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生活習慣病対策における国際貢献の推進に関する研究

平成２４年度総括研究報告書

研究代表者　中村　桂子

平成２５（２０１３）年　３月

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総括研究報告

平成２４年度厚生労働科学研究費補助金（地球規模保健課題推進研究事業）
総括研究報告書

生活習慣病対策における国際貢献の推進に関する研究

研究代表者　中村　桂子　東京医科歯科大学大学院　国際保健医療協力学分野

研究要旨　わが国の都市地域を単位とする非感染症（Non-communicable Disease : NCD）対策における地域調査の手法の分析、地域の目標設定手法による対策の推進とその評価手法の分析、保健医療分野以外の部門と共同で取り組むHealth in All Policies (HiAL)の政策立案と事業計画の事例分析、および、各国、諸都市の非感染症予防・コントロールを目的とした調査、計画、事業とその評価に関する事例分析に基づき、国外の諸地域に適用可能な生活習慣病対策とその適用方法を検討した。

都市地域単位の非感染症対策では、多部門連携による包括的、総合的な対策により相乗的な効果が期待されている。(1) 都市地域単位の非感染症対策における多部門間連携の概念、(2) 事業の内容例、(3)事業推進の組織例、(4)部門間の役割分担例、(5)指標によるプロセスと成果の評価の具体例を示して対策の全体像を示すことにより、国外の諸地域における非感染症対策への適用が促進されると考えられた。

A．研究目的

非感染症（Non-communicable Disease: NCD）は世界の疾病負荷の60%をしめ、今後はさらに途上国におけるNCDによる疾病負荷の増大が予測され、予防対策と適切な疾病管理の体制構築が急務である。

世界保健機関（WHO）によるNCD予防とコントロールに関するグローバル行動計画(2008)、国連ハイレベル会合決議(2011)において、リスクファクター、社会的健康決定要因について、政府のすべての部門による予防とコントロール（Health in All Policies:HiAL）に取組むべきことが指摘されている。

この研究の目的は、わが国の生活習慣病対策の成果に基づき、効果的なNCD対策手法、健康日本21などの地域の目標設定手法による対策の推進とその評価、多部門と共同で取り組むHiALの政策立案と事業計画および進捗評価のデータベースを作成し、これらに基づき、国外の諸地域に適用可能な生活習慣病対策とその適用方法を明らかにすることである。

B．研究方法

（１）政府、自治体、企業、住民組織を対象とする国内における健康推進、NCD予防の実施状況と評価の方法に関する基礎調査を実施した。

（２）アジア太平洋地域の諸都市において住民の健康を重視する都市政策を展開しているAlliance for Healthy Citiesの都市の協力を得て、アジア太平洋地域の各国におけるNCD予防に関する地域住民の生活習慣の状況、NCD予防を目的とした事業の実施状況、NCD予防活動の評価に関する現状を調査した。

（３）NCD予防・コントロールにおける、多分野横断的な取組の事例を収集した。

（４）国連ハイレベル会合決議・WHOアクションプランをふまえ、NCD予防・コントロー

ル　マルチセクター行動計画ガイドラインに必要な要素を検討した。

C．研究結果と考察

日本の都市単位で実施しているNCD予防・コントロールを目的とした地域調査の手法、地域の評価指標について分析を行った。各都市ではNCDの有病状況、受療状況、健康診断受診状況、生活習慣の他、地域の健康推進活動への参加状況、民間サービスの活用状況、地域住民との相互支援と交流の状況、地域の交流活動への参加状況の情報収集を行い、NCD予防活動を推進する地域資源開発を行っている。NCD予防に関する多部門間協力の事例として、安全な歩行通路の整備、自転車通行路の整備、全ての住民が同様にアクセス可能な公共交通の整備について分析した。多部門の人材に対する健康推進のプロセスに関する情報提供、多部門の参加による事業開発が、多部門間連携の強化に関与することが示唆された。

韓国、中国、オーストラリア、マレーシア、フィリピン、ベトナム、カンボジア、モンゴルにおける各国、諸都市のNCD予防・コントロールを目的とした調査、計画、事業とその評価に関する事例分析を行った。韓国、台湾の都市の一部では、目標設定型のNCD予防の計画に着手していた。一方、基礎自治体単位の、ポピュレーションベースのNCDの罹患、有病状況、喫煙、食生活、運動習慣などの生活習慣に関する基礎データベースは整っておらず、アウトカムとプロセス評価においての指標設定に課題があった。都市単位でのNCD予防啓発事業の取組が開始されており、NCD予防は、都市住民の健康推進の優先課題のひとつに組み入れられている。

D．結論

わが国の都市地域を単位とする非感染症対策手法、健康日本21などの地域の目標設定手法による対策の推進とその評価手法、保健医療分野以外の部門と共同で取り組むHealth in All Policies (HiAL)の政策立案と事業計画の事例分析、および進捗評価のデータベースの作成、各国、諸都市の非感染症予防・コントロールを目的とした調査、計画、事業とその評価に関する事例分析に基づき、国外の諸地域に適用可能な生活習慣病対策とその適用方法を検討した。

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E．研究発表

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community efficacy. Korea Healthy Cities Workshop, Wonju, ROK, May, 2012.
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Ｆ．知的財産の出願・登録状況

なし

研究成果の刊行に関する一覧表

研究成果の刊行に関する一覧表

書籍

著者氏名	論文タイトル名	書籍全体の編集者名	書　籍　名	出版社名	出版地	出版年	ページ
中村桂子	Addressing health vulnerabilities of the urban poor in the 'new urban settings' of Asia.	ED Sclar	The Urban Transformation : Health, shelter and climate change.	Earthscan, Routledge	Abington	2012	82-102.

雑誌

発表者氏名	論文タイトル名	発表誌名	巻号	ページ	出版年

研究成果の刊行物・別刷

Chapter 5

Addressing health vulnerabilities of the urban poor in the 'new urban settings' of Asia

Susan Mercado, Kirsten Havemann, Keiko Nakamura, Andrew Kiyu, Mojgan Sami, Ira Pedrasa, Divine Salvador, Jeerawat Na Thalang and Tran Le Thuy

Introduction

Asia is home to 60 per cent of the world's population. Demographers estimate that in the next few decades more than 60 per cent of the increase in the global urban population will be in Asia – mostly in China and India, but also in Pakistan, Bangladesh, the Philippines and Vietnam (Ling and Phua, 2006). Urban growth in Asia is the product of natural growth (the excess of births over deaths), net in-migration (the excess of inflow over outflow) and the growth that results from administrative changes or the redrawing of boundaries that reflect the reality of urban sprawl. In each country, these three sources of urban growth combine in unique ways, with unique implications for urban administration and national policy.

Unlike urban growth elsewhere, the growth of Asian cities and municipalities has usually been accompanied by economic prosperity. The Asian economic miracle was one of the most significant global developments of the twentieth century, and it has brought many benefits – higher incomes, better education, better health outcomes, declines in rates of infant mortality and longer life expectancies – not only to the East Asian 'tiger economies', but also to many other countries in South and Southeast Asia: the per-capita gross domestic product (GDP) of Asian cities is often higher than the per-capita national GDP, an economic pattern that well reflects the attraction of those cities for rural migrants seeking better economic opportunities. These benefits will continue to drive the rural-to-urban population shift for the foreseeable future, as well as the ongoing high levels of migration both within and between countries. These migrations play an important role in a nation's economic transformation, but they also demand a rethinking of how development policies may affect the health of urban populations.

Nevertheless, the economic picture in Asian cities is far from being uniformly positive. Where urbanization has been unplanned or has progressed at an unmanageable pace, the existing public infrastructure, the urban environment and the traditional social fabric have all deteriorated. Growth and wealth in such cities no longer confer their former 'urban advantage'. In those developing countries of Asia where the national and municipal authorities have not been

able to cope with the speed of change, the net effect is failure of governance, increased and unabated inequity, and the urbanization of poverty. In developed countries, economic inequities have intensified throughout the population, in addition to such traditional determinants of wealth as ethnicity, gender and age.

Unplanned growth has led to similar inequities in population health. In rapidly urbanizing environments, groups that are well-off co-exist with economically vulnerable groups who face serious threats to their health, even though both 'live in the same city'. Unfortunately, those differences may not be easy to glean from routine health statistics. To unmask the differences and develop relevant interventions for combating health inequity, new ways of looking at and evaluating health vulnerability are needed. The priorities of public health may need to move beyond simply improving the access to and quality of health services, and toward creating fairer opportunities for good health across entire urban regions.

Among those whose health is most at risk are the people in low-income and informal settlements ('slums')[1] (WHO Centre for Health Development, 2005). By some estimates, 60 per cent of the world's informal settlers and slum dwellers live in Asian cities. In South Central Asia, slums and squatter settlements constitute 58 per cent of the total urban population; in Eastern Asia, the corresponding number is 36.4 per cent; and in South Eastern Asia, 28 per cent. In absolute terms, the population of urban slum dwellers in three regions totals more than 500 million (Ling and Phua, 2006).

The social determinants of health

A number of scholarly studies, including papers by Wratten (1995), Rakodi (1995), Satterthwaithe (1997), Sen (1999), Kawachi and Wamala (2007) and the Knowledge Network on Urban Settings of the WHO Commission on Social Determinants of Health (WHO Centre for Health Development 2007), have pointed out that poverty is not only a matter of limited financial or material resources. It is also characterized by a diverse set of restrictive social conditions that determine health risks and outcomes, including lack of:

- *opportunities* (for employment and access to productive resources)
- *capabilities* (access to education, health and other public services)
- *security* (vulnerability to economic risks and violence)
- *empowerment* (absence of voice, power and participation in governance)
- a health-supporting physical *living environment* (poor housing, unsafe working conditions, unnecessary exposure to biological, chemical and physical threats to health).

These characteristics of poverty apply in both rural and urban settings, but they tend to be severe in the urban living environment (WHO Centre for Health Development 2007).

The urban poor who live in deprived urban settings, informal settlements and slums constitute the single largest group of vulnerable populations in Asian cities today. Subgroups within this population include women, children, the disabled, minority groups of various ethnic origins or countries, street children, commercial sex workers, survivors of HIV/AIDS, 'dalits' (outcastes), indigenous peoples, sexual minorities, transient workers and hawkers, among others. The knowledge and means to provide services to such vulnerable groups and treat their diseases are available. But health vulnerability is closely related to living and working conditions, to social status, and to the systematic social and political exclusion that renders vulnerable groups 'invisible' and powerless. Thus, although health vulnerability is reversible in principle, overcoming the social and political barriers to equitable health opportunities is a formidable challenge.

It is therefore not enough to address health vulnerability merely by providing better access to health services or information. The social determinants – 'the causes behind the causes' – of ill-health in urban settings demand attention. For the urban poor in Asia this means that stopping the development of new slums in urban settings is of paramount importance (Garau *et al.*, 2005). The logic behind this priority has been aptly summarized by Sir Michael Marmot, Chair of the WHO Commission on Social Determinants of Health: 'Why do we keep treating people, only to send them back to the conditions that made them ill in the first place?' (Marmot, 2006).

Urban governance and health inequity

It is widely believed that the urban poor should fend for themselves and that better job opportunities will erase social inequity in cities. Yet the data show otherwise: despite economic prosperity in many Asian cities, the growth of slums and informal settlements has escalated as well.

In Asia, as in other parts of the world, cities are 'engines of growth' that concentrate power and wealth, but they are also centres of opposition and dissent. Deep suspicions and polarizing disputes among various factions have given rise to conflicting policies and political stalemate in addressing the structural determinants of health for the urban poor. The reality is that uneven power structures, incomplete decentralization and weak local governmental capacity, coupled with cultural bias and social discrimination against the urban poor, remain deeply embedded both in health systems and in larger systems of governance. A framework for better urban governance is needed to change the urban socio-ecological phenomena that cause health inequity and unnecessary vulnerability. In other words, governance must be reformed if the half-billion people who live in Asian slums are to have better lives.

We take 'governance' to mean 'the management of the course of events within a social system' (Barten *et al.*, 2007). It encompasses a wide range of actors in addition to those in positions of governmental authority. Looking

at health from the perspective of governance can help identify nodes of power and influence that can enable the urban poor to gain greater control of their life circumstances and the determinants of their health (Barten *et al.*, 2007, Burris *et al.*, 2007). Such participation by the governed is one key feature of good governance, and so an emphasis on enabling participation underscores the importance of good governance in achieving better health for vulnerable groups. At the same time, the proliferation of informal settlements and the growth of slums reflect a 'failure of governance' – that is, current systems of governance have turned out to be inefficient, corrupt, unresponsive or irrelevant to the needs of the governed. Here, then, are some key principles of good governance:

1 Participation, the degree of ownership and involvement that stakeholders have in the political system.
2 Fairness, the degree to which rules are applied equally to everyone.
3 Decency, the degree to which rules are formed and implemented without humiliating or harming particular groups of people.
4 Accountability, the extent to which those with governing power are responsible and responsive to those who are affected by their actions.
5 Sustainability, the extent to which current needs are balanced with those of future generations.
6 Transparency, the extent to which decisions are made in a clear and open manner.
7 Political commitment to policies and procedures that implement the six principles above.
8 Equitable enforcement of laws.
9 Protection of human rights.

If one of the central goals of good governance is the creation of systems, institutions and processes that promote a higher level and fairer distribution of health in urban settings, we can list further principles of 'healthy urban governance' that are critical for improving population health in cities:

- Holding local governments accountable for health outcomes.
- Enabling and supporting the urban poor as they gain control over factors that determine their health and the quality of their lives.
- Putting health and development at the centre of urban planning, policies and action.
- Developing mechanisms that promote dialogue and cooperation among various groups in the private, public and civil society sectors, including national and local authorities.
- Winning and using resources – aid, investment, loans – to improve the living conditions of the urban poor.

Health in the 'new urban settings' of Asia

As early as 300 BC, the development of cities in Asia was linked to trade. Cities interconnected by the Silk Road flourished, as gold, silver, ivory, silk, precious stones and exotic animals and plants were traded between East and West. Asian cities engaged with the rest of the world through trade and commerce, and became strategic hubs for economic growth across the continents.

Recent proposals suggest how these historic trends will continue: land bridges are planned for connecting Europe through China (a route with stops in Tianjin, Beijing, Ulaanbaatar, Ulan and Irkutsk). A trans-Korean railway may one day join Japan with Eurasia through the Korean peninsula. In the near future, Bangladesh may become the transport hub of the entire Southeast Asian region, the gateway to the world for such countries as Bhutan, India, Myanmar and Nepal, via the Bangla Bandha land port and the Chittagong seaport. Malaysia has recently positioned itself to compete with Singapore as the key Southeast Asian shipping hub for the region. Its port city of Tanjung Pelepas, on the southern tip of the Malay Peninsula, faces the Strait of Malacca, one of the world's most important international shipping channels.

These lines of connectedness hold great potential for generating economic growth and prosperity. But as recent history has shown, extensive city-to-city connectedness also exposes every city in the trade network to serious risks: the spread of infectious diseases, harmful products such as tobacco and illicit drugs, and social tensions 'imported' from densely populated regions elsewhere in the world.

So what is different about Asian cities today?

Five interrelated conditions distinguish the current Asian urban context from that of any other historical period:

1 The unprecedented rate of urban growth and its effect on municipal governments.
2 Faster and continuing growth of market economies in 'primate cities' (a primate city is between four and ten times the size of a country's second largest city, which dominates urban life). Such growth is accompanied not only by marked improvement in quality of life and living conditions in some places, but also by an upsurge in poverty, slums, informal settlements and inequity in others.
3 Regrouping of marginalized and socially excluded groups along ethnic, cultural and religious lines within cities (the sub-communities of Nepalese refugees in the slums of New Delhi, for instance).
4 Sustained city-to-city interconnectedness through trade, commerce, industry and international travel.

5 New and emerging health vulnerabilities brought about by a confluence of biological, social, political and environmental tensions and risks.

Those cities, in which all five of these conditions hold, constitute what the WHO Centre for Health Development refers to as 'new urban settings'.

Given the practical and theoretical understanding described in the foregoing, we assessed a number of innovative programmes that aim to eliminate health inequities by addressing the social determinants of health and by improving urban governance. We identified examples of innovations from work by the WHO Healthy Cities project in the WHO Western Pacific Region and the Southeast Asian Region; by the Alliance for Healthy Cities; and by the Knowledge Network on Urban Settings of the WHO Commission on the Social Determinants of Health, of which the WHO Kobe Centre is the hub. (The lead author of this chapter, Mercado, as well as co-authors Havemann and Sami were all affiliated with the WHO Kobe Centre at the time this paper was written.) In all, we reviewed more than 500 case studies and reports. They included innovations that tackle upstream determinants of health (socio-ecological drivers) as well as downstream ones (access to quality health care, information, services and programmes). Where documentation was insufficient or outdated, we commissioned the writing of case reports through the Southeast Asian Press Alliance, an independent network of Asian journalists.

We considered a broad range of criteria in evaluating the programmes for rollout or adoption in other venues:

1 Their effectiveness in reducing the health vulnerability of the urban poor (we maintained that criterion even though we recognized that some programmes (e.g. providing low-cost public transport from urban to rural areas) do not target the urban poor per se, but the poor in general).
2 The attention they paid to overcoming social barriers to health, via interventions clearly consistent with principles of good governance.
3 The documentation they provided or that we were able to assemble through the efforts of the Southeast Asian Press Alliance. We wanted documentation at least to include lessons learned from implementing a programme, but we preferred reports that discussed tools, offered guidelines, and explained the methodology behind a successful programme, since those details would enable others to apply an innovative programme.

More specifically, we considered an improvement in disease morbidity and mortality to be only one of several sources of information relevant to judging the effectiveness of an innovation. For example, we looked at the indicators of good governance we listed earlier (participation, fairness, decency,

accountability, sustainability, transparency, political commitment, enforcement of laws and protection of human rights). We also considered the principles of healthy urban governance (accountability for health, support of the urban poor in controlling their own health, making health central to urban planning, promoting dialogue and cooperation among groups and investing resources in the lives of the urban poor); health-systems indicators (efficiency, capacity- and institution-building, sources and uses of funds for health); environmental health indicators (quality of housing, quality of indoor air, amount of pollution); and political and community indicators (public perception of the programme, community participation in it, the degree to which the programme fostered or improved social cohesion, support for policy and adherence to public health policies such as quarantine measures).

Innovative approaches to reducing health vulnerabilities of the urban poor

After evaluating more than 500 programmes according to the criteria stated earlier, we found that the most effective innovations incorporate one or more of six general features:

1 They encourage the urban poor to become key drivers and decision-makers in the upgrading of their own communities.
2 They help local governments learn to improve urban health and thereby hold themselves accountable for healthy urban settings.
3 They take advantage of infectious disease outbreaks to promote healthy settings over the longer term.
4 They improve the efficiency of financing health promotion in cities.
5 They apply information technology to population health activities.
6 They seek to optimize the social determinants of health in urban settings.

Each of these six features deserves individual discussion.

Encouraging the urban poor to become key drivers and decision-makers in the upgrading of their own communities

What makes change happen? What, for instance, has been the driving force behind what is arguably the most important innovation in population health for Asia: the effort to link the right to health of the urban poor to the more general requisites of a decent life – secure housing, land rights and access to credit through microfinancing? The answer is not the actions of ministries of health or housing. Rather, the urban poor themselves have made this link into an issue of social justice. They have the desire, the political will, the capacity to negotiate, the willingness to promote dialogue and the time and energy to manage funds and projects for upgrading their own communities. The primary stakeholders

of this movement for social justice in the face of health inequities are organized groups of urban poor, who negotiate for the requisites of a decent life and better health. These groups have discovered the power of their numbers, as well as the value of direct contact with other organized groups, international donors, partners and advocates for the poor throughout the world. They understand that these other groups, often outsiders, can act as 'nodes of governance' that help bring powerful gatekeepers and interests to the negotiating table.

The organizations and groups that have been most effective in facilitating this movement for health justice are the ones that have worked steadily to reshape common misperceptions about the role of the urban poor by others, as well as by the urban poor themselves. The poor have emerged from being 'targets' and 'beneficiaries' to being redefined as 'key drivers' and 'decision-makers'. Their incremental and hard-won gains in promoting the participation, decency, fairness and accountability of good local governance have led to meaningful changes in their day-to-day existence. Organizations and groups that have helped the poor to realize their powers have also documented the changes that resulted; such organizations include the Society for the Promotion of Area Resources Centres (SPARC), the Asian Coalition for Housing and Rights (ACHR), Slum Dwellers International and its member groups, the Women's Development Bank Federation, Nepalese National Squatters Federation, Philippines Homeless People's Federation, National Slum Dwellers Federation/Mahila Milan, and Homeless International.

Changing power relations

> What the urban poor federations have done is to show that an effective housing policy for low-income groups is actually about changing the relationships of 'slum shack' and 'pavement' dwellers with official agencies – not about physical improvements. The physical improvements – in housing, housing tenure and basic services – come from these changing relationships.
>
> Satterthwaite, 2005, p4

David Satterthwaite reached this conclusion as long as seven years ago, in a paper presented at a social policy conference in Arusha, Tanzania (Satterthwaite, 2005). He singled out six organizations, including the Community Organization Development Institute (CODI) in Thailand, that demonstrate how participatory and inclusive processes have brought good services, including health care, to slum and squatter settlers. CODI mobilized neighbourhood groups of slum dwellers, networks of sectors and networks of important stakeholders and leaders who were able to make a difference. The organization's tactic of forming 'networks of networks' has now been applied in 415 communities and 30,000 households in 140 Thai cities (Boonyabancha, 2005).

What accounts for its success? Somsook Boonyabancha, Director of CODI, explains that networking among organized groups creates new power bases (Boonyabancha, 2005). When communities of the urban poor can look at their city in its entirety, she notes, they no longer feel isolated within their individual settlements – they have allies and friends with similar difficulties, similar fates and similar ways of doing things. Their wider perspective can lead to political engagement, which can result in more direct access to power as well as greater influence over decision-making. The entire process can even lead to new 'nodes of governance' (Burris *et al.*, 2005) and power structures that are fairer, more responsive, more accountable and more transparent.

Confronting patronage politics and moving toward democratization

Municipalities – and municipal politicians from various parties – generally have their own intermediaries that engage with communities of urban poor. Within a given city, such communities tend to be divided into camps – one camp might 'belong' to the ruling party, for instance, whereas another might belong to the opposition. Politicians like to have one-on-one ('bilateral') relationships with community leaders, enabling them often to take a 'divide and rule' approach in dealing with their constituents and so maintaining power. But if this kind of patron–client relationship and its division between powerful 'benefactor' and lowly 'petitioner' is to change, such exclusive bilateral ties must be challenged. Development interventions can play an important supporting role in such a challenge by encouraging poor communities in a city to work together. The key goal is to foster city-wide processes that empower the urban poor not only to gain independence from the vertical strings of patronage that control their lives, but also to tap into them to advance their own interests.

A sharper focus on social cohesion: 'community-upgrading' versus 'slum-upgrading'

Within every community, even communities of the very poor, social gradients exist. Some individuals and families have better access to resources or social networks than others. Taking a sensitive approach to existing social gradients is crucial to the success of development interventions. 'Community-upgrading' emphasizes the restoration of shared space, shared resources and public goods, whereas 'slum-upgrading' is often a matter of improving only the poorest and perhaps excluded sections of a community. Thus the latter can be perceived as an assault on the very stability of a community, whereas community-upgrading can be a powerful intervention for rebuilding or reinforcing social cohesion. Social cohesion builds trust and creates opportunities for all individuals and families to take advantage of common resources and join social networks. Engaging the members