The spectrum of urban living conditions is reflected in the health of a city’s residents. Despite the wide disparities in health outcomes that stem from differential circumstances, few countries routinely examine such inequities within or between cities.

The Urban Health Equity Assessment and Response Tool (Urban HEART) helps urban policymakers, communities and other stakeholders better understand the local socio-economic factors that influence health outcomes. Developed by the World Health Organization (WHO), Urban HEART is designed to tackle urban health inequities – avoidable differences in health that are socially produced rather than biologically determined. The tool serves to identify and correct policies that perpetuate these inequities – for instance, the higher rates of illness and death among the children of families in urban poverty than among those born into relatively affluent homes.

Urban HEART provides local and national authorities with the evidence they need to set priorities, allocate resources and mobilize urban communities to promote health equity. To determine which interventions are likely to improve health and reduce inequities, this evidence seeks to show not just the immediate causes of disease but also the ‘causes of causes’ – underlying social hierarchies and the resulting conditions in which people grow, live, work and age.

Reducing health and social inequities is complex. Implementation of Urban HEART focuses on local solutions that engage all stakeholders, consider existing interventions and are effective and sustainable over time.

The tool is based on three essential elements:

- Sound evidence: reliable, representative and comparable data, disaggregated by sex, age, socio-economic status, major geographical or administrative region, and ethnicity, as appropriate
- Intersectoral action for health: building relationships beyond the health sector in order to influence a broad range of health determinants – in particular, working with other government sectors (e.g., education, transport and public works), community groups and non-governmental organizations
- Community participation: involving community members in all aspects of the process, from planning, designing and implementing interventions to helping ensure that these efforts are learned from and sustained beyond the initial phase.

Urban HEART revolves around a planning and implementation cycle comprising four phases: assessment, response, policy and programme. Monitoring and evaluation take place during each phase.

Urban health inequities are identified in the assessment phase. Evidence gathered at this stage forms the basis for raising awareness, determining solutions and promoting action.

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**Figure 4.1. Urban HEART planning and implementation cycle**

![Urban HEART planning and implementation cycle](source: WHO Urban HEART)
The response stage involves identifying appropriate responses, designating key actors, defining goals and establishing targets. This is an opportunity to engage all relevant sectors and communities in setting the agenda – determining which policies, programmes and projects should be introduced, continued, expanded, improved, changed or stopped to achieve equity goals.

During the policy stage, the most relevant interventions are prioritized and budgeted to ensure that they become part of the local government policy-making process. Success is measured by the laws, programmes and interventions implemented.

Programme implementation hinges on resources and time frames determined by local authorities. Health sector programmes implementing pro-equity health policies are complemented by other sectors’ actions to bring about health equity.

Monitoring and evaluation encompass both process and outcomes.

Core indicators
Indicators measuring selected health outcomes and social determinants for different urban population groups form the basis of the assessment component of Urban HEART. Indicators fall into two main categories: health outcomes (shown in blue in Figure 4.2) and social determinants of health (shown in grey). Twelve core indicators are used across all Urban HEART schemes, allowing comparison across cities and countries. This basic set was selected to provide a general picture of the urban health situation in any urban setting, based on generally available data, universality and potential to uncover inequity. The 12 ‘core’ indicators are complemented by ‘strongly recommended’ and ‘optional’ ones to provide an analysis responsive to local priorities and specific health equity concerns. It is recommended that each indicator be further disaggregated by location, sex, age and/or socio-economic group.

Embedding Urban HEART
Urban HEART is primarily a tool to enhance current interventions as part of existing national and local health planning and programme frameworks. The chosen health equity solutions should be results-focused, cost-effective and timely; use available local resources where possible; ensure broad support among affected communities; and comply with national priorities. Intervention strategies include incorporating health in urban planning and development, strengthening the role of urban primary health care and promoting an emphasis on health equity.

**Figure 4.2. Twelve core indicators**

<table>
<thead>
<tr>
<th>Health</th>
<th>Physical environment and infrastructure</th>
<th>Social and human development</th>
<th>Economics</th>
<th>Governance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant mortality</td>
<td>Access to safe water</td>
<td>Completion of primary education</td>
<td>Unemployment</td>
<td>Government spending on health</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Access to improved sanitation</td>
<td>Skilled birth attendance</td>
<td></td>
<td></td>
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<tr>
<td>Tuberculosis</td>
<td></td>
<td>Fully immunized children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Road traffic injuries</td>
<td></td>
<td>Prevalence of tobacco smoking</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

WHO Urban HEART was developed by the WHO Centre for Health Development in Kobe, Japan (WHO Kobe Centre), in collaboration with regional offices of WHO and city and national officials from across the world. In total, 16 municipalities and 1 state in 10 countries – Brazil, Indonesia, Iran (Islamic Republic of), Kenya, Malaysia, Mexico, Mongolia, the Philippines, Sri Lanka and Viet Nam – participated in the pilot scheme.