunity and support mental and social wellbeing, it was observed that they do not get investment and that youth are often rely on more harmful forms of recreation, including harmful alcohol and drug use.
- **Economic activities** such as vending, local brickmaking, housing schemes, sale of local nutritious foods such as peanut butter were found in all areas and were seen to promote incomes and address needs. However, these activities also sell unhealthy products, such as unwashed fruit, and there are many unregulated, temporary sites across the city. This was seen to call for the council to engage vendors and for more investment in the local economy to make a link with economic activities and social needs, such as between local construction and brick making and the shelter that people need. Yet these activities were seen to be controlled and in processes that are neither transparent to nor inclusive of young people.
- Access to **IT and social media** was seen to strongly promote wellbeing for many groups, as it facilitates information flow for work, cultural and social interactions. Internet has been used for e-applications for Grade 7 school places, although possibly with some bias towards those wealthier groups with easier internet access. Cellphones have also been used to send or receive money and to make payments at a time when cash is difficult to obtain. However, Harare youth say they face various barriers to accessing IT. For example, free Wi-Fi is often found at fast food restaurants and not at sports fields, public services, public libraries, museums and parks. This means that young people congregate at fast food places, with negative dietary consequences.
- **Transport infrastructures** were seen as an asset, but with poor, pot-holed roads, noise, poor safety, overcrowded and disruptive pickup points (ranks), abusive marshals (touts) for kombis, and littering and waste in public spaces. Residents in some areas have contributed money for young people to fix potholes. One person noted: "A group of university graduates joined to do street sweeping in first street in their graduation attire while singing about unemployment… sadly they were arrested as a public nuisance!"
- Wellbeing was visualised as being promoted through **places where youth views can be expressed,** such as in interactions with the council, ministries, and through bodies like the students councils. While the mechanisms are there, the youth noted that the hearings are not well publicised and that representative bodies do not adequately inform, consult or represent them.

Delegates discussing the social charts in Harare © T Loewenson, 2017

There were also some issues specific to particular groups: Unemployed youth and those in informal employment observed that the police and council should be protective but often are not, do not perceive youth as having any credible views and that the youth themselves lack information. Instead of processes that build co-operation and positive relations, they said that "…the interaction often only comes at a point of conflict, like at a road block or when a policy is imposed". Youth in tertiary education remarked that male and female students are vulnerable to wealthier adults using them (for boys to organise access to girls, and to pick up female students) with sex exchanged for money used for living expenses. Youth in the higher income Northern suburbs noted that while they benefit from university and other training in entrepreneurship, there is not adequate support or capital thereafter to apply the skills learned, or provision of adult learning opportunities, such as in apprenticeships and through online platforms.

Harare is a city where people are exercising local initiative to enhance their individual and social wellbeing, even in the face of economic and socio-political challenges! Sometimes these challenges are motivating new developments, such as the switch to gas and solar energy due to electricity shortages. Social networks are important in difficult environments, as the youth noted from their observations of their areas: "One woman pointed out how psychologically refreshing it was to walk from A to B and be greeted and converse with fellow residents as everyone knows everyone".

A poorly functioning public sector was seen to be taking a toll on optimism. In contrast, when states reinforce social assets, it was reported to stimulate trust and self-confidence: "Government schools connect more with parents than private institutions, and this makes parents feel more assured about the safety and quality of the school environment".

Similar issues were raised in Lusaka, with public infrastructures (schools, post offices), greater note of clinics than in Harare, social institutions (churches, entertainment grounds, youth friendly corners at services with free internet) and commercial services seen as positive contributors to wellbeing across the youth in the city. Many groups raised poor drainage and uncollected garbage as significant risks for wellbeing, creating a situation where children can pick food from the dumps risking their health. As in Harare, the Lusaka youth complained that bus stations harboured unruly people managing passengers.

While many of these were youth, giving them some employment, they are harassing other youth passengers, harming the wellbeing of both. They also complained of air pollution from factories and traffic; markets with no sanitation; and inadequate space for small enterprises, pushing vendors on to main roads, increasing their own and others' risk of traffic accidents.

The social maps in Lusaka showed visually the greater presence of health promoting green spaces, social and public facilities in higher income suburbs, and the greater presence of negative features in the poorer suburbs. This generates vicious cycles where youth in environments with poor public infrastructures and spaces and limited economic opportunities carry out risky activities, such as harmful alcohol use, or work in damaging conditions and ways, sometimes harassing people, that harm their own wellbeing and that of other youth. As in Harare the Lusaka youth saw that these social inequalities were matters for collective, public and state response.

6.3 Questions raised by youth for follow up

The discussion on the above factors across the different settings suggests that improving youth wellbeing in Harare would at minimum need to address:

- The extent to which the content, organisation of and access to education and information, social media, economic resources and investment support young people's need to access secure jobs, and also create economic activities that can provide steadily improving incomes.
- The opportunities young people have to access housing / shelter in clean and secure, violence free environments, public services and public spaces.
- The measures and access to information that build youth self-esteem and supportive networks.
- The opportunities for youth to discuss, build and communicate collective proposals for policies and services that concern them, and to be heard and integrated into decision making by authorities.

Given these conditions, priorities and experiences, the Harare and Lusaka youth collectively were interested to learn how these issues are being tackled in other cities globally, including by young people. In particular their questions were:

1. **On education:** How is access to education being supported? How are youth involved in shaping the education curriculum, content and systems? What social grants are there for health and education for young people to protect access and how does this work?
2. **On job creation:** What measures support job creation for youth, in what areas?
3. **On enterprise creation:** How are economic activities and youth entrepreneurship being stimulated, invested in with loans/capital and other resources, and encouraged?
4. **On the creative and green economy:** How is the creative and cultural economy being developed and organised to support youth employment, including through social media? What economic activities are youth doing in sport, in the creative economy and the green economy? What initiatives are underway to improve public spaces and green environments, reducing air pollution and eliminating dumped and uncollected waste?
5. **On shelter/social conditions:** How is youth access to shelter / housing being organised and supported, including through social housing? What facilities are in place for a non-violent enabling community environment for young people?
6. **On information and communication within youth:** How are youth influencing debates, norms and practices relating to issues important for them, such as gender equality? How is social media being used? How is solidarity being built across different groups of urban youth, including for improving mental health?
7. **On participating in government decision making:** How are youth issues raised locally to nationally? How are youth influencing decision making on economic and social policies, investments and programmes?

7. APPROACHES TO IMPROVING AND CLOSING GAPS IN URBAN WELLBEING

The literature reviews and statistical analyses in the prior sections and the participatory validation by the Harare and Lusaka youth identified a number of areas that would be important to improve current and future urban youth health and wellbeing. They are areas that were raised by youth across a diversity of settings and levels of income, suggesting a potential for support from higher income groups for universal approaches that reach the diversity of groups in the city and that integrate the voice and agency of youth:

1. **Education** and ensuring access and responsiveness of the curriculum to youth needs.
2. **Job creation** and measures to support job creation for youth.
3. **Enterprise creation** and support of health-promoting youth entrepreneurship.
4. **The creative and green economy**, how it is being developed and organised to support youth employment and wellbeing.
5. **Shelter/social conditions**, including youth access to shelter and non-violent enabling community environments.
6. **Information and communication,** how youth are influencing debates, norms and practices and using social media to promote wellbeing, gender equality and solidarity.
7. **Participatory government** and youth influence on decisions affecting wellbeing.

As a form of appreciative inquiry, we searched specific practices being applied in other countries globally to address these areas, as described in *Section 2.3.* We explored the features these concrete practices demonstrate, and used them to engage the youth in Harare and Lusaka. They are compiled in detail in a separate 'ideas book' (Loewenson and Masotya, 2017). This section highlights key features of the practices, experiences, tools and e-resources found. It took some searching and screening to locate them, and could be useful to have an online portal where people, including young people, can locate and connect to such resources more easily. Photographs and videos give direct representation and voice for those involved, and were a powerful means to show directly the realities and experiences. The summary below presents extracts of evidence, with links to websites where available, to exemplify issues and areas of work. Evidence from **monitoring and evaluation** of their outcomes or impact was limited, and is an area that appears to be important to strengthen.

7.1 Diverse interventions with cross cutting benefits

Interventions in other countries addressed a range of dimensions of wellbeing, whether material (such as shelter and sanitation), economic (such as resources and income), social (such as skills building, violence prevention or participatory planning) or personal (such as strengthening security and voice).

Box 1: Participatory Urban Planning in Kenya

For example, the Building in Partnership: Participatory Urban Planning (BiP:PUP) project implemented by Practical Action-East Africa in partnership with the Municipal Council of Kitale (MCK) and community members in three informal settlements implemented participatory surveys and used participatory planning to implement joint work on security of land tenure, improved service provision, including for water and sanitation, access to micro-credit and skills for small enterprises, construction of springs, wells and new boreholes and other improvements to living and social conditions (See for example a video on the work)

Source: Okello et al. 2008; Chege and Majale, 2005

Many address several dimensions of wellbeing, both material and social, with cross cutting benefits. For example, they build shared organisation and networking together with social skills in the process of addressing material issues; embed measures to promote access to education within nutrition interventions, or tackle issues such as environment and food security jointly. The Building in Partnership: Participatory Urban Planning (BiP:PUP) project adjacent reflects this place or area based approach, bringing multiple interventions within a local government area.

As a further example of this area-based approach to address multiple deficits affecting wellbeing, the Honduras Barrio Ciudad project was implemented to address high levels of homicide and youth violence in certain urban areas in Honduras. The high level of violence were attributed to inequity, unemployment, lack of public services, disintegrated families, gender-based violence and child abuse, drug abuse, school drop-out, and the availability of firearms. In marginal neighbourhoods in seven municipalities, crime and violence components were developed with the communities for:

- situational prevention – preventing crime through environmental design and urban renewal,
- capacity building – through training and technical assistance in multi-sectoral crime and violence prevention, including community crime mapping and diagnostics and community safety and monitoring, and
- complementary investments, such as municipal plans and grant funds for infrastructure and programmes for community safety.

Youth developed insecurity maps and conducted walkthroughs of hot spots at night with the community, to inform crime and violence prevention plans (Gamero, 2010).

7.2 Building visibility, voice and relationships

Many of the processes address a demand for visibility and voice, sometimes in contexts where there has been conflict between communities and authorities over conditions. For youth in informal settlements, in education institutions, and those who are unemployed and homeless, these processes provide a vehicle to demand recognition that 'we are here, study here, or live here', to generate confidence to assert their rights and change how others perceive their conditions.

For example, Voices of Youth in Chicago Education (VOYCE) is a youth organising collaborative for education and racial justice led by students of colour from six community organisations across Chicago. Student leaders set it up in 2007 to address inequities in quality, practices and safety of education services. Driven by the belief that those most affected by educational inequities – the students themselves – hold the solutions to improving the system, 250 youth leaders engaged over 350 000 students in online surveys and action research on a range of areas, including exclusionary discipline practices, investment in social/emotional supports and more effective approaches to school safety. They use this evidence to engage and plan changes with school authorities on these issues (VOYCE, 2011).

The processes build relationships between young people. They also connect young people with others with whom they need to interact, but with whom they may not have had an existing connection. These include local authorities, urban services, administrative and technical personnel, artists and different community leaders, some of whom took part in prior activities in their youth.

Processes such as the youth participatory budgeting, Joven de Rosario (PPJoven) in Rosario, Argentina, shown in *Box 2* overleaf, not only sought to bring youth voice into budget planning, but to do so in a way that would strengthen capacities of and communication between youth across the neighbourhoods of the city, increasing their understanding of each other's needs and supporting solidarity between them.

Box 2: Youth participatory budgeting

The youth participatory budgeting, *Joven de Rosario* (PPJoven) in Rosario, Argentina, began in 2004, raising the active participation of young people 13-18 years old in the budget process as a group traditionally excluded from the decision-making process. Participation is free and open to all of youth in the neighbourhoods of Rosario. The work process begins with a first round of assemblies. Between three and five assemblies take place in each district, diagnosing problems in the neighborhood from the youth's perspective, and on what needs to be done to improve their quality of life and recognise their rights and obligations as citizens. Male and female youth councilors are elected to a Youth Participatory District Council, a permanent forum that systematises the demands made by their peers, identifies the state and other responsibilities to address them and present projects to address their issues to the city mayor and the municipal cabinet for their technical and financial evaluation. Three months later, in the second round of assemblies the delegates give feedback on the district project presentations and inform others on what the Council has achieved. All youth in each district participate in this assembly, the youth discuss and prioritise which project(s) can be effectively completed with municipal officials. After this, the municipality integrates these elected priorities for the youth, while the youth review and assess the experience. A video shows the 2017 process. The municipality has selected 103 youth proposed projects and assigned 4,200 mn pesos in the budget in total.

Source: Fletcher and Smith, 2016

7.3 New practices link to local ideas and familiar settings

The participatory youth-oriented dialogue and capacity building within municipal budget processes, such as in the Rosario, Argentina case above, is one example of taking a common process, budget planning, into the community setting affected by it. As in this example, innovative practice often involves modification of something already in place to make it work for marginalised communities. As another example of this, the Equity for Tanzania loan scheme provides equipment rather than cash to address equipment needs in low income communities that lack collateral. After approval, the fund pays the supplier directly for the equipment purchase and delivery to the customer. Customers then make repayments to the fund over three years (EFTA Ltd, undated).

Box 3: 'Know your city': evidence by slum dwellers

Slum Dwellers International (SDI) is a network of federations in 33 countries that exchanges the shared realities, knowledge, aspirations and values of those growing up and living in slums. 'Know your city' SDI databases are some of the largest, publicly available databases on informal settlements in the world. The data are collected by SDI members and used to negotiate visibility and improvements by local slum dweller movements. For example, the Kenya Slum Youth Federation collects this information to give a presence to people otherwise invisible in formal records and to secure land tenure and services (Makau 2011).

As the VOYCE work above also demonstrates, online methods and social media provide new opportunities for communities in vulnerable settings to make connections, share information and advice or organise and discuss evidence on their experiences within and across cities. Information technology has been used to support participatory planning through online mapping and surveys, such as the example of the VOYCE and *Slum dwellers international* described in *Box 3.* above). Online methods have been used to facilitate crowdfunding of large funding needs by a large number of small, people's contributions, such as the *Luchtsingel infrastructure* in Rotterdam (ZUS 2015), described later, for young people to generate and model ideas for urban improvement or new enterprise without high costs. Another example is Spotholes in Boston, where people report potholes for road repair for local government accountability on its services.

Internet and social media provide a resource for raising the visibility of urban social conditions, for organising evidence and sharing information. They complement and do not replace more direct participatory processes, however. Many of the approaches build innovation around local ideas, practices and resources. Through participatory approaches they bring local experience, ideas and resources to the table and build on this to set and implement shared plans. The Human City project, for example, located in an informal settlement of Port Harcourt, Nigeria is one of many examples of such practice. Initiated to help excluded communities halt illegal demolitions, it has developed as a means for them to gain a place in the planning and politics of their city. The interventions were identified and designed with the community, including a floating 'Chicoco' radio station and 'Chicoco' inflatable cinema, a People Live Here' multi-platform media campaign, a building and planning element where residents voice their visions for the future, detail it through maps and action plans, display it in public spaces, and carry out rights-based action and research, awareness and litigation (CMAP, 2016; Forbes, 2012).

Human City Project Cities Alliance Presentation CMAP 2016

7.4 Raising social dimensions of and social resources for wellbeing

The innovations often give more prominence to social dimensions, such as the recognition in the Human City project of a radio and film intervention to respond to the community's desire for social debate and networking, or in the Green My Favela project, described in *Box 4,* of the role of desirable public and green spaces to support food security and incomes and to build shared and respected spaces for community interactions. They recognise, as in the case of CuidArte in Chile, the important link between social processes and art to awareness and public support for and input to therapeutic, educational, recycling and other service and material interventions. They also engage people's creativity and curiosity, such as the *Pulse of the City* art installation to check blood pressure in Boston.

Box 4: Green My Favela, Brazil

Green My Favela (GMF) is an environmental regeneration project located in the favelas (informal settlements or slum communities) of Rio de Janeiro, Brazil to reclaim degraded land and to create more productive green spaces inside favelas. Favela residents agree on what is possible through collaborations with individuals, families, NGOs, schools, the private and public sector and with social innovators to remediate neglected and abused land; cultivate nutritious crops; and make more productive, environmentally responsible, and desirable public space. The gardens create clean spaces and improved safe water supplies, they reduce pests and provide some income from food grown and sold locally.

Source: Green My Favela, 2014.

There are many examples of mechanisms and spaces that provide an enabling environment for youth to bring their ideas and views forward. These are youth-specific and youth-controlled spaces, (such as in VOYCE in Chicago, or *Innovate Kenya,* a non-profit network empowering Kenyan youth to solve pressing challenges in their local communities. Having their own space enables young people to articulate and build evidence around their issues. This appears to strengthen youth confidence to take these issues into formal platforms, such as in the campaigns of the Urban Youth Collaborative, where New York City students successfully engaged on education reforms.

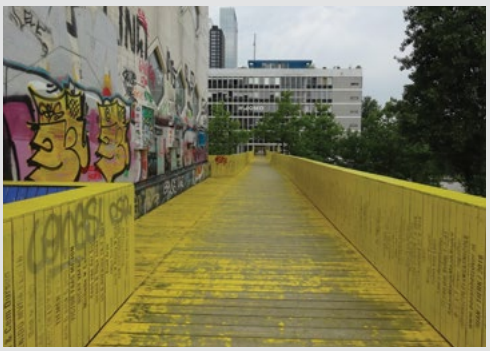
In many cases, the youth are themselves the resources in the process. In the Promoting Access to Community Education (PACE) programme in Kenya, for example, high school graduates are teaching school students, benefiting both their own career paths and the students' education (Gathenya et al., 2012). Nairobi youth community-based organisations in Taka Taka Solutions are building incomes from waste management, while improving urban environments (Njenga et al., 2010). Youth in the Youth Peacemaker Network in South Sudan have played a role in restoring peace in their own conflict-impacted communities (WIPD, undated). In 2014, Restless Development involved 1 452 youth mobilisers to reach 8 880 communities across twelve of the fourteen districts with Ebola in Sierra Leone with information on Ebola prevention and support (Restless Development, 2016). While the youth involved may not always initiate these processes, they contribute critical ideas and inputs to shape or strengthen them.

7.5 Facilitating co-operation between communities and services

Various measures facilitate co-operation and reduce barriers to interactions between communities and services. 'Co-locating' the different services needed by young people in the same place creates common entry points and overcomes barriers to uptake. For example, Finland launched one-stop guidance centres for youth, to strengthen and simplify services for them, including personal advice and guidance, career planning, social skills, education and employment support (Adams and Arnkil, 2013). This aimed to improve co-ordination across services, enabling shared staff training on competencies needed to work with youth in team approaches.

Co-operation is also built around funding. Initiatives such as the crowdsourcing of the Luchtsingel / ZUS infrastructure, described in *Box 5* adjacent, reflect a different mode of cross subsidy between high- and low-income settings than development aid. In these initiatives, common interest organisations and the public co-operate more directly in mobilising and organising resources. At the same time, states have also applied innovative approaches to funding initiatives. One example is Korea's K-Startup Grand Challenge 2016, using public resources to attract global innovators to make the country a prominent start-up business hub globally, particularly in relation to the green and creative economy, and the support for an *Angel Investment Support Center* to 'match-make' private funders with youth ventures (OECD, 2015b).

Box 5: Crowdfunding the Luchtsingel / ZUS



The Luchtsingel / ZUS is the world's first crowd funded public infrastructure. It has a 400-meter-long pedestrian bridge that reconnects three districts in the heart of Rotterdam. When, in 2011, it was announced that a planned development had been cancelled, Rotterdam residents took over with thousands of small donations. Just €25 bought one of the 17,000 planks that spans the 1,150-foot bridge. Each plank had the contributor's name etched in it, putting the 'public' in public works. Crowdfunding was used for the bridge to be financed in an alternative way [so that] construction could start and meant that improvement in the area was no longer fully dependent on real estate developments. (See the video at https://vimeo.com/49963764)

Source: ZUS, 2015; Photo Harry NL 2017 Creative commons

These innovations progress over time. They start with small-scale work and sometimes single ideas and demonstrations – like a technology for managing waste. In some cases, they use IT modelling as a way of showing what an idea can look like in practice to show to authorities or communities (UN Habitat 2016a). In the solar developments in Nicaragua's Sabana Grande, initial work to develop solar lighting extended to use of solar power in a community restaurant and in youth centre activities (Guevara-Stone, 2014). In Indonesia, sites for youth creative enterprises attract youth, but also grow as 'cool creative' tourist sites that over time generate new investment and new employment options (Azali 2015).

While they may build on local experience and in familiar settings, these approaches often imply doing things *differently*, rather than tweaking current approaches. UNIDO (2013) reports, for example, how youth entrepreneurship in the creative economy depends on the usual factors of access to markets, finance, investment and intellectual property rights, but also needs new approaches, such as market incubators, business residencies and innovative use of social media. Minecraft, a familiar online game, has for example been used for urban design with young people, providing an accessible means to generate project plans and build technical review and wider community confidence in youth proposals (UN Habitat 2016a).

7.6 Harare and Lusaka youth response to approaches in other cities

The innovations were discussed by the six groups of young people from different areas, economic and social situations in Harare in 2017, and similarly in Lusaka in 2018. In both areas, they saw a number of features as having relevance and feasibility for efforts to address wellbeing in their cities, particularly:

1. The use of internet platforms, to encourage entrepreneurs, to monitor council services and for youth to work together on their own issues, as one noted: "I liked the idea that the students were united and took their world into their own hands". An example was given of Ruzivo digital learning that is aligned to the Zimbabwean school curricula making support for education accessible to all pupils.
2. The role of community media in forming groups on issues, in sharing information and experiences, and turning conflictual situations into communication between residents and planners and the various approaches to involve people in urban planning.
3. The measures to improve quality and use of public spaces, such as providing free wifi and charging points in public spaces, combining social interaction with a service, or community organised urban agriculture: "We have green spaces in Harare and could cultivate them better – it would bring more unity among residents to produce and sell their produce and to generate income.
4. Youth engaging in improved environments, as communities certifying healthy public places (markets, schools, etc); co-operating to transform neglected spaces, waste dumps into green spaces and urban agriculture.
5. Stimulating employment and entrepreneurship in the creative economy, such as in health promoting economic activities and in economic activities that generate innovations
6. The role of participatory budgeting and crowdfunding as an approach to resourcing activities. Crowdfunding sites exist in Zimbabwe ('*tswanga.com*' and 'go-fund'). However they also said that "…they should not replace the duty of councils to involve us in setting a good budget".
7. The role of innovation festivals, as a 'festival of ideas' to share and innovations. Cultural events, such as Shoko festival in Harare, were seen as places where ideas and innovations could be shared, In 2017, the Harare youth set up a stand at this festival for people to draw, write and discuss their vision of what kind of city they want to live in.

The post it board, Shoko festival
R Loewenson, 2017

In general, the youth perceived the need for a range of informal approaches to create space for such innovation for wellbeing: peer-to-peer strategies, engaging with residents on specific issues; youth hubs and innovation festivals; online surveys, Facebook polls, social media and internet-based crowdfunding.

While formal mechanisms like the junior parliament or the local government junior council were seen to be useful and partnerships with state institutions essential to develop solutions to priority problems, it was perceived that formal mechanisms needed to link to and enable the informal spaces and processes above, to reach and engage young people across the whole city. In Lusaka, these informal processes were identified as enabling youth to build self-confidence to solve problems, through processes that foster their talents and independent thinking and to bring this into formal interactions. The Lusaka youth wanted to be more involved in an existing health literacy programme and for it to include their priorities, including mental health.

8. LEARNING AND INSIGHTS FOR ADVANCING URBAN HEALTH EQUITY

This section discusses the learning and insights across this multi-method body of work and the implications for action on urban health and health equity in east and southern Africa, including for primary health care systems and for monitoring progress and research.

8.1 Acting on urban health equity in ESA through the holistic lens of wellbeing

The findings of the literature review reported in *Section 3* suggest that a policy perception of an urban advantage is no longer valid for many health outcomes and determinants. Likewise, a focus on urban–rural differentials is no longer sufficient for addressing inequalities in health, especially those emerging from disadvantage and rising poverty *within* urban areas. WHO and UN Habitat (2016) similarly found this lack of urban advantage for many urban residents and that conditions for health vary widely even for cities in the same geographic region. While urban-rural inequalities are reasonably well measured in the ESA region, *Sections 3 and 5* highlight that urban planning is hampered by limited data on inequalities *within* urban areas.

The evidence from literature, data sets and the participatory validation suggest sources and forms of social differentials in health in urban areas, of ESA countries, including:

- A coexistence within the same broad locality of rising and often conspicuous wealth and access to infrastructure and markets for some groups, with extreme levels of deprivation, including poor and polluted living and community conditions, employment and income insecurity associated with poor quality diets, lack of capital for emergent entrepreneurs and affordable access to decent public services, psychosocial stress and social insecurity. *Section 3* highlights inequalities in the opportunities for health associated with recent migrancy, residency and tenure, age and social networks. It also raises limited documentation of the social networks and information from these groups as a source of evidence for health interventions. *Section 5* indicates, using youth as an example, the limited disaggregation of evidence on such groups in formal assessments.
- Urban areas are sites of new ideas and technology and a wide range of goods and services. However, many urban residents face deficits in the most basic material needs in terms of housing, sanitation, healthy foods, water and household energy, due to cost, stigma and social and legal barriers. An inequality in benefit from urban resources is exacerbated by weaknesses in regulation or control of practices harmful to health or enforcement of public health standards, as observed in *Section 3* and by youth in the participatory validation in *Section 6*. It is also affected by a lack of an appreciative inquiry lens, as suggested in *Section 3*, with youth in *Section 7* calling for resources and formal processes to support affirmative practice.
- Concentrated urban settlements and the expansion of information and social media are connecting people, mixing cultures, ideas and generations and offering new potentials for tolerance. At the same time, many people face cost barriers and limited public sites for free Wi-Fi access. Growing social literacy and networks provide assets for people's voice and roles in improving health. At the same time, the concentration of people in poor conditions and socio-economic insecurity is associated with social violence, harmful practices and abuse, a disruption of family and social networks and social alienation, stress and exclusion. For many, there may be dissonance between the cultures they grew up in and emergent cultures of the city, generating confusion on what culture means and how it supports urban social life and values.
- Urban residents have relatively high and growing levels of literacy and basic education. However, there are questions about the content and quality of education, and concerns about barriers to progression to higher education levels and limited adult education opportunities to secure economic and employment opportunities, or to build entrepreneurship.

- The combination of education levels, population density and social media suggests a potential for greater participation of diverse urban communities and social groups in local government planning and decision-making, yet the evidence suggests the continued exclusion of people from key decision-making processes that affect their lives.

The available data from across ESA countries discussed in *Section 5* mainly focus on negative indicators and miss a number of these dimensions and determinants of social differentials in health. While ad hoc surveys have been implemented within areas, these have not covered all countries in the region and use different indicators and levels of aggregation. The subjective report by social groups on their life satisfaction differs from measured evidence in databases and information systems.

This, the limited rural-urban disaggregation for many indicators, almost no disaggregated data *within* urban areas across ESA countries and a focus of many surveys on specific areas, such as on slum areas, undermines the possibility of assessing the significance of and progress in addressing social differentials for social groups in the cities in ESA countries. These groups include recent migrants, people living in informal housing and 'backyard shacks' or as lodgers in formal areas, elderly people or youth.

Section 3 raises that the literature and data sets appear in many respects to lag behind the rapid, diverse and multifactorial changes taking place in urban areas.These limitations are thus even more problematic when trying to understand and plan for the sometimes rapidly changing physical, socio-political and cultural environments in urban areas.

These shortfalls, while perhaps more pronounced in our region, are not unique to the ESA region. They have been identified in other countries as deficits in the way urban health is assessed, noting the limited, fragmented data on many within-area determinants and variations, a focus on negative rather than positive assets and outcomes, and an exclusion bias of communities with high rates of mobility, with no fixed abode and those that are reluctant to talk to authorities (Harpham, 2007).

Sidewalk Vendor in Johannesburg, J Hall 2006

Our current dominant approach of understanding health equity in relation to the distribution of morbidity and various deficits in immediate, proximal determinants of health thus appears to be necessary but not sufficient to understand, explain and proactively advance health equity in urban areas. This is particularly so when health services have become increasingly biomedical and focused on disease. This is particularly problematic for youth, as while they may appear to be in 'good health' in terms of freedom from disease, they face a number of physical, mental and social challenges that have immediate and long term effects on their wellbeing.

Holistic, integrated and affirmative approaches have the potential to overcome such deficits and to address and rebalance the multiple social, economic and environmental determinants of these different health outcomes. Recent 'health in all policies' approaches seek to address this by embedding health in the work of other sectors. However, the outcomes may still be motivated, perceived, defined and measured in terms of reducing immediate risks to *ill health* and morbidity, limiting ownership of other sectors of these outcomes and with limited application of bottom-up, participatory approaches. They may focus on individual measures for particular sectors, which while necessary, may not adequately encourage the cross-sectoral collaboration needed for sustained and significant changes for urban health, particularly given the pace and complexity of urbanisation.

Section 4 proposes 'wellbeing' for its role as a holistic, integrated, affirmative and shared outcome. Many countries have gravitated to this concept. Some have done so in criticising the equation of development with economic growth at the cost of social inequality and degeneration of nature, seeking a balanced relationship between socio-political, physical/material, psychosocial, knowledge, ecological and economic dimensions for individuals, for the community and future generations as a common good.

We argue that the concept has value in exploring and advancing health equity in urban areas. It is not 'owned' by any particular sector, and avoids the siloing of outcomes. Its focus reaches beyond control of negative outcomes to promotion of positive strategies and assets at individual and collective levels and it integrates both objective and subjective dimensions and current and future consequences that develop and emerge cumulatively over time (Adams and Arnkil, 2013). Notably, the WHO Constitution makes explicit reference to wellbeing as the affirmative dimension of health in its first principle "Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity" (WHO, 1948).

From our experience of the participatory youth validation, 'wellbeing' is (currently) a more accessible concept in its use, not (yet) owned or mystified by a technical community. As has been observed by others (Rees and Main 2015), using it enabled us to put youth at the centre of assessment, taking into account their lived experience and perceptions of their lives and future as active participants.

The gaps we found in assessment of urban wellbeing outlined in *Section 5* suggest that beyond applying a more comprehensive concept of wellbeing, our routine measurement, within and across countries, should measure: disaggregated positive and negative determinants and outcomes, people's perceptions of their conditions and services and, particularly for local urban planning, should blend routine information with participatory assessment by different social areas and groups in the city.

The participatory validation with young people in Harare and Lusaka showed the new evidence this provides. While the literature generally focused on wealth and area gradients in health and its determinants, what the youth reported did not always follow these gradients. For example, youth from the wealthier northern suburbs of Harare and less secure youth in informal employment both prioritised a peaceful, violence-free environment and social support networks as key dimensions, albeit for different reasons. While material issues were raised, and despite contexts of deep economic insecurity, youth in very different economic conditions gave priority to social issues given less formal attention, like participatory democracy, green spaces, access to Wi-Fi and positive self-esteem. They noted mental stress and psychosocial problems to be having a significant effect on their wellbeing, but to be largely ignored by services.

The participatory processes pointed to the interaction between social features and determinants: Unemployed youth in Harare raised insecure income as a factor, but saw entrepreneurship as more relevant than secure jobs to address this. In contracts, employed youth saw jobs as the means to improvement. All youth valued education, but those in less secure circumstances saw it as opening opportunities for employment and entrepreneurship, while those in formal employment or from higher income areas saw it as a means to improve their status and incomes. Epworth youth, coming from an informal settlement, not unexpectedly rated access to shelter as critical, but also pointed to the transparency of government decisions and the opportunities for participation in the building sector as key factors affecting their ability to improve both access to shelter and income security.

The participatory validation pointed to the potential of such processes in looking beyond currently measured indicators to understand drivers of health and wellbeing that may be important for equity, including to understand the context-dependent and dynamic nature of these drivers. A holistic wellbeing paradigm applied within a longer term planning framework provides opportunities to make better links between what we do now and the future of our cities, recognising the importance of early interventions on nutrition, in children, in shelter and other investments for the emergence of health or morbidity across the life course and across generations. This may be most important for young people, often the most excluded from visibility, opportunities, data systems, services and decisions, but most affected by the future of our cities.

This section thus proposes changes in the way we think about and analyse urban health equity:

1. To embed health and analysis of health equity within the wider concept of wellbeing, as a shared outcome more likely to be owned and understood by different sectors and communities, as a more holistic concept for integrating the range and interaction of both assets and risks in the psychosocial, material, economic, environmental determinants that affect current and future equity outcomes.
2. Beyond the current areas of attention, to pay more attention to enterprise creation, the creative economy, the green economy, shelter, internet access, psychosocial wellbeing and participatory democracy and to youth in urban wellbeing.
3. To develop, measure and use in urban planning and in monitoring state performance a wider set of parameters that cover the psychosocial, spiritual, cultural; physical; education and culture; living conditions and services; time use; economic; environmental; governance and citizenship dimensions of current and future wellbeing.
4. To integrate participatory methods to draw out, understand and use in planning the diversity of lived experience and perceptions that affect variations in urban health and wellbeing.

8.2 Analysing equity in urban wellbeing as a means for improvement

The deficits identified in *Sections 3 and 5* are observed to lead to a picture of cities for communities, planners and service providers that is often a series of disconnected facets and fragments. This is further reflected in systems and services that are themselves segmented and silo'ed, and better equipped to focus on technical aspects than the social factors and relations that influence their effectiveness and uptake.

In a context where health services have become narrowly defined and perceived as an issue for the medical profession for treatment of disease, and with data having increasing influence in planning, driven by target-driven approaches such as performance-based financing and target-linked budgets, these deficits in evidence can distort local plans and lead to poor recognition of conditions and experiences important for health equity. WHO and UN Habitat (2016: 213) suggests that we need to reclaim a multidimensional understanding of equity as a measure of good urban government. They cite Ambrogio Lorenzetti's portrayals of this in paintings in 1338-39 that reflect various facets of just rule, peaceful existence and social equity, with city walls inscribed with "how sweet and peaceful is that life of the city where is preserved this virtue [justice]".

In part this implies gathering and disaggregating evidence on social inequalities *within* urban areas and between determinants and social groups in ESA countries to better understand their interactions. The UN Habitat, reference to 'inclusive cities' seeks to overcome such structural and sectoral segregations (UN Habitat 2015). Applying a concept of wellbeing can help to lever this more holistic analysis by stimulating new ways of defining and measuring progress. Many countries in other regions have begun to do this to assess their performance, as discussed in *Section 5*, including in:

- The WHO Global Health Observatory urban health observatories (WHO and UN Habitat, 2016).
- The WHO Urban Health Equity Assessment and Response Tool (Urban HEART), the Urban Health and Demographic Surveillance Sites managed by the InDepth project in several African and Asian countries, and the within area surveys of the African Population Health Research Centre and the African Food Security Network (WHO and UN Habitat 2016).
- The range of psychosocial, social, time use, political, material, economic, service, governance and ecological indicators described in *Section 5* and their combination in composite indices such as the happiness index and the quality of life index.
- The involvement of citizens in the selection of parameters and construction of evidence on them, such as the Better Life initiative and Urban HEART (WHO 2010).

As noted in *Section 5,* there is much more limited evidence of such data being gathered or used in ESA countries, although the development of indicators for the sustainable development goals (SDGs) may partially address this. There is report of an urban health index being piloted with a flexible approach in the selection of indicators tailored to local health needs in 57 cities, including Dar es Salaam, Harare, Kampala, Lilongwe, Lusaka, Maputo, Nairobi, Windhoek, Kinshasa, Antananarivo, and Mbabane in ESA countries (Stauber et al., 2018). The index includes data on environment, education and immunisation from demographic and health surveys, but does not include other indicators we found to be important in our work, or those identified for assessing wellbeing in other regions. We would thus suggest that urban observatories and sentinel surveillance sites include indicators for measures of urban wellbeing shown in *Table 2*, making reference to those being monitored in other regions, such as those systems shown in *Table 1.*

At the same time, measured data have limitations in understanding these multidimensional and sometimes fast moving urban contexts. This calls for methods that draw more directly and systematically on the lived experience of different groups of urban residents. The participatory validation in Harare and Lusaka provided evidence and weightings for areas of wellbeing not well reflected in current data, including employment security in youth, support for entrepreneurship and the creative economy, security of shelter, access to green spaces and affordable publicly subsidised social media, and support for mental wellbeing.

Further, in contrast to the more negative focus on risk factors and problems in published papers and data, a wellbeing perspective led us to significant evidence on positive innovations in urban areas, building on and strengthening local assets and relations. Adding voice of those directly affected enriched the analysis, understanding and response.

We thus propose that we deepen how we assess and plan for urban health equity and wellbeing:

1. By identifying and measuring both positive and negative indicators across ESA countries for wellbeing parameters, harmonising with approaches used, including psychosocial, social, time use, political, material, economic, service, governance and ecological indicators and measuring risks and assets, and positive and negative outcomes. Loewenson and Masotya (2018) provide a detailed table of the specific wellbeing indicators used in other regions globally.
2. By complementing quantitative data from routine information and surveys with participatory, qualitative assessments and the voice of those directly affected, particularly for within-area assessment and planning. This implies participatory reflection and action approaches to enrich analysis, understanding and response of both communities and planners. Various efforts are being made to do this in urban health and planning (Bai et al., 2012; Corburn, 2017; Corburn and Cohen, 2012; WHO, 2010), while several Latin American countries are involving local knowledge and voice in urban health (Loewenson and Obando, 2017; Deneulin, 2012).

8.3 Implications for urban primary health care

There is a growing recognition of the need for more effective responses to urban health challenges, to deliver on both the right to health and people's 'right to the city' (WHO, 2016c). A 'healthy city' has been defined as one that enables people to have equitable access to economic opportunities and services; that empowers people to achieve their potential and that nurtures natural environments (WHO 2016c).

These intentions have resonance with comprehensive Primary Health Care (PHC) as a strategy for organising health systems to promote health. The WHO Constitution and the 1978 Alma Ata declaration on PHC equated health with improved mental, physical and social wellbeing and located the health sector as a key lever for these outcomes (PAHO/WHO, 2007). PHC encompasses political action to address the power relations and social determinants affecting health equity and the provision of universally available health care and intersectoral action for health, as a contributor to socio-economic development (PAHO/WHO, 2007). This comprehensive concept of PHC connects well with the holistic understanding of wellbeing, the collaborative role that many sectors play in achieving it and the key role of the health sector in levering and as one entry point for such collaborative action.

Sadly, the participatory validation by young people in Harare and Lusaka suggested that this understanding of PHC has become diluted, with health practice focused more on managing disease and health services as one of the 'silo'ed' sectors. Despite recent attention to work on social determinants of health, there is concern that the health sector in the ESA region has become weaker and more underfunded, especially in terms of the public health practices that engage or lever action on key determinants that affect the social distribution of improved health (EQUINET 2012). This is a challenge, but also an opportunity for work on urban health to progressively re-invigorate and organise urban PHC in its comprehensive form.

The innovative responses we found for promoting urban youth wellbeing have features that may inform what a reinvigorated urban PHC may involve in practice:

1. **Facilitating recognition, visibility and voice of active residents and citizens,** that 'we are here, study here, or live here', generating recognition of people's conditions and building people's confidence to assert their rights. This appears to be critical, not only for the self-confidence of marginalised or excluded groups, but for formal recognition of people's (changing) conditions and in shaping the mechanisms, spaces and processes for diverse social groups in cities to meaningfully bring their evidence and ideas into urban planning and services (WHO and UN Habitat, 2016). This implies a shift from an urban PHC that is singularly preoccupied with managing negative outcomes and that sees people particularly in terms of the specific diseases they come with, to greater use of participatory and asset based approaches that identify the strengths and capacities within and priorities of communities and that builds interventions on these assets. For this, youth in Harare and Lusaka said that health departments need to reach into community settings, ensure universal public service provision, work with communities and involve young people as promoters, watch dogs, and advocates for health in wellbeing. In doing this urban PHC has an important potential and role as a contributor to wider urban participatory democracy. It can provide safe spaces for all social groups in urban areas, build social confidence of marginalised groups and bring community experience, conditions and capacities into urban planning and services (WHO and UN Habitat, 2016). Further, as we found in our work and in processes described in *Section 7* such as VOYCE and participatory budgeting, bringing groups together across the city allows for appreciation of common and different concerns for collective and solidarity driven responses.

   This implies a different relationship between urban primary care services in ESA countries and their populations than the currently ad hoc one that depends on people presenting to facilities with health problems. It suggests having a register of the catchment population and integrated services for individual, family and community mental, physical and social health that plan proactively for family and population health, enhance continuity of care and link primary care and other services and payment systems to support the health of the whole community (Kalucy et al., 2009; Sans-Corrales et al, 2006; De Maeseneer et al., 2003; Hollander et al., 2009). Experience suggests that this is more likely to happen when health workers work as a team in place-based approaches, reaching into the community, applying participatory family and community mapping, including of the support services for families and feeding the information from communities to municipal administrations (Frenz et al., 2014; Matheson and Matheson, 2017).

2. **Addressing different dimensions of wellbeing, including social dimensions, at the same time or place.** Many of the positive approaches reported in *Section 7* bring different disciplines, sectors and actors together in a shared framework, often community driven, with shared organisation and skills. They recognize the role of social assets and networks, providing mechanisms and processes that facilitate bottom up practice and networking and platforms for these to be shared horizontally across cities. They point to public spaces as being important sites for generating integrated approaches, such as by 'co-locating' different services to support access, co-ordination across services, shared staff training, shared work practices and team approaches. 'Place' based approaches are observed to more likely yield *effective solutions... by addressing the urban environment rather than narrowly focusing on healthcare* (Corburn, 2017:466),

To tap into such features, investment is needed in the public health, prevention and promotion measures of urban PHC, co-locating and making links with other services and social platforms and using tools such as health and social impact assessment and participatory budgeting to connect health with other dimensions of wellbeing, in comprehensive place-based strategies outside health care facilities, such as in markets and schools (WHO and UN Habitat, 2016; Corburn and Sverdlik, 2017; Loewenson, 2017).

3. **Embedding ideas, innovation and collaborative advantage.** Listening to and involving urban youth in planning was a shared demand from both Harare and Lusaka youth. Many of the approaches used to promote wellbeing outlined in *Section 7* generate creative formal and informal spaces and processes to nurture new practices and relationships within familiar urban settings. They shift from preoccupations with competitive advantage to valuing collaborative advantage and to nurturing ecosystems for collaboration (Morisson, 2015). They use participatory processes, facilitated by state and non-state actors, for analysis and dialogue on institutional and social practices and preferences. They explore entry points or springboards for innovation, sometimes using smaller scale practice or online modelling to demonstrate ideas and to generate support for them within communities, services and planners (see *Section 7* and WHO and UN Habitat, 2016). Doing this implies urban PHC having both local capacities and flexibility to enable this. It also implies a shift in the often top-down approaches of health systems to engage the community and primary care levels as knowledge producers (and not just as knowledge implementers or reproducers), with local analysis and dialogue of evidence as a strategic activity, to review, design, act and learn from action.

4. **Stimulating and building relationships, trust and collaboration,** within social groups and with local authorities, urban services, administrative and technical personnel, artists and different types of community leaders. Innovation festivals, for example, were appreciated for the opportunity they provide to network and make links across people. Young people in Harare pointed to the potential for PHC practice to support this through: health authorities participating in local council dialogue with existing urban youth forums on programmes and budgets; bringing community evidence into decision making; facilitating voice of groups not usually heard; using e-governance, online forums and social media; and, while providing competent services, not stopping there, but ensuring that health teams go into the community to meet people in their own forums and spaces and to work with community members (including young people) as a voice, watchdog and social advocate for health. This calls for competencies for these roles and locates urban PHC as a contributor to these features in wider urban processes (South et al., 2014).

5. **Using online and social media.** Harare youth urged their councils to be more proactive in using e-governance, providing online places for people to report issues, get information and provide feedback. The experiences described in *Section 7* make creative use of online platforms for various processes supporting social networking and service planning and uptake. These processes give visibility to people, enable city-wide evidence to be built and the exchange and analysis of relevant experience. Online media provides a means for access in excluded groups, provided, as raised by the youth in Harare and Lusaka, digital access and data costs are not barriers. There are growing opportunities for urban PHC to use online and social media to make or support social connections for health and wellbeing; to share and discuss information and experiences across settings; to support participatory planning; for mapping and surveys; for crowdfunding; to generate and model ideas, to facilitate accountability on key services and contribute as above to urban democracy. While public PHC services may provide free Wi-Fi access in youth corners, as in Lusaka, the health sector could also join in advocacy for reduced data costs and for free Wi-Fi in all public services.

6. **Bringing investment and using innovative financing approaches.** Primary care, as the more pro-poor level of the health system, demands adequate funding without cost barriers at point of care. However, as outlined in *Section 3,* this is often not happening in urban services in ESA countries.

Adequate domestic funding of public sector urban PHC would appear to be a necessary basis for other sources to complement and not substitute this public sector duty. A range of such complementary sources are described in *Section 7* to support innovative, holistic financing, such as crowdfunding, public seed funding, innovation challenge competitions, angel investors and 'matchmaking' private funders with specific groups and ventures, or to provide incentives and environments to attract people and skills.

Introducing features such as the six above in shaping urban PHC is as much a product of political choice as of technical know-how. This paper points to a growing body of perspective, practice and learning to promote wellbeing, and the potential to tap the energy and capabilities that exist within the urban population in ESA countries, especially its young population, to contribute towards this.

It raises concern therefore that the literature presented evidence of the opposite taking place, with report of urban PHC initiatives struggling and facing shortfalls, weak links between local primary care services and public and community health; declining investment in public health capacities and weakening public health authority and a persistence of 'sectoral silos' (See *Section 3* ; Federal Republic of Ethiopia (undated); Harpham, 2007; 2010). Despite the potential for 'win-wins' for various sectors in achieving mutual goals in areas such as transport; food systems; energy use; clean water and waste management; shelter, green spaces, local enterprise and the creative economy, health sectors have faced difficulties in initiating, co-ordinating or sustaining intersectoral action for health (Adeleye and Ngozi 2010; WHO 2016c). Facing such challenges in a context of underfunding, a focus on 'the core business' of personal care services may further deepen challenges affecting current and future health in our cities (South et al., 2014).

Rural PHC was incubated in a moment of change in our region. It emerged from the confluence of new thinking in the 1976 Alma Ata conference and the political, democratic and nation building imperatives of the liberation struggles as a source of new ideas and practice in the health sector. The significant inequities between the opportunity for and experience of improved health and wellbeing in urban areas call for similarly new ideas and practice for *urban* PHC. The call for 'health in all policies' and raised attention to universal access to health services are positive, but are argued to fall short of an adequate response to the confluence of factors generating current or future social inequalities in health in our cities. This paper suggests that context specific discussions to plan and invest in urban PHC apply the Alma Ata principles within a more holistic concept of 'wellbeing', in place-based, collaborative /co-located, participatory and asset based approaches, and measuring progress through a wider set of wellbeing indicators. The rural PHC of the late 1900s was applied by states with support from rural society. Our work suggests that urban PHC would be stronger if built bottom up, with and by urban society, perhaps especially by young people, with support from states.

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REFERENCES

1. Adams E, Arnkil R (2013) Urban Solutions: Tapping the talents of urban youth, SALTO Inclusion https://www.salto-youth.net/downloads/4-17-2683/UrbanSolutions.pdf
2. Adeleye OA, Ngozi A.O (2010) Strengthening Intersectoral Collaboration for Primary Health Care in Developing Countries: Can the Health Sector Play Broader Roles? *Journal of Environmental and Public Health* doi:10.1155/2010/272896
3. Afrobarometer (2018) 'The online data analysis tool, Afrobarometer online'. Available at: http://afrobarometer.org/online-data-analysis/analyse-online.
4. Anielski M (2012) 'Building flourishing economies of wellbeing'. Available at: http://www.anielski.com/building-economies-well-being-edmonton-tahiti-bhutan/
5. Azali K (2015) Boosting youth entrepreneurship in creative industries, *Inside Indonesia* 120: Apr-Jun 2015 http://www.insideindonesia.org/boosting-youth-entrepreneurship-in-creative-industries-2
6. Bai X, Nath I, Capon A, Hasan N, Jaron D (2012) Health and wellbeing in the changing urban environment: complex challenges, scientific responses, and the way forward, *Current Opinion in Environmental Sustainability*, 4:465–472
7. Bailis R, Ezzati M and Kammen DM (2005) 'Mortality and greenhouse gas impacts of biomass and petroleum energy futures in Africa,' *Science* (New York, N.Y.) 308(5718): 98-103. doi:308/5718/98 [pii]
8. Bandason N (2008) 'Patterns and determinants of health care utilization: An assessment of high density urban areas in Harare, Zimbabwe,' Dissertation, University of Cape Town, Available at: http://open.uct.ac.za/handle/11427/9429
9. Boischio A, Clegg A and Mwagore D (2006) 'Health risks and benefits of urban and 'peri-urban' agriculture and livestock (UA) in Sub-Saharan Africa,' *Urban Poverty and Environment Series* Report 1 https://idl-bnc.idrc.ca/dspace/bitstream/10625/35531/1/127428.pdf
10. Boron A (2015) Buen Vivir (Sumak Kawsay) And The Dilemmas Of The Left Governments In Latin America, Extract in lifeontheleft.blogspot.ca, California, available at http://www.boliviamundo.net/buen-vivir-and-the-dilemmas-of-the-left-governments-in-latin-america-i/
11. Bradley HA and Puoane T (2007) 'Prevention of hypertension and diabetes in an urban setting in South Africa: Participatory action research with community health workers,' *Ethnicity and Disease* 17: 49-51.
12. Bryant JH, Bryant NH, Williams S, Ndambuki RN and Erwin PC (2012) 'Addressing social determinants of health by integrating assessment of caregiver-child attachment into community based primary health care in urban Kenya,' *International Journal of Environmental Research and Public Health* 9(10): 3588-3598.
13. Canadian Index of Wellbeing (CIW) (2018). Available at: https://uwaterloo.ca/canadian-index-wellbeing/
14. Centre for Bhutan Studies and GNH Research (2015) 'Bhutan's 2015 Gross National Happiness Index.' Available at: http://www.grossnationalhappiness.com/SurveyFindings/Summaryof2015GNHIndex.pdf
15. Centre for Educational Research and Innovation (2001) 'The wellbeing of nations: The Role of human and social capital', OECD: Paris. Available at: http://www.oecd.org/site/worldforum/33703702.pdf
16. Chalya PL, Mabula JB, Ngayomela IH, et al. (2010) 'Motorcycle injuries as an emerging public health problem in Mwanza City, Tanzania: A call for urgent intervention' *Tanzania Journal of Health Research* 12(4): 214-221.
17. Charmes J (2015) 'Time use around the world: Findings of a world compilation of time use surveys', UNDP: New York. Available at: http://hdr.undp.org/sites/default/files/charmes_hdr_2015_final.pdf
18. Chege P and Majale M (2005) 'Participatory Urban Planning in Kitale', Kenya. Presented at the Lecture Department of Architecture ITS. www.irbnet.de/daten/iconda/CIB1001.pdf
19. Chesire EJ, Orago AS, Oteba LP and Echoka E (2008) 'Determinants of under nutrition among school age children in a Nairobi peri-urban slum,' *East African Medical Journal* 85(10): 471-479.
20. Chuma J, Gilson L and Molyneux C (2007) 'Treatment-seeking behaviour, cost burdens and coping strategies among rural and urban households in coastal Kenya: An equity analysis,' *Tropical Medicine & International Health* 12(5): 673-686. doi:TMI1825 [pii]
21. CMAP (2016) 'Towards the Human City', Cities Alliance Inaugural Assembly, Brussels 04 06 2016
22. Corburn J (2017) 'Urban Place and Health Equity: Critical Issues and Practices'. *Int J Environ Res Public Health* 14(2):10.3390/ijerph14020117.
23. Corburn J and Cohen AK (2012) 'Why we need urban health equity indicators: integrating science, policy, and community'. *PLoS Med* 9(8):e1001285
24. Corburn J and Sverdlik A (2017) 'Slum upgrading and health equity,' *International Journal of Environmental Research and Public Health* 14(4): 10.3390/ijerph14040342. E342 [pii]
25. Deneulin S (2012) 'Justice and deliberation about the good life: The contribution of Latin American Buen Vivir social movements to the idea of justice', Centre for Developmental Studies: Bath. Available at: http://opus.bath.ac.uk/31884/
26. De Maeseneer JM, De Prins L, Gosset C et al. (2003 'Provider continuity in family medicine: Does it make a difference for total health care costs?' *Ann fam med.* 3:144–8

27. dos Santos FK, Maia JA, Gomes TN et al. (2014) 'Secular trends in habitual physical activities of Mozambican children and adolescents from Maputo city', *International journal of environmental research and public health* 11(10): 10940-50.
28. EFTA Ltd (undated) 'Equipment loans'. Available at: http://www.efta.co.tz/?page_id=160
29. EQUINET (2012) Regional Equity Watch 2012: Assessing progress towards equity in health in East and Southern Africa. EQUINET Harare
30. European Commission Joint Research Commission (nd) 'UrbanQoL: Citizens-harnessed indicators of quality of life' [ppt]. Available at: http://inspire.ec.europa.eu/reports/air_qlt/UQ_outline.pptx.pdf
31. European Environmental Agency (EEA) (2009) 'Ensuring quality of life in Europe's cities and towns tackling the environmental challenges driven by European and global change' (No. 5/2009), EEA: Copenhagen. Available at: http://www.upv.es/contenidos/CAMUNISO/info/U0564933.pdf
32. Eurostat (2015) 'Quality of life indicators – measuring quality of life'. Available at: https://tinyurl.com/y9ky6wxt
33. Federal Republic of Ethiopia (undated) 'Urban Primary Health Care reform', mimeo, Addis
34. Fletcher S and Smith C (2016) 'Youth participatory budgeting', Rosario (Argentina) at http://participedia.net/en/cases/youth-participatory-budgeting-rosario-argentina
35. Forbes J (2012) 'The Human City project, Nigeria'. Available at: https://cargocollective.com/jeffforbes/The-Human-City-Project-Nigeria
36. Fotso JC, Ezeh AC, Madise NJ et al. (2007) 'Progress towards the child mortality Millennium Development Goal in urban Sub-Saharan Africa: The dynamics of population growth, immunization, and access to clean water', *BMC public health 7*: 218. doi:1471-2458-7-218 [pii].
37. Fotso J, Ezeh A, Madise N et al. (2009) 'What does access to maternal care mean among the urban poor? Factors associated with use of appropriate maternal health services in the slum settlements of Nairobi, Kenya', Maternal and child health journal 13(1): 130-37.
38. Fotso JC, Speizer IS, Mukiira C et al. (2013) 'Closing the poor-rich gap in contraceptive use in urban Kenya: Are family planning programs increasingly reaching the urban poor?' *International journal for equity in health* 12: 71. doi:10.1186/1475-9276-12-71 [doi].
39. Gamero L (2010) 'Barrio Ciudad project', Fondo Hondureño de Inversión Social, Honduras.
40. Garenne M (2010) 'Urbanisation and child health in resource poor settings with special reference to under-five mortality in Africa', *Archives of disease in dhildhood* 95(6): 464-68.
41. Gathenya TW, Thiong'o M, Thungu J et al. (2012) 'A competency framework for teachers in Kenya: Working towards new standards for a new era', USAID: Kenya.
42. GNH Centre for Bhutan Studies (2016) 'What is GNH?' *GNH CBS: Bhutan*. Available at: http://www.gnhcentrebhutan.org/what-is-gnh/the-story-of-gnh/
43. GNH Centre for Bhutan Studies (2018b). GNH Index. Available at: http://www.grossnationalhappiness.com/articles/
44. Govender T (2011) 'The health and sanitation status of specific low-cost housing communities as contrasted with those occupying backyard dwellings in the City of Cape Town, South Africa', [Dissertation], Stellenbosch University. Available at: http://scholar.sun.ac.za/handle/10019.1/17992.
45. Green My Favela (2014) 'Conversation with GMF community gardeners in Manguinhos. A collaborative project between GMF / Hortas Cariocas / Manguinhos Residents' Association', conversation led by Natalia Westphal (GMF), 18 July.
46. Gudynas E (2011a) 'Transitions to post-extractivism: Directions, options, areas of action', Centro Latino Americano de Ecología Social (CLAES): Montevideo. Available at: https://www.tni.org/files/download/beyonddevelopment_transitions.pdf
47. Gudynas E (2011b) 'Buen Vivir: Today's tomorrow', *Development* 54(4), 441–47. Available at: https://link.springer.com/article/10.1057/dev.2011.86
48. Guevara-Stone L (2014) 'Solar innovation gives Nicaraguan community a brighter future', Rockey Mountain Institute. Available at: https://tinyurl.com/y8e63stb
49. Happy Planet Index (2016a) 'About the HPI'. Available at: http://www.happyplanetindex.org/about/
50. Happy Planet Index (HPI) (2016b) [website]. Available at: http://happyplanetindex.org/countries
51. Harpham T (2007) 'Improving urban population health systems', Center for Sustainable Urban Development: UK.
52. Harpham T (2010) 'Urban health in Africa: What do we know and where do we go', Centre for African Studies: Basel.
53. Helliwell J, Layard R and Sachs J (2016) *World Happiness Report, Update (vol.I).* Sustainable Development Solutions Network: New York.
54. Hollander MJ, Miller JA, MacAdam M et al. (2009) 'Increasing value for money in the Canadian healthcare system: New findings and the case for integrated care for seniors', *Healthc Q* 12(1): 38–47, 2.
55. Hopewell MR and Graham JP (2014) 'Trends in access to water supply and sanitation in 31 major sub-Saharan African cities: An analysis of DHS data from 2000 to 2012', *BMC public health* 14: 208. doi:10.1186/1471-2458-14-208.

56. Jenkins MW, Cumming O and Cairncross S (2015) 'Pit latrine emptying behavior and demand for sanitation services in Dar es Salaam, Tanzania', *International journal of environmental research and public health* 12(3): 2588-2611.
57. Kalucy L, Katterl R, Jackson-Bowers E et al. (2009) 'Models of patient enrolment', *Policy issues review.* South Australia: Primary Healthcare Research and Information Service (PHC RIS).
58. Karanja NN, Njenga M, Prain G et al. (2010) 'Assessment of environmental and public health hazards in wastewater used for urban agriculture in Nairobi, Kenya', *Tropical and subtropical agroecosystems* 12(1): 85-97.
59. Kirimi FK (2011) 'Factors Influencing Implementation of public health standards in selected city council markets in Nairobi, Kenya'. Available at: http://etd-library.ku.ac.ke/handle/123456789/1882
60. Kolling M, Winkley K and Von Deden M (2010) 'Research "For someone who's rich, it's not a problem": Insights from Tanzania on diabetes health-seeking and medical pluralism among Dar es Salaam's urban poor', *Globalization and health* 6(8).
61. Kothari A (2014) 'Radical ecological democracy: A path forward for India and beyond', Tellus Institute: Boston. Available at: https://tinyurl.com/yby7yefg
62. Kulabako RN, Nalubega M, Wozei E et al. (2010) 'Environmental health practices, constraints and possible interventions in peri-urban settlements in developing countries--a review of Kampala, Uganda', *International journal of environmental health research* 20(4): 231-57.
63. Lippman L, Moore K, Mcintosh H (2009) 'Positive Indicators of Child Well-Being: A Conceptual Framework, Measures, and Methodological Issues'. Innocenti Working Paper No. 2009-21, UNICEF Innocenti Research Centre, Florence
64. Loewenson R, Kadungure A, Laver S, Shamu S, Mushayi W (2012) Assessment of facilitators and barriers to maternal and child health services in four rural and urban districts of Zimbabwe TARSC, UNICEF CCORE Harare, Available at: https://tinyurl.com/ybrx2e65
65. Loewenson R, Laurell AC, Hogstedt C, D'Ambruoso L, Shroff Z (2014) Participatory action research in health systems: a methods reader, TARSC, AHPSR, WHO, IDRC Canada, EQUINET, Harare, Available at: www.equinetafrica.org/sites/default/files/uploads/documents/PAR_Methods_Reader2014_for_web.pdf
66. Loewenson R and Masotya M (2015) 'Responding to inequalities in health in urban areas: A review and annotated bibliography', EQUINET discussion paper 106, TARSC, EQUINET: Harare. Availableat: https://tinyurl.com/ybgc4ptw
67. Loewenson R, Masotya M (2017) Responding to inequalities in health in urban areas: An ideas book of approaches and interventions from diverse countries to strengthen wellbeing for urban youth, TARSC, EQUINET, Harare.
68. Loewenson R, Masotya M (2018) 'Responding to inequalities in health in urban areas: How well do current data measure urban wellbeing in East and Southern Africa?' EQUINET discussion paper 114, TARSC, EQUINET: Harare Available at: https://tinyurl.com/y8t8c4hj
69. Loewenson R, Obando F (2017) 'Short case study report: Metropolitan District of Quito, Ecuador', Learning from international experience on approaches to community power, participation and decision-making in health, TARSC, Available at: http://tinyurl.com/y9k3afas
70. Loewenson R with Beznec P; Coelho V; D'Ambruoso L et al., (2017) 'Building social power and participation in local health systems: Learning from practice', Training and Research Support Centre. Available at: https://tinyurl.com/yalzuhvk
71. Lusaka District Health Office(LDHO), Training and Research Support Centre (TARSC), Civic Forum on Human Development (CFHD) EQUINET (2018) Participatory meeting in Lusaka on health and wellbeing of urban youth, 26-27 June 2018, Lusaka, Zambia, Available at: https://tinyurl.com/y8qdv99y
72. Makau J (2011) "Like we don't have enough on our hands already!": The story of the Kenyan slum youth federation', *Environment & urbanization* 23(1): 203–06.
73. Matheson D and Matheson K (2017) 'Case study: Ngāti Porou Hauora, New Zealand' in the *Shaping programme on learning from international experience on approaches to community power, participation and decision-making in health,* in association with NPH, TARSC, July 2017. Available at: http://tinyurl.com/ydbkwzsl
74. Matzopoulos RG, Thompson ML and Myers JE (2014) 'Firearm and nonfirearm homicide in 5 South African cities: A retrospective population-based study', *American journal of public health* 104(3): 455-60
75. McGregor JA (2015) 'Global initiatives in measuring human wellbeing: Convergence and difference', CWiPP Working Paper No. 2, Centre for Wellbeing in Public Policy: University of Sheffield. Available at: https://www.sheffield.ac.uk/polopoly_fs/1.522118!/file/CWiPP_WP_201502_McGregor.pdf
76. Mendenhall E and Norris SA (2015) 'When HIV is ordinary and diabetes new: Remaking suffering in a South African township', *Global public health* 10(4): 449-62.
77. Mberu B, Mumah J, Kabiru C et al. (2014) 'Bringing sexual and reproductive health in the urban contexts to the forefront of the development agenda: The case for prioritizing the urban poor', *Maternal and child health journal* 18(7): 1572-77.
78. Mkupasi EM (2008) 'Prevalence of endoparasites of public health Importance in pigs alaughtered in Dar Es Salaam City, Tanzania', [Dissertation], Sokoine University of Agriculture. Available at: http://suaire.suanet.ac.tz:8080/xmlui/handle/123456789/297.
79. Morisson A (2015) 'In innovation districts: A toolkit for urban leaders', Amazon, Poland,
80. Mudege NN and Zulu EM (2011) 'Discourses of illegality and exclusion: When water access matters', Global public health 6(3): 221-33.

81. Muñoz F (2013) 'CuidArte Chile, Chile'. Available at: http://www.lacult.unesco.org/docc/cuidarte_chile_ingles.pdf
82. Musingafi MCC, Manyanye S and Ngwaru K (2014) 'Public health and environmental challenges in Zimbabwe: The case of solid waste generation and disposal in the city of Masvingo', *Journal of environments* 1(2): 68-72.
83. Mutowo J, Kasu CM and Mufunda E (2014) 'Women empowerment and practices regarding use of dual protection among family planning clients in urban Zimbabwe', *Pan African medical journal* 17: 300. doi:10.11604/pamj.2014.17.300.3282 [doi].
84. New Economics Foundation (NEF) (2012) *The Happy Planet Index: 2016 report: A global index of sustainable wellbeing,* NEF: London.
85. Njenga M, Romney D, Karanka N et al. (2010) 'Recycling nutrients from organic wastes in Kenya's capital city', in G Prain, N Karanja and D Lee-Smith (eds) *African urban harvest: Agriculture in the cities of Cameroon, Kenya and Uganda*. Springer: Ottawa.
86. Nsibande D, Doherty T, Ijumba P et al. (2013) 'Assessment of the uptake of neonatal and young infant referrals by community health workers to public health facilities in an urban informal settlement, KwaZulu-Natal, South Africa', *BMC health services research* 13: 47-6963-13-47. Doi: 10.1186/1472-6963-13-47.
87. Ntambue ML, Malonga K, Dramaix-Wilmet M et al. (2012) 'Determinants of maternal health services utilization in urban settings of the Democratic Republic of Congo: A case study of Lubumbashi City', *BMC pregnancy and chilbirth* 12:66. Doi: 1471-2393-12-66 [pii].
88. Nyemba A, Manzungu E, Masango S and Musasiwa S (2010) 'The impact of water scarcity on environmental health in selected residential areas in Bulawayo City, Zimbabwe', *Physics and chemistry of the earth*, parts A/B/C 35(13): 823-27.
89. Okello M, Oenga I, and Chege P (2008) 'Participatory urban planning toolkit based on the Kitale experience'. Available at https://practicalaction.org/docs/ia3/participatory-urban-planning-toolkit-kitale.pdf
90. Organisation for Economic Co-Operation and Development (OECD) (2013) *Measuring wellbeing and progress*, OECD Statistics Directorate: Paris.
91. OECD (2015a) *Quality of Life Indicators* (8+1) Available at: http://ec.europa.eu/eurostat/statistics-explained/index.php/Quality_of_life_indicators_-_measuring_quality_of_life
92. OECD (2015b) Korea Policy priorities for a dynamic, inclusive and creative economy, OECD, Paris https://www.oecd.org/korea/korea-policy-priorities-for-a-dynamic-inclusive-and-creative-economy-EN.pdf
93. OECD (2017) *Better life index 2017* [database]. Available at: http://stats.oecd.org/Index.aspx?DataSetCode=BLI
94. Oyebode O, Pape UJ, Laverty AA et al. (2015) 'Rural, urban and migrant differences in non-communicable disease risk-factors in middle income countries: A cross-sectional study of WHO-SAGE data', *PloS one* 10(4): e0122747. Doi: 10.1371/journal.pone.0122747.
95. Pan American Health Organization/World Health Organization (PAHO/WHO) (2007) 'Renewing Primary Health Care in the Americas', PAHO, Washington DC
96. Pantisano F, Craglia M and Sanchez CR (2014) 'New indicators of quality of life: A review of the literature, projects, and applications', Citizen Science Observatory of New Indicators of Urban Sustainability, European Commission. Available at: https://www.rd-alliance.org/system/files/documents/UQ201401_public.pdf
97. Perez, O (2012) "Interview with Rene Ramirez on the Socialism of Buen Vivir", P2P Foundation, online, Available at: http://p2pfoundation.net/Interview_with_Rene_Ramirez_on_the_Socialism_of_Buen_Vivir
98. Prasad A, Kano M, Dagg K, et al. (2015) 'Prioritizing action on health inequities in cities: An evaluation of Urban Health Equity Assessment and Response Tool (Urban HEART) in 15 cities from Asia and Africa', *Social Science & Medicine* 145 (2015) 237e242,
99. Pridmore P, Carr-Hill R, Amuyunzu-Nyamongo M, Lang'o D, McCowan T and Charnes G (2015) 'Tackling the urban health divide though enabling intersectoral action on malnutrition in Chile and Kenya,' *Journal of Urban Health* (Bulletin of the New York Academy of Medicine) 92(2): 313-321.
100. Rees G and Main G (eds) (2015) 'Children's views on their lives and well-being in 15 countries: An initial report on the Children's Worlds survey, 2013-14'. Children's Worlds Project, York, UK
101. Restless Development (2016) 'Unleashing the power of youth to change our world: A new vision for 2030' Available at: http://restlessdevelopment.org/file/the-way-to-a-new-strategy-pdf
102. Saifodine A, Gudo PS, Sidat M et al. (2013) 'Patient and health system delay among patients with pulmonary tuberculosis in Beira City, Mozambique', *BMC public health* 13: 559-2458-13-559. Doi: 10.1186/1471-2458-13-559 [doi].
103. Saisana M (2004) 'Composite indicators – A review', Second workshop on composite indicators of country performance, OEDC, Joint Research Centre: Paris. Available at: http://www.oecd.org/sti/ind/29398640.pdf
104. Sans-Corrales M, Pujol-Ribera E, Gené-Badia J, Pasarín-Rua MI, Iglesias-Pérez B, Casajuana-Brunet J. 'Family medicine attributes related to satisfaction, health and costs'. *Fam Pract*, 23(3):308–16
105. Scheffler E, Visagie S and Schneider M (2015) 'The impact of health service variables on healthcare access in a low resourced urban setting in the Western Cape, South Africa', *African journal of primary health care & family medicine* 7(1): 11 pages.
106. Schram A, Labonte R and Sanders D (2013) 'Urbanization and international trade and investment policies as determinants of noncommunicable diseases in sub-Saharan Africa', *Progress in cardiovascular diseases* 56(3): 281-301.

107. Soura AB, Mberu B, Elungata P, Lankoande B, Millogo R, Beguy D and Compaore Y (2015) 'Understanding inequities in child vaccination rates among the urban poor: Evidence from Nairobi and Ouagadougou health and demographic surveillance systems', *Journal of urban health* (Bulletin of the New York Academy of Medicine) 92(1): 39-54.
108. South J, Hunter D and Gamsu M (2014) 'What local government needs to know about public health: A local government knowledge navigator, UK.
109. Stauber C, Adams E, Rothenberg R, Dai et al. (2018) 'Measuring the impact of environment on the health of large cities, *Int. J. Environ. Res. Public Health* 15(6), 1216.
110. Stiglitz JE, Sen A and Fitouss J (2009) 'Report by the commission on the measurement of economic performance and social progress', Eurostat: Brussels.
111. Van Wyk, R. (2009).'A review of health and hygiene promotion as part of sanitation delivery programmes to informal settlements in the city of Cape Town (South Africa)'. proceedings of the 2007 National Conference on Environmental Science and Technology, 121-126
112. Vearey J, Palmary I, Thomas L, Nunez L and Drimie S (2010) 'Urban health in Johannesburg: The importance of place in understanding intra-urban inequalities in a context of migration and HIV, *Health and Place* 16(4): 694-702
113. Training and Research Support Centre (TARSC), Civic Forum on Human Development (CFHD) EQUINET (2018) 'Participatory meetings in Harare on health and wellbeing of urban youth, 2016-17', EQUINET, Harare, Available at: https://tinyurl.com/y9hjezwk
114. Tutu D (undated) 'Eco-ubuntu' in Enviropaedia. Available at: www.enviropaedia.com/topic/default.php?topic_id=336
115. United Nations (UN) (2016a) 'Millennium Development Goals indicators' [database]. Available at: http://mdgs.un.org/unsd/mdg/Data.aspx
116. United Nations (2016b) 'Sustainable Development Goals as defined in *Transforming Our World - the 2030 Agenda for Sustainable Development'*, United Nations Department of Public Information: New York.
117. UN Development Programme (UNDP) (2016) *Human Development Report 2015 statistical annex,* UNDP: New York. Available at: http://hdr.undp.org/sites/default/files/hdr_2015_statistical_annex.pdf
118. United National Educational, Scientific and Cultural Organisation (UNESCO) (2016) 'Data for the sustainable development goals' [database]. Available at: http://uis.unesco.org/
119. UN-Habitat (2015) 'Inclusive cities (issue paper)'. UN-Habitat III: New York. Available at: http://unhabitat.org/wp-content/uploads/2015/04/Habitat-III-Issue-Paper-1_Inclusive-Cities-2.0.pdf
120. UN-Habitat (2016a) 'UN-Habitat urban data' [database]: Nairobi'. Available at: http://urbandata.unhabitat.org/.
121. UN-Habitat (2016b) Partcipatory Slum Upgrading Programme (PSUP). Available at http://unhabitat.org/urban-initiatives/initiatives-programmes/participatory-slum-upgrading/
122. UN-Habitat (2016c) 'Using Minecraft 4 youth participation in urban design & governance, Kenya'. Available at: https://t.co/NT1NmAnbmp.
123. UNIDO (2013) 'Creative industries for youth: Unleashing potential and growth', UNIDO: Vienna.
124. UNICEF (2016) *State of the World's Children 2015 Statistical Tables*, UNICEF: New York.
125. United Nations statistical database (UNSD) (2016) 'UN data explorer [database]'. Available at: http://data.un.org/Explorer.aspx?d=ENV
126. VOYCE (2008) 'Student-Led Solutions to the Dropout Crisis', VOYCE, Chicago
127. VOYCE (2011) 'Failed policies, broken futures: The true cost of zero tolerance in Chicago', VOYCE, Chicago
128. WIPD (undated) 'The Youth Peacemaker Network in South Sudan' Available at: http://wpdi.org/sites/default/files/S.Sudan_Brochure_proof_final.pdf
129. World Bank (WB) (2016) 'Databank' [database]. Available at: databank.worldbank.org
130. World Health Organisation (WHO) (1948) *Constitution of the World Health Organisation,* WHO, Geneva
131. WHO (2010) Urban HEART User Manual. WHO Kobe Centre, Japan
132. World Health Organisation (WHO) (2016a) *World Health Statistics*, WHO: Geneva. Available at: www.who.int/gho/publications/world_health_statistics/2016/Annex_B/en/
133. WHO (2016b). *Global Report on Urban Health,* WHO: Geneva.
134. WHO (2016c) 'Health as the pulse of the new urban agenda', United Nations Conference on housing and sustainable urban development, WHO, Quito
135. WHO and UN Habitat (2010) 'Hidden cities: Unmasking and overcoming health inequities in urban settings', WHO Geneva and UN Habitat Nairobi: Geneva.
136. WHO and UN Habitat (2016) Global report on urban health, WHO,Geneva
137. Zyaambo C, Siziya S and Fylkesnes K (2012) 'Health status and socio-economic factors associated with health facility utilization in rural and urban areas in Zambia,' *BMC Health Services Research* 12: 389-6963-12-389. doi:10.1186/1472-6963-12-389
138. ZUS (2015) 'The Luchtsingel', ZUS, Available at: https://www.archdaily.com/770488/the-luchtsingel-zus

Equity in health *implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.*

EQUINET implements work in a number of areas identified as central to health equity in east and southern Africa

- Protecting health in economic and trade policy
- Building universal, primary health care oriented health systems
- Equitable, health systems strengthening responses to HIV and AIDS
- Fair Financing of health systems
- Valuing and retaining health workers
- Organising participatory, people centred health systems
- Promoting public health law and health rights
- Social empowerment and action for health
- Monitoring progress through country and regional equity watches

EQUINET is governed by a steering committee involving institutions and individuals co-ordinating theme, country or process work in EQUINET from the following institutions: TARSC, Zimbabwe; CWGH, Zimbabwe; University of Cape Town (UCT), South Africa; Health Economics Unit, Cape Town, South Africa; HEPS and CEHURD Uganda, University of Limpopo, South Africa, University of Namibia; University of Western Cape, SEATINI, Zimbabwe; REACH Trust Malawi; Min of Health Mozambique; Ifakara Health Institute, Tanzania, Kenya Health Equity Network; SATUCC and NEAPACOH

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