The regional workshop on urban health equity assessment and intersectoral response was held in New Delhi during 27–29 November 2012 as part of collaboration between WHO Kobe Centre and the WHO Regional Office for South-East Asia, to strengthen the capacities of the health sector, urban planners, municipalities, local government and relevant partners to assess and respond to health inequities in urban areas.

The Urban HEART (health equity and response tool) was introduced along with practical examples of local implementation from pilot sites. An integrative approach to respond to health inequities was drawn from intersectoral actions to address specific health, social, economic, environmental and human rights issues, using healthy cities as a positive umbrella to strategically engage multisectoral partners. The workshop has successfully increased the understanding, knowledge and capacity on Urban HEART and built a network of practitioners working for urban health.

This report is intended to be shared with the global network of urban health, Member States, UN agencies, and national counterparts working in the area of urban health in South-East Asia, including academia, nongovernmental organizations, mayors and local authorities.
Urban Health Equity Assessment and Intersectoral Responses

Report of the Regional Workshop
WHO Regional Office for South-East Asia, New Delhi, India
27–29 November 2012
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<td>Colombo Municipal Council</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic and Health Surveys</td>
</tr>
<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
</tr>
<tr>
<td>NMR</td>
<td>neonatal mortality rate</td>
</tr>
<tr>
<td>TB</td>
<td>tuberculosis</td>
</tr>
<tr>
<td>UHRC</td>
<td>Urban Health Resource Centre</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>Urban HEART</td>
<td>Urban Health Equity Assessment and Response Tool</td>
</tr>
<tr>
<td>USA</td>
<td>United States of America</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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1. Introduction

1.1 Background

The 28th Meeting of Ministers of Health of Countries of the South-East Asia Region in 2010, held in Bangkok, Thailand, resulted in the Bangkok Declaration on Urbanization and Health. The Declaration recommended Member States to tackle urbanization and health using multisectoral and so-called healthy city approaches. Intersectoral collaboration and an increased role of municipalities in ensuring infrastructures for health and promoting healthy cities are crucial. The World Health Organization (WHO) Regional Office for South East-Asia has called for support to facilitate the process and build capacity to establish suitable mechanisms to assess, monitor and evaluate the progress made to address health inequity in urban areas.

In October 2010, The Regional Consultation on Health of the Urban Poor was organized in Mumbai, India, to develop a strategic framework for improving health and health-care services for the urban poor. The framework called for recognition of health issues in urban areas, as well as health inequities resulting from social, economic and cultural factors. Recommendations were made for Member States to address social determinants of health in urban areas; establish mechanisms for ensuring health impact assessment of urban development projects; strengthen health information management and systems, including disaggregated information; increase capacity of planners, implementers at municipalities and local bodies, with integrated multisectoral initiatives for the urban poor; and improve the efficacy and effectiveness of interventions for the urban poor. Intersectoral collaboration and coordination is an important mechanism to advance actions to address health inequity in urban areas.

The WHO Regional Office for South-East Asia, in collaboration with the WHO Centre for Health Development (WHO Kobe Centre), provided technical support to address the issues, using the Urban Health Equity Assessment and Response Tool (Urban HEART). The tool has been widely implemented in other WHO regions, particularly in the Eastern
Mediterranean and Western Pacific Regions. In the South-East Asia Region, Urban HEART was piloted in two cities, namely Colombo, Sri Lanka and Jakarta, Indonesia, in 2009. In July and August 2011, the two pilot cities were evaluated and experiences in implementing the tool were documented and shared in this Regional Workshop on Urban Health Equity Assessment and Intersectoral Responses. The tool has recently been used in two selected cities in India, namely Indore and Bally, to investigate its adaptability in the South-Asian context. The study was completed in early 2012, with positive results. Based on the experience in the region and other cities across regions learning from the WHO Kobe Centre, participants could be encouraged to adopt and implement the tool to set targets for urban health issues and address health inequity in urban areas.

This workshop also facilitated the Member States to consider intersectoral actions to respond to the need of urban poor and address health inequity after implementation of Urban HEART. Experiences from a healthy city approach in selected countries showed promising intersectoral responses to addressing socioeconomic, cultural and environmental determinants of health. Member States exchanged their experiences for further implementation to address target groups in the urban areas, using identifiable mechanisms. The right to health in urban areas, and an integrated approach for urban health and equity, were introduced to strengthen the planning process. Coordination between health and urban development sectors was emphasized. The representatives from Member States drafted plans of actions to implement Urban HEART and address issues relating to the health of urban poor.

The agenda for the workshop is presented in Annex 1.

1.2 Participants

The workshop was attended by total of 47 participants (Annex 2), including 28 participants from 10 Member States, except India, and 5 temporary advisers from countries where pilot projects were carried out, namely India, Indonesia and Sri Lanka. The workshop drew interest from international agencies, namely the United Nations Children's Fund (UNICEF) and the United States Agency for International Development (USAID), and academics from the Indian Institute of Public Health attended the
workshop throughout. Nomination of participants from Member States was from the following categories:

- mayors of the capital cities;
- representatives of the municipality authority that is responsible for urban planning and development;
- programme managers/focal points for the so-called healthy city;
- health officers in municipalities, or health managers from the ministry of health with responsibility in the area(s) of social determinants of health, health promotion or urban health.

### 1.3 Objectives of the workshop

The objectives of the workshop were to strengthen capacity for health equity assessment and intersectoral collaboration in urban areas in the region.

The specific objectives included:

- to strengthen capacity of health managers, municipalities administrators and urban planners, to better understand the health determinants in urban areas;
- to introduce Urban HEART, with experiences from pilot cities and from other regions;
- to share country experiences in intersectoral collaboration, to address health inequity in an urban setting;
- to identify strategic, evidence-based priority interventions to address health inequities in urban areas.

### 2. Business session

#### 2.1 Inaugural session

The message of Dr Samlee Plianbangchang, WHO Regional Director for South-East Asia, was read out by Dr Athula Kahandaliyanage, Director, Department of Sustainable Development and Healthy Environment.
Distinguished participants, ladies and gentlemen,

It gives me great pleasure in welcoming you all to this important workshop and to convey greetings from the Regional Director, Dr Samlee Plianbangchang. Since Dr Samlee is unable to attend, I have the honour to deliver his message. I quote:

"As we all realize, the number of people living in cities is rapidly increasing and we will face one of the most challenging global issues in the 21st century. Globally, more than half of the population live in urban areas, and by 2050, the number will increase to seven out of ten. Among 1.6 billion people in South-East Asia, more than 500 million people live in urban areas and among them one quarter live in poverty.

One major reason for this rapid urbanization is rural to urban migration for better opportunities. Cities have a high concentration of opportunities and also include risks and hazards for health. Rapid and unplanned growth of cities has major social, political, economic and environmental implications. Unplanned urbanization leads to inequities in accessing health and social services among the urban population, particularly the poor and the vulnerable.

Member States and WHO-SEARO [the WHO Regional Office for South-East Asia] have been making great efforts in addressing health inequity and social determinants in different ways. The Bangkok Declaration on Urbanization and Health 2010\(^1\) recommended Member States to invest in pro-poor policies and increase capacity in all systems, to reduce the risk of health damage; to advocate to local government and municipalities to invest in health-promoting cities; and to work in collaboration with all other sectors and stakeholders to reduce or close the urban equity gap.

Commitments were reassured in the Regional Consultation on Health of the Urban Poor held in Mumbai, India, in October 2010, urging Member States to address social determinants of health in urban areas; strengthen health information management and systems, including disaggregated information; increase capacity of planners; and ensure implementers at municipalities and local bodies with integrated multisectoral initiative for the urban poor. We believe that these measures would help to reduce health inequity to a greater extent.
Similarly, the Regional Consultation on Intersectoral Actions for addressing Social Determinants of Health, held in New Delhi in August 2011, resulted in further calls for intersectoral actions addressing the health of vulnerable populations, with a whole-government approach and health in all polices at all levels. Using appropriate equity-measurement tools such as the Urban Health Equity Assessment and Response Tool (Urban HEART) developed by WHO, would strengthen the capacity of authorities and multisectoral partners to directly address equity matters with strategic priorities.

Ladies and gentlemen, I am pleased to inform you that two cities in the South-East Asia Region, namely Colombo in Sri Lanka and Jakarta in Indonesia, participated in developing the Urban HEART tool in 2009, as piloted sites among many cities around the world. Last year, we adopted the tool to be used in two cities, namely Indore in Madhya Pradesh State and Bally in West Bengal State in India, to investigate its effectiveness and feasibility in generating multisectoral response to address the needs of the urban poor in complex settings like those in India.

We have learnt from many cities around the globe that the health promotion approach is a primary intervention that addresses determinants of health at their roots, if implemented appropriately. The healthy city approach could be effectively used to address the health of urban populations, along with an equity and rights-based approach. We have a number of experiences in the region to be shared in this workshop, such as healthy cities in Bangalore, Bangkok, Delhi, Jakarta and Pyongyang and from other regions.

I believe that this workshop will provide an opportunity to share our country experiences, introduce existing tools, and initiate networks for future collaboration. Tools such as Urban HEART will be introduced in the workshop for Member States. Finally, we work together to develop the Regional Action Plan for Implementation of Urban HEART to tackle health inequity in urban dwellers.

WHO-SEARO is committed to mainstream health equity in urban settings. We need to lay emphasis on increasing the role of municipalities and local bodies in health equity assessment and investing in pro-poor policies. Healthy public policy and healthy cities should be promoted. We also need to reaffirm our commitments to holistic and multidisciplinary
approaches to bring equity in health outcomes and service delivery, especially focusing on urban health.

With great pleasure, I welcome all of you to this important Workshop on Urban Health Equity Assessment and Intersectoral Responses."

Dr Athula Kahandaliyanage concluded:

I shall, of course, apprise the Regional Director of the outcome of this workshop. I would also like to take this opportunity of wishing you all fruitful deliberations and an enjoyable stay in New Delhi.

2.2 Urban health matters and intersectoral actions

Dr Suvajee Good, Programme Coordinator for Health Promotion, Department of Sustainable Development and Healthy Environment, presented "Urban health matters and intersectoral actions", to set the tone of the meeting. It highlighted that the urban setting is a determinant of health that increasingly faces challenges from environmental degradation, growing inequity, heavy inflows of migrants, breakdowns in social support systems and networks, expanding metropolitan areas and the growth of informal settlements and slums.

The presentation demonstrated health inequity in urban areas in the South-East Asia Region. Disparities between urban rich and urban poor were revealed clearly in the status of maternal and child health. In India, only 54% of pregnant poor women had three antenatal care visits compared to 83% non-poor pregnant women in urban areas. Urban poor gave birth at health-care facilities 1.8 times less than urban non-poor. Only 51% of births were assisted by health-care personnel, compared to 84% in urban non-poor women. Regarding child health, in India, for example, the neonatal mortality rate, infant mortality rate, and under-five mortality rate was 34.9%, 54.6% and 72.7% in urban poor populations respectively in 2005-2006, compared to rates of 32.5%, 35.5% and 41.8% in urban non-poor populations.

The South-East Asia Strategic Framework for Improving the Health of the Urban Poor\(^3\), developed in the Regional Consultation on Health of the Urban Poor held in Mumbai, India in October 2010, was presented (see
Additional components to be integrated in the frameworks are included, namely the healthy city approach, health impact assessment, and urban health equity assessment. It was discussed that community education and empowerment, intersectoral cooperation, promotion of a healthy city approach, and development of an information system for improved health status and equity are needed.

In the South-East Asia Region, some cities have responded to the health needs of the urban poor and addressed urban health inequity through primary health care, development projects, health promotion programmes, and intersectoral collaboration and governance. However, very few of the cities have used Urban HEART, which could provide more systematic response with evidence-based participatory planning.

In combination with the commitment made on social determinants of health, the Regional Strategic Framework on Intersectoral Actions Addressing Social Determinants of Health was developed in the regional consultation, held at the WHO Regional Office for South-East Asia, New Delhi in August 2011. The Member States, civil society, academia, development partners, private sector, other relevant stakeholders and WHO were urged to take intersectoral actions and steps to address not only immediate determinants but also broader determinants of health, such as to tackle health inequities through political commitment; mainstream health equity in all policies; develop national strategies and plans of action to address health and social inequities; and establish national institutional mechanisms to coordinate and manage intersectoral action for health. Lesson learnt from past experiences were shared.

Figure 1: South-East Asia Strategic Framework for Improving the Health of the Urban Poor (3)
The presentation concluded that, to address complex health issues in urban areas, there is a need for multisectoral involvement; leadership from local government (e.g. municipality) and the ministry of health; coordination and support from other relevant sectors; and clear urban health policies and mechanisms. Urban HEART is a tool that can facilitate intersectoral/multisectoral involvement, from the start of planning to implementation and evaluation, with a systematic response to the needs.

2.3 Situation analysis on health inequity in selected cities

Participants presented situation analyses of health inequity in their respective countries, using existing information and data from selected cities. Presentations demonstrated key areas of health concerns and changes over a period of time. Mayors and health authorities from different cities also shared their first-hand experiences in addressing the determinants of health within their respective roles and responsibilities.

Kathmandu, Nepal

As presented by Department Chief of Public Health and Social Welfare, Kathmandu Metropolitan City, Nepal is a country with 17% urban population and more than 9% urban population growth annually, and is expected to reach an urban population of 15 million by 2035. Kathmandu Metropolitan City is the administrative, economic and cultural centre, with a population of approximately 1.5 million, accommodated in 35 wards. Thirty-one per cent of the total population, and 25.2% of the total urban population, lives below the poverty line. Among this 25.2% urban poor, the slum population is 60.7% and 7% are urban squatters.

Squatters' settlements, which are unorganized and densely populated, were established 50 years ago. Their population increased from 17% in 1985 to 45% in 2008. Squatters are often members of an unregistered population, without proof of origin, migration certificate, or land ownership. Unlike residents of squatter settlements, the residents of slums (see Figure 2) generally own their land and house and have formal title papers (lalpurja) to prove this (see Table 1).
Table 1: Slum and squatters' settlements in Kathmandu Valley (presented by Kathmandu Metropolitan City)

<table>
<thead>
<tr>
<th>Type of residence</th>
<th>Number of households</th>
<th>Total population</th>
<th>Average household size</th>
<th>% of households without piped water supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slums</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bhaktapur Municipality</td>
<td>754</td>
<td>3 274</td>
<td>4.34</td>
<td>32</td>
</tr>
<tr>
<td>Madhyapur Municipality</td>
<td>382</td>
<td>1 981</td>
<td>5.19</td>
<td>85</td>
</tr>
<tr>
<td>Lalitpur sub-Metropolitan City</td>
<td>391</td>
<td>1 866</td>
<td>4.77</td>
<td>62</td>
</tr>
<tr>
<td>Kathmandhu Metropolitan City</td>
<td>3 784</td>
<td>16 575</td>
<td>4.38</td>
<td>58</td>
</tr>
<tr>
<td>Kirtipur Municipality</td>
<td>1 674</td>
<td>7 767</td>
<td>4.64</td>
<td>64</td>
</tr>
<tr>
<td>Squatters</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kathmandhu Metropolitan City</td>
<td>1 861</td>
<td>8 774</td>
<td>4.71</td>
<td>95</td>
</tr>
<tr>
<td>Total</td>
<td>8 846</td>
<td>40 237</td>
<td>4.5</td>
<td>21.98</td>
</tr>
</tbody>
</table>

The key issues and challenges of urban areas in Nepal were presented: 46.3% of urban households have no piped drinking water facilities; 45.6% of households of urban areas have no proper sanitary system and 55% have a poor garbage disposal system.

Figure 2: Slum area in Kathmandu city

(Contributed by Kathmandu Metropolitan City)

The Urban Health Policy has recently been developed, but has yet to be finalized. However, it was presented that the roles and responsibilities of the Ministry of Health and Population, Ministry of Urban Development,
Ministry of Local Development, Municipality, and District Public Health Office were unclear, particularly on the coordination mechanisms. Urban health clinics were mostly operated with limited resources, space, time and services. Urban poor often relied on self-medicated pharmacies, because the cost of private clinics was unaffordable.

Jakarta, Indonesia

In 2010, the population of Indonesia reached 237.6 million and it became the fourth most highly populated country after China, India and the United State of America. The annual population growth, according to the census conducted in 2000-2010, was 1.49% per year, with an estimated increase of 3.5 million per year. This means that 52% of the total population in Indonesia lived in an urban area in 2010 and this is estimated to increase to 65% by 2025. Most of the urban populations are living in the capital of provinces and municipalities such as Bandung, Denpasar, Jakarta, Makassar, Medan, Semarang, Surabaya, Yogyakarta and other cities in outer Java islands.

In 1998, Indonesia launched healthy city programmes in six cities. Policies were developed for implementation of healthy city programmes, such as The Joint Ministerial Decree between the Ministry of Health and the Ministry of Home Affairs. Guidelines on administration of a healthy district/city were developed in 2005. Since then, the Government of Indonesia has been giving awards for cities and districts that have fulfilled the healthy city indicators.

In the area of improving health equity, the Government of Indonesia uses an existing mechanism called the Desa Siaga or Alert Village programme that empowers the community to live a healthy life, particularly by encouraging them to adopt healthy behaviour through various activities tailored to their needs. The government set up a Special Operational Fund (called BOK, abbreviated from Bahasa), Special Allocation Budget (called DAK, abbreviated from Bahasa), and the National Health Security Programme for strengthening the role of primary health centres, providing health insurance for the poor, and providing services for safe deliveries, including provision of free medical treatments at public health centres and hospitals.
In order to increase the accessibility of education and the quality of life of the poor communities, the government introduced the Hope Family Programme and Cash Direct Facility. The Ministry of Health has made an agreement with 19 community-based organizations and 29 private-sector organizations to accelerate health programmes for improving maternal and child health, reducing communicable disease and controlling noncommunicable diseases.

In order to reduce social inequality in Jakarta, policies such as free education at primary and secondary school and free basic health services were implemented. The local government of Jakarta city also introduced smoke-free areas and a car-free day programme in certain areas. The public transportation facility was improved.

The presentation clearly showed that health equity could be achieved when there was a fair distribution of resources by the government. Commitment from the local governments played an important role for improving health equity.

**Colombo, Sri Lanka**

A representative of Sri Lanka presented that the average population growth rate in Sri Lanka is 0.4% annually. The 2001 census showed that Colombo is a city with 642,020 people. The major health concerns in Colombo include inadequate access to improved water and sanitation, high population density, low literacy rate, high unemployment rate, high number of alcohol outlets, high incidence of road traffic accidents, low measles vaccine coverage, high rate of teenage pregnancies, and anaemia among pregnant mothers.

In response to these health issues, the Colombo Municipal Council has adopted five strategic actions:

1. incorporate health in the priority of urban development;
2. emphasize and strengthen the role of urban primary health care;
3. strengthen the health equity focus in urban settings;
4. put health equity in the priority agenda of local governments;
5. pursue a national agenda for healthy urbanization.
The presentation highlighted the intersectoral collaboration among government agencies and actions taken by the Colombo Municipal Council, such as urban development; national housing, water and drainage; and public administration for improvement of waste supply, sanitation, drainage and roads. The council has established new health centres such as New Bazaar Maternity Homes and dispensaries around the cities. There have been various programmes conducted for improvement of health services, such as the Vision 2020 programme, filariasis night blood filming programme, and improved laboratory testing facilities for the urban poor. Colombo also introduced the Suwa Diviya (Healthy Living) programme for the urban poor, a dengue fever prevention programme, and a child resource centre for urban poor children and teenagers.

**Bangkok, Thailand**

Bangkok is located on the Chao Phraya River basin, which is the largest basin in Thailand, covering an area of 1568 km² (50 districts). The city is the centre of economy, society and administration, with 5 669 979 inhabitants. Moreover, including the commuters from surrounding neighbouring provinces, the city serves around 9 million people. Average personal income is 11 829 baht/month (US$ 390), while the income of poor people is less than 2135 baht/month (US$ 70).

The Bangkok Metropolitan Administration has collaborated with the National Health Security Office and other government and private hospitals to provide health services in Bangkok. It has 27 302 beds for inpatients and 68 public health centres to provide primary care for people, including the poor.

The presentation highlighted the health statistics of people living in Bangkok as listed below. The data were collected from the National Statistic Office Surveys 2010 and health information from the Ministry of Public Health.

- Infant mortality rate is 7.1 per 1000 live births.
- Diabetes prevalence is 9100 cases per 100 000 population.
- Diabetes mortality is 8700 deaths from diabetes per 100 000 population.
- The tuberculosis (TB) detection rate is 64.62%.
- The TB cure rate is 76.82%.
- TB prevalence is 74.99 cases per 100 000 population.
- TB mortality is 7.4 deaths per 100 000 population.
- The road traffic death rate is 4.1 deaths per 100 000 population.
- Health insurance coverage is 94.5%.
- The smoking population aged over 15 years is 15.43%.
- Access to safe water is 94.3%.
- The proportion of households that have a toilet is 98.7%.
- Gross intake and the percentage to the last grade of primary education is 84%.
- The proportion of children who are fully immunized is 87.2%.
- The proportion of the population that is unemployed is 0.4%.

**Phanat Nikom Town Municipality, Thailand**

Phanat Nikom Town Municipality is located in Chonburi Province, 87 km from Bangkok, in the eastern part of Thailand, and has an area of 2.67 km$^2$. There is a population of 11 204 (5091 males, 6113 females).

The Mayor of Phanat Nikom presented that the most vulnerable populations in the urban area were newborn children, pregnant women and elderly people. Major health problems are hypertension, diabetes, TB, etc. The health services in the municipality are provided by one district hospital with 140 beds, and 18 private medical clinics. The incidence of hypertension and diabetes is an increasing trend, as highlighted in the presentation (see Table 2).
Table 2: Situation analysis of hypertension and diabetes in Phanat Nikom Town Municipality

<table>
<thead>
<tr>
<th>Year</th>
<th>Hypertension</th>
<th>Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Primary</td>
<td>Pure hypercholesterolaemia</td>
</tr>
<tr>
<td>2011</td>
<td>2 690</td>
<td>235</td>
</tr>
<tr>
<td>2012</td>
<td>2 712</td>
<td>212</td>
</tr>
</tbody>
</table>

Phanat Nikom Municipality is part of industrial areas of Eastern Sea Board where numbers of industrial workers recided. The Mayor of Phanat Nikom showed that the number of smoking and TB increased from 2011 to 2012 (see Table 3). The data collected in 2012 included migrant workers in the area. It showed that with rigorous survey, the Mayor could understand the situation and address them appropriately.

Table 3: Situation analysis of smoking and TB in Phanat Nikom Town Municipality

<table>
<thead>
<tr>
<th>Year</th>
<th>Smoking behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Smoking</td>
</tr>
<tr>
<td>2011</td>
<td>306</td>
</tr>
<tr>
<td>2012</td>
<td>543</td>
</tr>
</tbody>
</table>

The Mayor presented that there existed a health inequity between the urban poor and general urban population. The Phanat Nikom Municipality has adopted three strategies to overcome the health equity gap:

1. prevention and control of communicable and noncommunicable diseases;
2. ensuring improvement for better quality of life through provision of health facilities in communities and in low-income settlements;
3. promotion of people participation in activities and programmes related to the environment and a self-sufficiency economy.

From the experiences of countries in the South-East Asia Region, health inequity seems to exist in every city presented, despite rigorous data analysis on health status and living conditions between the rich and the poor in urban areas. Out-of-pocket payment and other indicators
demonstrating disparities of health outcomes were rarely identified. During the discussion, most of the cities’ representatives agreed that there is limited availability of data on health and determinants of health, which had not been used to analyse health inequity systematically. Thus, introduction of Urban HEART was valuable and practical for the participants to be able to take back to their respective countries.

2.4 Introducing Urban HEART and practices

Technical Officer, Mr Amit Prasad from the WHO Kobe Centre and HPE provided introduction and practical guidance for using Urban HEART. Urban HEART is considered globally to be a decision-support tool to identify and reduce health inequities in urban areas. It enables local authorities, communities, programme managers and municipal and national authorities: to better understand the distribution of health determinants and unequal health risks and disparities in health outcomes faced by people belonging to different socioeconomic groups within a city (or across cities); to use evidence when advocating and planning health equity interventions; to design and participate in intersectoral collaborative actions addressing inequity; and to apply a health equity lens in policy-making and decision-making for resource allocation.

The three pillars of Urban HEART, namely intersectoral action, community participation and sound evidence, were discussed. The ultimate goal is to integrate the Urban HEART process into the local government planning cycle (see Figure 3).

Figure 3: Urban HEART planning cycle
The presentation discussed the steps involved in implementation of Urban HEART. These include:

- Step 1: build an inclusive team;
- Step 2: define the local indicator set and benchmarks;
- Step 3: assemble relevant and valid data;
- Step 4: generate evidence;
- Step 5: assess and prioritize the health equity gaps and gradients;
- Step 6: identify the best responses.

After each step, participants were assigned into groups and practised the step with a guided tool for each one.

**Step 1: build an inclusive team**

Urban HEART requires (and fosters) strong coordination among diverse policy sectors, levels of government and communities, to address health inequities. Team building may be the most time-consuming step in the process, but the most important step is to identify the right stakeholders. Creating an inclusive team sets the foundation for the productive implementation of Urban HEART.

**Group work 1: stakeholder analysis and building an inclusive team**

The participants were asked to build the longest structure they could, using the provided materials, within 15 minutes. The aim of this group work is for participants to experience the elements necessary to build a successful Urban HEART team. By the end of the group work, the participants realized that it is essential to use all available resources and to understand the common goal of the Urban HEART team.

**Step 2: define the local indicator set and benchmarks and Step 3: assemble relevant and valid data**

The workshop presented a number of examples of predefined sets of indicators in the Urban HEART manual that stakeholders can select to
measure health inequity among different groups of populations or localities within a city or different cities. Local indicators could be presented in a different set of issues or within a core indicator. Clusters of indicators reveal areas of health inequities that persist within population groups or geographical areas. The stakeholders can analyse where the inequity exists and to what extent. It is important to note that the process suggests optimal use of existing data available in a locality. In cases where there are no data, rapid assessment from local survey, observations, and focus group interview could be employed. Core indicators presented in the Urban HEART manual provide important cues for health equity-lens analysis and assemble relevant data that facilitate decision-making.

**Group work 2: identifying the local indicator set and data sources**

The participants from each country worked together to identify the key indicator set and the possible sources of quality and disaggregated data. The participants were able to identify the key core indicators and optional indicators of Urban HEART.

**Step 3: generate evidence**

The purpose of step 4 is to generate the evidence. This step involves generating the urban health matrix and equity monitor chart, which was explained to the participants. The matrix and monitor chart reveal the types of health equity problems that are most and least pronounced in a city, and who is the most and the least affected. The urban health matrix is the beginning of the Urban HEART assessment phase. The equity monitor chart shows equity trends over a period of time.

**Group work 3: constructing a matrix and monitor based on provided data**

The group worked together to generate an urban health matrix and equity monitor chart from the sample data. Members of the team developed a better understanding of how to produce the matrix and monitor. The participants were able to analyse the matrix and monitor and understand what the charts/graphs revealed about health inequities within or between cities/regions.
**Step 4: assess and prioritize the health equity gaps and gradients**

It was discussed with the participants how to raise awareness of the equity gaps and to prioritize the problems that require actions. From the experience, this process is important to involve policy-makers and stakeholders in setting the Urban HEART committee. The committee would function as a core group to support priority-setting, which should be done in participatory workshops and meetings with stakeholders. The committee may rank the order of equity priorities provided by stakeholders, with planning for greater support across groups.

**Group work 4: prioritizing health equity issues**

The participants were divided into four groups and they practised prioritizing the health equity issues on the sample data and matrix provided. The participants were able to identify and prioritize the health inequity effectively, using the matrix.

**Step 5: identify the best responses**

The purpose of step 6 is to produce clear and strong recommendations about what governments and communities need to do to reduce the priority areas of health inequities identified in step 5. Each group presented items of evidence that required immediate action, and also demonstrated the relevance, effectiveness and feasibility of the proposed responses to assumed policy-makers. The exercise provided participants with skills to build their case for policy-makers, and to demonstrate the importance of the responses required, using support and back-up from relevant sectors, stakeholders, communities and champions, to tackle health and social inequities.

**Group work 5: identifying the best responses**

The participants worked in the assigned groups and practised using the recommended criteria for selecting the best responses for the given health equity problems listed in the Urban HEART manual. The participants produced clear and strong evidence for governments and communities to reduce the priority areas of inequities uncovered through Urban HEART.
Group work 6: pitching the response to local authorities

Finally, the four groups practised presenting their proposal for improving health equity in their cities to their mayors. They presented their findings and the recommendations revealed through Urban HEART. The groups gained insight on improving the strategies for approaching a mayor or local authority with evidence such as from Urban HEART.

Recap: Urban HEART "Jeopardy"

At the end of the workshop, Mr Amit Prasad led the participants to take part in a quiz about the knowledge and skills learnt from Urban HEART, to examine their understanding of the tool. The quiz ("Jeopardy") was participatory and enabled all participants to engage in team work. All the participants performed well.

2.5 Experiences applying Urban HEART in selected cities

The workshop demonstrated lessons learnt and experiences from selected cities in Indonesia and Sri Lanka that have implemented Urban HEART and been evaluated.

Jakarta, Indonesia

In 2010, Urban HEART was tried out in three pilot sites in Indonesia, namely the city of North Jakarta (Jakarta Special Province), city of West Jakarta, and city of Denpasar (in Bali Province) (see Table 4). In each site, Urban HEART was implemented by the healthy city committee, composed of government officials from the city and ministry of health.

The community-based data collected by the National Institute of Health Research and Development - NIHRD (Riskesdas) was mainly used to ensure the quality of data, combined with information from focus group discussions. The disaggregation data by socioeconomic status, geographical area and sex were collected, determining health inequities among various population groups. Health determinants and health outcomes were used to generate the matrix. The project followed the agreed indicators from Urban HEART guidelines, which the committee found to be very useful.
### Table 4: Urban HEART pilot areas: general characteristics of pilot cities

<table>
<thead>
<tr>
<th>Variables</th>
<th>North Jakarta</th>
<th>West Jakarta</th>
<th>Denpasar, Bali Province</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>1,471,663</td>
<td>2,221,243</td>
<td>671,035</td>
</tr>
<tr>
<td>Density (per km²)</td>
<td>10,349</td>
<td>17,608</td>
<td>5,251</td>
</tr>
<tr>
<td>Subdistricts</td>
<td>6</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Hospitals</td>
<td>17</td>
<td>21</td>
<td>18</td>
</tr>
<tr>
<td>Health centres</td>
<td>49</td>
<td>75</td>
<td>11</td>
</tr>
<tr>
<td>Villages</td>
<td>31</td>
<td>56</td>
<td>43</td>
</tr>
</tbody>
</table>

Source: Dr. H. Riza Falepi, Mayor of Paykumbuh, West Sumatara, Indonesia

The health equity gaps were identified by assessing different indicators for health outcomes and health determinants. During the implementation, few new interventions were provided besides regular health services organized by government, such as free health services for the poor in all pilot cities. Local specific initiatives, such as sanitation and sewerage improvement; community latrine and water; provision of a communal septic tank for latrine; kampong/village improvement; and nutrition were provided during the implementation in West Jakarta. A few local initiatives were found in North Jakarta, such as green environmental activities, recycling of plastic garbage, Village Woman Working Group (PKK), and an activity called "Bank of Garbage with Care Initiative", where people turn their garbage in for recycling. In Denpasar, stakeholders in the city developed integrated community sanitation and garbage management, along with a garbage-recycling project, healthy housing and an environment-improvement project.

The lessons learnt through the pilot were shared with the participants. The pilot sites had positive experiences and gained benefit from the Urban HEART project, triggering actions for decision-makers to improve public policies ensuring health and equality in the cities. The project also opened up opportunities to improve intersectoral collaboration among different authorities and communities, to address health inequities and social determinants.

Some challenges were identified, such as harmonizing the response and coordination for intersectoral professionals to respond to act on health
and inequity together. The local government and many cities did not have readily available data to be used as evidence; thus, some investment for survey and assessments was needed. The evaluation team recommended that national and subnational commitments for improving urban health using this tool were needed. Improvement of intersectoral collaboration for the sustainability of the programme was also recommended.

Colombo, Sri Lanka

The Urban HEART pilot application in Sri Lanka was carried out in the Colombo Municipal Council (CMC) in Sri Lanka, from 2008 to 2010. It was implemented through discussions with the Chief Medical Officer of Health of the CMC, who was the project director. The council also set up a team of technical experts and a project coordinator. Urban HEART was implemented in the six areas under CMC and covered the entire population of 650,000 in Colombo. The pilot sites adopted the whole package of Urban HEART - both the assessment and response components. The results of implementation reveal systematic information and evidence on health inequity in urban areas.

From the Sri Lanka experience, an important lesson learnt is that the intersectoral collaboration among various departments made the project a success, namely the Ministry of Health; CMC; the Ministries of Labour, Water Supply and Sanitation, Census and Statistics; the Police; and National Housing and Urban Development Authorities.

The availability of existing data was an advantage for the project. CMC routinely generated data on some specific diseases and on social determinants of health indicators. Data from other sectors were utilized. However, the quality, validity and reliability, timeliness, access, and coverage were questionable.

CMC utilized the assessment to identify health and other equity gaps to be addressed by different sectors. The response strategies identified by CMC to address equity gaps included incorporating health in urban planning and development; emphasizing and strengthening the role of urban primary health care; strengthening the health equity focus in urban settings; putting health equity higher on the agenda of local governments; and pursuing urban health as a national agenda.
The recommendations for improving and scaling up the implementation of Urban HEART were presented. These recommendations included identifying mechanisms to institutionalize the application of Urban HEART; establishing a system to regularly implement Urban HEART with inclusive intersectoral participation; utilizing Urban HEART in policy-making, programme planning, implementation and financial allocation within the bodies/statutory committees of the city administrations; making appropriate improvement in responses; and supporting rigorous data generation, storage and retrieval, ensuring quality and timeliness, and establishing electronic databases that would ease the implementation of Urban HEART.

**Indore and Bally, India**

The WHO Regional Office for South-East Asia commissioned the Urban Health Resource Centre (UHRC) during 2011 to pilot Urban HEART in selected cities in India, namely Indore (Madhya Pradesh) and Bally (West Bengal). The first challenge found during implementation was the lack of availability of data in the cities or wards. UHRC adapted the tool using focus group discussions and key informants to analyse the situation and generate reliable evidence. Stakeholders' meetings were used to understand substantial evidence on health inequities and the sense of unfairness that could be found across different wards of the city. In Indore, the evidence was collected from community participation in focus group interviews and rapid assessment with community organizations and local authorities in slum areas.

UHRC presented the experience using Urban HEART as an important tool to map the health inequities at city level, such as in Bally and across different communities in Indore. UHRC found that the response phase of the implementation is the most crucial in finding the right interventions to reduce health inequities in different settings. The Municipality of Bally had been playing important roles in facilitating the implementation process of Urban HEART and coordinating with multisectoral stakeholders (including elected representatives of state governments, departments and nongovernmental organizations [NGOs]). The multisectoral stakeholders were engaged in providing important responses, namely on health services, improvement of hygiene, sanitation, housing programmes, and nutrition, across a population of 300,000 in 35 wards and 135 slums in Bally city.
Implementation of Urban HEART in Indore city was adapted to the setting of slums/neighbourhoods, with simplified methodology designed for people with low literacy. The Urban HEART adaptation was carried out in 12 slums (approximately 23,000 people) and with a federation of 37 women's groups.

The knowledge of slum-level community organizations working towards betterment of their neighbours was used for planning context-responsive interventions to reduce health inequities in the ward. Core indicators and indicators adapted to local context were compared across different groups. It was found that qualitative methods and community participation were very useful when there were no existing data available. Using local knowledge from diverse groups of stakeholders was vital for making an explicit account of health and social inequity. Spatial maps of the areas served as an effective visual tool, with potential adaptation to other issues that concern communities. The spatial maps also facilitate demarcation of areas of responsibility by ward and city authorities. Adaptation of Urban HEART to assess slums and neighbourhoods proved to produce valuable results, particularly when it operated through consultation with stakeholders, using local knowledge. It was found to be an inexpensive tool and approach that, in return, created a sense of responsibility, ownership and commitment among organizations.

**Experiences of a longitudinal study on the causes of urban mortality in countries/cities of the South-East Asia Region**

WHO Regional Office for South-East Asia, in collaboration with the WHO Kobe Centre, commissioned a longitudinal study on the causes of urban mortality, with a focus on noncommunicable diseases, and aiming to identify the information gaps with health equity concerns. Professor Aggrawal presented that a few countries with significant urban population were selected for the study, using variety of data sources including web search (e-journals, health project reports, Demographic and Health Surveys (DHS), city health directories, disease registries); the WHO Global Health Observatory and Medline search engine were explored for this purpose.

The researchers found that longitudinal, time-series, consistent data at both aggregate and disaggregate levels were not available for most countries. Researchers had to use different methodologies, with limited
data sources, both published and unpublished, which restricted comparability. It was difficult to find meaningful trends on identifiable social gradients. An urban health information system including monitoring and surveillance is almost non-existent for scientific policy interventions.

However, with limited data sources, the researcher was able to find that, among the urban poor, noncommunicable diseases are on the rise, when compared with communicable diseases. Noncommunicable diseases, including injuries, contributed about two thirds of the total mortality and disease burden with disability-adjusted life-years for the whole region. Cancers, accidents, acute respiratory infections, diabetes and hypertension occupy major ranks, with a rising trend in the disease incidence and mortality across all countries. Since longitudinal data were not available, the trends are indicative only. Increasing mortality is attributed to behavioural risk factors, including tobacco smoking, alcohol consumption, eating insufficient amount of fruits and vegetables, and low physical activity.

The presentation finally recommended that an urban health information system needs to be put in place. The system needs to include information from the national network of chronic disease registries, networking of government and private hospitals, and surveillance of noncommunicable diseases through governmental health departments and academic institutions. With leadership and collaboration, between WHO Regional Office for South-East Asia and the WHO Kobe Centre, an urban health system framework could be developed, and WHO collaborating centres on urban health research could be established to support countries of the South-East Asia Region to carry out meaningful implementation of urban HEART and interventions for the health of urban poor.

2.6 Implementation of a healthy city approach to address health inequity

Delhi

Sulabh International Academy of Environmental Sanitation and Public Health (SIAESPH), with the support of the WHO Country Office for India, implemented the "Delhi Healthy Urban Project (DHUP)" as a pilot project for Delhi. Mr Acheintya Kumar Sen Gupta, the Director of SIAESPH, presented the experience from DHUP. The objective of DHUP was to
demonstrate a holistic approach in the overall perspective of promoting Delhi as a so-called healthy city, with adequate provision of safe water, basic sanitation and improved health and hygiene practices through appropriate policy changes, knowledge-sharing and capacity-building.

This project covered a population of 90 000 population in nine districts of Delhi, for developing these localities into so-called healthy settings, wherein the citizens recognize the physical, mental, social and spiritual nature of health and work together to create conditions that promote healthy living and make their community better for themselves.

The methodology adopted by Sulabh is "project based and setting specific", mainly aimed at improving the overall health and environmental conditions of the settings in an integrated manner. This approach would result in development of a "healthy community" that generates leadership; shapes its future; embraces diversity; connects people and resources; fosters a sense of self-reliance; and creates an ongoing dialogue for its well-being, thus reducing health inequity in the communities.

The major findings of the project include: improvement of urban households and public toilets (see Figure 4); cleanliness of roads and drains; better waste management; increased awareness of physical activities; improved personal hygiene; reduced consumption of tobacco and junk food; increased attendance for vaccination programmes; and better control of pollution and road safety.

*Figure 4: Sulabh toilet complex and cleaning of the toilet by schoolchildren as part of DHUP*

*Source: contributed by Mr. Achintya Kumar Sen Gupta, Director-General, SIAESPH*
Finally, the presentation concluded that the DHUP project contributed to a new paradigm shift in the overall governance process for promoting sustainable city development. Health becomes an integral component of city planning by involving innovative strategies for settlement management and development, with an equitable economy, environment and social values for the sustainable development of a healthy city.

**Bangkok Metropolitan Administration**

The Bangkok Metropolitan Administration (BMA) has implemented several projects and activities that have contributed to improving the health and quality of life of populations in Bangkok. In 2009, it implemented the strategic plan on health development of residents of Bangkok, called the "Healthy Bangkok Plan". The plan included strategies such as sheltered and social development and eradication of poverty; economic development; environmental management; and governance. Dr Sunthorn Sunthornchart, Director of the Office of Public Health System Development, BMA, presented that the plan has enabled better understanding of the situation, through research where BMA analyses people's lifestyles and major health impacts on city life, in order to better manage a healthy city that is suitable for people's ways of life.

Actions taken by BMA include the assessment of public health impacts from development projects; inspections and monitoring of waste water management from industries and workplaces; and advocacy for urban health across public sectors, industries and the community. The Bangkok Clean and Green Project addressed health issues, with the aim to make Bangkok free from diseases, reduce the risk of contagious disease, decrease environmental pollution, and improve transport infrastructure, to enhance urban quality of life.

BMA has ensured health coverage of all urban populations, particularly by increasing access to health services for the urban poor by increasing capacity and infrastructure for health service deliveries. Currently, BMA has eight hospitals and 68 public health centres in 50 districts, with several health volunteers, family doctors and nurses. BMA also established Bang Khunthain Elderly Hospital, to ensure the ageing population, particularly those with no family members or without social support, can have access to hospital care. The presentation concluded that
collaboration among all sectors and stakeholders to reduce the health equity gap was the most crucial and the partnership need to be sustained.

**Phanat Nikom Town Municipality, Thailand**

Mr Vijai Amaralikit, Mayor of Phanat Nikom Town Municipality, Chonburi Province, presented that the healthy city approach had been very useful for the city administration to develop a multisectoral collaborative framework (see Figure 5). The vision of Phanat Nikom Town Municipality is "Better health and environment, peaceful society, conspicuous of tradition-art-culture-education, toward healthy city ". The presentation shared the approaches adopted in Thailand, such as capacity-building, good governance, participation, and financial management. The major stakeholders involved in the healthy city approach were the National Health Security Organization, provincial and district hospitals, 10 communities and four municipal schools.

![Figure 5: The healthy city approach in Phanat Nikom Town Municipality, Thailand](image)

The activities and outcomes of this approach were: prevention and control of epidemic diseases such as control of avian influenza in 2009, by distributing hand-cleaning gel and increasing knowledge and practices to avoid viral infection; prevention of noncommunicable diseases, by screening diabetes and high blood pressure, eye check-ups to prevent cataract for elderly people, screening for cervical and breast cancers for
women, and promotion of prenatal and maternal care; provision of health facilities to low-income settlements, such as established primary health-care centres; increasing physical activity by creating public parks, playgrounds, swimming pools, gym rooms and exercise equipment for communities and low-income settlements (see Figure 6). The municipality has also supported various kinds of sport clubs and senior citizens' clubs (see Figure 7), and promotes people participation in environmental and self-sufficiency economy initiatives, such as the use of bio-liquid detergent from organic waste.

Figure 6: Activities for better health

Figure 7: Health services and fitness

Source: contributed by Mr Vijai Amaralikit, Mayor, Phanat Nikom Town Municipality
The presentation highlighted major benefits of the healthy city approach and lessons learnt, particularly in reducing the medical treatment costs of households; reducing the fiscal budget of the municipality for health-care investment; improving the relationship between the municipality and the community; increasing community participation and contributions; and generating a "clean and green" city. It was concluded that local authorities should take the comprehensive approach of a healthy city focus, not only for health but also for social and environmental aspects. A healthy city can only be achieved and sustained through participation of strategic partners in collaboration with the local government.

Jakarta, Indonesia

Dr H Riza Falepi, Mayor of Paykumbuh, presented that the healthy city/district concept in Indonesia was started from 2005, with a Joint Ministerial Decree signed by the Ministry of Health and Ministry of Home Affairs. The healthy city requires continuous efforts to change people's attitude, to place importance on preventive care rather than curative services. The local government played an important role in improving the environment and integrated health in community culture. A healthy city forum was initiated with collaboration among traditional leaders, representatives from Minangkabau Traditional Cultural Institute, and a healthy subdistrict forum and healthy urban working group that was mutually funded by the city government and community.

The presentation highlighted the healthy city strategies in Indonesia that include: community-initiated "Healthy Living for Community" through sports, and healthy hearts clubs; implementation of Car-Free Day; enforcement of smoking regulation; improvement of community health services; and formation of bodies that look into cross-sector issues, such as the Child Protection Committee, City Anti-Narcotics Agency, and Community Health Service and Insurance. Healthy city activities also include prevention of road and traffic accidents; having a regulated traffic and transportation zone; monitoring vehicle carbon monoxide emissions; and regulated non-smoking zones in public places, industries and offices (see Figure 8-11). A healthy tourism zone was initiated to ensure a non-smoking zone, certified healthy and clean restaurants and cafeterias, certified hotels with health assurance, and special polyclinics for tourists.
Indonesia has also promoted healthy social life, through inclusive education for children with special needs; special education facilities for individuals who are mute and deaf; vocational training; and rehabilitation of uninhabitable houses. The city plays an important role in promoting malnutrition-free districts, ensuring food safety and nutrition through nutrition consultation clinics. Promotion of a healthy forest zone and healthy settlement has been shown to be a good strategy for environmental health, as well as addressing climate change through enforcing 3R (reduce, recycle, reuse), improving river and water quality, improving clean water coverage in communities, and promoting sport zones that increase green areas in the city.

Source: contributed by Dr H Riza Falepi, Mayor of Paykumbuh
Pyongyang, the Democratic People's Republic of Korea

The Ministry of Public Health reported that the Government of the Democratic People's Republic of Korea has developed a set of policies and programmes in all social sectors, providing free and universal access to health, childcare, education, maternity benefits and other schemes. The presentation highlighted the major outcomes of the healthy city in the Democratic People's Republic of Korea. This includes: safe water supply facility installed for 96% household in urban areas; garbage disposal facility installed in 99.2% of households; sanitation facilities installed in 92% of households; a "healthy community" established in Pyongyang; and a "healthy country" established in the Democratic People's Republic of Korea since 1980.

A well-organized system for health-care delivery has also been established, providing all people in the country with free universal medical care.

Emerging and unplanned urbanization is one of the major threats to public health, and the government is fully committed to promoting and advocating the healthy city for preventing premature death resulting from various social determinants of health. The government has adopted a slogan of "City in a Park" and implemented the project in full scale, to make Pyongyang a model of the world through building and upgrading basic service, infrastructures, and improved housing; creating more green areas; and improving public transport.

With increasing awareness of the risks for noncommunicable diseases, local legislation on public health, tobacco control, road safety and transport, environment protection, food safety, and sport has been adopted in the Democratic People's Republic of Korea. These legislative measures are to ensure improvement of people's health outcomes with active implementation towards the healthy city. Smoking and any sponsorship or advertisement of tobacco use is strongly banned in the Democratic People's Republic of Korea and not permitted in public.

The Democratic People's Republic of Korea has designated every March, April, September, October, and the period for protection of...
national territory and environment that occurs in May and November, to be the months of hygiene and sanitation in the cities. During these periods, all citizens are actively involved in the healthy city activities. Sport areas like a basketball court, volley ball court, tennis court, roller skate court, and mini-golf course have been developed in Pyongyang to promote active well-being of its citizens.

The presentation concluded that realistic and substantial comprehensive urban planning that includes health promotion, such as so-called healthy city, healthy schools, or healthy community, need to be developed and scaled up to national strategy. Holistic and multidisciplinary approaches for the healthy city need to be advocate to all relevant sectors of government.

2.7 **Integrated approach to the healthy city and the right to health for urban poor**

In coordination between HPE and a health and human rights focal point, the presentation on "Integrated approach to the healthy city and the right to health for urban poor" was developed to promote linkages between human rights and the healthy city in concrete and practical matters. The rights-based approach for urban planning and implementation of the healthy city are intertwined when addressing health inequity. As a continuous approach from Urban HEART, health advocates need to use a multidimensional approach to convince public policy-makers of why there is a need to address health inequity and what is feasible within their legal responsibilities.

The right to health includes not only access to health-care services but also addressing the underlying determinants of health, which include the rights to water and sanitation; food; a healthy environment; adequate housing; education; employment; participation; and access to information. The right to health is "a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health ".

A rights-based approach is about non-discrimination, accountability and transparency; equality; promotion of participation; and applying the values of international human rights law to all development cooperation.
Active participation and empowerment of people are key components and common ground in the right-based approach and health promotion actions. Applying an integrated approach for rights-based planning and participatory policy development would ensure that good governance; social protection; and empowerment of the urban poor and vulnerable groups through education and investment in human capital are addressed.

2.8 Panel discussion on the roles of development partners in all urban policies

**Moderator:** Dr Suvajee Good, Programme Coordinator for Health Promotion, WHO Regional Office for South-East Asia

**Participants:** Dr M Jagadeesan, Health Specialist (Policy and Planning), UNICEF, India; Mr Amit Prasad, Technical Officer, Urban Health Metrics, WHO Kobe Centre, Japan

Since the 1970s and 1980s, Dr M Jagadeesan has shared UNICEF interest in urban health and moving towards "child-friendly cities", ensuring the rights of the child are recognized and children receive appropriate protection. UNICEF recognized that children in urban areas were subjected to various vulnerabilities. Of the 377 million people living in urban areas, 97 million are poor. There are about 49,000 slums in India, and about 70% of these are concentrated in the states of Andhra Pradesh, Gujarat, Maharashtra, Tamil Nadu and West Bengal. Rapid urbanization and migration have brought up multiple issues related to health inequity and access to health services for the poor. Dr Jagadeesan presented data showing that adverse health effects on the urban poor were greater than those on the rural poor. However, UNICEF's focus is to put children at the centre of health and development in urban areas, where partnership with WHO is crucial for broader determinants of health and moving health forward in the agendas for other public policies.

Mr Amit Prasad, representing WHO Kobe Centre, highlighted several issues that address the importance of understanding health inequity and address them with concrete and convincing evidence. Current challenges include the availability of health information that is sufficiently disaggregated to be useful to measure urban health disparities or inequity. Most of the national surveys, such as DHS, often collect data from
recognized inhabitants and thus the situation of urban poor is underestimated. The situation of urban poor varies from country to country, raising challenges for cross-country comparison and global reporting. There is clearly a need for better strategies to reach the unreached, unrecognized population in urban areas. Urban HEART could be one way of reaching out the unreached and capturing situations that a national information system could not reach. However, there is a need for sustainable practice to implement the tool from the beginning of the planning and policy-development processes. As the WHO Regional Office for South-East Asia has proposed, health in all urban policies is an approach to pursue and should be advocated to address broad determinants of health with an integrated approach, as discussed in this workshop.

Dr Suvajee Good informed attendees that representatives from USAID and the Department for International Development could not participate in the panel discussion but had conveyed their interest in collaborative actions for strengthening health information, health systems and services for vulnerable populations. A collaborative platform with a common agenda should be clearly visible in the future.

**Discussion points**

- Definition of the urban poor needs to be verified using the World Bank definition of the poor as people who subsist on less than US$ 2 per day, or means defined by countries.
- The need for disaggregated data to understand the situation of the urban poor was emphasized.
- Geographical "mapping of the poor" along with services and interventions would facilitate multisectoral actions.
- Internal migration (seasonal and weigh labour migration) needs to be considered while designing interventions.
- The scope of the terms "the poor" and "vulnerability" should be differentiated, as many people who may not be classified as poor suffer inequities due to other vulnerabilities.
2.9 The healthy city approach and intersectoral responses

Dr Suvajee Good presented the healthy city approach from WHO's perspective, in which a healthy city is "a city that is continually creating and improving those physical and social environments and expanding community resources which enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential" WHO (1998) Health Promotion Glossary. Key players in the healthy city include the community members; local, provincial/state and national politicians; government service providers from a variety of sectors (e.g. health, welfare, transport, police, and public housing authority); community service providers; nongovernmental/community-based organizations; private enterprise interests; consumer groups; local government authorities; provincial/state government authorities; relevant national government authorities; ethnic groups; community media; and educational institutions.

The principal elements of healthy cities projects were also discussed, as presented in Figure 12. This stresses that integration of Urban HEART in healthy cities enables evidence-based health promotion in an urban area; addresses and responds to health concerns and equity matters; strengthens intersectoral coordination with clear roles and responsibilities; prioritizes health promotion activities within given contexts; promotes a healthy physical and social environment; and builds sustainable collaborative mechanisms with appropriate resources.

Figure 12: Principal elements of a healthy cities project
There was also a discussion on healthy urbanization, as defined by the WHO Kobe Centre in 2005, and healthy urban planning and governance. Dr Good highlighted that it is necessary to put health equity and human development at the centre of government policies and actions in relation to urbanization. Recognizing the pivotal role of local government in ensuring adequate basic services, housing and access to health care, healthy urban planning needs to be introduced to ensure healthier and safer urban environments where people live, work, learn and play. Healthy urban planning needs to build on and support community grassroots efforts to enable the people to gain control over their circumstances and supply the resources they need for better living environments. Local government and urban authorities need to develop mechanisms to bring together private, public and civil society sectors, and define roles and mechanisms to enable national actors to support collaborative governance capacity. Intersectoral partners have crucial roles and responsibilities for the promotion of fairer and healthier cities.

To facilitate the group discussion to draft a roadmap for actions addressing urbanization and health inequity, HPE presented a generic/theoretical example of a roadmap for actions (see Figure 13), which Member States could consider while drafting the plans for action and implementation of Urban HEART.

Figure 13: Roadmap for actions on urbanization and Urban HEART

![Roadmap for Actions on Urbanization and Health](image-url)
2.10 **Group work: developing a draft country plan of action for implementing Urban HEART and improving the health of the urban poor**

The representatives from each country worked together to develop their plan of action for implementing Urban HEART and improving the health of the urban poor. The facilitators helped the participants in developing the plans of action. The plan of action prepared by each country except India is presented in Annex 3. The selected groups presented their plan of action and the discussion was completed.

3. **Conclusions and recommendations**

The workshop concluded through discussion on the country-level plan of actions for implementing Urban HEART and improving the health of the urban poor (Annex 3) and recommendations for regional actions. The roadmap for actions was endorsed, based upon the recommendations made by the country representatives.

3.1 **Recommendations for Member States**

- Develop and strengthen the information system (disaggregated data) for equity assessment and generate evidence for policy-makers.
- Develop a health equity monitoring system using a participatory approach to reach information from disadvantaged and vulnerable populations in urban areas.
- Implement Urban HEART in the country as recommended in the Bangkok Declaration on Urbanization and Health (1).
- Strengthen national policies on urban health, ensuring basic services and reduction of inequity and improved social justice.
- Build and strengthen intersectoral coordination and mechanisms at city/municipality level, to address health inequities.
Advocate for integrated health promotion and healthy settings in urban areas (namely health-promoting cities, healthy schools, health-promoting hospital, healthy workplaces, healthy markets).

Ensure health is taken into account in all urban policies.

Promote investment in pro-poor policies and strategies to mitigate health inequity.

Use/promote/regulate implementation of health impact assessment in all urban development projects.

### 3.2 Recommendations for WHO

- Build capacity to implement Urban HEART in countries.
- Generate evidence on health inequity in the region.
- Advocate for health in all policies and health equity in all urban policies.
- Advocate for primary urban health-care services and universal health coverage, to reduce health inequity in urban areas.
- Encourage and build capacity on health impact assessment of all urban development projects.
- Support the Urban HEART international network.
4. References


Annex 1

Agenda for the workshop

(1) Opening remarks by the Director, SDE
(2) Introduction to urban health equity matters and intersectoral actions
(3) Situation analysis on health equity in selected cities
(4) Introduction and demonstration of the Urban Health Equity Assessment and Response Tool (Urban HEART)
(5) Group work
(6) Experiences of applying Urban HEART from Jakarta, Indonesia; Colombo, Sri Lanka; Indore and Bally, India
(7) Implementation of a healthy city approach to address health equity in selected cities (New Delhi, India; Bangkok, Thailand; Phanat Nikhorn, Thailand; Jakarta, Indonesia; and Pyongyang, Democratic People's Republic of Korea)
(8) The right to health approach and equity issues
(9) Panel discussion on intersectoral response for urban health
(10) Recommendations and conclusion of the plan of action for implementing Urban HEART and improving the health of the urban poor
(11) Concluding remarks from SDE
## Annex 2

### List of participants

#### Bangladesh

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Role</th>
<th>Organization/Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Md Feroze Alam</td>
<td>Assistant Health Officer</td>
<td>Dhaka North City Corporation</td>
</tr>
<tr>
<td>Dr Md Matiur Rahman</td>
<td>Chief Health Officer</td>
<td>Barishal City Corporation</td>
</tr>
<tr>
<td>Mr Ranjit Chandra Sarker</td>
<td>Deputy Secretary</td>
<td>Dhaka South City Corporation</td>
</tr>
</tbody>
</table>

#### Bhutan

<table>
<thead>
<tr>
<th>Name</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Mr Jigme Dorji</td>
<td>Head</td>
<td>Development Control Division Thimphu Thromde</td>
</tr>
<tr>
<td>Mr Rinchen Namgyel</td>
<td>Chief Programme Officer</td>
<td>Health Care and Diagnostic Division Department of Medical Services Ministry of Health</td>
</tr>
</tbody>
</table>

#### Democratic People's Republic of Korea

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Role</th>
<th>Organization/Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Ri Yong Hwa</td>
<td>Director</td>
<td>National Institute Public Health Administration Ministry of Public Health</td>
</tr>
<tr>
<td>Dr Han Jong Ok</td>
<td>Officer</td>
<td>National Institute Public Health Administration Ministry of Public Health</td>
</tr>
<tr>
<td>Dr Ri Kwang Sun</td>
<td>National Programme Officer - HPR</td>
<td>WHO Country Office for the Democratic People's Republic of Korea</td>
</tr>
</tbody>
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#### Indonesia

<table>
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<tr>
<th>Name</th>
<th>Position/Role</th>
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<tbody>
<tr>
<td>Dr H Riza Falepi</td>
<td>Mayor of Paykumbuh</td>
<td>West Sumatra</td>
</tr>
<tr>
<td>Mrs Theresia Irawati</td>
<td>Head</td>
<td>Subdivision of Health Promotion Method Centre for Health Promotion Ministry of Health</td>
</tr>
<tr>
<td>Dr Lily S Sulistyowati</td>
<td>Head, Centre for Health Promotion</td>
<td>Secretariat General Ministry of Health</td>
</tr>
<tr>
<td>Mrs Andi Sari Bunga Untung</td>
<td>Head</td>
<td>Subdivision of Advocacy Division of Advocacy and Partnership Centre for Health Promotion Ministry of Health</td>
</tr>
<tr>
<td>Mr Bagus Satrio Utomo</td>
<td>Staff</td>
<td>Centre for Health Promotion Secretariat General Office Ministry of Health</td>
</tr>
</tbody>
</table>

#### Maldives

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Role</th>
<th>Organization/Location</th>
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</thead>
<tbody>
<tr>
<td>Mr Abdul Hameed Ali</td>
<td>Director General</td>
<td>Malé City Council</td>
</tr>
<tr>
<td>Ms Fathmath Seerath</td>
<td>Land Officer</td>
<td>Ministry of Housing and Infrastructure</td>
</tr>
</tbody>
</table>
Myanmar
Dr Wai Phyo Aung
Deputy Director
Department of Health
Nay Pyi Taw Development Committee
Dr Mya Thein
Assistant Director
Occupational Health Division
Department of Health

Nepal
Dr Babu Ram Gautam
Department Chief of Public Health and Social Welfare
Kathmandu Metropolitan City
Dr Anand Kumar Shrestha
Director
PHC Revitalization Division
Department of Health Services

Sri Lanka
Hon AG Peramunage
Mayor
Municipal Council
Kurunegala
Dr PM Ratnayake
Director - Estate and Urban Health
Ministry of Health
Dr RMSK Ratnayake
Provincial Director of Health Services
PDHS Office
North Western Province
Kurunegala

Thailand
Mr Vijai Amaralikit
Mayor
Phanat Nikom Town Municipality
Chonburi Provincial Local Administration Office
Ministry of Interior
Mrs Neeranuch Arphacharus
Policy and Plan Analyst
Senior Professional Level
Bureau of Environmental Health
Department of Health
Ministry of Public Health

Dr Sunthorn Sunthornchart
Director
Office of Public Health System Development
Bangkok Metropolitan Administration

Timor-Leste
Dr Avelino Gutteres Correia
Advisor to health Management Information System
Ministry of Health
Mr Agostinho de Oliveira
Waste management Unit Officer
Environment Health Department
Ministry of Health

Temporary advisers (resource persons)

India
Dr Siddharth Agarwal
Executive Director
Urban Health Resource Centre
Dr Surinder Aggarwal
Retired Professor
University of Delhi
Mr Achintya Kumar Sen Gupta
Director-General
Sulabh International Academy of Environmental Sanitation and Public Health

Indonesia
Dr AM Meliala
Executive Director
Indonesia Epidemiologist Association
Jakarta

Sri Lanka
Professor Rohini Seneviratne
Merit Professor
Department of Community Medicine

Observers
Ms Anjali Borhade
New Delhi
Ms Devaki Nambiar
Postdoctoral Research Fellow
Public Health Foundation of India Adjunct Faculty
Indian Institute of Public Health
Other agencies
Dr M Jagadeesan
Health Specialist (Policy and Planning)
UNICEF, India
Mr Anand Rudra
Project Management Specialist
Urban Health and Water
USAID, India

WHO Secretariat

WHO Kobe Centre, Japan
Mr Amit Prasad
Technical Officer
Urban Health Metrics

WHO Country Office for India
Mr Himanshu Pradhan
Temporary Office

WHO Regional Office for South-East Asia
Dr Athula Kahandaliyanage
Director
Department of Sustainable Development and Healthy Environment

Dr Sudhansh Malhotra
Regional Adviser
Primary and Community Health Care
Ms Payden
Regional Adviser
Water, Sanitation and Health
Mr Bikesh Bajracharya
Temporary International Professional for Urban Health
Ms Briot Benedicte
Technical Officer
Health and Human Rights
Dr Suvajee Good
Programme Coordinator (Health Promotion)
Department of Sustainable Development and Healthy Environment
Mr SK Bajaj
Secretary, Health Promotion and Education Unit
Ms Ruchika Acharya
Clerk, Health Promotion and Education Unit
Annex 3

Country plans of action for implementing Urban HEART and improving the health of the urban poor

Bangladesh

<table>
<thead>
<tr>
<th>Priority steps</th>
<th>Existing mechanism</th>
<th>Responsible agencies</th>
<th>Support needed</th>
<th>Time frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orientation meeting with mayor and concerned stakeholders</td>
<td>Through city health coordination committee</td>
<td>City corporation</td>
<td>Financial and technical by WHO</td>
<td>January 2013</td>
</tr>
<tr>
<td>Develop and strengthen the information system</td>
<td>City-level establishment of Urban HEART information cell</td>
<td>City corporation</td>
<td>Logistic support by WHO</td>
<td>February to April 2013</td>
</tr>
<tr>
<td>Build and strengthen intersectoral coordination at city level</td>
<td>Through city health-coordination committee</td>
<td>City corporation</td>
<td>City corporation</td>
<td>February 2013</td>
</tr>
<tr>
<td>Develop health equity monitoring system</td>
<td>Through city health-coordination committee</td>
<td>City corporation</td>
<td>Financial and technical support by WHO</td>
<td>May to July 2013</td>
</tr>
<tr>
<td>Advocate for integrated health promotion and health settings</td>
<td>Local government, Ministry, City Corporation</td>
<td>City corporation</td>
<td>Ministry of Local Government</td>
<td>August 2013</td>
</tr>
<tr>
<td>Ensure health equity in urban policy</td>
<td>Through Mayor and local government, Ministry</td>
<td>City corporation</td>
<td>Ministry of Local Government</td>
<td>July 2013</td>
</tr>
<tr>
<td>Ensure primary health-care services to urban poor</td>
<td>Through city health-coordination committee</td>
<td>City corporation, Ministry of Local Government, Ministry of Health</td>
<td>Technical and financial support by WHO</td>
<td>July 2013 to __________.</td>
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</table>
Ensure safe water to urban slum areas

<table>
<thead>
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<th>Priority steps</th>
<th>Existing mechanism</th>
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<th>Support needed</th>
<th>Time frame</th>
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<tbody>
<tr>
<td>Develop and strengthen information system (disaggregated data) for equity assessment and generate evidence for policy-makers</td>
<td>City information system and health management information system</td>
<td>Thimphu City Corporation</td>
<td>No</td>
<td>February 2013</td>
</tr>
<tr>
<td>Conduct high-level advocacy/sensitization workshop on Urban HEART for relevant stakeholders</td>
<td>New plan</td>
<td>Ministry of Health/Ministry of Work and Human Settlement/City</td>
<td>No</td>
<td>March 2013</td>
</tr>
<tr>
<td>Form Healthy City Initiative Committee to strengthen intersectoral coordination and mechanism.</td>
<td>New plan</td>
<td>Ministry of Health/Ministry of Work and Human Settlement/City</td>
<td>No</td>
<td>March 2013</td>
</tr>
<tr>
<td>Sign memorandum of understanding among the key stakeholders for better intersectoral cooperation and coordination</td>
<td>New plan</td>
<td>Ministry of Health/Ministry of Work and Human Settlement/City</td>
<td>No</td>
<td>March 2013</td>
</tr>
</tbody>
</table>
Incorporate health workplan and healthy city initiative into city development  
City development plan  
Thimphu City Corporation  
No  
April 2013

Capacity development of relevant stakeholders on Urban HEART and Health City Initiative  
Ad hoc  
Ministry of Health  
Financial support & TA  
July 2013

Assess the size and determinants of the urban and peri-urban population (Gelephu, Phuentsholing, Samdrup Jongkhar and Thimphu)  
In plan  
Ministry of Health/City Corporation  
Financial support  
January to March 2014

Pilot Urban HEART and Healthy City Initiative in Thimphu City  
New plan  
Ministry of Health/City Corporation  
Financial support  
July 2013 to June 2014

Monitor Urban HEART activities  
New plan  
Ministry of Health/Ministry of Work and Human Settlement  
No  
Quarterly

Evaluate Urban HEART activities  
New plan  
Ministry of Health/Ministry of Work and Human Settlement  
No  
July 2014

Democratic People’s Republic of Korea

<table>
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<tr>
<th>Priority steps</th>
<th>Existing mechanism</th>
<th>Responsible agencies</th>
<th>Support needed</th>
<th>Time frame</th>
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</thead>
<tbody>
<tr>
<td>Healthy school settings</td>
<td>Healthy school curriculum, healthy activities</td>
<td>Ministry of Public Health, Ministry of Education</td>
<td>Government commitment, WHO financial support</td>
<td>January 2013 to December 2013</td>
</tr>
<tr>
<td>Healthy community settings</td>
<td>Regular check-up by household doctor, healthy environment</td>
<td>Ministry of Public Health, Elderly Association, Ministry of Land and Environment</td>
<td>Government commitment, WHO financial support</td>
<td>April 2013 to April 2014</td>
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## Indonesia

<table>
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<th>Priority steps</th>
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<th>Responsible agencies</th>
<th>Support needed</th>
<th>Time frame</th>
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</thead>
<tbody>
<tr>
<td>Information dissemination within Ministry of Health</td>
<td>Regular meeting, planned meeting</td>
<td>Ministry of Health, WHO</td>
<td>Experience from country, Urban HEART material</td>
<td>End of 2012</td>
</tr>
<tr>
<td>Adaptation of Urban HEART guidelines to Indonesia</td>
<td>Healthy city meeting, regular meeting</td>
<td>Ministry of Health, WHO</td>
<td>Urban HEART material</td>
<td>January 2013</td>
</tr>
<tr>
<td>Interministerial information dissemination</td>
<td>Regular meeting, planned meeting</td>
<td>Related ministries</td>
<td>Political commitment</td>
<td>February 2013</td>
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<tr>
<td>Socialization of Urban HEART for all provinces</td>
<td>Health national meeting</td>
<td>Ministry of Health, Ministry of Home Affairs, Province Health Department, Bureau of National Planning</td>
<td>Political commitment</td>
<td>March 2013</td>
</tr>
<tr>
<td>Integration of Urban HEALTH programme into national programme</td>
<td>National development planning forum meeting</td>
<td>President, Bureau of National Planning</td>
<td>Budget allocation for Urban HEALTH</td>
<td>April 2013</td>
</tr>
<tr>
<td>Monitoring implementation of Urban HEART in Denpasar and Jakarta</td>
<td>Regular supervision</td>
<td>Ministry of Health, Ministry of Home Affairs</td>
<td>Budget allocation</td>
<td>February 2013, May 2013, July 2013, December 2013</td>
</tr>
<tr>
<td>Development of Urban HEART programme in selected city</td>
<td>Specific allocation of budget</td>
<td>Ministry of Health, local government</td>
<td>Ministry of Health budget, local budget, donor</td>
<td>July 2013</td>
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</table>
# Maldives

<table>
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<th>Priority steps</th>
<th>Existing mechanism</th>
<th>Responsible agencies</th>
<th>Support needed</th>
<th>Time frame</th>
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<tbody>
<tr>
<td>Identify target groups</td>
<td>National survey, through local media</td>
<td>Malé City Council, city councils and island councils, Ministry of Health</td>
<td>National level and subnational NGOs</td>
<td>January 2013 to June 2013</td>
</tr>
<tr>
<td>Conduct awareness programme</td>
<td>National level and NGOs</td>
<td>Malé City Council, city councils and island councils, Ministry of Health</td>
<td>Local government, Ministry of Health,</td>
<td>January 2013 to June 2013</td>
</tr>
<tr>
<td>Provide Urban HEART information to relevant authorities</td>
<td>Ministry of Health, through resource personnel</td>
<td>Local government, Ministry of Health, Ministry of Environment and Energy</td>
<td>January 2013 to December 2013</td>
<td></td>
</tr>
<tr>
<td>Identify stakeholders</td>
<td>National level and NGOs</td>
<td>Malé City Council, city councils and island councils, Ministry of Health</td>
<td>Local government, Ministry of Health,</td>
<td>January 2013 to March 2013</td>
</tr>
<tr>
<td>Access to safe water</td>
<td>50 out of 200 inhabited islands have access to safe water</td>
<td>Water and Sanitation Authority</td>
<td>Local government, Ministry of Health,</td>
<td>January 2013 to December 2017</td>
</tr>
<tr>
<td>Improve sanitation</td>
<td>Manage by central government and Water and Sanitation Authority</td>
<td>Ministry of Environment and Energy, Water and Sanitation Authority</td>
<td>Local government, Water and Sanitation Authority</td>
<td>January 2013 to December 2017</td>
</tr>
<tr>
<td>Improve sea and road transport</td>
<td>Manage by Transport Authority</td>
<td>Transport Authority</td>
<td>Maldives Transport and Contracting company</td>
<td>January 2013 to December 2017</td>
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<tr>
<td>Create more awareness on environmental health</td>
<td>Ministry of Environment and Energy</td>
<td>Local government, national media</td>
<td>January 2013 to December 2015</td>
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**Myanmar**

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<th>Support needed</th>
<th>Time frame</th>
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<tbody>
<tr>
<td>Report to stakeholders</td>
<td>Ministry of Health, City Development Committee, Ministry of Home Affairs</td>
<td>Budget, technology and human resources</td>
<td>Half to one month</td>
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<tr>
<td>Define local indicators</td>
<td>Ministry of Health, City Development Committee, Ministry of Home Affairs, NGOs</td>
<td>Budget, technology</td>
<td>1 to 2 years</td>
<td></td>
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<tr>
<td>Data collection</td>
<td>Ministry of Health, City Development Committee, Ministry of Home Affairs</td>
<td>Budget, technology</td>
<td>1 to 2 years</td>
<td></td>
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<tr>
<td>Evidence generation</td>
<td>Ministry of Health, City Development Committee</td>
<td>Budget, technology</td>
<td>1 year</td>
<td></td>
</tr>
<tr>
<td>Access gaps</td>
<td>Ministry of Health, City Development Committee</td>
<td>Budget, technology</td>
<td>1 year</td>
<td></td>
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<tr>
<td>Best response</td>
<td>Ministry of Health, City Development Committee</td>
<td>Budget, technology</td>
<td>1 year</td>
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**Nepal**

<table>
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<th>Support needed</th>
<th>Time frame</th>
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<tbody>
<tr>
<td>1. Sanitation programme</td>
<td>Municipality, Department of Water Supply, Ministry of Health, NGOs, international NGOs, community-based organizations, donor partners</td>
<td>Municipality, Ministry of Health, Ministry of Urban Development</td>
<td>Technical and financial support</td>
<td>2 years</td>
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## Sri Lanka

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<th>Responsible agencies</th>
<th>Support needed</th>
<th>Time frame</th>
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</thead>
<tbody>
<tr>
<td>Identify the team member, local authority, health professional, NGO and other relevant stakeholders</td>
<td>None</td>
<td>Kuruneella Municipal Council, Public Health Unit</td>
<td>WHO support</td>
<td>January 2013 to February 2013</td>
</tr>
<tr>
<td>Set indicators and benchmarks</td>
<td>Colombo Municipal Council</td>
<td>Focal point of Kuruneella Municipal Council</td>
<td></td>
<td>January 2013 to February 2013</td>
</tr>
<tr>
<td>Assemble relevant and valid data</td>
<td>The Public Health Department with expansion</td>
<td>Urban Council Health Authority and other stakeholders e.g. provincial authority</td>
<td>Local authority, other stakeholders e.g. education, Water Board, WHO, RDA, electricity, provincial health</td>
<td>March 2013</td>
</tr>
<tr>
<td>Monitor and matrix</td>
<td>Urban Council, Colombo Municipal Council monitoring and matrix</td>
<td>Urban Council, Health Authority, provincial authority, other stakeholders</td>
<td>All stakeholders and WHO</td>
<td>March to April 2013</td>
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</table>

2. Noncommunicable disease: diabetes

<table>
<thead>
<tr>
<th>Ministry of Health, Municipality, NGOs/international NGOs, public sector</th>
<th>Municipality, Ministry of Health</th>
<th>Technical and financial support</th>
<th>1 year</th>
</tr>
</thead>
</table>
Prioritizing and taking response

| Prioritizing and taking response | Public Health Unit, Provincial Authority | All stakeholders | All stakeholders | May 2013 |

**Thailand**

<table>
<thead>
<tr>
<th>Priority steps</th>
<th>Existing mechanism</th>
<th>Responsible agencies</th>
<th>Support needed</th>
<th>Time frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Convince policy-maker at national level</td>
<td>Monthly executive board meeting, National Environmental Health Committee, National Health Commission</td>
<td>Ministry of Public Health (MOPH), Ministry of Interior (MOI), BKK and Pattaya City, Municipality League of Thailand</td>
<td>Technical support from WHO</td>
<td>1 month (2013)</td>
</tr>
<tr>
<td>Strengthen national policies on urban health, focusing on the urban poor and vulnerable</td>
<td>National Health Assembly</td>
<td>National Health Commission, MOPH</td>
<td></td>
<td>2 months</td>
</tr>
<tr>
<td>Build inclusive team at national level</td>
<td>National Health Commission, MOPH, MOI, BKK and Pattaya City, Mahidol University</td>
<td>Technical support from WHO</td>
<td></td>
<td>3 months (2013)</td>
</tr>
<tr>
<td>Review, develop and strengthen the information system for equity assessment for policy-maker</td>
<td>National Census, National Health Survey, National Household Economic Survey</td>
<td>National Statistics Office, Mahidol University, MOPH</td>
<td>Technical support from WHO</td>
<td>3 months (2013)</td>
</tr>
<tr>
<td>Develop health equity monitoring system by participatory approach</td>
<td></td>
<td>National Health Commission, MOPH, Mahidol University</td>
<td>Technical support from WHO</td>
<td>3 months (2013)</td>
</tr>
<tr>
<td>Urban HEART in the pilot province</td>
<td>Cities that joined in Healthy City Project</td>
<td>MOPH, MOI, BKK and Pattaya City, Mahidol University, Municipality League of Thailand</td>
<td></td>
<td>Start in 2014</td>
</tr>
</tbody>
</table>
# Timor-Leste

<table>
<thead>
<tr>
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<th>Responsible agencies</th>
<th>Support needed</th>
<th>Time frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presentation: The result of the 3-day workshop “Urban HEART”, to Ministry of Health (directorate levels)</td>
<td>Board of Directors, Ministry of Health</td>
<td>Department of Environmental Health, participants during workshop, WHO Country Office for Timor-Leste</td>
<td>Technical assistance from WHO Country Office for Timor-Leste, financial support</td>
<td>January 2013</td>
</tr>
<tr>
<td>Request to Minister of Health to present this programme to the Council of Ministers</td>
<td>Council of Ministers Meeting</td>
<td>Ministry of Health and WHO Country Office for Timor-Leste</td>
<td>Information and book in regard to Urban HEART</td>
<td>January 2013</td>
</tr>
<tr>
<td>Translation of the Urban HEART user manual (official language of Timor-Leste)</td>
<td>To be discussed</td>
<td>Department of Environmental Health</td>
<td>WHO Country Office for Timor-Leste</td>
<td>January 2013</td>
</tr>
<tr>
<td>Establishment of Internal Commission from the Ministry of Health, ot it depends on the Council of Ministries’ decision (approval)</td>
<td>Ministry of Health structure and dispatch for the nomination</td>
<td>Ministry of Health or relevant ministry will nominate someone (Director-General) to lead this commission</td>
<td>WHO Country Office for Timor-Leste</td>
<td>February 2013</td>
</tr>
<tr>
<td>Commission will take action</td>
<td>Ministry of Health</td>
<td>WHO Country Office for Timor-Leste</td>
<td></td>
<td>February 2013</td>
</tr>
<tr>
<td>The Commission will call for meeting among relevant stakeholders to explain the objective of the meeting with regard to Urban HEART</td>
<td>Coordination among relevant ministries through formal invitation</td>
<td>Commission that has been nominated by Minister of Health</td>
<td>Ministry of Health, WHO Country Office for Timor-Leste and other stakeholders</td>
<td>February 2013</td>
</tr>
</tbody>
</table>
Annex 4

Urban HEART training workshop evaluation

Did the workshop fulfill your expectations?

<table>
<thead>
<tr>
<th>Expectations</th>
<th>Number of Responses</th>
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<tbody>
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<td>Yes</td>
<td>25</td>
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<tr>
<td>No</td>
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Note: One response was not recorded

Your level of understanding of the material

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<tr>
<th>Understanding</th>
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<th>Good</th>
<th>Fair</th>
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<tr>
<td></td>
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Your level of confidence in applying Urban HEART

<table>
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<th>Fair</th>
<th>Poor</th>
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<tbody>
<tr>
<td></td>
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<td>9</td>
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Likelihood of using Urban HEART in your country

<table>
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<tr>
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<th>Fair</th>
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<td></td>
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<td>5</td>
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Instructor's ability to make complex topics easy to understand

<table>
<thead>
<tr>
<th>Instructor's Ability</th>
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<th>Fair</th>
<th>Poor</th>
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Instructor's ability to answer questions

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<th>Fair</th>
<th>Poor</th>
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Instructor's ability to manage time

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<thead>
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<th>Fair</th>
<th>Poor</th>
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<tr>
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<td>10</td>
<td>10</td>
<td>6</td>
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Comprehensiveness of the workshop program

<table>
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<th>Poor</th>
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<td>19</td>
<td>1</td>
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Overall quality of the training

<table>
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<tr>
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<th>Poor</th>
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<tr>
<td></td>
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Which sections would you like to see MORE of?

<table>
<thead>
<tr>
<th>Sections</th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
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</thead>
<tbody>
<tr>
<td>Matrix/monitor</td>
<td></td>
<td>5</td>
<td>4</td>
<td>3</td>
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<tr>
<td>City implementation examples</td>
<td></td>
<td>5</td>
<td>3</td>
<td>2</td>
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<tr>
<td>Group work</td>
<td></td>
<td>5</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Prioritization</td>
<td></td>
<td>5</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>None</td>
<td></td>
<td>6</td>
<td>5</td>
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The regional workshop on urban health equity assessment and intersectoral response was held in New Delhi during 27–29 November 2012 as part of collaboration between WHO Kobe Centre and the WHO Regional Office for South-East Asia, to strengthen the capacities of the health sector, urban planners, municipalities, local government and relevant partners to assess and respond to health inequities in urban areas.

The Urban HEART (health equity and response tool) was introduced along with practical examples of local implementation from pilot sites. An integrative approach to respond to health inequities was drawn from intersectoral actions to address specific health, social, economic, environmental and human rights issues, using healthy cities as a positive umbrella to strategically engage multisectoral partners. The workshop has successfully increased the understanding, knowledge and capacity on Urban HEART and built a network of practitioners working for urban health.

This report is intended to be shared with the global network of urban health, Member States, UN agencies, and national counterparts working in the area of urban health in South-East Asia, including academia, nongovernmental organizations, mayors and local authorities.