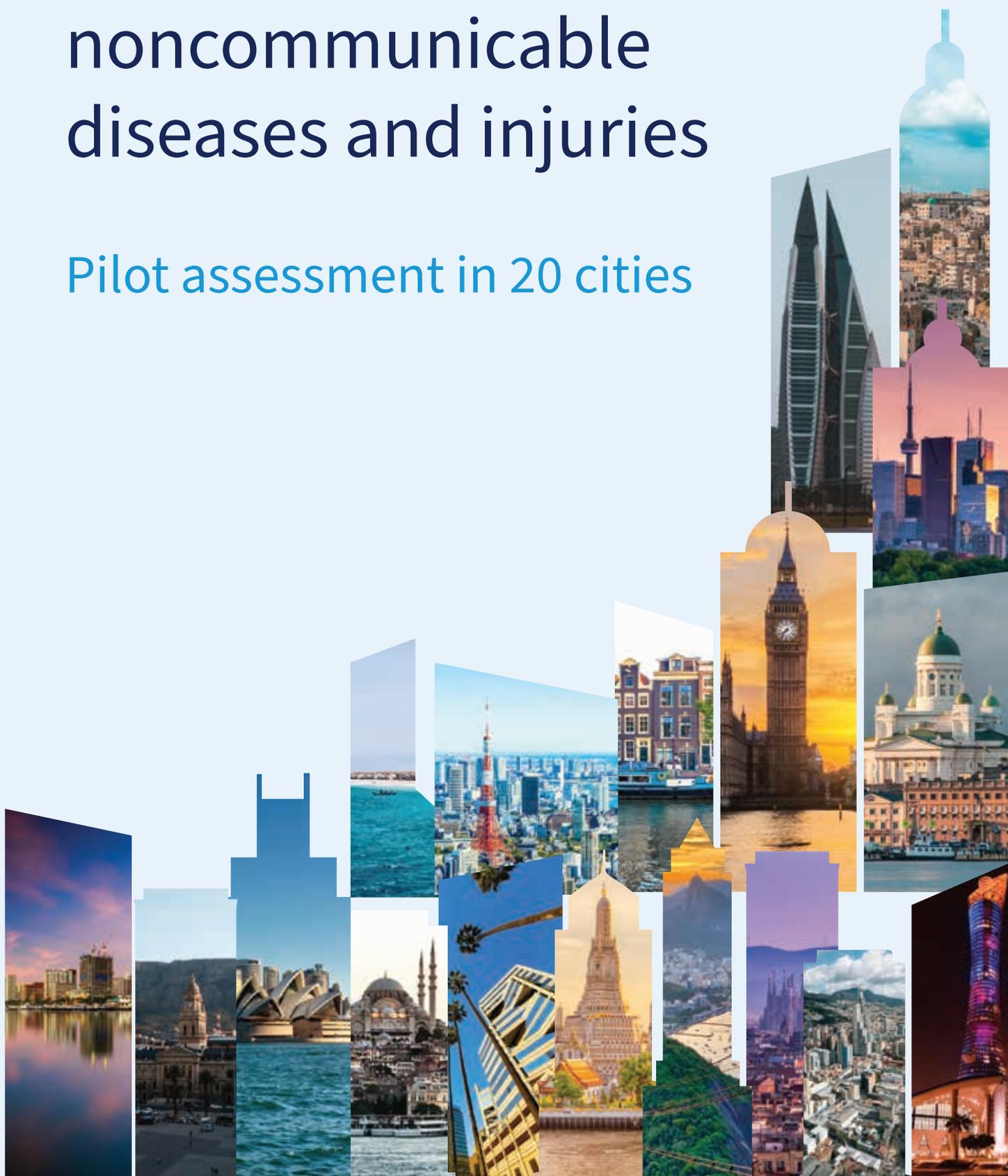

Monitoring noncommunicable diseases and injuries

Pilot assessment in 20 cities



World Health
Organization

Monitoring noncommunicable diseases and injuries

Pilot assessment in 20 cities

Monitoring noncommunicable diseases and injuries: pilot assessment in 20 cities

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Abbreviations

NO₂	nitrogen dioxide
O₃	ozone
PM_{2.5}	particulate matter $\leq 2.5\mu\text{m}$ diameter
PM₁₀	particulate matter $\leq 10\mu\text{m}$ diameter
NCDs	noncommunicable diseases
SDGs	Sustainable Development Goals
WHO	World Health Organization

Indicator groups

AP1, AP2 etc.	air pollution reduction
AC1, AC2 etc.	alcohol control
OP1, OP2 etc.	overdose prevention
HD1, HD2 etc.	promoting healthy diets
RS1, RS2 etc.	road safety
WC1, WC2 etc.	safe walking and cycling
TC1, TC2 etc.	tobacco control
S1, S2 etc.	NCD and injury surveillance

1 Introduction

By 2050, approximately 68% of the world's population will be living in urban areas (1). Cities already play a fundamental role in protecting and promoting people's health, and increasing rates of urbanization make their contribution even more essential. Cities are integral to achieving the Sustainable Development Goals (SDGs), including health-related goals that require strong and coordinated local implementation of national and sub-national policies (2).

When managed effectively, rapid urbanization can create positive impacts on the environment, economy and society for sustainable futures (1,2). On the other hand, if not managed properly, it can jeopardize health and wellbeing. Unplanned built environments, poorly designed transportation systems, inequitable access to health services, poor air quality and unhealthy food systems can all impede health and sustainable development. These issues particularly expose urban residents to a higher risk of noncommunicable diseases (NCDs) and injuries, two major public health concerns both globally and in urban areas (2,3,4).

Yet the association between these risks and urban environments is not inevitable. City leadership can introduce and implement effective interventions to reduce risk factors for NCDs and injuries. They can enact and enforce policies on road design and infrastructure that promote safe walking and cycling, adopt programmes that promote a healthy food environment, or monitor implementation of smoke-free policies and tobacco advertising bans (5).

To support city-level action on mitigating NCDs and injuries, the World Health Organization (WHO) has developed indicators that can be used by cities to monitor progress and actions across these issues. In 2019, experts proposed a number of city-level qualitative and quantitative indicators across eight policy intervention areas:

- Air pollution reduction.
- Alcohol control.
- Overdose prevention.
- Promoting healthy diets.
- Road safety.
- Safe walking and cycling.
- Tobacco control.
- NCD and injury surveillance.

Between 2021 and 2023 the indicators were piloted in 20 cities from a range of settings. The aim of the pilot was to carry out a baseline assessment of indicator availability across different cities,

to understand their feasibility in different contexts, and to ensure that the data collection tool was fit for purpose.

This report presents the results of the pilot assessment. It represents the first application of the guidance in cities from a range of geographical regions and income levels. The results provide a snapshot of the implementation status of key NCD and injury prevention and control interventions at a municipal level. They also serve as a baseline against which the participating cities can, if they wish, monitor changes over time for topics of particular interest, and as a model for other cities to replicate to support their own work.

The final set of indicators is available in the *WHO City-level monitoring guidance for the prevention and control of noncommunicable diseases and injuries (6)*. The guidance contains a minimum set of core and optional indicators that city-level authorities can use to track their progress in implementing evidence-based policies for preventing and controlling NCDs and certain types of injuries. The indicators are intended as a technical resource for cities around the world, enabling them to conduct an initial self-assessment of work on one or more of the eight topics, to identify areas for improvement and which policies could support this, and to monitor progress against internal or external targets.

2 Methods

2.1 City selection

Cities were invited to participate in the project at different times over a two-year period, between 2021 and 2023. They were selected through consultation with WHO technical departments, regional and country offices, and through existing WHO collaborations such as the Partnership for Healthy Cities, a global network of cities working to promote NCD and injury prevention (7). To ensure balanced representation, a maximum number of cities from each WHO region was set and cities were included from a range of World Bank Group country classifications by income.

A total of 20 cities were included in the final pilot, representing a mix of cities with varying urban population sizes, ranging from around 7000 to over 8 million inhabitants (Table 1). These cities represent a wide range of geographies (Fig. 1), with two to five participating cities in each of the six WHO regions. Just over half of the cities were from middle-income countries, and the remainder were from high-income settings (Table 2).

TABLE 1. National capital classification, city size type and estimated population of participating cities

City	National capital classification (8)	City size type ¹ (2)	Estimated population ² (8)
Amman	Yes	Large	3 999 008
Bangkok	Yes	Very large	8 421 212
Barcelona	No	Large	1 627 559
Bogotá	Yes	Very large	7 901 653
Bursa	No	Large	3 147 818
Cape Town	Yes	Large	4 772 846 (9)
Doha	Yes	Large	1 186 023
Goiânia	No	Large	1 437 366 (10)
Greater Geelong	No	Medium	271 057 (11)
Harare	Yes	Large	1 698 122
Helsinki	Yes	Medium	656 920
Lalitpur	No	Small	133 305
London	Yes	Very large	8 945 309 (12)
Maio	No	Small	6980 (13)
Manama	Yes	Small	176 909
Obu	No	Small	93 123 (14)
Parañaque	No	Medium	689 992
Quezon City	No	Large	2 960 048
Utrecht	No	Medium	367 984 (15)
Vancouver	No	Medium	725 778 (16)

¹ Small cities have populations of fewer than 250 000 inhabitants, medium-sized cities range from 250 000 to 1 million, large cities have populations between 1 million and 5 million, and very large cities have at least 5 million inhabitants.

² Population estimates of cities for the latest available year between 2003 and 2023. All city population estimates are taken from the United Nations Department of Economic and Social Affairs Demographic Yearbook 73rd issue 2022, unless the city was not listed, or in cases where a city specifically requested an alternative source. There is some variation in reference years based on data availability. Data reported by local authorities may not accurately reflect WHO official statistics.

FIG. 1. Geographic spread of participating cities

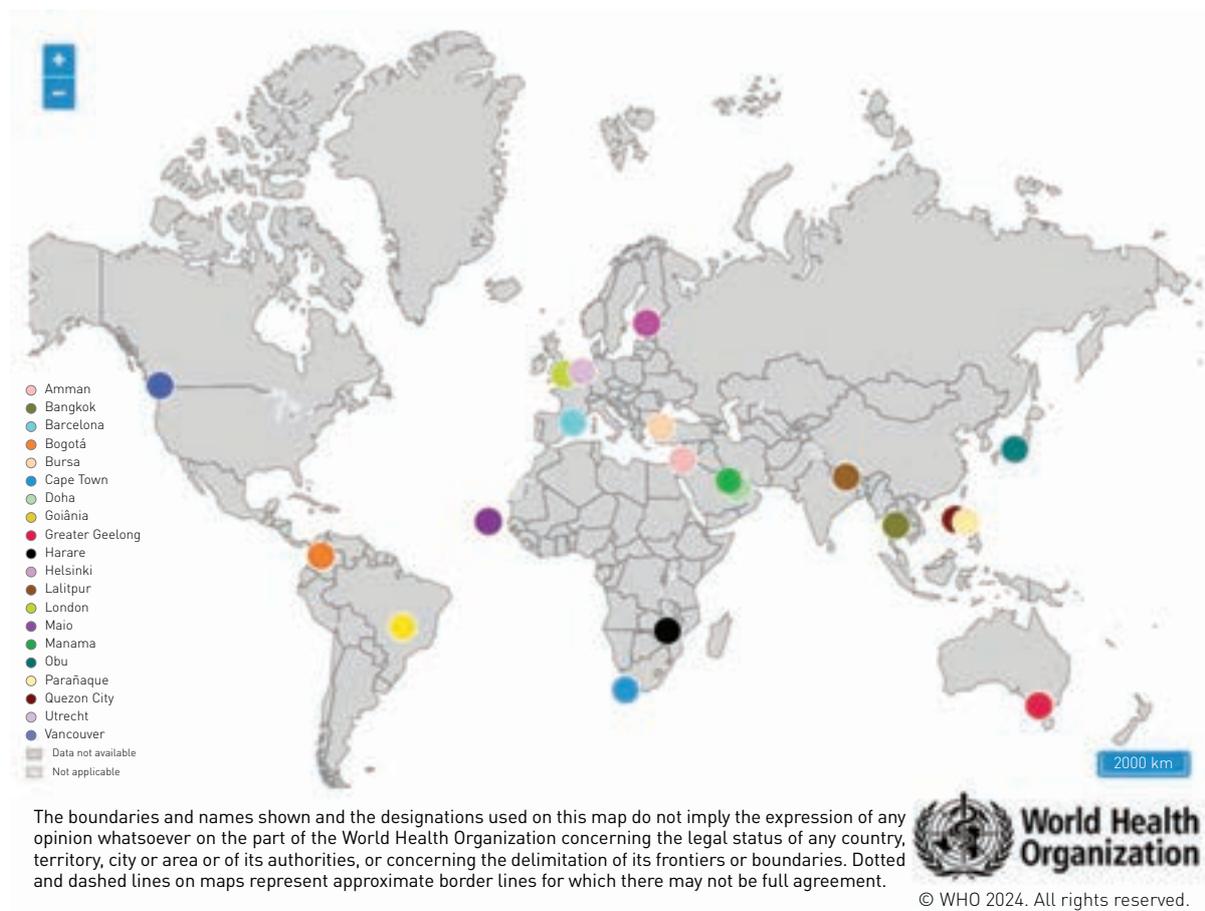


TABLE 2. Number of participating cities by WHO region and World Bank Group country classifications by income level (17)

WHO region	Lower-middle-income	Upper-middle-income	High-income	Total
African Region	2	1		3
Region of the Americas		2	1	3
South-east Asia Region	2			2
European Region		1	4	5
Eastern Mediterranean Region	1		2	3
Western Pacific Region	2		2	4
Total	7	4	9	20

2.2 Data collection, review and verification

Four cities were involved in a preliminary first-stage assessment to assess the availability and relevance of an initial set of 63 draft indicators identified by WHO. Cities were asked to identify sources for indicators that they collected and to provide additional feedback on the indicators such as their relevance for their work, monitoring responsibility and any other aspect of the indicators.

Based on feedback, the following adjustments were made:

- Indicators with low availability were either removed, classified as optional or consolidated with other indicators.
- Indicators with issues on actionability at city level or applicability in all cities were either removed, classified as optional, or redefined to improve their responsiveness to city-level action.
- Some of the quantitative/prevalence indicators were either classified as optional or consolidated with other indicators.
- Some indicators were reclassified as optional to achieve balance across policy areas.
- All indicators were simplified where possible to improve ease of collection and use.

This first-stage assessment reduced the number of indicators from 63 to 56, and defined 34 as core and 22 as optional. A second round of assessment was then conducted to identify the baseline status of those 56 indicators in a wider range of pilot cities. A further 16 cities were selected and invited to participate in the process.

The review process was consistent for both the first-stage assessment and the broader baseline assessment. At least one focal point was designated for each participating city to coordinate city indicators review, collection of data sources and submission. Cities were asked to respond to simple questions about indicators and to provide existing data sources to support their response. Responses were submitted via an online survey platform or by email. In some cases, ministries of health and WHO country offices supported city compilation of data sources and data entry.

A desk review was then conducted by two members of the project team focused on sources identified by the cities. This was supplemented with additional search of online databases such as the WHO Global Health Observatory (18) and websites containing national, sub-national or city-level legislations or city-specific policies, plans, strategies, reports and surveys.

The desk review was used to verify city responses and to complete the assessment instrument (Annex 1) using an internal web-based platform. The instrument contained all the necessary components for assessing the status of each indicator. To ensure that assessment was consistent between the two reviewers, a review of indicator ratings and related items was conducted by topic. Technical experts were consulted to clarify assessment of items that were vague or ambiguous. For some indicators related to established national-level indicators, availability was checked at national or other sub-national levels.

Applying a tripartite scoring framework, preliminary city profiles were generated with the achievement level for each indicator presented as 'nascent' (score = 1), 'developing' (score = 2) or 'advanced' (score = 3). These profiles were subsequently shared with city focal points and technical experts of individual policy areas so they could verify the results and provide additional or updated information as needed. Desk review and data verification were performed iteratively with the cities, as necessary to ensure that city profiles accurately reflected the status of each city.

2.3 Analysis

Desk review data from the platform were exported to an Excel-readable file. Data cleaning and calculation of scores of each indicator by city was done using STATA 17 software (Stata Corporation, 2021). City profiles providing the baseline status were generated using a simple listing of indicators with corresponding status icon. Bar charts depicting counts of cities by achievement level were generated to identify indicators depicting high or low levels of activity. To compare results within and across policy areas, the tripartite classification was converted into a numeric range, with 1 corresponding to nascent, 2 to developing, and 3 to advanced. The mean scores of core indicators were plotted by World Bank Group country classifications by income level of the corresponding countries (i.e. high-income countries; upper-middle-income countries; lower-middle-income countries). Frequencies of components of indicators were assessed to determine the most prevalent actions being undertaken in cities.

3 Results and discussion

3.1 Summary

The outputs of the baseline assessment include:

- A summary of core indicators by topic, showing their availability based on the aggregate results from all pilot cities.
- Individual profiles reporting the status of core indicators for each city.
- City case studies³ highlighting good practices and examples for each topic.

In addition to the core indicators, cities provided feedback for a selection of optional indicators also included in the WHO guidance. These were not included in the city profiles or main analysis, but have served to provide additional insights into indicator availability and relevance. Some of the feedback is included in the general commentary.

The results should not be used out of the context of the pilot project, and cannot be extrapolated into broader generalizations about cities from different countries, regions or income groups. They are intended to provide a snapshot of indicator status within a range of cities at a specific moment in time. City feedback collected during the pilot was also instrumental in highlighting additional factors to consider for indicator definitions, assessment scoring and use.

The baseline assessment reflects the status of the following 34 core indicators (Fig. 2) for prevention and control of noncommunicable diseases and injuries in 20 cities:

- 4 indicators connected to air pollution reduction.
- 5 indicators connected to alcohol control.
- 4 indicators connected to overdose prevention.
- 5 indicators connected to promoting healthy diets.
- 4 indicators connected to road safety.
- 4 indicators connected to safe walking and cycling.
- 4 indicators connected to tobacco control.
- 4 indicators connected to NCD and injury surveillance.

³ Data reported by local authorities that are presented in the case studies may not accurately reflect WHO official statistics.

FIG. 2. Core indicator distribution and status across the eight policy areas, 20 cities, 2023

Policy area	Indicator	Advanced	Developing	Nascent
 Air pollution reduction	1. Air pollution measurement capacity	7	8	5
	2. Availability of air quality information and trends	7	6	7
	3. Availability of emission estimates	8	4	8
	4. Existence and enforcement of air quality standards	4	12	4
 Alcohol control	1. Existence of comprehensive strategy, plan of action and activities to reduce harmful use of alcohol	1	9	10
	2. Existence of policy to restrict commercial and public availability of alcohol	1	17	2
	3. Existence of bans or comprehensive restrictions on alcohol advertising, sponsorship and promotion	1	12	7
	4. Existence and enforcement of drink-driving legislation	6	8	6
	5. Availability of brief intervention and treatment for problematic alcohol use	4	7	9
 Overdose prevention	1. Availability of key medications for opioid dependence treatment	5	7	8
	2. Existence of service governance mechanisms for drug use disorder treatment	10	6	4
	3. Availability of non-structured harm reduction services for people with drug use disorders	7	5	8
	4. Availability of take-home naloxone at city level	2	2	16
 Promoting healthy diets	1. Existence and enforcement of policies to restrict marketing of unhealthy foods and non-alcoholic beverages		12	8
	2. Existence and enforcement of nutrition standards for foods and beverages served and/or sold in public settings	3	14	3
	3. Existence and enforcement of policies and programmes to improve healthy eating in restaurants, food outlets or vending machines	2	4	14
	4. Existence and enforcement of urban planning/zoning policies to increase healthier food options	3		17
	5. Existence and enforcement of policies to ensure free safely managed drinking water is available in all public settings	9		11
 Road safety	1. Existence and enforcement of speed limit legislation for private passenger vehicles	1		19
	2. Existence and implementation of road design standards that include speed management and safe infrastructure for pedestrians and cyclists	5	13	2
	3. Existence and enforcement of legislation on helmet use for two- and three-wheeled motor vehicles including helmet use standards and wearing requirements	6		14
	4. Existence and enforcement of legislation for seat-belt use	7		13
 Safe walking and cycling	1. Existence of city policy promoting walking	5	11	4
	2. Existence of city policy promoting cycling	5	10	5
	3. Existence of city policy on access to public open space	5	8	7
	4. Existence of city urban planning policy to encourage compact urban design and mixed land use	12	5	3
 Tobacco control	1. Existence and compliance measurement of smoke free legislation	8		12
	2. Existence and compliance measurement of bans on advertising, promotion and sponsorship	5		15
	3. Existence of anti-tobacco mass media campaigns	1	12	7
	4. Availability of tobacco cessation services	3	12	5
 NCD and injury surveillance	1. Adult NCD risk factor surveillance capacity	8		12
	2. Adult injury risk factor surveillance capacity	3		17
	3. Access to and use of routine health facility data on alcohol and substance use disorders and tobacco dependencies	3	7	10
	4. Access to and use of cause-of-death data on NCDs and injuries	6	9	5

Status: ■ advanced ■ developing ■ nascent

Overall, there was considerable variation in core indicator status across the 20 participating cities. All indicators were at a ‘developing’ level in at least two cities, and 29 indicators were at ‘advanced’ level in at least one city. There were eight indicators that appeared to have low availability across all cities, meaning at least 50% of cities only rated them as ‘nascent’ level.

Common reasons for not reaching an advanced rating included a lack of evidence of policy enforcement, the absence of: data for specific indicator criteria; data that met the criteria for either methodology or definitions of key parameters; or data that had been collected within a sufficiently recent period (typically between two to five years). In some cases, gathering the requisite information to complete the assessment was a lengthy process, particularly if the topic was led by a different level of government or another non-municipal authority.

The desk review conducted by WHO provided the following insights:

- City-level data on indicators that were reported as not collected by cities were at times available from other sources. These were collected by other government institutions or at other national/regional/provincial levels. Their absence from city survey responses may indicate that that data is not used by the cities in their programmatic work, or that they are unaware of its collection.
- Some of the proposed policy indicators needed to be assessed by reviewing national, regional or provincial sources, in cases where cities did not have the authority to independently introduce legislation.
- Although quantitative or prevalence indicators were available, there were differences in definitions, recency, target age groups/populations. Some data could not be verified as age-standardized. These inconsistencies presented a challenge for comparability.

Aggregated summaries of indicator ratings for each topic are provided in Sections 3.1.1 to 3.1.8, with more detail on trends and insights from all 20 cities. The final core indicator profiles for each city are available in Section 3.2.

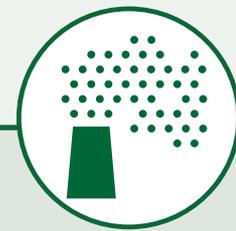
In addition to providing a self-assessed rating of indicator status, cities also shared qualitative feedback connected to the indicator definitions, scoring criteria or perceived utility to their work.

A key issue raised was around legislative authority. Even within the relatively small cohort of the pilot, cities had significantly varying levels of legislative authority over individual policy areas that affected their ability to effect change. This meant that some cities faced greater barriers to certain kinds of actions, such as introducing a new policy if a national one did not exist.

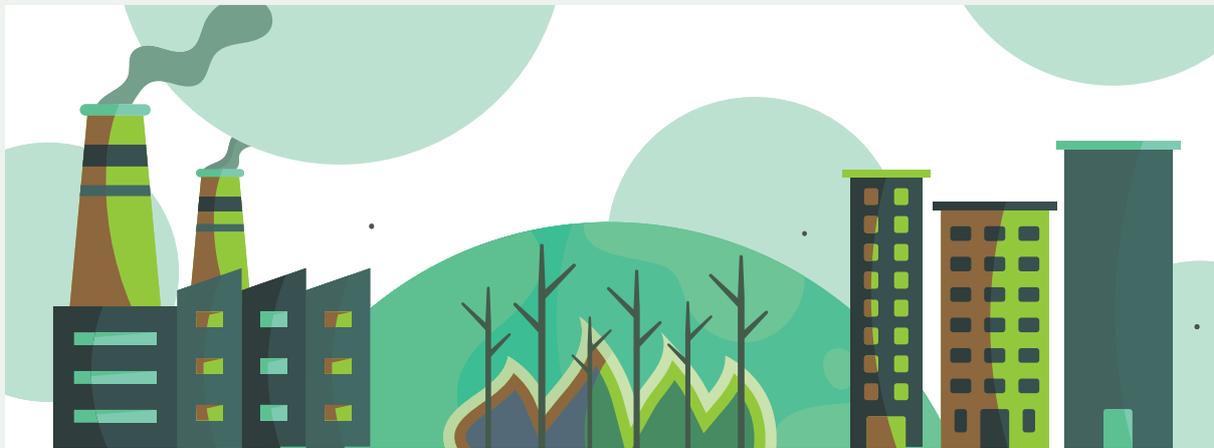
Perspectives were also shared around the question of prioritization. Each indicator is composed of various sub-criteria, which together create the composite score of nascent, developing or advanced. In some cases, cities noted that meeting all of the sub-criteria required to mark an indicator as ‘advanced’ would entail allocating significant amounts of time and resources to areas that could have been used to support another area of work in greater need. In real-world usage, cities would

likely also conduct the assessment for only the topic/s which they were most interested in advancing, or where they were concerned about progress.

Finally, an important factor flagged by many cities was the role of context. The profiles do not capture the hugely varying legislative, socioeconomic and historical contexts underpinning each city's work, and consequently affecting the status of each indicator. While the standards for achieving specific ratings are a consistent global standard, the reasons behind the gaps and barriers to action vary hugely. The primary aim of the indicator guidance is to support individual cities to assess and monitor their own progress over time, against a common global standard for surveillance, policy development or enforcement. Comparisons in levels of advancement between different cities should not be made without understanding and acknowledging the factors affecting their operational context. The case studies for each topic area demonstrate the breadth of contextual variation, whilst also showing how cities have successfully managed to advance work in specific indicator areas.



3.1.1 Air pollution reduction



Core indicators: 4

Key observations

- ⚙️ The indicator that was most frequently scored as developing or advanced was the **existence and enforcement of air quality standards** (Fig. 3). At the same time, comparatively few cities achieved an advanced score for this indicator. This was most commonly due to: the absence of quality norms around the use of solid fuels by households; a lack of emission controls during periods of poor air quality; and the absence of environmental impact assessments in construction projects.
- ⚙️ Of all indicators, **availability of emission estimates** had the highest number of cities with advanced levels compared to other indicators. However, it was also the indicator with the highest number of nascent cities.
- ⚙️ When classified by income (Fig. 4), the indicator with the strongest average assessment level for pilot cities was different for each group:
 - Lower-middle-income settings: **existence and enforcement of air quality standards**.
 - Upper-middle-income settings: **availability of air quality information and trends**.
 - High-income settings: **air pollution measurement capacity**.
- ⚙️ Common barriers that were reported as preventing cities from achieving an advanced indicator level included: a lack of evidence of enforcement; a lack of recent information or data (within the past three to five years); and the absence of data on specific emissions or pollutants.

FIG. 3. Status of air pollution reduction indicators across 20 cities, 2023

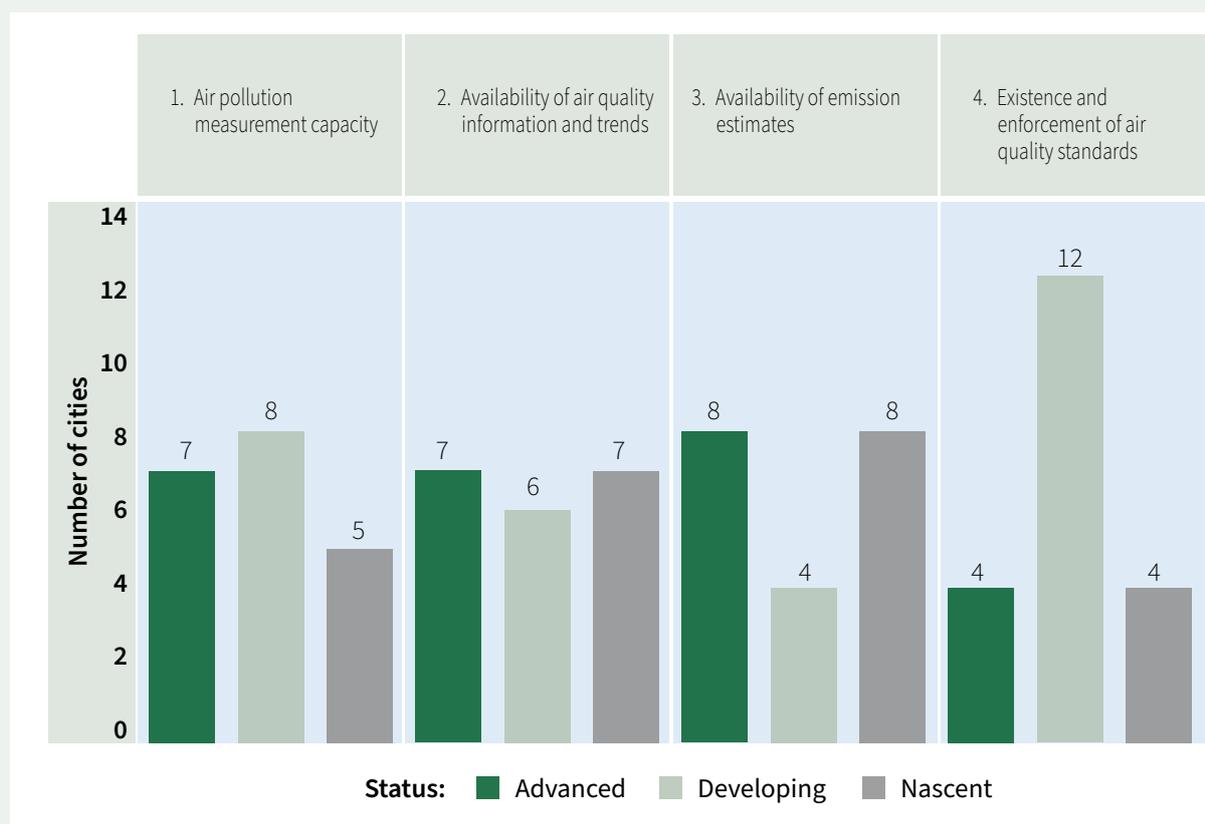


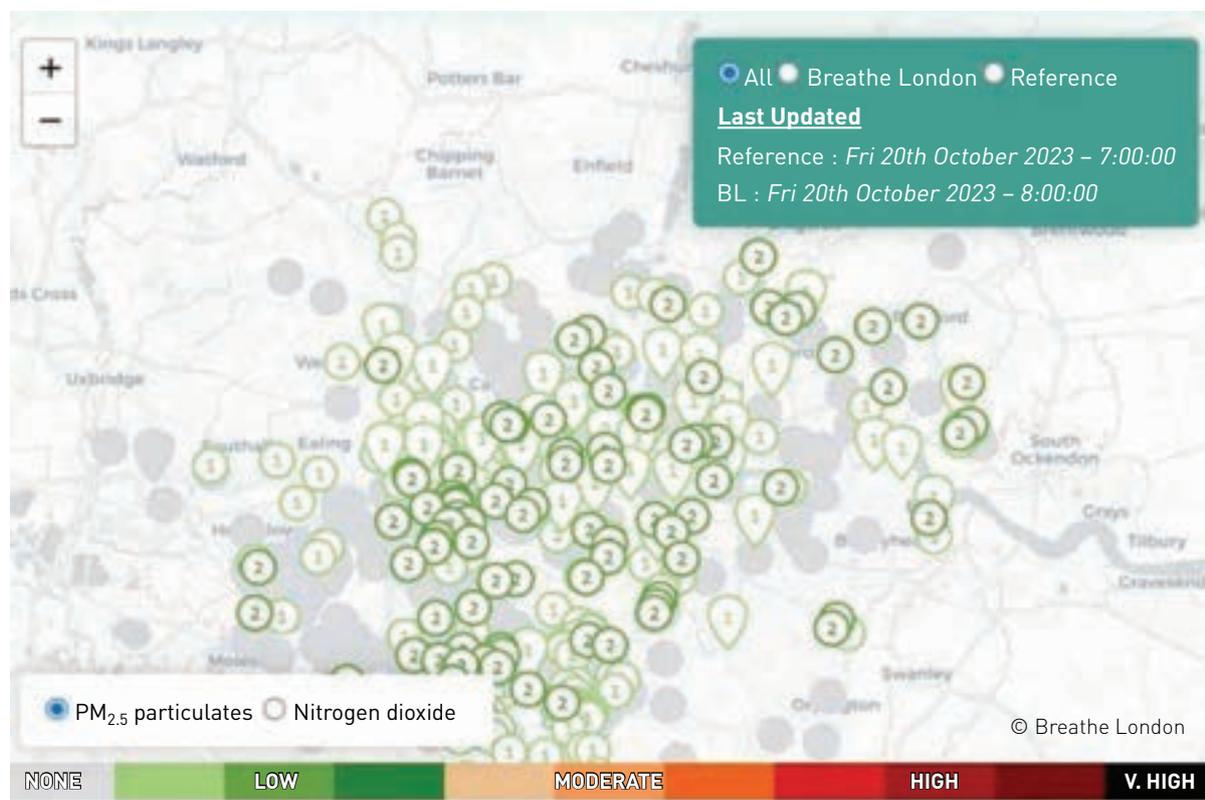
FIG. 4. Mean scores of air pollution indicators by World Bank Group country classifications by income level, 20 cities, 2023

Indicator	Lower-middle-income (n=7)	Upper-middle-income (n=4)	High-income (n=9)
1. Air pollution measurement capacity	1.6	2.0	2.6
2. Availability of air quality information and trends	1.3	2.3	2.4
3. Availability of emission estimates	1.4	2.0	2.4
4. Existence and enforcement of air quality standards	1.7	1.8	2.3
All indicators	1.5	2.0	2.4
	1 2 3 Average score	1 2 3 Average score	1 2 3 Average score

Case study

Breathing life into the city: Monitoring information on air quality

London, United Kingdom of Great Britain and Northern Ireland



A map of air quality index based on PM_{2.5} in air quality monitoring sites in London

Almost the entire global population (99%) breathes air that exceeds WHO air quality guidelines and threatens their health.^a Air quality is a particular concern in cities, and its importance is reflected in at least two global Sustainable Development Goal targets.

Air quality monitoring in cities is essential to understand emission sources, target policy responses, and measure progress. In the United Kingdom, London is considered a leading example of how this can be achieved.

London's boroughs have been funding automatic air quality monitoring since the early 1990s. This reference-quality monitoring network now includes approximately 150 monitors across the city. The measurement data is used to assess and officially report on pollution levels in different areas of the city, track trends over time, and model or evaluate how different local policies affect air pollution.^b The data is publicly available and helps to inform public alerts from the Mayor on days when air quality reaches dangerous levels, including notifications at underground stations, bus stops, and via direct messages to schools.^c The Mayor is also working in partnership with the London Air Quality and Health Programme Office to develop air quality alerts to health professionals which are due to be launched in February 2024.^d Great Ormond Street Hospital for Children now also includes annual average levels

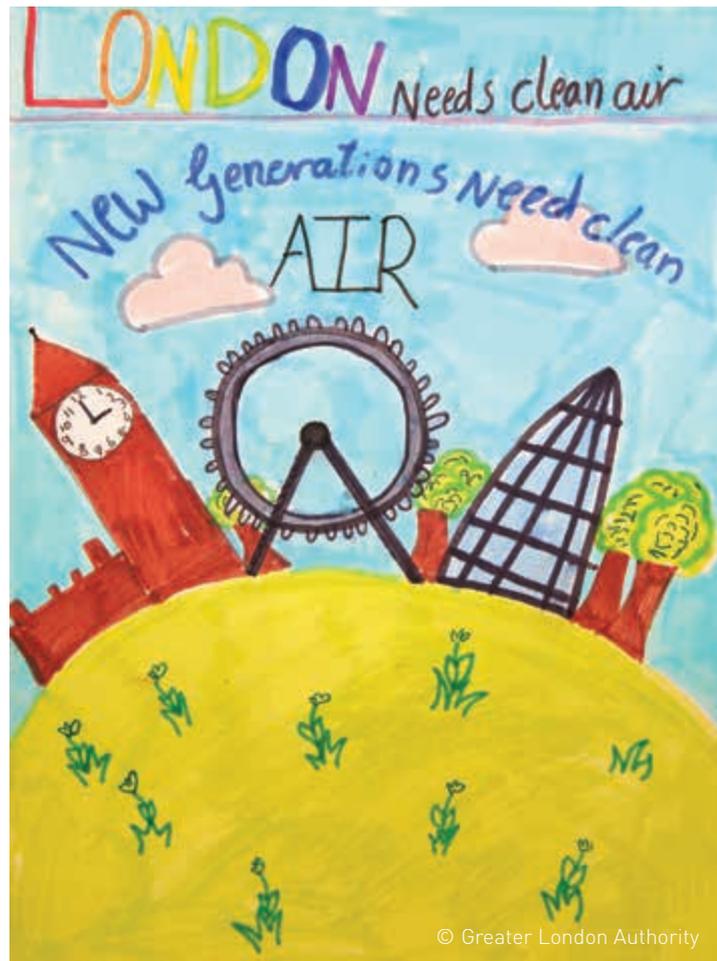
of PM_{2.5} (particulate matter $\leq 2.5\mu\text{m}$ diameter) and NO₂ (nitrogen dioxide) for home addresses in their electronic patient records. This highlights to hospital staff those patients who are living in postcodes where levels are above the WHO air quality guidelines, and provides additional materials for education and action.^e

In addition to the reference-grade monitoring, the London Mayor's Office has installed a community sensor network: Breathe London. This uses smaller but more affordable air quality sensors to measure pollution in real time in specific local areas and empowers citizens to choose the location of these monitoring sites and use this data to manage exposure and advocate for change.^f There are now around 450 Breathe London sensors across London, monitoring both NO₂ and particulate matter.

These monitors, plus the extensive network of NO₂ diffusion tube monitors across the city, shows that London leverages diverse monitoring systems to obtain a very comprehensive picture of air quality. The combination of reference-grade and community-led monitoring, along with the active use of data in policy and communications, makes the London system a highly robust model for monitoring and modelling air quality.

Sources:

- ^a Billions of people still breathe unhealthy air: new WHO data. Geneva: World Health Organization; 2022 (<https://www.who.int/news/item/04-04-2022-billions-of-people-still-breathe-unhealthy-air-new-who-data>, accessed 1 April 2024).
- ^b London air [website]. London: Imperial College London; 2024 (<https://www.londonair.org.uk/LondonAir/nowcast.aspx>, accessed 1 April 2024).
- ^c Monitoring and predicting air pollution [website]. London@ Greater London Authority; 2024 (<https://www.london.gov.uk/programmes-and-strategies/environment-and-climate-change/pollution-and-air-quality/monitoring-and-predicting-air-pollution>, accessed 1 April 2024).
- ^d London Air Quality and Health Programme Office (<https://www.gov.uk/government/groups/london-air-quality-and-health-programme-office>, accessed 19 August 2024)
- ^e Air pollution levels added to patient's postcodes. London: Great Ormond Street Hospital for Children; 2023 (<https://www.gosh.nhs.uk/news/air-pollution-levels-added-to-patients-postcodes/>, accessed 1 April 2024)
- ^f Breathe London. London: Imperial College London; 2024 (<https://www.breathelondon.org/about>, accessed 1 April 2024). [case study ends]



Artwork by a primary school pupil from Latchmere School in Kingston upon Thames, Greater London. One of the winning artworks from the Mayor of London's Clean Air Day 2023 schools' competition, responding to 'what does clean air mean to me?':



3.1.2 Alcohol control

Core indicators: 5



Key observations

- ✿ From the core indicators, the indicator that was most commonly available at developing level was the **existence of a policy to restrict the commercial and public availability of alcohol** (Fig. 5). With only one city achieving an advanced score, most had gaps in legislation that would undermine its overall effectiveness. These gaps included a lack of regulations on informally produced alcohol and regulations on combatting illicit alcohol.
- ✿ **Existence of bans or comprehensive restrictions on alcohol advertising, sponsorship and promotion** was the second most commonly observed indicator as developing in cities. However, most cities reported a lack of bans on sponsorship activities for alcohol, or around relatively new marketing channels such as social media.
- ✿ **Existence and enforcement of drink-driving legislation** had the highest number of cities with advanced levels compared to other indicators.
- ✿ The indicator with the most limited availability was **existence of comprehensive strategy plan of action and activities to reduce harmful use of alcohol**. Half of the pilot cities had only a nascent score for this indicator. Its availability was much more limited in the cities from lower income settings.
- ✿ When classified by income (Fig. 6), the indicator with the strongest average availability for pilot cities was different for each group:
 - Lower-middle-income settings: **existence of a policy to restrict the commercial and public availability of alcohol**.
 - Upper-middle income settings: **availability of brief intervention and treatment for problematic alcohol use**.
 - High-income settings: **Existence and enforcement of drink-driving legislation**.
- ✿ Common barriers that were reported as preventing cities from achieving an advanced indicator level included the absence of monitoring or evaluation frameworks for activities, a lack of restrictions on the consumption of alcohol in specific public spaces; gaps in existing marketing regulations; and limited options for brief interventions and treatment.

FIG. 5. Status of alcohol control indicators across 20 cities, 2023

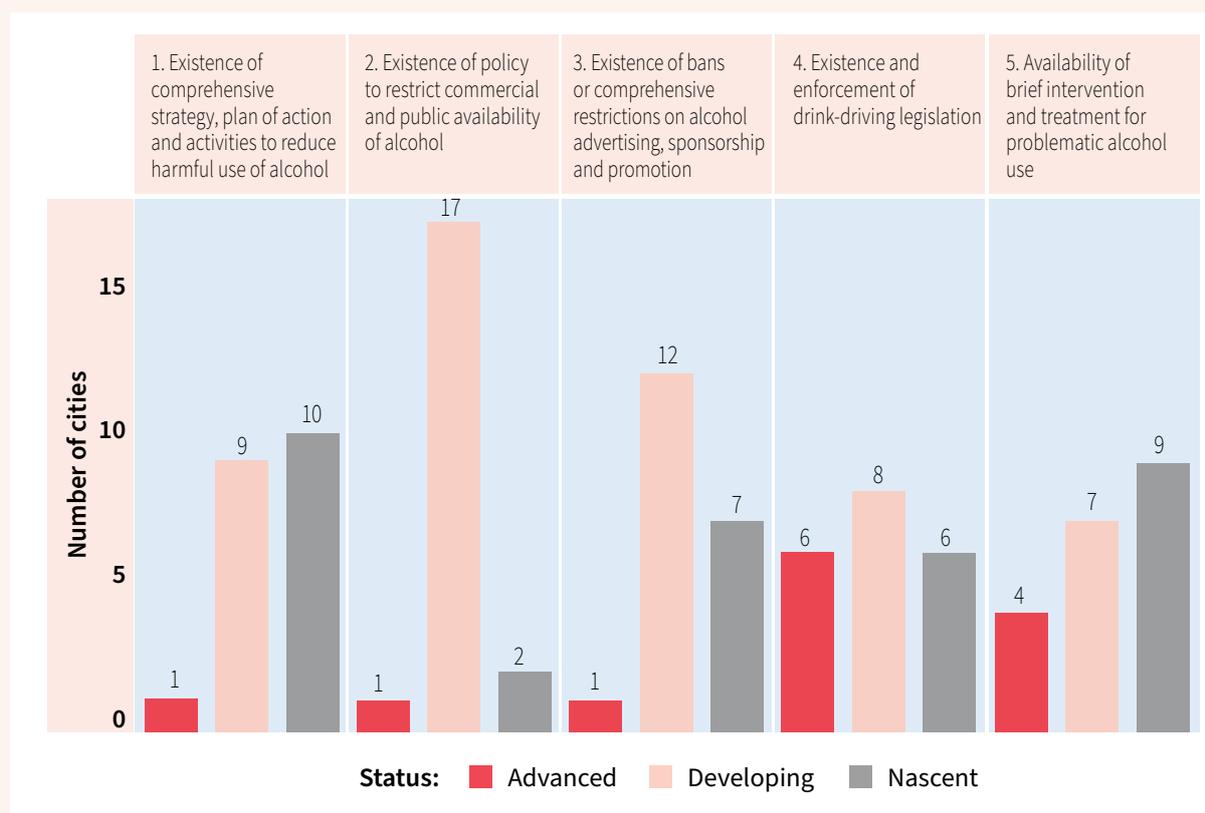


FIG. 6. Average scores of alcohol control indicators by World Bank Group country classifications by income level, 20 cities, 2023

Indicator	Lower-middle-income (n=7)	Upper-middle-income (n=4)	High-income (n=9)
1. Existence of comprehensive strategy, plan of action and activities to reduce harmful use of alcohol	1.1	1.5	1.9
2. Existence of policy to restrict commercial and public availability of alcohol	1.9	1.8	2.1
3. Existence of bans or comprehensive restrictions on alcohol advertising, sponsorship and promotion	1.4	1.8	1.9
4. Existence and enforcement of drink-driving legislation	1.6	1.8	2.4
5. Availability of brief intervention and treatment for problematic alcohol use	1.1	2.0	2.1
All indicators	1.4	1.8	2.1
	1 2 3	1 2 3	1 2 3
	Average score	Average score	Average score

Case study

Creating comprehensive policy to reduce the harmful use of alcohol

Cape Town, South Africa

Worldwide, around 2.6 million deaths every year result from the consumption of alcohol. It is a causal factor in more than 200 diseases, injuries and other health conditions.^a In addition to health consequences, it also brings significant social and economic losses to individuals and society at large. In South Africa, around 7.3% of all deaths in 2019 can be attributed to alcohol consumption.^b

The City of Cape Town is committed to minimizing and mitigating harmful use of alcohol through a multi-faceted approach. Since 2008, Cape Town has had a mandate to respond to substance abuse by devising and implementing local strategies, working in tandem with other levels of government. In 2011, an initial city-wide strategy on alcohol control was published under the *Policy position on alcohol and drugs and alcohol and other drug harm minimization and mitigation strategy 2011–2014*.^c This aimed to promote greater access to treatment and services for alcohol use disorders, while also reducing the unlicensed sale of alcohol products. An accompanying document was developed in 2013 which focused specifically on prevention and early intervention as ways to reduce harms from alcohol (and other substances) in the city.^d

Building on learnings from the first strategy, the city released an updated version in 2014: the *Alcohol and other drug strategy 2014–2017*.^e This focused on strengthening the delivery of policies by focusing on four core areas: prevention, intervention, suppression and coordination. It is also explicitly aligned with other municipal, regional and national policies and strategies to ensure integration and coordinated action.

To ensure its policies deliver outcomes, Cape Town works to translate these strategies into action. For example, the city offers a Matrix® program, meaning free treatment for alcohol and drug use is offered at eight community-based alcohol and drug treatment sites. By providing services that are free, local and delivered for outpatients, the aim is to improve access to evidence-based treatment for citizens, and particularly for economically or socially vulnerable groups.



Front cover of City of Cape Town's Alcohol and other drug strategy 2014-2017



Entrance to Town II Community Day Centre, Khayelitsha, Cape Town

The 2014–17 strategy document continues to guide the city’s alcohol control efforts to this day. The emphasis on evidence-based interventions and a comprehensive, inclusive approach reflects the city’s ongoing approach. This gives the document continuing relevance as a guide for preventing the harmful use of alcohol in Cape Town.

Sources:

- ^a Global status report on alcohol and health and treatment of substance use disorders. Geneva: World Health Organization; 2024 (<https://iris.who.int/handle/10665/377960>, accessed 23 September 2024).
- ^b Alcohol-attributable fractions, all-cause deaths (%) [website]. Geneva: Global Health Observatory, World Health Organization; 2019 ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/alcohol-attributable-fractions-all-cause-deaths\(-\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/alcohol-attributable-fractions-all-cause-deaths(-)), accessed 23 September 2024).
- ^c Policy position on alcohol and drugs and alcohol and other drug harm minimization and mitigation strategy, 2011–2014. Cape Town: City of Cape Town; 2011 (<https://alcoholsouthafrica.files.wordpress.com/2012/04/cape-town-policy-position-on-alcohol-and-drugs-2011-2014.pdf>, accessed 1 April 2024).
- ^d Prevention and early intervention of alcohol and other drug use policy. Cape Town: City of Cape Town; 2013 ([https://resource.capetown.gov.za/documentcentre/Documents/Bylaws%20and%20policies/Prevention%20and%20Early%20Intervention%20of%20Alcohol%20-%20\(Policy%20number%2012399B\)%20approved%20on%2004%20December%202013.pdf](https://resource.capetown.gov.za/documentcentre/Documents/Bylaws%20and%20policies/Prevention%20and%20Early%20Intervention%20of%20Alcohol%20-%20(Policy%20number%2012399B)%20approved%20on%2004%20December%202013.pdf), accessed 1 April 2024).
- ^e Alcohol and other drug strategy 2014–2017. Cape Town: City of Cape Town; 2014 (https://resource.capetown.gov.za/documentcentre/Documents/City%20strategies,%20plans%20and%20frameworks/Annexure%20H%20-t%20Alcohol%20and%20Other%20Drugs%20Strategy%202014_2017.pdf, accessed 1 April 2024).



3.1.3 Overdose prevention

Core indicators: 4



Key observations

- ✿ From the core indicators, the indicator that was most frequently scored as advanced was the **existence of service governance mechanisms for the treatment of drug use disorders** (Fig. 7). It was also the indicator with the highest average availability for each income group (Fig. 8). The vast majority of the cities reported having a designated focal point for the prevention and treatment of drug use and most of these cities had a policy and action plan for service development. However, only half of the cities had legal provisions in place for protecting people undergoing treatment for substance use disorders, the absence of which may hinder service uptake.
- ✿ The indicator with the highest number of nascent cities was the **availability of take-home naloxone at the city level**. This was likely to be connected to national regulation around access to naloxone as either a supervised or take-home medication. For cities that did provide take-home naloxone, it was not always recorded as available in all settings regardless of insurance or residence status, which might further restrict access for individual users.
- ✿ Over half of the cities reported having some form of **non-structured harm reduction services available**. However, there tended to be limited support beyond medication. Only a few cities reported having formal interventions that included broader rehabilitation assistance such as employment assistance, special housing services or welfare assistance.
- ✿ Common barriers that were reported as preventing cities from achieving an advanced indicator level included a lack of legislative authority over the provision of specific medications for treating opioid dependence, or for certain non-structured harm reduction services such as safe injection sites. This tended to be related to the existence (or absence) of national policies around these issues, which would supersede city-level policies.

FIG. 7. Status of overdose prevention indicators across 20 cities, 2023

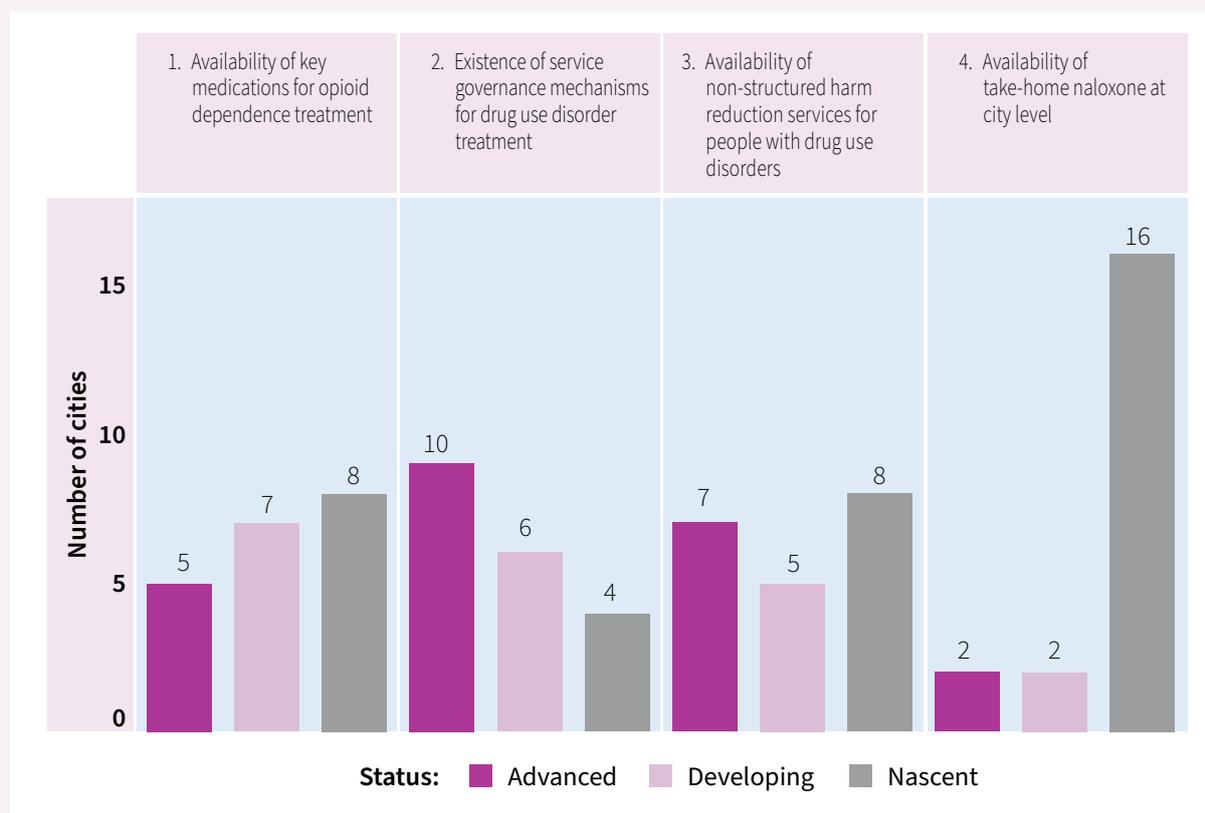


FIG. 8. Average scores of overdose prevention indicators by World Bank Group country classifications by income level, 20 cities, 2023

Indicator	Lower-middle-income (n=7)	Upper-middle-income (n=4)	High-income (n=9)
1. Availability of key medications for opioid dependence treatment	1.4	1.8	2.2
2. Existence of service governance mechanisms for drug use disorder treatment	2.0	2.3	2.6
3. Availability of non-structured harm reduction services for people with drug use disorders	1.4	2.0	2.3
4. Availability of take-home naloxone at city level	1.0	1.0	1.7
All indicators	1.5	1.8	2.2
	1 2 3 Average score	1 2 3 Average score	1 2 3 Average score

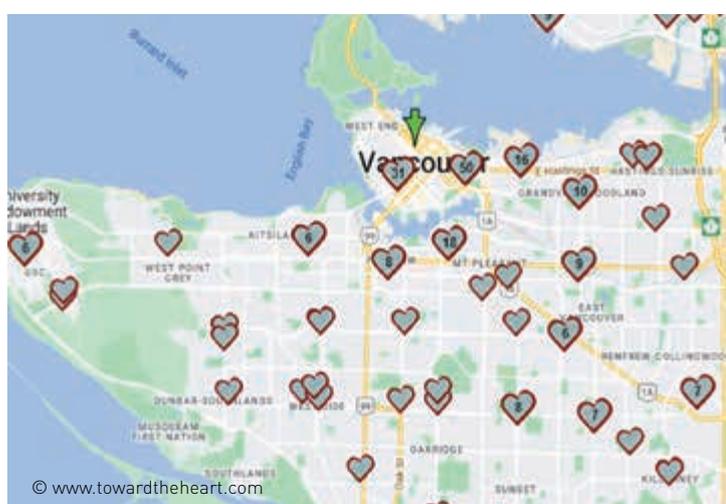
Case study

A concerted effort to reduce deaths from opioid overdoses

Vancouver, Canada

Opioids are commonly used for the treatment of pain. However, their non-medical use, prolonged use, misuse or use without medical supervision can lead to opioid dependence, and other health problems. Due to their pharmacological effects opioids can cause breathing difficulties, and opioid overdose can lead to death. Of the estimated 177 000 global deaths due to drug use disorders in 2021, about 130 000 were caused by opioid overdose.^a

There are effective treatment interventions for opioid dependence that can decrease the risk of overdose, yet as low as 0.3% to a maximum of 35% of people who need such treatment are receiving it.^b The medication naloxone can prevent deaths from opioid overdose if administered in time, but not everyone who could benefit from the drug is able to access it in time.^c



A map of Take Home Naloxone sites in Vancouver

In Canada, more than 30 000 people have died from opioid overdoses since 2016. Over two-thirds of these deaths have been in the province of British Columbia (BC), which declared the issue a public health emergency in April 2016.^{d,e} Its largest city, Vancouver, is estimated to have seen more than 3300 deaths due to drug overdose.^f In response, the city has also been at the forefront of efforts to reduce deaths and harm attributable to non-medical opioid use.

One way the city has done this is by working with provincial, regional and local partners to support the availability of take-home naloxone. In partnership with the B.C. Take Home Naloxone programme, take-home naloxone kits are available at over 568 local pharmacies and dedicated Take Home Naloxone (THN) sites around Vancouver.^g Naloxone is available without a prescription and the kits are given to both individuals at risk of an overdose, and to those likely to witness and respond to an overdose such as family or friends of someone at risk. The city also makes training freely available on preventing and responding to overdose.^h



A view of buildings along Hastings Street in the Downtown Eastside of Vancouver, a neighbourhood at the epicentre of the toxic drug emergency

The availability of naloxone is led by the provincial authority, as part of their mandate for health service provision.ⁱ While COVID-19 exacerbated the overdose crisis nationally, both the city and provincial authorities remain committed to supporting access to treatment for people living with opioid dependence.^e

Alcohol-attributable fractions, all-cause deaths (%) [website]. Geneva: Global Health Observatory, World Health Organization; 2019

Sources:

- ^a Global Health Estimates: Life expectancy and leading causes of death and disability. Geneva: Global Health Observatory, World Health Organization; 2021 (<https://www.who.int/data/gho/data/themes/mortality-and-global-health-estimates>, accessed 23 September 2024).
- ^b Global status report on alcohol and health and treatment of substance use disorders.I. Geneva: World Health Organization; 2024 (<https://iris.who.int/handle/10665/377960>, accessed 23 September 2024).
- ^c Opioid overdose. Geneva: World Health Organization; 2023 (<https://www.who.int/news-room/fact-sheets/detail/opioid-overdose>, accessed 1 April 2024).
- ^d Fischer B. The continuous opioid death crisis in Canada: changing characteristics and implications for path options forward. *The Lancet Regional Health – Americas*. 2023;19:100437 ([https://www.thelancet.com/journals/lanam/article/PIIS2667-193X\(23\)00011-X/fulltext](https://www.thelancet.com/journals/lanam/article/PIIS2667-193X(23)00011-X/fulltext), accessed 1 April 2024).
- ^e Vancouver’s approach to the overdose crisis. Vancouver: City of Vancouver; 2016 (<https://vancouver.ca/people-programs/drugs.aspx>, accessed 1 April 2024).
- ^f For more information on drug overdose mortality, please see the City of Vancouver data portal: (<https://opendata.vancouver.ca/pages/indicator/?q=cardid%3D100>, accessed 1 April 2024).
- ^g Toward the heart [website]. Vancouver: British Columbia Centre for Disease Control; 2024 (<https://towardtheheart.com/site-finder>, accessed 1 April 2024).
- ^h Overdose response, naloxone & training [website]. Vancouver: Vancouver Coastal Health; 2024 (<https://www.vch.ca/en/overdose-response-naloxone-training>, accessed 1 April 2024).
- ⁱ Four Pillars drug strategy [website]. Vancouver: City of Vancouver; (<https://vancouver.ca/people-programs/four-pillars-drug-strategy.aspx>, accessed 1 April 2024).



3.1.4 Promoting healthy diets

Core indicators: 5



Key observations

- ✿ The indicator that was most frequently scored as developing or advanced was the **existence and enforcement of nutrition standards for foods and beverages served and/or sold in public institutions** (Fig. 9). It was the indicator with the highest average rating for each income group (Fig. 10). However, a lack of enforcement meant that only three cities rated it as advanced.
- ✿ The indicator with the most limited availability was **existence and enforcement of urban planning/zoning policies to increase healthier food options**. Only three cities reached a developing level with this indicator, and none reached the advanced level due to a lack of monitoring and enforcement.
- ✿ Over half of cities reported having a **policy to restrict exposure to food and beverage marketing**. However, only three cities reported conducting monitoring or enforcement activities and none registered data on compliance rates with the policy, which is likely to undermine the health impact of those existing policies.
- ✿ In general, a major barrier that was reported as preventing cities from achieving higher availability levels across indicators was the absence of monitoring and enforcement mechanisms for their policies. This is likely to limit the effectiveness of policies in place, and could be an area for cities to consider strengthening if resources allow. For policies aligned with national or regional legislation, authorities from other levels of government may be able to provide additional resourcing support.

FIG. 9. Status of promoting healthy diet indicators across 20 cities, 2023

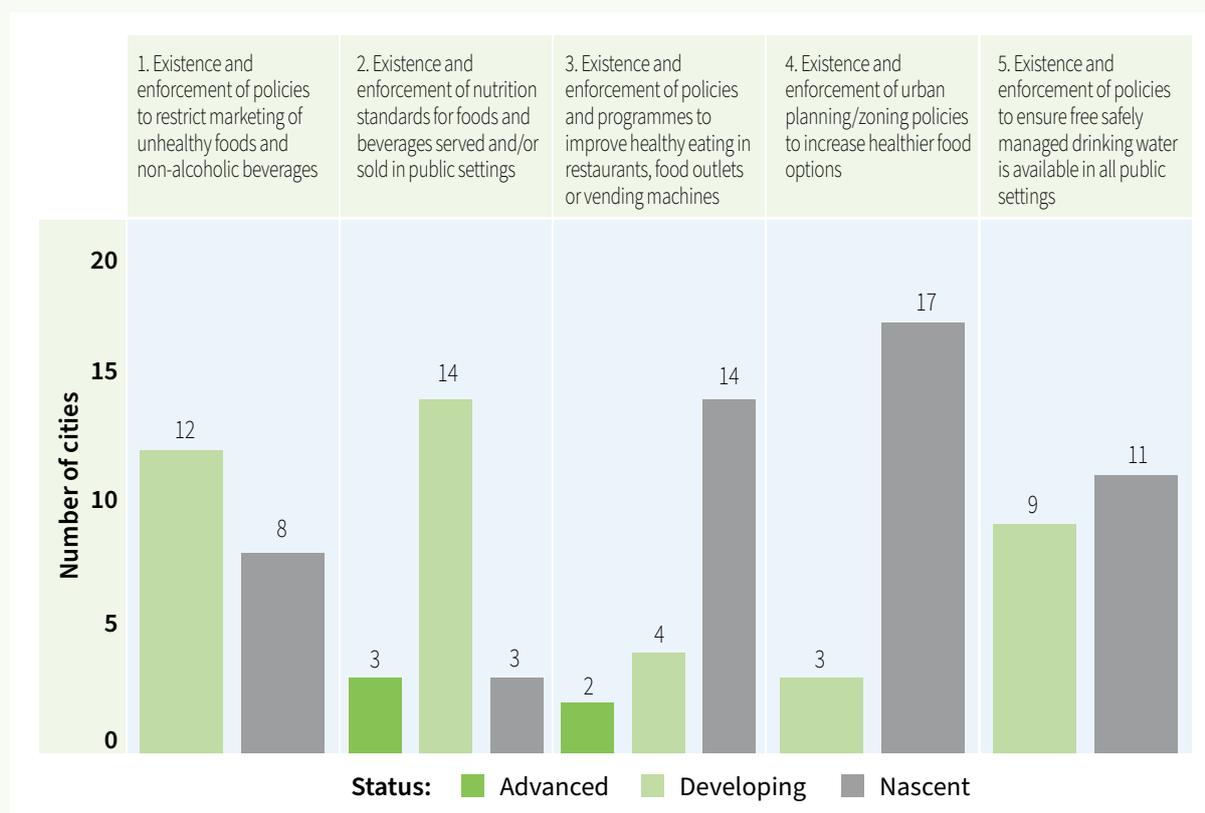


FIG. 10. Average scores of promoting healthy diets indicators by World Bank Group country classifications by income level, 20 cities, 2023

Indicator	Lower-middle-income (n=7)	Upper-middle-income (n=4)	High-income (n=9)
1. Existence and enforcement of policies to restrict marketing of unhealthy foods and non-alcoholic beverages	1.3	1.8	1.8
2. Existence and enforcement of nutrition standards for foods and beverages served and/or sold in public settings	1.7	2.3	2.1
3. Existence and enforcement of policies and programmes to improve healthy eating in restaurants, food outlets or vending machines	1.0	1.3	1.8
4. Existence and enforcement of urban planning/zoning policies to increase healthier food options	1.0	1.0	1.3
5. Existence and enforcement of policies to ensure free safely managed drinking water is available in all public settings	1.3	1.5	1.6
All indicators	1.3	1.6	1.7
	1 2 3	1 2 3	1 2 3
	Average score	Average score	Average score

Case study

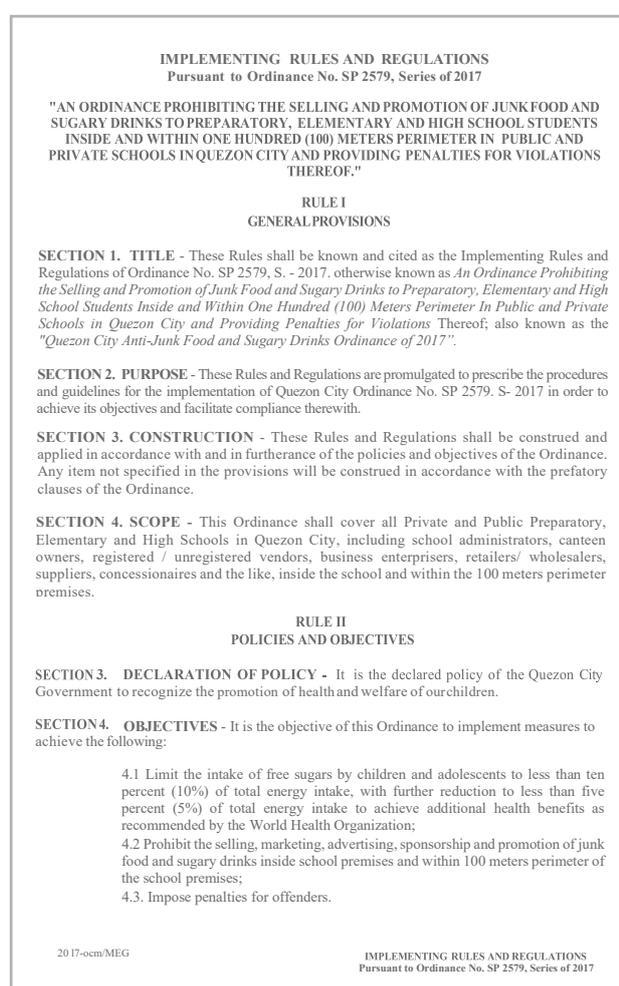
Harmonized implementation of central and local regulation to ensure healthy food in schools

Quezon City, Philippines

A healthy diet helps to protect against malnutrition in all its forms, including noncommunicable diseases.^a It is especially important for children and young people to be guaranteed a healthy food environment, in order to protect them from immediate health problems as well as an increased risk of adult obesity and NCD-related issues later in life.

To promote healthy eating among students in public elementary and secondary schools, the National Department of Education (DepEd) in the Philippines established the *Policy and guidelines on healthy food and beverage choices in schools and in DepEd offices* in 2017.^b The policy established food guidelines and prohibited the sale and marketing of foods and beverages rich in saturated fat, sugar, and/or sodium, as well as trans fats. A food colour-coding system based on nutritional composition was also introduced to classify foods that should not be consumed, sold or offered on school grounds, such as soft drinks, strongly salted snacks, chocolates and ice cream. Students are also not permitted to bring certain foods to school (whether prepared at home or purchased elsewhere).

To support implementation of the DepEd policy, the Quezon City administration passed its own ordinance prohibiting and penalizing the sale and marketing of 'junk' foods and sugary drinks among preparatory, elementary and high school children on school campus, and within one hundred metres of the perimeter of private and public schools.^c After broad consultation on ordinance implementation, the 2019 Quezon City Healthy Diet in Schools Ordinance was enacted, replacing the previous ordinance. A school health council was created to support proper implementation of the ordinance, including an information, education and communication campaign, and trainings



First page of the "Implementing Rules and Regulations" of the ordinance for prohibiting the selling and promotion of junk food and sugary drinks in schools in Quezon City.

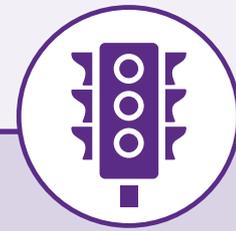


A school canteen in Quezon city with posters about the healthy food guidelines

for evaluation of foods and drinks in school canteens, and a specific budget was allocated for implementation.^d The work is part of Quezon City’s broader commitment to ensuring a healthy food environment for its citizens. In 2021, they were the first local government unit in the country to establish a healthy food procurement policy, and the city has also announced plans to promote healthier restaurant environments through a local calorie labelling policy.^e

Sources:

- ^a Healthy diet. Geneva: World Health Organization; 2022 (<https://www.who.int/en/news-room/fact-sheets/detail/healthy-diet>, accessed 1 April 2024).
- ^b Policy and guidelines on healthy food and beverage choices in schools and in DepEd offices. Manila: Philippines Department of Education, 2017 (<https://www.deped.gov.ph/2017/03/14/do-13-s-2017-policy-and-guidelines-on-healthy-food-and-beverage-choices-in-schools-and-in-deped-offices/>, accessed 22 August 2024).
- ^c Ordinance enacting the “Quezon City Health Diet in Schools Ordinance”. Quezon City: Quezon City Council; 2019 (<https://quezoncitycouncil.ph/ordinance/SP/SP-2846,%20S-2019.pdf>, accessed 1 April 2024).
- ^d QC first LGU to implement healthy food procurement policy. Quezon City: Quezon City Council; 2021 (<https://quezoncity.gov.ph/qc-first-lgu-to-implement-healthy-food-procurement-policy/>, accessed 1 April 2024).
- ^e Calorie labelling policy agreement. Quezon City: Quezon City Council; 2023 (<https://quezoncity.gov.ph/calorie-labelling-policy-agreement/>, accessed 1 April 2024).



3.1.5 Road safety

Core indicators: 4



Key observations

- ⚙ From the core indicators, all cities received a rating of developing or advanced for three of the four core indicators: namely the **existence and enforcement of legislation for speed limits, helmet use for two- and three-wheeler vehicles, and seat-belt use** (Fig. 11). National laws exist for all of these topics, but the presence of enforcement activities at the city level is encouraging, given their important role as implementors for national legislation.
- ⚙ The indicator with comparatively limited availability was the **existence and implementation of road design standards that include speed management and safe infrastructure for pedestrians and cyclists**. However, most cities reported some level of technical design standards required for all new roads which were intended to promote safety for all road users. Design standards in the majority of the cities included evidence-based elements such as safe crossings for pedestrians and cyclists, or their safe separation from vehicles on roads.
- ⚙ When classified by income (Fig. 12), the indicator with the strongest average availability for pilot cities was different for each group:
 - Lower-middle-income settings: **existence and enforcement of legislation for seat-belt use**.
 - Upper-middle-income settings: **existence and implementation of road design standards**, and **existence and enforcement of legislation on helmet use for two- and three-wheeled vehicles**.
 - High-income settings: **existence and enforcement of legislation for seat-belt use**.
- ⚙ Limitations that were reported as preventing cities from achieving higher availability of road safety indicators included the absence of particular types of implementation evidence, and a lack of enforcement evidence for regulation on helmet or seat-belt use.

FIG. 11. Status of road safety indicators across 20 cities, 2023

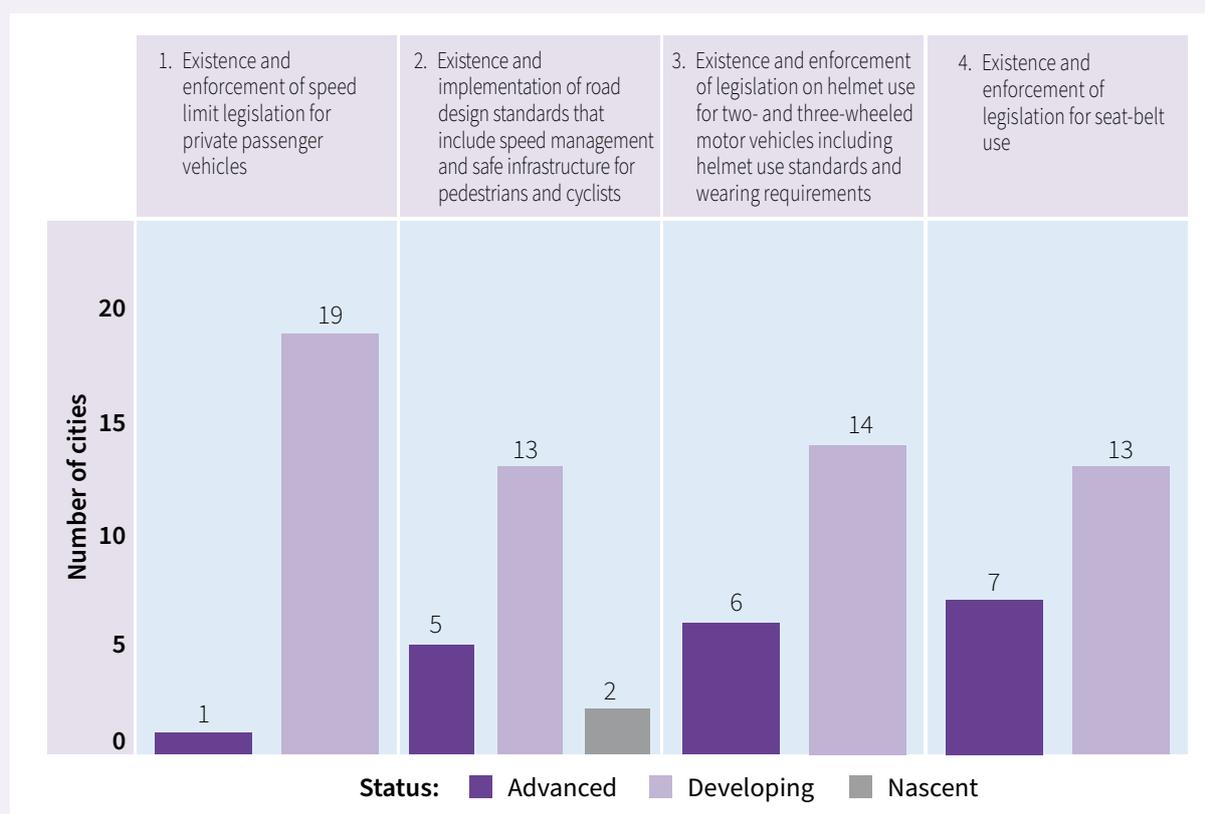


FIG. 12. Average scores of road safety indicators by World Bank Group country classifications by income level, 20 cities, 2023

Indicator	Lower-middle-income (n=7)	Upper-middle-income (n=4)	High-income (n=9)
1. Existence and enforcement of speed limit legislation for private passenger vehicles	2.0	2.0	2.1
2. Existence and implementation of road design standards that include speed management and safe infrastructure for pedestrians and cyclists	1.7	2.3	2.4
3. Existence and enforcement of legislation on helmet use for two- and three-wheeled motor vehicles including helmet use standards and wearing requirements	2.0	2.3	2.6
4. Existence and enforcement of legislation for seat-belt use	2.1	2.0	2.7
All indicators	2.0	2.1	2.4
	1 2 3 Average score	1 2 3 Average score	1 2 3 Average score

Case study

Not taking a back seat: strengthening national policy through local enforcement

Bangkok, Thailand

In 2021, there were over 117 000 road traffic crashes reported in Bangkok, leading to 614 deaths and over 70 000 injuries.^a Improving road safety is a long-standing priority for the city. To achieve it, the Bangkok Metropolitan Administration (BMA) use a dual approach of both enforcing national regulations and developing new municipal-level policies.

An example of their key role in enforcement can be seen in seat-belt use. Seat-belts have saved more lives than any other road safety intervention in history, reducing deaths among vehicle occupants in crashes by up to 50%.^b

In Thailand, seat-belts were previously only required for front-seat passengers. But in April 2017 a national law was passed also mandating their use by rear-seat passengers.^c With support from partners, the BMA supported the law's enforcement by working with local police to check seat-belt usage and issue warnings to those found to be non-compliant. The city also promoted messages on seat-belt use in local and national campaign materials, including at key times such as around Songkran (Thai New Year) when roads around Bangkok are especially busy.



Cover of "Road Safety Master Plan and Road Safety Action Plan: Bangkok 2021-2025"



A busy road in Bangkok

Data from a third-party survey conducted between 2015–2019 showed that higher rates of rear seat-belt use were observed in Bangkok after the passing of the new law, with a high of 38.5% of rear-seat occupants using seat-belts, compared to the previous high of 21.7% before the law. However, this was not an automatic gain since at times rates were lower.^c These results highlighted the important role that subnational actors can hold in enforcing national laws and ensuring they deliver their intended outcomes.

Sources:

- ^a Data source: Accident Data Center of Thailand (<http://www.thairsc.com/eng/>). Summary graphic provided by Bangkok Post Graphics (<https://www.bangkokpost.com/thailand/general/2259819/its-not-just-motorists-at-fault>, accessed 1 April 2024).
- ^b New global guidelines to boost the use of life-saving safety restraints in vehicles. Geneva: World Health Organization; 2023 (<https://www.who.int/news/item/06-03-2023-new-global-guidelines-to-boost-the-use-of-life-saving-safety-restraints-in-vehicles23>, accessed 1 April 2024).
- ^c Sutanto E, Zia N, Taber N, Rinawan FR, Amelia I, Jiwattanakupaisarn et al. Rear-seat seatbelt use in urban Southeast Asia: results from Bandung and Bangkok. *International Journal of Injury Control and Safety Promotion*. 2021;29(2):247–255. doi:10.1080/17457300.2021.1998135.



3.1.6 Safe walking and cycling

Core indicators: 4



Key observations

- ⚙ In general, the pilot results indicated reasonably good availability of the existence of city policies to promote safe active mobility.
- ⚙ In this policy area, the indicator with the highest number of cities reporting developing and advanced levels was the **existence of city urban planning policy to encourage compact design and mixed land use** (Fig. 13). Availability was reported as good across different income settings, with over half of the cities recording an advanced rating for this indicator (Fig. 14).
- ⚙ Two other indicators that showed good availability were the **existence of city policy promoting walking** and **existence of city policy promoting cycling**, which were reported as either ‘developing’ or ‘advanced’ by at least three-quarters of the cities.
- ⚙ The indicator that averaged the lowest rating was **existence of city policy on access to public open space**. Seven cities rated this as only being at the nascent level.
- ⚙ Limitations reported as preventing cities from achieving higher availability levels included the absence of monitoring frameworks to assess progress and implementation of key policies. In almost three-fifths of the cities there was no set target for increasing areas of and access to open public spaces. Limited use of public engagement around active mobility was also an issue. In the past two years less than half of the cities had run a city-wide mass media and participation campaign, and only four cities had conducted any survey to assess community perceptions of walking and cycling.

FIG. 13. Status of safe walking and cycling indicators across 20 cities, 2023

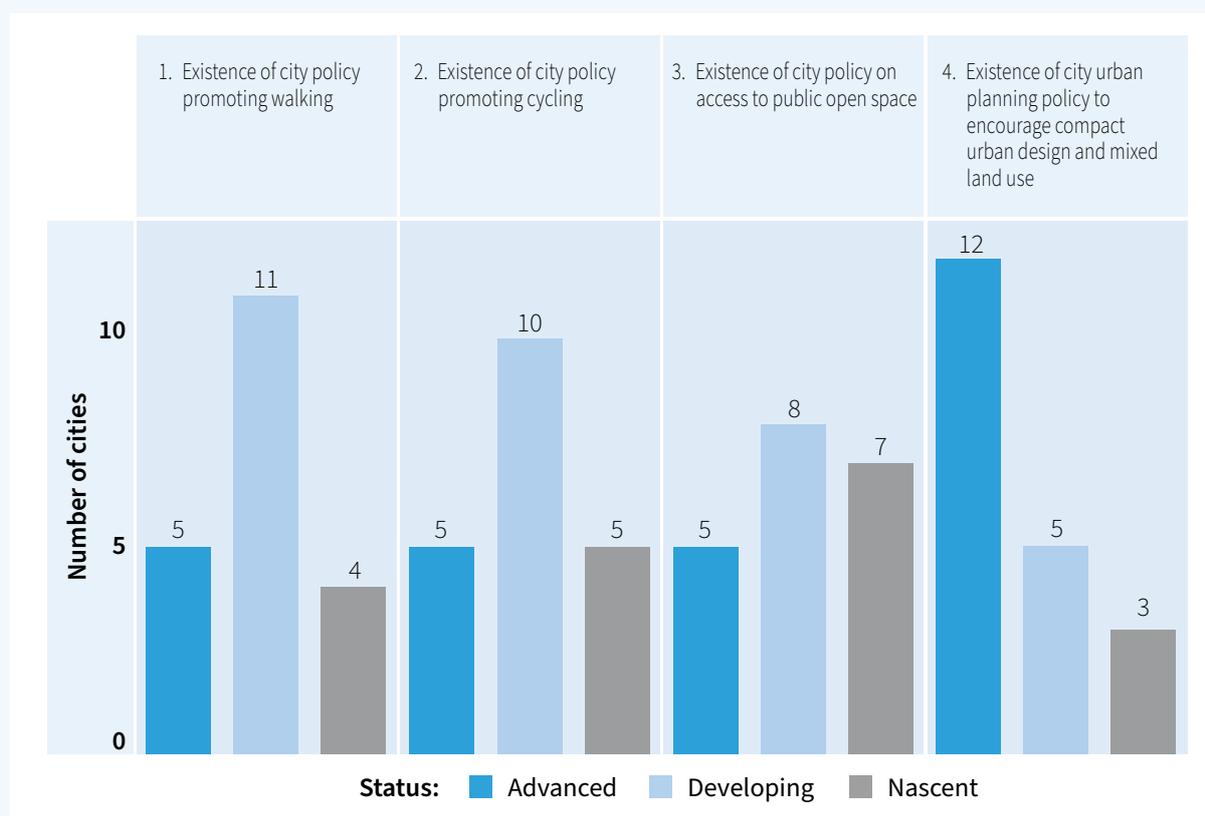


FIG. 14. Average scores of safe walking and cycling indicators by World Bank Group country classifications by income level, 20 cities, 2023

Indicator	Lower-middle-income (n=7)	Upper-middle-income (n=4)	High-income (n=9)
1. Existence of city policy promoting walking	1.7	2.3	2.2
2. Existence of city policy promoting cycling	1.6	1.8	2.4
3. Existence of city policy on access to public open space	1.6	1.3	2.4
4. Existence of city urban planning policy to encourage compact urban design and mixed land use	1.9	2.5	2.9
All indicators	1.7	1.9	2.5
	1 2 3	1 2 3	1 2 3
	Average score	Average score	Average score

Case study

Ensuring access to safe public space for staying active

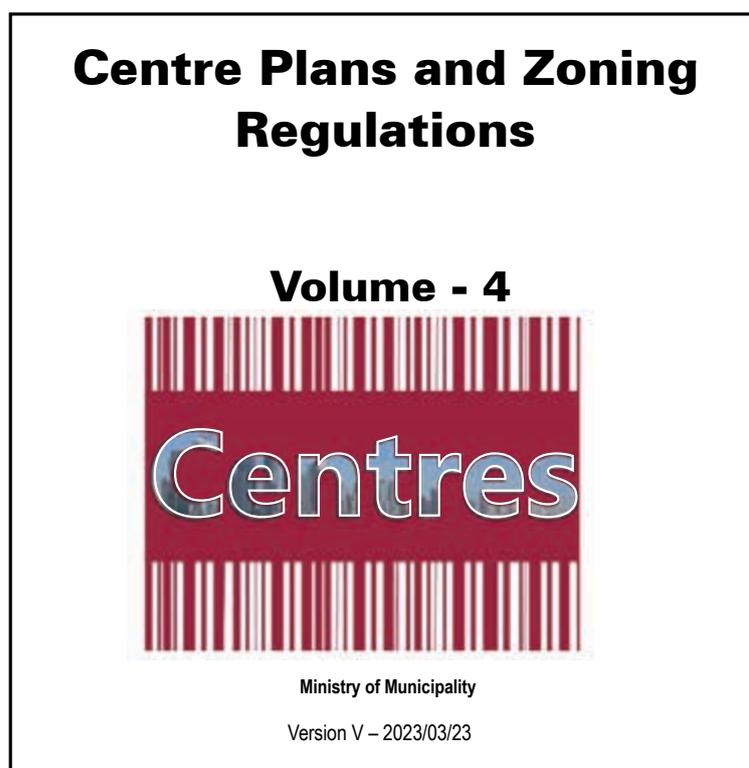
Doha, Qatar

Within urban environments, public open spaces – such as parks, recreational spaces and sports amenities – are an important way to ensure all residents have safe spaces for being physically active. Improving access to public open spaces is a core action recommended by the WHO ACTIVE technical package to promote safe, equitable access to places for walking, cycling and other kinds of physical activity.^a

In a 2021 global NCD survey, less than 50% of countries in the WHO Eastern Mediterranean Region reported implementing national policies to promote public open spaces.^b However, for Qatar promoting physical activity has been a priority in recent years. This is partly due to relatively high rates of physical inactivity – in 2022 over half of all Qatari adults did not do enough physical activity, and nearly half of all adult women.^c It has also received special attention due to the country's hosting of the 2022 FIFA World Cup, which galvanized interest in sports and physical activity.

The country's capital city of Doha is supporting this commitment

through its own urban design policies. In 2022 the Ministry of Municipalities published a National Plan on Centre Plans and Zoning Regulations, which outlined how land should be used to promote sustainable development and accessible walking and living environments.^d The plan includes a section on how different districts within the Municipality of Doha plan to manage future urban development, using a range of approaches based on local needs and existing spaces. Policies include using public-private partnerships to provide open spaces for communities, the development of parks near schools and other community facilities, and the provision of 'pocket parks' to enhance access to open spaces.



Cover of Volume 4 of "Centre Plans and Zoning Regulations" by Ministry of Municipality Qatar



Families enjoying one of Doha's open green spaces, which offer a safe environment for recreation and social interaction

By using a range of policies, local districts can target actions to specific issues for their communities, whilst also integrating into a broader strategy of sustainable urban development and active transport for the municipality – and country – as a whole.

Sources:

- ^a ACTIVE: a technical package for increasing physical activity. Geneva: World Health Organization; 2018 (<https://iris.who.int/bitstream/handle/10665/275415/9789241514804-eng.pdf>, accessed 1 April 2024).
- ^b Assessing national capacity for the prevention and control of noncommunicable diseases: report of the 2021 global survey. Geneva: World Health Organization; 2023 (<https://iris.who.int/handle/10665/370423>, accessed 1 April 2024).
- ^c Prevalence of insufficient physical activity among adults. Data by country. Geneva: Global Health Observatory; 2022 [https://www.who.int/data/gho/data/indicators/indicator-details/GHO/prevalence-of-insufficient-physical-activity-among-adults-aged-18-years-\(crude-estimate\)-\(-\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/prevalence-of-insufficient-physical-activity-among-adults-aged-18-years-(crude-estimate)-(-)), accessed 23 September 2024).
- ^d Centre Plans and Zoning Regulations, Volume IV. Ministry of Municipality, 29/05/2022



3.1.7 Tobacco control

Core indicators: 4



Key observations

- ⚙️ All cities were assessed as having ‘developing’ or ‘advanced’ levels for the indicators for **existence and compliance measurement of smoke free legislation** and **existence and compliance measurement of bans on advertising, promotion and sponsorship** (Fig. 15). A common reason for cities not reaching advanced level on either of these was a lack of compliance measurements.
- ⚙️ The indicator on **existence and compliance measurement of smoke-free legislation** had the highest average rating in all income settings (Fig. 16).
- ⚙️ **Existence of anti-tobacco mass media campaigns** was assessed as nascent in seven cities. Anti-tobacco mass media campaigns had been conducted in two of the seven cities in the past, but not within the time period required by the indicator definition (within the previous three years).
- ⚙️ A quarter of the cities did not have any policy to promote cessation of tobacco use nor provide **treatment for tobacco cessation**. However, the three cities that scored advanced for this indicator showed evidence of comprehensive cessation services, such as tobacco cessation advice in primary care services, free and easily accessible telephone, and free low-cost cessation medicines.

FIG. 15. Status of tobacco control indicators across 20 cities, 2023

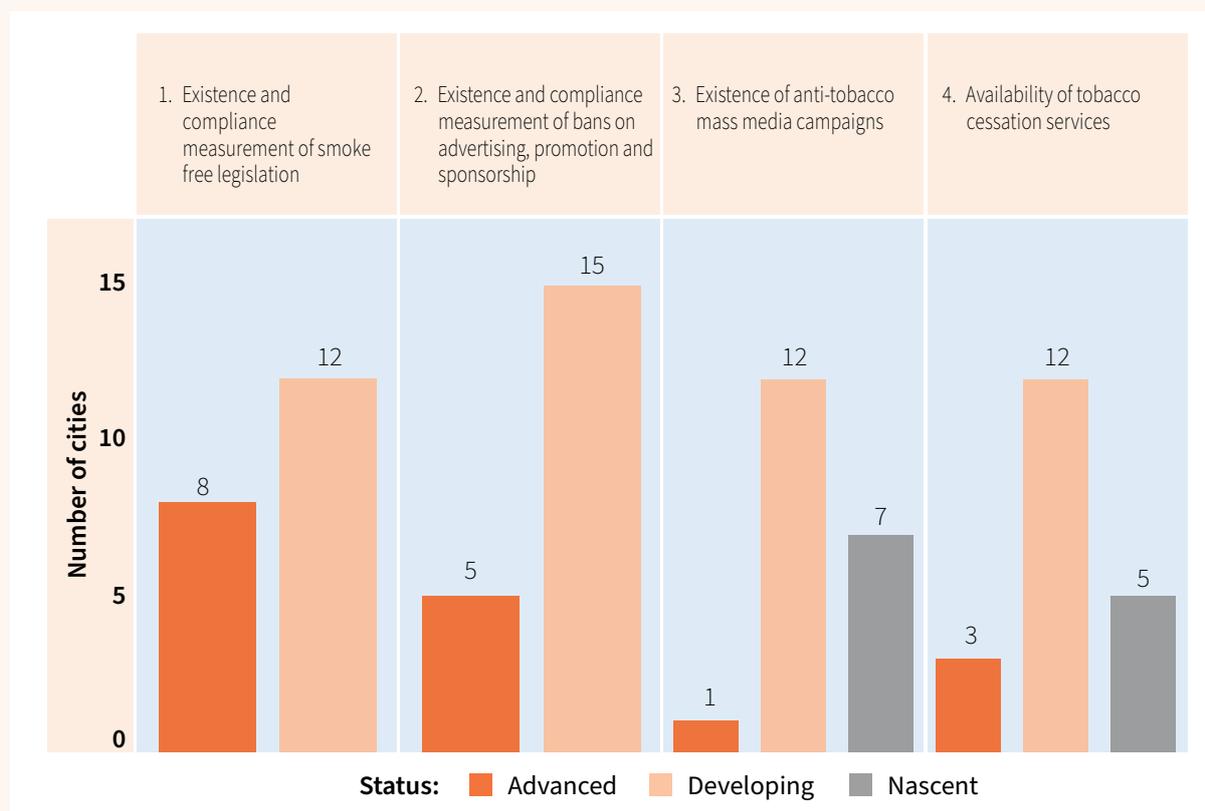


FIG. 16. Average scores of tobacco control by World Bank Group country classifications by income level, 20 cities, 2023

Indicator	Lower-middle-income (n=7)	Upper-middle-income (n=4)	High-income (n=9)
1. Existence and compliance measurement of smoke free legislation	2.0	2.8	2.6
2. Existence and compliance measurement of bans on advertising, promotion and sponsorship	2.0	2.8	2.2
3. Existence of anti-tobacco mass media campaigns	1.3	2.0	1.9
4. Availability of tobacco cessation services	1.4	1.8	2.3
All indicators	1.7	2.3	2.3
	1 2 3 Average score	1 2 3 Average score	1 2 3 Average score

Case study

Bringing smoke-free legislation to life

Geelong, Australia



No smoking sign

Second-hand smoke kills over 1 million non-smokers every year, and causes heart disease, cancer and many other diseases.^a There is no safe level of exposure, so by creating smoke-free spaces people can be protected from its harmful effects. As a result, smoke-free spaces are considered a key component of effective tobacco control.^b

Local authorities play a key role in ensuring enforcement of relevant smoke-free laws. The City of Greater Geelong, Australia has demonstrated this in the way it has supported implementation of state-level tobacco legislation. Under the state of Victoria's Tobacco Act Legislation, smoking is prohibited in all enclosed workplaces and many public spaces including outdoor dining and recreational areas, the grounds of primary and secondary schools, sporting venues during underage sporting events and public transport.^c The city's official website explicitly acknowledges the council's role in enforcing the Tobacco Act 1987 and provides information on the restrictions that apply to different spaces. It also offers links to signs and factsheets for business owners and managers, as practical

tools to help inform staff and customers about these rules within their establishments.^d The council's responsibility to enforce smoke-free spaces is also included within their Neighbourhood Amenity Local Law 2014, which clearly lays out the council's legal rights to enforce smoke-free spaces, along with the accompanying penalty for infringements based on nationally set rates.^e

In addition to enforcement, many cities also have the legislative authority to pass their own local smoke-free laws for areas such as municipal buildings, public transport, local parks and other public spaces.^f The Neighbourhood Amenity Local Law outlines Geelong's legal right to declare specific municipal places as smoke-free, providing that they follow the guidelines of a Local Laws Procedures Manual. Other cities in the state of Victoria, such as Melbourne, have already used similar powers to create their own local smoke-free spaces – ensuring their citizens can breathe cleaner air and enjoy a healthier environment.

Sources:

- ^a Protecting people from tobacco smoke. Geneva: World Health Organization (<https://www.who.int/activities/protecting-people-from-tobacco-smoke>, accessed 1 April 2024).
- ^b MPOWER. Geneva: World Health Organization (<https://www.who.int/initiatives/mpower>, accessed 1 April 2024).
- ^c Smoke-free and vape-free areas. Melbourne: Victoria Department of Health; 2024 (<https://www.health.vic.gov.au/tobacco-reform/smoke-free-and-vape-free-areas>, accessed 1 April 2024).
- ^d Tobacco laws. Geelong: City of Greater Geelong; 2023 (<https://www.geelongaustralia.com.au/safety/article/item/8d0600e8c48116a.aspx>, accessed 1 April 2024).
- ^e Neighbourhood Amenity Local Law 2014. Geelong: City of Greater Geelong; 2023 (<https://www.geelongaustralia.com.au/locallaws/documents/item/8cb952796cb30ae.aspx>, accessed 1 April 2024).
- ^f Making cities smoke-free. Geneva: World Health Organization; 2011 (<https://iris.who.int/handle/10665/44773>, accessed 1 April 2024).



3.1.8 NCD and injury surveillance

Core indicators: 4



Key observations

- ✿ Three-quarters of the cities reported having **access to and use of cause-of-death data on NCDs and injuries**, and half of the cities had **access to and use of routine health facility data** (Fig. 17). These two indicators were observed to have the best performance across all income settings (Fig. 18).
- ✿ No other indicators were assessed as advanced in any of the cities. The primary reason for this was a lack of available data within the time parameters required (typically, collected within the past two or five years).
- ✿ The indicator for assessing **adult injury risk factor surveillance capacities** saw the lowest performance: just three cities rated this as developing, and none as advanced. Reasons for this were connected to a lack of recent data, and gaps in data for key risk factors.
- ✿ In general, the results indicated limited city capacity to conduct regular surveys on NCD or injury prevention. Reasons for this may include the cost of data collection, or that data collection is carried out by national authorities, reducing city agency over frequency or the inclusion of specific topics.

FIG. 17. Status of NCD and injury surveillance indicators across 20 cities, 2023

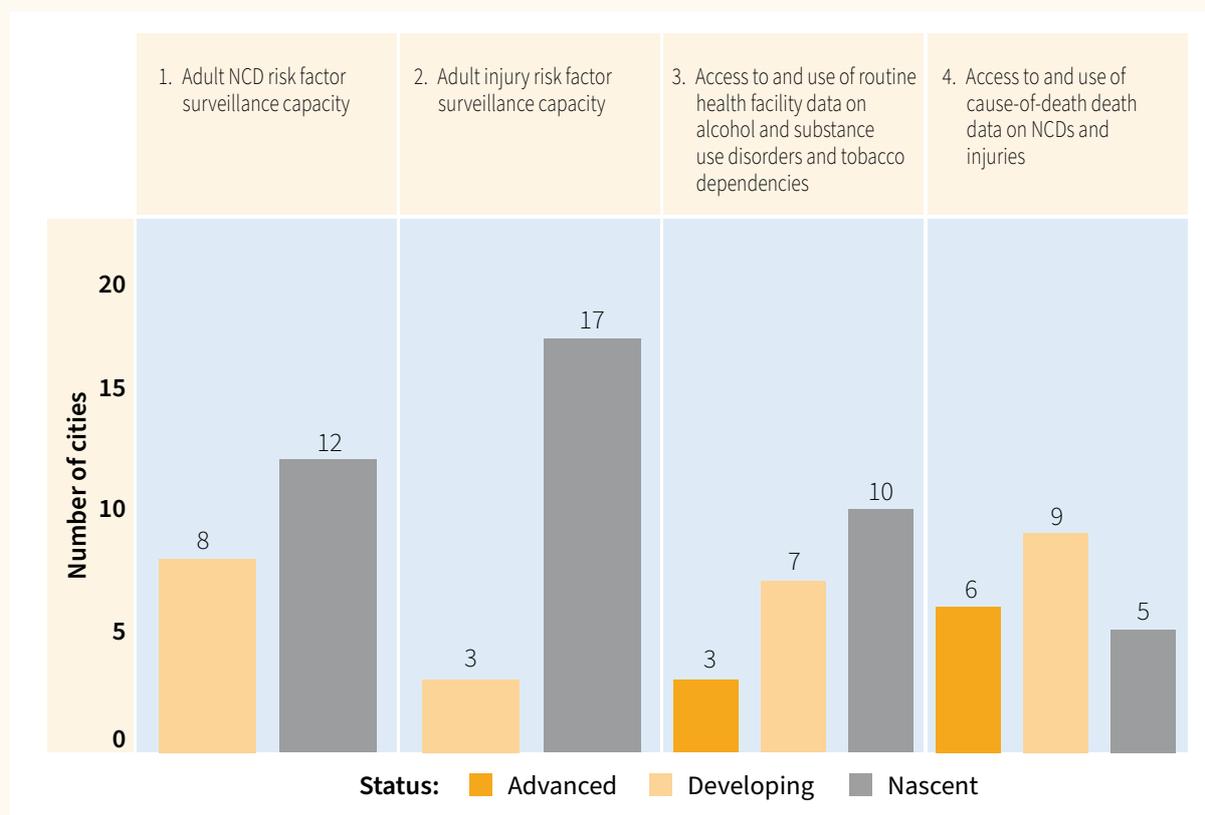


FIG. 18. Average scores of NCD and injury surveillance indicators by World Bank Group country classifications by income level, 20 cities, 2023

Indicator	Lower-middle-income (n=7)	Upper-middle-income (n=4)	High-income (n=9)
1. Adult NCD risk factor surveillance capacity	1.1	1.0	1.8
2. Adult injury risk factor surveillance capacity	1.0	1.0	1.3
3. Access to and use of routine health facility data on alcohol and substance use disorders and tobacco dependencies	1.4	1.3	2.0
4. Access to and use of cause-of-death data on NCDs and injuries	1.4	2.0	2.6
All indicators	1.3	1.3	1.9
	1 2 3	1 2 3	1 2 3
	Average score	Average score	Average score

Case study

Promoting a culture of accessible, action-oriented data to improve health and reduce health inequalities

Barcelona, Spain

Since 1983, the Barcelona Public Health Agency (ASPB) has generated an annual analytical report on health status and determinants across the city.^{a,b} The report is an essential tool for monitoring and prioritizing policies aimed at improving the health of the population. It provides an analysis of the health status and its determinants in the city of Barcelona, with a special focus on social inequalities in health. Each report reveals the situation and key city health trends, covering a wide range of topics linked to determinants, health and well-being. In addition to the full report, there is also an 'easy read' edition which presents the results in a simple, accessible manner to promote wider readership.

One of the report's major strengths is the integration of multiple data types into a single unified document, drawing from a variety of sources. It is structured according to the conceptual framework for social determinants for health and health inequalities for cities.^c Headline categories include:

- **Environmental data** – such as air and noise pollution, climate conditions, and transport.
- **Socioeconomic data** – such as incomes, employment rates and sociodemographic trends.
- **Core health data** – such as survey data on health status or risk factors, data from primary care information systems, and mortality trends.

Under each category, the report offers succinct summaries of relevant data, providing key messages and data products such as charts, tables and infographics. The aim of this comprehensive but centralized data summary is to provide the city council and others with the right information for planning policies and actions linked to priority health issues and reduction of health inequalities.

The report's approach is indicative of Barcelona's efforts to ensure data is both usable and accessible. There are a number of dashboards that shows the environment, socioeconomic, and health data by inequality axes such as age, gender, socioeconomic status and territorial, when available. These include data by district, from an adult household health survey, from a secondary school health survey, and from health inequalities surveillance.



Cover of the 2022 edition of "Health in Barcelona"



The Observatori Fabra in Barcelona

In addition, the Health and Policy Impact Observatory (OBSIP) is a tool that allows the monitoring of health status in the city as a whole, and the existing inequalities between neighbourhoods and social groups. It also provides a repository of health impact evaluations of policies developed in Barcelona.^d

The work is aligned with the city's broader commitment to open, accessible data. Since 2011 the city has hosted a platform, Open Data BCN, which optimizes access to all information collected or managed by public bodies to make it usable and relevant for citizens. To reflect its commitment to global issues, the platform even includes a section on the 2030 Agenda, where the city's data sources are catalogued against the 17 Sustainable Development Goals, highlighting the city's potential contribution to each topic.^e For health alone, the city reports 56 datasets relevant to SDG 3, demonstrating the breadth of its contribution to this goal.^f

Sources:

- ^a Borrell C, Bartoll X, García-Altés A, Pasarín MI, Piñeiro M, Villalbí JR. Veinticinco años de informes de salud en Barcelona: una apuesta por la transparencia y un instrumento para la acción. *Revista Española de Salud Pública*. 2011;85:449–458.
- ^b La salut a Barcelona. Barcelona: l'Agència de Salut Pública de Barcelona; 2022 (<https://www.aspb.cat/wp-content/uploads/2023/12/ASPB-salutbarcelona2022-breu-231211.pdf>, accessed 1 April 2024).
- ^c Borrell C, Pons-Vigués M, Morrison J, Díez È. Factors and processes influencing health inequalities in urban areas. *J Epidemiol Community Health*. 2013;67(5):389–391.
- ^d (<https://dades.aspb.cat/obsip/>, accessed 1 April 2024).
- ^e The 2030 Agenda for Sustainable Development and Open Data BCN [website]. Barcelona: Barcelona City Council (<https://opendata-ajuntament.barcelona.cat/en/ods-agenda2030>, accessed 1 April 2024).
- ^f Open Data BCN Datasets [website]. Barcelona: Barcelona City Council (https://opendata-ajuntament.barcelona.cat/data/en/dataset?ODS_Principal_agenda_2030=ODS+3%3A+Salut+i+benestar, accessed 1 April 2024).



3.2 City profiles

The following profiles were produced by WHO using information submitted by cities as part of the pilot testing of the indicators. All information was collected between 2021–2023.

Amman, Jordan

City Population: 3 999 008 (8)



Air pollution reduction

1. Air pollution measurement capacity
2. Availability of air quality information and trends
3. Availability of emission estimates
4. Existence and enforcement of air quality standards



Alcohol control

1. Existence of comprehensive strategy, plan of action and activities to reduce harmful use of alcohol
2. Existence of policy to restrict commercial and public availability of alcohol
3. Existence of bans or comprehensive restrictions on alcohol advertising, sponsorship and promotion
4. Existence and enforcement of drink-driving legislation
5. Availability of brief intervention and treatment for problematic alcohol use



Overdose prevention

1. Availability of key medications for opioid dependence treatment
2. Existence of service governance mechanisms for drug use disorder treatment
3. Availability of non-structured harm reduction services for people with drug use disorders
4. Availability of take-home naloxone at city level



Promoting healthy diets

1. Existence and enforcement of policies to restrict marketing of unhealthy foods and non-alcoholic beverages
2. Existence and enforcement of nutrition standards for foods and beverages served and/or sold in public settings
3. Existence and enforcement of policies and programmes to improve healthy eating in restaurants, food outlets or vending machines
4. Existence and enforcement of urban planning/zoning policies to increase healthier food options
5. Existence and enforcement of policies to ensure free safely managed drinking water is available in all public settings





Road safety

1. Existence and enforcement of speed limit legislation for private passenger vehicles
2. Existence and implementation of road design standards that include speed management and safe infrastructure for pedestrians and cyclists
3. Existence and enforcement of legislation on helmet use for two- and three-wheeled motor vehicles including helmet use standards and wearing requirements
4. Existence and enforcement of legislation for seat-belt use



Safe walking and cycling

1. Existence of city policy promoting walking
2. Existence of city policy promoting cycling
3. Existence of city policy on access to public open space
4. Existence of city urban planning policy to encourage compact urban design and mixed land use



Tobacco control

1. Existence and compliance measurement of smoke free legislation
2. Existence and compliance measurement of bans on advertising, promotion and sponsorship
3. Existence of anti-tobacco mass media campaigns
4. Availability of tobacco cessation services



NCD and injury surveillance

1. Adult NCD risk factor surveillance capacity
2. Adult injury risk factor surveillance capacity
3. Access to and use of routine health facility data on alcohol and substance use disorders and tobacco dependencies
4. Access to and use of cause-of-death death data on NCDs and injuries



Nascent



Developing



Advanced

Bangkok, Thailand

City Population: 8 421 212 (8)



Air pollution reduction

1. Air pollution measurement capacity
2. Availability of air quality information and trends
3. Availability of emission estimates
4. Existence and enforcement of air quality standards



Alcohol control

1. Existence of comprehensive strategy, plan of action and activities to reduce harmful use of alcohol
2. Existence of policy to restrict commercial and public availability of alcohol
3. Existence of bans or comprehensive restrictions on alcohol advertising, sponsorship and promotion
4. Existence and enforcement of drink-driving legislation
5. Availability of brief intervention and treatment for problematic alcohol use



Overdose prevention

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5. Existence and enforcement of policies to ensure free safely managed drinking water is available in all public settings





Road safety

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4. Existence and enforcement of legislation for seat-belt use



Safe walking and cycling

1. Existence of city policy promoting walking
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3. Existence of city policy on access to public open space
4. Existence of city urban planning policy to encourage compact urban design and mixed land use



Tobacco control

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4. Availability of tobacco cessation services



NCD and injury surveillance

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2. Adult injury risk factor surveillance capacity
3. Access to and use of routine health facility data on alcohol and substance use disorders and tobacco dependencies
4. Access to and use of cause-of-death death data on NCDs and injuries



Nascent



Developing



Advanced

Barcelona, Spain

City Population: 1 627 559 (8)



Air pollution reduction

1. Air pollution measurement capacity
2. Availability of air quality information and trends
3. Availability of emission estimates
4. Existence and enforcement of air quality standards



Alcohol control

1. Existence of comprehensive strategy, plan of action and activities to reduce harmful use of alcohol
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Overdose prevention

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5. Existence and enforcement of policies to ensure free safely managed drinking water is available in all public settings





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Safe walking and cycling

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4. Availability of tobacco cessation services



NCD and injury surveillance

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2. Adult injury risk factor surveillance capacity
3. Access to and use of routine health facility data on alcohol and substance use disorders and tobacco dependencies
4. Access to and use of cause-of-death death data on NCDs and injuries



Nascent



Developing



Advanced

Bogotá, Colombia

City Population: 7 901 653 (8)



Air pollution reduction

1. Air pollution measurement capacity
2. Availability of air quality information and trends
3. Availability of emission estimates
4. Existence and enforcement of air quality standards



Alcohol control

1. Existence of comprehensive strategy, plan of action and activities to reduce harmful use of alcohol
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Tobacco control

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NCD and injury surveillance

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2. Adult injury risk factor surveillance capacity
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4. Access to and use of cause-of-death death data on NCDs and injuries



Nascent



Developing



Advanced

Bursa, Türkiye

City Population: 3 147 818 (8)



Air pollution reduction

1. Air pollution measurement capacity
2. Availability of air quality information and trends
3. Availability of emission estimates
4. Existence and enforcement of air quality standards



Alcohol control

1. Existence of comprehensive strategy, plan of action and activities to reduce harmful use of alcohol
2. Existence of policy to restrict commercial and public availability of alcohol
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NCD and injury surveillance

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4. Access to and use of cause-of-death death data on NCDs and injuries



Nascent



Developing



Advanced

Cape Town, South Africa

City Population: 4 772 846 (9)



Air pollution reduction

1. Air pollution measurement capacity
2. Availability of air quality information and trends
3. Availability of emission estimates
4. Existence and enforcement of air quality standards



Alcohol control

1. Existence of comprehensive strategy, plan of action and activities to reduce harmful use of alcohol
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4. Access to and use of cause-of-death death data on NCDs and injuries



Nascent



Developing



Advanced

Doha, Qatar

City Population: 1 186 023 (8)



Air pollution reduction

1. Air pollution measurement capacity
2. Availability of air quality information and trends
3. Availability of emission estimates
4. Existence and enforcement of air quality standards



Alcohol control

1. Existence of comprehensive strategy, plan of action and activities to reduce harmful use of alcohol
2. Existence of policy to restrict commercial and public availability of alcohol
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Overdose prevention

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5. Existence and enforcement of policies to ensure free safely managed drinking water is available in all public settings





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Tobacco control

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NCD and injury surveillance

1. Adult NCD risk factor surveillance capacity
2. Adult injury risk factor surveillance capacity
3. Access to and use of routine health facility data on alcohol and substance use disorders and tobacco dependencies
4. Access to and use of cause-of-death death data on NCDs and injuries



Nascent



Developing



Advanced

Goiânia, Brazil

City Population: 1 437 366 (10)



Air pollution reduction

1. Air pollution measurement capacity
2. Availability of air quality information and trends
3. Availability of emission estimates
4. Existence and enforcement of air quality standards



Alcohol control

1. Existence of comprehensive strategy, plan of action and activities to reduce harmful use of alcohol
2. Existence of policy to restrict commercial and public availability of alcohol
3. Existence of bans or comprehensive restrictions on alcohol advertising, sponsorship and promotion
4. Existence and enforcement of drink-driving legislation
5. Availability of brief intervention and treatment for problematic alcohol use



Overdose prevention

1. Availability of key medications for opioid dependence treatment
2. Existence of service governance mechanisms for drug use disorder treatment
3. Availability of non-structured harm reduction services for people with drug use disorders
4. Availability of take-home naloxone at city level



Promoting healthy diets

1. Existence and enforcement of policies to restrict marketing of unhealthy foods and non-alcoholic beverages
2. Existence and enforcement of nutrition standards for foods and beverages served and/or sold in public settings
3. Existence and enforcement of policies and programmes to improve healthy eating in restaurants, food outlets or vending machines
4. Existence and enforcement of urban planning/zoning policies to increase healthier food options
5. Existence and enforcement of policies to ensure free safely managed drinking water is available in all public settings





Road safety

1. Existence and enforcement of speed limit legislation for private passenger vehicles
2. Existence and implementation of road design standards that include speed management and safe infrastructure for pedestrians and cyclists
3. Existence and enforcement of legislation on helmet use for two- and three-wheeled motor vehicles including helmet use standards and wearing requirements
4. Existence and enforcement of legislation for seat-belt use



Safe walking and cycling

1. Existence of city policy promoting walking
2. Existence of city policy promoting cycling
3. Existence of city policy on access to public open space
4. Existence of city urban planning policy to encourage compact urban design and mixed land use



Tobacco control

1. Existence and compliance measurement of smoke free legislation
2. Existence and compliance measurement of bans on advertising, promotion and sponsorship
3. Existence of anti-tobacco mass media campaigns
4. Availability of tobacco cessation services



NCD and injury surveillance

1. Adult NCD risk factor surveillance capacity
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Nascent



Developing



Advanced

Greater Geelong, Australia

City Population: 271 057 (11)



Air pollution reduction

1. Air pollution measurement capacity
2. Availability of air quality information and trends
3. Availability of emission estimates
4. Existence and enforcement of air quality standards



Alcohol control

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Nascent



Developing



Advanced

Harare, Zimbabwe

City Population: 1 698 122 (8)



Air pollution reduction

1. Air pollution measurement capacity
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4. Existence and enforcement of air quality standards



Alcohol control

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Nascent



Developing



Advanced

Helsinki, Finland

City Population: 656 920 (8)



Air pollution reduction

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4. Existence and enforcement of air quality standards



Alcohol control

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Nascent



Developing



Advanced

Lalitpur, Nepal

City Population: 133 305 (8)



Air pollution reduction

1. Air pollution measurement capacity
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Nascent



Developing



Advanced

London, United Kingdom of Great Britain and Northern Ireland

City Population: 8 945 309 (12)



Air pollution reduction

1. Air pollution measurement capacity
2. Availability of air quality information and trends
3. Availability of emission estimates
4. Existence and enforcement of air quality standards



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Nascent



Developing



Advanced

Maio, Cabo Verde

City Population: 6980 (13)



Air pollution reduction

1. Air pollution measurement capacity
2. Availability of air quality information and trends
3. Availability of emission estimates
4. Existence and enforcement of air quality standards



Alcohol control

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Nascent



Developing



Advanced

Manama, Bahrain

City Population: 176 909 (8)



Air pollution reduction

1. Air pollution measurement capacity
2. Availability of air quality information and trends
3. Availability of emission estimates
4. Existence and enforcement of air quality standards



Alcohol control

1. Existence of comprehensive strategy, plan of action and activities to reduce harmful use of alcohol
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Nascent



Developing



Advanced

Obu, Japan

City Population: 93 123 (14)



Air pollution reduction

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Alcohol control

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Nascent



Developing



Advanced

Parañaque, Philippines

City Population: 689 992 (8)



Air pollution reduction

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Alcohol control

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Nascent



Developing



Advanced

Quezon City, Philippines

City Population: 2 960 048 (8)



Air pollution reduction

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Nascent



Developing



Advanced

Utrecht, Netherlands (Kingdom of the)

City Population: 367 984 (15)



Air pollution reduction

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Alcohol control

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Nascent



Developing



Advanced

Vancouver, Canada

City Population: 725 778 (16)



Air pollution reduction

1. Air pollution measurement capacity
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3. Existence and enforcement of legislation on helmet use for two- and three-wheeled motor vehicles including helmet use standards and wearing requirements
4. Existence and enforcement of legislation for seat-belt use



Safe walking and cycling

1. Existence of city policy promoting walking
2. Existence of city policy promoting cycling
3. Existence of city policy on access to public open space
4. Existence of city urban planning policy to encourage compact urban design and mixed land use



Tobacco control

1. Existence and compliance measurement of smoke free legislation
2. Existence and compliance measurement of bans on advertising, promotion and sponsorship
3. Existence of anti-tobacco mass media campaigns
4. Availability of tobacco cessation services



NCD and injury surveillance

1. Adult NCD risk factor surveillance capacity
2. Adult injury risk factor surveillance capacity
3. Access to and use of routine health facility data on alcohol and substance use disorders and tobacco dependencies
4. Access to and use of cause-of-death death data on NCDs and injuries



Nascent



Developing



Advanced

4 Conclusion

The pilot assessment process was an instrumental step in the finalization and testing of the indicators. Participation from the cities was highly valued and appreciated by technical teams, and provided key insights into the practical application of the indicators, the data collection tool, and the rating criteria.

Ultimately, the indicators are intended to facilitate an initial assessment of a city's status of work on one or more of the eight topics covered. The results of this baseline assessment can also be used to identify areas of improvement, by advancing ratings for particular sub-components, and to monitor progress over time.

With global rates of NCDs and injuries on the rise, action to address them is needed from all levels of government. The results of the pilot highlight how cities can play a key role in this by advancing policy development, implementation, enforcement and monitoring, and that many are already doing so. However, as the variation in ratings across the pilot cities demonstrates, these gains and capabilities are not automatic. Whilst the indicators are a starting point for action, cities must continue to be empowered with the political, financial and technical support they need to make positive changes and deliver public health impact.

References

1. World urbanization prospects: The 2018 revision 2022: Summary of results. New York: United Nations, Department of Economic and Social Affairs; 2019 (<https://population.un.org/wup/Publications/Files/WUP2018-Report.pdf>, accessed 1 April 2024).
2. World cities report 2022: Envisaging the future of cities. Nairobi: United Nations Human Settlements Programme (UN-Habitat); 2022 (https://unhabitat.org/sites/default/files/2022/06/wcr_2022.pdf, accessed 1 April 2024).
3. Health topics: Urban health [website]. Geneva: World Health Organization; 2024 (https://www.who.int/health-topics/urban-health#tab=tab_3, accessed 1 April 2024).
4. Urban health: key facts [website]. Geneva: World Health Organization; 2021 (<https://www.who.int/news-room/fact-sheets/detail/urban-health>, accessed 1 April 2024).
5. The power of cities: tackling noncommunicable diseases and road traffic injuries. Geneva: World Health Organization; 2019 (<https://iris.who.int/handle/10665/329429>, accessed 1 April 2024).
6. City-level monitoring guidance for the prevention and control of noncommunicable diseases and injuries. Geneva: World Health Organization; 2024 (<https://iris.who.int/handle/10665/374874>, accessed 1 April 2024).
7. Partnership for Healthy Cities [website]. New York: Vital Strategies; 2024 (<https://cities4health.org/>, accessed 1 April 2024).
8. Demographic Yearbook 73rd Issue 2022. New York: United Nations Department of Economic and Social Affairs Population Division; 2023 (<https://unstats.un.org/unsd/demographic-social/products/dyb/dybsets/2022.pdf>, accessed 22 August 2024).
9. City of Cape Town, Cape Town census and population statistics 2022. <https://www.capetown.gov.za/Family%20and%20home/education-and-research-materials/data-statistics-and-research/cape-town-census>, accessed 27 October 2024.
10. Censo Demografico 2022. Rio de Janeiro: Instituto Brasileiro de Geografia e Estatística; 2022 (<https://censo2022.ibge.gov.br/apps/pgi/#/mapa/>, accessed 1 April 2024).
11. Australian Bureau of Statistics. Census of Population and Housing 2021. ([https://urldefense.com/v3/___https://www.abs.gov.au/census___;!!lcNgQMDWPGTU!kGjaL-ozpeKgDdoZFK5Kafq2MaF4erEClKtNwnTdAQWPx5EA!hgMF0bTl6A5sc3WZLcSiriukjXmOkFIFrEadCA9bSdKvWBJ3A\\$](https://urldefense.com/v3/___https://www.abs.gov.au/census___;!!lcNgQMDWPGTU!kGjaL-ozpeKgDdoZFK5Kafq2MaF4erEClKtNwnTdAQWPx5EA!hgMF0bTl6A5sc3WZLcSiriukjXmOkFIFrEadCA9bSdKvWBJ3A$), accessed 22 August 2024).
12. Office for National Statistics, Population estimates for England and Wales: mid-2023 (<https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/populationestimatesforenglandandwales/mid2023>, accessed 16 August 2024).
13. Cabo Verde 2015 Statistical Yearbook. Praia: Instituto Nacional de Estatística; 2015 (https://ine.cv/wp-content/uploads/2017/02/statistical-yearbook-cv-2015_en.pdf, accessed 22 August 2024).

14. 2020 Population Census: Basic Complete Tabulation of Population and Households. Tokyo: Ministry of Internal Affairs and Communications; 2021 (<https://www.e-stat.go.jp/en/stat-search/files?page=1&layout=datalist&toukei=00200521&tstat=000001136464&cycle=0&year=20200&month=24101210&tclass1=000001136466>, accessed 22 August 2024).
15. Personal records database: Personal data: Population 2023 (BRP). Den Haag: Ministry of the Interior and Kingdom Relations, Government of Netherlands; 2023 (<https://www.government.nl/topics/personal-data/personal-records-database-brp>, accessed 1 April 2024).
16. British Columbia population estimates: Municipal and subprovincial areas population 2011 to 2023. Victoria: Government of British Columbia; 2024 (<https://www2.gov.bc.ca/gov/content/data/statistics/people-population-community/population/population-estimates>, accessed 13 March 2024).
17. World Bank country and lending groups. Washington, DC: The World Bank Group; 2024 (<https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups>, accessed 18 October 2024).
18. Global Health Observatory. Geneva: World Health Organization; 2024 (<https://www.who.int/data/gho>, accessed 1 April 2024).

Annex

Annex 1. City indicators assessment instrument

Modules

- I. Air pollution reduction
- II. Alcohol control
- III. Overdose prevention
- IV. Promoting healthy diets
- V. Road safety
- VI. Safe walking and cycling
- VII. Tobacco control
- VIII. Noncommunicable disease and injury surveillance

I. Air pollution reduction

AP1. Air pollution measurement capacity

- 1a) Is air pollution monitoring available in at least one populated urban background site in the city? Yes No Don't know
➔ If No or Don't know, skip to question 2a)
- 1ai) Please specify which pollutants are monitored in the populated urban background site. Check all that apply.
- PM2.5
 - PM10 particulate matter $\leq 10 \mu\text{m}$ diameter
 - NO2
 - O3 (ozone)
 - Others, specify _____
- 1b) Has the monitoring station in the populated urban background site been operational for at least one year? Yes No Don't know
- 1c) Are there other air pollution monitoring stations located near industries or roadways? Yes No Don't know
- 1d) Is a quality control procedure applied to data before it is finally released? Yes No Don't know

- 1e) Are the sites reviewed at least every five years to ensure they still meet the objectives of the network and hence are appropriate? Yes No Don't know
- 1f) Is there city-level data on air pollution (PM2.5) that is weighted by population density? Yes No Don't know

AP2. Availability of air quality information and trends

- 2a) Is air quality information publicly available in public reports, on the internet or on information boards in the city centre? Yes No Don't know
 ➡ If No or Don't know, skip to 2c)
- 2b) Is air quality information available as raw and/or aggregated data? Yes No Don't know
- 2c) In the last three years, has there been any mass media education and awareness campaign on air pollution? Yes No Don't know
- 2d) In the last five years, the city -level trend of air pollution for PM2.5 has been:
 Decreasing Stable Increasing
- 2e) Are warnings to the public issued during or before forecasted periods of poor air quality? Yes No Don't know

AP3. Availability of emissions estimates

- 3a) Have emission inventories for air pollution sources within the city been conducted in the past five years? Yes No Don't know
 ➡ If No or Don't know, skip to 4a)
- 3b) Are there available emission estimates for the following emission sources:
- 3bi) Residential emissions Yes No Don't know
- 3bii) Power-generating facility emissions Yes No Don't know
- 3biii) Industrial emissions Yes No Don't know
- 3biv) Traffic emissions Yes No Don't know
- 3bv) Agricultural emissions Yes No Don't know

AP4. Existence and enforcement of air quality standards

- 4a) Is the city covered by air quality standards? Yes No Don't know
➡ If No or Don't know, skip to 4e)
- 4ai) Please specify at which level the air quality standards are established. Check all that apply.
 National Regional (subnational) City
- 4b) Are ambient air quality standards such as limit values for acute effect (i.e. 24hr period) available? Yes No Don't know
- 4bi) Please specify which pollutants have limit values for acute effect. Check all that apply.
 PM2.5 PM10 NO2 O3
 Others, specify _____
- 4c) Does the city have ambient air quality standards such as limit values for chronic effect (monthly or yearly averaging time)? Yes No Don't know
- 4ci) Please specify which pollutants have limit values for acute effect. Check all that apply.
 PM2.5 PM10 NO2 O3
 Others, specify _____
- 4d) Are there enforced regulations to ensure compliance with air quality standards (if an area exceeds an air quality standard, are additional measures enforced to control emissions and ensure this is not repeated)? Yes No Don't know
- 4e) Are environmental impact assessments conducted before the construction of major new projects such as roads or industrial facilities? Yes No Don't know
- 4f) Are additional emission controls imposed on industry, or vehicle use restricted during episodes of particularly poor air quality? Yes No Don't know
- 4g) Are there quality norms imposed on solid fuels to be used by households for:
- 4gi) coal Yes No Don't know
- 4gii) wood/biomass Yes No Don't know

AP5. Proportion of population with primary reliance on clean fuels and technologies for cooking

- 5a) Proportion of people with access to clean fuels and technologies for cooking: _____%

II. Alcohol control

AC1. Existence of a comprehensive strategy, plan of action and activities to reduce harmful use of alcohol

- 1a) Is there a city-level comprehensive strategy, plan of action and activities to reduce the harmful use of alcohol? Yes No Don't know
➡ If No or Don't know, skip to 2a)
- 1b) Is there funding available to reduce the harmful use of alcohol? Yes No Don't know
- 1c) Is/are there (a) designated institution(s) with responsibilities for coordinating and following up policies, strategies and plans? Yes No Don't know
- 1d) Are there effective awareness programmes about the full range of alcohol-related harm, including harm to others? Yes No Don't know
- 1e) Are there effective frameworks and responsible institutions for monitoring, surveillance and evaluation activities including periodic city surveys on alcohol consumption and alcohol-related harm and on an annual basis (at least) reporting back to a broad group of constituents on progress made? Yes No Don't know

AC2. Existence of policy to restrict commercial and public availability of alcohol

- 2a) Is there a policy/law to restrict commercial and public availability of alcohol? Yes No Don't know
➡ If No or Don't know, skip to 3a)
- 2ai) Please specify at which levels the policies/laws are established. Check all that apply.
 National Regional (sub-national) City
- 2b) Are the following applicable:
- 2bi) Licensing of production of beer OR wines OR spirits Yes No Don't know
- 2bii) Licensing of sales of beer OR wines OR spirits Yes No Don't know
- 2c) Is there a monopoly on production and sale of beer, wines or spirits? Yes No Don't know
- 2d) Are there restrictions for on-premises sales of beer or other alcoholic products? Yes No Don't know

- 2e) Are there restrictions for off-premises sales of beer or other alcoholic products? Yes No Don't know
- 2f) Is there a legal minimum age restriction for sale of beer or other alcoholic products? Yes No Don't know
- 2g) Are there restrictions on drinking in public places in the following places:
- 2gi) Healthcare Yes No Don't know
- 2gii) Educational institutions Yes No Don't know
- 2giii) Government offices Yes No Don't know
- 2giv) Public transport Yes No Don't know
- 2gv) Parks, streets, beaches etc. Yes No Don't know
- 2gvi) Sporting events Yes No Don't know
- 2gvii) Leisure events Yes No Don't know
- 2gviii) Workplaces Yes No Don't know
- 2gix) Religious places Yes No Don't know
- 2h) Is there organized quality control on production and distribution of alcoholic beverages? Yes No Don't know
- 2i) Are there regulations on informally produced alcohol and attempts to bring it into the taxation system, an efficient control and enforcement system, including tax stamps? Yes No Don't know
- 2j) Do local and national authorities cooperate and exchange relevant information on combatting illicit alcohol? Yes No Don't know

AC3. Existence of bans on alcohol advertising, sponsorship, and promotion

- 3a) Is there a regulatory framework for alcohol marketing? Yes No Don't know
 ➔ If No or Don't know, skip to 4a)
- 3ai) Please specify at which level the regulatory framework is established. Check all that apply.
 National Regional (sub-national) City
- 3b) Does it include regulation of content and the volume of marketing? Yes No Don't know
- 3c) Does it include regulation of direct and indirect marketing in certain or all traditional media? Yes No Don't know
- 3d) Does it include regulation of new forms of alcohol marketing techniques, for instance social media? Yes No Don't know
- 3e) Does it include regulation of sponsorship activities that promote alcoholic beverages? Yes No Don't know

- 3f) Does it include restriction or ban of promotions in connection with activities targeting young people? Yes No Don't know
- 3g) Are there public agencies or independent bodies or effective systems of surveillance of marketing of alcohol products? Yes No Don't know

AC4. Existence and enforcement of drink driving legislation

- 4a) Is there a drink-driving law?
 ➔ If No or Don't know, skip to 5a)
- 4ai) Please specify at which level the law is established. Check all that apply.
 National Regional (sub-national) City
- 4b) Is there a legal blood alcohol concentration (BAC) for the following:
- 4bi) General population Yes No Don't know
- 4bii) Young/novice drivers Yes No Don't know
- 4biii) Professional drivers Yes No Don't know
- 4c) Is there breath-testing at specific locations or time?
- 4ci) Random breath testing Yes No Don't know
- Random breath testing is defined as a test given by the police to drivers chosen by chance to measure the amount of alcohol the drivers have. It means that any driver can be stopped by the police at any time to test the breath for alcohol consumption.
- 4cii) Sobriety checkpoints Yes No Don't know
- Sobriety checkpoints means checkpoints or roadblocks established by the police on public roadways to control for drink driving.
- 4d) Is there graduated licensing for novice drivers with zero tolerance for drink-driving? Yes No Don't know
- 4e) Is the use of mandatory ignition interlock imposed by courts to reduce persons from driving intoxicated? Yes No Don't know
- 4f) Is there mandatory driver education? Yes No Don't know
- 4g) Is there counselling or, as appropriate, treatment programmes for persons found to have violated drink-driving regulations? Yes No Don't know

AC5. Availability of brief intervention and treatment for problematic alcohol use

- 5a) Are brief intervention and treatment for hazardous drinking and health conditions due to alcohol provided through any of the following facilities/services:
- | | | | |
|--------------------------------------|------------------------------|-----------------------------|-------------------------------------|
| 5ai) Antenatal services | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| 5aii) Primary health care services | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| 5aiii) Schools/ educational services | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| 5aiv) Telephone/e-Health services | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| 5av) Web-based services | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |

AC6. Access to and use of price data on alcoholic beverages

- 6a) Does the city have access to and use price data on alcoholic beverages? Yes No Don't know
- 6b) Does the city use historical price data on alcoholic beverages with latest estimates available within the past two years, to assess/monitor affordability of the most-sold alcoholic beverages? Yes No Don't know

AC7. Prevalence of heavy episodic drinking in drinkers aged 15 years and over

- 7a) Proportion of drinkers aged 15 years and over engaging in heavy episodic drinking, defined as having had at least 60 grams of pure alcohol on at least one occasion in the past 30 days: _____%
- (Drinkers are people who reported having consumed an alcoholic standard drink (10 grams) within the past 12 months).

AC8. Age-standardized rates of liver cirrhosis, cancer and traffic crash mortality

- 8a) Age-standardized death rates for liver cirrhosis (per 100 000): _____
- 8b) Age-standardized death rates for traffic crashes (per 100 000): _____
- 8c) Age-standardized death rates for cancers likely to have alcohol-attributable fractions (per 100 000): _____

III. Overdose prevention

OP1. Availability of key medications for opioid dependence treatment

- 1a) Is there official registration of key medications for the treatment of opioid dependence that includes:
- 1ai) Methadone Yes No Don't know
 - 1aii) Buprenorphine (with or without naloxone) Yes No Don't know
 - 1aiii) Others (extended-release formulations of opioid agonists, oral and injectable opioid agonists, such as diacetylmorphine and hydromorphone) Yes No Don't know
 - 1aiv) Naltrexone Yes No Don't know
- 1av) Alpha-2 adrenergic agonists for management of opioid withdrawal Yes No Don't know
- 1b) Are the following available in health facilities in the city:
- 1bi) Methadone Yes No Don't know
 - 1bii) Buprenorphine (with or without naloxone) Yes No Don't know
 - 1biii) Others (extended-release formulations of opioid agonists, oral and injectable opioid agonists, such as diacetylmorphine and hydromorphone) Yes No Don't know
 - 1biv) Naltrexone Yes No Don't know
 - 1bv) Alpha-2 adrenergic agonists for management of opioid withdrawal Yes No Don't know
- 1c) Are the following used for treatment of opioid use disorders in the city:
- 1ci) Methadone Yes No Don't know
 - 1cii) Buprenorphine (with or without naloxone) Yes No Don't know
 - 1ciii) Others (extended-release formulations of opioid agonists, oral and injectable opioid agonists, such as diacetylmorphine and hydromorphone) Yes No Don't know
 - 1civ) Naltrexone Yes No Don't know
 - 1cv) Alpha-2 adrenergic agonists for management of opioid withdrawal Yes No Don't know

OP2. Existence of service governance mechanisms for drug use disorders treatment

- 2a) Does a government unit or a government official exist that/ who is responsible for a policy regarding the prevention of drug use and the treatment of drug use disorders? Yes No Don't know
- ➡ If No or Don't know, skip to 2b)

2ai) Please specify at which level the government unit is established. Check all that apply.

National Regional (sub-national) City

2b) Does a policy and action plan for service development exist? (Defined as an official statement by a government or health authority that provides the overall direction for health development by defining a vision, values, principles and objectives and by establishing a broad model for action to achieve that vision).

Yes No Don't know

➡ If No or Don't know, skip to 2c)

2bi) Please specify at which level policy and action plan for service development are established. Check all that apply.

National Regional (sub-national) City

2c) Do laws or legal regulations that protect people in treatment for substance use disorder exist? (This can include voluntary treatment as an alternative or addition to criminal sanctions and laws/legal regulations that protect the confidentiality of people in treatment for drug use disorders).

Yes No Don't know

➡ If No or Don't know, skip to 3a)

2ci) Please specify at which level the laws or legal regulations are established. Check all that apply.

National Regional (sub-national) City

OP3. Availability of non-structured (harm reduction) services for people with drug use disorders

3a) Are non-structured harm reduction services for people with drug use and drug use disorders available in the city?

Yes No Don't know

3b) Are the following non-structured harm reduction services available:

3bi) Low-threshold community outreach services

Yes No Don't know

3bii) Drop-in services/centres

Yes No Don't know

3biii) Testing and counselling for infectious diseases (e.g. HIV, hepatitis, TB and STI) at low-threshold community programmes

Yes No Don't know

3biv) Mutual help/peer support groups for people with drug use disorders

Yes No Don't know

- 3bv) Open-access interventions (e.g. telephone, helplines, web-based interventions, mobile phone-based interventions) Yes No Don't know
- 3bvi) Supervised injection sites Yes No Don't know
- 3bvii) Needle exchange programme for injecting drug users Yes No Don't know

OP4. Availability of naloxone

- 4a) Can take-home naloxone be obtained within the city? Yes No Don't know
- 4b) Is it available at no cost regardless of insurance and residence status at:
- 4bi) Low-threshold/community outreach services Yes No Don't know
- 4bii) Drop-in services/centres Yes No Don't know
- 4biii) Opioid use disorders treatment facilities Yes No Don't know
- 4biv) Pharmacies Yes No Don't know
- 4bv) Medical facilities/emergency medical services/primary health care providers Yes No Don't know
- 4biv) Housing/shelters Yes No Don't know
- 4bvii) Prisons Yes No Don't know
- 4bviii) Supervised injection facilities Yes No Don't know

OP5. Availability of programmes on primary prevention of drug use

- 5a) Are there existing programmes for the primary prevention of drug use in the city? Yes No Don't know
 ➔ If No or Don't know, skip to 6a)
- 5b) Are the following primary prevention activities included in the existing programmes:
- 5bi) Mass media campaigns Yes No Don't know
- 5bii) School-based programmes Yes No Don't know
- 5biii) Workplace programmes Yes No Don't know
- 5biv) Parental programmes Yes No Don't know
- 5bv) Community-based programmes Yes No Don't know
- 5c) Is there an allocated budget for the existing programmes for primary prevention of drug use? Yes No Don't know

OP6. Service capacity for drug use disorders treatment

- 6a) Are there drug use disorder treatments provided within the city free of charge through public sector or through basic insurance package? Yes No Don't know
 ➔ If No or Don't know, skip to 7a)

- 6b) Are the following key interventions included in the treatment of drug use disorder:
- 6bi) Screening, brief intervention, and referral to treatment Yes No Don't know
- 6bii) Pharmacological treatment Yes No Don't know
- 6biii) Psychosocial treatment Yes No Don't know
- 6biv) Rehabilitation Yes No Don't know
- ➡ If 6bi is No or Don't know, skip to 6d)
- 6c) Are the following components covered under screening, brief intervention, and referral to treatment interventions:
- 6ci) Substance use screening tools Yes No Don't know
- 6cii) Screening in specialized services with expected high prevalence of substance use among patients and clients (e.g. mental health, infectious diseases) Yes No Don't know
- 6ciii) Brief interventions to patients and clients screened positively Yes No Don't know
- 6civ) Referral to other treatment modalities Yes No Don't know
- 6cv) screening, brief intervention, and referral to treatment for special populations (such as emergency health services/trauma centres/ services for children and adolescents, in antenatal services, in employee assistance programmes) Yes No Don't know
- ➡ If 6cii is No or Don't know, skip to 6e)
- 6d) Are the following components covered under pharmacological treatments:
- 6di) Pharmacological treatment of substance-related emergency conditions (excluding withdrawal syndrome) Yes No Don't know
- 6dii) Pharmacological treatment of withdrawal syndrome Yes No Don't know
- 6diii) Opioid agonist maintenance treatment for opioid dependence (with methadone and/or buprenorphine) Yes No Don't know
- 6div) Pharmacological treatment other than opioid agonist maintenance treatment for substance dependence (naltrexone) Yes No Don't know
- 6dv) Pharmacological treatment of co-morbid conditions (physical and mental health) Yes No Don't know
- ➡ If 6diii is No or Don't know, skip to 6f)
- 6e) Are the following components covered under psychosocial treatment:
- 6ei) Psychoeducation for patients with substance use disorders Yes No Don't know

- 6eii) Cognitive behavioural therapy (CBT) for patients with substance use disorders Yes No Don't know
- 6eiii) Motivational enhancement therapy/motivational interviewing for patients with substance use disorders Yes No Don't know
- 6eiv) Family/couples therapy for patients with substance use disorders Yes No Don't know
- 6ev) Contingency management (CM) approach for patients with substance use disorders Yes No Don't know
- 6evi) Twelve-step approach Yes No Don't know
- ➡ If 6biv is No or Don't know, skip to 7a)

6f) Are the following components covered under rehabilitation:

- 6fi) Rehabilitation in-patient programmes Yes No Don't know
- 6fii) Rehabilitation out-patient programmes Yes No Don't know
- 6fiii) Education programmes for people with substance use disorders Yes No Don't know
- 6fiv) Employment assistance programmes for people with substance use disorders Yes No Don't know
- 6fv) Special housing services for people with substance use disorders Yes No Don't know
- 6fvi) Welfare assistance/benefits for people with substance use disorders Yes No Don't know

OP7. Availability of drug use disorder treatment in prisons

- 7a) Is opioid agonist maintenance treatment available in prison? Yes No Don't know
- 7b) Is opioid agonist maintenance treatment available upon release from prison? Yes No Don't know

OP8. Coverage of drug use disorders treatment

- 8a) Coverage of drug use disorders treatment (the number of people who received treatment in a year divided by the total number of people with drug use disorders in the same year, multiplied by 100%): _____

OP9. Opioid overdose mortality rate

- 9a) Opioid overdose mortality rate per 100 000: _____

IV. Promoting healthy diets

HD1. Existence and enforcement of policies to restrict marketing of unhealthy foods and non-alcoholic beverages

- 1a) Is there an existing policy to restrict both exposure to and power of marketing of unhealthy foods and beverages? Yes No Don't know
➡ If No or Don't know, skip to 2a)
- 1ai) Please specify at which level the policy is established. Check all that apply.
 National Regional (sub-national) City
- 1b) Does the policy cover food and non-alcoholic beverages that are high in these nutrients and/or energy:
- 1bi) Sugars Yes No Don't know
- 1bii) Salt/sodium Yes No Don't know
- 1biii) Total fat Yes No Don't know
- 1biv) Saturated fats Yes No Don't know
- 1bv) Trans fats Yes No Don't know
- 1bvi) Energy Yes No Don't know
- 1c) Does the policy protect children up to the age of 18 years? Yes No Don't know
- 1d) Is it being monitored and enforced (i.e. through monitoring the marketing practices of foods and non-alcoholic beverages including used channels and techniques, and imposing sanctions in case of breaches)? Yes No Don't know

HD2. Existence and enforcement of nutrition standards for foods and beverages served and/or sold in public settings

- 2a) Are there existing nutrition standards for foods and beverages served and/or sold in public settings as well as in close proximity of where children gather? Yes No Don't know
➡ If No or Don't know, skip to 3a)
- 2ai) Please specify at which level the nutrition standards are established. Check all that apply.
 National Regional (sub-national) City

- 2b) Do these standards cover key nutrients of concern or food that is typically high in the following key nutrients:
- | | | | |
|----------------------|------------------------------|-----------------------------|-------------------------------------|
| 2bi) Sugars | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| 2bii) Sodium | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| 2biii) Total fat | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| 2biv) Saturated fats | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| 2bv) Trans fats | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| 2bvi) Energy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
- 2c) Do these standards apply to all categories of foods and beverages?
- Yes No Don't know
- 2d) Do the standards apply to following:
- | | | | |
|---|------------------------------|-----------------------------|-------------------------------------|
| 2di) Foods and beverages served/sold in school canteens | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| 2dii) Foods and beverages served/sold at events | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| 2diii) Foods and beverages served/sold at school kiosks | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| 2div) Foods and beverages brought from home to schools | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
- 2e) Are there standards for foods served or sold in the following settings:
- | | | | |
|----------------------------------|------------------------------|-----------------------------|-------------------------------------|
| 2ei) Childcare sites | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| 2eii) Hospitals and caring homes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| 2eiii) Workplaces | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| 2eiv) Government workplaces | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| 2ev) Military bases | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| 2evi) Prisons | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| 2evii) Universities | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| 2eviii) Other, specify _____ | | | |
- 2f) Is it being monitored and enforced (i.e. through related activities monitoring the types of foods and beverages served or sold in public settings and imposing sanctions in case of breaches)?
- Yes No Don't know

HD3. Existence and enforcement of policies or programmes to improve healthy eating in restaurants, food outlets or vending machines

- 3a) Are there existing policies and programmes to improve the healthiness of foods and beverages being sold and served at restaurants and other food outlets?
- Yes No Don't know
- ➡ If No or Don't know, skip to 4a)

- 3ai) Please specify at which level the policies and programmes are established. Check all that apply.
 National Regional (sub-national) City
- 3b) Does the policy cover specific measures including:
- 3bi) Menu labelling Yes No Don't know
- 3bii) Product placement in the service area Yes No Don't know
- 3biii) Reduced pricing of healthy food/increased pricing of unhealthy food Yes No Don't know
- 3biv) Marketing restrictions in the restaurant (including promotions, give aways etc.) Yes No Don't know
- 3bv) Ban on placing salt-shakers or sugar sachets in service areas or on tables Yes No Don't know
- 3bvi) Controlling portion sizes Yes No Don't know
- ➡ If No or Don't know for 3bi), skip to 3d)
- 3c) Does the menu labelling target nutrients of concern or food that is typically high in these key nutrients of concern:
- 3ci) Sugars Yes No Don't know
- 3cii) Sodium Yes No Don't know
- 3ciii) Total fat Yes No Don't know
- 3civ) Saturated fats Yes No Don't know
- 3cv) Trans fats Yes No Don't know
- 3cvi) Energy Yes No Don't know
- 3d) Is the policy being monitored and enforced (i.e. through monitoring the types of foods and beverages being sold and served at restaurants and other food outlets, and imposing sanctions in case of breaches)? Yes No Don't know

HD4. Existence and enforcement of urban planning/zoning policies designed to increase the availability of healthier foods and beverages

- 4a) Are there existing policies designed to limit the density of food outlets selling predominantly unhealthy foods and beverages compared to outlets selling predominantly healthy foods and beverages? Yes No Don't know
- ➡ If No or Don't know, skip to 5a)
- 4ai) Please specify at which level the policies are established. Check all that apply.
 National Regional (sub-national) City

- 4b) Does the policy cover specific measures such as:
- 4bi) Restricting the density of outlets that sell unhealthy food and beverages Yes No Don't know
- 4bii) Encouraging the establishment of outlets that sell fresh fruit and vegetables Yes No Don't know
- 4c) Does the policy cover the following places where children gather:
- 4ci) Areas near childcare sites Yes No Don't know
- 4cii) Areas near school Yes No Don't know
- 4d) Does the policy cover low-income communities? Yes No Don't know
- 4e) Is the policy being monitored and enforced (i.e. through monitoring the outlets selling predominantly healthy and unhealthy foods and beverages, and imposing sanctions in case of breaches)? Yes No Don't know

HD5. Existence and enforcement of policies that ensure free safely managed drinking-water is available in all public settings

- 5a) Is there existing policy or legislation that ensures free safely managed drinking-water is available in all public settings?
 ➡ If No or Don't know, skip to 6a)
- 5ai) Please specify at which level the policy or legislation is established. Check all that apply.
 National Regional (sub-national) City
- 5b) Does the policy provide access to free safely managed drinking-water in public settings? Yes No Don't know
- 5c) Does the policy ensure availability of safely managed drinking-water in public settings all year round? Yes No Don't know
- 5d) Does the policy apply to the following public settings:
- 5di) Childcare sites Yes No Don't know
- 5dii) Schools Yes No Don't know
- 5diii) Hospital Yes No Don't know
- 5div) Workplaces Yes No Don't know
- 5dv) Near childcare sites Yes No Don't know
- 5dvi) Near schools Yes No Don't know

- 5e) Is the policy being monitored and enforced (i.e. through monitoring that safe drinking-water is freely available in public settings and adheres to nutrition criteria of the policy and imposing sanctions in case of breaches)? Yes No Don't know

HD6. Access to and use of sugar-sweetened beverages price data

- 6a) Does the city have access to and use price data on sugar-sweetened beverages? Yes No Don't know
- 6b) Does the city use historical price data on sugar-sweetened beverages with latest estimates available within the past two years?
- 6c) Does the city use historical price data on sugar-sweetened beverages with latest estimates available within the past two years, to assess/monitor affordability of the following beverage product types:
- 6ci) Carbonated soft drinks Yes No Don't know
- 6cii) Energy or sport drinks Yes No Don't know
- 6ciii) 100% fruit or vegetable juices Yes No Don't know
- 6civ) Fruit or vegetable drinks that are not 100% juice Yes No Don't know
- 6cv) Syrups and concentrates containing sugars Yes No Don't know
- 6cvi) Sugar-sweetened flavoured waters Yes No Don't know
- 6cvii) Other, specify _____

HD7. Mean population salt intake

- 7) Age-standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 18+ years: _____

HD8. Prevalence of low fruit and vegetable intake

- 8) Age-standardized prevalence of persons consuming less than five total servings (400grams) of fruit and vegetables per day: _____

HD9. Prevalence of overweight and obesity in adolescents and adults

- 9a) Prevalence of overweight in adolescents (10–19 years of age %): _____
- 9b) Prevalence of obesity in adolescents (10–19 years of age %): _____
- 9c) Prevalence of overweight in adults (≥ 18 years of age %): _____
- 9d) Prevalence of obesity in adults (≥ 18 years of age %): _____

V. Road safety

RS1. Existence of speed limit legislation enforcing speed limits for motorized passenger vehicles

- 1a) Is there existing legislation on speed limit for private motorized vehicles? Yes No Don't know
➡ If No or Don't know, skip to 2a)
- 1ai) Please specify at which level the legislation is established. Check all that apply.
 National Regional (sub-national) City
- 1ai) Does it limit speeds to 30km/h (20 mph) in areas where vulnerable road users and vehicles mix in a frequent and planned manner? Yes No Don't know
- 1aii) Does it limit speeds to 50km/h (30 mph) in urban areas? Yes No Don't know
- 1b) Is the speed limit legislation enforced in the city? Yes No Don't know
- 1c) Are the following enforcement mechanisms implemented:
- 1ci) Police officers carrying speedometers Yes No Don't know
- 1cii) Automatic detection systems (e.g. cameras) Yes No Don't know
- 1ciii) Speed limiters, at least in certain vehicles (e.g. trucks, buses) Yes No Don't know
- 1civ) Infrastructure modifications (e.g. speed, roundabouts, cobble streets) Yes No Don't know
- 1cv) Geofencing Yes No Don't know
- 1cvi) New vehicles are required to have intelligent speed assistance systems to help drivers Yes No Don't know
- 1cvii) Other, specify _____

RS2. Existence and implementation of road design standards that include speed management and safe infrastructure for pedestrians and cyclists

- 2a) Does the city have technical design standards that are required to be met in the development of new roads that account for the safety of all road users? Yes No Don't know
- 2b) On roads where pedestrians and cyclists are present, do design standards provide for:
- 2bi) Managing speed to safe system outcomes (e.g. 20 mph or 30 km/h) Yes No Don't know
- 2bii) Safe crossings for pedestrians and cyclists Yes No Don't know

- 2biii) Separation of pedestrians and cyclists from vehicular traffic Yes No Don't know
- 2c) Are road design standards/guidelines implemented in the city? Yes No Don't know
- 2d) Which source types are evidence of implementation in the city? Check all that apply.
- Observational study
 - Police report
 - Research survey
 - Population representative survey
 - Other, specify _____

RS3. Existence of legislation on helmet use for two- and three-wheeled motor vehicles including helmet use standards and wearing requirements

- 3a) Is there existing legislation requiring helmet use among users of motorcycles? Yes No Don't know
- ➡ If No or Don't know, skip to 4a)
- 3ai) Please specify at which level the legislation is established. Check all that apply.
- National
 - Regional (sub-national)
 - City
- 3b) Does the legislation meet international harmonized standards? (e.g. UN standard ECE 22.05) Yes No Don't know
- 3c) Does the legislation cover the below components:
- 3ci) Requirement of drivers and passengers to wear a helmet on all roads Yes No Don't know
- 3cii) Specification that helmets should be fastened Yes No Don't know
- 3ciii) A reference to a helmet standard Yes No Don't know
- 3d) Is helmet use legislation enforced in the city? Yes No Don't know
- 3e) Which source types are evidence of enforcement in the city? Check all that apply.
- Observational study
 - Police report
 - Research survey
 - Population representative survey
 - Other, specify _____

RS4. Existence and enforcement of legislation for seat-belt use

4a) Is there existing legislation requiring seat-belt use? Yes No Don't know

➡ If No or Don't know, skip to 5a)

4ai) Please specify at which level the legislation is established. Check all that apply.

National Regional (sub-national) City

4b) Is the legislation regarding seat-belts available in the following:

Only driver's seats

Only front seats

All seats in vehicle

4c) Does the legislation include seat-belt standards? Yes No Don't know

4d) Is seat-belt legislation enforced in the city? Yes No Don't know

4e) Which source types are evidence of enforcement in the city? Check all that apply.

Observational study

Police report

Research survey

Population representative survey

Other, specify: _____

RS5. Prevalence of helmet use among all motorized vehicle users (i.e. drivers, passengers, motorbikes, bikes)

5) Prevalence of helmet use among all motorized vehicle users (%): _____

RS6. Prevalence of seat-belt use in all seating positions

6) Prevalence of seat-belt use in all seating positions (%): _____

RS7. Prevalence of road traffic deaths per 100 000

7) Prevalence of road traffic deaths per 100 000: _____

VI. Safe walking and cycling

WC1. Existence of city policy promoting walking

- 1a) Is there a city policy/strategy/action plan that sets the agenda for promoting walking? Yes No Don't know
➡ If No or Don't know, skip to 2a)
- 1b) Does it include actions to improve, extend and/or enhance provision of walking infrastructure (e.g. footpaths quality, quantity, pedestrian crossing, street furniture, other pedestrian safety measures)? Yes No Don't know
- 1c) Is there a designated institution with responsibilities for coordinating and following up policies, strategies and plans? Yes No Don't know
- 1d) Is there a dedicated budget line to support implementation? Yes No Don't know
- 1e) Is there a monitoring framework to assess progress and implementation? Yes No Don't know

WC2. Existence of city policy promoting cycling

- 2a) Is there a policy/strategy/action plan that promotes cycling?
➡ If No or Don't know, skip to 3a)
- 2ai) IF YES to 1a) and 2a) items:
Are there separate policy documents for walking and for cycling? Yes No Don't know
- 2b) Does it include actions aimed at improving and/or extending provision of cycling infrastructure (e.g. cycle lanes, measures to improve cycle safety, provision of facilities such as bike storage)? Yes No Don't know
- 2c) Is there a designated institution with responsibilities for coordinating and following up policies, strategies and plans? Yes No Don't know
- 2d) Is there a dedicated budget line to support implementation? Yes No Don't know
- 2e) Is there a monitoring framework to assess progress and implementation? Yes No Don't know

WC3. Existence of city policy on access to public open space

- 3a) Is there a policy/strategy/plan on the provision of public open space in the city boundary? Yes No Don't know
➡ If No or Don't know, skip to 4a)

- 3b) Is there a dedicated budget line to support policy implementation? Yes No Don't know
- 3c) Does it include actions to enhance the provision of public open space (e.g. maintenance, improve park amenities and facilities, increase park safety)? Yes No Don't know
- 3d) Is there a designated institution with responsibilities for coordinating and following up policies, strategies, and plans? Yes No Don't know
- 3e) Is there a set target for increasing areas and access to public open space? Yes No Don't know
- 3f) Is the city measuring the amount of, and access to, public open space? Yes No Don't know

WC4. Existence of city urban planning policy that encourages compact urban design and mixed land use

- 4a) Is there a policy/strategy/plan for urban development and/or land use in the city? Yes No Don't know
 ➔ If No or Don't know, skip to 5a
- 4b) Does it prioritize urban planning that aims to deliver compact mixed land use neighbourhoods? Yes No Don't know

WC5. Implementation of walking and cycling campaigns and promotion

- 5a) Has the city implemented any city-wide mass media public education campaign on walking or cycling within the past two years? (A campaign would include messages on walking and or cycling and use at least one mass media channels such as TV, Radio, newspapers, or digital such as websites or social media). Yes No Don't know
- 5b) Has the city implemented any mass participation walking or cycling events to encourage participation by the general public within the past two years? (This refers to large community-based, events and are offered free. It can include, for example, celebration of international days of walking, cycling or physical activity, national care-free days, but does NOT include hosting of competitive walking, running or cycling events such as marathons unless there is clear provision of free access to participate in shorter distances and or provision of non-competitive activities). Yes No Don't know

WC6. Implementation of city surveys on knowledge and awareness on cycling and walking

- 6a) Has the city conducted any knowledge and awareness surveys which assesses the level of cycling and walking? Yes No Don't know
- 6b) Has the city conducted any survey to assess community perceptions on walking and cycling (e.g. community perception of safety, amenities, etc.)? Yes No Don't know

VII. Tobacco control

TC1. Existence and compliance measurement of smoke-free legislation

- 1a) Is there legislation to eliminate exposure to second-hand tobacco smoke in all indoor workplaces, public places and public transport? Yes No Don't know

➡ If No or Don't know, skip to 2a)

- 1ai) Please specify at which level the legislation is established. Check all that apply.

National Regional (sub-national) City

- 1b) Does the city measure compliance of the legislation? Yes No Don't know

➡ If No or Don't know, skip to 2a)

1bi) How often is compliance measured? _____

TC2. Existence and compliance measurement of bans on advertising, promotion and sponsorship

- 2a) Is there legislation that comprehensively bans tobacco advertising, promotion, and sponsorship? Yes No Don't know

➡ If No or Don't know, skip to 3a)

- 2ai) Please specify at which level the legislation is established. Check all that apply.

National Regional (sub-national) City

- 2b) Does the city routinely measure compliance of tobacco advertising, promotion and sponsorship? Yes No Don't know

➡ If No or Don't know, skip to 3a)

2bi) How often is compliance measured? _____

TC3. Implementation of anti-tobacco mass media campaigns

- 3a) Has there been an anti-tobacco mass-media campaign implemented in the city? Yes No Don't know

- 3b) Was a campaign conducted within the past three years with a duration of at least three weeks? Yes No Don't know

➡ If No or Don't know, skip to 4a)

- 3bi) Please specify at which level the was the campaign conducted. Check all that apply.
 National Regional (sub-national) City
- 3c) Did the campaign include the following characteristics:
- 3ci) The campaign was part of a comprehensive tobacco control programme Yes No Don't know
- 3cii) Before the campaign, research was undertaken or reviewed to gain a thorough understanding of the target audience Yes No Don't know
- 3ciii) Campaign communication materials were pre-tested with the target audience and refined in line with campaign objectives Yes No Don't know
- 3civ) The implementing agency worked with journalists to gain publicity or news coverage for the campaign Yes No Don't know
- 3cv) Process evaluation was undertaken to assess how effectively the campaign had been implemented Yes No Don't know
- 3cvi) An outcome evaluation process was implemented to assess campaign impact Yes No Don't know

TC4. Availability of tobacco cessation services

- 4a) Is there a policy to promote cessation of tobacco use and provide treatment for tobacco cessation? Yes No Don't know
 ➡ If No or Don't know, skip to 5a)
- 4ai) Please specify at which level the policy is established. Check all that apply.
 National Regional (sub-national) City
- 4b) Are the following programmes implemented and available:
- 4bi) Tobacco cessation advice incorporated into primary and routine health care services Yes No Don't know
- 4bii) Easily accessible and free telephone help lines (known as 'quit lines') Yes No Don't know
- 4biii) Free and low-cost cessation medicines including nicotine replacement therapy Yes No Don't know

- 4c) Are the following public places covered:
- | | | | |
|--|------------------------------|-----------------------------|-------------------------------------|
| 4ci) Health clinics or other primary care facilities | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| 4cii) Hospitals | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| 4ciii) Office of a health professional | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| 4civ) Community settings | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
- 4d) Are availability and/or accessibility to these services in the city monitored? Yes No Don't know
- ➡ If No or Don't know, skip to 5a)
- 4di) How often are availability and/or accessibility to these services monitored? _____

TC5. Access to and use of tobacco price data

- 5a) Does the city have access to and use tobacco price data? Yes No Don't know
- 5b) Does the city use historical tobacco price data with latest estimates available within the past two years, to assess/monitor affordability of the most-sold alcoholic beverages? Yes No Don't know

TC6. Prevalence of tobacco use in adults

- 6a) Population aged 18 years and over who currently use any tobacco product (smoked and/or smokeless tobacco) on a daily or non-daily basis (%): _____

VIII. Noncommunicable disease (NCD) and injury surveillance

S1. Adult NCD risk factor surveillance capacity

- 1a) Was a comprehensive city level survey (or wider survey with usable city-level results) conducted on adult NCD risk factors? Yes No Don't know

➡ If No or Don't know, skip to 2a)

- 1b) When was the survey conducted?

- Within the past five years
 Five to ten years ago
 More than ten years ago

- 1c) Did the survey capture data on the following risk factors:

- 1ci) Alcohol use Yes No Don't know
1cii) Fruit and vegetable intake Yes No Don't know
1ciii) Overweight and obesity Yes No Don't know
1civ) Physical inactivity: walking and cycling Yes No Don't know
1cv) Salt/sodium intake Yes No Don't know
1cvi) Tobacco use Yes No Don't know

S2. Adult injury risk factor surveillance capacity

- 2a) Was a city-level survey (or wider survey with usable city-level results) conducted on adult injury risk factors? Yes No Don't know

➡ If No or Don't know, skip to 3a)

- 2b) When was the survey conducted?

- Within the past five years
 Five to ten years ago
 More than ten years ago

- 2c) Did the survey capture data on the following injury risk factors:

- 2ci) Drink-driving Yes No Don't know
2cii) Driving beyond the speed limit Yes No Don't know
2ciii) Helmet use Yes No Don't know
2civ) Seat-belt use Yes No Don't know

S3. Adolescent NCD risk factor surveillance capacity

- 3a) Was a city level survey (or wider survey with usable city-level results) conducted on adolescent NCD risk factors? Yes No Don't know
➡ If No or Don't know, skip to 4a)
- 3b) When was the survey conducted?
 Within the past five years
 Five to ten years ago
 More than ten years ago
- 3c) Did the survey capture data on the following risk factors:
- 3ci) Alcohol use Yes No Don't know
 - 3cii) Fruit and vegetable intake Yes No Don't know
 - 3ciii) Overweight and obesity Yes No Don't know
 - 3civ) Physical inactivity: walking and cycling Yes No Don't know
 - 3cv) Tobacco use Yes No Don't know

S4. Child NCD risk factor surveillance capacity

- 4a) Was a city-level survey (or wider survey with usable city-level results) conducted on child NCD risk factors? Yes No Don't know
➡ If No or Don't know, skip to 5a)
- 4b) When was the survey conducted?
 Within the past five years
 Five to ten years ago
 More than ten years ago
- 4c) Did the survey capture data on the following risk factors:
- 4ci) Overweight and obesity Yes No Don't know
 - 4cii) Physical inactivity: walking and cycling Yes No Don't know

S5. Access to and use of routine health facility data on alcohol and substance use disorders and tobacco dependencies

- 5a) Does the city have access to statistics from a routine health facility reporting system? Yes No Don't know
➡ If No or Don't know, skip to 6a)

- 5b) Does the city report/use health facility statistics on the following:
- 5bi) Alcohol use disorder treatment Yes No Don't know
- 5bii) Drug use disorder treatment Yes No Don't know
- 5biii) Tobacco dependence treatment Yes No Don't know
- 5c) How recent are the statistics reported/used by the city?
- Within the past two years
- Two to five years ago
- More than five years ago

S6. Cause-of-death certification and reporting system

- 6a) Does the city have access to data generated from police reports, coroner inquest reports or vital registration systems, with cause-of-death statistics? Yes No Don't know
- ➡ If No or Don't know, end of questionnaire.
- 6b) Does the city use NCD and injury mortality statistics from vital registration systems with medical certification of cause-of-death that are compliant with International Classification of Diseases coding, to inform their progress on NCD and injury prevention work? Yes No Don't know
- 6c) How recent are the mortality statistics used by the city?
- Within the past two years
- Two to five years ago
- More than five years ago

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