Report on documentation and evaluation of Urban HEART pilot in Ho Chi Minh City, Viet Nam

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Contents

1. Introduction

A report on the economic and social situation of Viet Nam for 2011 (*1*) gives many instances of efforts made by the National Assembly of Viet Nam to take action in the areas of health care and protection, family planning, children's health and gender equality. However, health inequities still exist between different groups of the population, as shown by the data from a 2010 survey assessing urban poverty in Hanoi and Ho Chi Minh City (*2*). The inequalities are evident when low- and high-income groups are compared and even more noticeable when permanent residents and unregistered or temporary migrants are compared (*2*).

Viet Nam was chosen by the World Health Organization (WHO) for testing the Urban Health Equity Assessment and Response Tool (Urban HEART). The Institute of Hygiene and Public Health (IHPH) was the agency implementing the pilot testing of Urban HEART in Ho Chi Minh City (as well as in Ba Ria-Vung Tau and Can Tho). The pilot testing in Ho Chi Minh City was completed in late 2009, and the present report is part of efforts to document and evaluate the experience in order to draw lessons for implementing the tool in future in Ho Chi Minh City as well as in other cities with similar situations.

2. Brief description of country

Viet Nam is the easternmost country of the Indochina peninsula in South-East Asia. It is bordered by China to the north, Lao People's Democratic Republic to the north-west, Cambodia to the south-west, and the East Sea to the east. With an estimated 90.5 million inhabitants (2011), Viet Nam is the world's 13th most populous country, and the eighth most populous Asian country.[1] Gross national income per capita is US$ 2700. Life expectancy at birth is 70 years for men and 74 for women. The under-5 mortality rate is 22 per 1000 live births, and the mortality rate for age 15–60 years is 173 for men and 107 for women per 1000 population. The total expenditure on health per capita is US$ 215, or 6.8% of gross domestic product (GDP).[2]

3. Brief description of pilot site

Ho Chi Minh City, located in the south of the country, is the largest city in Viet Nam, with a population of over 6 million by the end of 2006, of which 85.9% live in urban areas of the administrative unit. The city consists of 24 districts, of which 19 are urban districts, and 322 communes, of which 264 are urban communes. There are 25 city-level hospitals (8 general hospitals and 17 specialized hospitals) with 16 102 beds. The doctor-to-population ratio is 5.45 doctors per 10 000 people. However, the city-level hospitals are located mostly in the central area of the city; in other parts of the city, including rural areas, there are only regional or district-level hospitals and commune-level health posts. The gap in health services for people in different areas of the city is a concern for the government, and the pilot implementation of Urban HEART in 2009 was welcomed by government.[3]

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[1] Viet Nam country entry, Wikipedia http://en.wikipedia.org/wiki/Vietnam.

[2] Viet Nam country profile, World Health Organization http://www.who.int/countries/vnm/en/.

[3] Proposal on Urban HEART pilot testing in Viet Nam, 2009.

4. Overview of process of Urban HEART pilot in Ho Chi Minh City

As described in the IHPH report on the Urban HEART pilot testing, the following steps were taken in implementing Urban HEART in Ho Chi Minh City (*3*):

1. The IHPH leader assigned specialists to carry out the pilot. These formed the core of the technical working group (TWG) that developed and implemented all phases of the workplan.
2. The IHPH sent an official letter to the district people's committees of the four chosen districts (districts 4, 5, 8 and Cu Chi) to explain about the proposed workplan and to request the committees to assign representatives to the TWG for implementation of the plan.
3. The TWG, including the representatives from the IHPH and the four chosen districts, used its first meeting to familiarize its members with Urban HEART and develop the workplan for conducting the pilot.
4. The TWG organized a workshop for its members to discuss and identify social determinants that were appropriate and realistic for the four pilot districts of Ho Chi Minh City.
5. The TWG members from the four districts collected data relating to the selected social determinants and submitted the data to the TWG members from the IHPH, who were undertaking the data analysis.
6. The TWG organized its second meeting, in which those from the IHPH presented the results of the data analysis and the Urban Health Equity Matrix for the plan, and the district representatives discussed the appropriate responses for each district based on the data analysis.
7. At a further workshop, the results of the assessment and the response tools were presented to all TWG members.
8. The final report was written by the IHPH and submitted to WHO and to the local authorities from the four districts. There was no further follow-up on the reaction of the local authorities.

5. Method of documentation and evaluation

The methodology for documentation and evaluation made use of existing data found in databanks and documents, augmented by additional information from interviews and focus group discussions, and the following activities were undertaken:

- Contacting and interviewing the TWG focal point at the IHPH (Dr Phung Duc Nhat) to gather information about the overall procedure for implementation of the Urban HEART pilot, including the report of the pilot;

- Interviewing the coordinator of the project, also based at the IHPH (Ms Ha Thi Ninh), and collecting from her documentation related to implementation of the pilot;
- Studying the documentation and comparing it to guidelines for Urban HEART, and drawing up appropriate comments;
- Collecting further information from Dr Phung Duc Nhat via direct interview and questionnaire (annex A);
- Collecting further information from the members of the TWG from the four pilot sites via direct interview and questionnaire (annex B);
- Conducting a focus group discussion with the members of the TWG from the four districts to gain more information through interaction between the members (themes for the focus group discussion are found in annex C, and the list of participants is in annex D);
- Analysing the data gathered and writing the report.

6. Results of documentation and evaluation

6.1 Overall evaluation of Urban HEART

Almost all informants at different levels and in different institutions stated that Urban HEART was a very useful means of providing and presenting data relating to health inequities to local leaders, enabling them to review the health status of people across different urban areas. The data could also be used as a basis for developing a comprehensive plan (including both prevention and control) to improve the quality of life of inhabitants in different urban areas and to ensure equity in health care.

> "This tool [Urban HEART] is innovative, good, and realistic, and should be applied to identify the necessary responses to the health inequities of each locality" (health officer, Cu Chi district).

Conducting the assessment for the first time took about nine months, but this could be reduced to about three months for future assessments, given that the documents have already been translated and the members are trained in and familiar with the procedures. The actual timeframe for completing Urban HEART in Ho Chi Minh City was as follows (a detailed timetable is contained in annex E):

- 1 month for writing the proposal and for translating from English to Vietnamese the documents needed for implementing the assessment;
- 1 month for preparing and organizing the training workshop;
- 3 months for collecting and analysing the data;
- 3 months for feedback on the first draft and collecting and analysing the complementary data;
- 1 month for completing the report.

6.2 Issues in different phases of implementation of Urban HEART in Ho Chi Minh City

Pre-assessment phase

Orientation of pilot sites

Four pilot sites were chosen in Ho Chi Minh City, according to the following criteria:

- District 5: rich urban district
- District 8: poor urban district
- District 4: poor urban district in the past, now becoming a more prosperous district
- District Cu Chi: rural district in the process of urbanization.

The four pilot sites were chosen as representative of different sections of Ho Chi Minh City. The results of the pilot can therefore help to identify the health inequities between different urban areas of the city, and one rural district in the process of urbanization. Differentiation of districts according to the applied criteria will facilitate implementation of Urban HEART for the whole city in the future, and facilitate further analysis of relevant data.

Engagement of national and local government officials

As requested by the IHPH, the vice-chiefs of the four district people's committees, who are responsible for cultural and social services, assigned the officials from the people's committee offices (districts 4 and 8) and from the district health sectors (all districts) to participate officially in the TWG and to gather the required data. In Viet Nam, this mechanism of engagement can be effective, as the people's committees at all levels are responsible for the welfare of the population and have the right to assign the appropriate officials to undertake the activities required by Urban HEART. Such engagement of national and local government officials is also necessary in order to access the required data.

Organization of the local TWG

For the Urban HEART project in Ho Chi Minh City, the IHPH sent letters requiring the district people's committees in the four pilot locations to set up local TWGs and select members for the groups. The people's committee for each district then assigned three or four representatives: one from the office of the people's committee, one from the district health department, and one or two from the district centre for preventive medicine. These representatives fulfilled the mandate of the IHPH, including gathering data and developing proposed responses. As the pilot was principally carried out in the health sector, health officials were primarily involved, and few officials from other sectors were mobilized, presenting difficulties in gathering data in areas outside health.

> "It was mostly the officers from the health sector who participated actively in the assessment activities, while the participation of those from other sectors was limited. Cooperation between the health sector and other sectors is not close enough, and the usual thinking is that health is the responsibility of the health sector only" (Dr Phung Duc Nhat, IHPH).

It is suggested that WHO should make authorities of countries or sites where Urban HEART is implemented more aware of the comprehensive meaning of "health" (including physical, mental and social aspects), and that implementation of Urban HEART requires nearly all sectors to participate in the assessment activities.

Resources used

The budget for this phase came from the project budget and was distributed by the IHPH. In future, it would be preferable for WHO to support allocation of the budget by the government. For that purpose, a detailed proposed budget should be prepared, with an analysis of cost-effectiveness, to help convince the authorities to participate in the project.

Facilitating factors

The good support from the local authorities at the pilot sites was recognized. This is an essential facilitating factor that Urban HEART implementers should always seek. Other facilitating factors included (a) close cooperation and strong commitment of members of the TWG; and (b) separate budget for Urban HEART implementation. Choosing appropriate members of the TWG, and allocating a separate budget for Urban HEART implementation (for example from the government), are worthwhile actions.

Hindering factors

The members of the TWG from the four pilot sites were busy with their daily work, so the time they were able to devote to the Urban HEART pilot project was limited. In addition, the pilot project was not included in the yearly plan of the related organizations. It is recommended that the government undertake more advanced planning for Urban HEART, and ensure its inclusion in yearly plans.

Lessons learnt

Obtaining the support of all authorities from national to local level is critical to ensuring that implementation of Urban HEART is incorporated in the yearly plan and is allocated sufficient budget. Care should be taken to ensure that the members of the TWG are chosen based on relevant experience.

Assessment phase

Stakeholder engagement

When some specific types of data were needed, different stakeholders at district level were engaged, including from the Police Department, the Department of Resources and Environment, the Department of Demography and the Department of Education. The district people's committee and health sector agencies were found to be most actively involved, with other sector agencies providing relevant data but less actively engaged. Greater efforts to explain the purpose of Urban HEART would assist in obtaining the active participation of other stakeholders in the assessment.

Indicator selection

The full list of actual indicators compiled is in annex F. The list was the result of a process of discussion among TWG members, taking account of the real situation in the pilot sites.

As mentioned in the full report on the Urban HEART pilot in Ho Chi Minh City, the specialists suggested redefinition of the indicators relating to tuberculosis, leprosy and mental diseases so that they were calculated based on incidence rates.

The specialists also suggested that some indicators could be subdivided, for instance by splitting the indicator on occupational accidents and occupational diseases into its two components, as the data for each were collected by different entities – the indicator on occupational accidents by the Police Department or hospital, and that on occupational diseases by the district centre for preventive medicine. It was also suggested that the indicators on coverage of primary education be replaced by those on coverage of secondary education.

Some new indicators were also recommended by the TWG, for example extent of slum areas in order to reflect urban poverty, or the proportion of people at district level who had physical exercise every day to reflect social and human development. However, those indicators were eventually not used, as the data were not available. Some data, such as disaggregated data on the impact of traffic accidents in a district, could not be collected without doing a survey.

As the data collected for the project were secondary only, many health indicators suggested by the guidelines were not chosen because they could not be found in the existing databanks. Data were also not available for some other indicators (for example on infrastructure and education). According to many TWG members, a survey must be carried out to collect data that are not available in the existing databanks of the districts.

It was concluded that the system of indicators should be adapted to the real situation of each specific locality and a survey must be done to collect data that are not available in the existing databank of a locality, rather than just neglecting them.

Data collection and validation

Different groups of indicators were assigned to each member of the TWG according to their field of work: health indicators were collected by those from the health sector, while indicators relating to social determinants were collected by those from the people's committee. The data were not validated, though validity was claimed for the data collected by the members of the TWG, while the validity of the data collected by others was not known. This occurred because the members of the TWG were actually the officers who worked in the fields relating to the data.

> "The reported data collected by the technical working group are actually precise, while the other data are not known to be valid or not" (health officer, district 5).
>
> "For some indicators, the reported data might not be reliable, as they can affect competition results such as the net enrolment ratio in primary and secondary school" (health officer, Cu Chi district).

For data validation, many TWG members said that a survey should be carried out. In reality, it is very difficult for the TWG to validate data collected from different sources, especially in the fields the TWG members do not work in, so it is advisable that a survey be carried out when implementing Urban HEART.

Urban health equity assessment (Matrix and Monitor)

After collecting the data, the members of the TWG from the districts sent the data to the TWG members from the IHPH for them to build up the Urban Health Equity Matrix based on the following criteria (annex G):

- Green: indicator value reaches or goes beyond both the national and Ho Chi Minh City averages
- Red: indicator value is below both the national and Ho Chi Minh City averages
- Yellow: indicator value is between the national and Ho Chi Minh City averages.

The Monitor chart was not drawn, as the work under the project was limited to identifying and not implementing the response activities.

It will be observed that the criteria applied did not conform to those suggested in the Urban HEART user manual. However, this reflects a reality that in Ho Chi Minh City, the largest city of Viet Nam, the average level values of many indicators are higher than those at national level. Therefore, the Urban HEART project needed to deal with a situation when the urban average values were already better than national Millennium Development Goals of the nation.

Regarding the usefulness of the Matrix, the implementers found it a good visual aid to see more clearly the inequities in different aspects of health. Those inequities matched well with their impressions and expectations. However, from the Matrix, the TWG members noted that the more prosperous districts (districts 4 and 5) also had their specific health problems, such as mental disorders, overweight and obesity, implying that the definition of "health inequities" should include health problems arising from the living conditions of the higher-income groups as well as those of the lower-income groups.

The Matrix proved to be effective in presenting health inequities in a clearly visible format, and demonstrated that red indicators can be found in both low-income and high-income urban areas.

Resources used

The budget for implementing this phase was provided by the IHPH from the project budget.

Facilitating factors

The TWG members were governmental officials, so were able to access official data. TWG members found that the time schedule for the whole project was appropriate.

Hindering factors

As only secondary data were collected, data for many indicators could not be collected and many were also invalid. For example, data were only available on the number of traffic accidents in a district, and were not sufficiently disaggregated to be of use as Urban HEART indicators. In addition, attendance of patients with HIV/AIDS at district centres for preventive medicine, including to receive antiretroviral therapy, was not limited to those who lived in the district, so those data could not be used to reflect the health status of people in a district.

Many data suggested by the Urban HEART guidelines were not recorded in Ho Chi Minh City, including data about certain noncommunicable diseases for which there were as yet no national programmes (exceptions included hypertension).

The Matrix in the pilot was built within a limited period of time and in a situation where data for several indicators were not available or were available for some years but not others in the data collection and management system, so that it was difficult to comprehensively assess health inequities in the urban area of Ho Chi Minh City. Differences between districts in the quality of data collection and management was also a hindering factor.

Lessons learnt

For each locality or district, the indicator set must be revised to reflect the real situation. For the Matrix to be a more comprehensive tool to assess health inequities in an urban area, the indicators needed for building the Matrix should be included in the current data collection and management system for a district, and should be maintained for all years. Also, to enable a comprehensive assessment of health and social status, a survey needs to be conducted to gather those data that are not otherwise available.

Response prioritization phase

To develop the responses for dealing with the inequities disclosed by the Matrix, the TWG was divided into four subgroups corresponding to the four districts. Each district group brainstormed to develop a system of responses for their district (annex H). However, the TWG did not prioritize the responses, only listing all responses for each district and submitting the results of the Urban HEART pilot project, including the Matrix and the table of responses, to the four district people's committees. Although the TWG did prioritize the responses submitted, the mere listing of the responses represented great progress, as the implementation of Urban HEART gave the government valuable information on the problems and proposed response activities specific to each urban area.

Regarding the responses, a TWG member (health officer in district 5) commented that due to limited time and the fact that the responses were developed subjectively by the TWG, they needed to be implemented in the field in a pilot before being applied to a whole district. An officer from the people's committee in district 8 observed that as the TWG members were mostly health officers the responses may not be comprehensive, so officers from other sectors must be involved. Two health officers from district 4 said that the responses should be included in the national health programmes (even just optionally) to help obtain budget allocation and permission to act from the authorities.

No monitoring or follow-up was carried out in the Urban HEART pilot project in Ho Chi Minh City; as one representative from the IHPH observed, it had not been required at the beginning of the project. Yet, many TWG members reported that some district people's committees had already taken up ideas from the results of the pilot project in developing their annual plans of action. For example, in district 4, a programme of environmental sanitation was being implemented; and in Cu Chi district, health education activities had been implemented to deal with malnutrition problems.

In order to facilitate implementation of this phase and the following phases in the future, the government should allocate appropriate budgetary resources and include the responses in national health programmes or in sectoral and subsectoral annual plans of action.

Resources used

The resources for implementing this phase were provided by the IHPH from the project budget.

Facilitating factors

The TWG members were actually officers who worked in the health care sector so could use their experience in formulating responses (though responses for other sectors were lacking).

Hindering factors

The resources for carrying out this phase were only from the project budget and not from the government, so the implementation of response activities, even a pilot, could not be done. Furthermore, the responses were not incorporated into annual planning, reducing potential for appropriate action.

Lessons learnt

Even for testing the tool, commitment from the government to implement actions based on the responses is required, and governmental budgetary resources must be allocated for implementation.

Summary of key lessons, impacts/outcomes, and recommendations

Key lessons learnt from the overall experience of the Urban HEART pilot, and issues to be considered in the future implementation of Urban HEART, are as follows:

- The active work of the technical agency (IHPH) and the TWG and the support of local government at the four pilot sites were good, and such coordination should be a feature of any future implementation.
- However, the pilot project was not fully implemented and there was a lack of follow-up on the suggested responses for dealing with inequities, as they were not incorporated into the annual plans of the districts.
- Furthermore, most of those participating in the assessment were health officers and other sectors were inadequately represented, so the data collection and identification of responses were not comprehensive enough.
- Many indicators suggested by Urban HEART need to be revised to adapt to the situation of each locality.
- A survey is crucial for collecting data not available in the existing databank and for validating existing data.

Key impacts and outcomes of the pilot experience include the following:

- Those who participated in the pilot project, especially those from the districts, became more aware of health inequities between districts.

- Participants also learnt techniques to assess the health inequities in a visual way based on the Matrix and to identify possible responses to deal with the inequities.

Recommendations on implementation issues are as follows:

- Primary data should be considered as crucial to assess health inequities, and must be collected. A budget should be allocated to carry out a survey in the community.
- Other sectors at district level should be included in the TWG so that the assessment and response identification can be carried out more comprehensively.
- The pilot was implemented by a technical medical agency only (IHPH) and not by the government itself, so appropriate response activities could not be implemented. Urban HEART should be led by the city-level government following the direction of higher-level authority (national government), and should be incorporated into annual workplans at the city and district levels.
- The city-level government and sectors must participate in Urban HEART, as many data are stored at city level rather than at district level.
- The response activities identified for each district need budgetary allocation by the government.

Annex A. Questionnaire for documenting and evaluating Urban HEART implementation for specialists from IHPH

Pre-assessment phase

Orientation of the pilot sites

What did the participants think of the orientation? Was it useful?

Engagement of national and local government officials

How were the national and local government officials engaged in this process?

Organization of the local technical working group

How was the technical working group convened?

What were its organizational structure, mandate, membership, roles and responsibilities?

Was the group multisectoral?

Who were the key stakeholders?

Who was the most/least supportive of the project?

Resources used

What were the funds required, including breakdown by major components (e.g. meetings, materials)?

What was the staff time required, including breakdown by different skill sets (e.g. project manager, data analyst)?

How were the resources mobilized?

What is a realistic timeframe in which this phase can be completed in a similar context?

How can the Urban HEART pre-assessment component be improved? What other resources are needed?

Facilitating factors

What were the things that facilitated this phase?

Hindering factors

What were the things that made this phase difficult?

Lessons learnt

Did the stakeholders think this phase went well? Why or why not?

What are the lessons learnt about completing this phase successfully?

How to improve this phase of Urban HEART?

Assessment phase

Stakeholder engagement

What was the mechanism to engage stakeholders in this phase?

How were community groups included in this phase?

What were the stakeholders' (including community) perceptions of being involved in this phase?

Indicator selection

How were the indicators selected? What were the key decision factors?

Data collection and validation

What were the data sources and data types used for each indicator?

How were the data collected and validated?

Were the data appropriate and accurate?

Urban health equity assessment (Matrix and Monitor)

How were the Matrix and Monitor created?

What did the resulting Matrix and Monitor look like?

Did the results match the impressions and expectations of different stakeholders?

Resources used

What were the funds required, including breakdown by major components (e.g. meetings, materials)?

What was the staff time required, including breakdown by different skill sets (e.g. project manager, data analyst)?

How were the resources mobilized?

What is a realistic timeframe in which this phase can be completed in a similar context?

How can the Urban HEART assessment component be improved? What other resources are needed?

Facilitating factors

What were the things that facilitated this phase?

Hindering factors

What were the things that made this phase difficult?

Lessons learnt

Did the stakeholders think this phase went well? Why or why not?

What are the lessons learnt about completing this phase successfully?

Response prioritization phase

Stakeholder engagement

What was the mechanism to engage stakeholders in this phase?

How were community groups included in this phase?

What were the stakeholders' (including community) perceptions of being involved in this phase?

Prioritization of health equity issues

What were the priority health equity issues, and why?

How were the Matrix and Monitor results used to prioritize health equity issues?

What other information or factors influenced the prioritization of health equity issues?

What did community members think of the prioritized health equity issues?

Prioritization of strategies and interventions

What were the priority strategies and interventions, and why?

How was Urban HEART used to identify and prioritize strategies and interventions?

What other information or factors influenced the prioritization of health equity issues?

What did community members think of the prioritized strategies and interventions?

Development of proposal or action plan

Was a proposal or action plan developed based on the Urban HEART implementation results?

How and to whom was the proposal or action plan presented?

Resources used

What were the funds required, including breakdown by major components (e.g. meetings, materials)?

What was the staff time required, including breakdown by different skill sets (e.g. project manager, data analyst)?

How were the resources mobilized?

What is a realistic timeframe in which this phase can be completed in a similar context?

How can the Urban HEART response component be improved? What other resources are needed?

Facilitating factors

What were the things that facilitated this phase?

Hindering factors

What were the things that made this phase difficult?

Lessons learnt

Did the stakeholders think this phase went well? Why or why not?

What are the lessons learnt about completing this phase successfully?

Policy development and programme implementation phase (if applicable)

Policy uptake and development

Was the proposal or action plan accepted or rejected, and by whom?

What were the key factors that influenced the decision?

What did the decision-makers think of Urban HEART?

[If it was accepted] How closely was the proposal or action plan followed?

Programme development and implementation

Was a programme or intervention developed and implemented?

What were the key factors that influenced the decision?

What was the programme or intervention? How closely was it linked to the proposal?

What did the stakeholders (including community) think of the programme or intervention?

Status of implementation

What is the project's current status?

Sustainability measures

Is Urban HEART implementation sustainable at this site?

Are there any mechanisms (legal, organizational, financial, etc.) in place to ensure sustainability of Urban HEART implementation?

What are the key sustainability factors?

Facilitating factors

What were the things that facilitated this phase?

Hindering factors

What were the things that made this phase difficult?

Lessons learnt

Did the stakeholders think this phase went well? Why or why not?

What are the lessons learnt about completing this phase successfully?

Impact and outcome evaluation

Monitoring and evaluation mechanisms

Have you been monitoring and evaluating the process? If so, how? If not, why?

What are the main accomplishments of the project?

What, if any, are the negative effects of the project?

Who has benefited the most or least from participating in the project?

Improvement in awareness and priority setting

Did the Urban HEART implementation increase awareness about health equity issues among stakeholders and in the community?

Did the Urban HEART implementation result in putting health equity issues higher on the agenda of local, regional or national governments and other agencies?

Scale-up of Urban HEART

Are there plans for scaling up Urban HEART implementation in the region or country?

Have other municipalities adopted or taken interest in Urban HEART?

Additional policies and programmes

Did the Urban HEART implementation generate or strengthen other policies or programmes beyond those directly resulting from the pilot project?

Intersectoral action on health

Did the Urban HEART implementation generate or strengthen intersectoral collaboration to address health and health equity issues?

How was the intersectoral collaboration viewed by participants?

Community participation

Did the Urban HEART implementation generate or strengthen community participation in the local planning process (health planning, urban planning)?

How was the community participation viewed by the participants?

Intervention outcomes on health and health equity

Did the programme or intervention generated by the Urban HEART project affect health, health determinants or health equity? What is the evidence of these effects or outcomes?

Additional questions

What was the rationale for choosing the four pilot districts?

What were the criteria for assigning the colours for the Matrix?

What were the difficulties encountered (if any) when building up the Matrix or Monitor?

What comments were received regarding the health inequities between districts? What are the most important and urgent problems that need to be prioritized to achieve health equity?

For the response tools, did the technical working group identify who would be responsible for each response? Were there any non-medical organizations who participated in developing responses? Were the responses prioritized? What rationale was used in prioritization?

What were the reasons for discontinuing Urban HEART after identifying the responses? Did local government and the health sector have any plans for implementing response activities?

What experience did the technical working group draw from implementing the Urban HEART pilot in Ho Chi Minh City? How can Urban HEART be applied in the future in Ho Chi Minh City?

Annex B. Questionnaire for documenting and evaluating Urban HEART implementation for health specialists (Department of Health, Centre for Preventive Medicine) and specialists from people's committee

Name of interviewee: ……

Position: ……

Organization: ……

1. What do you think of Urban HEART? Is it useful? How is it useful?

2. How did local government (district people's committee) engage in the Urban HEART testing pilot?

3. How did the local technical working group work? What comment can you make regarding the technical working group (its organizational structure, mandate, membership, roles and responsibilities)?

4. Apart from the local technical working group, were there any stakeholders who also took part in the pilot testing of Urban HEART?

5. Who was the most/least supportive of the project?

6. What comments do you have on the timeframe for implementing Urban HEART in Ho Chi Minh City (meetings, data collection, workshops, etc.)?

7. How were the indicators selected? What were the key decision factors?

8. How were the data collected and validated?

9. What comments do you have on creating the Matrix?

10. Did the results of the Matrix match your impressions and expectations?

11. What health equity issues were chosen as priorities for response?

12. How were the Matrix results used to prioritize health equity issues?

13. What other information or factors influenced the prioritization of health equity issues?

14. What did stakeholders think of the prioritized health equity issues?

15. What comments do you have on the reasons for choosing the interventions?

16. What did stakeholders think of the strategies to choose the interventions?

17. After completing Urban HEART, was there any action plan based on the results? If so, what?

18. If any action has been taken, were there any influences on health indicators? What indicators were influenced?

19. What factors facilitated Urban HEART implementation?

20. What factors made Urban HEART implementation difficult?

21. What are the lessons learnt from completing the Urban HEART?

22. Did Urban HEART implementation generate or strengthen community participation in the local planning process (health planning, urban planning)?

23. What needs to be improved in the implementation procedure for Urban HEART?.

Annex C. Themes for focus group discussion among specialists from Department of Health, centre for preventive medicine and people's committee

- The benefits of Urban HEART
- Activities of the technical working group
- Timeframe
- The activities in implementing Urban HEART
- The participation of the government
- The participation of the stakeholders
- The participation of the community
- Facilitating factors, hindering factors, lessons learnt.

Annex D. List of participants of focus group discussion for assessment of Urban HEART implementation in Ho Chi Minh City, 30/11/2011

No.	Names	Position	Organization
1.	Tô Thị Tuyết Mai	Director	Centre for Preventive Medicine, Cu Chi district
2.	Trà Nhi		Centre for Preventive Medicine, Cu Chi district
3.	Trần Phạm Quế Hạnh		Centre for Preventive Medicine, district 5
4.	Lê Hoàng Mai		Centre for Preventive Medicine, district 5
5.	Trịnh Phương Thảo		Health Department, district 5
6.	Đặng Thế Hệ		Centre for Preventive Medicine, district 8
7.	Ngô Thanh Hiền		Health Department, district 8
8.	Vũ Bảo Ngọc		Centre for Preventive Medicine, district 4
9.	Đoàn Bích Hồng		Health Department, district 4
10.	Bùi Thanh Hải		People's committee, district 4
11.	Lê Thúy Nga		People's committee, district 8
12.	Nguyễn Hồng Biên		Centre for Preventive Medicine, district 8
13.	Phan Kim Chi		Centre for Preventive Medicine, district 4

Annex E. Timetable of activities, pilot testing of Urban HEART, Ho Chi Minh City

(extracted from *Report on Urban HEART pilot testing in Ho Chi Minh City, Viet Nam, 2009*)

Activity	Responsible unit	Timeframe	Resources required	Financial source	Output/outcomes	Process indicator
Submit proposal and get approval	IHPH	February 2009	Material Staff time from IHPH	IHPH	Proposal submitted	
Set up local team	IHPH	25 March 2009	Staff from IHPH Key stakeholders from four districts – experts from district people's committees, health sector, centres for preventive medicine	WHO	Urban HEART team of IHPH and districts	
Translation	Team	March 2009	Team	WHO	Materials of Urban HEART in Vietnamese	Materials in local language (Vietnamese)
Implement first workshop	IHPH	15 April 2009	Finance from WHO Human resources from IHPH Staff time from IHPH Stakeholders' time – experts from district people's committees, health sector, centres for preventive medicine	WHO	Adapted Urban HEART pilot testing version to local circumstances, including identification of data sources	Intersectoral commitment to address health equity
Initial meeting in site convenient for four districts	Urban HEART team of IHPH Stakeholders	20 May 2009	Finance from WHO Experts' time from IHPH Stakeholders' time – experts from district people's committees, health sector, centres for preventive medicine	WHO	Start of assessment Data collected	Indicators chosen and data collected One meeting conducted

Data collection and analysis using existing data from meeting (rapid assessment)	Team	May 2009	Experts' time Analysis technology Material from WHO	WHO	Gaps in existing data identified	Matrix set up
Focus group discussion for four districts	Team Stakeholders	26 June 2009	Finance from WHO Experts' time from IHPH Stakeholders' time – experts from district people's committees, health sector, centres for preventive medicine	WHO	Data collected	Indicators and data collected One meeting conducted Response tool compiled as result of focus group discussion
Final analysis and write initial report	Team	August 2009	Experts' time Analysis technology Material from WHO	WHO	Inequities identified	Report written Matrix set up
Implement second workshop: report of each district, initial report of team	IHPH	16–17 September 2009	Finance from WHO Human resources from IHPH Experts' time from IHPH Stakeholders' time – experts from district people's committees, health sector, centres for preventive medicine	WHO	Matrix	Intersectoral commitment to use response tool Response tool approved by local authorities
Write final report and submit it to WHO	Experts from IHPH	October 2009	Experts' time from IHPH	WHO	Assessment and response tool report on Urban HEART pilot testing	Final report written on assessment phase and response tool (technical and financial)

Annex F. Selected indicators from Urban HEART

(extracted from *Report on Urban HEART pilot testing in Ho Chi Minh City, Viet Nam, 2009*)

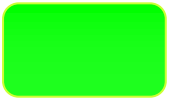
No.	**Indicator**		**National average**	**Urban average**
I. Health outcome indicators, including disease-specific morbidity and mortality rates	Infant mortality rate (per 1000)		16 (2010)	9.33 (2010)
	Under-5 mortality rate (per 1000)		18.4 per 1000 (2015)	n.a.
	Maternal mortality rate (per 1000)		32.5 (2015)	4.42 (2008)
	Tuberculosis (rate per 100 000 population)	Incidence rate	63.9 (2007)	106 (2008)
		Mortality rate	24 (2007)	n.a.
	Leprosy (rate per 100 000 population)	Incidence rate	0.69 (2007)	0.86 (2008)
		Mortality rate	n.a.	n.a.
	Mental illness (rate per 100 000 population)	Prevalence rate	55.2 (2007)	119.4 (2008)
		Mortality rate	0.38 (2007)	n.a.
	HIV/AIDS (rate per 100 000 population)	Incidence rate	22.4 (2007)	104.7 (2008)
		Mortality rate	4.6 (2007)	9.9 (2008)
	Dengue fever	Cases per 100 000 population	113.26 (2007)	220.3 (2008)
		Number of deaths per 100 000 population	0.11 (2007)	0.19 (2008)
II. Physical environment and infrastructure	Proportion of population with access to improved water source (%)		90 (2010)	90 (2008)
	Proportion of population with access to improved sanitation (%)		90 (2010)	100 (2010)
	Proportion of households served by municipal solid waste management system (%)		90 (2010)	n.a.
	Working injuries	Number of cases	4 040 (2007)	n.a.
		Number of deaths	18 (2007)	n.a.
	Working diseases	Number of cases	n.a.	n.a.
		Number of deaths	n.a.	n.a.
	Traffic accidents	Number of traffic accidents	n.a.	1 136 (2008)
		Number of injuries	115 666 (2007)	442 (2008)
		Number of deaths	4 040 (2007)	950 (2008)
	Proportion of standardized primary health care centres (%)		80 (2010)	64.9 (2009)

No.	**Indicator**	**National average**	**Urban average**
	Number of public hospitals	1 515 (2007)	91 (2008)
	Number of private hospitals	77 (2007)	n.a.
III. Social and human development	Literacy rate (%)	93.1 (2007)	99 (2010)
	Net enrolment ratio in secondary school (%)	80 (2010)	98.02 (2008)
	Proportion of 1-year-old children immunized against seven diseases (%)	95 (2010)	94.51 (2008)
	Prevalence rate of underweight children under 5 years of age (%)	19 (2009)	10 (2009)
	Prevalence rate of overweight and obesity in children under 5 years of age (%)	1.3 (2007)	n.a.
IV. Economics	Unemployment rate (%)	5 (2010)	5.4 (2008)
	Proportion of poor (%)	16 (2006)	0.6 (2008)
	Per capita GDP at current market prices (US$)	1 213 (2009)	3 112 (2010)
V. Governance	Percentage of government spending allocated to health	8.67 (2009)	16 (2010)
	Percentage of government spending allocated to education	25 (2009)	n.a.
	Voter participation rate in districts	n.a.	n.a.
	Proportion of population covered by health insurance (%)	45 (2007)	57 (2009)
	Population density (persons/km^2)	260 (2007)	3 458 (2010)
	Cultural households (%)	n.a.	60 (2005)

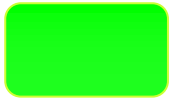
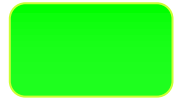
Annex G. Matrix of health equity in Ho Chi Minh City, Viet Nam

(extracted from *Report of Urban HEART pilot testing in Ho Chi Minh City, Viet Nam, 2009*)

		District 4	District 5	District 8	Cu Chi district
Health outcome indicators	Infant mortality rate				
	Under-5 mortality rate				
	Maternal mortality rate				
	Incidence rate of tuberculosis				
	Mortality rate of tuberculosis				
	Incidence rate of leprosy				
	Mortality rate of leprosy				

		District 4	District 5	District 8	Cu Chi district
	Incidence rate of mental illness				
	Mortality rate of mental illness				
	Incidence rate of HIV/AIDS				
	Mortality rate of HIV/AIDS				
	Dengue fever (cases per 100 000 population)				
	Dengue fever (number of deaths per 100 000 population)				
Physical environment and infrastructure	Proportion of population with access to improved water source				
	Proportion of population with access to improved sanitation				

		District 4	District 5	District 8	Cu Chi district
	Proportion of households served by municipal solid waste management system				
	Number of traffic accidents				
	Number of deaths of traffic accidents				
	Proportion of standardized primary health care centres				
	Number of public hospitals				
	Number of private hospitals				
Social and human development	Literacy rate (%)				
	Net enrolment ratio in secondary school				

		District 4	District 5	District 8	Cu Chi district
	Proportion of 1-year-old children immunized against seven diseases				
	Prevalence rate of underweight children under 5 years of age				
	Prevalence rate of overweight and obesity in children under 5 years of age				
Economics					
	Unemployment rate (%)				
	Per capita GDP at current market prices (US$)	n.a.		n.a.	n.a.
	Proportion of poor				
Governance					
	Percentage of government spending allocated to health				
	Percentage of government spending allocated to education				

	District 4	District 5	District 8	Cu Chi district
Voter participation rate in districts				
Proportion of population covered by health insurance				
Population density (persons/km^2)				
Proportion of cultural households				

Annex H. Responses from four districts

(extracted from *Report of Urban HEART pilot testing in Ho Chi Minh City, Viet Nam, 2009*)

District 4

Indicators	Selected indicator	Response tool
Health outcome indicator	Infant mortality rate Incidence rate of tuberculosis, mental illness, HIV/AIDS	Develop antenatal care: find out as soon as possible about foetus malnutrition, foetal defects Decrease incidence of certain illnesses, including HIV/AIDS, tuberculosis Implement national measures to prevent tuberculosis, HIV/AIDS, dengue fever and others Focus mainly on urban poor for these diseases Improve mental health care and working conditions Decrease unemployment rate and proportion of the poor
Physical environment and infrastructure	Proportion of population with access to improved sanitation (%) Proportion of households served by municipal solid waste management system (%) Proportion of standardized primary health care centres (%)	Cooperate with the people's committee on improved water source supply and sanitation Focus on need of community, especially where diseases such as tuberculosis, diarrhoea and HIV/AIDS are common Municipal solid waste management system: organize public education programme in order to improve waste management at home and in neighbouring zones Consolidate primary health care network, especially regarding infrastructure, tools and equipment
Social and human development	Prevalence of overweight and obesity in children under 5 years of age (%)	Create recreational areas in school and other localities
Economics		Focus on women's health in projects that create jobs for women
Governance	Percentage of government spending allocated to health (%) Percentage of government spending allocated to education (%) Proportion of population covered by health insurance (%) Population density (persons/km^2)	Advertise health insurance to population Improve medical examination and quality of treatment by health insurance service

District 5

Indicators	Selected indicator	Response tool
Health outcome indicator	Incidence rate of mental illness, HIV/AIDS, dengue fever	Vary recreation models to attract attention and participation of citizens Allocate resources to mental health care activities Raise awareness of mental illness, HIV/AIDS and dengue fever, and educate community on effective prevention methods
Physical environment and infrastructure	Proportion of standardized primary health care centres (%)	Spend more budget on constructing primary health care centres with standardized infrastructure, and ensure all primary health care centres meet national standards
Social and human development	Proportion of 1-year-old children immunized against seven diseases (%) Prevalence rate of overweight and obesity in children under 5 years of age (%)	Increase communication activities on benefits of immunization and knowledge of possible side-effects Increase awareness of consequences of obesity and possible solutions among teachers, students and parents Cooperate with Department of Education to implement intervention programme against obesity at one kindergarten
Governance	Percentage of government spending allocated to health (%)	Invest in health care centres, including building centres for preventive medicine, hospitals, and primary health care centres according to national standards for health care facilities Make living environment more comfortable

District 8

Indicators	Selected indicator	Response tool
Health outcome indicator	Incidence rate of tuberculosis, HIV/AIDS, dengue fever	Strengthen tuberculosis prevention programme by detecting more tuberculosis cases with improved sputum test Increase action against illegal drug use Increase activities to combat HIV/AIDS
Physical environment and infrastructure	Proportion of population with access to improved sanitation (%) Proportion of standardized primary health care centres (%)	Construct housing for citizens living alongside canals and improve their living environment Improve environments in areas liable to flooding Organize waste treatment system and educate community in classifying household waste for appropriate treatment Develop network of quality primary health care centres to serve citizens (infrastructure + machines and equipment + capability of health personnel)
Social and human development	Proportion of 1-year-old children immunized against seven diseases (%) Prevalence rate of overweight and obesity in children under 5 years of age (%)	Raise awareness of immunization programme Communicate and educate on child nutrition Create support groups for breastfeeding
Economics		Support poor through occupational training, job support, pre-employment training courses in real working environments, microcredit, business guidance
Governance	Proportion of population covered by health insurance (%) Population density (persons/km^2)	Encourage citizens to buy health insurance, including through subsidies Build housing for low-income citizens Support construction of urban zones, redevelopment of residential areas bordering canals

Cu Chi District

Indicators	Selected indicator	Response tool
Health outcome indicator	Infant mortality rate Incidence rate of tuberculosis, leprosy, mental illness, HIV/AIDS	Assure all infants are fully immunized against seven illnesses Raise women's awareness of pregnancy issues, including regular health care examination Improve effectiveness of national tuberculosis prevention programme Support leprosy patients in finding accommodation, jobs Ensure that primary health care officers have good working conditions and appropriate medication to facilitate management of patients with mental illness Carry out drug abuse prevention programme Improve control of HIV/AIDS
Physical environment and infrastructure	Proportion of population with access to improved sanitation (%) Proportion of households served by municipal solid waste management system (%) Traffic accidents	Implement waste management projects, including biogas for households breeding domestic animals, improved sanitation Improve traffic management Improve transportation conditions on Trans-Asia Highway Employ more stringent measures to reduce driving offences, including driving under the influence of alcohol and speeding
Economics	Proportion of poor (%)	Job creation activities, including occupational training, job supply projects, job advertising programme, and support for the poor in finding employment, including through microcredit and loans
Governance	Percentage of government spending allocated to health (%) Proportion of population covered by health insurance (%)	Increase proportion of budget allocated to health at local level, including for infrastructure, increase in number of beds in district hospitals, construction and standardization of primary health care centres Promote health insurance, including by encouraging citizens, especially the poor, to join health insurance schemes, and raising the quality of health care examination by training more qualified and specialized personnel Invest in medical equipment for testing and diagnosis

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