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Right to the city, right to health: what are the interconnections?

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Abstract *Right to health intertwines with right to the city: guaranteed access to healthy urban spaces reduces inequities among the population, so that disadvantaged groups can also enjoy positive urbanization effects. In this sense, interconnection between right to the city and right to health promotes equity. This article seeks to explore the interconnection between right to the city and right to health on the basis of an integrative review guided by the question 'What knowledge about right to the city and right to health has been produced in the light of equity?' For this purpose, we analyzed evidence available in the literature indexed in PubMed/Medline, Lilacs, and SciELO between 1986 and 2016. Over this three-decade span, we identified the presence of different degrees of right to the city and right to health in the formulation of policies and in social movement agendas. Formulations regarding population growth moved away from the rights agenda, but in a later phase of democratic consolidation, the fight for rights to health re-emerged. In a third moment of the political visibility of excluded geographical spaces and multiple identity agendas, the struggle to ensure everyone's right to the city came on strong in the game.*

Key words *Right to the city, Urbanization, Right to health, Equity*

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Right to the city, right to health: history

Globally, more people live in urban areas (54%) than in rural areas. The urban population has increased dramatically worldwide: from 746 million in 1950 to 3.9 billion in 2014[1]. Unplanned urban growth is a threat to sustainable urban setting development because policies alone fail to ensure equal distribution of urban life benefits.

In the Americas, between 43% and 78% of the urban dwellers live in slums without basic public services like water and sanitation, waste and refuse collection and elimination, transportation, electricity, healthcare, and education. These dwellers are not protected against the high prevalence of transmissible diseases, violence, or large mortality rates, either[2].

"Right to the city" was introduced as the title of a book authored by the French philosopher Henry Lefebvre in 1968. The definition of "Right to the city" sought to highlight the non-exclusion of any part of the society from access to urban life quality and benefits. The author also criticized the urban reality interpreted in terms of spatial issues only. He considered that this interpretation was reductionist and simplistic because it did not consider individuals as subjects acting in the social space[3,4].

Popular movements like the movement of Abahlali base Mjondolo residents in South Africa, who live in precarious housing conditions; the Right to the City Alliance in the United States of America; Recht auf Stadt, a network of occupiers, tenants, and artists in Hamburg; and various movements in Asia and Latin America have incorporated the idea of right to the city for more democratic governance in response to gentrification and urban displacement[5].

The type of city the population desires cannot be divorced from the type of social bonds the population wants to establish, the relationship the population wishes to have with nature, the lifestyles the population wants to enjoy, and the technologies and esthetic values the population wishes to foster. David Harvey, a British geographer, advanced this debate by offering a more connective reflection about citizens, cities, values, and nature. In his view, right to the city depends on exercising a collective power to shape the urbanization process once the freedom to build and rebuild the city and ourselves is one of the most precious and neglected human rights[6].

Right to health is part of the set of social rights that some countries recognize and guarantee. Right to health is inspired by the state's duty to finance health actions and to promote universal access to health as a right to citizenship.

Right to health intertwines with right to the city: guaranteed access to healthy urban spaces reduces inequities among the population, so that disadvantaged groups can also enjoy positive urbanization effects. In this sense, interconnection between right to the city and right to health promotes equity.

But what is equity? Figure 1 illustrates the difference between equality and equity, bringing the concept of social justice to light.

John Rawls, an American political philosopher, indicated some theoretical paths to a society that seeks to establish social justice and to distribute opportunities fairly. His theory of justice was based on promoting equity or, as he put it, on promoting an 'original position of equity' or a fair starting point for everyone:

Those that can be supported by their families and who receive good formal education have obvious advantages. Allowing everyone to participate in the race is a good thing. However, if runners start at different positions, it will hardly be a fair race[7].

With the main goal of distributing resources, the equity notion admits that the unequal are unequally assisted. Hence, the most vulnerable must be prioritized for equality to be achieved. Equity should be considered a "transversal dimension" and should be taken into account during analysis of all the proposed interventions. Nevertheless, it is necessary to clarify a conceptual framework that allows the equity issue to be analyzed and interpreted[8-11].

Some fundamental questions underlie the construction of conceptual models to study equity in health. One example of these questions is 'How do inequities including the lack of systematic individual investment and community infrastructure (education, health services, transport, etc.) affect health?'

The discussion of health inequalities among social classes does not usually identify the origin or the nature of the problem. Income inequality would be just one of the many manifestations of material conditions that impact the general population's health[9-15].

In search of interconnections

This article seeks to explore the interconnection between right to the city and right to health on the basis of an integrative review guided by

the question 'What knowledge about right to the city and right to health has been produced in the light of equity?'

This study followed the protocol for keyword choice, data search and selection, eligibility evaluation, and article screening and selection described by Mendes et al.[16]. We analyzed evidence available in the scientific literature indexed in PubMed/Medline and in the Virtual Health Library (Lilacs and SciELO). We used the following keywords: urbanization, right to health, and equity.

The inclusion criteria were as follows: articles that analyzed the interconnections between right to the city/urbanization and right to health, article format, and time frame spanning from 1986 to 2016, which we defined to coincide with the period between the first WHO Global Health Promotion Conference held in Ottawa and the latest WHO Global Health Promotion Conference held in Shanghai, China, in 2016.

Information extracted during the data evaluation and categorization phase took the concepts of Polit et al.[17] into account because, in addition to the synthesis, we sought to fill knowledge gaps about how urbanization, health, and equity promotion were related. The flowchart (Figure 2) describes the selection and choice of articles listed in this review.

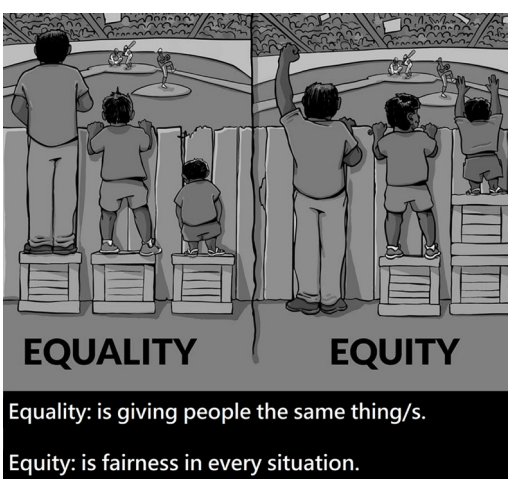

Figure 1. Image taken from the Internet.

What will we learn from this review?

As for the origin of the collected material, 40% (8), 20% (4), 15% (3), 15% (3), and 10% (2) of the selected studies were conducted in North America, Asian countries, European countries, Brazil, and Australia, respectively. Regarding the language, 85% (17), 10% (2), and 5% (1) of the studies were published in the English, Portuguese, and French language, respectively. Most studies were qualitative.

We grouped the data according to the publication period: from 1986 to 1995, from 1996 to 2005, and from 2006 to 2016. Subsequently, on the basis of their prevalent approach, we classified the articles into three thematic categories: Urbanization and Population Growth, City Response to Right to the City and Right to Health, and Urban Areas of Exclusion and Groups in Situations of Vulnerability. Charts 1 to 3 present the material in a descriptive way.

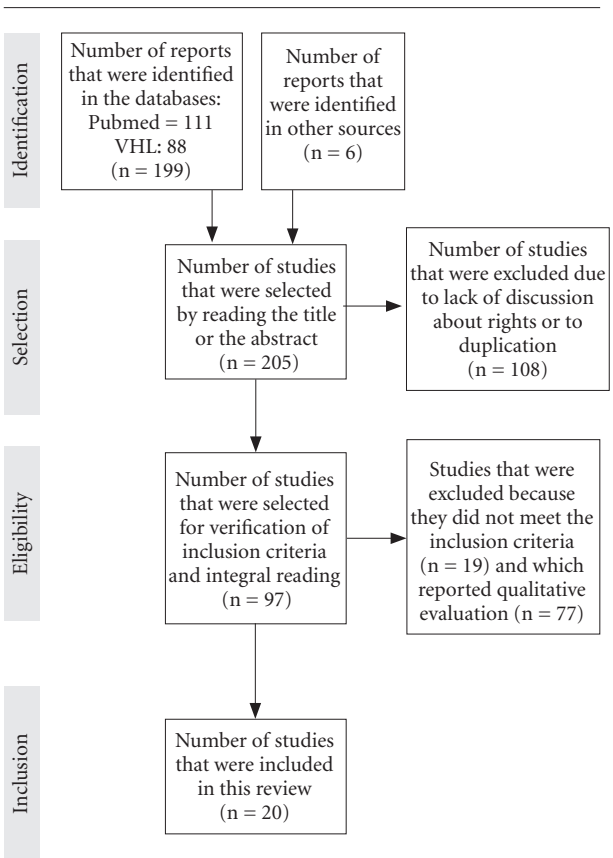

Figure 2. Flowchart of included studies.

Chart 1. Urbanization and Population Growth, 2017.

Thematic Category	Article/ Reference	Objectives	Main results/considerations
Urbanization and Population Growth	Tabbarah[18]	To analyze the Arabian development in terms of production factors - land, labor, and capital.	To eliminate the gap between social and economic aspects of urban development, it would be necessary to improve education, to provide policy options, to create institutions that ensure implementation of social and cultural projects, and to offer economic alternatives for migration.
	Richardson[20]	To analyze the policies for population distribution in developing countries.	In the 1980s, population distribution policies received attention in developing countries. Several social benefits, like efficiency, equity, environmental quality, national security, and integration, were provided. The problem lay in poorly drawn strategies.
	Efremov et al.[21]	To relate environmental hygiene and population health.	Ecological urban planning, environmental conditions, and basic trends (prophylactic attitudes and creation of a conflict-free urban environment) potentiate health development.
		To discuss the demographer's role in populational education.	Demographics includes population phenomena, such as high fertility, declining mortality in developing countries, AIDS epidemic, interaction between the population and the environment, and increased migratory movements resulting from urbanization.

Source: Elaborated by the authors.

Chart 2. City Responses to Right to the City and Right to Health, 2017.

Thematic Category	Article/ Reference	Objectives	Main results/considerations
City Responses to Right to the City and Right to Health	Fraser[22]	To present the report "The 1996 State of the World Population".	The urbanization process and urban life descriptions are key to improving cities and to raising awareness about equality issues. Human rights should not be obstructed by the cultural, social, or religious values imposed on women.
	Stephens et al.[23]	To evaluate socioeconomic, health, and environmental inequalities in two cities.	The unequal distribution of socioeconomic conditions exposes the myth of urban health and reveals inequalities in terms of life chances between groups in each environment and age group. It emphasizes the importance of the data to managers.
		To list the specialists' opinions about population trends and events in the 2^{0th} century	Trends: declined fertility, increased number of elderly citizens, hormonal contraceptive development, stagnant population growth in economically rich countries and in countries with high literacy rates, gender equality and equity promotion, woman empowerment, adoption of comprehensive reproductive health and rights policies, prevention and treatment of sexually transmitted diseases, including HIV/ AIDS.

Source: Elaborated by the authors.

The first decade: from 1986 to 1995

Only in the 1960s did some countries become aware of changes in population dynamics and their consequences to the quality of life and to the aims of socioeconomic development[18,19]. Population phenomena and their implications were still poorly understood, but education at all

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Chart 3. Urban Areas of Exclusion and Groups in Situations of Vulnerability, 2017.

Thematic Category	Article/ Reference	Objectives	Main results/considerations
Urban Areas of Exclusion and Groups in Situations of Vulnerability	Jung[25]	To identify social and health quality indicators in South Korean communities.	Regional social and health quality indicators are considerably different from local economic index or health indicators. Disparities probably originate from the degree of urbanization and from the degree of citizens' cohesion. Hence, government relations must be analyzed in order to elucidate what causes these disparities and to develop policies that will improve social quality in general and continuously.
	Schwarz et al.[26]	To examine urban tree coverage in seven cities of the United States.	There is a positive correlation between afforestation and average family income. However, interventions to increase afforestation should consider distributive equity and the community's needs (desire, willingness to care), or the costs may exceed the benefits.
	Attoh[27]	To analyze the concept of right to the city as well as its sources of tension and contradictions.	Right to the city represents costs, requires compromise, and may come at the expense of other rights. The question of what kind of right is right to the city destroys the contradictions that must be fulfilled by those who wish to see the city's progressive potential. This process must be collective because strategic fragility can be politically convenient.
	Skinner, Masuda[28]	To explore the personal health geography and the right to the city, mapping of Aboriginal youth.	Location, mobility, and limits affect health and reflect inequalities. Urban spaces produce and are produced by racist geographies that isolate, segregate, and increase risk exposure. Right to the city and right to health require that such attitudes and behaviors be dismantled.
	Friel et al.[29]	To describe how urban and social planning influences health equity.	Different types of governance can shape agendas, policies, and programs, which will either help to promote health or perpetuate social exclusion. Unequal resource distribution associated with health inequalities suggests that the local urbanization model needs to be reconsidered.
	Rice, Hancock[30]	To discuss ecological sustainability, social equity, and their interactions in the urban governance process.	To inspire future generations, urban governance should use participatory tools, forums, and virtual networks with intersectoral committees, civil society organizations, and excluded groups to channel policy and program development processes that produce fairer cities as well as healthy and sustainable environments.
	Rolnik[31]	To assess obstacles to the urban reform agenda implementation.	In Brazil, urban reform advancement requires a policy based on strengthening of democratic spaces, social control, and a fundamental plan for political reform and development of urban governance to consolidate democracy in the country.

it continues

Chart 3. continuation

Thematic Category	Article/ Reference	Objectives	Main results/considerations
Urban Areas of Exclusion and Groups in Situations of Vulnerability	Caiaffa et al.[32]	To explore the transformations of contemporary cities and the impacts on human health.	Health studies in the urban environment require transdisciplinarity to develop theories, concepts, and methods. Negative urban impacts amplify adverse effects on health, suggesting that assessments and non-health interventions must be reconsidered.
	Friel et al.[33]	To describe the relationship between climate change and urban health inequities.	Climate change exacerbates social inequalities and urban health. Despite the help of policies, health programs, and urban planning, gaps still have to be addressed in different socio-economic contexts as well as in the living and working environments. The authors suggest a global research agenda.
	Caiaffa, Friche[34]	To bring individuals who produce academic knowledge and individuals who draw up public policies closer.	The authors reinforce that it is important to bring the academia and politicians closer in order to discuss urban land transport, public health investments, equity-focused programs, as well as actions involving the government and the society with a view to a safe and healthy urban life.
	Martenies et al.[35]	To evaluate metrics of health impacts and similar metrics for air quality management.	Recommendations for metrics selection: they must be comprehensive and capable of identifying morbidity and mortality and of communicating health impacts, they must use local data, and they must incorporate public health outcomes into spatial and temporal dimensions and the equity of impacts.
	Prasad et al.[36]	To analyze the use of the WHO Urban HEART tool, which addresses health inequalities in cities.	Improved access to drinking water, sanitation, and unemployment guide intervention in cities. Local governments and stakeholders have shown greater control and confidence in using the HEART tool to drive local action and to improve equity in health.
	Wu et al.[37]	To explore cellular network collaboration as a means to identify resource use.	City management faces the challenges related to resource (water, food, and energy) supply efficiency, equity, and quality by using the cellular network, which spatially records the movement of resource use. This has a significant impact on resource consumption and brings a new perspective of study that integrates human movement with spatial distribution.

levels had already been identified as an alternative to face such challenges.

In the 1980s, population distribution policies received increasing attention in developing countries, especially in countries combining modest urbanization levels with high population growth rates. Richardson[20] argued that measures like shifting the national capital location and creating new cities were not worth adopting frequently because they were expensive and had minimal impact on population growth. He suggested that population distribution across different geographic spaces could be more effective. He also considered that strategies to control city growth and to implement rural development programs were complementary rather than alternative.

Urban development processes positively affect the population's health, so it is necessary to

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find ways to protect and maintain such development. Promoting and clarifying prophylactic attitudes and creating public and collective living environments could potentiate healthy urban planning[19,21].

Population distribution policies have received attention in developing countries. Among other benefits, these policies provide social benefits, efficiency, and equity. Urban planning has contributed to enhancing health in these places. Studies have indicated the existence of local information systems that help to monitor and to evaluate projects. However, most initiatives have only used management information systems to monitor policy implementation and formulation[20,21].

The second decade: 1996 to 2005

In the late 1990s, Fraser[22] and Tarmann[24] highlighted that urbanization was happening fast, that megacities were emerging, and that democracy was expanding. Gradual evolution of social policies and programs highlighted the pressing need to grant a large number of vulnerable individuals access to these programs. A series of conferences from various segments of the society focused on global issues. The focus of population issues shifted to people and their health, which required cooperation actions and forms of government that protected social rights[22,24].

To understand these issues and to contitnuously improve the population's life conditions, managers and policy makers must identify the structural origins that produce disparities in the close relationship between a community's ability to remain healthy and its quality of life[23,25].

Urban change has given rise to problems that still represent significant challenges for development. This has been true especially after 2001. Given that many national issues have a global dimension, different proposals to solve this confrontation have turned to the conditions created by urban life itself, particularly to the conditions that affect the health and quality of life of people living in countries with poor levels of infrastructure and debilitated health system. According to the literature, in these cases equity is key when formulating political agendas and inclusive programs to achieve development goals[22,29,30,33,34,36].

The population living in developing countries may increasingly experience territorial exclusion. In these countries, there are rich neighborhoods that rely on all types of services whereas nearby people live illegally and without infrastructure. Each of these fragments seems to function autonomously. As it stands today, in most countries right to the city is increasingly restricted to a small political and economic elite that can shape cities according to their own desires[38].

In Latin America, health policies were implemented in the context of democratization, in the process of post-dictatorship decentralization. In general, social disorders in the 1980s brought about government expansion and new configurations for public policy, including assemblies that rewrote Constitutions. The new Constitutions included language related to health and democracy[30].

Years after the Brazilian 1988 Constituent Assembly and the National Health Conferences, when efforts to think about health in a broader way were made, Brazil remains one of the countries with the greatest social imbalance if we consider the ratio between poverty and wealth indexes. This imbalance has social, structural, and economic causes. In this sense, cities guided by equity should provide opportunities and reduce inequities.

The claim for right to the city expresses issues related to urban development and to the effects of political and economic crises. This claim demands higher degree of democratization in the cities and higher degree of decision-taking processes based on the principles of solidarity, freedom, equity, dignity, and social justice. Since the World Social Forum in 2001, entities of the civil society have discussed, debated, and assumed the challenge to construct a sustainable model of society and urban life, which has resulted in the World Charter for Right to the City. This document prioritizes common interests over the individual right to property as well as the socially just and environmentally balanced use of the urban space[39].

The World Charter for Right to the City was adopted in steps during the Social Forum of the Americas held in Quito in July, 2004, the World Urban Forum held in Barcelona in September, 2004, and the V Social World Forum held in Porto Alegre in January, 2005. The Charter has become a cry of mobilization for numerous organizations interested in urban justice issues[27,39].

The third decade: 2006 to 2016

In the beginning, this third and last investigation period focused on urban spaces of exclusion and on agendas that identifed equity paths and led the authors of the cited articles (Chart 3) to

think about actions that would defend human rights. The complexity of mediating the role of right to health and right to the city is worthy of note.

Law institutionalization, particularly in a world characterized by scarcity and conflict, requires commitment[27].

Urbanization can be both the cause of and the potential solution to social changes and inequalities in health. In particular, city populations are vulnerable to issues that impact social equity because of the social conditions the people live in. However, there is scope for revisiting interventions that do not necessarily originate from health. Moreover, interventions are not only about a political issue, but also about intersectoral actions[29,32,33].

Latin America has provided examples of successful strategies, including the use of participation tools, the establishment of intersectoral committees, the increased participation of civil organizations, and the design of forums and virtual networks to channel participative and collaborative processes in urban policy decision-making processes[30,31].

A study linking personal health geographies to right to the city in the case of Aboriginal young people living in Canada demonstrated several ways in which location, mobility, and boundaries affected their health experiences and perceptions about health inequality. This study confirmed that urban spaces can produce and are produced by highly racist geographical regions that seek to isolate, segregate, and immobilize young Aborigines from a social standpoint, which concomitantly increases this population's exposure to health risks and poor living conditions[28].

In this way, quality of life can be perceived by how favorable urbanization, health, and education indicators, among others, are. Identifying the components that negatively affect an individual's life is necessary to elucidate the causes of disparities in the indicators[25].

With respect to the environment, a study showed that urban afforestation positively correlated with the average family income. This finding suggested concerns with environmental justice. However, in addition to distributive equity, interventions must consider the community's needs (desire, access to infrastructure, and willingness to care, among others) because the costs inherent to afforestation may exceed the benefits[26].

Metrics are quantitative instruments that help to assess and analyze comprehensiveness as well as spatial and temporal resolution. In addition, metrics facilitate equity considerations when mitigating environmental injustices. The selection and combination of appropriate metrics will depend on the problem, its context, and its boundaries. Involving a large group of stakeholders is recommended[34-37].

Managers face daily challenges related to resource (water, food, and energy) supply efficiency, equity, and quality. In a study conducted in China, the authors created a shared network to monitor resource distribution and collective human behavior at spatially distributed service points. This approach offered a new perspective for better understanding of the spatially distributed supply system and of consumer behavior[37].

Formulating effective public policies that cater for the wide scope of the socioterritorial development of cities would break with the traditional model used in the biomedical area. Instead, the path to equity entails approaching urban health transversally and multidimensionally and tackling issues such as economy, employment, education, housing, transportation, culture, family, leisure, and access to health[34].

After examining the literature, it became evident that as local governments and stakeholders get more involved and gain greater knowledge of the real needs of the population, they can take improved decisions about the city in which they want to live and therefore help each other to achieve equity in health.

Final considerations

We divided the selected literature articles into three periods: 1986-1995, 1996-2005, and 2006-2016, which revealed three relevant axes: (1) city size, (2) need for answers, (3) urban spaces of social exclusion and groups in situations of vulnerability.

These three axes indicated different degrees of presence of right to the city and right to health in the formulation of policies and in the social movement agenda. Population growth was the authors' concern in the first period. In the second period, the authors were concerned about geographic density and right to health. Later, the focus shifted to geographic spaces where excluded populations resided and their identity agendas.

We initially defined this 30-year timeframe (1986-2016) to coincide with the period between the first WHO Global Conference on Health Promotion held in Ottawa in 1986 and the latest WHO Global Conference on Health Promo-

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tion held in Shanghai, China, in 2016. Our intention was to observe if there was any degree of concomitance between the agendas of the nine events and the right to the city and right to health agendas. However, the present review did not allow for such conclusion.

We will conduct further study on this issue because, besides promoting health, the WHO global conferences intend to advocate right to the city. These are two fundamental prerogatives to promote equity and to call for ethical and political commitment of the promotional agenda.

Collaborations

GLA Figueiredo, CHG Martins, AB Mainegra and M Akerman designed and delineated the study, drafted the article, critically reviewed the article, and approved the final version for submission. JL Damasceno and GG Castro extracted the data and participated in study design, analyzed and interpreted the data, and approved the final version for submission.

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