REPORT

of the

Expert Consultation on Urban HEART

(Urban Health Equity Assessment and Response Tool)

6-8 November 2013

Kobe, Japan

World Health Organization
Centre for Health Development

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1. Background

1.1 In collaboration with city and national policy-makers, academics and researchers, and international organizations, WHO developed the Urban Health Equity Assessment and Response Tool (Urban HEART), and launched the tool in 2010;

1.2 Utilizing a social determinants of health (SDH) framework, Urban HEART guides local and national stakeholders through a process to identify, prioritize and track inequities in health and its SDH using secondary data and, only if necessary and feasible, primary data. The tool offers a range of response strategies aiming to reduce identified inequities;

1.3 Between 2007 and 2010 a number of activities were conducted to develop Urban HEART:

1.3.1 A review of existing relevant tools focusing on urban health and health equity was conducted. The knowledge and experiences from these tools contributed significantly to the development of Urban HEART;

1.3.2 A pilot version of Urban HEART was tested between 2008-10 in 17 cities of ten low- and middle-income countries - Brazil, Indonesia, Iran, Kenya, Malaysia, Mexico, Mongolia, Philippines, Sri Lanka, and Viet Nam - to assess its applicability in varied urban settings;

1.3.3 An Ad-hoc Advisory Group on Urban HEART of policy-makers, academics, and international organizations provided technical guidance for the development of the tool.

1.4 In 2010-13, Urban HEART was scaled up across and within countries and a series of training workshops was conducted to increase uptake of the tool. Nearly 400 city and national officials from 80 countries have been trained through WHO workshops across the world till end-2013;

1.5 Urban HEART has now been used or is being used in 50 cities from 35 countries across the world. A number of cities and countries have also established mechanisms to sustain the use of Urban HEART;

1.6 Independent evaluations on the process and outputs of Urban HEART were also conducted in 15 cities from seven countries that piloted the tool in 2008-09. The 15 cities include: Denpasar, North Jakarta, West Jakarta (Indonesia); Tehran (Iran); Nakuru (Kenya); Ulaanbaatar (Mongolia); Davao, Naga, Olongapo, Parañaque, Tacloban, Taguig, Zamboanga (Philippines); Colombo (Sri Lanka); and Ho Chi Minh City (Viet Nam);

1.7 Urban HEART is expected to evolve through the years and adapt to emerging issues of rapid urbanization, climate change, urban planning, and ageing populations among others, which are likely to have a significant impact on health equity;

1.8 Based on feedback from experts, city officials and other international organizations, it was considered a timely opportunity to review and update Urban HEART, and to develop a new

version of the tool. An important step in the process was to bring together a number of key stakeholders together for an expert consultation to discuss how Urban HEART can better support decision-making;

1.9 The Expert Consultation on Urban HEART held in Kobe, 6-8 November 2013, brought together experts on urbanization, urban health, and health metrics, representatives from Urban HEART piloting cities, and WHO officials (see Annex 1 for list of participants);

1.10 A combination of plenaries and group work were utilized during the meeting to solicit opinions on future modifications to Urban HEART. Questions posed to the participants during the group work were derived from the independent evaluation reports and other feedback from cities and experts. The plenaries also enabled participants to express and debate issues of concern beyond those mentioned in the feedback from cities and experts (see Annex 2 for the Programme);

1.11 The **objectives** of the meeting were:

1.11.1 To collectively examine the critique of Urban HEART between 2008-2013 and develop inputs for a new version of the tool: Urban HEART ver 2.0;

1.11.2 To explore opportunities to scale up and expand the network of cities using Urban HEART.

Day ONE: Nov 6th 2013

2. Setting the context

2.1 Opening remarks for the meeting were provided by Mr Alex Ross, Director WHO Kobe Centre (WKC), who emphasized the importance of using Urban HEART to address health inequities in cities and utilizing the momentum around universal health coverage, globally, to achieve our objectives;

2.2 A presentation on the **Global Update of Urban HEART** was given by Mr Amit Prasad (WKC)

2.2.1 Mr Prasad explained the historical context and timeline for the conceptualization and development of Urban HEART between 2006-2010 and gave a brief introduction to the different components of the tool such as the 'four desirable characteristics' and 'the six steps of Urban HEART'.

2.2.2 Mr Prasad also highlighted that officials from 80 countries had been trained on the use in Urban HEART since 2007, while 50 cities from 35 countries had proceeded to use the tool between 2008 and 2013.

2.3 In the proceeding **discussion** the following observations and comments were made;

2.3.1 In the context of Tehran, the tool was not found to entirely meet one of the four desirable characteristics which emphasizes sustainability, and it was suggested that more guidance on sustainability and efforts to support cities should be provided in the future;

2.3.2 WKC should begin to engage other United Nations (UN) agencies, and other international health organizations for disseminating the tool as well as to provide support during the implementation process of Urban HEART;

2.3.3 Based on the context in Iran and Morocco, a number of comments were made directed towards the involvement of the Ministry of Health (MOH):

2.3.3.1 It was suggested that advocacy for Urban HEART needs to start at the MOH level, who can then start engaging other sectors;

2.3.3.2 In the context of Iran, it was noted that the MOH plays a key role in advocating for Urban HEART and in bringing in other key ministries. However, the initial advocacy for the tool within MOH was low;

2.3.3.3 According to the representative from Morocco, this will require more materials and guidance for promoting the key concepts embedded within Urban HEART such as the social determinants of health (SDH) and health equity.

2.3.4 There has been limited advocacy on the importance and effectiveness of a tool such as Urban HEART within WHO Geneva;

2.3.5 In the context of Toronto (Canada) and Australia, it was suggested that the private sector should be regarded as another key constituency because of their direct/indirect role in urban development and community level data collection;

2.3.6 Representatives from WHO Europe (EUR), WHO Western Pacific (WPR) and South East-Asia (SEAR) regions noted that although Urban HEART encourages cities to collect data by a number of different stratifiers (e.g. age, gender, socio-economic level, etc.), in practice, cities were too narrowly focused on geographically disaggregated data. It was recommended that the tool should balance information and advice on the different ways to stratify the data, considering spatial, demographic and socioeconomic determinants.

3. Implementation of Urban HEART

3.1 Three city presentations were made during this session:
   3.1.1 Paranaque City, Philippines (Dr Olga Zerrudo Virtusio);
   3.1.2 Tehran, Iran (Dr Mohsen Asadi Lari) ;
   3.1.3 Indore, India (Dr Siddharth Raj Agarwal).

3.2 Dr Olga Zerrudo Virtusio presented on the process the Paranaque (Philippines) team used in implementing Urban HEART in 2008-2010. This included the challenges faced during each phase and the lessons learned towards the end of the process.

3.3 Dr Virtusio also emphasized that in order to sustain the tool, teams had to go beyond what was provided within the manual to truly adapt Urban HEART to the local needs of the community. This included:

    3.3.1 Strengthening public and private sector partnerships through an intermediate representative (e.g. NGOs);

    3.3.2 Putting most of the responsibility of developing interventions in the community to increase self-empowerment and health awareness;

    3.3.3 Incorporating Urban HEART within the regular city planning cycle.

3.4 Dr Virtusio stated that the main barriers encountered during implementation was the lack of available data in all districts in Paranaque City, balancing conflicting priorities between other sectors and key stakeholders, and introducing Urban HEART to local agencies that have already begun using different assessment tools;

3.5 The key facilitating factor was the strong involvement of the local community, especially during the response phase, which aided in the development and the sustainability of selected interventions;

3.6 Major outcomes from the Urban HEART implementation process in Paranaque City was stronger links with other health agencies and the private sector, increased health-seeking behaviour within the local community, and an increased advocacy for this tool at the national level;

3.7 Dr Mohsen Asadi Lari presented an overview of the two completed rounds of Urban HEART implementation conducted in Tehran (Iran). This focused on how the tool was adapted to address the perceived health issues of the population e.g. adding in an additional domain of Nutrition and new indicators;

3.8 Dr Asadi Lari noted that the Urban HEART team found adapting the tool to their local context the most challenging issue. However, once the assessment was complete the Matrix was considered an important facilitating factor towards prioritizing local health issues;

3.9 The main achievements of the second round of implementation included institutionalization of Urban HEART in Tehran municipality, neighborhood-based data availability, analysis and development of action plans for 375 neighbourhooods with each neighbourhood selecting 1-3 priorities based on the assessment.

3.10   Dr Siddharth Raj Agarwal presented the results from assessing health equity across slum neighbourhoods in Indore (India) in the absence of quantitative data and strong pre-established multi-sectoral action;

3.11   Dr Agarwal stated that the uniqueness of their Urban HEART implementation process comes from the complete involvement and management of the process by local community groups such as the Federation of Slum Women;

3.12   Dr Agarwal emphasized that with basic training and general assistance, community run teams are capable of collecting survey data, developing and implementing their own interventions.

3.13   In the **plenary discussion** that followed, a number of comments and observations were made:

3.13.1 There was a concern that since different cities were collecting different sets of indicators there would be a loss of global comparability. If global comparability on at least some parameters is desirable, this could be solved by having a stronger set of core indicators or strongly encouraging cities to collect a majority of the core indicators;

3.13.2 Early education and regular dissemination of results to community representatives generated strong support and participation during the response phase;

3.13.3 Sustainability and ease of introduction is best facilitated through a well-established entry point e.g. Healthy Cities or other pre-established initiative;

3.13.4 Lack of data relevant to particular indicators or of a population group may be an indication of potentially extreme inequalities;

3.13.5 Although cities were able to develop interventions addressing the highlighted health priorities, participants were particularly interested in knowing whether the interventions had positively impacted disadvantaged populations:

3.13.5.1 What were the unintended effects of these interventions?

3.13.5.2 Who had actually benefitted?

3.13.5.3 These questions should be addressed in order to avoid negative impacts such as developing plans/programmes that increase inequalities, or have unevenly shared benefits;

3.13.5.4 A possible solution might be to conduct Urban HEART 2-3 years after implementation of interventions. This could help monitor intended equity impacts on targeted groups.

3.13.6 While the 'supply' aspect is important in implementing Urban HEART and developing urban health plans/programmes there needs to be more emphasis on the 'demand' side. Without strong political will, key stakeholder support, and community participation, the demands will not reach the policy-makers.

3.14 A presentation on the **Synthesis of Urban HEART** was done by Dr Megumi Kano (WKC).

3.14.1 Dr Kano presented the common methods and practices of cities during the piloting of the first version of Urban HEART, as well as providing information on the common barriers, facilitators, and lessons learned from 23 cities in 14 countries based on availability of reports in English;

3.14.2 Dr Kano also emphasized the key suggestions and recommendations for each phase of implementation that were provided in the evaluation and city reports;

3.14.3 Overall, users had found Urban HEART to be effective and easy-to-use, created an increased awareness of health equity among policy makers as well as communities, strengthened intersectoral action for health, and facilitated the planning process for health and health equity;

3.14.4 However, there were some common barriers in the implementation of Urban HEART. These included inadequate initial understanding of the concepts and framework, unclear roles and responsibilities, limited community participation, unclear guidelines for the process of selecting interventions, and insufficient information on monitoring and evaluation methods.

3.15 Additional observations and comments made by participants during the **plenary discussions** were as follows:

3.15.1 It was noted by representatives from Tehran that intersectoral action for health was not strong enough throughout the implementation of Urban HEART, particularly with regards to community and non-health sector involvement. They stated that this can be addressed by strongly advocating for the incorporation of Urban HEART into the local planning cycle as well as increasing the time and effort needed to locate key stakeholders during the pre-assessment phase;

3.15.2 Although it was noted that the Urban HEART manual does highlight the importance of continual and regular assessment in a cyclical fashion, it was requested that this be

emphasized more to avoid teams just focusing on the frequency of assessments and not on their quality;

3.15.3 The relationship between the SDH mentioned in Urban HEART and health equity is not clearly established in the manual;

3.15.4 WHO was also requested to encourage cities to conduct regular external evaluations of Urban HEART, and to share their results with other cities using Urban HEART;

3.15.5 Urban HEART should be looked at as an approach for assessing urban health inequities, with the objective to compile evidence on urban health inequities in order to inform political decision-making, and not to develop blueprint options for all possible solutions.

4. Group work 1: Review of urban health trends and concepts

4.1 Participants were divided into four groups including two groups of city officials and two groups of experts for the first group work. A different set of questions were answered by city officials and experts;

4.2 Group work 1: Groups I & II questions and responses (city officials)

4.2.1 ***Based on your experience of using Urban HEART till now, please mention the main difficulties you faced in understanding or explaining the key concepts such as health equity, urbanization and SDH:***

4.2.1.1 The concept of health equity is more complex than what is presented in the tool, especially in terms of how equity is related to different non-health sectors. This concept was found to be difficult for individuals outside of the health sector to understand;

4.2.1.2 The local authorities generally define the term 'health' by its medical implications and tend to forget that all levels of city planning (education, infrastructure, etc.) relate to the health of a population. Advocacy for Urban HEART will succeed only if other sectors understand how the term 'health' relates to their work. In Toronto, for example, emphasis was laid on 'equity' rather than on achieving 'health equity' which was better received by non-health sectors;

4.2.1.3 There is an insufficient amount of emphasis placed on the impact of urbanization on SDH and health.

4.2.2 *How can Urban HEART guidance be improved so that a wider audience finds it easier to understand the key concepts?*

4.2.2.1 There needs to be greater emphasis on the linkages between the different indicators, especially those that cross sectoral boundaries, e.g. literacy, in order to create demand for data relevant to indicators;

4.2.2.2 Additional operational definitions of terms and concepts should be provided to improve the communication of the tool and methods to new participants;

4.2.2.3 Improve or update Urban HEART to reflect the diverse forms in which it can be implemented. This will further demonstrate the flexibility and adaptability of the tool;

4.2.2.4 Get feedback on Urban HEART from government sectors beyond the health sector, other organizations working on related issues (e.g. World Bank, etc), academia, etc.;

4.2.2.5 Given the number of cities that have already used Urban HEART, WKC could prepare a series of vignettes based on real experiences of various cities in implementing Urban HEART.

4.2.3 *Are the newly introduced concepts of universal health coverage (UHC), emergency management, and health ageing relevant to your cities or context? Can you explain why or why not?*

4.2.3.1 Inclusion of new concepts may overcrowd and complicate Urban HEART, which will lower its appeal and ease-of-use. Therefore, it was suggested that while new concepts can be introduced, they should be considered for optional implementation if they do not relate directly to the core objective of the tool;

4.2.3.2 Ageing was not perceived as a high priority within cities of low- and middle-income countries, although, it is a priority for cities in high-income countries. However, it was also noted that older populations in cities of low- and middle-income countries are likely to be more vulnerable to its negative impacts. Therefore, ageing should be considered as an important issue for addressing health equity in cities in low- and middle-income countries as well;

4.2.3.3 Emergency management is highly relevant for cities, but should be considered for optional implementation with a minimal number of indicators for regular assessment and monitoring. Further, a clear definition of what is considered an 'emergency' will need to be provided e.g. natural vs. man-made disasters, while retaining an emphasis on addressing equity;

4.2.3.4 It was unanimously agreed upon by both groups that UHC is strongly linked to health equity, and it was noted that this concept may already be a part of Urban HEART.

4.2.4 *What forms of guidance would you like Urban HEART to provide on the new concepts to engage a wide group of stakeholders in the process?*

4.2.4.1 There are already pre-existing tools to address some of the proposed new issues. In order to avoid complicating Urban HEART, links or references should be made to existing tools that address these new concepts e.g. indicators for Global Network of Age-Friendly Cities;

4.2.4.2 Emergency management should be included but not limited to being a health system issue. It should be introduced as a new domain with indicators;

4.2.4.3 A limited number of core indicators relating to the newly proposed issues can be added into the current list;

4.2.4.4 Operational definitions that explain how these concepts are related to health equity should also be provided.

4.2.5 *Are there other key concepts that you would like to see addressed in Urban HEART or linked to the tool?*

4.2.5.1 No new concepts were agreed upon by the different groups. There was, however, a request for more guidance on the following issues already in Urban HEART:

4.2.5.1.1 *Present the linkages with other public health programmes so that different public health departments can better understand why urban health is relevant to them;*

4.2.5.1.2 *A list of critical dimensions of environmental determinants was suggested for better integration into the tool. Details on these dimensions are provided in section 6.3.1 of this report;*

4.2.5.1.3 *Stronger emphasis should be placed on "community ownership" and additional guidance provided on the role community members play throughout the implementation process;*

4.2.5.1.4 *Elaborate more on the uniqueness of "health in the urban setting" by including issues such as mobility/migration.*

4.2.6 ***Will introducing many new concepts or guidance in Urban HEART reduce its ease of use or any other "desirable characteristics"? Which concepts will be more critical to emphasize in the current environment?***

4.2.6.1 There was a discrepancy between the two groups regarding this question;

4.2.6.1.1 Some members mentioned that the addition of these new concepts would complicate the use of the tool if they are compulsory. However, if the new concepts are <u>optional</u> then this should keep the tool easy to use;

4.2.6.1.2 Other members felt that adding these new concepts would not affect its ease of use because some of the new concepts (e.g. UHC) were already addressed within the current list of indicators, and these concepts would just need to be highlighted.

4.3 Group work 1: Groups III & IV questions and responses (experts)

4.3.1 ***How can Urban HEART improve its focus on addressing key issues related to urbanization keeping in mind the on-going debates e.g. around sustainable environments?***

4.3.1.1 Similar to the introduction of "health equity," urbanization should be addressed in the first few pages of Urban HEART referring possibly to UN HABITAT, UN Millennium Task Force on Urbanization among others;

4.3.1.2 Key issues that will need to be addressed when linking urbanization to equity are migration, slums or informal settlements, environmental impacts including climate change, violence and conflict, pollution, transportation, energy, built environment and green spaces, gender, mental health, and income inequality/wealth gap.

4.3.2 ***If you think Urban HEART should further improve the quality of information it provides on "health equity" and "SDH", can you provide ideas on how to do so?***

4.3.2.1 Include a conceptual framework which explains the links between urban health and the SDH as well as the impacts and roles that different health and non-health sectors have within the framework;

4.3.2.2 The information provided in Urban HEART should be communicated in more user-friendly ways, e.g. the use of animations to present concepts;

4.3.2.3 Gender as a dimension of health equity should be in the glossary as well as in the text. The interventions linked to violence do not include gender-related

violence. Additionally, some interventions need to be modified so that they are more gender-sensitive;

4.3.2.4 The following activities should be undertaken to improve quality of information: encourage use of multiple sources of information; build capacity for data collection and analysis; improve validity through crowd sourcing; triangulate the information and share information across sectors.

4.3.3 *How can universal health coverage be incorporated in Urban HEART? What should be the scope and form of its coverage in Urban HEART?*

4.3.3.1 It was unanimously agreed that UHC is relevant to all city populations and **Urban HEART is potentially a monitoring tool of UHC**;

4.3.3.2 Indicators monitoring progress of UHC should be linked to Urban HEART e.g. indicators that are currently being jointly developed by WHO and World Bank (expected by March 2014). Focus should be placed on financial and physical accessibility of services and resources: access to services, access to drugs and technology, out of pocket expenditure, proportion of people covered, range of services, financial costs covered;

4.3.3.3 It was suggested that the indicator on "insurance coverage" in Urban HEART indicator already addresses an aspect of UHC;

4.3.3.4 UHC is a movement at the national level and is not limited to urban areas, so Urban HEART will need to demonstrate how cities can address this concept at the local level.

4.3.4 *Given that emergency management will be introduced as a new domain within Urban HEART, what kind of guidance should be provided to cities especially considering tools that already provide a similar function?*

4.3.4.1 The term "emergency" will need to be clearly defined to explain the kind of disasters and emergencies being addressed;

4.3.4.2 Guidance should also be targeted towards cities that are not disaster prone. Definitions should be written in a simple format that can be easily understood by individuals with or without experience in disaster situations;

4.3.4.3 Provide defined roles and impacts that different health and non-health related sectors have on emergency management in order to increase awareness and support in this area.

4.3.4.4 Urban HEART should provide an equity lens and indicators related to vulnerability to disasters should be the focus. The new domain for the tool should also look into preventive dimensions and not just post-disaster management.

4.3.5 *Should "ageing" be specifically addressed in Urban HEART or would it be better to focus on disaggregation of data?*

4.3.5.1 Urban HEART already encourages cities to stratify data by age groups. However, this aspect could be further improved by referring to a set of indicators where disaggregation is particularly relevant;

4.3.5.2 A link should be provided to the WHO tool being developed on monitoring age-friendliness of cities.

4.3.6 *Are there any other key concepts that could be referred in Urban HEART especially considering the post-2015 development goals?*

4.3.6.1 There needs to be a stronger emphasis on how the environment impacts health, e.g. air pollution, which could be referred to in the introduction of the tool;

4.3.6.2 While the current version of the tool encourages the disaggregation of data by gender, the importance of improving gender equity needs to be better emphasized as it is clear from the first round of implementation that it was only occasionally the focus of the exercise, e.g. Bogota;

4.3.6.3 Other issues to be considered are social capital, quality of life, education, disability, nutrition, and mental health.

4.4 In the **plenary discussion** that followed a number of observations and suggestions were made;

4.4.1 While the new concepts are important aspects of urban development, incorporating a greater number of indicators, particularly within the core set of indicators, will make the tool unmanageable and less desirable. There is a need to keep the tool "lean";

4.4.2 However, participants discussed possible solutions such as including a core indicator for each of the concepts, with more indicators included in the optional section. A greater focus could be on referring to existing tools and instruments that can suggest indicators to address UHC, emergency management, and ageing issues;

4.4.3 Caution should be undertaken to ensure that newly introduced concepts and their respective indicators assess urban health issues from an equity perspective;

4.4.4 Given that neighbourhoods in cities can be quite small with limited resources, a common issue encountered by many users was the limited availability of data related to most indicators at the local level. If these new concepts are to be included, the tool needs to provide more guidance on how and where to collect data from including alternative methods of collection, if data does not currently exist;

4.4.5 Urban HEART should provide information concerning the cost-effectiveness of using the tool. Providing calculated costs and the resulting benefits will aid in the promotion of Urban HEART to city officials and policy-makers. However, it was also noted that while it was tempting to focus on the direct impacts on decision making, it is important to remember that many users appreciate the indirect benefits more as evinced in the experience of health impact assessments.

4.4.6 While it was agreed that providing additional information which displays the links between the SDH, equity, and urbanization is critical for improving advocacy and support for Urban HEART, some suggested that it would be more effective and motivating to show how Urban HEART can help different sectors reach their goals, instead of changing them to fit the tool's objectives;

4.4.7 In some ways the most useful thing that health systems can do is to regularly report on a broad range of health indicators at city and sub-city (disaggregated) levels, so cities can smoothly and easily collect data when implementing Urban HEART and other related approaches;

4.4.8 Urban HEART is well-structured and comprehensible which makes it easier when approaching governments. A strong emphasis should be maintained on the link between the assessment phase and the response prioritization phase. This is the best value added by Urban HEART to decision making, according to some participants;

Day TWO: Nov 7th 2013

5. Identifying areas of future improvement within Urban HEART

5.1 Two presentations were made at the start of this session:

    5.1.1 Urban Trends (Professor Oyebanji Oyelaran-Oyeyinka, UN-HABITAT) ;

    5.1.2 Urban HEART experience in Toronto, Canada (Ms Kelly Murphy).

5.2 Professor Oyebanji Oyelaran-Oyeyinka demonstrated the relationship between health inequities and urbanization and emphasized the importance of promoting sustainable urban development to counter the number of increasing health issues found within the growing global urban population;

5.3 Professor Oyelaran-Oyeyinka highlighted the new post-2015 development goals which will be focusing heavily on equity in the agenda;

5.4 Ms Kelly Murphy presented the Urban HEART adaptation and implementation process undertaken by Toronto (Canada), the challenges faced and lessons learned;

5.5 Ms Murphy noted that while Urban HEART promotes "health equity," focusing on the term "equity" alone allowed for more flexibility in engaging other sectors and assured that the health sector was not made the priority of the assessment;

5.6 Ms Murphy also stated that Urban HEART is easy to use but not easy to "produce". The process is clear but the sources of data are not, which leads to a potential misinterpretation of the results e.g. stigmatising areas or only focusing in "red" areas when gains could be made in "yellow" ones;

5.7 In the proceeding **discussion** the following observations and comments were made:

    5.7.1 Political will to follow through with the findings of Urban HEART was demonstrated in Toronto by expanding intervention investments worth CAD 90 million into the identified 19 "red" districts, and combining the efforts of other NPOs/NGOs (e.g. United Way) to increase community participation;

    5.7.2 The Toronto experience was highlighted as a good example for showing that intersectoral action cannot be regarded as a quick fix to solving health issues. This was demonstrated by the lengthy one year process it took to identify potential team members, outline responsibilities, and designate leaders. Creating trust between all team members was a major struggle in Toronto;

    5.7.3 Despite the initial appearance that Urban HEART was more relevant to low- and middle-income cities, Toronto found that it was a useful approach and that the domains of the tool were even relevant to major cities in high-income countries.

6. Group work 2: Review of indicators in Urban HEART

6.1 Participants were divided into four groups for this group work.

    6.1.1 **Groups I and II** focused on UHC, Ageing, and the current set of Urban HEART indicators;

    6.1.2 **Group III** focused on identifying environmental indicators, tool adaptation to high-income countries, and data collection and validation;

6.1.3 **Group IV** focused on identifying emergency management indicators and data collection and validation.

6.2 Group work 2: Groups I & II questions and responses

6.2.1 *What indicators are best suited for <u>monitoring universal health coverage</u>? Could any of the <u>current</u> Urban HEART indicators be modified or built upon to address health inequities in relation to UHC?*

　　6.2.1.1 WHO Geneva in collaboration with The World Bank has already begun the process of identifying UHC indicators. It was agreed that WKC should wait and select indicators appropriate to Urban HEART;

　　6.2.1.2 Some aspects of UHC are outside the control of the local government. So even if inequities are identified local governments may not be able to implement the interventions needed to facilitate change;

　　6.2.1.3 Indicators that may be relevant to Urban HEART are:

　　　　6.2.1.3.1 Coverage: what per cent of people are covered? Rate of health insurance card ownership among the community;
　　　　6.2.1.3.2 Range of services: people centred primary health care – is all primary care accessible? Geographic location of services within a city;
　　　　6.2.1.3.3 Financial protection schemes and out-of-pocket expenditure: how many people are pushed into poverty? Do programmes provide financial protection? Incidence of catastrophic health expenditures among the community;
　　　　6.2.1.3.4 Accessibility of services: Utilization of health services required by the community. Responsiveness to needs of people e.g. hours of service, gender sensitivity, culturally appropriate services.

　　6.2.1.4 At least one indicator relating to UHC should be included in the 'core' list.

6.2.2 *What indicators on ageing if any should be included in Urban HEART? Take into consideration that WKC is developing indicators for monitoring age-friendliness of cities.*

　　6.2.2.1 There should be more emphasis on the need for disaggregation of data by age groups, including the collection of demographic data by sex and age in the city;

　　6.2.2.2 It would be more efficient to link Urban HEART to the work WKC has been doing on the indicators for monitoring age-friendliness of cities. This could be a separate or optional module in the tool;

6.2.2.3 The concept of ageing was not perceived as a critical issue for all cities, and so it was suggested that additional indicators relating to ageing issues should not be introduced into the 'core' set;

6.2.2.4 Ageing indicators considered relevant to Urban HEART were:

6.2.2.4.1 Indicators addressing services for the elderly, specifically looking at rehabilitation and long term care;
6.2.2.4.2 Social isolation and discrimination at the local level.

6.2.3 ***Looking at the provided list of <u>highlighted</u> indicators and based off of the survey feedback, do you agree with its current placement? Should some indicators be removed or shifted into different categories (core, strongly recommended, or optional)? Which can be left as is?***

6.2.3.1 There should be at least one non-communicable disease (NCD) indicator in the core list:

6.2.3.1.1 Groups were not able to decide the best place for the 'Diabetes" indicator which is currently a core indicator;
6.2.3.1.2 Indicators relating to cardiovascular disease or hypertension were considered more appropriate to be placed in the core set of indicators for the new version of Urban HEART.

6.2.3.2 At any rate a clear link should be established between the Urban HEART indicators on NCDs and WHO's global monitoring framework and voluntary global targets for prevention and control of non-communicable diseases (2012);

6.2.3.3 Physical activity is an important indicator but the current definition will need to be refined. Data collected for this indicator should be disaggregated by age since standards vary for different ages;

6.2.3.4 Voter participation was seen as a culturally sensitive topic in some cities and, therefore, was proposed to be placed in the optional indicator set. It was also questioned whether this indicator addresses the primary issue of community empowerment;

6.2.3.5 Life expectancy at birth was considered an important outcomes indicator. However the issue is that there isn't enough capacity to collect this data at the local level since this indicator is generally monitored at the national level.

6.2.4 *Which <u>additional/new</u> indicators from the provided lists given in the background paper should be included in Urban HEART?*

6.2.4.1 Among the list of additional/new indicators, both groups unanimously agreed that air pollution (indoor and outdoor) and access to public transportation should be included in the strongly recommended list.

6.2.4.2 Dengue fever was suggested as another new indicator because of its increasingly high prevalence in urban areas.

6.3 Group work 2: Group III questions and responses

6.3.1 *What environmental indicators should be added into the current list? Include domain location, definition and any additional information.*

6.3.1.1 It was suggested to have two sub-domains within the physical environment and infrastructure domain on Urban HEART: (1) physical environment, and (2) infrastructure. This split of domains should also be reflected clearly in the framework for Urban HEART;

6.3.1.2 Some core indicators for the environment should be included that are comparable between cities. Suggestions for core indicators include:
   6.3.1.2.1 Air quality;
   6.3.1.2.2 Indoor and outdoor air pollution;
   6.3.1.2.3 Water availability and 'quality' (i.e. mineral content and level of water contamination).

6.3.1.3 Some of the current indicators on solid waste management and sanitation were considered very relevant for cities especially in low- and middle-income countries;

6.3.1.4 Other suggested indicators were:

   6.3.1.4.1 Noise pollution;
   6.3.1.4.2 "Heating applications in houses", "air conditioning" ;
   6.3.1.4.3 "Overcrowding": utilizing the international definition but leaving room for cities to define the term locally.

6.3.1.5 The current Urban HEART definition for the access to green spaces indicator needs to be contextualized or made more operational. However, it was noted by participating WHO officials that the tool already provides the standardized definition for this indicator.

6.3.2 *How can the <u>current list</u> of indicators be more relevant for cities in high-income countries?*

6.3.2.1 The problem is not that the indicators are irrelevant for high-income countries as revealed by the example from Toronto. However, a two-fold problem was identified:

6.3.2.1.1 The indicators were not considered *appealing* to highly developed cities as the tool does not highlight some of their priority issues. This may be more of a communication or packaging problem;

6.3.2.1.2 Another problem is that in the current political and economic scenario cities and governments may not be interested in addressing equity in the political agenda, since they impact marginal populations within highly developed cities. Urban HEART could, in this case, appeal to the moral obligation of city officials to address critical issues of disadvantaged or vulnerable populations;

6.3.2.2 Support in cities can be increased by first asking politicians the question: "What do you want to change in cities?"; and then assisting them in defining priorities through focus on a few issues;

6.3.2.3 The inclusion of the issue of ageing is seen as more relevant to cities in high-income countries, especially around disability and accessibility.

6.4 Group work 2: Group IV questions and responses

6.4.1 Prioritize emergency management indicators that: 1) will give a good overall assessment of a city's health emergency management system, and 2) can be easily collected and monitored to determine a city's level of preparedness for response to and recovery from diverse risks, emergencies and disasters.

6.4.1.1 Completed disaster risk assessment and emergency management plan at the unit of analysis of Urban HEART (e.g. districts, neighbourhoods) was selected as a core indicator;

6.4.1.2 Indicators placed in the strongly recommended list were:

6.4.1.2.1 *Number of settings with emergency standard operating procedures (SOP) in place*
6.4.1.2.1.1 *At the household level, this could mean receive training/information on emergency planning and response – this requires a household survey;*
6.4.1.2.1.2 *Schools, work places, hospitals, community centres should have SOPs – data on this could be collected administratively (part of reporting requirements);*

6.4.1.2.2   Number of buildings resistant to earthquakes;

6.4.1.2.3   Number of people trained in emergency risk management;

6.4.1.2.4   Number of trained rapid response teams;

6.4.1.2.5   Presence of system for emergency response information dissemination and communication in place;

6.4.1.2.6   Stockpile of lifesaving supplies in safe places;

6.4.1.3 The remaining indicators in the list could either be placed in the optional list or removed.

6.4.2 ***What are other emergency management indicators that you think are worth looking into and should be included?***

6.4.2.1 Multisectoral coordination for emergency management was suggested. However, it was noted that while this is very important it is a difficult indicator to measure.

6.5 Group work 2: Group III and IV shared questions and responses

6.5.1 ***How can Urban HEART guide city officials in collecting qualitative evidence? What would be the scope of such guidance? Are there existing methods/tools?***

6.5.1.1 Qualitative data should be regarded as a complement to quantitative data and not as "second best". It can add substantial value when explaining the Matrix by adding in the "stories" behind the numbers;

6.5.1.2 A pre-requisite is that officials and communities have the 'capacity' to appropriately execute qualitative research;

6.5.1.3 NGOs, community networks and population groups should be utilized more to provide their suggestions through interviews or focus groups. Other methods of collection can include concept mapping, photographs, or through social media;

6.5.1.4 Urban HEART should provide guidance on the use of such methods for collecting and analysing qualitative evidence, especially in the absence of quantitative data especially to promote community ownership.

6.5.2 ***Is there information on basic methodologies or guidelines on data validation that can be linked in with Urban HEART?***

6.5.2.1 It was emphasized that Urban HEART should **not** provide elaborate details on the issues and methods of data validation;

6.5.2.2 Urban HEART teams should be able to clarify the meaning and implications of the 'reds' and 'greens' designated in their assessments. Their explanation will be a form of validation;

6.5.2.3 There should be a thorough examination of the population coverage within a data source. There may be instances when certain populations are not included and this introduces a bias. This also relates to the sample size and representation of household surveys conducted by assessment teams;

6.5.2.4 Urban HEART should emphasize the use of geocoding data;

6.5.2.5 The use of qualitative information, particularly addressing perceptions and opinions of the community, will aid in quantitative data validation;

6.6 In the **plenary discussion** that followed a number of observations and suggestions were made;

6.6.1 There was a general consensus that WKC will need to be cautious in the amount of new information that is added to the manual, so as not to dilute the focus of Urban HEART. The tool should only concentrate on indicators that have a strong impact on equity;

6.6.2 It may be too ambitious to identify and incorporate additional indicators and domains into Urban HEART;

6.6.3 The representative from Toronto stated that although qualitative data can be used to validate the quantitative results, it should not be collected solely for validation purposes. Policy-makers tend to be more motivated by the experiences of the community than numbers;

6.6.4 In the Indore (India) context, qualitative data collection was seen as an additional method of strengthening participation and motivation among the community, particularly during the response phase of Urban HEART;

6.6.5 UHC planning and funding are outside the realm of the local government, which will make it difficult to collect information on any financial protection, catastrophic expenditure, and OOP indicators;

6.6.6 It will be important to engage research institutions in implementing Urban HEART to ensure data validity, especially in developing countries where such capacity does not usually reside within local authorities;

6.6.7 There was a large amount of debate centred on the appropriateness of Emergency Management (EM), especially in terms of equity;

6.6.7.1 It was agreed that EM is a critical issue because of the growing number of disasters over the years and how disproportionally their effects are felt in a city's disadvantaged population;

6.6.7.2 It was agreed that there should be at least one core indicator. However, the addition of an entirely new EM domain does not seem to flow well with the original set of domains and indicators;

6.6.7.3 Based on the provided list of indicators, it was not understood how this new domain can be addressed from an equity perspective. Participants questioned whether this was an equity-sensitive domain or not;

6.6.7.4 There is a need for indicators that can measure the potential impacts of a disaster within specific areas/population groups;

6.6.7.5 Urban HEART will need to generate an understanding of the arguments and activities needed to respond to the identified EM issues at a local level.

6.7 Mr Jose Velandia presented the Urban HEART implementation process undertaken in the Bosa District of **Bogota, Colombia**;

6.8 Mr Jose Velandia emphasized that the execution of Urban HEART was performed by the city hospital. One of the major barriers was that there was little understanding of the concepts within the tool. All team members had to go through training outlining the concept of health equity and SDH;

6.9 The Bosa District assessment exercise included a number of indicators that were particularly relevant for the local context. For example, for the domain of social and human development, indicators related to flood risk, domestic violence, sexual abuse were also assessed;

6.10 The Urban HEART Matrix in Bosa District is being used to evaluate the impact of a New Model of Health Care. Given its utility in Bosa District, Urban HEART was also subsequently expanded to cover all districts in Bogota;

Day THREE: Nov 8th 2013

7. Group work 3: Guidance for helping cities prioritize action

7.1 Participants were divided into four groups; two groups of city officials and two groups consisting of experts. Groups were asked to answer a set of two questions based on their background along with three additional questions given to all groups.

7.2 Group work 3: Groups I & II questions and responses (city officials)

7.2.1 *Although the monitor was found useful for highlighting inequities, it was used less often than the matrix for prioritization. <u>How can the monitor be made more useful for prioritization?</u>*

7.2.1.1 The lack of data over several years contributed to the limited use of the Monitor. However, it was noted that as cities continue to use Urban HEART the data needed to utilize the Monitor will begin to accumulate for the years;

7.2.1.2 The Monitor was not found to be an appropriate tool for data representation of all the indicators;

7.2.1.3 Monitor needs to be created separately for each indicator which is more cumbersome compared to Matrix which can present data for multiple indicators;

7.2.1.4 The Monitor is more technical than the Matrix and is more difficult to produce/interpret for people with minimal experience in data analyses.

7.2.2 *Based on your experience, <u>what methods in Urban HEART are the most useful for selection of interventions?</u> (5 strategy packages and "best practice" examples, list of six criteria). Which part of the response guidance in the Urban HEART should be improved?*

7.2.2.1 The strategy packages were found to be very useful in developing and selecting interventions. However, they should be better integrated and presented as a part of the toolkit including an example of each application;

7.2.2.2 It was noted that the tool gives the impression that Urban HEART teams should start a new intervention instead of modifying existing interventions. The tool should better explain that the response can be used to modify existing interventions and not just used to start up new interventions;

7.2.2.3 The community can play a key role in response prioritization and Urban HEART should provide guidance emphasizing the importance of developing community ownership throughout the project;

7.2.2.4 Urban HEART should emphasize the importance of proper briefing and advocacy from the very beginning to create awareness that the selection of the best response should be guided by evidence and a set of predetermined criteria;

7.2.2.5 Urban HEART should also emphasize that people should look for locally adapted innovative solutions and not expect the tool to provide prescribed approaches.

7.3 Group work 3: Group III & IV questions and responses (experts)

7.3.1 *It may be possible to use <u>Health Impact Assessment (HIA)</u> to support prioritization and intervention selection. What would be the negative and positive aspects of using rapid-appraisal HIA for this purpose?*

7.3.1.1 Groups recognized that HIA is a valuable tool for selecting interventions. However, not all cities have the technical capacity to conduct HIA and its inclusion could complicate the Urban HEART process. In addition, Urban HEART already has criteria for selecting interventions that are comprehensive enough;

7.3.1.2 Other highlighted aspects of HIA that would make it difficult to integrate into Urban HEART were:

7.3.1.2.1 *HIA does not have a built-in equity focus;*
7.3.1.2.2 *HIA is not necessarily an appropriate tool to select the most suitable interventions;*
7.3.1.2.3 *Even Rapid Appraisal HIA is a lengthy process that requires a number of pre-requisites before it is performed;*
7.3.1.2.4 *Strategic HIA approaches could be considered as they focus on the assessment of plans and policy options.*

7.3.1.3 HIA could be linked in as an option available for cities. The Urban HEART manual can selectively highlight specific useful tips and approaches from HIA that could show how it can prioritize interventions.

7.3.2 *Can Urban HEART draw upon other already <u>existing tools to support the response</u> process? Which ones and how much guidance should be given in the Urban HEART?*

7.3.2.1 Instead of introducing new tools, Urban HEART can expand upon the already provided six criteria;

7.3.2.2 Other tools and methods that could be referred to were:

7.3.2.2.1 *UN HABITAT best practices data base;*
7.3.2.2.2 *Vignettes – provide the experiences cities went through in prioritizing their own interventions;*
7.3.2.2.3 *Multi-Criteria Decision Analysis;*

7.3.2.2.4   *Cost-benefit analysis;*

7.3.2.2.5   *Equity lens (developed in New Zealand);*

7.3.2.2.6   *Hanlon's method of prioritization.*

7.4 Group work 3: Group I to IV shared questions and responses

7.4.1 ***How can <u>community needs and opinions</u> be better taken into consideration during prioritization and intervention selection? What kind of guidance should WHO give in this regard?***

7.4.1.1 There is a need to go beyond the idea of community participation and encourage more community ownership of the planning process;

7.4.1.2 Encourage the use of questionnaires, focus groups, and other qualitative approaches to collect the opinions and concerns of the community;

7.4.1.3 Teams should be careful of acquiring a sample that has an equal representation of all the different population groups within an urban area;

7.4.1.4 Groups were not able to agree on the phase of Urban HEART that community participation would be the most effective. However, the tool encourages participation in all phases of Urban HEART;

7.4.1.5 All groups agreed that advocacy and education within the community should start at the beginning when building an inclusive team. This will increase the level of engagement and support by the local population;

7.4.1.6 A potential risk of participation in the selection phase, especially in the case where a certain minority group is most affected, was also flagged. Advantaged groups have better capacities to engage in participatory discussions and processes. When advantaged groups are in the majority in these processes, the most efficient solution to address inequity may not always be selected, especially if their impact is focused on only improving the situation of a minority population group;

7.4.1.7 A resource list of other methodologies (e.g. Participatory Rural/Rapid Appraisal) that encourage community participation should be provided.

7.4.2 ***How can the <u>"good practice" response strategies</u> in Annex VII of the Urban HEART Manual (p. 84) be improved?***

7.4.2.1 Annex VII of the Urban HEART User Manual was not commonly referred to by Urban HEART teams;

7.4.2.2 There is no need to create an all-encompassing guide book that goes into detail about how each intervention was executed. However, the list need to be reviewed from evidence on "what works, works better, in which contexts and how";

7.4.2.3 The manual should focus on a select number of case studies that can be further referenced in an electronic database. These examples can go into detailed descriptions of best practices, innovative responses, and the methods used to tackle different barriers, as well as provide contact information for easier communication within the Urban HEART community;

7.4.2.4 All case studies provided in the manual should be updated periodically, particularly with regards to the impacts each described interventions had on a city's health equity situation.

7.4.2.5 Users of Urban HEART should also record the impact of various responses that they undertake. The cost-effectiveness, or other measures of efficiency, of the impact of responses should also be indicated to users, where possible;

7.4.2.6 Participants concurred that examples of good responses should only be included in the electronic links of Urban HEART given the constant update on evidence for best practices;

7.4.3 ***What kind of guidance should Urban HEART provide to facilitate <u>self-monitoring and evaluation</u> in cities?***

7.4.3.1 The Monitor in Urban HEART could be adapted into a self-monitoring tool;

7.4.3.2 A basic monitoring template could be developed with a check list that highlights basic steps to take and key moments of evaluation;

7.4.3.3 It was suggested that monitoring can be handled by the appointed Urban HEART teams but an independent evaluation should be conducted by a third party;

7.4.3.4 The impact of other kinds of analyses, cost-benefit, and cost-effectiveness is not that clear. The focus should be on the impacts rather than costs. The priority should be outcome evaluation focused on who benefits from the interventions;

7.4.3.5 A simple method of monitoring that can be taken by teams is asking direct questions such as "were the responses adopted", and distal questions such as "is there a better understanding of health equity?", "has data-sharing improved?" etc.;

       7.4.3.6 WKC could include a short and easy reporting system for the city i.e. a way for the cities to report back to WKC on their Urban HEART experience to WHO or to the general public;

       7.4.3.7 However, Urban HEART need not provide elaborate guidance on monitoring and evaluation.

7.5 In the **plenary discussion** that followed a number of observations and suggestions were made;

    7.5.1 With respect to community participation, participants emphasized that additional tools should not be incorporated into the manual. However, there is a need for guidance that encourages community engagement at the beginning of implementation and explains the role the community can play during the entire process;

    7.5.2 There has not been enough emphasis on the dissemination of results back to the community. In order to increase health equity awareness within the local population, the evidence generated by Urban HEART needs to be presented back to the community;

    7.5.3 The manual can provide a resource list of other tools and strategies that will promote community participation and ownership;

    7.5.4 From experiences in Indore (India) allowing the community members to have a leading role in the Urban HEART teams increased community empowerment and motivated members to take action in areas that the authorities had not yet come to a consensus on;

    7.5.5 In the context of both Toronto and Tehran, community involvement was seen as most useful during equity analysis and intervention prioritization. In both cases, community members from different neighbourhoods were presented with a list of issues and interventions that they were asked to rank;

    7.5.6 WKC is strongly encouraged to provide an electronic link which holds a select number of case studies that describe, in detail, city experiences, methods of execution, best practices, etc.;

    7.5.7 There was considerable debate on whether Urban HEART should go into further detail about <u>how</u> to implement interventions;

       7.5.7.1 One of the participants' perspective was that Urban HEART was seen as a very good diagnostic measure but not good at explaining "how" to implement interventions:

7.5.7.1.1   *Outlining the "how" will provide cities with examples of possible barriers, methods of overcoming these issues, and who are important parties to involve;*

7.5.7.1.2   *An electronic data base could provide case studies that better explain how interventions were implemented*

7.5.7.2   However, city representatives from Iran, Africa, and the Philippines felt that Urban HEART's strength lay in the diagnostics and guidance for developing a plan. Urban HEART should not endeavour to become a "how to" tool since city authorities are better placed to do so within their local contexts:

7.5.7.2.1   *Participants from Africa and Iran stated that the tool does its best at giving cities the evidence they need to make decisions from an equity perspective and it is the city's responsibility to figure out the best ways to address the identified issues;*

7.5.7.2.2   *It was further noted by the Philippines representative that the interventions and their respective methods of implementation will be locally tailored to fit each individual city.*

7.5.8   Prioritized indicators do not need separate interventions, but should be addressed through integrated programs;

7.5.9   The manual needs to explain that Urban HEART teams should not necessarily start planning new projects or programmes but look into modifying pre-existing interventions i.e. equity needs to be integrated into day-to-day planning.

8. Scale-up and sustainability of Urban HEART

8.1 **One city presentation** by Dr Madeleine Ntetani-Nkoussou discussed the use of Urban HEART in Brazzaville, Congo;

8.2 Dr Madeleine Ntetani-Nkoussou noted that the teams struggled initially with acquiring the necessary funds, running campaigns in the community and gaining substantial support to build their teams;

8.3 In addition, Dr Madeleine Ntetani-Nkoussou stated that the assessment was conducted in selected districts of Brazzaville and not done for the entire city. This allowed teams to identify the major issues in previously established "disadvantaged" areas;

8.4 The teams in Brazzaville were satisfied with the final results of the tool and of the participative approach used to assess health equity. Urban HEART helped the city identify the four indicators

that required greater response, in particular around the provision of health services and prevention activities;

8.5 A final **plenary discussion** focused on methods of sustainability and scale-up as well as the overall key messages from the expert consultation meeting:

8.5.1 There were several comments made regarding the inclusion of case studies and the development of an electronic database:

8.5.1.1 There was a general consensus that there needs to be an easy and effective method for cities to communicate with each other and share experiences.   A method suggested by a number of representatives from the USA, Iran, Congo, and Australia was the development of a case study template for documenting and reporting the critical processes, issues, methods of implementation, and key outcomes of Urban HEART;

8.5.1.2 Participants from Kenya and Europe continued to endorse this idea by stating case studies should be stored in an online data base. This will further facilitate the sharing of best practices and different experiences as well as strengthen the communication within the Urban HEART community because of its easy online access (i.e. create a Urban HEART network);

8.5.1.3 Additional advantages of providing online access to case studies presented by participants were:

8.5.1.3.1 *Case studies can aid in strengthening support and advocacy for the tool by demonstrating the clear successes of a city;*
8.5.1.3.2 *The information can be utilized as an additional resource for new Urban HEART users by providing examples of methods that can be used in different socio-economic environments and potential solutions to common issues teams have encountered.*

8.5.1.4 However, it was noted by representatives from Africa, that if WKC provides a web database for case studies, the information will need to be updated regularly to ensure that all the information is relevant to the current global environment;

8.5.2 Urban HEART should provide indications on how it can be further incorporated in the existing strategies, development plans and programmes of local governments/ organizations/ institutions. It should be seen as a tool that can complement and help sustain ongoing activities;

8.5.3 It would be useful to articulate what success may look like. It should be clear to Urban HEART teams what it is they want to change. For example, movement in selected

indicators and closing of the equity gap is one possible outcome. Though, there are likely to be many other facets of success including disaggregation of data, creation of mechanisms to address health equity, sensitization of policy makers etc.;

8.5.4 Individuals from Iran and Kenya stated WKC should look into having master Urban HEART trainer(s) in each of the UN regions as well as in the implementing countries. However, it was noted by a representative from SEARO that if WKC looks into developing master trainers, they would also have to look into quality control and methods of reporting back to ensure that all trainer are within a specified standard;

8.5.5 It was unanimously agreed that there is a need to look into methods of enhancing the current level of advocacy and education in order to maintain/grow further support for the tool as well as increase awareness of the different concepts presented in Urban HEART;

8.5.6 Participants from Iran, Europe, and the Philippines stated that one possible method of advocating for Urban HEART within the scientific community is by publishing papers highlighting the key success and data in scientific journals;

8.5.7 According to a participant from Australia, the tool should emphasize links with other professional associations so that the tool is not completely health sector oriented;

8.5.8 In addition to professional associations, other participants stated that WKC should begin looking at the different roles that international organizations such as UN HABITAT can play in the Urban HEART implementation process and at what stage would they be the most effective;

8.5.9 Having a vignette of Urban HEART in every city and including the successes will improve advocacy and understanding of the tool. The issue of urban health is not always the responsibility of the MOH. Sometimes, this responsibility resides in the Ministry of Environment, Human Settlements, and Local Governments etc. Therefore, it is critical to always have urban planners, public administrators and professionals from other sectors always on board;

8.5.10 Sustainability of interventions and Urban HEART can come from encouraging community ownership: empower the community to take charge of their own issues based on the evidence produced by the tool;

8.5.11 It was stated by a representative from India, that while methods of sustainability need to be improved, it should not be done at the risk of increased costs to the local community and government;

8.5.12 A critical issue to be deliberated upon will be on how to make Urban HEART sustainable within a constantly changing political environment at the local and national levels;

8.5.13 The meeting was then concluded by delineating the next steps.

9. Next steps

9.1 Synthesize the results from the group work and plenary discussions;

9.2 Consult with meeting participants, city officials and experts on the final synthesis report;

9.3 Decide on a strategy of key stakeholder, city official, and expert engagement during the planning and writing process of the next Urban HEART;

9.4 Begin development of the next version of Urban HEART;

9.5 Review the revised areas with WHO officials, experts and city officials;

9.6 Finalize the next version of Urban HEART and related products in 2014-15.

KEY EXPECTED DELIVERABLES

- **Urban HEART version 2.0**;
- **Policy brief** advocating the use of Urban HEART;
- **Electronic version of Urban HEART 2.0:**
    - Interactive guidance e.g. users can construct Matrix and Monitor on the internet;
    - Platform for sharing information between cities;
    - Best practice database and references.
- **Vignettes** of Urban HEART achievements in cities;
- Brief **case study template** for cities**;**
- Publish study on **impact of Urban HEART.**

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10. Annex 1: List of Participants

Dr Siddharth Raj Agarwal, Executive Director, Urban Health Resource Centre, New Delhi, India

Dr Mohsen Asadi Lari, Director General, International Relation Department, Ministry of Health and Medical Education, Tehran, Iran

Ms Agnes Charlotte Bickart, Manager, International Relations and Training Institute Development Strategy, METROPOLIS The World Association of the Major Metropolises, Barcelona, Spain

Dr Carme Borrell, Chief of Service, Health Information Systems, Agència de Salut Pública de Barcelona, Barcelona, Spain

Dr Mohammadmehdi Golmakani, Directorate General, Office for Health, Health Department, Tehran Municipality, Tehran, Iran

Mr Ben Harris-Roxas, Senior Consultant, Urbis, Sydney, Australia

Dr Mohcine Hillali, Head of Service, Service of Ambulatory Care, Ministry of Health, Rabat, Morocco

Ms Jiang Fanxiao, Chief, Public Health Emergency Management Center, School of Public Health, Tianjin Medical University, Tianjin, China

Professor K. Srinath Reddy, President, Public Health Foundation of India, New Delhi, India

Professor Katsunori Kondo, Director, Centre for Well-Being and Society, Nihon Fukushi University, Nagoya, Japan

Dr Soewarta Kosen, Senior Researcher and Coordinator, Health Economics and Policy Analysis Unit - PHKKPM, National Institute of Health Research and Development, Ministry of Health, Jakarta, Indonesia

Ms Kelly Murphy, Staff Scientist and Manager, Knowledge Transfer and Partnerships, Li Ka Shing Knowledge Institute, Center for Research on Inner City Health, St. Michael's Hospital, Toronto, Canada

Dr Madeleine Ntetani-Nkoussou, Head, Department of Health Promotion, Directorate of Public Health and Health Promotion, Ministry of Health and Population, Brazzaville, Congo

Mr Ibrahim Basweti Nyasani, Senior Public Health Officer, Public Health, Ministry of Health, Nairobi, Kenya

Professor Toshiyuki Ojima, Department of Community Health and Preventive Medicine, Hamamatsu University School of Medicine, Hamamatsu, Japan

Dr Daniel Okello, Ag. Director, Directorate of Public Health and Environment, Kampala Capital City Authority, Kampala, Uganda

Professor Oyebanji Oyelaran-Oyeyinka, Director, Monitoring and Research Division, UN-HABITAT, Nairobi, Kenya

Dr Marilyn Rice, CEO, Marilyn E Rice Consulting International, Fairfax, VA, United States of America

Mr Jose Velandia, Urban HEART Project Coordinator and Health Services Assistant Manager, Hospital Pablo VI Bosa ESE I Nivel, Bogota, Colombia

Dr Arpana Verma, Senior Lecturer, Manchester Urban Collaboration on Health, Institute of Population Health, University of Manchester, Manchester, United Kingdom

Dr Olga Zerrudo Virtusio, City Department Head II, City Health Office, City Government of Paranaque, Paranaque, Philippines

WHO Regional Offices

Ms Hawa Senkoro, Technical officer, HPR/PHE, the WHO Regional Office for Africa, Libreville, Gabon

Dr Oscar Mujica, Advisor, Social Epidemiology, SDE, the WHO Regional Office for the Americas/Pan American Sanitary Bureau, Washington, D.C., United States of America

Dr Mohammad Assai, Coordinator, Integrated Service Delivery, the WHO Regional Office for the Eastern Mediterranean, Cairo, Egypt

Mr Matthias Braubach, Technical Officer, Housing/Urban Planning, the WHO European Centre for Environment and Health, Bonn Office, Bonn, Germany

Dr Suvajee Good, Health Education Specialist, SDE/HPE, the WHO Regional Office for the South-East Asia, New Delhi, India

Dr Anjana Bhushan, Technical Officer, DHS/HCF, the WHO Regional Office for the Western Pacific, Manila, Philippines

Mr Peni Veilave, Healthy Settings Coordinator, NCD, the WHO Regional Office for the Western Pacific, ACO/PIC, Suva, Fiji

WHO Kobe Centre (WKC)

Mr Alex Ross, Director

Mr Amit Prasad, Technical Officer, Urban Health (UH)

Dr Megumi Kano, Technical Officer, UH

Ms Suvi Huikuri, Technical Officer, UH

Ms Riikka Rantala, Technical Officer, UH

Ms Kendra Anne-Masako Dagg, Consultant, UH

Ms Stephanie Steels, Consultant, UH

Ms Meredith Knaak, Intern, UH

11.   Annex 2: Programme

Day ONE: Wednesday, 6 November 2013

0900 – 0915	Welcome remarks and meeting objectives	Alex Ross
0915 – 0945	Introduction of participants	
0945 – 1030	Global update on Urban HEART	Amit Prasad
	Q&A	
1030 – 1045	*Coffee break*	
1045 – 1200	City presentations on Urban HEART:	
	Parañaque City, PHILIPPINES	Olga Virtusio
	Tehran, IRAN	Mohsen Asadi-Lari
	Indore, INDIA	Siddharth Aggarwal
1200 – 1300	Plenary discussion	
1300 – 1400	*Lunch break*	
1400 – 1430	Synthesis of Urban HEART evaluation reports	Megumi Kano
	Q&A	
1430 – 1700	**Group work 1**: Review of urban health trends and concepts	
	Presentation: Introduction to group work 1	WHO Kobe Centre
	Group discussions	
	Coffee break	
	Group work 1 presentations	
1700 – 1745	Plenary discussion	
1745 – 1800	Closing remarks	

Day TWO: Thursday, 7 November 2013

0900 – 0915	Recap of Day One	Chair
0915 – 0945	City presentation on Urban HEART: Bogotá, COLOMBIA	Jose Velandia Rodríguez
	Q&A	

0945 – 1300	**Group work 2:** Review of indicators in Urban HEART	
	Presentation: Introduction to group work 2	WHO Kobe Centre
	Group discussions	
	Coffee break	
	Group work 2 presentations	
1300 – 1400	*Lunch break*	
1400 – 1500	Plenary discussion	
1500 – 1530	City presentation on Urban HEART: Toronto, CANADA	Kelly Murphy
	Q&A	
1530 – 1545	*Coffee break*	
1545 – 1745	**Group work 3:** Guidance for helping cities prioritize action	
	Presentation: Introduction to group work 3	WHO Kobe Centre
	Group discussions	
1745 – 1800	Closing remarks	

Day THREE: Friday, 8 November 2013

0900 – 0915	Recap of Day Two	Chair
0915 – 0945	Group work 3 presentations	
0945 – 1030	Plenary discussion	
1030 – 1045	*Coffee break*	
1045 – 1115	City presentation on Urban HEART: Brazzaville, CONGO	Madeleine Ntetani-Nkoussou
1115 – 1245	Plenary discussions	
	Presentation: Scale up and sustainability of Urban HEART	WHO Kobe Centre
	Strategies to scale up and increase awareness	
	Format of new version of Urban HEART	
1245 – 1300	Conclusions	