Urban HEART

Urban Health Equity Assessment and Response Tool

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PREFACE

In the words of World Health Organization (WHO) Director-General, Dr Margaret Chan, "When health is concerned, equity really is a matter of life and death." Tackling differentials in health across population groups is regaining prominence in the agenda of national and local governments, and international organizations. In 2005, WHO established the Commission on Social Determinants of Health to support countries and global health partners and to draw their attention to the social determinants of health, which are significant factors in poor health and inequities in health between and within countries. Earlier, in 1978, at the International Conference on Primary Health Care at Alma-Ata, world governments had endorsed the notion that health is linked to living and working conditions of the population, and acknowledged the role of community participation. Despite the commitment to "Health for All" at Alma-Ata, evidence shows that gaps between rich and poor countries and between the rich and poor within countries have since widened.

The impact of the urban setting on health and, in particular, inequity in health has been widely documented. Evidence shows that while, on average, public services, including health and health service provision, in urban areas may be better than in rural areas, these averages often mask wide disparities between more and less disadvantaged populations. One key factor is the exclusion of the marginalized and vulnerable in public health planning and response systems (*1*). Urban health is influenced by a dynamic interaction between global, national and subnational policies; within that wider context, city governments and local communities can play an instrumental role in closing the gap between the better off and the worse off.

Regardless of the evidence, only a few countries have examined their inter- or intra-city health inequities, and few do so regularly. Information that shows the gaps between

cities or within the same city is a crucial requirement to trigger appropriate local actions to promote health equity. Evidence should be comprehensive enough to provide hints on key health determinants, and concise enough to facilitate policy-making and prioritization of interventions.

In order to facilitate the process of proactively addressing health inequities, WHO collaborated with 17 cities from 10 countries[1] in 2008–2009 to develop and pilot-test a tool called the Urban Health Equity Assessment and Response Tool (Urban HEART). Urban HEART guides local policy-makers and communities through a standardized procedure of gathering relevant evidence and planning efficiently for appropriate actions to tackle health inequities. This collective effort towards a common goal has galvanized both city governments and communities to recognize and take action on health inequities. It is envisaged that cities in varied contexts can locally adapt and institutionalize Urban HEART, while maintaining its core concepts and principles.

The aspiration for closing the health gap in cities can be met by guiding public health policies through evidence and in-depth analysis of inequities, using a participatory and intersectoral approach. Urban HEART provides an opportunity for policy-makers from different sectors, and communities, to cooperate in using evidence to identify and prioritize interventions for tackling health inequities. Local chief executives are provided with a tool to lead and engage their governments in more efficient allocation of resources with a broad-based support for action. Importantly, the tool empowers local communities to use evidence and take action on their priorities with the support of local and national authorities.

[1] Cities from the following 10 countries pilot-tested an initial version of the tool: Brazil, Indonesia, Islamic Republic of Iran, Kenya, Malaysia, Mexico, Mongolia, Philippines, Sri Lanka and Viet Nam.

ACKNOWLEDGEMENTS

The Urban Health Equity Assessment and Response Tool (Urban HEART) is a collective effort and has been jointly developed by the WHO Centre for Health Development, Kobe (Japan), in collaboration with regional offices of WHO, and city and national officials from across the world. Inputs from the teams in cities who pilot-tested the tool have been critical in the development of Urban HEART:

- Guarulhos (Brazil)
- Jakarta, Denpasar (Indonesia)
- Tehran (Islamic Republic of Iran)
- Nakuru (Kenya)
- State of Sarawak (Malaysia)
- Mexico City (Mexico)
- Ulaanbaatar (Mongolia)
- Davao, Naga, Olongapo, Paranaque, Tacloban, Taguig, Zamboanga (Philippines)
- Colombo (Sri Lanka)
- Ho Chi Minh City (Viet Nam).

In particular, the enthusiasm of community groups in various pilot sites and their leadership in building broad-based support for applying the tool to address health inequities in their cities were vital. Their inputs and emphasis on a participatory approach have been a key building block of Urban HEART.

The development of the tool has also benefited much from the expertise of officials at WHO headquarters in Geneva, especially from the Noncommunicable Diseases and Mental Health Cluster and the Information, Evidence and Research Cluster.

Finally, the 12 members of the Urban HEART Ad Hoc Advisory Group brought in a variety of expertise to contribute to the development of the tool. The advisors, a mix of academics, policy-makers and experts from international organizations, provided much-needed technical inputs and advice to strengthen both the scientific validity and the practical applicability of the tool.

A. CONCEPTS AND PRINCIPLES

A.1 INEQUITY IN HEALTH

Differences in health across the population can be observed in any city. Genetic and constitutional variations ensure that the health of individuals varies, as it does for any other physical characteristic. Older people tend to be sicker than younger people, because of the natural ageing process. However, three features, when combined, turn a mere difference in health into an inequity in health. A difference in health that is systematic, socially produced (and, therefore, modifiable) and *unfair* [2] is an inequity in health (*2*).

Figure 1 Under-five mortality rates per 1000 live births by urban wealth quintiles in selected countries