Report on documentation and evaluation of Urban HEART pilot in the Philippines

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Contents

Executive summary

The World Health Organization (WHO), in its effort to address health inequity, worked together with 17 cities from 10 countries between 2008 and 2009 to develop and pilot-test the Urban Health Equity Assessment and Response Tool (Urban HEART), a planning and standardized tool intended for local policy-makers and leaders to guide them in using evidence to take action on health equities. Urban HEART was designed as a user-friendly guide for decision-makers at national and local levels to 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.

The Philippines was selected as one of the pilot countries for the application of Urban HEART. Seven cities – Naga, Tacloban, Parañaque, Taguig, Olongapo, Zamboanga and Davao – were chosen as initial implementation sites. The general objectives of this report are to document how Urban HEART was applied; and evaluate the processes and impact of its application in the pilot cities in the country. Hence, it may provide a basis for continuous improvement of the tool, advocacy of its use, and creation of greater consciousness to promote urban health equity.

The process evaluation focused on documentation of the different processes involved in the use of Urban HEART at different stages of the planning cycle.

In the **assessment phase**, all the local government units formed multisectoral and multi-agency technical working groups (TWGs), mostly headed by the City Health Office, except for Tacloban, where leadership was lodged under the Office of the City Mayor. Most of the cities were able to gather secondary data from different local agencies, though some faced difficulties due to lack of disaggregated data by barangay, or unavailability of data (for example life expectancy at birth, households using solid fuel). Primary data collection was conducted in three cities. Of particular interest at this stage was the use of the Urban Health Equity Matrix and the Urban Health Equity Monitor, whereby TWGs in the pilot cities came up with their own criteria for selecting their priority barangays because there were no common criteria for "richest" and "poorest" barangays.

In the **response phase**, the pilot local government units identified and prioritized appropriate strategies and interventions that could address inequities in urban health based on the results of the assessment, using the Matrix and Monitor. During this phase, stakeholder engagement varied from city to city. Naga TWG prioritized health equity issues while Zamboanga engaged the community. Identification of interventions and strategies to address equity gaps was based on the criteria provided in the Urban HEART programme guidelines. Intervention plans were developed and approved by the cities' respective local chief executives. One issue worth noting is that the intervention plans failed to include desired objectives and expected outcomes that had visible and measurable results.

In the **policy phase**, selected interventions identified during the response phase were budgeted and prioritized to ensure their inclusion in the policy-making process at the local government level. Most of the policies adopted under Urban HEART were either through the

passing of resolutions or issuance of an executive ordinance by the local chief executives for the creation of the TWG. No comprehensive and integrated programme to address health inequities, including social determinants of health, was developed in any of the pilot cities.

In the **programme phase**, the interventions to address the identified health inequities in the pilot cities were at their different stages of implementation. Except for Parañaque, where local government offices issued and approved a resolution adopting Urban HEART as a guideline in the formulation of health policies for the city, the rest of the pilot cities had not reached this phase. Visible particularly were the identified interventions that involved infrastructure and capacity-building activities. Some however were either subverted or held in abeyance. For the seven pilot cities, the concept of monitoring and evaluation was not included in the plan, thus deterring any assessment of effectiveness.

Key factors that facilitated the implementation of the Urban HEART programme by local government units were (a) the support of the local chief executives, which was crucial for generating and rallying support for the programme from the different departments in the local government units, and other stakeholders from government, the private sector and communities; (b) establishment of multisectoral and multi-agency TWGs that facilitated collaboration and coordination in the conduct of the different activities of the programme; (c) the user-friendliness of the Urban HEART tools; and (d) financial support provided by the Department of Health/WHO in the conduct of the different activities under Urban HEART.

On the other hand, some of the key difficulties encountered by the TWGs that may have hindered the smooth implementation of the programme included (a) delays in the release of funds, affecting the timely implementation of planned activities; (b) absence of a standard process and criteria for selecting extreme population groups where the identification of "rich" and "poor" population groups forms a critical foundation for Urban HEART; (c) difficulty in data collection activities and securing disaggregated data; and (d) lack of a standard rating system for prioritizing interventions. Likewise, Urban HEART was considered a special project in most of the pilot cities, thus giving it a "temporary" status that hindered it from being integrated into the developmental planning processes and frameworks in the local government units. The absence of standard templates, and guidance on frequency, responsibility and methodology, also made it difficult for the TWGs to institutionalize an effective and efficient monitoring and evaluation system to manage results.

The general recommendations for scaling-up Urban HEART, both in the pilot cities and other expansion cities, include (a) clarify the roles of various representatives at various levels in the TWG, and set guidelines for managing the TWGs; (b) strengthen the integration of Urban HEART into the local development planning and performance management frameworks of local government units; (c) set standard criteria and processes for selecting the richest and poorest population groups, and include these in the implementing guidelines; (d) strengthen the participation of the target communities in the identification of interventions so as to respond to identified equity problems; (e) strengthen project planning and project management following the results-based management framework, to be included in the implementing guidelines; and (f) strengthen and institutionalize the programme's monitoring and evaluation mechanisms.

1. Introduction

1.1 Rationale

By 2020 the world's urban population will rise by almost 1.5 billion. Cities and towns house a growing proportion of marginalized people, partly because of the increased share of urban population of the total but also because economic recession and adjustment policies often hit poorer urban residents the hardest. Cities are associated with economic growth and wealth generation and yet inequality is high. Health equity is a moral position as well as a logically derived principle, and there are both political proponents and opponents of its underlying values. Equity is clearly not only about numbers that can be statistically processed and presented in tables and charts – it is about people, their values and what they want from life (*1*). There is a need to "focus not only on the extremes of income poverty but on the opportunity, empowerment, security and dignity that disadvantaged people want in rich and poor countries alike" (*2*).

One view of equity in delivery holds that the poor and other vulnerable groups should be guaranteed an essential package of health services. The burden of disease exacts a much heavier toll on the poor, who continue to suffer premature death and disability from communicable diseases, childbearing and other conditions, many of which are amenable to treatment through basic medical interventions but tend to be characterized by limited access to and low utilization of health services. Households in the lowest income quintile, and those in rural areas, use fewer health services than those in higher income quintiles or in urban areas.

Furthermore, there is ample evidence that social factors, including education, employment status, income level, gender and ethnicity, have a marked influence on how healthy a person is. In all countries – whether low, middle or high income – there are wide disparities in the health status of different social groups, in large part due to these social determinants of health. The lower an individual's socioeconomic position, the higher their risk of poor health. These disadvantaged groups face financial, geographical and sociocultural barriers to equitable access to health services.

In 2008 and 2009, the World Health Organization (WHO), in its effort to address inequity, worked together with 17 cities from 10 countries and developed and pilot-tested the Urban Health Equity Assessment and Response Tool (Urban HEART). This is a planning and standardized tool intended for local policy-makers and leaders to guide them in gathering evidence and taking action on health inequity. WHO research on the social determinants of health has concluded that both technical analysis and political commitment are needed to strengthen health systems and address health inequity. Technical analysis can help identify which features of health systems to nurture and protect. Political action and commitment is needed to confront the powerful actors, institutional constraints and sociocultural norms that act as brakes on health system development for health equity.

In the Philippines, urban dwellers made up 60% of the total population in 2007, with the prospect of reaching between 70% and 75% in the next decade (*3*). This swift urbanization

presents new challenges to the national health care policy and health systems. With the devolution of the health care delivery system to local government units, it is more than ever necessary to equip local decision- and policy-makers on health care outcomes with sufficient tools to diagnose gaps and inequities in delivery of urban health services.

Urban HEART must be the first tool used when approaching the urban health system. Urban HEART was developed by WHO to equip policy-makers with the necessary evidence and 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 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.

The Philippines was selected as one of the pilot countries for the application of Urban HEART. Seven cities were chosen as the implementation sites: Naga, Tacloban, Parañaque, Taguig, Olongapo, Zamboanga and Davao. The processes, mechanisms and achievements of Urban HEART implementation in the Philippines need to be documented and evaluated. This will provide the basis for continuous improvement of the tool, advocacy of its use and creation of 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 using an equity perspective on health and development work, with the end goal of narrowing inequities in health.

1.2 Objectives

The general objectives were:

1. to document how Urban HEART was applied
2. to evaluate the process and impact of the Urban HEART pilot application.

Specific objectives of the project were:

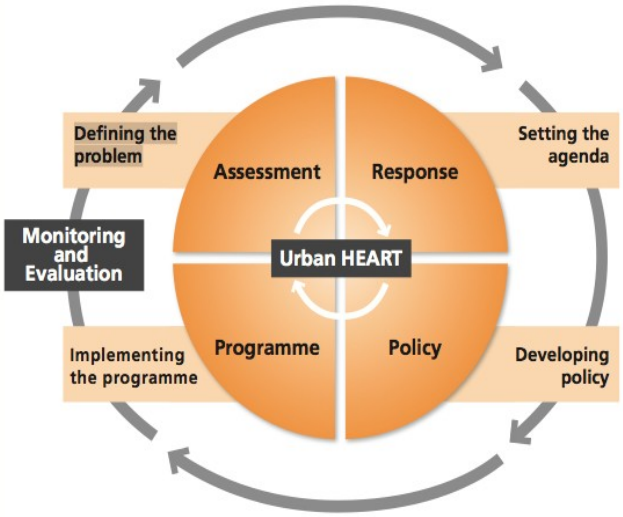
1. to describe the following:
   - 1.1 content of Urban HEART as adapted to the pilot sites
   - 1.2 processes, structures and mechanisms of implementation
   - 1.3 intersectoral actions generated or strengthened by the process
   - 1.4 implementation issues, including hindering and facilitating factors
   - 1.5 accomplishments of the project
2. to review and validate the data generated for the health equity assessment
3. to identify recommendations for improving and scaling up the implementation of Urban HEART.

1.3 Framework and methodology

Framework

This evaluation and documentation is consistent with the framework for implementation of Urban HEART, as shown in figure 1, and focuses on two main areas: *process* and *outcome*.

Figure 1. Urban HEART integrated into the local planning cycle



Source: Urban HEART user manual (*4*).

The process evaluation focused on documentation of the different processes involved in the use of Urban HEART at different stages of the local planning cycle, including the implementation issues encountered and actions taken to address those issues. In addition, it documented the different strategies adopted by the pilot local government units in the use of Urban HEART depending on the specific situation and environment of the pilot local government units.

For the *assessment phase*, the process evaluation described the processes, structures and mechanisms involved and established the means to identify the indicators for each of the pilot local government units, and to gather and validate data for agreed indicators. Of particular interest at this stage was the documentation and validation of how the pilot local government units gathered and presented their data using the Urban Health Equity Matrix and the Urban Health Equity Monitor.

For the *response phase*, the process evaluation focused on describing how the pilot local government units identified and prioritized appropriate strategies and interventions that could address inequities in urban health based on the results of the assessment. Issues and challenges encountered in engaging the different stakeholders in the identification of priority response strategies and interventions are discussed in this section.

Although the Urban HEART user manual (*4*), published by WHO in 2010, does not provide specific guidance on how participating local government units would tackle the policy and programme phases of Urban HEART, this evaluation nonetheless included those phases in the evaluation report.

For the *policy phase*, the process evaluation described how selected interventions identified during the response phase were budgeted and prioritized to ensure their inclusion in the policy-making process at the local government level. Processes, structures and mechanisms put in place in support of the priority strategies and interventions, including the issues and challenges encountered, are likewise expounded in this section.

For the *programme phase*, the process evaluation described the processes, structures and mechanisms adopted and put in place to support the effective and efficient implementation of the priority strategies and interventions on urban health equity. Documentation of the issues and challenges encountered, and project accomplishments, are included in this section.

For the *results evaluation*, this attempted to capture the results of the programme interventions using Urban HEART as a planning and management tool. While it is ideal that the impact (goal level) of Urban HEART is captured in this evaluation, it is important to appreciate that the sustainable long-term effects of the technology and planning framework for ensuring urban health equity may not yet be evident at this time. As such, this evaluation focuses on assessing the output- and outcome-level results of Urban HEART.

Methodology

Development of evaluation instruments. The development of the evaluation instruments included documents review, focus group discussion and key informant interview guides, and an on-site observation checklist. Annex A presents the tools used.

Data-gathering activities included:

Key informant interviews and focus group discussions. Respondents included key officers and personnel from the Department of Health and its Bureau of Local Health Development, the WHO Country Office, city health offices, local health boards, city mayors and other stakeholders that have directly been recipients or have participated in Urban HEART interventions.

Review and analysis of data from documents and secondary data. Various documents, though not all were available from all seven cities, were reviewed and analysed, including the following:

- orientation materials used
- minutes of meetings
- executive order on the composition, duties and responsibilities of the technical working group (TWG)
- activity documentation
- data gathered from activities
- Urban Health Equity Matrix and Monitor
- action plans
- intervention plans

- draft policies and legislation
- minutes of legislative deliberations
- approved policies and legislation
- project plans and other project documents (e.g. budget, project management structure)
- project reports.

Annex B lists the documents that were gathered.

2. Results and discussion: process documentation

2.1 Defining the problem: pre-assessment phase

Orientation of the pilot sites

The initial introduction of Urban HEART was made by the Bureau of Local Health Development of the Department of Health through an orientation for the regional centres for health development to which the pilot cities belonged. The purpose of the orientation was to introduce to key officials the concepts of urban health equity and Urban HEART, and to assist them to plan for advocacy activities on the adoption of the tool and the organization of local Urban HEART focal teams in the pilot cities.

In Naga, the regional director of the Centre for Health Development met with the city mayor on the planned inclusion of the city as a pilot site. The meeting also resulted in the identification of the Urban HEART focal team.

In Parañaque and Taguig, an orientation for Urban HEART was conducted, which resulted in the creation of the local TWG. The TWGs of both cities underwent a short course on urban health equity, simultaneously implementing the initial phases of data gathering in the city.

In Olongapo, the city mayor was chosen to be the chair of the TWG with the assistant city health officer as the focal person.

No such similar meetings were reported to have happened in the cities of Tacloban, Davao and Zamboanga.

Following the orientation of centres for health development by the Bureau of Local Health Development, the seven pilot cities were informed, through an official communication from the Department of Health Central Office, of their inclusion in the pilot implementation of Urban HEART in the Philippines. The communication also asked them to organize focal teams and invited them for a common orientation of all focal teams of the seven pilot cities.

A common orientation for all Urban HEART focal teams was conducted on 7–8 August 2008 in Marikina City. The orientation was organized and facilitated by the Bureau of Local Health Development and attended by representatives of WHO.

Engagement of national and local officials

Following the orientation in Marikina, all focal teams reported back on the details of Urban HEART, including the processes, tools, structures and support mechanisms for implementing the tool, to their respective local chief executives. Results from the key informant interviews did not reveal any resistance from the local chief executives on the adoption of the tool, including the inclusion of their respective cities in the pilot implementation.

In Tacloban, a resolution by the City Legislative Council was immediately passed adopting Urban HEART as a guideline for the formulation of policies related to health and the social determinants of health.

In Naga, a resolution was passed adopting the Urban HEART programme through the Office of the City Mayor, and a resolution appropriating the amount of 100 000 Philippine pesos (PHP) as city equity for future programme implementation was also adopted.

In Parañaque, to facilitate dissemination and use of the tool, the Urban Health Equity Matrix was endorsed by the local chief executive, in line with Council Resolution No. 08-055 Series 2008 adopting Urban HEART as a guideline for the formulation of health policies of the city. This resolution was approved and passed on 3 July 2008.

No such similar resolutions were reported to have been passed in the other pilot cities.

Organization of local TWGs

The formal organization of the local TWGs was undertaken through an executive order signed by the respective local chief executives of the pilot cities. The compositions of the TWGs varied according to local circumstances in the pilot cities (table 1). The TWGs in the different pilot cities were composed mainly of representatives from the different social sector departments in the local government units and centres for health development, with some minor differences in membership across cities. In Davao, a representative from the Department of Labour and Employment was included as a member. In Naga, the Centre for Health Development provincial team leader of Camarines Sur was included as a TWG member. In the cities of Taguig and Zamboanga, pilot communities had representatives in the TWGs. In Parañaque, representatives from the Local Housing Development Office, League of Barangays and Youth Council were members. Only Parañaque had a nongovernmental organization (NGO) representative in their TWG.

The identification of membership in the TWGs was primarily based on their possible participation in the provision of data requirements of Urban HEART, based on the list of indicators for health outcomes and social determinants of health, and potential participation in data analysis, project identification, planning and implementation of project responses to address equity gaps.

In most of the pilot cities, the city health officers played a lead role in the TWGs, except in Tacloban, where leadership was lodged under the Office of the City Mayor through its Special Projects for Health Office. For most of the pilot cities, placing the leadership and coordination of Urban HEART under the city health officers was seen as the logical thing to do, considering that the tool was primarily for addressing health equity issues. In Tacloban, the programme was placed directly under the Office of the City Mayor to facilitate the mobilization of the members of the TWG. It was also envisioned that such an arrangement would not limit the utilization of Urban HEART to the health sector but would help extend it to other sectors in planning and response.

The functions, duties and responsibilities of the TWGs revolved mainly around the following:

- review and identification of indicators
- data gathering and data analysis
- identification of poorest and richest barangays

- identification of response packages to address equity gaps
- planning and implementation of identified projects
- monitoring and evaluation.

Table 1. Offices and departments represented in Urban HEART TWGs in the seven pilot cities

Davao	Naga	Olongapo	Parañaque	Tacloban	Taguig	Zamboanga
City level	***City level***	***City level***	***City level***	***City level***	***City level***	***City level***
City Health Office	City Health Office	City Mayor	City Health Office	Special Projects for Health, Office of the City Mayor	City Health Office	City Health Office
City Budget Office	Committee on Health	City Health Office	City Planning and Development Office	City Health Office	City Planning and Development Office	City Planning Office
City Planning and Development Office	City Planning and Development Office	Budget Office	Budget Office	City Environment and Natural Resources Office	City Budget Office	City Social Welfare and Development Office
Centre for Health Development	City Civil Registry	James L. Gordon Memorial Hospital	City Social Welfare and Development Office	City PopCom	City Nutrition Office	City Environment and Natural Resources Office
City Environment and Natural Resources Office	City Police Office	City Planning and Development Office	Committee on Health	City Nutrition Office	***Regional level***	City Police Office
City Civil Registrar's Office	Centre for Health Development	City Social Welfare and Development Office	Information Office	City Planning and Development Office	Centre for Health Development	***Regional level***
City Treasurer's Office	City Population Office	Department of Education	Florencio M. Bernabe Memorial Hospital	Limpyo Tacloban	***Barangay level***	Centre for Health Development
Department of Education	City Nutrition Office	City Civil Registry	Engineering Department	City Hospital	Kagawad for Health of Signal Village	***Barangay level***
City Police Office	Naga City Hospital	City Nutrition Office	Department of Education	***Regional level***		Barangay chairs of three poorest and three richest barangays
City Social Services and Development	Department of Education	PhilHealth	Local Civil Registry	Centre for Health Development		
PhilHealth	***Provincial level***	***Regional level***	Solid Waste and Environmental Sanitation Office			
Regional level	Centre for Health Development (Provincial Team Leader)	Centre for Health Development	League of Barangays			
Centre for Health Development	***Regional level***		Local Housing Development Office			
Department of Labour and Employment	Centre for Health Development		Youth Council			
			Regional level			
			Centre for Health Development			
			NGO representative			
			Rotary Palanyag			

2.2 Defining the problem: assessment phase

Stakeholder engagement

During the assessment phase, stakeholder engagement was limited mainly to the members of the TWG, with some cities engaging stakeholders at the community level. Identification and engagement of stakeholders during the assessment phase was primarily premised on their potential participation in the gathering and analysis of data.

Prior to data gathering, engagement of stakeholders at the community level was also done, mainly through orientation sessions to inform them of the objectives and activities of Urban HEART, with the end view of generating their buy-in and participation. Community consultations were also conducted after data gathering to present to them the results of data analysis and to generate inputs and reach agreements on possible interventions to address equity gaps.

Indicator selection

Results from document reviews, key informant interviews and focus group discussions revealed that the TWGs in the pilot cities saw no need to modify the original set of recommended indicators, including the disease-specific indicators on cancer, tuberculosis, diabetes mellitus and cardiovascular disease.

Data collection and validation

Identification of data sources

Prior to data gathering, the TWGs in the pilot cities initiated activities to identify their sources of data. The summary of sources of data per indicator by pilot city is presented in table 2.

Data for most health outcome indicators, including the disease-specific mortality and morbidity indicators, are from the Field Health Service Information System (FHSIS) or Rural Health Information System (RHIS), with some local government units identifying the Community-Based Monitoring System (CBMS) and local civil registry (LCR) as alternative sources of data. While other local government units, the city planning and development office (CPDO), and city health office (CHO) were possible sources of data, it is possible and safe to assume that those offices had other tertiary sources for their data, most possibly FHSIS, RHIS and LCR.

Table 2. Sources of data per indicator, by city

Indicator	Sources of data						
	Davao	**Naga**	**Olongapo**	**Parañaque**	**Tacloban**	**Taguig**	**Zamboanga**
Health outcomes							
Life expectancy at birth	–	–	–	–	CPDO	–	–
Maternal mortality ratio	RHIS	FHSIS	FHSIS, CPDO	FHSIS	FHSIS	CHO	CHO, LCR, FHSIS
Infant mortality rate	RHIS	FHSIS	FHSIS, CPDO	FHSIS	FHSIS	CHO	CHO, LCR, FHSIS
Under-5 mortality rate	RHIS	FHSIS	FHSIS, CPDO	FHSIS	FHSIS, CBMS	CHO	CHO, LCR, FHSIS
Disease-specific mortality and morbidity:							
Cardiovascular disease	LCR	FHSIS	FHSIS	FHSIS	–	CHO	–
Cancer	LCR	FHSIS	FHSIS	FHSIS	–	CHO	–
Tuberculosis	LCR	FHSIS	FHSIS	FHSIS	–	CHO	–
Policy domain 1: Physical environment & infrastructure							
Households with access to safe water	RHIS	FHSIS	FHSIS	FHSIS	CBMS	survey	FHSIS
Households with access to sanitary toilet facility	RHIS	FHSIS	FHSIS	FHSIS	CBMS	survey	FHSIS
Households served by city solid waste management system	CENRO	NESO	FHSIS	SWESO	CENRO	survey	survey
Households using solid fuel (wood, charcoal, paper, etc.)	CPDO	survey	–	–	–	survey	survey
Incidence of road traffic injuries (fatal, non-fatal)	PNP	PNP	–	PNP	PNP	TMO	PNP, survey
Policy domain 2: Social & human development							
Youth literacy rate	DepEd, CPDO	–	–	–	–	survey	DepEd
Elementary completion rate	DepEd, CPDO	DepEd	DepEd	–	DepEd	DepEd	DepEd
PhilHealth enrolment rate	PHIC	PHIC	PHIC	–	PHIC	PHIC	PHIC
Fully immunized child	RHIS	FHSIS	FHSIC	FHSIS	FHSIS	FHSIS	FHSIS
Under-5 moderately to severely underweight	RHIS	CNPO	CNO	FHSIS	CNO, FHSIS	FHSIS	FHSIS
Infants exclusively breastfed until 6 months	RHIS	FHSIS	FHSIS	FHSIS	FHSIS	FHSIS	FHSIS
Prevalence rate of teenage births	RHIS	FHSIS	LCR	–	CPO	LCR	survey

Indicator	Sources of data						
	Davao	**Naga**	**Olongapo**	**Parañaque**	**Tacloban**	**Taguig**	**Zamboanga**
Facility-based deliveries	RHIS	FHSIS	FHSIS	FHSIS	CBMS, FHSIS	FHSIS	FHSIS, LCR
Skilled birth attendance	RHIS	FHSIS	FHSIS	FHSIS	CBMS, FHSIS	FHSIS	FHSIS, LCR
Prevalence of tobacco smoking, 13–15-year-olds	barangay, survey	FHSIS	–	FHSIS	CPO	survey	survey
Policy domain 3: Economics							
Employment rate	CPDO	FHSIS	–	–	CPDO	survey	DLE, survey
Housing with secured tenure	CPDO	no city average; barangay data	–	–	CPDO, CBMS	survey	survey
Mean family income	CPDO	FHSIS	–	–	CPDO, CBMS	survey	survey
Extreme poverty (subsistence threshold)	CPDO	no city average; barangay data	–	–	CPDO, CBMS	survey	survey
Policy domain 4: Governance							
Government spending allocated to health and other social services (education, housing)	CBO, CPDO	CBO	CBO	CBO	CBO	CBO	–
Social participation rate	CPDO	–	–	–	CBMS	survey	–
Voter participation rate	COMELEC	COMELEC	COMELEC	COMELEC	COMELEC	COMELEC	COMELEC
% of locally generated revenue out of total budget	CBO	CBO	CBO	CBO	CAO	CBO, Treasury	–
Index crime rate	PNP	PNP	PNP	PNP	PNP	PNP	PNP

Key:

–	no data available
CAO	City Accounting Office
CBMS	Community-Based Monitoring System
CBO	City Budget Office
CENRO	City Environment and Natural Resources Office
CHO	City Health Office
CNO	City Nutrition Office
CNPO	City Nutrition and Population Office
COMELEC	Commission on Elections
CPDO	City Planning and Development Office
CPO	City Population Office
DepEd	Department of Education
DLE	Department of Labour and Employment
FHSIS	Field Health Service Information System
LCR	Local Civil Registry
NESO	Nursing and Environmental Sanitation Office
PHIC	Philippine Health Insurance Corporation
PNP	Philippine National Police
RHIS	Rural Health Information System
SWESO	Solid Waste and Environmental Sanitation Office
TMO	Traffic Management Office

It is worth noting than most local government units were not able to identify possible data sources for the indicator on life expectancy at birth, except for Tacloban, which will source data for this indicator from its CPDO.

For most pilot local government units, common secondary data sources for indicators under policy domain 1 were FHSIS and RHIS for access to safe water and sanitary toilet facility. Tacloban and Taguig, however, used CBMS and household survey to provide data for the above-cited indicators. Data sources for households served by the city's solid waste management system were through the CENRO/Solid Waste and Environmental Sanitation Office, CBMS or survey. Data for road traffic injuries were mostly sourced from the Philippine National Police (PNP). No secondary data sources for households using solid fuel were identified in most of the pilot local government units, with the cities of Olongapo, Parañaque and Tacloban not identifying any source of data at all. Only Davao claimed to have available data on that indicator from their CPDO.

Data sources for policy domain 2 have similarity across the pilot local government units.

Data for elementary completion rate were sourced mostly from the Department of Education (DepEd), except for Parañaque, which was not able to gather data for this indicator. Data for youth literacy rate in Davao and Zamboanga were sourced from DepEd. Data for that indicator were not available in the cities of Naga, Olongapo, Parañaque and Tacloban.

Data for PhilHealth enrolment rate were, as expected, sourced from the local offices of the Philippine Health Insurance Corporation (PHIC) in almost all of the pilot local government units, except in Parañaque, where no data for the indicator were gathered.

Data for fully immunized child, infants exclusively breastfed until six months, facility-based deliveries and skilled birth attendance were gathered from FHSIS and RHIS, with the addition of CBMS and LCR for facility-based deliveries and skilled birth attendance as data sources in the cities of Tacloban and Zamboanga, respectively.

Data for under-5 children moderately to severely underweight were sourced from FHSIS, RHIS, City Nutrition Office or City Population Office. Data for prevalence rate of tobacco smoking among 13–15-year-olds were gathered from FHSIS, City Population Office or through household surveys. No data were gathered in Olongapo for this indicator.

For policy domain 3, the pilot cities gathered data for the relevant indicators from various sources. In Davao and Tacloban, data were sourced from CPDO and CBMS; in Taguig and Zamboanga, from the household survey (including Department of Labour and Employment for employment rate); and in Naga, from FHSIS for employment rate and extreme poverty. No data were gathered for any indicator under this policy domain in the cities of Olongapo and Parañaque.

For indicators under policy domain 4, the Budget Offices in the pilot cities were the main sources of data for indicators on government spending allocated to health and other social services, and percentage of locally generated revenue of total budget. The local Commission on Elections (COMELEC) offices were key data sources for the indicator on voter participation rate, while PNP was the sole source of data for index crime rate. CPDO, CBMS and household survey were sources of data for social participation rate in the cities of Davao,

Tacloban and Taguig, respectively. No data were gathered on social participation rate in the cities of Naga, Olongapo, Parañaque and Zamboanga.

Data gathering

Following the identification of data sources, members of the TWG gathered the data requirements of the different indicators. Data pertaining to health status and programmes were taken from FHSIS and RHIS. Other secondary data relating to social services, finance, peace and order, and economics were provided by the respective members of the TWG. Relevant and available data from CBMS in the different communities were also gathered.

Aside from the data gathered from secondary sources, the cities of Zamboanga, Davao and Taguig also conducted household surveys.

Urban health equity assessment (Matrix and Monitor)

Selection of priority barangays

The guidelines for the implementation of Urban HEART in the pilot cities did not contain common specific criteria for the selection of the "richest" and "poorest" barangays. As such, the TWGs in the pilot cities came up with their own criteria for selecting their priority barangays (table 3).

Table 3. Criteria for selection of richest and poorest barangays

Davao	Naga	Olongapo	Parañaque	Tacloban	Taguig	Zamboanga
Income of the barangay Population size Presence of slum areas	Economic status of residents (proportion of households: rich including the average and poor) Households of at least 1000 Located in the urban area	Remoteness or geographical situation Clustering of poor households Mean family income	Number of depressed areas per barangay	Presence of slums/squatter areas and classified as urban poor based on CPDO assessment Barangay income Barangay population	Number of depressed areas present in barangay	Barangay income based on internal revenue allotment Percentage of poor residents in the area Accessibility of the area

In general, the criteria adopted by the pilot cities in the identification of "rich" and "poor" barangays revolved around the following:

- barangay income
- population
- household income
- presence of slum areas
- geographic location.

Urban Health Equity Matrix and Monitor

Once data had been gathered, the TWGs in the pilot cities made use of the Urban Health Equity Matrix and Monitor to analyse equity gaps between the "rich" and "poor" barangays.

Following the instructions provided in the Matrix and Monitor, the TWGs plotted the data they had gathered for the different indicators.

For the Matrix, data for the different indicators were tabulated by barangay, with the "poorest" barangays occupying the left-hand columns and the "richest" barangays occupying the right-hand columns. The city average by indicator was placed in the rightmost column.

In tabulating the data using the Matrix, the following colour codes were used:

- **Red:** barangay performance is worse than the 2006 national average.
- **Yellow:** barangay performance is worse than the 2010 national target but better than the 2006 national average.
- **Green:** barangay performance is equal to or better than the 2010 national target.

The TWGs also plotted their data on the Monitor, using the following colours and symbols:

- **Circle:** average performance of the city for a specified period of time.
- **Diamond:** performance of the richest barangays within a specified period of time.
- **Triangle:** performance of the poorest barangays within a specified period of time.
- **Red:** level of performance is worse than the 2006 national average.
- **Yellow:** level of performance is worse than the 2010 national target but better than the 2006 national average.
- **Green:** level of performance is equal to or better than the 2010 national target.

2.3 Setting the agenda: response

Prioritization phase

Under this phase, the focus was on the identification of appropriate interventions to narrow equity gaps between rich and poor barangays based on the data gathered in the previous phase. For the purpose of guidance, a five-step approach was suggested in identifying appropriate interventions, as follows:

Step 1. Prioritization of issues to be addressed based on the assessment done, and on the national and local priorities and resources.

Step 2. Identification of desired objectives and expected outcomes that have visible and measurable results.

Step 3. Identification of a relevant group of interventions that was determined in a participative manner.

Step 4. Selection of feasible interventions based on a prescribed set of criteria.

Step 5. Monitoring and evaluation of processes and outcomes.

Stakeholder engagement

During the prioritization phase, variations in the level of stakeholder engagement from city to city were recorded.

In Naga, Parañaque and Taguig, health equity issues and response strategies were initially prioritized and a plan developed by the TWG, and a report was then presented to city and barangay leaders in a formal forum called to generate ideas as to its acceptability and feasibility. Based on the feedback during the forum, the plan was then enhanced prior to implementation.

In Zamboanga and Davao, engagement of community stakeholders seemed very strong in the identification of priority problems and response strategies. Barangay-level consultations were conducted in order for the communities to be able to appreciate their current situation and for them to identify acceptable and feasible programme interventions to address equity gaps.

The rest of the pilot cities did not report similar community-level engagements under this phase. Analysis and prioritization of health equity issues and consultations on the identification of possible response strategies and packages were mostly limited to members of the TWGs.

Prioritization of health equity issues

In prioritizing health equity issues that need to be addressed, the TWGs made full use of the Urban Health Equity Matrix and Monitor. The colour codes used in the Urban HEART forms proved valuable in facilitating the identification of problematic indicators. Indicators with the most barangays recording red were classified as priority indicators. In terms of geographical scope, barangays with the most red indicators were classified as priority barangays.

Prioritization of intervention and strategies

The identification of intervention and strategies to address equity gaps in priority health equity issues was based on the criteria provided in the Urban HEART programme guidelines. Priority interventions and strategies are programmes that:

- **reduce health inequities**. The intervention should address the gaps and issues that result in disparities in health outcomes between the rich and the poor, or between groups with different levels of social standing.
- **can access resources**. This involves commitment from all key stakeholders, the need for additional resources to gather more data, and accountability of each of the parties involved.
- **are acceptable to communities**. The interventions should be culturally sensitive and culturally acceptable. More importantly, the community should take an active part in choosing the interventions to be implemented.
- **are achievable within a certain timeframe.** Given the limited time and resources for pilot testing, the chosen interventions should be implemented and should at least show an initial impact that is socially, politically and economically acceptable.

- **have proven efficacy of intervention.** There are available interventions, strategies and activities, which, according to studies, are cost-effective.
- **comply with national priorities.** The interventions should be aligned with the political agenda and should garner political support.

The pilot cities referred to the recommended service packages in Urban HEART in the identification of interventions and strategies to address equity gaps. Most of the cities claimed to have conducted consultations in the identification and prioritization of interventions and strategies to address health equity gaps.

Development of action plan

All pilot cities prepared and submitted intervention plans for the priority intervention packages identified. The intervention plans were studied and approved by the local chief executives before they were submitted to the respective centres for health development, the Bureau of Local Health Development and the WHO Regional Office for the West Pacific.

The interventions plans contained the following elements:

- practical methods
- tasks
- timeframe
- milestones
- project implementation committee or office
- resources needed
- sources of funding.

The intervention plans did not include desired objectives and expected outcomes that have visible and measurable results, contrary to what is expected in step 2 in the five-step approach for the identification of appropriate interventions, as discussed above.

2.4 Developing policy

Policy uptake and development

Most of the policies adopted as part of Urban HEART were developed primarily during the pre-assessment phase, with most pilot cities either passing a resolution by the City Legislative Council, or the local chief executive issuing an executive order, or both. This phase mostly revolved around creation of the Urban HEART TWG or adoption of Urban HEART as a planning tool for addressing health inequity.

In Tacloban, the Barangay Council passed a local resolution adopting Urban HEART. Another resolution creating a Barangay Health Committee was also adopted.

In Zamboanga, two ordinances were issued as a result of implementing Urban HEART: an ordinance establishing a septage management system in Zamboanga, and an ordinance establishing city solid waste management.

In Parañaque, two ordinances were approved and passed related to the implementation of Urban HEART: the Parañaque City Birthing Homes Regulation Act of 2008, and a resolution adopting Urban HEART as a guideline for the formulation of health policies of the city.

In Taguig, the local chief executive signed a memorandum of understanding with the Department of Health, Centre for Health Development, allotting an initial fund, placed in the trust fund for the Short Course on Urban Health Equity (SCUHE) project.

In Olongapo and Davao, no such policy was developed.

No other additional policies at later stages or phases during the implementation of Urban HEART were reported to have been issued.

Programme development

No comprehensive and integrated programme to address health inequities, including the social determinants of health, were reported to have been developed in any of the pilot cities as a result of Urban HEART.

3. Implementation of Urban HEART in pilot cities

3.1 Status of implementation

The interventions to address identified health inequities in the pilot cities were at different stages of implementation. Some interventions had been completed, and others were still continuing, while most have yet to be implemented. A more detailed discussion on the status of the different identified interventions in the seven pilot cities is presented below. It must be noted that the discussion focuses on an assessment of the results of the interventions implemented by the pilot cities. It presents the results compiled by the different TWGs during the assessment phase of the planning cycle, the corresponding interventions identified, agreed and implemented, and the results of those interventions, if any.

3.2 Davao

Data from the assessment phase showed that equity gaps between the rich and the poor exist for at least five indicators:

- households with access to sanitary toilet
- households using solid fuel
- elementary completion rate
- skilled birth attendance
- housing ownership.

Based on the above, the Davao TWG identified the following interventions to address those inequities:

Water and sanitation. Construction of a communal sanitary toilet in Barangay 6-A at a cost of PHP 150 000 is expected to increase access to sanitary toilet facilities in that location. The project also includes the formulation of policies and guidelines on the use of sanitary toilets, training of food handlers, and conducting inspections of households, food establishments and water sources. Funds for the construction of sanitary toilets would be sourced from Urban HEART, while funds for the conduct of the class for food handlers would be sourced from the owners of food establishments participating in the training.

Women's health. This project involves the following activities: organization of a women's health team; training of doctors, nurses and midwives in community-managed maternal and newborn care; provision of a pre-pregnancy package to pre-pregnant women; and provision of regular maternal and child health and reproductive health services in the health centres. Funds for the organization of the women's health team would be sourced from the Centre for Health Development, amounting to PHP 5000; funds for the training of doctors, nurses and midwives on community-managed maternal and newborn care, and provision of the pre-pregnancy package, amounting to PHP 200 000 and PHP 100 000, respectively, would be sourced from the United Nations Children's Fund (UNICEF). It is not clear from documents what the expected outcome of this project is.

Youth health. This project involves the establishment of youth centres in six barangays at a cost of PHP 20 000, and the conduct of an adolescent reproductive health class at a cost of PHP 10 000. Sources of funds for the projects, and their expected outcomes, were not included in the document provided.

Literacy. This project intends to organize literacy programmes with the objective of increasing the literacy rate in the six pilot barangays. No amount was allocated for this project.

Income and employment. This project involves the conduct of activities to encourage out-of-school youths and unemployed men and women to enrol in the Alternative Learning System with the intention of enhancing skills that may enable them to pursue gainful employment and earn income. The project also includes the provision of support to job fair activities through information drives in the barangays in order to increase employment. No budget was allocated to either activity.

Child survival health and nutrition. This project involves the following: upgrading of Barangay 6-A health centre; organization of a mothers' support group for breastfeeding; support for immunization programmes; and provision of a regular expanded programme on immunization services in health centres. Funding for the upgrading of Barangay 6-A health centre, amounting to PHP 50 000, would be sourced from Urban HEART, while funding of PHP 50 000 for the organization of the mothers' support group for breastfeeding would be sourced from UNICEF. No clear outcome-level objectives were identified for the projects.

Safe household fuels. This involves the conduct of an information drive on how to improve stove designs and home ventilation, with the cost of PHP 3000 being sourced from Urban HEART. The objective of this initiative is to reduce the use of solid fuels.

Social insurance. This involves the enrolment of indigents to the PhilHealth-sponsored programmes through coordination and collaboration with congressional district representatives in the city.

Voting rights and political participation. To increase the rates of voter participation and social participation in the barangays, a plan was developed to include in health classes the topic of the rights of persons to participate in governance. No budget was allocated for this project.

During the conduct of the on-site validation, it was established through key informant interviews that none of the above projects had been implemented to date attributable solely to the utilization of Urban HEART. Most the identified interventions were either subsumed or integrated into the existing or incoming programmes or projects of the City Health Office. In the case of the sanitary toilet project, implementation never materialized through Urban HEART due to unsettled land donation and financial limitations. The City Health Office Urban HEART team basically abandoned the project because of those issues. However, it was the barangay captain through the Barangay Council who finished the construction of the two toilets on site with funding from the barangay funds.

3.3 Naga

Based on the data gathered and analysed by the Urban HEART TWG in Naga, the following were indicators where an equity gap between the rich and poor barangays existed:

- access to sanitary toilet facilities
- access to safe water.

In order to address those equity gaps, the TWG prepared a plan to implement a set of interventions based on the strategy packages. The initial plan was presented during the regional and local Urban HEART meeting, attended by barangay officials of the poorest pilot barangays, who offered their comments and additional inputs. The plan was then revised based on the feedback gathered during the meeting, before it was presented to, and approved by, the Local Health Board.

The following were the objectives of the identified interventions:

- to disseminate information on women's health among young people in 27 barangays of the city;
- to put in place a system for reporting road traffic injuries and assessing the index crime rate in the 27 barangays and develop an intervention plan;
- to increase facility-based delivery in the pilot poor barangays and eventually reduce maternal mortality;
- to enrol indigents in PhilHealth in the pilot poor barangays;
- to develop a barangay plan to increase access to safe water and sanitary toilets in the pilot poor barangays.

To achieve those objectives, implementation of the following interventions was planned:

Conduct a "Hearts and Minds" programme. This project has the following long-term objectives: to improve and promote the total well-being, including self-esteem, of young people; to reduce the incidence of reproductive health problems (premarital sex, teenage pregnancies, abortion, early marriage, sexually transmitted diseases, HIV/AIDS, and other problems such as alcohol and drug abuse) among those aged 15–24; and to reach young hearts and minds effectively and sensitively so that the young develop a sound compass that can help them grow into responsible parents and productive members of their community.

Hearts and Minds is under the umbrage of the Philippine Population Management Programme and has become a major component of the City Population and Nutrition Office programmes. Two batches of seminars on Hearts and Minds were included under Urban HEART, with a total fund allocation of PHP 70 000 to be sourced from the Department of Health/Urban HEART.

Consultative meeting with Philippine National Police and barangay officials. This project is part of a bigger project to conduct road safety seminars with the objective of reducing road traffic accidents. This also includes the establishment of a reporting system for road traffic

accidents in 27 barangays. This project was allocated PHP 30 000 from the Department of Health/Urban HEART.

Organization and training of the women's health team. This is part of a bigger project aimed an improving women's health through information, education and communication. This project was allocated a total of PHP 35 000, to be sourced from the Department of Health/Urban HEART.

Conduct *buntis* classes. This involves the conduct of classes targeting 960 pregnant women on maternal and child care, breastfeeding and family planning. It has a total budget allocation of PHP 68 000, to be sourced from the Department of Health/Urban HEART.

Upgrading of health centres as birthing facilities. This entails the provision of equipment, emergency and medical supplies, and instruments needed for birthing facilities in the barangays of Concepcion Pequeña and Cararayan. The stated objective of the intervention is to reduce complications at birth and other problems, thus decreasing infant mortality and morbidity.

Assess Puericulture Centre and City Hospital for upgrading. This project involves the assessment of the Puericulture Centre and City Hospital in order to identify needs and make recommendations for their establishment as basic emergency obstetric and newborn care centres. No other details are available for this project.

Training of midwives. This involves the training of midwives on community-managed maternal and newborn care. It has a total budget allocation of PHP 105 000 to be sourced from the Department of Health/Urban HEART.

Enrolment of indigents in PhilHealth-sponsored programmes. This programmes aims to enrol 600 indigent families in PhilHealth, with a total budget allocation of PHP 360 000, to be provided by the city government.

Dialogue with private establishments. This is an activity connected to increasing PhilHealth enrolment by proactively generating buy-in and commitment from owners of private business establishments to enrol their employees in PhilHealth.

Conduct planning workshop on water and sanitation. The planning workshop with officials of the identified poorest barangays is part of a bigger project with the objective of providing access to water and sanitation in those barangays. The implementation of water and sanitation action plans in those barangays would be funded through a PHP 400 000 budget allocation to be sourced from the Department of Health/Urban HEART.

Based on the field evaluation conducted, and the results of key informant interviews, focus group discussions and document reviews, the following are the results of the interventions implemented in Naga:

Hearts and Minds. Two batches of seminars have been conducted, each with 60 participants, for a total of 120 participants. The first batch was conducted on 11 August 2011, and the second batch on 12 August 2011. No document was presented to show how, and to what extent, the interventions have been able to achieve their objectives.

Road safety and traffic management seminar. Two batches of half-day seminars were conducted on 21 August 2011 (one batch in the morning and one in the afternoon), with the participation of public transport operators, drivers, barangay officials, pedestrians and the riding public. Representatives from the Bicol Medical Centre, Philippine National Police, Land Transportation Office and Public Safety Office were invited to discuss various subjects on road traffic and safety. No report was provided on the number of participants in the seminars, nor any data gathered on the effect of the seminars in terms of reduction in road traffic accidents and injuries.

***Buntis* classes.** Based on documents provided by the Naga TWG, nine batches of *buntis* classes have been held, attended by a total of 122 participants. No document was provided assessing the effects of those classes, though there was anecdotal evidence of an increase in the health-seeking behaviours and practices of pregnant women in the city.

Upgrading of health centres as birthing facilities. The supplies and equipment programmed for this project have reportedly been purchased and delivered to the recipient barangays, and are currently being utilized. In Concepcion Pequeña, the barangay provided for needed renovation and expansion of their health centre to make sufficient room for the birthing facility. In an interview with the barangay midwife in Concepcion Pequeña, she mentioned an increase in the number of deliveries being done at the birthing facility, not only for women from the barangay but also from nearby barangays and municipalities. She also made an observation that, by her recollection, there had never been an instance of home-based delivery in the barangay since the birthing facility was established. While those observations may be indicative of the project's success, there were however no official records provided to support such claims.

Water and sanitation. Six communal faucets have been constructed benefiting at least 48 households in three poor barangays. The construction of the communal faucets was carried out in coordination with Task Force Tubig, which was established to facilitate the application and construction of public faucets within the Metro Naga Water District. No report was provided with regard to the project's outcome in terms of increasing the rate of access to potable water supply. No report was likewise provided with regard to accomplishments in the area of sanitation.

No reports were submitted on accomplishments and results on the following interventions: organization and training of the women's health team; assessment of the Puericulture Centre and City Hospital as basic emergency obstetric and newborn care centres; training of midwives on community-managed maternal and newborn care; enrolment of indigents in PhilHealth-sponsored programmes; and dialogue with private establishments.

3.4 Olongapo

Based on the Urban Health Equity Matrix and Monitor, equity gaps were identified in the following indicators:

- facility-based deliveries and a citywide problem on policy
- teenage birth prevalence rate

- PhilHealth enrolment, particularly among indigents.

To address the problems on maternal deaths and facility-based deliveries, doctors, nurses and midwives are being sent to training on basic emergency obstetric and newborn care. Health centres are being upgraded, and provided with necessary equipment and apparatus needed for normal deliveries. To date, seven doctors, seven nurses, and seven midwives have completed training on basic emergency obstetric and newborn care at Fabella Medical Hospital.

Gordon Heights and New Cabalan health centres were improved and upgraded, and converted into birthing facilities. Funds from Early Child Care and Development were allocated for the structural improvement. Equipment and apparatus for normal deliveries were provided through the United Nations Population Fund (UNFPA) Reproductive Health Project.

A maternal care package voucher scheme was formulated and is currently being implemented in the city. The scheme was designed to provide free services for normal and spontaneous delivery, particularly for the urban poor. The UNFPA Reproductive Health Project allotted funds of PHP 3000 per indigent pregnant woman to assist with delivery expenses and provide an incentive to attend health personnel, including the volunteer barangay health workers.

The local PhilHealth office is intensifying its campaign to increase enrolees. Meetings were conducted with community groups and organizations such as the Tricycle and Jeepney Drivers Association.

The City Health Department, in collaboration with the Department of Education, has intensified the sex education programme in public and private high schools. Rural health physicians and public health nurses are tasked to conduct lectures in schools within their catchment areas. Counselling seminars for teachers were conducted through the UNFPA Reproductive Health Project. Teen centres in two of the three poorest barangays (Gordon Heights and New Cabalan) were established wherein private counselling rooms are provided. These centres are also equipped with computers and various paraphernalia that can be utilized by the youths for their amusement, such as guitars, badminton and board games.

A centre for women was also established by the local government of Olongapo to address the needs of women who are victims of violence. The centre serves as a venue for counselling and temporary shelter for the victims. It also serves as a skills training centre for women.

No documents were, however, provided to assess the outcome of those interventions, particularly in terms of narrowing equity gaps between the rich and the poor.

3.5 Parañaque

Based on the data gathered by the Urban HEART TWG, and after plotting those data in the Matrix and Monitor, equity gaps were identified for the following indicators:

- infant mortality rate
- households with access to safe water
- facility-based deliveries
- index crime rate.

With the problematic indicators identified, the TWG then brainstormed on the strategy packages to be used in the implementation of interventions to address the above equity gaps. They initially came up with a long list of activities per strategy package per problem. Using a decision matrix for prioritization of recommended interventions, they then ranked each activity in the long list of activities using a strict ranking method according to the weighted criteria listed in table 4.

Table 4. Criteria and weighting for prioritization of activities, Parañaque

Criterion	**Weight**
Reduce health inequities	0.2
Systemic impact	0.2
Achievable	0.15
Cost-effective	0.15
Complies with national policies and priorities	0.15
Can be implemented without additional cost	0.15

Table 5 shows a sample decision matrix for prioritization of recommended interventions to address the problem of "low percentage of households with access to safe water".

Table 5. Decision matrix for household access to safe water

Criterion	**Reduce health inequities**	**Systemic impact**	**Achievable**	**Cost-effective**	**Complies with national policies & priorities**	**Can be implemented without additional cost**	**Score**	**Rank**
Weight	0.20	0.20	0.15	0.15	0.15	0.15		
A. Water & sanitation: Promote knowledge of apt water storage, sanitation and personal hygiene practices	2 (0.20)	1 (0.20)	2 (0.20)	1 (0.20)	2 (0.15)	2 (0.15)	1.8	1
	= 0.4	= 0.2	= 0.4	= 0.2	= 0.3	= 0.3		
B. Provide community water supply and infrastructure	1 (0.20)	2 (0.20)	1 (0.15)	2 (0.15)	1 (0.15)	1 (0.15)	1.35	2
	= 0.2	= 0.4	= 0.15	= 0.3	= 0.15	= 0.15		

The TWG followed the same process for identifying and prioritizing interventions to address equity gaps in facility-based deliveries and index crime rate. However, as the Urban HEART team members in Parañaque were already part of the Short Course on Urban Health Equity (SCUHE) project, they nonetheless prepared an action plan for all identified possible interventions as part of the course requirements, despite the prioritization of projects previously made. The projects included in the action plan are the following:

On water and sanitation:

- promote knowledge of apt water storage, sanitation and personal hygiene practices
- provide community water supply and infrastructure.

On high index crime rate:

- organize peace councils and community-provided crime prevention
- organize neighbourhood watch initiatives, develop community "signals", check systems to discourage domestic violence, invest in promoting street lights.

On low percentage of facility-based deliveries:

- establish a birthing facility in District II
- increase awareness of clients about the location of health facilities and availability of services
- encourage PhilHealth coverage among low-income clients
- motivate pregnant women to give birth in birthing facility to ensure safe delivery
- increase awareness of clients on complications and risks of home deliveries.

Based on the key informant interviews, focus group discussions and documents submitted to the evaluation team, the following have been the major accomplishments and initial results of interventions in Parañaque:

The construction of the birthing facility in District II was completed on 15 October 2008, and it was formally inaugurated on 20 October 2008. The birthing facility is now aptly called Paanakan, an acronym derived from "Parañaque ang aalalay sa nanay at anak magpakailanman" – "Parañaque will take care of the mother and son forever."

The construction of the birthing facility was funded through a PHP 1.5 million grant from the Centre for Health Development. Equipment and supplies were sourced from various partners, including the Rotary Club Payanlag of Parañaque, Florencio M. Bernardo Memorial Hospital, District Hospital, and Las Piñas General Hospital and Trauma Centre. Barangay residents have likewise been reported to have given donations of unspecified amounts and supplies for the birthing facility.

In support of the establishment of the birthing facility and to maximize its utilization, the TWG conducted the following parallel activities:

- Installation of signage in all depressed areas of the barangay of San Martin de Porres to inform people of the location and services of the birthing facility. This was also published in local and national dailies for wider information dissemination.
- The health education and promotion officer was tasked to conduct a series of continuing lectures to increase awareness of mothers on the complications and risks of home deliveries.
- The health centre staff were given education sessions on risks of pregnancy and other related topics to further equip them in managing and running the birthing facility.

As a result of these interventions, the TWG reports a decrease in the rate of home-based deliveries based on records from the local registry, as proclaimed by the City Health Office, though no data were shown during the validation visit.

To increase membership among low-income clients, the local PhilHealth medical coordinator, together with the health promotion and education medical coordinator, were tasked to give lectures in all depressed areas in the pilot barangay on the benefits of PhilHealth membership. The PhilHealth team at the national level was likewise tapped to join in the lecture activities. Barangay health workers and the newly formed women's health team were also oriented on PhilHealth membership so they could assist in information dissemination.

Anecdotal evidence was gathered on the high turnout of applications for PhilHealth membership among participants in the lecture sessions conducted, although a more thorough analysis on the outcome of this intervention has yet to be conducted.

The Parañaque City Epidemiology and Surveillance Unit adopted Urban HEART as part of its health information system. Computerization of data using Epi Info 3.3.2 was done, and a database was set up for master listing of pregnancies, prenatal check-ups, and postpartum check-ups. A monitoring tool was also developed to keep track of the different activities. With the new system in place, follow-up of pregnant women and defaulters was facilitated and organized.

3.6 Tacloban

Based on an analysis of the data gathered, the Urban HEART TWG in Tacloban identified equity gaps in the indicators:

- infant mortality rate
- households with access to sanitary toilet
- elementary completion rate
- PhilHealth enrolment rate
- facility-based deliveries
- employment rate
- extreme poverty threshold
- government spending on health.

Following a process of project prioritization using the criteria set out in section 2.3 of this report, the TWG identified the following priority interventions to address the equity gaps identified:

Community organization and development. This includes the conduct of various activities in support of the programme, including:

- organization and training of the Barangay Health Committee for the implementation of urban primary health care;

- skills development of women on basic cosmetology, tailoring, food processing, foot spa and reflexology;
- marketing of community-based skills from the "Learn and Earn" programme;
- formation and organization of cooperatives;
- training of community health educators with integration of human values such as respect for one's neighbour, integrity and excellence;
- information, education and communication on family health.

Composting facility. This involves the provision of training and technical assistance on solid waste management, composting and sanitation.

Sanitary toilet facilities. This involves the construction of public sanitary toilets.

Based on the focus group discussions, key informant interviews and documents reviewed for this evaluation, the following is a discussion of the status of the interventions and the corresponding results, if any.

For **community organization and development**, members of the Barangay Council in the pilot barangay confirmed that the TWG had been providing them with technical assistance in tackling local health-related issues, including waste and sanitation, cooperative organization and family health care. They were oriented on Urban HEART, and they have passed a local resolution adopting the tool, and another resolution establishing a Barangay Health Committee for the implementation of a holistic urban primary health care approach in the barangay. As a result, the Barangay Health Committee had been instrumental in health-related activities in the barangay, including the organization and training of 20 community health educators, and provision of information, education and communication on family health care. The community health educators have been tasked to conduct health care orientation and facilitate the provision of primary health care to the households assigned to them. As a result, members of the TWG and Barangay Health Committee claim an increase in health-seeking behaviours of people in the barangay. No studies have, however, been conducted to establish the veracity of that claim.

On **environment and sanitation,** the Barangay Health Committee has been carrying out advocacy on solid waste management and sewage disposal through the community health educators. They have also conducted a mangrove tree planting activity with assistance from the City Environment and Natural Resources Office. As a result of the interventions, the Barangay Health Committee, in a focus group discussion, claimed that they had been able to maintain cleanliness in their surroundings, resulting in decreased incidence of dengue. No official documents were, however, presented to support such claims.

On **sanitary toilet facilities**, the construction of a communal toilet in the pilot barangay has been started, courtesy of the City Engineering Office, through a fund sourced from the Department of Health/Urban HEART. The septic tank has been completed, but the construction has been stopped because the materials originally intended for the toilet facility were used by the City Engineering Office in another project. No revised or alternative plans were presented to ensure that the project would be completed soon.

No status updates were provided on the skills development interventions.

3.7 Taguig

Based on the analysis of data gathered by the TWG on SCUHE and Urban HEART, the following are indicators of equity gaps:

- solid waste management
- elementary completion rate
- voter participation
- crime rate
- child immunization
- teenage pregnancy
- facility-based deliveries
- skilled birth attendance
- tobacco smoking.

The city had ongoing projects to address the first four of those indicators even before Urban HEART, and while those issues lie immediately outside the City Health Office's sphere of influence, it can serve as a stimulating agency to encourage the lead agency to act on the identified issues. The remaining indicators were addressed by an intervention based on the strategy package provided by Urban HEART.

On-site validation revealed that two issues were addressed by the Taguig team under Urban HEART: expanding immunization coverage, and construction of a facility for breastfeeding mothers, in response to the low rate of breastfeeding among mothers in the chosen area. This was accomplished through the creation of a functional breastfeeding station (a converted container van) for mothers. According to the key information interview informant, providing a breastfeeding centre was rolled out to other barangay health stations in the city. In addition, capacity building was conducted for health workers on birthing and delivery. Coverage for expanded immunization was achieved by utilizing the services of youths in the barangay, with the supervision of health workers.

It must be noted that the Taguig Urban HEART team was fully supported by the local government; however, due to a change in leadership, the activities were never followed through, as the new leadership had other priorities on hand.

3.8 Zamboanga

Based on their assessment of data gathered, the Urban HEART TWG in Zamboanga identified equity gaps in the following indicators:

- access to city solid waste management
- elementary completion rate

- facility-based deliveries
- skilled birth attendance.

No equity gap was assessed in terms of health outcomes.

The results of the assessment phase were presented to community leaders and other stakeholders during a consultative workshop. It was also in this workshop that participants identified the following interventions to address the identified equity gaps:

Potable water supply system. This project aims to increase the number of households with access to potable water supply in the pilot barangay.

Upgrading of health centres to birthing facilities. This project aims to increase the rate of facility-based deliveries in poor barangays. It includes the renovation of existing health centres, hiring of midwives and implementation of an innovative health financing strategy (Buntis Baby Bank).

Provision of syringes to child immunization. This project is expected to increase fully immunized child coverage to 95% in low-performing barangays.

The following are the status and results of the interventions implemented in Zamboanga:

A water supply system worth PHP 3 million has been completed in the pilot barangay. The project was funded through city funds and implemented in collaboration with the Zamboanga City Water District. As a result, there have been anecdotal reports of a significant decrease in the incidence of diarrheal cases, although no official records were gathered to support such claims.

The upgrading of health centres in two priority barangays has been completed, including the provision of additional personnel, equipment and supplies. Both are currently fully functional. Rehabilitation and construction of 12 additional health centres and lying-in clinics are currently under way.

No report was provided to determine the status of the provision of syringes to barangays performing poorly in child immunization.

4. Conclusions from Urban HEART pilot in Philippines

4.1 Summary of documentation process

Table 6 provides a summary overview and analysis of the documentation process for the pilot cities, organized by Urban HEART phase.

Table 6. Summary of documentation process, by Urban HEART phase

Defining the problem (assessment)
A. Pre-assessment phase
Orientation of pilot sites
• Urban HEART orientation for seven pilot cities was conducted by the Bureau of Local Health Development, Department of Health: introduction of concepts of urban health equity and Urban HEART, plan for advocacy activities to adopt the tool, and organization of focal teams in pilot cities.
Engagement of national and local government officials
• All focal teams reported back on the details of Urban HEART to their respective local chief executives. • Orientation on Urban HEART for local chief executives was conducted simultaneously with the technical working group (TWG).
Organization of the local TWG
• Organization of the local TWGs was through an executive order signed by the respective local chief executives of the pilot cities. • Composition of the TWG varied among the seven pilot cities, and included other government offices (local and regional) and a youth group. Only Parañaque included an NGO in the TWG. • In most of the pilot cities, the city health officers played a lead role in the TWGs, except in Tacloban where leadership was lodged under the Office of the City Mayor. • Roles and responsibilities of TWGs were identified for the seven pilot cities.
B. Assessment phase
Stakeholder engagement
• Stakeholder engagement was limited to the TWG, with some cities engaging partners at community level. • Prior to data gathering, engagement of stakeholders occurred at community level through orientation of Urban HEART. Community consultations were also conducted after data gathering to present results, generate inputs and reach agreements on possible interventions to address equity gaps.
Indicator selection
• There was no modification to original recommended indicators, which included disease-specific indicators on cancer, tuberculosis, diabetes mellitus and cardiovascular disease.
Data collection and validation
• Most secondary data for the different indicators were gathered from FHSIS and RHIS, with some local government units identifying CBMS and LCR as alternative sources of data. Other data sources for specific domains were different national and local government offices. • Local government units were not able to identify possible data sources for the indicator on life expectancy at birth. • Most of the pilot local government units had no data on households using solid fuel. • Four of the seven pilot cities were not able to identify the data source for literacy rate.

- All seven pilot cities were not able to complete secondary data collection for all indicators due to unavailability of data or lack of inclusion of the indicators in the data gathering of the different offices.
- The cities of Zamboanga, Davao and Taguig also conducted household surveys.

Urban health equity assessment (Matrix and Monitor)

- No common criteria for "richest" and "poorest" barangays.
- TWGs in the pilot cities came up with their own respective criteria for selecting their priority barangays, including barangay income, population, household income, presence of slum areas, geographical location.
- Utilizing the secondary data, all seven pilot cities made use of the Urban Health Equity Matrix and Monitor to identify the "richest" and "poorest" barangays and health equity issues.

Setting the agenda (response)

Prioritization phase

Stakeholder engagement

- Stakeholder engagement varied from city to city, e.g. Naga TWG initially prioritized health equity issues, while Zamboanga engaged the community.

Prioritization of health equity issues

- Utilizing the Urban Health Equity Matrix and Monitor, local government units identified the "richest" and "poorest" barangays and health equity issues.
- Indicators with the most barangays with "red" were classified as priority indicators. In terms of geographical scope, barangays with the most number of "red" indicators were classified as priority barangays.

Prioritization of intervention and strategies

- The identification of intervention and strategies to address equity gaps in priority health equity issues was based on the criteria provided in the Urban HEART programme guidelines.
- Pilot cities likewise referred to the recommended service packages in Urban HEART in the identification of interventions and strategies to address equity gaps.

Development of action plan

- All pilot cities prepared and submitted intervention plans for the priority intervention packages identified. The intervention plans were discussed and approved by the local chief executives before they were submitted to their respective centres for health development, Bureau of Local Health Development and WHO Regional Office for the West Pacific.
- The intervention plans did not include desired objectives and expected outcomes that have visible and measurable results.

Developing policy

Policy development phase

Policy uptake and development

- Most of the policies adopted as part of Urban HEART were developed primarily during the pre-assessment phase, with most pilot cities either passing a resolution by the City Legislative Council, or the local chief executive issuing an executive order, or both, and most revolved around the creation of the Urban HEART TWG or adoption of Urban HEART as a planning tool for addressing health inequity.
- Other ordinances or resolutions related to Urban HEART: Parañaque passed a resolution adopting Urban HEART as a guideline for the formulation of health policies of the city.

Programme development

- No comprehensive and integrated programmes to address health inequities, including social determinants of health,

were developed in any of the pilot cities.
Implementation (programme)
Implementation phase
Status of implementation • The interventions to address identified health inequities in the pilot cities were at different stages of implementation. Some interventions have been completed, others are still ongoing, while most have yet to be implemented. ***Sustainability measures*** • Except for Parañaque, where local government offices issued and approved a resolution adapting Urban HEART as a guideline in the formulation of health policies for the city, the rest of the pilot cities had not reached this phase. ***Monitoring and evaluation mechanism*** • From the onset of the introduction of Urban HEART as a planning tool to the seven pilot cities, the concept of monitoring and evaluation was not incorporated in the plan, giving rise to difficulties in the evaluation phase.

4.2 Sustainability and monitoring and evaluation

Sustainability measures

Except for Parañaque, where local government offices issued and approved a resolution adopting Urban HEART as a guideline in the formulation of health policies for the City, none of the pilot cities had reached the stage where measures were being taken to ensure sustainability.

Monitoring and evaluation mechanism

From the onset of the introduction of Urban HEART as a planning tool to the seven pilot cities, the concept of monitoring and evaluation was not incorporated in the plan. Monitoring was in the form of progress reports at different stages or phases of the planning cycle, and failed to put emphasis on the variance of health outcomes and indicators. Such omissions in the implementation of Urban HEART placed particular limitations on the final evaluation.

4.3 Facilitating and hindering factors

This section contains a summary and discussion of the hindering and facilitating factors encountered by the TWGs in the implementation of Urban HEART.

Facilitating factors

The following were identified as the key factors that facilitated the implementation of the programme in the pilot local government units:

Support of the local chief executives. The support of the local chief executives was crucial for generating and rallying support for the programme from the different departments in the local government units, and other stakeholders from government, the private sector and communities. With the organization of the TWGs through an executive order of the

respective local chief executives in the pilot cities, the TWGs were able to facilitate the mobilization of various resources, including finance, human resources, supplies and materials for the different activities under the programme.

Multisectoral and multi-agency composition of TWG. The composition of the Urban HEART TWGs came from health and non-health departments in government, and in some cases from NGOs (as in the case of Parañaque) and community leaders (as in the case of Zamboanga). This multi-agency and multisectoral composition of the TWGs facilitated collaboration and coordination in the conduct of the different activities of the programme: data gathering, data analysis, and identification and implementation of activities of Urban HEART.

Urban HEART tools. The user-friendliness of the Urban HEART tools was cited as a key facilitating factor in implementing the programme. The Urban HEART Matrix and Monitor made it easy to analyse, plot and understand equity gaps between population groups, even for those who have limited training in undertaking the different tasks in Urban HEART. The colour coding and shapes used also made it very easy for everyone, from community members to decision-makers, to understand equity data.

Financial support from Department of Health and WHO. The financial support provided by the Department of Health and WHO provided significant support to the TWGs in the conduct of the different activities under Urban HEART.

Hindering factors

The following were identified as some of the key difficulties encountered by the Urban HEART TWGs that may have hindered the smooth and expeditious implementation of the programme:

Delays in the release of funds. Although the grant funds provided by the Department of Health/WHO for the pilot implementation of Urban HEART facilitated the rollout of the programme, difficulties in accessing those funds affected the timely implementation of planned activities. This is due to the fact that the funds were managed under existing government accounting rules and regulations, and as such, Urban HEART funds for pilot cities with existing unliquidated cash advances could not be released unless the cash advances were first cleared.

No standard process and criteria set for the selection of rich and poor barangays. The identification of "rich" and "poor" population groups forms a critical foundation for Urban HEART. The validity of analysis of equity gaps, the identification of interventions to address those equity gaps, and the measurement of effectiveness of interventions to narrow inequities all rest on the premise that the correct "rich" and "poor" population groups were selected prior to assessment. The absence of a standard process and criteria for selecting extreme population groups was identified as a key bottleneck during assessment.

Difficulty in data collection activities and in securing disaggregated data. Lack of time for data collection, non-availability of some data, data discrepancies and errors from multiple sources, and absence of barangay-level disaggregated data were some of the major

difficulties encountered by most TWGs in data collection, significantly affecting the quality and quantity of data collected. Although not openly admitted by the key informants and focus group discussion participants, uncertainties related to the quality and amount of data that they collected may put into question the real health equity status in the pilot barangays. This will also potentially raise questions on the relevance of the interventions selected to address the identified equity gaps.

Lack of standard rating system for prioritizing interventions. Although there were recommended criteria for prioritizing possible interventions, there was no standard formula for rating those interventions. Most cities used check marks to indicate that a criterion had been met, with the intervention meeting the most criteria adjudged as the priority intervention. However, it was difficult to appreciate the process by which the TWGs assessed a proposed intervention as having met or not met a specific criterion. Only Parañaque adopted a rating system that assigned weights per criterion.

Weak integration of Urban HEART in the planning frameworks of local government units. Urban HEART was considered a special project in most of the pilot cities. The inherent "temporary" character of projects under Urban HEART has hindered it from being integrated into the development planning processes and frameworks in the local government units.

Limited monitoring and evaluation system. The monitoring and evaluation done in the pilot cities were limited mostly to input- and activity-level monitoring and reporting. The absence of standard templates, and guidance on frequency, responsibility and methodology, made it difficult for the TWGs to institutionalize an effective and efficient monitoring and evaluation system to manage results.

5. Recommendations for scaling up Urban HEART

This section contains a summary and discussion of the general recommendations for scaling up Urban HEART, both in the pilot cities and other expansion cities.

5.1 Clarify the roles of TWG members

It is important to clarify the roles of various representatives in the Urban HEART TWGs, and set guidelines for their management. Results from this evaluation seem to point to a strengthening of intersectoral actions among the various stakeholders in the pilot local government units. Through membership in the local TWGs, respondents from the key informant interviews confirmed that Urban HEART provided them with opportunities to work collectively as a team in analysing the current health equity status between "rich" and "poor" population groups. Civil society organizations and NGOs have likewise been involved in at least one of the pilot cities (Parañaque), while strengthened participation of community-based stakeholders was evident in some respects in all pilot cities. However, stakeholder participation had been evident mostly during the assessment phase of the Urban HEART implementation, when the different representatives in the TWGs participated in the local adaptation of the Urban HEART indicators, identification of sources of data for the different indicators, and data gathering. There was significant reduction in collaborative undertakings in data analysis and assessment and identification of priority interventions, and most especially during project implementation, and monitoring and evaluation. Project implementation and some aspects of monitoring and evaluation were managed mainly by the local city health offices (or in the case of Tacloban, the Office of the City Mayor through the Special Projects for Health Office) with very minimal engagement of community stakeholders and project beneficiaries in managing project implementation.

The interest, support and buy-in of stakeholders to collaborate in all phases of Urban HEART implementation is of paramount importance if it is to succeed in achieving its objectives, especially if taken in the context of local development. This documentation and evaluation has shown that getting stakeholder support for Urban HEART in its initial phases seemed to be easy and straightforward, especially with the expressed support of the local chief executive and after signature of an executive order organizing the TWG. This was shown in the focus group discussions and key informant interviews, as evidenced by the organized mobilization and other start-up activities of the different TWGs during the pre-assessment and assessment phases of the programme. However, as discussed above, the coordination and collaboration among the TWG members decreased during implementation of interventions, monitoring and evaluation, and programme replication and scale-up.

In order to help ensure that the programme is sustained by the different TWGs, it is recommended that their roles be clarified in the different phases, both individually and collectively, including representatives from the different government departments at different levels (barangay, city, provincial, regional and central offices), civil society organizations and NGOs. And in line with the second recommendation below, it might be worth exploring the

possibility of integrating the Urban HEART TWG into existing planning and management structures in local governments.

5.2 Strengthen integration of Urban HEART in planning frameworks

Efforts should be made to strengthen the integration of Urban HEART into local development planning and performance management frameworks for local government units. The planning and implementation of Urban HEART has been designed to be consistent with local governance processes. It is also designed to complement existing planning processes and performance management systems by providing a social and health equity lens (*4*). However, results from this documentation and evaluation seemed to suggest a disconnect between Urban HEART and the existing planning and performance management frameworks that are currently being utilized in local governments. As such, the process and results of implementing Urban HEART have failed to influence the local planning process and policy and programme development and implementation at a more strategic level in addressing health equity issues. No evidence was gathered to show that the results of the Urban HEART assessment were able to influence the development of the local development plans, nor the executive-legislative agenda in the pilot local government units.

In order to fully maximize the strengths of Urban HEART in local development, the Department of Health and WHO may need to engage in high-level discussions with other national government agencies with oversight functions over local government units, notably the Department of the Interior and Local Government and the National Economic Development Authority. The objective is to explore and formalize possible integration of Urban HEART in local development processes. The process of formalization would also ensure sustainability of the tool.

5.3 Set criteria and process for selecting rich and poor population groups

The identification of "rich" and "poor" barangays is a critical step in analysing and comparing equity gaps between two extreme population groups. One of the difficulties encountered by the pilot cities in implementing Urban HEART was the identification of "richest" and "poorest" barangays because of the absence of standard criteria for adjudging a barangay as "rich" or "poor". Although there are similarities in the set of criteria they have adopted, it would significantly facilitate implementation if a standard set of criteria were included in the implementation guidelines.

The process for selecting the "rich" and "poor" population groups also needs to be standardized, and included in the implementing guidelines.

5.4 Strengthen participation of target communities

Participation of the target communities in the identification of interventions to respond to identified equity problems should be strengthened. One of the strengths of Urban HEART is its ease of use in analysing equity gaps in terms of health outcomes and social determinants of health. It may, however, need to strengthen processes and mechanisms to engage community members and stakeholders in the identification of response initiatives to address

those equity gaps. As it was, most of the pilot local government units made full use of the menu of strategy packages to address identified equity gaps, sometimes limiting the participation of community stakeholders and restraining their ability to appreciate their situation and identify possible interventions to address identified problems. Besides, community participation has been proven as a fundamental requirement to achieve health and sustainable development at the local level.

Community participation requires going beyond consultation to enable citizens to become an integral part of the decision-making and action process. It reflects the need for the development of more active communities in their own right: people seeing a need and acting upon it. Community participation draws on the energy and enthusiasm that exists within communities to define what that community wants to do and how it wants to operate (*5*). Community participation could also address the issues of project ownership by communities.

Details of proposed processes and mechanisms on community participation in the different phases of Urban HEART could be included in the implementing guidelines.

5.5 Strengthen project planning and project management

While it is made clear that programme planning and implementation are outside the scope of Urban HEART as it is not an implementation tool (*4*), results of this documentation and evaluation nonetheless point to a significant need for guidance to local government units on project planning and management. The project or intervention plans prepared by the pilot local government units are all plans for actions or activities, without clear and objectively verifiable indicators on target outcomes. As a result, the interventions have been managed only to ensure that activities are conducted, and sometimes outputs produced. There were no clear indications that the projects had been managed to ensure that the interventions would result in changes in health outcomes or improvement in health determinants. That limitation in the project plans has also made it difficult to assess the success of interventions in terms of their level of achievement of outcomes.

In order to help ensure that projects are managed to produce results and to establish a clearer link between equity gaps and interventions, it is recommended that guidance on how project planning and management are undertaken following the results-based management framework be provided and included in the implementing guidelines.

5.6 Strengthen monitoring and evaluation mechanisms

Monitoring and evaluation need to be strengthened and institutionalized to help those involved with development projects to assess if progress is being achieved in line with expectations. Monitoring is the ongoing collection and analysis of data that informs project managers if progress towards established goals is being achieved. Evaluation is a comprehensive appraisal that looks at the long-term impacts of a project and exposes what worked, what did not, and what should be done differently in future projects. Monitoring and evaluation serve to drive accountability and transparency, inform decision-making about project design and management, and provide lessons learned for future projects.

Again, while project planning and management, and by extension monitoring and evaluation, is beyond the scope of Urban HEART, as already mentioned above, it may be in the best interest of the Department of Health and WHO to include appropriate guidance on the processes, tools and mechanisms on monitoring and evaluating the implementation of the tool and the corresponding interventions that would be identified and implemented to respond to health equity gaps.

At the level of inputs, activities and outputs, guidance on possible tools, frequency and responsibilities for monitoring and evaluation could be provided. At the level of outcome and impact, monitoring and evaluation could be integrated into the Local Governance Performance Management System (LGPMS) developed and managed by the Department of the Interior and Local Government. The existing LGPMS has a subsystem containing the local government unit scorecard on health, which was developed by the Department of Health. This subsystem could be reviewed and enhanced to accommodate the specific requirements of Urban HEART.

Annex A. Urban HEART process documentation and results evaluation tools

Process documentation

The focus of the process documentation is to capture how Urban HEART was applied in the seven pilot cities in the Philippines. The documentation will follow the ideal steps for implementing Urban HEART, as described in the Urban HEART guide published by WHO in 2010, and objectively describing the processes, resources used, facilitating and hindering factors, and lessons learned in the different phases of the Urban HEART planning and implementation cycle (table A.1).

Table A.1 Process documentation guide

Component / areas for process documentation	Methodology
Defining the problem (assessment)	
A. Pre-assessment phase	
Orientation of the pilot sites Engagement of national & local government officials Organization of the local TWG	***Documents review*** Orientation materials used Minutes of meetings Executive order on the composition, duties and responsibilities of the TWG ***Key informant interview*** Local chief executive City health office Chair, local health board ***Focus group discussion*** Urban HEART team (TWG)
B. Assessment phase	
Stakeholder engagement Indicator selection Data collection and validation Urban health equity assessment (Matrix and Monitor)	***Documents review*** Materials used Minutes of meetings Activity documentation Data gathered Urban Health Equity Matrix and Monitor ***Key informant interview*** Local chief executive City health office Chair, local health board ***Focus group discussion*** Urban HEART team (TWG) Other stakeholders involved in assessment phase

Component / areas for process documentation	Methodology
Setting the agenda (response)	
Prioritization phase	
Stakeholder engagement Prioritization of health equity issues Prioritization of intervention and strategies Development of action plan	***Documents review*** Materials used Minutes of meetings Activity documentation Action plans Intervention plans ***Key informant interview*** Local chief executive City health office Chair, local health board Community representatives (e.g. barangay captain, beneficiaries) ***Focus group discussion*** Urban HEART team (TWG) Community groups
Developing policy (policy)	
Policy development phase	
Policy uptake and development Programme development	***Documents review*** Materials used Minutes of meetings Draft policies, legislation Minutes of legislative deliberations Approved policies, legislation ***Key informant interview*** Local chief executive City health office Chair, local health board Chair, committee on health ***Focus group discussion*** Urban HEART team (TWG)
Implementation (programme)	
Implementation phase	
Status of implementation Sustainability measures Monitoring and evaluation mechanism	***Documents review*** Project plans and other project documents (e.g. budget, project management structure) Project reports ***Key informant interview***

Component / areas for process documentation	Methodology
	Local chief executive City health officer Chair, Local health board Project manager Community representative ***Focus group discussion*** Project staff Beneficiary groups

Results evaluation

The results evaluation of Urban HEART focuses on assessing, based on objectively verifiable information, the extent to which the tool has been effective in bringing about change in urban health equity. The results evaluation takes as its starting point the baseline data gathered during the assessment phase, and compares them against the latest available data to determine possible negative and positive variances in identified urban health equity indicators. Due to the timing of this evaluation, only the output- and outcome-level results were assessed. The evaluation focuses on hindering and facilitating factors that may have contributed to the level of achievement of results at the output and outcome levels. Table A.2 presents a results evaluation template.

Table A.2 Results evaluation template

Objective	Objectively verifiable indicator	Means of verification	Target	Accomplishment	Variance	Level of accomplishment (%)	Hindering / facilitating factors
(1)	(2)	(3)	(4)	(5)	(6) (5) – (4)	(7) ((5)/(4))100	(8)
Outcome							
Health outcomes	(Depending on the intervention package)						
Governance outcomes (participation and awareness)	(e.g. participation, awareness, intersectoral action on health)						
Outputs							
(Related to the four domains)							

WHO Urban HEART process documentation and evaluation

Key informant interview guide

Name of key informant: _____ Date of interview: _____

Position/designation: _____

i. What is the nature of your involvement in the implementation of Urban HEART? *(Allow the interviewee to be as exhaustive as possible in identifying his/her involvement in the implementation of Urban HEART. You may need to refer to the different components of Urban HEART to help the interviewee. Take note of his/her involvement and probe)*

ii. Based on your experience in the use of Urban HEART as a tool for identifying and addressing urban health inequity, what were the key factors the helped you (facilitating factors) in its utilization? *(Refer to the interviewees' responses in question #i. Ask for specific examples)*

iii. Based on your experience in the use of Urban HEART as a tool for identifying and addressing urban health inequity, what were the difficulties (hindering factors) that you encountered? *(Refer to the interviewees responses in question #i. Ask for specific examples)*

iv. What, in your assessment, are the benefits in using Urban HEART? *(Ask for specific examples that could support his/her response)*

v. If Urban HEART were to be replicated in other areas, what are the things that should be considered to make it successful?

vi. What did or did not get implemented that was planned?

vii. What congruence was there between what was intended to be implemented and what actually happened?

viii. How appropriate and close to plan were the costs, time requirements, capacity, availability of required financial resources, facilities and staff, and also – importantly – political support?

ix. What unanticipated (thus unintended) outputs or outcomes emerged from the implementation phase?

WHO Urban HEART process documentation and evaluation

Focus group discussion guide

Urban HEART team/technical working group

City: _____ Date: _____

Participants	Position/office/agency

Guide questions:

- Describe your participation/involvement in Urban HEART.
- What are the things that helped you in the implementation of Urban HEART? How?
- What are the difficulties that you encountered in implementing Urban HEART? How did you address those difficulties?
- How would you assess Urban HEART as a planning and response tool for health equity? Explain.
- If Urban HEART were to be replicated in other areas, what do you think are necessary considerations to make it successful?

Community groups/beneficiary groups

City: _____ Date: _____

Participants	Position/office/agency

Guide questions:

- Describe your participation/involvement in Urban HEART.
- How would you assess Urban HEART in terms of responding to your community needs? Explain.
    - In terms of identifying health equity problems in your community
    - In terms of identifying and prioritizing problems & solutions
    - In terms of implementing identified solutions
- What can you recommend to make Urban HEART more effective?

Project staff

City: _____ Date: _____

Participants	Position/office/agency

Guide questions:

- Describe the project currently being implemented.
- Describe the process for identifying the current project and its link with the Urban HEART process.
- Describe how the different stakeholders are being involved in the different activities of the project.
- Describe how the project is impacting on health inequities.
- What are the hindering and facilitating factors related to ensuring effective and efficient project implementation?
- What can you recommend to make Urban HEART more effective?

Annex B. List of data gathered

Documents collected and reviewed

Urban HEART report of Parañaque

Urban HEART report of Taguig

Urban HEART report of Olongapo

Urban HEART report of Naga

Urban HEART report of Tacloban

Urban HEART report of Davao

Urban HEART report of Zamboanga

All records/files from the inception, planning and roll-out stages of Urban HEART from the Department of Health, central office level

Local legislative and executive issuances relating to Urban HEART

Organizational structures

Urban health equity data (e.g. Urban Health Equity Matrix, Urban Health Equity Monitor)

Activity reports/minutes of meetings

Project documents (plans, budget, monitoring and evaluation reports)

Other related documents

Note: Reports from the seven cities include activity documentation reports.

PowerPoint slides reviewed

Davao City Health Office, 2011: Urban HEART implementation status report.

Naga City Health Office, 2011: Status and progress of Urban HEART interventions.

Olongapo City Health Office, 2011: Urban HEART implementation in Olongapo City.

Tacloban City Health Office, 2011: Urban HEART Tacloban.

Taguig City Health Office, 2011: Urban Heart Equity Assessment and Response Tool (HEART) updates and results.

Virtusio OZ, 2011: Urban HEART lessons from pilot experience, Parañaque City, Philippines.

Zamboanga City Health Office, 2011: Urban HEART monitoring.

Urban HEART evaluation: list of key informants

Department of Health officials

USec. Mario C. Villaverde

Dir. Lilibeth C. David

Dir. Asuncion Anden

Dir. Juanito Taleon

Bureaus

Bureau of Local Health Development: staff in charge

HPDPB: staff in charge

Centres for health development Under Urban HEART

Seven centres for health development: RDS

LHAD coordinator

City health officers

Seven city health officers

Seven city health coordinators

Seven TWG members (optional/random)

Local government chief executives

Hon. Jesse M. Robredo
Secretary of the Department of Interior and Local Government
(Former Mayor, Naga City)

Hon. James Gordon
Mayor, Olongapo City

Hon. Sarah Duterte
Mayor, Davao City

Hon. Lani Cayetano
Mayor, Taguig City

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