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Prioritizing action on health inequities in cities: An evaluation of Urban Health Equity Assessment and Response Tool (Urban HEART) in 15 cities from Asia and Africa

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ABSTRACT

Following the recommendations of the Commission on Social Determinants of Health (2008), the World Health Organization (WHO) developed the Urban Health Equity Assessment and Response Tool (HEART) to support local stakeholders in identifying and planning action on health inequities. The objective of this report is to analyze the experiences of cities in implementing Urban HEART in order to inform how the future development of the tool could support local stakeholders better in addressing health inequities.

The study method is documentary analysis from independent evaluations and city implementation reports submitted to WHO. Independent evaluations were conducted in 2011–12 on Urban HEART piloting in 15 cities from seven countries in Asia and Africa: Indonesia, Iran, Kenya, Mongolia, Philippines, Sri Lanka, and Vietnam.

Local or national health departments led Urban HEART piloting in 12 of the 15 cities. Other stakeholders commonly engaged included the city council, budget and planning departments, education sector, urban planning department, and the Mayor's office. Ten of the 12 core indicators recommended in Urban HEART were collected by at least 10 of the 15 cities. Improving access to safe water and sanitation was a priority equity-oriented intervention in 12 of the 15 cities, while unemployment was addressed in seven cities.

Cities who piloted Urban HEART displayed confidence in its potential by sustaining or scaling up its use within their countries. Engagement of a wider group of stakeholders was more likely to lead to actions for improving health equity. Indicators that were collected were more likely to be acted upon. Quality of data for neighbourhoods within cities was one of the major issues.

As local governments and stakeholders around the world gain greater control of decisions regarding their health, Urban HEART could prove to be a valuable tool in helping them pursue the goal of health equity.

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1. Background

The proportion of the population living in urban areas, globally, had increased from 13% in 1900 to more than 50% in 2008, and is projected to account for 67% of global population in 2050 (United Nations, 2014). A major concern of rapid unplanned urbanization has been the pressure on availability and distribution of social, economic, and environmental resources (World Health Organization and United Nations Human Settlements Programme, 2010). The United Nations Human Settlements Programme (UN HABITAT) estimates that nearly one billion, or one-third, of urban dwellers lived in slums or informal settlements in 2007, with the

global slum population likely to double by 2030 (UN HABITAT, 2006). Furthermore, in 2008, the World Health Organization (WHO) identified urbanization, globalization, and population ageing as three demographic trends that would pose major public health challenges in the 21st century (WHO, The World Health Report, 2008a,b,c).

In 2008, the WHO's Commission on Social Determinants of Health (the Commission) elicited evidence that inequities in health are the consequences of conditions in which people grow, live, work, and age (WHO, 2008a,b,c). One of the nine social determinants of health (SDH) themes addressed by the Commission was "urbanization". A global network of researchers formed the Knowledge Network on Urban Settings (KNUS) to collate and synthesize evidence on broad policy interventions relating to healthy urbanization. In its final report, among other issues, KNUS recommended the development and global application of an equity assessment and response tool to monitor and act on health inequity (World Health Organization Centre for Health Development, 2008).

In collaboration with city and national policy-makers, academics and researchers, and international organizations, WHO launched the Urban Health Equity Assessment and Response Tool (Urban HEART) in 2010 (WHO, 2010a,b; St. Michael's Hospital, 2012). Utilizing an SDH framework, Urban HEART guides local and national stakeholders through a process to identify, prioritize, and track inequities in health and its SDH using best available evidence, and offers a range of response strategies aiming to reduce identified inequities. The tool was developed between 2007 and 2010 which included piloting in 17 cities from nine countries, a WHO internal review, and recommendations from an external advisory group of experts (Prasad et al., 2013; WHO, 2009a,b).

Urban HEART has been or is being used in cities from 40 countries to date. The tool has been incorporated in national and local policies in many countries such as Canada, Colombia, Indonesia, Iran, Philippines, and Sri Lanka. The objective of this report is to analyze the experiences of cities in implementing Urban HEART in order to inform how future development of the tool could support local stakeholders better in addressing health inequities.

2. Methods

Between 2008 and 2010 Urban HEART was piloted in 17 cities from nine countries around the world. The cities were selected from low- and middle-income countries based on their leadership's willingness to tackle health inequities, representativeness of different regions of the world, and availability of relevant data. An independent evaluation was expected to be conducted after the piloting of the tool in 2011–12 in cooperation with the various sites. However, Mexico City (Mexico) and Guarulhos (Brazil) pilots could not be evaluated as the former had not completed the process, and the latter had undergone a change in government. Therefore, the process was evaluated in 15 cities from seven countries: Denpasar, North Jakarta, West Jakarta in Indonesia (Indonesian Epidemiological Association, 2013); Tehran in Iran (National Public Health Management Centre and Tabriz University of Medical Sciences (2013)); Nakuru in Kenya (Infore Services, 2013); Ulaanbaatar in Mongolia (Mongolian Association of Environmental and Occupational Health (2011)); Davao, Naga, Olongapo, Parañaque, Tacloban, Taguig, Zamboanga in the Philippines (University of Philippines (2013)); Colombo in Sri Lanka (University of Colombo (2013)); and Ho Chi Minh City in Vietnam (Pham Ngoc Thach University of Medicine (2011)).

Major activities of the evaluation included document reviews, stakeholder interviews and field visits to observe actions. The lead evaluation agencies were selected by national authorities with the understanding that this was an independent undertaking and that

the selected agency had no role in the process of Urban HEART. All evaluation agencies were either universities or public health agencies with the exception of Kenya where a consulting firm was contracted for the purpose. Specific terms of reference were prepared by WHO for the evaluation, and evaluators prepared their survey questionnaires for key informants, checklists for field visits, and methodology for document reviews based on the expected outputs.

No primary data from human subjects has been collected for the preparation of this report. Therefore, ethics approval was not sought as all data presented have been synthesized from secondary sources of information. The complete evaluation reports have been made publicly available on the website of the WHO Kobe Centre (http://www.who.int/kobe_centre/).

To ensure completeness, supplementary information has been utilized from city reports on the piloting of Urban HEART (Basweti, 2009; Asadi-Lari M et al., 2009; Paranaque Urban HEART Team, 2009). This report is primarily a documentary analysis of the independent evaluations and city implementation reports.

The information in the evaluation reports has been analyzed to answer the following questions:

1. How closely have the various cities followed the recommendations of Urban HEART with respect to the three core elements of the tool?
2. What were the barriers and facilitators faced by the various cities in the process of using the tool?
3. What were the main suggestions from pilot cities for improving the guidance in Urban HEART?

The three core elements of Urban HEART include engagement of relevant stakeholders, collection of quality evidence especially with respect to the 12 core indicators in Urban HEART, and prioritization of equity gaps. Of the 37 indicators recommended in Urban HEART, 12 were identified as "core". The 12 core indicators include infant mortality, tuberculosis, diabetes, road traffic injuries, safe water, improved sanitation, primary education, fully immunized children, skilled birth attendance, smoking, unemployment, and government expenditure on health. In addition, the utility of the two data presentation tools in Urban HEART − the Urban Health Equity Matrix and Monitor − was analyzed with respect to their frequency of construction and use in determining priorities.

The four desirable characteristics of Urban HEART provide a framework within which to analyze the barriers and facilitators. According to these characteristics Urban HEART is expected to be comprehensive and inclusive, easy to use, include evidence linked to actions, and be operationally feasible and sustainable.

2.1. Findings

Table 1 presents demographic and other relevant information for each of the 15 cities. The population of cities ranged from 101 571 for Naga to 12 million for Tehran. All cities, except those from Indonesia, conducted an intra-city inequity analysis, comparing the status of districts (or sub-divisions) within a city, as opposed to comparing averages between cities for an inter-city comparison.

The findings from the piloting are first presented within the framework of the three core elements of implementing Urban HEART:

2.2. Engagement of stakeholders

Health authorities at the national level were responsible for leading Urban HEART piloting in cities from Indonesia and Vietnam. Local health authorities led the process in Colombo and in all cities