Report on documentation and evaluation of Urban HEART pilot in Indonesia

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1. Introduction

Indonesia is the fourth most populated country in the world, after China, India and the United Stated of America. The national census in 2010 revealed the Indonesian population to be 237.6 million. The annual population growth (according to the census) between 2000 and 2010 was 1.49%, or an increase of around 3.5 million per year. The population of Jakarta is growing by 1.39% annually, while that of Bali is increasing by 2.15% annually. In 2010 the urban population reached 52% of the total population. It is estimated that the urban population will be 65% of the total Indonesia population in 2025. Most of those are living in the capitals of provinces and other municipalities, including the Jakarta Metropolitan Area, Surabaya, Yogyakarta, Bandung, Semarang, Medan, Makassar and Denpasar, and other cities of the outer Java islands.

Administratively, the Government of Indonesia consists of central, province, and district or municipal levels. Law No. 32/2004 on local government gives autonomous rights to provinces, districts and municipalities. This means that there are two steps of decentralization being operated throughout Indonesia: provincial government, and district or municipal government. The districts and municipalities are categorized as being at the same autonomous level and are the spearhead of autonomy in Indonesia. Each district and municipality consists of subdistricts that are further divided by village (*desa* or *kelurahan*). Throughout Indonesia, there are 33 provinces with 98 cities and 399 districts, further subdivided into 6543 subdistricts and 75 226 villages (Ministry of Interior 2009 and 2011 figures).

The impact of urbanization on population health, health equity and the environment has become of important concern for city and national authorities. The rapid shift from a rural subsistence economy to an urban, market-oriented and industrial economy also brings a range of urban health problems, including environmental health problems.

For a long time it has been observed that the health status of the urban poor is lower than for other urban communities. The infant mortality rate and the mortality rate of children under 5 years among low-income groups is about four times higher than among high-income groups. The poor environmental conditions, including low-quality housing and shortage of clean water and basic sanitation facilities, make the situation worse, and add to the social and economic inequality among urban families. Unemployment and underemployment also aggravate the financial and economic situation, and there is a shortage of public resources to mitigate poverty and improve the physical infrastructure and social services.

The Urban Health Equity Assessment and Response Tool (Urban HEART) was developed by the World Health Organization (WHO) in 2008. It aims to equip policy-makers with the necessary evidence on which to base strategies to reduce inter-city and intra-city health inequities. The tool was designed as a user-friendly guide for decision-makers at national and local levels to help analyse inequities in health between people living in various parts of cities or belonging to different socioeconomic groups within and across cities. It is also intended to facilitate decisions on viable and effective strategies and interventions to reduce health inequities.

Indonesia was selected as one of the pilot countries for the application of Urban HEART in 2009. Jakarta and Denpasar were selected as the implementation sites. The processes, mechanisms and achievements of the Urban HEART implementation in Indonesia need to be documented and evaluated. This will provide the basis for continuous improvement of the tool, and will assist in advocating its use and creating greater consciousness to promote urban health equity.

The technical documentation and evaluation results, targeted for wide dissemination, will be useful for stakeholders in other urban areas to become familiar with Urban HEART and eventually utilize the tool to address health differentials and socioeconomic determinants of health. It is envisioned that the expansion of the use of Urban HEART in different cities and countries will contribute to the broader goal of applying an equity perspective in health and development work, with the end goal of narrowing inequities in health.

2. Background to piloting in Indonesia

Indonesia, in common with other developing countries, has experienced a rural to urban shift in population. At present the urban population of Indonesia has reached over 50% of the total population, and is mainly found in the capitals of provinces and districts as well as in municipalities. In 2009, there were 98 cities (19.7%) out of 497 districts (all districts + cities) that were categorized as autonomous areas in Indonesia.

The main cause of rapid urbanization in Indonesia is rural-urban disparities. Urbanization cannot totally be avoided due to strong urban pull factors, including socioeconomic factors, the availability of public services such as health and education, and job opportunities in urban areas. Therefore, centres for socioeconomic development need to be created in rural areas or outside cities in order to reduce the rural push and urban pull trend. To help cope with the problems of urbanization, Indonesia is developing a Master Plan for Fostering and Expanding Economic Development. Efforts will be made to develop infrastructure in the first stage of the plan, which aims to reduce rural-urban disparities.

The impacts of urbanization on population health, health equity and the environment have become important concerns of city and national authorities. The rapid shift from a rural subsistence economy to an urban, market-oriented and industrial economy also brings a range of urban health problems, including environmental health problems.

Urban HEART is a tool to provide policy-makers and key stakeholders at national and city levels with a guide to assess and respond to urban health inequities. It assists in identifying and analysing differences in health opportunities between people living in different cities and in different parts of cities, as they affect people in different socioeconomic groups. It also helps to plan interventions and implement effective strategies to reduce inter-city and intra-city health inequalities.

Urban HEART was piloted in three sites in Indonesia: the City of West Jakarta and the City of North Jakarta (Jakarta Special Province) and the City of Denpasar (Bali Province).

Urban health is a complex issue because the solutions to health challenges in towns and cities do not lie within the health sector alone but also with decisions made by others, including

local government officials, educationalists, urban planners, engineers and those who determine physical infrastructure and access to social and health services. These professionals have to face the challenges of overloaded water and sanitation systems, polluting traffic and factories, lack of space to walk or cycle, inadequate waste disposal, crime and injury.

Nevertheless, solutions exist to tackle the root causes of urban health challenges. Urban planning can promote healthy behaviour and safety through investment in active transport, designing areas to promote physical activity and passing regulatory controls on tobacco and food safety. Improving urban living conditions in the areas of housing, water and sanitation will go a long way to mitigating health risks, as will building green, inclusive cities that are accessible, healthy and bestow age-friendly benefits on all urban residents. The Healthy Cities programme emphasizes the need for community participation in the decisions that affect people's lives.

3. Method used to conduct documentation and evaluation

The method use for documentation and evaluation was as follows:

1. Document reviews undertaken, including report of pilot area, updated Urban HEART manual produced by WHO Kobe Centre, Healthy Cities programme.
2. Consultative meeting held with a number of government representatives, including Jakarta and Denpasar officials, and with other related stakeholders and WHO experts.
3. Field observation of Urban HEART pilot implementation in North Jakarta, West Jakarta and Denpasar, along with discussion with concerned stakeholders and coordination and steering committee, focusing on activities undertaken before, during and after assessment.
4. Site visit and pictures taken.
5. Updating data and information and analysing them according to Urban HEART indicators and response tools.
6. Discussion about the implementation stage, including constraints and possible measures for improvement, with field implementers and decision-makers.
7. Organize meeting with stakeholders for review and study leading to identification of necessary actions to be taken for better Urban HEART implementation.
8. Writing report based on findings and discussions.
9. Finalize complete report along with the summary and recommendations for enhancement of government and stakeholder commitment at central, provincial and city levels on Urban HEART implementation.

4. Process undertaken

4.1 Document reviews

A review was made of the written report of the application of Urban HEART in the pilot areas of West Jakarta, North Jakarta and Denpasar in 2009. The 29-page report was presented in Nairobi in 2009 by the former Urban HEART pilot team led by Dr Suarta Kosen, a senior researcher of the National Institute of Health Research and Development, Ministry of Health, Jakarta.

The report was comprehensive and concise and followed the Urban HEART guidelines provided by the WHO Kobe Centre. The report covered the process of Urban HEART application at three cities using community health data from various surveys by the National Institute of Health Research and Development and the Central Bureau of Statistics, and from other sources such as the Demographic and Health Survey and the Basic Health Survey (Riskesdas) of the National Institute of Health Research and Development.

Urban HEART was introduced in three cities in Indonesia in 2009, and provided several tools with the potential to reduce health inequities in urban settings. Prior to introduction of Urban HEART, Indonesia has been developing several policies and undertaking strategic approaches to deal with health equity, including:

- Health for All by the year 2000 (HFA/2000), a goal introduced by the International Conference on Primary Health Care, Alma-Ata, 1978, and since developed by WHO and subsequently adopted by the Government of Indonesia.
- The WHO Healthy Public Policy initiative, adopted by Indonesia on 1 March 1999.
- Launch of the Policy on Healthy Indonesia, 2010.
- Decentralization Policy of Indonesia, adopted in 1999 and formalized in Law No. 32/2004.
- Implementation of the Healthy Districts and Healthy Cities initiatives by Decree No. 34 of the Ministry of Home Affairs and Decree No. 1138 of the Ministry of Health in 2005.
- Based on the above-mentioned policies, Indonesia has developed a policy for implementation of minimal service standards for health, as a basis for action in following up and achieving the Healthy Indonesia 2010 targets.
- Indonesia is also engaged in measures to achieve the Millennium Development Goals (MDGs), and is committed to achieving their targets by the year 2015.

As a WHO Member State, Indonesia is committed to the organization's policies and strategies. For instance, Indonesia aligns with the principles of the Alma-Ata Declaration and Health for All, and health equity has become a subject of national and subnational concern. Efforts have been made to enhance access to health services and improve their quality. Issues relevant to HFA/2000 will be explored within Indonesian health settings in the years to come, including revitalization of primary health care.

With regard to endeavours to enhance intersectoral collaboration in health, the Healthy Public Policy was declared as a strategic policy by President B.J. Habibie of Indonesia on 1 March 1999. This aimed to stimulate various strategic actions on related health developments, including the Healthy Cities initiative, the Adipura Clean City programme to achieve healthy and clean cities and resolve environmental health issues, development of primary health care for slum and poor settlements, and universal immunization coverage.

To ensure the achievement of the Healthy Indonesia goals by the year 2010, Indonesia declared that minimal health services be provided for populations by district and city health offices as part of the National Decentralization Policy. Each district and city health office has responsibility to provided minimal services for all the population in its area. Currently, there are 18 services to be provided by the health service at district and city levels (annex A).

4.2 Consultative activities

The following consultative activities took place with health officials and stakeholders in different organizations at the beginning of the process of documentation and evaluation of the Urban HEART pilot.

Consultations with WHO

At the commencement of the documentation and evaluation of Urban HEART, activities undertaken included preliminary consultation with the WHO officials dealing with Urban HEART. It was agreed that the documentation and evaluation assignment would be based mainly on the experiences of pilot implementation of Urban HEART in the City of North Jakarta, City of West Jakarta, and Denpasar City. It was also agreed that the Urban HEART pilot implementation would be documented and evaluated according to the terms of reference provided by WHO through the APW mechanism. Efforts should be made to document all important matters on the assessment of health equity and health inequity, based on health outcome issues and health determinants within the four policy domains, namely physical environment and infrastructure, social and human development, economics, and governance. Responses to the assessment results would then be formulated. Matters that needed to be documented and evaluated included degree of implementation, what policies and strategies had been developed, the actions that had been carried out, what obstacles were faced and further steps to be undertaken.

Consultations with Ministry of Health

The documentation and evaluation team held discussions with the Environmental Health Director (Director-General of Disease Control and Environmental Health), Ministry of Health. This directorate unit is responsible for managing, and for monitoring and evaluating, the environmental health programmes, including the Healthy Cities programme.

Generally, the unit is more familiar with the Healthy Cities approach than the Urban HEART approach. However, they are interested in taking advantage of Urban HEART to improve health equity as part of an integrated approach in line with the Healthy Cities movement. Healthy Cities programmes have been promoted by WHO since 1986, and “Healthy Cities for better life” was the theme of the 1996 World Health Day. In 1998, a Healthy Cities pilot

project was launched by the Ministry of Home Affairs in six cities in Indonesia, namely Cianjur, Balikpapan, Bandar Lampung, Pekalongan, Malang and East Jakarta. Further action was undertaken to developed healthy tourist areas at eight locations – Anyer, Baturaden, Kota Gede, Brastagi, Senggigi, Bunaken, Tana Toraja, and Nongsa Point and Marina (Batam Island). These healthy city and healthy special area developments are in line with the Healthy Public Policy launched in 1999 to help achieve the goals of Healthy Indonesia 2010.

In addition, the documentation team visited the Subdirectorate of Healthy Cities and Sport at the Ministry of Health to discuss matters related to Urban HEART. The unit is responsible for organizing and facilitating Healthy Cities programmes throughout the country, according to the new structure of the Ministry of Health. Unfortunately the subdirectorate was not well informed about the pilot implementation of Urban HEART in Jakarta and Bali, though the guidelines for Urban HEART had been circulated through the website by WHO and the report of the previous assessment team for Jakarta and Denpasar has been submitted to the unit for its view and comments.

An overview meeting on implementation of Urban HEART in Jakarta, with emphasis on the cities of West Jakarta and North Jakarta, took place at the Provincial Health Office on 7 September 2011. The meeting was attended by intersectoral officials from the City of Jakarta, including officials from the Special Province of Jakarta and from North and West Jakarta. Offices represented included the Regional Development Planning Agency (Bappeda), Division of Social Welfare, Bureau of Governance, Disease Control Unit, Environmental Health Unit and Health Promotion Unit.

The meeting recognized that Urban HEART was very relevant to the Healthy Cities programme and other urban health initiatives. Many healthy city activities had been undertaken in line with Urban HEART without the back-up of written evidence, clear target setting and a timeframe for implementation. The results of the meeting can be seen in the assessment component related to stakeholder engagement.

4.3 Healthy Cities overview in Indonesia

While Urban HEART is a newly introduced tool for health equity improvement in urban areas, the Healthy Cities programme has been implemented in most cities throughout Indonesia since 1999. As a tool for health equity, Urban HEART is very much related to the Healthy Settings approach, of which Healthy Cities is an example. The approach embraces a wide range of settings, including cities, districts and public environments (for example schools). According to Indonesian Health Law No. 36, 2009, the Government of Indonesia is responsible for planning, managing, implementing, guiding and controlling implementation of affordable health provisions for the whole population, which can only be achieved by taking account of health equity.

The WHO Healthy Cities programme is a global movement that emerged in response to the deteriorating health conditions linked with urbanization. The WHO Healthy Cities programme was launched in the South-East Asia Region in 1994. The programme aims at realizing its objectives through partnerships between public, private and voluntary agencies. It engages local governments in health development through a process of political

commitment, institutional change, capacity building, partnership-based planning and innovative projects. Health is the business of all sectors, and local governments are in a unique leadership position, with power to protect and promote their citizens' health and well-being.

The Healthy Cities movement promotes comprehensive and systematic policy and planning for health and emphasizes the need to address inequality in health and urban poverty; the needs of vulnerable groups; participatory governance; and the social, economic and environmental determinants of health. It is not only concerned with the health sector, but includes health considerations in economic spheres and in regeneration and urban development efforts.

The concept of Healthy Cities in Indonesia is an integral part of health system strengthening. A healthy city aims to achieve clean, comfortable, safe and healthy living and working conditions for the benefit of its people. This can be realized through the implementation of a wide range of integrated activities, as agreed upon by community and local government. A healthy city also contains healthy areas and healthy villages within its boundaries.

At city level, a healthy city project should include a community forum to facilitate community involvement and take account of people's aspirations. The forum would enable the community to contribute inputs in providing direction, deciding on priorities, and developing an integrated plan to achieve healthy city objectives. At subdistrict level, establishment of a village communication forum could support the coordination, integration and synchronization of health-related activities, including through inter-village cooperation. The forum, or similar working group, could assist in organizing community efforts for economic, social, cultural and health development at village level.

Given the integrated nature of these programmes and activities, it is strongly recommended that a Healthy Settings Committee be set up at city level. One of its main functions would be act as a steering committee for the implementation of Urban HEART.

4.4 Urban HEART contribution to primary health care in urban areas

A consultative meeting to prepare guidelines for primary health care implementation in suburban slum areas was held at the Hotel Lor Inn, Sentul Bogor, 8 September 2011. The meeting was organized by the Ministry of Health under the auspices of the Director-General of Nutrition and Maternal-Child Health, who has responsibility for policies and strategies and for the provision of guidelines to ensure the implementation of urban health in Indonesia. The steering committee for the consultative meeting invited a WHO representative to present the concept of Urban HEART to assist preparation of the proposed guidelines. The meeting was attended by 35 key officials, mostly from the Ministry of Health and also representing the Ministry of Public Works, National Planning Board, Ministry of Interior and National Family Planning Board.

The representative of WHO, outlining the concept of Urban HEART at a plenary session, explained why Urban HEART mattered, how it was implemented and what were the expectations. Information was also given on the Indonesian experience in application of Urban HEART in the pilot areas – North Jakarta, West Jakarta and Denpasar – including

elaboration of the two components of Urban HEART, namely the assessment component and the response component. The health equity assessment component used health outcome indicators and health determinant indicators covering four main policy domains – physical environment and infrastructure, social and human development, economics, and governance. From the outcomes of the exercise, five main response strategies were proposed to deal with health inequities:

- Organize health inequity issues within intersectoral programmes
- Concentrate on urban poor as the target for primary health care interventions
- Focus health equity measures on urban settings
- Enhance capacity to respond to health inequity locally
- Develop national health-oriented urbanization policies.

The consultative meeting agreed that Urban HEART was a useful tool in developing primary health care and health equity improvement interventions, particularly in slum and suburban areas of a city. The meeting agreed that the Urban HEART concept be incorporated into the guidelines for primary health care implementation in suburban and slum areas, as a useful tool in counteracting health inequity**.** The participants urged that the Urban HEART concept be widely disseminated to all (98) cities throughout Indonesia, reflecting the commitment of officials and stakeholders at national level to incorporate Urban HEART into the Healthy Cities programme in the country. The indicators selected for implementation of the project in 2009 had been assessed in the evaluation process and the decision was made to retain them unchanged. The meeting also recognized that intersectoral collaboration was the key to successful implementation of the primary health care programme in urban slums.

5. Results of documentation and evaluation

5.1 Pre-assessment phase

The Urban HEART pilot was implemented at three sites in Indonesia: City of West Jakarta and City of North Jakarta (Jakarta Special Province) and City of Denpasar (Bali Province). An assessment team was established in carrying out the Urban HEART pilot.

The general objective of the pilot activities was to improve the health and social status of the urban population, with a focus on vulnerable and disadvantaged people, through intersectoral action and social participation.

The specific objectives were as follows: to identify and analyse gaps in health outcomes and opportunities between people living in different parts of cities, or belonging to different socioeconomic groups within cities or among cities; and to facilitate policy decisions on viable and effective strategies, resource allocations, interventions and actions to reduce intra- and inter-city inequities in health outcomes, access and determinants.

Orientation of pilot sites

City of North Jakarta

The Special Province of Jakarta, capital of the Republic of Indonesia, is located in the north-west of Java island. It has an area of 650 square kilometres and a population (2009) of around 9.2 million, giving a population density of over 14 000 persons per square kilometre. About 11.5% of the population has never attended school. There are five municipalities and one district (Pulau Seribu) in Jakarta, as well as 44 subdistricts and 267 villages.

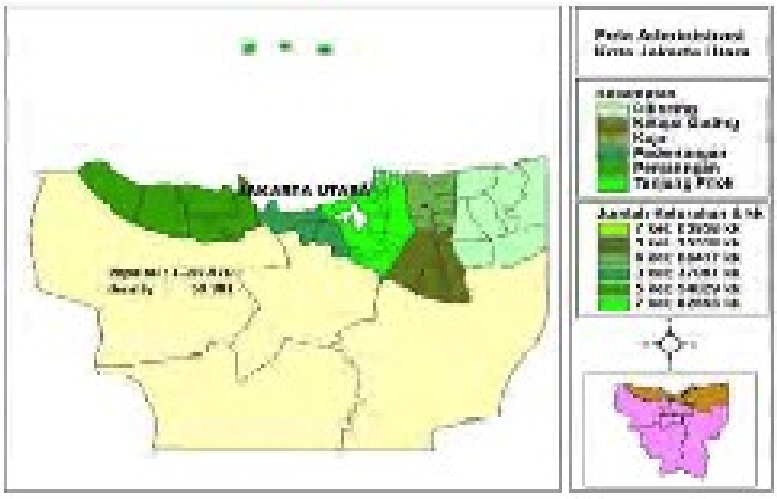
North Jakarta (figure 1) covers a coastal area of 134 square kilometres and extends around 35 kilometres from west to east. The height above sea level is generally less than 2 metres, and in several swampy areas the height is below sea level. As a result, the area is subject to flooding due to overflowing rivers or high tides. The average annual temperature is 28.9°C and annual rainfall is about 200 millimetres.

Utilization of land in North Jakarta is as follows:

- Housing 52.7%
- Industry 15.3%
- Offices and commercial 10.4%
- Vacant land, farms, other uses 21.6%

The City of North Jakarta is divided into 7 subdistricts and 35 urban villages (kelurahan), with a total population of about 1.2 million, and a population density of nearly 9000 per square kilometre.

Figure 1. Map of City of North Jakarta



City of West Jakarta

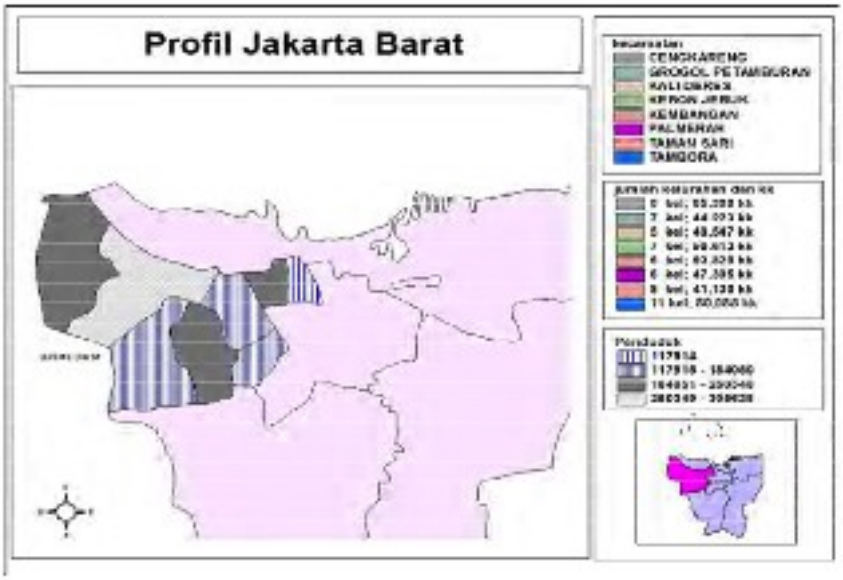
West Jakarta (figure 2) is an old part of Jakarta with many ancient buildings. It is about 128 square kilometres in extent. Average temperatures are relatively high. Land utilization is as follows:

- Housing 52.5%

- Industry 13.4%
- Offices and commercial 9.8%
- Agriculture 8.3%
- Vacant land, other uses 16.0%

The city is divided into 8 subdistricts and 56 urban villages (kelurahan). The total population is around 2.22 million, and the population density is over 17 000 per square kilometre.

Figure 2. Map of City of West Jakarta



City of Denpasar

Denpasar is located in the southern part of Bali island, with an average height of about 500 metres above sea level. The coastal zone, parts of which are mangrove forest, is around 11 kilometres length. The average monthly rainfall ranges from 1 millimetre (September) to 437 millimetres (January), with average temperatures ranging from 22.7°C to 33.9°C. Irrigated rice fields occupy 21.3% of the city area. The main economic activities of Denpasar are related to tourism and include trades, hotels, restaurants and transport.

Administratively, Denpasar consists of 4 subdistricts and 43 villages. It has an area of 127.8 square kilometres and a total population of 629 000, giving a population density of nearly 5000 per square kilometre. The population defined as “poor” numbers 15 646, or around 2.5% of the total. Many of the poor are originally derived from the islands of Java or Lombok, and come to Denpasar to earn a living, for example as construction workers.

General characteristics of pilot cities

Tables 1–7 present data and information relevant to the Urban HEART pilot project undertaken in the three pilot cities.

Table 1. Population and health administration structure (2009)

Variable	North Jakarta	West Jakarta	Denpasar
Population	1.2 million	2.22 million	629 000
Density per sq. km	9000	17 000	5000
Subdistricts	7	8	4
Villages	35	56	43
Hospitals	17	21	18
Health centres	49	75	11

Table 2. Proportion of urban villages with selected organizations, by city (2007)

Type of PVO/NGO	West Jakarta (%)	North Jakarta (%)	Denpasar (%)
Moslem religious group / majelis ta'lim	100.0	100.0	79.1
Christian religious group	78.6	71.0	37.2
Foundation for burial ceremony	66.1	64.5	100.0
Other PVOs	58.9	93.5	58.1

Note: PVO = private voluntary organization; NGO = nongovernmental organization.

Source: Village potency survey, Statistical Office, 2007.

Table 3. Proportion of urban villages with selected health personnel, by city (2007)

Type of personnel	West Jakarta (%)	North Jakarta (%)	Denpasar (%)
Male physician	94.6	96.8	93.0
Female physician	85.7	93.5	86.0
Dentist	75.0	61.3	74.4
Midwife	94.6	93.5	97.7
Other	32.1	19.4	58.1
Traditional healer	39.3	67.7	7.0

Source: Village potency survey, Statistical Office, 2007.

Table 4. Proportion of urban villages with specific characteristics, by city (2007)

Characteristic	West Jakarta (%)	North Jakarta (%)	Denpasar (%)
River crossing slum area	58.9	77.4	37.2
Households living at riverside	12.5	51.6	62.8
Households living near high-voltage electricity	19.6	35.5	18.6
Active integrated service post	91.1	93.5	93.0

Table 5. Health outcome indicators (2007)

Indicator	Jakarta	Denpasar	Indonesia
Life expectancy at birth (yrs)			
Male	71.3	69.0	64.2
Female	75.1	72.9	68.1
Infant mortality rate (per 1000 live births)	28	34	34
Under-5 mortality rate (per 1000 children under 5)	36	38	44
Maternal mortality rate (per 100 000 live births)	–	–	228

Sources: National Human Development Report, 2004; Demographic and Health Survey, 2007.

Table 6. Proportion (%) of population with noncommunicable diseases (2007)

Disease	West Jakarta	North Jakarta	Denpasar	Indonesia
Neoplasm	3.8	8.7	0.5	4.3
Diabetes	1.5	1.4	1.4	1.1
Heart disease	0.6	2.0	0.4	0.9
Hypertension (measured)	23.8	28.7	25.8	31.7
Stroke	8.1	1.0	0.3	6.0
Mental illness	0.3	1.8	0.1	4.6
Mental emotional disorder	11.0	14.0	3.7	11.6

Source: Basic Health Survey (Riskesdas), 2007.

Table 7. Proportion (%) of population with communicable diseases (2007)

Disease	West Jakarta	North Jakarta	Denpasar	Indonesia
Acute respiratory infection	9.1	10.7	1.0	8.1
Pneumonia	0.3	0.5	0.3	0.6
Tuberculosis	0.4	1.1	0.2	0.4
Diarrhoea	6.3	10.2	4.2	9.0

Source: Basic Health Survey (Riskesdas), 2007.

Engagement of national and local government officials

National officials engaged during the pre-assessment phase were from the Directorate of Environmental Health, Directorate-General of Disease Control and Environmental Health, Subdirectorate of Healthy Cities and Sport, Directorate-General of Nutrition and Maternal-Child Health, and Ministry of Health. As mentioned above, Urban HEART was accepted in principle as a tool to help implement the Health Settings and Healthy Cities programmes, which are important health development programmes at national level. Implementation guidelines for the Healthy Districts and Healthy Cities initiatives were issued as Ministry of Interior and Ministry of Health Regulation No. 34/2005 and No. 1138/Menkes/PB/VIII/2005.

Organization of local technical working group

The Healthy Cities programme was implemented through various activities with community involvement facilitated by local government through forums or community organization structures. The forums were instituted as working groups at different levels – village, subdistrict and city. In accordance with the above-mentioned Ministry of Interior and Ministry of Health regulation, each city should establish a steering committee for synchronization of community demand in line with local development and planning. The team leader was to be the head of the local government planning body, with members from all related units. The steering committee would be established by the decree of the mayor.

The existing Healthy Cities Committee was the focal point for Urban HEART pilot implementation. The National Institute of Health Research and Development, the Ministry of Health, and the Urban HEART Reporting Committee were represented on the Healthy Cities Committee. City officials engaged in the process came from the Regional Development Planning Agency (Bappeda), Division of Social Welfare, Ministry of Public Works, Health Office, City Health Council, Centre for Health Systems and Policy Research and Development, and private voluntary organizations working on behalf of the urban poor.

The committee was responsible for overseeing and guiding implementation of Urban HEART and for ensuring the quality of the final assessment and response reports. The committee also proposed the budget and other resources to the city government.

Resources used

Budgetary resources for the Healthy Cities initiative are provided by local government. The implementation of Urban HEART will, of course, stimulate new demand for the budgetary resources required for follow-up action based on the findings and recommendations. However, information on Urban HEART has to be properly disseminated to ensure that policy-makers are aware of the benefits and to ensure commitment to the tool at local government level.

Facilitating factors

Identification of facilitating factors during the pre-assessment stage was not straightforward. As the issue of health equity is cross-cutting in a number of programmes, support from local government was part of the overall facilitation provided for existing development programmes.

Hindering factors

The Urban HEART concept has not been widely disseminated among sectors where health inequity is an issue. There has been no special effort or budget provided for dissemination of the tool by local government. This may be due to insufficient efforts to accelerate the use of the Urban HEART concept.

Lessons learnt

It was found that the Urban HEART framework could be applied and used for existing healthy city projects, for instance through use of the self-assessment survey as a tool to determine health inequity problems at community level. The term “Urban HEART” tended to be misunderstood by stakeholders and the community.

5.2 Assessment phase

Stakeholder engagement

The consultative meeting dealing with the Urban HEART pilot took place at the provincial Health Office, Jakarta. The objective of the meeting was to obtain information regarding the previous Urban HEART pilot that had been carried out in West Jakarta and North Jakarta in order to document and evaluate the overall application of the tool. The meeting was chaired by a senior health officer of the Directorate-General of Disease Control and Environmental Health, Jakarta City. The meeting was attended by intersectoral stakeholders, including officials from the Regional Development Planning Agency (Bappeda), Bureau of Governance, Division of Social Welfare of Jakarta, Provincial Health Office, and Indonesian Epidemiologist Association.

During the course of the meeting, those attending were informed of the definition and scope of Urban HEART, and its background, objectives and main elements. In addition, the main components were outlined, namely the assessment and response and prioritization phases, and information provided on health determinants and health outcome indicators, within the

four policy domains that encompass the key determinants of health: physical environment and infrastructure, social and human development, economics, and governance.

The main outcomes of the consultative meeting were as follows:

- Participants recognized that Urban HEART was a useful tool for policy-makers to improve health equity based on robust evidence. Use of Urban HEART can help ensure the effectiveness and efficiency of health equity efforts.
- The use of Urban HEART for improving health equity, especially through intersectoral collaboration, is straightforward and simple, and adds to the understanding of health-related sectors of health issues.
- The tool is very relevant to the Healthy Cities and Healthy Settings programmes, also initiated by WHO.
- However, many activities have been undertaken in line with Urban HEART without the back-up of written evidence, clear target setting and a timeframe for implementation.
- Since Urban HEART is accepted as a positive tool for improving health equity, efforts should be made to ensure the correct mechanisms and procedures are applied.

In-depth assessment of the implementation of Urban HEART will be made at the next focal group discussion among stakeholders and implementers of health-related issues in the city of Jakarta.

Indicator selection

During the course of pilot implementation of Urban HEART, indicators were selected for analysing the current health equity situation and making recommendations, on the basis of the results of the health equity assessment, on appropriate responses to rectify health inequity.

The key health outcome indicators used were:

- Life expectancy at birth
- Infant mortality rate
- Under-5 mortality rate
- Maternal mortality ratio
- Disease-specific prevalence.

The status of health outcome indicators is presented in tables 8 and 9.

Table 8. Health outcome indicators

	Jakarta		Denpasar		Indonesia	
	2007	**2010**	**2007**	**2010**	**2007**	**2010**
Life expectancy at birth (years)		73.0		69.3		69.2
Male	71.3	n.d.	69.0	n.d.	67.9	n.d.
Female	75.1	n.d.	72.9	n.d.	71.9	n.d.
Infant mortality rate (per 1000 live births)	28	n.d.	34	n.d.	34	n.d.
Under-5 mortality rate (per 1000 children under 5)	36	n.d.	34	n.d.	44	n.d.
Maternal mortality ratio (per 100 000 live births)	–	n.d.	_	n.d.	228	n.d.

Sources: Intercensal Population Survey (SUPAS), 2005; Indonesia Demographic and Health Survey, 2007; BPS, 2009.

Table 9. Disease-specific prevalence

	West Jakarta		North Jakarta		Denpasar		Indonesia	
Disease	**2007**	**2010**	**2007**	**2010**	**2007**	**2010**	**2007**	**2010**
Cancer	3.8	n.d.	8.7	n.d.	0.5	n.d.	4.3	n.d.
Diabetes mellitus	1.9	n.d.	2.8	n.d.	2.0	n.d.	0.7	n.d.
Heart disease	3.3	n.d.	11.6	n.d.	2.6	n.d.	7.2	n.d.
Hypertension	23.8	n.d.	28.7	n.d.	25.8	n.d.	31.7	n.d.
Stroke	8.5	n.d.	1.1	n.d.	0.4	n.d.	8.3	n.d.
Mental emotional disorder	11.0	n.d.	14.0	n.d.	3.7	n.d.	11.6	n.d.
Mental illness	0.3	n.d.	17.7	n.d.	0.1	n.d.	4.6	n.d.
Acute respiratory infection	9.1	n.d.	10.7	n.d.	1.0	n.d.	8.1	n.d.
Pneumonia	0.3	n.d.	0.5	n.d.	0.3	0.31[a]	0.6	n.d.
Tuberculosis	0.4	1.03[a]	1.1	1.03[a]	0.2	0.31[a]	0.4	n.d.
Diarrhoea	6.3	n.d.	10.2	n.d.	4.2	n.d.	9.0	n.d.

a. Basic Health Survey (Riskesdas), 2007 and 2010.

Policy domain 1: Physical environment and infrastructure

The following indicators were selected for physical environment and infrastructure:

- Access to safe water (%)
- Access to sanitary toilet facility (%)
- Access to sanitary toilet facility, by level of income (%)
- Households using fuels, by type (%).

The status of those indicators is presented in table 10.

Table 10. Physical environment and infrastructure indicators

Indicator	West Jakarta		North Jakarta		Denpasar		Indonesia	
	2007	**2010**	**2007**	**2010**	**2007**	**2010**	**2007**	**2010**
Access to safe water (%)	56.0	87.0[a]	56.0	87.0[a]	32.4	79.7[a]	57.7	67.5[a]
Access to sanitary toilet facility (%)	66.6	82.7[a]	66.6	82.7[a]	74.4	71.8[a]	43.0	55.5[a]
Access to sanitary toilet facility, by level of income (%)								
Quintile 1	50.8	n.d.	49.7	n.d.	57.8	n.d.	25.1	n.d.
Quintile 2	61.5	n.d.	54.0	n.d.	67.9	n.d.	34.6	n.d.
Quintile 3	63.0	n.d.	59.6	n.d.	74.1	n.d.	42.3	n.d.
Quintile 4	73.4	n.d.	73.3	n.d.	82.6	n.d.	50.5	n.d.
Quintile 5	85.3	n.d.	81.7	n.d.	89.9	n.d.	63.5	n.d.
Households using fuels, by type (%)								
Electricity	4.6	99.4[a]	4.6	99.4[a]	7.4	72.7[a]	1.9	60.0[a]
LNG (gas)	29.5		29.5		47.3		10.6	
Kerosene	60.8		60.8		38.1		36.6	
Charcoal	0.2	0.6[a]	0.2	0.6[a]	0.1	27.3[a]	0.8	40.0[a]
Wood	0.1		0.1		1.5		49.4	
Other	4.8		4.8		5.5		0.8	

a. Data from Riskesdas, 2010.

Policy domain 2: Social and human development

The following indicators were selected for social and human development:

- Illiteracy rate by age group and sex
- Percentage of births attended by skilled health personnel

- Percentage of fully immunized children (12–23 months)
- Moderate to severe underweight children (under 5 years)
- Active tobacco smokers (over 15 years).

The status of those indicators is presented in table 11.

Table 11. Social and human development indicators

Indicator	West Jakarta		North Jakarta		Denpasar		Indonesia	
	2007	2010	2007	2010	2007	2010	2007	2010
Illiteracy rate by age group (years) (%)								
20–29	1.7	n.d.	0.6	n.d.	–	n.d.		n.d.
30–39	1.2	n.d.	1.1	n.d.	1.9	n.d.		n.d.
40–49	2.9	n.d.	2.3	n.d.	15.1	n.d.		n.d.
50–59	6.9	n.d.	12.0	n.d.	20.8	n.d.		n.d.
60+	10.4	n.d.	9.1	n.d.	20.8	n.d.		n.d.
Literacy rate by sex (% of total)								
Male	34.1	98.5[a]	34.1	96.6[a]	20.8	98.0[a]		
Female	65.9	93.6[a]	65.9	92.6[a]	79.2	95.4[a]		
Births attended by skilled health personnel (%)	98.7	95.8[b]	98.5	95.8[b]	99.6	97.3[b]	72.5	82.2[b]
Fully immunized children (12–23 months) (%)	38.9	53.2[b]	30.5	53.2[b]	64.1	66.1[b]	46.2	53.8[b]
Moderate–severe underweight children (under 5 years)								
Severely underweight	4.1	2.6[b]	3.1	2.6[b]	2.9	1.7[b]	5.4	4.9[b]
Moderately underweight	9.2	8.7[b]	14.4	8.7[b]	7.1	9.2[b]	13.0	13.0[b]
Active tobacco smokers (over 15 years) by sex								
Total		23.9[b]		23.9[b]		25.1[b]		28.2[b]
Male	62.7		59.3		46.9		55.7	54.1[b]
Female	2.7		3.7		22.0		4.4	2.8[b]
Active tobacco smokers by level of income (%)								
Quintile 1	34.6	n.d.	30.9	n.d.	20.8	n.d.	29.0	27.2[b]
Quintile 2	29.8	n.d.	30.4	n.d.	27.4	n.d.	29.7	29.3[b]
Quintile 3	32.5	n.d.	30.7	n.d.	23.5	n.d.	29.5	29.7[b]
Quintile 4	29.2	n.d.	29.6	n.d.	24.4	n.d.	29.5	28.5[b]
Quintile 5	25.7	n.d.	24.6	n.d.	22.9	n.d.	28.7	26.3[b]

Sources: National Socioeconomic Survey (Susenas), 2007; Basic Health Survey (Riskesdas), 2007.

a. Badan Pusat Statistik (BPS) (Statistics Indonesia).

b. Riskesdas, 2010.

Policy domain 3: Economics

The following indicators were selected for the economics domain:

- Proportion of population with income below $1 (PPP) per day
- Percentage of households with access to credit or income-generating activities
- Proportion of households in different accommodation types.

The status of those indicators is presented in table 12.

Table 12. Economics indicators

Indicator	West Jakarta		North Jakarta		Denpasar		Indonesia	
	2007	2010	2007	2010	2007	2010	2007	2010
Proportion of population with income below $1 (PPP) per day	4.2	3.5[a]	14.8	3.5[a]	2.4	4.0[a]	5.2	13.3[a]
% households with access to credit or income-generating activities	2.0	n.d.	2.6	n.d.	2.8	n.d.	5.3	n.d.
Proportion of households in different accommodation types								
Self-owned	47.3	45.2[b]	45.4	45.2[b]	47.5	60.2[b]	79.1	78.0[b]
Rented	39.3	40.6[b]	36.8	40.6[b]	39.0	28.1[b]	8.4	10.3[b]
Not rented	13.0	–	17.2	–	13.5	–	12.3	–
Other	0.4	14.2[b]	0.6	14.2[b]	–	11.7[b]	0.3	11.7[b]

Source: National Socioeconomic Survey (Susenas), 2007.

a. Central Bureau of Statistics, 2010.

b. Susenas, 2010.

Policy domain 4: Governance

The following indicators were selected for the governance domain:

- Allocation of government spending to health and other related social services:
    - Total government health expenditure
    - Ministry of Health budget
    - General government expenditures on health as % of total
    - Private health expenditure on health as % of total
    - Expenditure on health per capita

- Voter participation rate in local and national elections
- Number of development projects planned and implemented with the community
- Corruption index or measure.

The status of those indicators is presented in table 13.

Table 13. Governance indicators

Indicator	West Jakarta		North Jakarta		Denpasar		Indonesia	
	2007	2010	2007	2010	2007	2010	2007	2010
Allocation of government spending to health and other related social services:								
Total government health expenditure	Greater Jakarta: 1.3 billion Indonesian rupees				85 848 million Indonesian rupees		18.34 billion Indonesian rupees	
Ministry of Health budget							2.5%	
General government expenditures on health as % of total							51.3%	
Private health expenditure on health as % of total							48.7%	
Expenditure on health per capita	Greater Jakarta: US$18.5		Greater Jakarta: US$18.5				US$46	
Voter participation rate in local and national elections	70%		70%		70%			
Number of development projects planned and implemented with the community								
Corruption index or measure	Jakarta 4.06		Jakarta 4.06				Indonesia 4.57	

Data collection and validation

Data collection for the Urban HEART pilot in North Jakarta, West Jakarta and Denpasar was undertaken by the previous assessment team. No special effort was made to collect primary data, and most of the data used were secondary data. The aim of using publicly available data

was to ensure the validity and representativeness of the data and information, analysis of which would provide evidence for policy-making and decision-making processes. In reality, the data derived from routine data collection were, in most cases, either not complete or underreported.

Generally, data collected for the assessment of health equity was derived from publicly available data sources, including:

- Intercensal Population Survey (SUPAS), 2005
- Indonesia Demographic and Health Survey, 2007
- National Socioeconomic Survey (Susenas), 2007
- Basic Health Survey (Riskesdas), 2007 and 2010
- National Health Account (NHA), 2008
- Local Government in Figures, 2008
- Transparency International Indonesia, 2009.

With regard to qualitative data and information collection to obtain an overview of previous Urban HEART pilot implementation, focus group discussions were organized in Jakarta and Denpasar on 12 September and 28 September 2011, respectively. Each focus group discussion was attended by 25 participants, mostly intersectoral officials. The discussions were facilitated by a representative of the Indonesian Institute for Epidemiological Development and Study. Five topics were discussed:

- participants' understanding of the concept of Urban HEART
- role of teamwork in implementation of Urban HEART
- roles and tasks of various stakeholders
- indicators used
- follow-up action.

The outcomes of the focus group discussions have been used in the consideration of specific issues in this report. A summary of the outcomes can be found in annex B.

Urban Health Equity Matrix

Based on Urban HEART guidelines provided by the WHO Kobe Centre, the data collected were processed and analysed, and transferred to the Matrix used to compare indicators both between cities and within the city. Different colour codes were used according to the results for each indicator, using different threshold values as a basis for comparison. The Matrix, which is presented in annex C to this report, summarizes the performance of cities in the selected domains and enables analysis of the comparative effectiveness of the policy and programme interventions at city level.

Urban Health Equity Monitor

The Urban Health Equity Monitor is constructed to track the performance of health indicators over time and to show the trends in the inequity situation between cities and within a city. Figure 3 shows the trends in infant mortality rates in Greater Jakarta, Denpasar and Indonesia as a whole, 1994 to 2007, based on the results of the Demographic and Health Survey. As can be seen, rates for Jakarta and Denpasar are lower than for all Indonesia, though they are still higher than the rate of 17 deaths per 1000 live births needed for Indonesia to attain its target for MDG4 on reducing child mortality.

Figure 3. Infant mortality rates: Jakarta, Denpasar and Indonesia (1994–2007)

Resources used

On a trial basis, the Urban HEART pilot used resources from WHO through the APW mechanism. US$ 10 000 were provided by WHO to implement Urban HEART and develop response strategies to combat inequities identified between and within cities. So far, no pipeline budget has been provided by national or local government for Urban HEART, including for the pilot locations. However, the budget line for the Healthy Cities initiative may be available to finance health programmes related to safe water supply, provision of sanitation and other environmental health activities.

Facilitating factors

The implementation of Urban HEART in three cities in Indonesia was facilitated by the National Institute of Health Research and Development in collaboration with the Healthy Cities coordinating team. However, the output of Urban HEART needs to be followed up by policy-makers. Action is required by the respective sectors and through intersectoral action, based on the assessment results. Linkages should be made according to the coordination required to address health inequity problems, for example through provision of safe water supply. Intersectoral facilitation is also vital to address pressing health problems such as dengue haemorrhagic fever, which is the subject of a government control programme (table 14).

Table 14. Healthy Settings for dengue haemorrhagic fever control programme

Healthy settings for control of dengue fever	Areas of work	Multisectoral responsibilities
Settlements	Houses, apartments, habitations	Municipal offices for environmental health, development companies, public works, government departments for building and development guidelines
Educational institutions	Schools, campuses, religious centres, colleges	Government education agencies, administrations of educational and religious institutions
Workplaces	Government and private offices	Government agencies for trade and industry, occupational guidelines
Public places	Markets, malls, terminals, stations, airport, harbours, social locations, hotels	City governance, relevant administrations for public locations
Food establishments	Restaurants, canteens, catering services	Relevant municipal administrations and offices of food-related establishments
Health facilities	Hospitals, health centres, delivery facilities, pharmacies, clinics	Ministry and departments of health, private institutions
Sports facilities	Sports halls, playing fields, stadia	Sports ministry, private institutions

Hindering factors

As previously mentioned, health inequity is determined by multiple factors involving many sectors. Therefore, assessment for health equity should be built on the basis of a range of intersectoral components, and intersectoral coordination is key to the success of any health equity programmes. That coordination should be in place from the start of the planning process, and analysis of health-related data should be the "cement" that binds together integrated intersectoral planning. The alternative is disintegrated, sector-specific planning, with the potential for duplication of action and piecemeal implementation.

Lessons learnt

The Healthy Cities initiative could not be successfully undertaken by the health sector alone**.** Comprehensive planning is therefore needed for implementation of Urban HEART, as the assessment indicators used are multisectoral, requiring a comprehensive response. Sustainability of that response depends on a high level of multisectoral commitment to an improvement in health equity. Community involvement at grass-roots level is another key requirement for success.

5.3 Response prioritization phase

Stakeholder engagement

Health inequity has been a long-standing issue, regardless of Urban HEART. It is a human rights matter. In recognition of that, engagement of stakeholders in Urban HEART needs to be widened to other cities, and efforts made to strengthen and enhance utilization of the tool in line with Healthy Cities policies and strategies.

Prioritization of health equity issues

Health equity issues need to be given high priority in urban development and other programmes, including the National Long-Term Development Plan. Various objectives of the Ministry of Home Affairs are pertinent to raising the profile of health equity from an intersectoral viewpoint:

Objective: competitiveness

- Improve workplace and worker welfare
- Embrace a multi-ethnic and multicultural approach to sustainable development
- Promote a healthy investment climate
- Improve urban resources and infrastructure, inter-city and city-village linkages
- Adopt an environment-friendly philosophy
- Promote efficient use of energy
- Develop residential areas without slum growth
- Provide basic services, including adequate transport.

Objective: equity and fairness

- Ensure balanced growth of cities
- Promote inter-city economic linkages
- Undertake proper urban planning
- Consider the role and function of small and medium-sized urban settlements
- Ensure the urban environment is conducive to economic activities
- Revitalize cities and towns through zoning and functional definition
- Provide public facilities and services.

Prioritization of interventions and strategies

Prioritization of interventions is based on the mechanism of the Development and Planning Forum, which is a system of bottom-up planning through the participation of a wide range of stakeholders from community, through village, to central level. In line with the Healthy Cities initiative, efforts are concentrated on the development of health centres in different urban locations and the provision of health services for urban slum areas. National guidelines

for the latter are being prepared for publication and dissemination, and will include the Urban HEART concept.

Development of proposal or action plan

The specific proposal or action plan is undertaken by a community working group at village level. In Jakarta action is at the level of the family peace neighbourhood, which is a subvillage community organization. The Healthy Cities initiative includes creation of a working group for community self-assessment to help identify community needs and actions required. A plan of action is set up on that basis.

Resources used

Human, financial and material resources were provided by local government. In addition, resources for implementation of the Urban HEART pilot were provided by WHO, though there was no budget for follow-up action; any resources for such action were expected to come from the city budget.

Facilitating factors

As the Urban HEART concept is intended to guide policy- and decision-makers, a facilitating factor is ensuring that the results are used as evidence by policy- and decision-makers. Social acceptance of the measures to be implemented is also crucial. When undertaking trial activities under Urban HEART, it is essential to build the capacity of concerned personnel at city level, though to some extent that has been provided for in the Healthy Cities initiative.

Hindering factors

Introduction of a new concept such as Urban HEART requires that efforts are made to create an environment conducive to the success of the operation. Piloting Urban HEART is only the starting point, and needs to be followed by further action, including disseminating the results for replication in other areas. In this connection, efforts are needed to widen social acceptance and knowledge of the tool. Training workshops would help introduce the concept to relevant officers and stakeholders and build capacity to sustain the momentum of activities, and this eventuality has been provided for by WHO.

In addition, disaggregated data for health outcome indicators, and for physical, social, economic and governance indicators, are still difficult to obtain. The data used are mostly secondary data from various surveys or institutions. Community-based data may differ from routinely collected facility-based data, leading to some disagreements between government officials.

A further problem has been delays in documentation and evaluation of the Urban HEART pilot, leading to a slowing of momentum and a decline in stakeholder interest. Several of those involved have moved to different posts.

Lessons learnt

The Urban HEART pilot was undertaken by the National Institute of Health Research and Development along with City Health Office staff, in accordance with the Urban HEART

guidelines provided by WHO. The results presented to the intersectoral team of the Healthy Cities programme demonstrated the value of support from local government and other related sectors and the commitment of all stakeholders. There was agreement that the exercise would improve the process of identifying interventions through the sharing of successful experiences among sectors and the active participation of local community groups. Problems identified included the extent to which the principle of equity can be extended to illegal residents, and illegal occupancy of public land. Other issues for further discussion include the experience of local government in implementing free health care for the poor, the distribution of cheap rice and cash transfers, and free contraception for the poor, all of relevance to closing the health equity gap.

5.4 Policy development and programme implementation phase

Policy uptake and development

A number of policies have been developed with regard to urban health equity. After much debate, the House of Representatives finally agreed to enact the Social Security Providers (BPJS) Law on 28 October 2011, thus providing full health and job protection for all Indonesian citizens. The new law requires state-owned insurance companies PT Askes, PT Jamsostek, PT Taspen and PT Asabri to become non-profit institutions working directly under the President's supervision, with the last three companies merged into one. The law will be effected in 2014.

Other relevant regulations and decrees include:

- Law No. 32/2004 on decentralization of local government;
- Government Regulation No. 38/2007 on distribution of tasks among central, provincial, and district or municipal governments;
- Common Rule No. 34/2009 between the Ministry of Interior and the Ministry of Health about the implementation of the Healthy Districts and Healthy Cities initiatives;
- Ministry of Interior Regulation No. 57/2010 on guidance for city service standards;
- Ministry of Health Decree No. 828/2008 on guidelines for minimum service standards for health at district and city level, with 18 indicators;
- Jakarta Government Rule No. 4/2009 on provincial health systems.

Programme development and implementation

Programme development includes health inequity reduction measures based on the Development and Planning Forum mechanism and discussed through the Regional Development Planning Agency (Bappeda) and approved by local parliament. The main priority of efforts to reduce health inequity is to increase access to and quality of community health services, especially for poor, disadvantaged and marginal populations within the city. The implementation of activities is carried out at the community village level through intersectoral collaboration and in coordination with the City Health Office.

Status of implementation

Several site visits were undertaken to West Jakarta, North Jakarta and Denpasar to inspect selected activities that are attempting to upgrade local community facilities and reduce health inequities. Relevant ongoing activities include:

City of West Jakarta

A site visit to the village of Duri Kosambi in Cengkareng subdistrict, West Jakarta, was undertaken to look at the community village activities related to reduction of health inequities, with intersectoral government support. The following are examples of actions undertaken.

- For sanitation and sewerage improvement, a community water and latrine project was organized by the community working group for Healthy Cities at village level at Duri Kosambi village.

  [Picture 1: Community latrine and piped water]

  [Picture 2: Village housing]

- A healthy and clean environment was promoted through improvements to small roads and alleys within crowded housing areas. Stagnant water was drained away and the environment improved by planting greenery in both public areas and individual compounds.

  [Picture 3: Improved environment with pavement and greenery]

  [Picture 4: Plan of latrine with communal septic tank]

- To improve nutrition for children under 5 years of age, local soybean was mixed with fish to make a more nutritious food.

- The village community has also developed communal, concrete septic tanks, each covering nine households. This helps avoid water pump contamination by sewage in crowded housing areas.

- The National Programme on Community Empowerment, inaugurated in 2009, helped rehabilitation of village roads in collaboration with local communities.

City of North Jakarta

A site visit to Rawa Badak village on 24 October 2011, organized by the Jakarta Provincial Health Office along with North Jakarta City Health Office, looked at current activities related to health inequity problems. Field visits were undertaken to community villages to witness the following activities.

- A green environment programme, similar to that carried out in West Jakarta, was put in place, providing benefits in a coastal area with relatively high daytime temperatures.

  [Picture 5: The Healthy Cities evaluation team visits Rawa Badak village]

- An integrated health post was set up. In addition to the regular activities of the health post, a number of community-based income-generating activities were organized, some of which are described below.
- A scheme was put in place to recycle both organic and inorganic garbage, including plastics. The recycling was carried out by the village women's working group, which creates such products as handbags, mats and children's toys.
- Under the aegis of the integrated health post, a healthy city working group was set up at village level. Its main function was to organize regular development planning forums for Rawa Badak village. The forums would identify community problems and needs requiring a multisectoral approach for their resolution in line with local and national policies.
- In addition, a bank was set up in a community village at Cilincing for people to deposit various types of garbage for recycling, including processing green vegetable waste into fertilizer by machine; shredding plastic bottles and glass materials into smaller pieces for recycling; and making useful products, such as tables or plastic bags, from recycled materials. Other activities associated with the garbage bank include fish farming and growing herbs. Management of the bank uses a simple computerized administration system.

  [Picture 6: Processing green matter into fertilizer]

  [Picture 7: Shredding plastic and glass]

  [Picture 8: Various items made from recycled materials, including plastics]

  [Picture 9: Fish farming]

  [Picture 10: Garbage bank office]
- The system flow for the bank comprises garbage detection; collection; processing; and marketing. Members pay a basic price of 1500 Indonesian rupiahs per kilogram of garbage. A borrowing system is also in place for members, giving benefits of better garbage management, income regeneration, and environment-friendly recycling of organic and inorganic materials at community level. The bank started with 70 members, and current membership is over 500.

City of Denpasar

A site visit was undertaken to Pemecutan Kaya in Denpasar to look at the community village activities related to health inequity reduction. Ongoing activities are described below.

- To provide community sanitation, the Public Works and Environment Office, Denpasar, set up a sewerage system for households in poor and crowded living conditions. The infrastructure aimed to protect household in slum areas against sewage contamination.

  [Pictures 11 and 12: Sewerage system established in community sanitation project]

- For sanitary garbage management, a project is being developing to assist garbage disposal and recycling. This involves construction of a facility in Denpasar for processing garbage and recycling it into useful products. All organic and inorganic garbage will be collected and separated into different categories, and processed according to the objectives of the programme, which is an intersectoral initiative aiming to improve equity.

  [Pictures 13 and 14: Construction of infrastructure for garbage disposal and processing]

- An integrated community sanitation programme is being implemented to remove sewage from family housing using a solar-powered system. Again, the programme adopts an intersectoral approach.

  [Picture 15: Integrated community sewage disposal programme]

While the above-mentioned programmes fall under the Public Works and Environment Office of the City of Denpasar, they are organized and coordinated by the community village working group under the Healthy Cities initiative.

Other health equity-related projects in Denpasar include a healthy housing and environmental improvement project, and free health service provision for poor populations under a health maintenance scheme.

Sustainability measures

Efforts have been made to ensure the sustainability of ongoing activities, as follows:

- The ongoing activities are being carried out by the concerned subvillage community working groups, as proposed on the basis of the community needs assessment through a self-assessment survey.
- Proposed activities are submitted through a given procedure, depending on the cluster in which they fall, for consideration by the City Health Office or the Local Planning Board, or at national level if necessary. Sustainability considerations should be included within the proposal.
- Planning is on an annual basis according to the mechanism of the Development and Planning Forum, which is standard procedure for bottom-up planning in Indonesia, starting from the community village level and proceeding through subdistrict, district or city, province and finally central level.
- The district and city levels are mainly responsible for ensuring the sustainability of activities according to Law No. 32/2004 on decentralization of local government.

Facilitating factors

The urban health equity assessment is influenced by many factors, including the above-mentioned procedural issues. Other facilitating factors include:

- The assessment requires mobilization of human resources with the capacity to undertake and manage the process of assessment, including the capacity to interpret the findings through application of the Urban Health Equity Matrix.
- As Urban HEART is a relatively new tool for most of the stakeholders, adequate explanation of the methodology and the benefits of using the tool is needed.
- The results of the assessment need to be discussed and analysed and response strategies proposed to deal with the issues of health inequity revealed by the assessment.
- All of these matters require support and facilities – not only through mobilization of human resources, but also financial support and government commitment to the use of the tool by decision-makers.

Hindering factors

The application of Urban HEART requires a certain level of competency and supportive conditions, absence of which can hinder the process:

- The assessment needs to be undertaken by a cohesive intersectoral team who have a clear understanding of the tool before the assessment is undertaken.
- Each related sector should be clearly informed and accept their role, either in assessment or in providing response activities for inequity reduction. Preconditioning is needed in readiness for implementation of Urban HEART.
- Positive perception and acceptance by government officials and related stakeholders, as well as community involvement in the utilization of Urban HEART, are extremely important for further actions.
- Support and cooperation among health and other programmes is also required, organized under strong leadership and displaying good governance.
- The assessment results and responses need to be presented to and agreed upon by key intersectoral decision-makers and stakeholders.

Lessons learnt

- The support and commitment of the city authorities and local government, including at sectoral level, is key to the effectiveness and success of any programme on health inequity reduction.
- It is advantageous to improve the process of identifying interventions through the sharing of successful experiences by each sector, and active participation of local community groups.
- Specific problems may arise and need to be taken into account to ensure the success of a health equity programme, such as the presence of illegal migrants, who do not have the rights and access of ordinary citizens and may illegally occupy public land.
- The availability of sound data and information determines the sensitivity of the assessment and specificity of the provision of responses.

5.5 Impact and outcome evaluation

Benefit: to learn how to assess the health inequity situation systematically, and to focus on problems related to health inequity.

Challenges: Lack of availability of data, inadequate budget allocation and prioritization, inadequate attention to monitoring and assessing the impact of interventions.

Monitoring and evaluation mechanisms

The implementation status of health equity assessment and efforts to respond to inequities need to be regularly monitored and evaluated according to timeframe, location and human resources.

- Efforts to monitor the responses to the assessment results should be undertaken by the relevant working unit using the appropriate mechanism.
- Health-related sectors should be familiarized with the selected indicators for assessment of health inequity and the selected strategies for responses.
- Evaluation of health inequity and responses should be built into the available system, with emphasis on the use of the above-mentioned indicators.
- Collection of specific data for monitoring and evaluation of certain aspects of health inequity needs to be undertaken.

Improvement in awareness raising and priority setting

With regard to improvement of awareness raising and priority setting, the evaluation finds that:

- In theory, using the Matrix for targeting and prioritization should be easier for those indicators where the widest gaps are apparent.
- More stakeholders should be made aware that health inequity is a result of inadequate social and economic conditions.
- Intersectoral collaboration on health determinants, such as those related to social and economic conditions, public works, the environment, and governance, should be enhanced.

Scaling up Urban HEART

- The Ministry of Health has included the Urban HEART concept in guidelines for strengthening primary health care for slum and peripheral areas and poor and disadvantaged populations.
- Dissemination of Urban HEART guidelines is essential, as Indonesia currently has 98 cities that are categorized as being at the same level as districts.
- Urban HEART has the capacity to promote and improve implementation of the Healthy Cities initiative in Indonesia.

Additional policies and programmes

As health equity is a dynamic human issue, there is scope for extending or adapting it in accordance with national and subnational (decentralization) policies and regulations, including:

- The Social Security Providers (BPJS) Law, passed by the House of Representatives on 28 October 2011, which allows full health and job protection for all citizens. This national law will be effected in 2014.
- Jakarta Government Rule No. 4/2009 on provincial health systems, which covers the whole rule for health system development programmes and services to be followed by health and health-related sectors.
- The policy on free health care for the poor, implemented in Jakarta and Denpasar.

Intersectoral action on health

As mentioned above, documentation and evaluation for Urban HEART, undertaken in Jakarta and Denpasar, revealed several examples of intersectoral action for health, including:

- Action at community village level in West and North Jakarta
- Green environment activities in West and North Jakarta
- Community sanitation project and sewerage development in Denpasar
- Integrated community sanitation project using solar power, Denpasar
- Garbage management and recycling in Denpasar
- Health insurance with free services for the poor in Jakarta and Denpasar.

Intervention outcomes on health and health equity

- Life expectancy at birth has been increased significantly, as shown by the health outcome indicators.
- There has been a decrease in the infant mortality rate due to interventions in the health and health-related sectors.
- The maternal mortality ratio has also moved towards the MDG target.
- Data show a trend towards improvement of almost all selected outcome indicators on a year-to-year basis.

6. Summary of key lessons, impacts and outcomes, and recommendations

6.1 Lessons learnt

Key lessons learnt from the overall process of the piloting experience, and issues to be considered in future implementation of Urban HEART, include the following:

- Health inequity is actually a long-standing issue that has been identified in a number of international initiatives and forums, including Health for All by the year 2000, and other outcomes of the International Conference on Primary Health Care, Alma-Ata, 1978.
- The piloting of Urban HEART has provided an additional effective tool for the City Health Office in its efforts to accelerate health inequity reduction in various sectors in the coming years.
- The tool itself is not entirely new but the systematic and practical approach makes it very user friendly. The indicators selected for implementation of Urban HEART in 2009 have been assessed during the evaluation process and will be retained unchanged.
- A key to the success of the assessment is the availability of accurate and relevant data, starting from community data at village level, through subdistrict to city level.
- Where data are not available, the assessment should be ready to undertake a simple rapid survey for collection of relevant data and information.
- The response strategies prompted by Urban HEART may be difficult to incorporate into the decision-making process due to sectoral self-protection and conservatism. Policy-makers at city level should show guidance and leadership in resolving this problem.
- The experience of Urban HEART implementation in three pilot cities could play an important role in inspiring decision-makers and health-related stakeholders to gear up policies for better health equity in the 98 cities of Indonesia.
- As health is related to almost all aspects of human life, Urban HEART could be modified to embrace other sectors, depending on their suitability for such an approach.

6.2 Key impacts and outcomes of the piloting experience

- Given the importance of urban health, it is important to organize intersectoral responses towards health challenges in towns and cities. Responses do not lie with the health sector alone but with decisions made in other sectors and areas: in local government, education, urban planning, physical infrastructure, and access to social and health services.
- The concerned professionals have to face the challenges of overloaded water and sanitation systems, polluting traffic and factories, lack of space to walk or cycle, inadequate waste disposal, and crime and injury.
- The Urban HEART pilot experience has opened up opportunities to improve intersectoral collaboration for health inequity reduction.
- More government officials and stakeholders now have a better understanding of health inequity problems and an appropriate tool to respond to those problems through community action and support, and intersectoral collaboration.

- The availability of high-quality, disaggregated data and information remains a key problem for assessment and formulation of responses. However, Indonesia has long experience of undertaking self-assessment, including for identification of needs at community level.
- Urban HEART has been perceived as having a close connection with health policy and the Healthy Cities and Healthy Districts initiatives in Indonesia. Urban HEART is recognized as an improved approach and tool for health inequity reduction and a vital component of any measures to improve urban health. It will be incorporated in the new guidelines for primary health care in slum areas.
- The Social Security Providers (BPJS) Law, which will become effective in 2014, will be an important tool in enabling full health and job protection for all citizens of Indonesia.

6.3 Recommendations

- The six steps of the Urban HEART process, provided within the guidelines, need to be carried out consistently and with strong leadership.
- Quantitative data collection for assessment may need to be combined with qualitative data collection to assist evidence-based policy-making.
- As Urban HEART cannot be implemented by the health sector alone, its application should be coordinated by a suitable unit to facilitate intersectoral action at city level. In the case of Jakarta and Denpasar, the Bureau of Social Welfare and the Local Planning Board offer suitable focus points.
- As the Healthy Cities initiative has been in place in Indonesia over a long period, the application of Urban HEART needs to be modified according to the existing Indonesian Healthy Cities approach to ensure its convergence and sustainability. To assist this, functional alignment should be considered between the Healthy Cities team and the Urban HEART team.
- The response strategies for reduction of health inequities should be a part of the wider social and development agenda for improvement in the quality of human life. The success of selected priority strategies depends on how best social determinant factors are identified and analysed in relation to the health inequities occurring in a particular community.
- Use of Urban HEART should be promoted and disseminated widely in all (98) cities in Indonesia. This includes development of Indonesian Urban HEART guidelines and provision of training for city support teams (which, as stated above, may comprise the Healthy Cities team).
- Urban HEART should be introduced into the decision-making processes at an early stage to ensure acceptance of the results.
- Health equity is a never-ending issue. It should always be developing within a real context and in line with national and local development policies and strategies, as

well as with their existing programmes. At the moment, Urban HEART has been used to some extent in the formulation of public health policy, implementation of healthy city projects, and attaining the MDG targets in cities.

- To be more relevant, outcome indicators should use data from higher administrative levels (for example province level).
- Adequate external resources need to be provided by WHO, especially for socialization of Urban HEART implementation and development of an established model suitable for Indonesia conditions in order to ensure sustainability.
- Strong support should be mobilized through a WHO collaborative programme with the Government of Indonesia on urban health and Healthy Cities.

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Annex A. Minimum service standards on health at district and city levels (Ministry of Health Rule No. 741/2008)

A	Basic health service indicators	Target 2010	Target 2015
1	Coverage of antenatal care (fourth visit)		95%
2	Coverage of pregnancy complications handled		80%
3	Coverage of deliveries assisted by personnel with midwife competencies		90%
4	Coverage of postnatal service		90%
5	Coverage of neonatal cases handled	80%	
6	Coverage of neonatal visits	90%	
7	Coverage of universal childhood immunization by villages	100%	
8	Coverage of health services for children under 5	90%	
9	Coverage of additional food for poor children (aged 6–24 months)	100%	
10	Coverage of children with moderate to severe malnourishment receiving health care	100%	
11	Coverage of primary school children receiving health screening	100%	
12	Coverage of active family planning participants	70%	
13	Coverage of case detection and disease treatment	100%	
14	Coverage of primary health care for the poor		100%
B	**Referral of health service**		
1	Coverage of referral health services for poor patients		100%
2	Coverage of first-level emergency services		100%
C	**Epidemiological investigation and containment measures for emergencies**		
1	Coverage of village emergency events with epidemiological investigation within 24 hours		100%
D	**Health promotion and community empowerment**		
1	Coverage of active village alerts		80%

Annex B. Summary of results of focus group discussions on Urban HEART

Discussion topics / guiding questions	North and West Jakarta responses 12 Sep 2011	Denpasar responses 28 Sept 2011
A. Participants' understanding of Urban HEART concept		
What is your level of understanding of Urban HEART?	It is a community effort, as opposed to government work units It is an effort to improve health status and focus on improvement of environmental factors It is an instrument to improve community status at city level, with an emphasis on less fortunate community groups It is a WHO concept to find out information about the balance of health for policy-making – "what and how to do"	Most participants knew nothing about Urban HEART before explanation Institutional representatives who were invited were not familiar with the term Urban HEART They were, however, familiar with health service equity and intersectoral collaboration on health
Which government work unit was involved in previous Urban HEART?	City of Jakarta Health Office Public Works and Environment Office is responsible for physical infrastructure and health & environment programmes, including community sanitation Economic, sport, social welfare, family planning departments	City of Denpasar Health Office Public Works and Environment Office is responsible for physical infrastructure and health & environment programmes, including community sanitation
B. Potential for teamwork on Urban HEART		
Any special team to handle Urban HEART?	There is no special team to handle Urban HEART in Jakarta However, the Healthy Cities team has an intersectoral basis and could contribute Some team efforts to combat health inequity could be of assistance, including rice for the poor, health management and care for the poor, working group for the poor	There is a lack of such expertise in Denpasar The Healthy Cities team, however, may have the intersectoral potential required
What are the job requirements for working units within the established team?	Most sectors have issues of health equity that are relevant to Urban HEART For example, the family welfare empowerment unit has a function to enhance health lifestyles There are many examples of community team participation on health matters Regional work units have synergistic	Working unit themes: Landscape and housing issues: take account of populations without housing, poor people Family planning: relevant issues include empowerment of women, free family planning Tourism: include hotel and tourism staff

Discussion topics / guiding questions	North and West Jakarta responses 12 Sep 2011	Denpasar responses 28 Sept 2011
	aspects Any working unit will have a role to play in health inequity reduction, the question is whether they are given an appropriate role to play and a functional mandate	in matters of disease and illness control Social welfare: consider the unemployed and poor, and poor housing conditions
Any regular meetings among team members?	Team meetings are held for specific purposes, for example healthy city forum, with exchange of information and action plan if needed Each working unit applies its own mechanism	Regular meetings of the healthy city forum, exchange information and develop action plan if needed Tasks distributed according to the main job responsibilities and indicators Community role and involvement in meetings Three-monthly monitoring and evaluation
C. Roles or tasks of stakeholders		
Any activities carried out relevant to Urban HEART?	Each unit carried out their own roles in terms of given activities according to the established plan of local government, including community village alert These activities are coordinated and implemented at community and subvillage level	Activities have been undertaken prior to the introduction of Urban HEART, including community sanitation and garbage disposal and recycling projects These activities are usually well coordinated Meetings are held for exchange of information and experiences
Any focus areas for application of Urban HEART in your area, and what criteria are used?	The areas of work related to Urban HEART are: Sanitation and garbage disposal Environment, green projects Community village alert Integrated health post, including nutrition	Health facilities, including hospitals Transport, tourism, insurance of visitors
D. Indicators used		
Source of budget for activities related to Urban HEART?	Source of budget for activities related to Urban HEART is mostly from local budget Special budget for health services and treatment of the poor covered by local insurance scheme	Source of budget for activities related to Urban HEART is mostly from local budget Special budget for free health care and treatment for the poor is covered by local government
Indicators used in relation to working	Three aspects of measurement for slum areas, namely population, housing,	Implementation status of community sanitation, including integrated septic

Discussion topics / guiding questions	North and West Jakarta responses 12 Sep 2011	Denpasar responses 28 Sept 2011
units (other than health sector) of relevance to Urban HEART?	environment Indicators relate to population density, governance, housing construction and ventilation, road conditions, sewage and garbage disposal Other indicators may refer to distribution of rice to the poor, achievement of MDGs	tank Sustainability of project maintained by local community Active role of community in health equity matters Indicators for disadvantaged groups, including distribution of rice to the poor, achievement of MDGs, free health care for the poor Each related unit used their own indicators to measure their targets
What sort of data used for measuring programme indicators?	Regular reports Ad hoc field monitoring Statistics Office data	Regular reports Ad hoc field monitoring Statistics Office data
E. Follow-up action		
How will follow-up action plans and budgeting be undertaken with regard to Urban HEART?	As a formal government mechanism, the working unit programmes related to health equity should have their respective plans for follow-up The development and planning forum can function as the first step to prepare responses to reduce health gaps, integrate resources, and gather data for submission to higher levels The village community working group is the implementation unit for follow-up actions The problem remains of development planning coordination between sectors and departments due to compartmentalized institutional thinking	A new or special team is not necessary All working units have their own follow-up planning Local planning bodies deal with slum areas, including where migrants are illegally occupying land Development and planning forum could integrate resources and gather data for sustainable follow-up actions Development and planning forum could instigate intersectoral action, depending on the involvement of related sectors

[Picture 16: Focus group discussion in Jakarta health office, 12 September 2011]

[Picture 17: Focus group discussion in Denpasar health office, 28 September 2011]

Annex C. Urban Health Equity Matrix

			West Jakarta		North Jakarta		Deapaser		Jakarta	
			2007	2010	2007	2010	2007	2010	2007	2010
Health Out comes		Life Expectancy at birth	ND	ND	ND	ND	ND	ND		
	MORTALITY	Infant Mortality Rate / 1000 LB	ND	ND	ND	ND	ND	ND		
		Under-five Mortality Rate2	ND	ND	ND	ND	ND	ND		
		Maternal Mortality Rate2	ND	ND	ND	ND	ND	ND		
	MORBIDITY	Tumors /cancer		ND		ND		ND		
		Diabetes Mellitus		ND		ND		ND		
		Heart Diseases (D)		ND		ND		ND		
		Hypertension (D)		ND		ND		ND		
		Stroke (D)		ND		ND		ND		
		Gangguan Mental Emosional		ND		ND		ND		
		Mental Illness		ND		ND		ND		
		Acute Respiratory Infection		ND		ND		ND		
		Pneumonia		ND		ND		ND		
		Tuberculosis								

		Diare (DG)		ND		ND		ND		
Policy Doneel n 1		Proportion of population with sustainable access water source								
		Percentage of households with access sanitation								
		Percentage of households using solid fuels (wood, charcoal, etc)								
Policy Doneel n 2		Literacy rate								
		Proportion of births attended by skilled health personnel								
		Percentage of fully immunized infants								
		Proportion of underweight children under five years of age (severely)								
		Prevalence rate of tobacco smoking, adult								
Policy Doneel n 3		Proportion of population below $1 (PPP) per day								
		Percentage of households with access to credit/income-generating activities		ND		ND		ND		
		Percentage of HH that rent the houses they are staying								
Policy Doneel n 4		Percentage of government spending allocated to health and education		ND		ND		ND		
		Voter participation rate in local / national elections.	ND	ND	ND	ND	ND	ND		

		Corruption index or measure	ND	ND	ND	ND	ND	ND		ND