Reaching the Urban Poor Initiative

MANUAL OF OPERATIONS

2012
Reaching the Urban Poor Approach

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Purpose of the Manual

The Reaching the Urban Poor Manual of Operations (RUP MOP) is meant to serve as a practical guide for City Health Office, Health Center staff, or other stakeholders who are working with urban poor communities who would want to partner with the local government unit in implementing strategies to reach the urban poor population. It highlights suggested structures, approaches, activities, and actions that are simple and feasible to use in engaging urban poor communities and yet, flexible enough to be adapted to local conditions.

The program managers and technical officers from the Department of Health Central Office and Centers for Health Development may also find this manual a useful reference in supporting their commitment to serve the disadvantaged individuals and families in our communities by increasing access to health services and addressing equity issues.
### Abbreviations and Acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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</thead>
<tbody>
<tr>
<td>ABC</td>
<td>Association of Barangay Captains</td>
</tr>
<tr>
<td>AO</td>
<td>Administrative Order</td>
</tr>
<tr>
<td>AOP</td>
<td>Annual Operation Plan</td>
</tr>
<tr>
<td>BHW</td>
<td>Barangay Health Worker</td>
</tr>
<tr>
<td>CHD</td>
<td>Center for Health Development</td>
</tr>
<tr>
<td>CHITS</td>
<td>Community Health Information Tracking System</td>
</tr>
<tr>
<td>CHO</td>
<td>City Health Office</td>
</tr>
<tr>
<td>CIPH</td>
<td>City-wide Investment Planning for Health</td>
</tr>
<tr>
<td>DepEd</td>
<td>Department of Education</td>
</tr>
<tr>
<td>DILG</td>
<td>Department of Interior and Local Government</td>
</tr>
<tr>
<td>DOH</td>
<td>Department of Health</td>
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<tr>
<td>DOTC</td>
<td>Department of Transportation and Communication</td>
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<tr>
<td>DPWH</td>
<td>Department of Public Works and Highways</td>
</tr>
<tr>
<td>DSWD</td>
<td>Department of Social Welfare and Development</td>
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<tr>
<td>EPI</td>
<td>Expanded Program of Immunization</td>
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<tr>
<td>ESHUT</td>
<td>Environmentally Sustainable and Healthy Urban Transport</td>
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<tr>
<td>FHSIS</td>
<td>Field Health Surveillance Information System</td>
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<tr>
<td>HC</td>
<td>Health Center</td>
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<tr>
<td>HSD</td>
<td>Health Service Delivery</td>
</tr>
<tr>
<td>IMCI</td>
<td>Integrated Management of Childhood Illnesses</td>
</tr>
<tr>
<td>IYCF</td>
<td>Infant and Young Child Feeding</td>
</tr>
<tr>
<td>LCE</td>
<td>Local Chief Executive</td>
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<tr>
<td>LGU</td>
<td>Local Government Unit</td>
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<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
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<td>MOP</td>
<td>Manual of Operations</td>
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<tr>
<td>MSE</td>
<td>Supervision, Monitoring, and Evaluation</td>
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<tr>
<td>MWSS</td>
<td>Metropolitan Waterworks and Sewerage System</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
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<tr>
<td>NHA</td>
<td>National Housing Authority</td>
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<tr>
<td>NSCB</td>
<td>National Statistical Coordination Board</td>
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<tr>
<td>PUCP</td>
<td>Presidential Commission on Urban Poor</td>
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<tr>
<td>REB</td>
<td>Reaching Every Barangay Strategy</td>
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<tr>
<td>RED</td>
<td>Reaching Every District/Depressed Area Strategy</td>
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<tr>
<td>RHU</td>
<td>Rural Health Unit</td>
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<tr>
<td>RUP</td>
<td>Reaching the Urban Poor Approach</td>
</tr>
<tr>
<td>SC</td>
<td>Steering Committee</td>
</tr>
<tr>
<td>SCUHE</td>
<td>Short Course on Urban Health Equity</td>
</tr>
<tr>
<td>TA</td>
<td>Technical Assistance</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TCL</td>
<td>Target Client List</td>
</tr>
<tr>
<td>TWG</td>
<td>Technical Working Group</td>
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<tr>
<td>UHC</td>
<td>Universal Health Care</td>
</tr>
<tr>
<td>UHS</td>
<td>Urban Health Systems</td>
</tr>
<tr>
<td>UHSD</td>
<td>Urban Health System Development</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>Urban HEART</td>
<td>Urban Health Equity Assessment and Response Tool</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
REACHING THE URBAN POOR (RUP) APPROACH

1 Module

Definition of RUP

The RUP Approach is a strategy to address urban health inequities among the urban poor population and increase their access to basic health services. It is guided by the principles of inter-sectoral action, community partnership, social cohesion and empowerment.

Components

a. Target at risk (urban poor) and services identification
b. Community partnership
c. Multi-sectoral involvement
d. Health service improvement

Goals

Reduced health inequities through:

a. Improved health status of the urban poor
b. Financial risk protection for the urban poor
c. Responsiveness of the health system to the urban poor

Objectives

a. To increase access to and utilization of health services
b. To empower communities
c. To enhance inter-sectoral action
The RUP Approach was established in 2004 and was initially called the Reaching Every District (RED) Strategy. The RED strategy was developed by WHO in July 2002 initially designed for rural African Countries and their Expanded Programs on Immunization (EPI) to address common obstacles to increasing immunization coverage especially in hard to reach areas. This strategy, aiming to capacitate the health workers to provide appropriate immunization services and improve their skills in managing such services at the health center level, was found to be very effective leading to its expansion to other Asian countries.

The RED strategy was introduced by the World Health Organization in the Philippines in 2004 as an answer to the challenges in the implementation of the Ligtas Tigdas Door-to-Door Campaign and the national consultation on EPI. Both found the need to identify a strategy to locate the urban poor and provide them with basic services and life-saving interventions.

Pasig City was selected as a pilot site for the RED Strategy to improve health care coverage, to reduce inequities, and to identify pockets of the “truly poor” population. community health and non-health issues.

Caloocan’s Experience in Implementing their IYCF Program using the Reaching the Urban Poor Approach

In 2007, the Caloocan City Health Office collaborated with the World Health Organization and the Center for Health Development-Metro Manila (CHD-MM), to implement an initiative that aimed to improve the maternal, infant and young child health and nutrition using the reaching the urban poor strategy. Breastfeeding support groups were developed and trained to conduct advocacy and peer counseling, home visitations and monitoring of breastfeeding mothers. Functional city and barangay technical working groups were also created and organized. Capacity building and advocacy activities for health workers and decision makers were conducted to improve their knowledge and skills in management, facilitation and coordination.

In 2009, the program was expanded to other depressed areas of Barangay 8 and depressed areas of Barangay 18, under the financial support of Center for Health and Development (CHD-MM). The support-groups are still functional and have expanded their reach to other health center services such as OPT, Garantisadong Pambata, Mop- up Immunization.

Through the project, the city was able to test and develop a cost-effective strategy in changing the breastfeeding behavior of the community which could lead to child survival, women empowerment and community development. Since the implementation of the program, there has been a marked increase in maternal, child health nutrition accomplishments and improvement of the delivery of health services among the urban poor.
When the project started in *Sitio Kapitbahayan* in Barangay Sta. Lucia, the strategy was applied in an urban poor setting and was renamed to **Reaching Every Depressed (RED) Area/Barangay strategy** following the local terminologies. It was initiated through a series of capability building among the city-level and health center staff while the community leaders similarly underwent participative processes of identifying and addressing community health and non-health issues.

Due to the successful pilot project, the EPI program implementation in the Philippines was then revised to adopt the RED strategy focusing on reaching the unreached. The term Reaching Every Depressed Area/Barangay strategy was used interchangeably with the term Reaching Every Barangay (REB) strategy. By 2005, the same strategy was replicated and further improved in the cities of Makati, Paranaque, and Taguig in Metro Manila and the municipality of Bacoor in the province of Cavite. In short, this process of community empowerment helped make the whole health system responsive to community needs.

This RED/REB Strategy has then evolved to the **Reaching the Urban Poor (RUP) Approach** with primary aim of reaching the unreached segment of population to address access to basic health services and equity issues on health and non-health areas. Since its implementation in 2004, the RUP Approach has been scaled up with the target to reach at least 600,000 people living in urban poor populations in at least nine (9) cities in the Philippines by the end of 2011.

**Figure 1.1**: The evolution of the Reaching the Urban Poor (RUP) Approach in the Philippines
As the urban population grows, inequities especially in health also increase across population groups within the cities. The rapid rate of urbanization has outpaced the ability of governments to build essential infrastructure for health and social services. There has been an increasing realization at the national level to address urban health challenges. This paved the way for the issuance of the Urban Health System Development (UHSD) as contained in DOH Administrative Order No. 2011-0008.

### General principles of UHSD:

<table>
<thead>
<tr>
<th>Healthy urbanization</th>
<th>Urban Health Systems (UHS) must promote healthy urbanization so that cities develop in ways that achieve better health and avoid risks to ill health under conditions of rapid urbanization.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inter-sectoral action</td>
<td>UHS must be designed through inter-sectoral collaboration with people and institutions from outside the health sector to influence a broad range of health determinants and generate responses producing sustainable health outcomes.</td>
</tr>
<tr>
<td>Inter-city coordination</td>
<td>Inter-city coordination between contiguous cities is important because a city, particularly if it is not a Highly Urbanized City may not have all the resources, institutions and capacities to be able to respond to the entire health needs of its constituents, and may thus benefit from resources, institutions and capacities of other cities through inter-city or inter-LGU coordination.</td>
</tr>
<tr>
<td>Social Cohesion</td>
<td>Social cohesion is action through core groups.</td>
</tr>
<tr>
<td>Community Participation</td>
<td>Community participation must be integrated in all aspects of the intervention process, including planning, designing, implementing, and sustaining any project/program.</td>
</tr>
<tr>
<td>Empowerment</td>
<td>Empowerment is enabling individuals and communities to have ultimate control over key decisions involving their wellbeing through strategies such as building knowledge and purchasing power, and mechanisms to increase client accountability.</td>
</tr>
</tbody>
</table>

### Goals of the UHSD:

- to improve health system outcomes
- to influence social determinants of health
- to reduce health inequities
Rationale and History

RUP and the Urban Health Systems Development

Under the USHD Framework, RUP is a component strategy for all programs seeking to reach the urban poor and improve performance on equity.

Components of the UHSD

1. Programs and Strategies
   1.1 Healthy Cities Initiative
   1.2 Reaching Every Depressed/Reaching the Urban Poor (RUP)
   1.3 Environmentally Sustainable and Healthy Urban Transport (ESHUT);

2. Tools and Framework
   2.1 Urban HEART
   2.2 City-wide Investment Planning for Health (CIPH)

3. Capacity building through the Short Course on Urban Health Equity (SCUHE).

The Urban HEART or Urban Health Equity Assessment and Response Tool was developed by the World Health Organization (WHO) Center for Health Development in Kobe, Japan to assist health departments or ministries in systematically gathering evidence to assess and respond to unfair health conditions and inequity in urban settings. It is a user-friendly guide that enables policy and decision-makers at the national and local levels to identify and analyze problems related to health inequities and decide on viable and effective interventions to address these inequities. In the Philippines, the tool was piloted in Paranaque and Taguig, and eventually to Naga, Olongapo, Tacloban, Zamboanga and Davao.

In August 2010, the Department of Health issued Department Memo 2010-0207, which iterates guidelines and principles on the use of Urban HEART in Highly Urbanized Cities (HUCs) in the context of the Urban Health Systems Development.

<table>
<thead>
<tr>
<th>Inter-sectoral TWG</th>
<th>Inclusive team to manage the use of the Urban HEART in planning, monitoring and evaluation, designing, and implementing interventions.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Collection</td>
<td>Quality data from available data sources to establish evidences on health inequity (i.e. between the rich and poor barangays) in the city.</td>
</tr>
<tr>
<td>Data Assessment</td>
<td>Assembly of collected data to produce easy-to-read charts, (Urban Health Equity Matrix and Monitors, to illustrate health inequities in the city.</td>
</tr>
<tr>
<td>Response</td>
<td>Problems prioritized using evidences from the Matrix &amp;Monitors, and inter-sectoral interventions implemented to address problems &amp; social exclusion</td>
</tr>
</tbody>
</table>

THE FOUR COMPONENTS OF THE URBAN HEART
RUP and Primary Health Care

The Alma Alta Declaration of 1978 defined primary health care as an essential health care that should be based on practical, scientifically sound and socially acceptable methods and technology. Primary health care, it is further stated, should be made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development. Furthermore, it also underlined the importance of providing primary health care in the spirit of self-reliance and self-determination.

The declaration also emphasized that inequalities in the health status of people is “politically, socially and economically unacceptable”. It also called attention to the need for all sectors in the society, not just the health sector, to ensure that all people achieve the highest possible level of health. It further stressed that health is a key element of social justice and human rights and is essential in the achieving sustained social and economic development. The World Health Organization’s 2008 report highlighted the urgency of translating these declarations to specific actions and reforms. The WHO recommended reforms in four areas: universal coverage, service delivery, public policy and leadership in health.

According to the WHO, these reforms should be directed towards: 1) universal access and social health protection, 2) primary care that is more socially relevant and more responsive to the changing world while producing better outcomes, 3) healthier communities in which public health actions are integrated with primary care and the presence of healthy public policies across sectors and 4) inclusive, participatory, negotiation-based leadership.

Figure 1.2: The Four Areas of Reform in Primary Health Care
(Source: WHO 2008 Annual Report)
The Philippine health sector has undergone packages of reforms in the past decades with the objective of improving key health outcomes. Since then, substantial gains in health status improvements such as life expectancy, mortality and morbidity rates have been achieved to some extent.

Issues of poor accessibility, inequities, and inefficiencies of the health system continue to be a challenge even if these were the targeted issues of the health reforms over the last 30 years. Great disparities in health outcomes across income groups and geographic areas still persist. Challenges in ascertaining physical and financial access to health services – as evidenced by high out-of-pocket expenditures, concentration of physical and human resources for health in urban areas, and migration of health professionals – still exist. Cognizant of the continuing issues of inequity in access to health services, the current administration’s health agenda (Aquino Health Agenda) has articulated the goal of Universal Health Care (UHC) as contained in DOH Administrative Order No. 2010-0036.

Universal Health Care or "universal coverage" generally refers to a scenario where everyone is covered for basic healthcare services, and no one is denied care. The Aquino Health Agenda aims to provide UHC for Filipinos, starting with improving the access of the poor and the vulnerable to health services. In the 2011 Philippine Development Forum, the social services sector of the government articulated a vision of enabling the poorest income quintile of about 5.2 million families to have access to health care at the national and local levels by 2013.

**As the RUP approach employs community mobilizing and organizing strategies, it can help in ensuring that the “poorest of the poor” are properly identified and enrolled in PhilHealth, and are prioritized in the delivery of basic health services. The RUP is a recognized approach to realize the goal of universal health care in the Philippines.**

**Strategic Thrusts:**

**Financial Risk Protection through expansion in NHIP enrolment and benefit delivery**

The poor are to be protected from the financial impacts of health care use by improving the benefit delivery ratio of the NHIP.

**Improved access to quality hospitals and health care facilities**

Government-owned and operated hospitals and health facilities will be upgraded to expand capacity and provide quality services to help attain MDGs, attend to traumatic injuries and other types of emergencies, and manage non-communicable diseases and their complications.

**Attainment of the health-related MDGs**

Public health programs shall be focused on reducing maternal and child mortality, morbidity and mortality from TB and malaria, and the prevalence of HIV/AIDS, in addition to being prepared for emerging disease trends, and prevention and control of non-communicable diseases.
Community participation

The Alma Ata Declaration of 1978 underscores the right and the duty of people to participate individually and collectively in the planning and implementation of their health care. In its annual report in 2008 aptly entitled, Primary Health Care - Now More Than Ever, the World Health Organization’s also reiterated the need to introduce health system reforms that would ensure more people-centered service delivery and participatory leadership, highlighting the need for increased involvement of the community in planning and decision-making not only on health issues but also its social determinants.

Under the RUP Approach, health center staff members directly engage volunteer community members to identify their key health issues and to facilitate open and unbiased dialogues with the rest of the community, helping them to manage their priority concerns.

Local health center staff as enablers of the community organizing process
By initially facilitating dialogues and supervising the processes of planning, implementation, and monitoring and evaluation, health center staff, in partnership with NGOs or other local stakeholders, gradually enable the members of the community to organize themselves and build their capacities in managing key issues and problems.

Communities as primary mobilizers
Through a gradual process of supportive supervision, community members ultimately become the primary mobilizers for community-based primary health care. They are enabled to identify and address their own issues and problems, translating them into critical improvements in their access to life-saving interventions and facilitating other developmental processes.
Social Cohesion

The local government through the city health office and health center staff along with community leaders and other stakeholders pool their efforts and resources to achieve common goals, which are to ensure the well-being of all the members of the community, minimize disparities and avoid marginalization of the urban poor in the community.

Inter-sectoral Action

Health center staff members are trained to facilitate linkages between the members of the community with relevant agencies, local chief executives, and NGOs to address identified issues. Through the established linkages with stakeholders, both health and social determinants (livelihood, education, housing, water and sanitation, etc.) may be addressed by the mandated agencies through existing organizational structures and mechanisms. This approach brings about the translation of community concerns into city-wide action.

Key Processes of RUP

1. Engagement and Stewardship
   a. Advocacy and community engagement
   b. Health situation assessment
      b.1 Data collection
      b.2 Situational analysis
   c. Problem definition and prioritization
   d. Action planning

2. Implementation: Piloting and Modeling
   a. Health service delivery strengthening
   b. Community organizing
   c. Social mobilization
   d. Linking with other relevant agencies
   e. Addressing social determinants of health

3. Scaling up and Sustainable expansion
   Leadership and governance strengthening

4. Monitoring, Supervising & Evaluation
**Figure 1.3:** The Key Processes of RUP at each phase of implementation.

*site selection will be done for new sites and for DOH/CHD funded RUP projects. Donor or LGU-funded projects may or may not undergo the process of site selection.*
Half of the world’s population now lives in cities. It is estimated that, by the year 2030, the number of urban residents will rise by more than two billion people.

In the Philippines, the same picture of rapid urbanization is also seen (see Table 1). Currently, there are more than 70 million Filipinos or almost 73% of the total population living in urban areas. This is expected to increase to 80% by 2050. High expectation of city life, strong notion of high employment in cities, and the concentration of basic social services, and trade and seats of government in cities are some factors of urban population growth. However, in recent years, people have been migrating to urban areas due to insurgency and counter-insurgency operations in the countryside, other forms of conflicts and due to natural disasters. There is a pervading belief that disaster and crisis response and management are quicker in urban areas than in rural.

![Growth of PHL Urban Population (1990-2010)](image)

**Figure 2.1.** This graph illustrates the growth of the total population and the corresponding rapid increase of the urban population in the Philippines over a period of 30 years.
The Effects of Rapid Urbanization

With the continuous growth of the urban population, a parallel increase of urban poverty also manifests as evidenced by the rise of informal settlements or slums. The Philippine National Housing Authority (NHA) estimates that there are about 1.2 million families in informal settlements all over the country. Based on the latest survey of NSCB in 2006, 4.7 million Filipinos were living below the poverty threshold with a family with five members needing an average monthly income of PhP 6,274 just to make ends meet and stay out of poverty. This current picture of poverty, that thirty-three out of every 100 Filipinos are poor, was no different when compared to the one in 2000.

![Distribution of Informal Settlers in PHL](chart)

Figure 2.2 NHA 2007 data shows that majority (40%) of the informal settlers are located in private-owned lands, closely followed by those located in Government-owned lands (33%).

The Urban Poor

The term urban poor, as defined by the Philippine Presidential Commission on Urban Poor (PCUP) and the Social Reform and Poverty Alleviation Act of 1997 (Republic Act 8425), includes:

a. individuals or families in urban areas whose income falls below the poverty line,
b. those who are incapable of meeting their minimum basic needs (food, health, education, housing and other social amenities),
c. those who live in slums, squatter and resettlement areas, or along dangerous zones like railroad tracks, esteros, riverbanks, cemeteries, and high tension wires.
The RUP Approach expands the above definition of the PCUP and RA 8425 to include the concept of exclusion. The urban poor, as characterized by Kawachi et al, are systematically excluded from opportunities, decent employment, security, capacity, and empowerment that would have given them better control over their health and lives. Because of this exclusion, they are at times forced to live in densely populated areas whose houses/domiciles are makeshift, dilapidated, and/or made of light or poor materials. They may use mobile or container vans, neglected vehicles, wooden pushcarts, or even abandoned unfinished or condemned buildings which may be located along streets/sidewalks, under bridges, along or over waterways, highways, dumpsites, railroad tracks, parks, or trees, beside village walls or buildings, cemeteries, and private and government lots. They do not have regular jobs and are often unemployed causing them to gravitate together towards the more relatively low-cost and unplanned slum settlements mentioned above. Environmental hazards such as landslides and flashfloods to which such marginal lands are prone make matters, such as poor infrastructure and housing quality, and overcrowding, even worse.

The poor in cities also suffer from the double burden of communicable and non-communicable diseases due to limited access to safe water, sanitary toilets, and health services. Due to their limited income, misplaced priorities, and lacking awareness, inequities are more tangible in urban areas than in rural ones despite the better geographical placement and number of public health facilities. Although the private sector plays a prominent role in the provision of urban health care, the urban poor are again excluded from accessing such services because of their inability to pay expensive fees.

However, according to the Urban Poor Associates (UPA), income-wise, the urban poor are not a homogeneous class. The lower middle class and the moderately poor are formally employed as low-level employees in the public and private sectors while the 30% poorest of the poor survive in the underground economy providing cheap services to the well-off.
A study conducted by the Abt Associates for the program, Partners for Health Reform plus (PHRplus) in India and Metro Manila revealed that most of the men in informal settlements have temporary jobs in the informal sector (Abt Associates, 2006). However, the income from low-level employment and underground economic activities are not enough to meet their basic need. Most of the respondents in the PHRplus study also indicated that their daily income is not enough for their household expenses; and that they have very little cash for food, which is the most basic need (Abt Associates, 2006).

Urbanization and the Health Care System

Urbanization, despite it being traditionally associated with development and better health outcomes, faces monumental challenges on urban health due to the rapid increase of informal settlements. Urban populations are increasingly exposed to unhealthy environments, disasters, climate change, violence and injuries, tobacco and other drugs, and epidemics. Without good governance, access to health care and shelter, adequate resources and capacities, the urban poor carry the greatest burden.

Poverty-driven health problems include malnutrition, injuries, and communicable and non-communicable diseases. In the Philippines, almost one third (30%) of children below 5 years old are underweight, meaning they are not eating enough both in quantity and quality. About 21% of Filipino households do not have safe water supply and 18% do not have sanitary toilets leaving them vulnerable to diseases and infection due to poor sanitation. Infectious diseases such as measles, tuberculosis and diarrhea spread quickly in crowded urban environments with young children, the elderly and people with poor immune systems being the most vulnerable. If the crowded slums are affected by such diseases, all areas of the city are threatened. Addressing these problems it will require more than the provision and use of health services to improve the health of urban populations. The Urban Health System must help cities address the challenges of rapid urbanization brought about by the interplay of different social determinants of health.

Addressing these problems it will require more than the provision and use of health services to improve the health of urban populations. The Urban Health System must help cities address the challenges of rapid urbanization brought about by the interplay of different social determinants of health.
Cities and urban centers are unique as they have bigger population sizes, higher income levels and more autonomous decision-making & governance. As a result, the effects of the devolution of health services - are less apparent in the urban areas. Moreover, there is a high concentration of health facilities and personnel, specialization and appropriate technologies in urban areas, thus the supply side of the health care system is not a problem. The urban poor lack access to health care services because they cannot pay for it. They are dependent on cash for their basic needs and have difficulty acquiring even smallest amounts. Thus, even in the government facilities where services are free, the poorest of the poor still cannot afford other important components of care such as medicines and supplies, which are purchased on cash-basis. In some cases, the poor cannot afford the transportation cost that would be incurred in going the health facilities.

The challenges of rapid urbanization to the health care system and the need to develop a system specifically for the urban centers has been taken up by the government through the Urban Health System Development (UHSD) as detailed in DOH’s Administrative Order No. 2011-0008, which was discussed in Section 1 of this manual.

RUP Approach: Improving Access of the Urban Poor to the Health Care Delivery System

With the increasing proportion of urban poor population especially in highly urbanized cities, efforts to improve health service delivery among the urban poor are being undertaken. Capacity building and advocacy work for both health workers and decision makers are conducted to change their perspectives, make use of information in a holistic way, and improve their skills in facilitation and coordination. Strategies such as initiating home visits or follow-ups, and increasing outreach/street visits are just examples of what community health workers now employ to reach the urban poor.

Successful Practices in Implementing RUP

B.R.E.A.D for L.I.F.E: The RUP Experience in Paranaque City

In 2005, the Paranaque City Health Office, in collaboration with the World Health Organization and the Center for Health Development-Metro Manila (CHD-MM), spearheaded the Bernabe Reaching Every Area with Depressed families for Livelihood, Income-generating projects, Family Planning, and Expanded Program on Immunization (B.R.E.A.D. for L.I.F.E.) project. The project is Paranaque’s version of the Reaching Every District (RED) approach. Its goal is to establish mother- and baby-friendly communities by supporting the empowerment of women, men, adolescents, infants, and young children to access basic health services.
BREAD for LIFE started in Sitio Gulayan in Barangay Moonwalk, Paranaque City in 2005. The following year, four other areas (SAMAPA, Scarlet Ibaba, Dukha Neighborhood and Kawayanan) experienced the same. Due to the impact to these depressed communities, two new Barangays, Sto. Nino and San Isidro, took on the challenge in 2007. Sto. Nino focused the work in Kaingin, which is a conglomeration of five communities, namely, Valenzuela, Scarha, Halik-Alon, Diamond and Santos. San Isidro, on the other hand, focused in the areas of Napoleon and Booc. In 2008, Manggrahan was added to the communities of Barangay San Isidro, while in 2009, the areas of Dahlia, 17th Extension and Multi-Riverside in Barangay Sto. Nino was initiated on the project. In 2010, BREAD for LIFE was expanded to the whole of barangays Moonwalk, San Isidro and Sto. Nino.

Accomplishments

Paranaque’s brand of RUP focused on improving performance in the Expanded Program on Immunization (EPI) at first. Let us look at the case of Sitio Gulayan in Barangay Moonwalk, one of the first communities that implemented the approach:

After only four months of implementation of the RED approach, there were already improvements in the EPI coverage in Sitio Gulayan in 2005. There was an improvement of 23% in the coverage of DPT3 and a 30% improvement in measles vaccination coverage. The improvement of the coverage in EPI was due to the community mobilization activities conducted by the health service providers themselves. When their initial outreach activities failed to reach the number of people that they expected, they turned to community health volunteers and leaders to identify and organize families to prepare for the outreach activities.

Figure 2.3 Four-year data (2005-2009) of selected EPI antigens from Sitio Gulayan, Barangay Moonwalk, Paranaque City
Coverage for DPT 1, DPT 3, AMV and HB3 slightly dipped in 2007 but surged to more than 100% in 2008 and again in 2009 (see figure 2.3). This was because of the efforts of the health center staff to actively identify and reach children below five years old in its urban poor communities. The more than 100% accomplishment in 2008 and 2009 in terms of DPT1 and DPT3 was due to the fact that most of these children reached by the health center belong to transient families who move from one area to another depending on job and livelihood opportunities. Transient populations, particularly those that are in informal settlements are usually not included in the population projections of government agencies.

As of 2011, Barangay Moonwalk has already scaled-up the approach to 54 communities, and is continuing to see improvements in their EPI performance.

When Paranaque began expanding the RED approach into other communities in 2007, the approach was renamed: Reaching the Urban Poor approach. The services were also expanded - from EPI to MNCHN. The city also saw some marked improvements in its MCH indicators in 2008 compared to 2007. The following outcome indicators for Maternal and Child Health were monitored from 2007 to 2008. Sitio Gulayan showed improvements in selected MNCHN indicators just one after it expanded its program coverage from EPI to MNCHN:

<table>
<thead>
<tr>
<th>Sitio Gulayan (Target: 42)</th>
<th>2007 Data</th>
<th>2008 Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of pregnant women 1st seen at HC</td>
<td>10</td>
<td>35</td>
</tr>
<tr>
<td>No. of women with complete pre-natal visits (≥4)</td>
<td>3</td>
<td>18</td>
</tr>
<tr>
<td>No. of women given tetanus toxoid (1st dose)</td>
<td>3</td>
<td>17</td>
</tr>
<tr>
<td>No. of women with post-partum (PP) care</td>
<td>9</td>
<td>37</td>
</tr>
<tr>
<td>Malnourished children (0-71 mos)</td>
<td>6</td>
<td>4</td>
</tr>
</tbody>
</table>

*Figure 2.4* Comparison of 2007 and 2008 accomplishments on selected MNCHN indicators in Sitio Gulayan, Barangay Moonwalk, Paranaque City

Sto. Nino, one of the expansion-barangays in 2007, can be found northwest of Barangay Moonwalk. When it started, only six communities were covered then, in 2010, four more communities were added. As of 2011, the RUP approach is being implemented in 20 communities.

A three-year trending (2007-2010) of selected MCH indicators points to some improvements in the MCH outcomes in barangay Sto.Nino (figure 2.5): ➔
In three years of implementing the RUP approach, there were marked improvements in the MCH program coverage in the barangay, particularly in the ten urban poor communities. Accomplishments in various MCH indicators were more than 100%. The health center staff attributes this marked improvement in their performance to the mobilization of volunteers, who were able to reach households which were not reached by health service providers in the past. The health center was also able to update its masterlists for pregnant women and children under five, thus, they were able to identify and provide services to more clients.

More than the EPI and MCH accomplishments, the RUP approach also brought about changes in the behaviors of the residents, particularly the mothers. Both the health center staff and community volunteers continue to conduct community mobilization activities that have resulted to increases in the frequency of consultations, immunization coverage, prenatal check-ups, and counseling visits. The community volunteers and leaders were instrumental in organizing the community and providing services such as health information and education, counseling and referral to the community.

The relations among the community, the HC staff, and the Barangay officials also improved which paved the way to the successes of other programs such as Land and Housing, Water and Sanitation, Livelihood, Infrastructure, and others. These programs were established to respond to the identified needs of the community based on the survey and community consultations that were conducted at the start of the implementation of the RUP approach. The community maintains its strategic relationships with NGOs, agencies and groups that helped in establishing these programs that addressed social determinants of health and other non health problems.
Figure 3.1: The RUP Implementation Framework: Multisectoral Collaboration Towards Healthier Communities
Multi-Sectoral Collaboration in Implementing RUP

It is of common knowledge that many of the urban poor population are deprived of basic health amenities inevitably leading to high disease burden and socio-economic risks. Although the government continuously exerts all possible efforts to improve their health and welfare, still there is a need to be more responsive to their concerns and to provide new opportunities to develop their full potentials. This can be realized through RUP, the innovative urban health approach that utilizes mutually supportive structures and organizations that help and share resources for the healthy development of the disadvantaged sector of the population.

The organizational structure and management which would be established for the implementation of the RUP should ultimately aim to build healthier communities by improving health outcomes and reducing health inequities using the RUP Approach. Based on the experiences of the cities that have implemented the RED, and later on the RUP strategy, the city health office/department (CHO) would be the main implementing structure for the RUP approach. The city health office or department should be supported by the Local Chief Executive, civil society organizations such as NGOs and development agencies and government agencies in implementing the RUP approach. At the community level, the health center staff (including health staff of hospitals and other health facilities) would be the main implementing structure, but the People’s Organizations, as well as other stakeholders should be mobilized to actively participate in key activities, particularly in identifying, prioritizing and addressing health problems and their social determinants. The barangay LGU should also be

Simply put, to sustain the implementation of RUP in the communities, policy and financial support, in addition to the active participation of all stakeholders in all phases, are necessary.

Functional Arrangements

The cities that have started implementing the RUP approach have varied experiences in terms of establishing a functional structure that would effectively operationalize the RUP approach in their areas. The structures (including the functions and basic composition) and the functional arrangements presented below are based on the experiences of these cities and the opinions of experts on health governance and the health care system. It is the City Local Government Unit through the City Health Department, who will ultimately decide on the composition and leadership of the Steering Committee, or the Technical Working Group (TWG) or any management structures that would be set up for the implementation of the RUP approach.

Figure 3.2: The functional arrangements under the RUP shows the three key bodies in implementing the approach.
1. **STEERING COMMITTEE**

The Steering Committee (SC) provides the local over-all direction and policy support in the implementation of RUP strategy in the City. Its composition and perhaps its functions may be similar to the Local Health Board; so ideally, the LHB could serve as the SC of the RUP approach. If the city decides to do this, it has to expand the membership of the LHB to include other key people. However, if the city does not have an LHB or it is inactive and/or non-functional; or if the city LGU chooses to create another structure as the steering committee, it may do so.

1.1. **Basic Composition (as separate SC or as expanded LHB)**

1.1.1 City Mayor  
1.1.2 City Health Officer/ Asst. City Health Officer  
1.1.3 City Council Chair of the Committee on Health  
1.1.4 City Planning Officer/Urban Planning  
1.1.5 City Surveillance Officer  
1.1.6 Urban Poor Affairs Officer or City Social Welfare and Development Officer  
1.1.7 CHD Representative  
1.1.8 Association of Barangay Captains (ABC) President  
1.1.9 Representative from the civil society organizations

1.2 **Roles and Responsibilities of the Steering Committee**

1.2.1 Oversee and provide guidance in the design and implementation of RUP in the City  
1.2.2 Ensure proper management of funds allocated for RUP  
1.2.3 Conduct resource mobilization activities to support the implementation of the RUP approach  
1.2.4 Ensure that RUP is included in the city and Barangay investment plans and other plans  
1.2.5 Ensure the institutionalization and sustainability of the RUP Approach  
1.2.6 Develop and enact ordinances, resolutions, guidelines, and operating procedures at the City level to strengthen the implementation of RUP
2. TECHNICAL WORKING GROUP

2.1. Basic Composition

2.1.1 City Health Officer/Asst. City Health Officer
2.1.2 City Health supervisors (Physician, Nurse, Midwife)
2.1.3 City Health Program Coordinators
2.1.4 City Surveillance Officer
2.1.5 Urban Poor Affairs Officer or
2.1.6 City Department Heads (Social Welfare, Education, Interior and Local Government)
2.1.7 CHD Representative
2.1.8 Barangay Captains of implementing barangays
2.1.9 NGO partners (if implemented through an NGO partner)
2.1.10 Representatives from other civil society organizations
2.1.11 Other resource persons as deemed necessary (ex. Head of Social Hygiene)

2.2 Roles and Responsibilities of the TWG

2.2.1 Advocate to the City Chief Executives, members of the City Council, Department Heads, and other relevant institutions on relevance and use of the RUP Approach to provide the health and related services to the urban poor communities
2.2.2 Provide guidance to and ensure the strengthening of the capacities of the implementers and other partners of RUP:

- Knowledge (national policies and guidelines relevant to RUP, concepts and principles of RUP, relevant health programs being promulgated by DOH and recognized organizations and agencies)
- Skills (facilitation, coordination, documentation, data analysis, resource mobilization, and others)
- Attitude (approachable, caring, sensitive, able to work with a team efficiently and cordially even beyond the official office hours, able to handle multiple tasks at the same time, etc.)
- Prepare and submit reports, financial/ fund utilization reports and other reportorial requirements.
- Develop and propose guidelines and operating procedures at the City level to strengthen the implementation of RUP
- Review, monitor, evaluate, and provide feedback to RUP implementers based on the outcomes of prioritized health programs
- Ensure the documentation of good practices and learning experiences generated in RUP and assist in the dissemination of such evidence-based information.
- Ensure that RUP is included in the city and Barangay investment plans and other plans.
3. IMPLEMENTERS

The Implementers are the health service providers who directly engage and work with the Urban Poor. As such, they may be required to take on many roles as organizers, negotiators, mentors, planners, support groups, collaborators, and others. The implementers should be supported by the Barangay LGU in terms of mobilizing other stakeholders in the community such as Peoples’ Organizations, Sectoral Organizations and other private organizations in the community, to support the implementation of the program.

3.1 Implementers at the Community Level:

3.1.1 Health Center Physician
3.1.2 Clinic or hospital staff
3.1.3 Community NGO partners
3.1.4 Community Health Teams
3.1.5 People’s organizations, private sector, and other stakeholders
3.1.6 Other health staff – nurse, dentist, midwife, nutritionist, paramedical staff (Barangay Health Workers, Aides, and others)

3.2 Roles and Responsibilities of Implementers (together with the community and other stakeholders)

3.2.1 Collect and analyze data on the initial health situation and other relative conditions of the selected site for presentation to the SC
3.2.2 Prepare a practical and realistic health center work plan incorporating the inputs of the Barangay or community
3.2.3 Facilitate the formation of linkages between the community and its Barangay leaders and stakeholders
3.2.4 Facilitate dialogues and collaborate with partner agencies (community-based or city-based) for sharing of information and resources, resolving issues, and advocating for the strengthening of RUP in the area
3.2.5 Develop innovative interventions to deliver the needed services with maximum community participation
3.2.6 Monitor and document RUP performance in terms of:
   • the process or status of RUP in the respective Barangays
   • the outcomes of identified priority health programs based on their respective indicators
   • the issues and problems identified and the actions undertaken
3.2.7 To provide feedback to the community on the progress of RUP in improving access to health services and health outcomes.
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1.1 City Local Government Unit

The city government, through the City Health Office (CHO):

1.1.1 Spearheads, initiates, manages, and provides support to the overall implementation of Reaching the Urban Poor Approach.

1.1.2 Provides effective plans, key policy directions and insightful decisions supporting the city-wide implementation of RUP

1.1.3 Ensures that the capacities of the health center staff participating in the process are strengthened in providing quality and pro-poor health services

1.1.4 Effectively mobilizes resources and enforce policies to sustain implementation of RUP

1.1.5 Provides supportive supervision to the health center staff in conducting RUP activities

Key People at the City Level:

City Health Officer
- Overall project manager
- Oversee project implementation
- Chairs the Technical Working Group (TWG).
- Mobilize resources for RUP initiatives (covers advocacy and lobbying for additional health budget or for RUP-related activities)
- Mobilize NGOs, private (business, academe, CSO, PO) sector, and other partners and agencies to support the RUP initiatives.
- Designates RUP coordinator at the city level.

City RUP Coordinator
- Alter-ego of CHO; performs technical leg work of RUP
- Develop workplan, in coordination with NGO partners and other stakeholders
- Provide TA through training, monitoring, evaluation, supervision
- Supervises implementation at health center level
2. The Department of Health (Central Office and Centers for Health Development)

The Department of Health is the lead agency that provides policy directions and guidelines in the implementation of a more comprehensive and effective Urban Health System. With the passage of Department Memorandum 2010-0038, DOH has defined the directions and framework for Urban Health System Development, upon which RUP, as well as other key programs, is now anchored.

2.1 Provide technical assistance and strategic support to LGUs in line with their continuous effort to set up urban health systems that are responsive particularly to the needs of the more disadvantaged communities. Such include the following:

2.1.1. Assist and support the LGUs in their planning, capacity building, advocacy, partnership, monitoring and evaluation, and others

2.1.2. Facilitate the processing of RUP project proposals of LGUs that are aligned with the technical policies and programs of the DOH

2.1.3 Strengthen linkages and partnerships with agencies, civic society, private organizations, non-government organizations, development partners, and other stakeholders

2.2 Help promote and disseminate the significant results, lessons, and gains that can also be applied to other programs or settings

2.3 Distill of experiences for translation into policies and guidelines

2.4 Technical and logistical support for expansion

3. Civil Society Organizations

3.1 Non Government Organizations

3.1.1. To provide technical expertise and other resource in the various activities of the RUP implementation, particularly those that require participatory methods or community organizing or in addressing social determinants of health identified by the communities;

3.1.2 To influence popular opinion on MNCHN and RUP-related issues by incorporating these issues into their Information, Education, Communication activities;

3.1.3 To provide assistance to the city health department in linking the communities to the appropriate agencies that can help them address the social determinants of health problems or non health problems that they have identified;

3.1.4 To advocate for enactment or amendment of laws and policies to support MNCHN and RUP initiatives to the Local Chief Executive, legislators and other key officials of the city.

3.2 People’s Organizations and Civic Organizations including the business sector

3.2.1 Support and participation to advocacy among members, community planning, decision-making, and service delivery, and resource mobilization.
Institutional Arrangements

4. Other support organizations (other government agencies, donor agencies, etc)

4.1 Other Government Agencies

These are non-health government agencies mandated to address specific social determinants such as social welfare, education, and others. Such agencies have specific programs that can be linked with current health programs using the RUP Approach.

- Based on their specific mandates, to help the LGUs and RUP communities in addressing their identified issues on the social determinants of health.

4.2 Development Partners

Health sector development partners are national or international institutions, organizations, or agencies that can contribute time, resources, and effort in achieving a specific goal.

- 4.2.1 To provide technical and financial assistance on Urban Health system Development, particularly the RUP Approach
- 4.2.2 To contribute and support RUP implementation in a coordinated and concerted effort towards reaching the urban poor populations

5. At the Community/ Barangay (Barangay Level)

5.1 The Barangay LGU

The smallest unit of the government is the Barangay. Headed by the Barangay Captain or Chairman, the members of the Barangay Council are tasked to govern all the individuals and families in their community, including the urban poor.

- 5.1.1 Formulate Barangay Resolutions in support of the RUP Approach
- 5.1.2 Ensure that the RUP activities are included in their Barangay Health Plan
- 5.1.3 Provide support to all the programs and activities carried out by stakeholders ensuring that such are within legal and ethical frameworks and remain true to the spirit of RUP.

5.2 HC Staff

- 5.2.1 Facilitate the establishment and mobilize Community Health Teams
- 5.2.2 Capability-building of Community Health Teams People’s Organizations and community volunteers, including barangay officials.
- 5.2.3 Coordinate and work with barangay officials.
- 5.2.4 Provide a comprehensive and integrated primary health care services to the community, including the urban poor
- 5.2.5 With the CHO, facilitate the development of barangay/ community workplans prioritizing the activities needed to address the identified issues with the Barangay and the community

5.3 Peoples’ Organizations or Sectoral Groups

People’s Organizations or Sectoral Groups should be mobilized by the service providers of Barangay Health Centers and the BLGU to provide manpower, technical expertise, and other types of support to the implementation of the RUP approach in their community. They could be sources of volunteers who will be mobilized to provide health information and education. In particular, they can also provide assistance in linking the community to other organizations in addressing the social determinants of health problems.
The road towards building a healthier world for the people living in urban poor communities is certainly a difficult but challenging task. Because of limited resources of the city and pressing problems that call for immediate attention, the government has to gain the cooperation and support from other sectors. The road towards building a healthier world for the people living in urban poor communities is certainly a difficult but challenging task. Because of limited resources of the city and pressing problems that call for immediate attention, the government has to gain the cooperation and support from other sectors.

The RUP Strategy was conceptualized to enable the disadvantaged communities address the barriers they face, especially those that are health-related. The approach works by strengthening the existing public health system to reach the urban poor and empowering the communities to demand for better services and to address the social determinants of their health without creating any parallel systems. Its successes in the pilot cities are proof of its capacity to help the urban poor organize themselves and find solutions to their identified issues.

As discussed in the previous sections, the city government, as represented by the City Health Office, manages the actual implementation. The CHO serves as the link between the city management, the health center, and the urban poor communities through the provision of policy direction and key decisions. To ensure that RUP will succeed, the CHO has to strengthen the capacities of health center staff to provide not only quality health services that are responsive to the needs of the community, but also the skills to facilitate, teach, and organize the community. The community should be capacitated to actively and fully participate as equal partners in all phases of RUP implementation, especially in the management process.
To help the city, the DOH-CHD, in collaboration with other regional government agencies, development partners, and other stakeholders, provides technical and financial support which reinforces the foundation of RUP – a community-driven urban primary health care approach.

With proper coordination, the RUP Implementers can be mobilized by any level (by the city’s CHD, an NGO at the grass root level, or even the community itself) when immediate actions are needed to be undertaken for pressing issues. However, being the direct governing unit of the community, it is still the city’s primary responsibility to prepare the groundwork of the RUP and strengthen the capacity of the health center staff.

The CHO (as the implementing arm of the LGU in terms of the RUP approach) has the option to partner with a Non-Government Organization, a civic group (e.g. Rotary Clubs), the academe or other civil society organizations in implementing the RUP approach. Civil society organizations (CSO’s) can provide technical assistance to the CHO in terms of: 1) community organizing component, 2) implementing initiatives or linking the community to the appropriate agencies/organizations to address the social determinants of health; 3) financial management of the funds for RUP, 4) advocacy and lobbying for resources and policy support and 5) strengthening health governance at the community and city levels. The CSO’s must, of course, go through the accreditation and selection processes that are being implemented in the respective cities.

This section describes the phases of RUP implementation and the ways to integrate RUP into the city health care delivery system to improve the health outcomes of the urban poor and reduce the inequities they face.

Phases of RUP Implementation

The implementation of RUP in urban poor communities covers four (4) phases. These phases, their corresponding activities per level, and their minimum expected outputs including the desired outputs are discussed in the succeeding text. The timelines reflected per phase were established based on certain assumptions/considerations: 1) political (e.g. change of administration due to elections, etc); 2) multiple roles or expectations of service providers – implementing the RUP approach is one of many programs and strategies being implemented by the local service providers, it is imperative that their absorptive capacity in performing multiple tasks and implementing multiple programs be considered and 3) presence of NGOs in the city and other areas – as one of the strategies to effectively implement the RUP approach is to engage NGOs and PO’s at different capacities (as funds manager, community mobilizers/ organizers, capacity-builders, among others), the presence of NGOs and PO’s is a major factor in determining the expected timeframe and even the efficacy of implementing the approach in general.
The actual implementation of the RUP requires the commitment and involvement of all levels of the health system from the DOH-CHD, the City Government through the City Health Office, the Health Center (HC), the Barangay, and communities. The role of advocacy work and coordination during the Engagement Phase cannot be overemphasized. These are important activities to gain the support of key decision makers which will help in the sustainability of the RUP Approach. Advocacy activities can be done by the city health department staff or they can mobilize key people in the community to become advocates.

In this phase, the City Health Office formulates its City-wide Investment Plan for Health (CIPH) based on the RUP Approach, identifies and selects from candidates its RUP site, and engages Health Center staff and the Barangay to organize a community action group for RUP.

**Minimum Expected Outputs of the Engagement Phase**

- RUP Site selected
- Barangay agreed to participate
- Community action group organized
Phase 1: ENGAGEMENT (6 months to one year)

PHASE 1.1. RUP SITE SELECTION (6 months)

1.1.1 New City-Level RUP Site Selection – Center for Health Development

CONTEXT: CHD regular reviews may see the cities that may require support for urban poor. This does not exclude spontaneous request from cities willing to work on RUP on their own.

1.1.1a The CHD Local Health Assistance Division will organize and conduct orientation and advocate for RUP to other (CHD) regional personnel.
1.1.1b Review of Urban Heart cities profile to identify possible RUP sites based on proportion of brgys in the cities with low performance.
1.1.1c The POTENTIAL RUP CITIES shall be visited by the CHD to conduct orientation mtg to LGU executives and present the pre-qualified RUP barangay sites (i.e. red areas in Urban HEART) based on criteria. (Start-up barangays will cover 20% of the Urban poor area).
1.1.1d Initiate and conduct consultative meetings with LGU chief executives health program coordinators to advocate for RUP and gain political commitment.
1.1.1e Invite LGUs willing to participate and would like to request for technical assistance is to send a Letter of intent address to the CHD Regional Director showing proof of feasibilities:
   1) health as an agenda or,
   2) vibrant POs, NGO recognized by LGUs as potential partners or,
   3) other pro poor programs supported by LGU.

Minimum Expected Output:
Partner RUP city level site/s selected/identified

1.1.2 RUP BARANGAY SITE SELECTION/PARTNERSHIP: City Level

1.1.2a CHO w/ other key officials (CHD representatives, CPDO) will validate through field visits/ocular and meet the barangay leaders regarding RUP initiative.
1.1.2b Request for barangay letter of intent/resolution. (Work on ongoing barangay resolution)
1.1.2c Strengthen capacities of Health Center staff:
- Communication skills
- Community Organizing and Mobilization
- Facilitation, negotiation, public speaking, and interactive discussion
- Project management skills at the micro level
- Organizational management skills
- Values clarification

Minimum expected output: Letter of Intent from the barangay (Annex A for pro-forma)

Desired output:
Approved Barangay Resolution (Annex B for pro-forma)
Approved Barangay Resolution with sitio/areas

**PHASE 1.2 STEWARDSHIP: (1 month)**

1.2.1 Create or revitalize existing management structure for RUP agenda/initiative (a. Advisory/Steering Committee from the city level; b. CTWG from the city level; c. Implementers-Barangay action group).
1.2.2 Assign external officer for financial accountability
1.2.3 Development of the RUP workplan and integration in the CIPH/AOP
1.2.4 Raise awareness of HC and Barangay through orientation and consultative workshops on RUP
   - Conduct orientation and consultative workshops on RUP principles
   - Share experiences and evidences in the implementation of RUP in pilot cities
1.2.5 Provide assistance to HC and Barangay in the identification of issues and problems encountered, their root causes, and the possible actions to address them
1.2.6 Assist on the Organization of the community action group

Minimum expected output for Stewardship:
- Management arrangement defined
- Financial Management Plan
- Reporting flow defined

Desired output for Stewardship:
Phase 2: PILOTING AND MODELING (1 - 3 years)

Minimum Expected Outputs for Piloting/Modeling Phase

- Barangay /City workplan for health developed with immediate priorities identified amongst the urban poor
- At least one (1) major urban poor health issue or concern co-managed (from planning, implementation, to evaluation) by health center and community
- List of identified pro-poor partners.
- Barangay has started to address social determinants or has linked with agencies who can help

2.1 Center for Health Development Technical Support

2.1.1 CHD will mobilize technical assistance to the city and barangay with regard to program management among the priority will be financial mgt, project development and mgt, negotiating skills, conflict management, resource generation, local governance, documentation, results based management monitoring and evaluation.

2.1.2 Review City plan and advocate to increase LGU investment plan on health

2.1.3 Provide quality health care services including functional referral system

2.1.4 Raise awareness of community members and advocate for RUP Piloting

Minimum expected output for Piloting and Modeling-CHD Technical Support:
Inclusion of Urban Poor Health Response or RUP activities as a line item in the investment plan; harmonization of RUP barangays workplan with city wide investment plan/AOP

Desired output for Piloting and Modeling-CHD Technical Support:
Barangay/City Ordinance (see annex pro-porma developed by Paranaque)

2.2 City level/Health Center with NGO partners

2.2.1 Prepare city health plan with budget allocation ensuring the integration of the RUP approach in programme implementation

2.2.2 In partnership with NGOs provide technical assistance in the conduct community planning workshops, which includes identification and prioritization of problems and the corresponding strategies and activities to address them.

2.2.3 With the private sector, NGO partner advocate for enactment and/or amendment of city-wide laws and policies related to urban poor
Phase 2: PILOTING AND MODELING (1 - 3 years)

2.2.4 Do an environmental scan on other pro poor initiatives to ensure RUP partners under these programmes to be fully utilized

2.2.5 Ensure availability of quality health care services including functional referral system can be access by the urban poor this includes:
- Enrollment to philhealth
- Enrollment to 4Ps
- Community support mechanism ex. Transport, financing schemes etc

2.2.6 With NGO partners, organize community volunteers as community health teams to assist; identify community leaders.

2.2.7 Preparation of (Joint) RUP workplan as guided by the Steering Committee and based on the workplans developed by the barangays

2.2.8 Initiate documentation of RUP in the selected sites

2.2.9 Strengthen coordination with Barangay officials and key stakeholders

2.2.10 In coordination with the CTWG, NGosco-manage identified health and non-health issues together with the community:
- Conduct simple survey and reality mapping with Community Problem identification thru processes and
- Conduct community assembly including other stakeholders
- Define interventions and how to implement them
- Document health outcomes and results of interventions
- Document good practices and learning experiences

2.1.11 Facilitate linkages with other partners facilitated by the CTWG and Community support team

2.1.12 Conduct monitoring and facilitative supervision (see Section 7)

2.1.13 Organize community based mechanisms for the health agenda using local/community informal discussion mechanism (ex. Buntis tsismis, kuwentonburo, SMS) likewise in the City level raise the health agenda in a formal forum

Phase 3: SCALING-UP AND SUSTAINABILITY

Minimum Expected Outputs for Scaling Up/Sustainability Phase

- Scaling up and Sustainability plan on LGU
- NGO scaling up beyond original RUP city
- City Ordinance
- Identified platform to mainstream urban poor health agenda at the brgy and city level
- CHD: Use of integrated urban poor database across national government agencies (e.g. NHTS) for planning and policy development; Support to pro-poor programmes; Integration of the Urban Poor in the Strategic Plan
3.1 Center for Health Development

3.1.1 Assess readiness of the RUP initiative for the city level for possible scaling-up (Evaluability assessment) AND/OR provide a venue for scaling-up strategy strategy/plan

3.1.2 Continue supportive supervision, monitoring and evaluation

3.1.3 Continue provision of technical assistance (TA) including referral network

3.1.4 Conduct RUP program evaluation review

3.1.5 Provide feedback:
   - recognize good performance
   - address operational issues

3.1.6 Encourage participation of other LGUs through the data and documentation of RUP site

3.1.7 Provide technical assistance (example: study visits) to potential LGUs for RUP

3.2 City level

3.2.1 Integration of monitoring & evaluation findings in the annual plan

3.2.2 Organize core of trainors on RUP from Pilot Community

3.2.3 Continue supportive supervision, monitoring and evaluation

3.2.4 Continue capability building as need arises

3.2.5 Ensure adequate and appropriate logistics in the HC

3.2.6 Initiate Phase over plan thru the SC in coordination with the Health Center staff.

3.2.7 Ensure that RUP initiatives are included in the CIPH/AOP

3.2.8 Finalize project documentation and submit to concerned agencies

3.2.9 Continue providing supportive supervision, monitoring and evaluation

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**Phase 3: SCALING-UP AND SUSTAINABILITY**

**Minimum Expected Outputs for Scaling Up/Sustainability Phase**

**National:** Evidence-based policy development or updated policies related to urban poor with link to other national government agencies initiatives

**Desired output for Scaling Up/Sustainability Phase**

1) Improve Health seeking behavior
2) Organized Urban Poor communities/People's Organization and may be LHB member
3) Functional Public-Private Service Delivery Network with urban poor clientele
Phase 3: SCALING-UP AND SUSTAINABILITY

3.1 Health Center
3.1.1 Continue provision of quality health care services including functional referral system
3.1.2 Continue documentation of results, health outcomes, good practices, and learning experiences
3.1.3 Strengthen partnership and collaboration with other stakeholders and partners
3.1.4 Conduct monitoring and evaluation visits to the RUP sites
3.1.5 Continue provision of quality health care and functional referral system
3.1.6 Ensure that the RUP initiatives are included in the barangay development plan
3.1.7 Submit documentation to the SC
3.1.8 Replication of RUP to other areas
3.1.9 Conduct annual PIR
3.1.10 Set standards and protocols (see attached documentations)
3.1.11 Conduct Researches
3.1.12 Write publications

3.2 Barangay
3.2.1 Maintain open lines of communication with HC staff
3.2.2 Participate in all designed interventions and HC activities
3.2.3 People’s Organization to initiate positive changes in the community
3.2.4 Carry out phase over plan
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<thead>
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- recognize good performance  
- address operational issues |

**Table 4.1: Summary of the Phases of RUP: Roles of the CHD and the Local Government Unit**
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</table>

**Phase 1: Engagement**

1.1.1 Choose of key officials and stakeholders

1.1.1.1a CHD representatives, CPDO, CSO, and barangay leaders

1.1.1.1b Creation of Steering Committee to guide the implementation of the RUP initiative

1.1.1.1c Remote barangay leaders re: grant of RUP initiative from the city level. CPDO will validate through field visit and meet the barangay leaders regarding RUP initiative.

1.1.2 Stewardship

1.1.2.1 City Health Office

1.1.2.2 Assign external officer for financial accountability. (Work on on-going barangay resolution. Work on on-going barangay resolution.)

1.1.2.3 Development of the RUP workplan and integration in the CIPH/AOP

1.1.2.4 Raise awareness of RUP in the OCP/AOP

1.1.2.5 Conduct orientation and consultative workshops on RUP principles

1.1.2.6 Share experiences and evidences in the implementation of RUP in pilot cities

1.1.2.7 Provide assistance to HC and Barangay in the identification of issues and problems encountered, and the possible actions to address them.

1.1.2.8 Assist on the Organization of the community action group

1.1.2.9 Continue providing monitoring, evaluation, and reporting and evaluation findings for the health center.

1.1.2.10 Continue providing monitoring, evaluation, and reporting and evaluation findings for the barangay.

1.2.1 Create or revitalize existing management structure for RUP agenda/initiative (a. Advisory/Steering Committee from the city level; b. CTWG from the city level; c. Implementers-Barangay action group).

1.2.2 Assign external officer for financial accountability.

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Table 4.1: Summary of the Phases of RUP: Roles of the CHD and the Local Government
### Reaching the Urban Poor Initiative

**MANUAL OF OPERATIONS**

#### Phase 1: Engagement

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<th>Desired Outputs</th>
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### Minimum Expected Outputs
1. Barangay work plan for immediate priorities identified at the community level
2. At least one (1) major health issue or concern co-managed (from planning, implementation, to evaluation) by health center and community
3. Pro-poor partners identified and profiled
4. Barangay has started to address social determinants or has linked with agencies who can help
5. Scale up plan
6. Platform to mainstream urban poor health agenda at the barangay level, identified
7. Inclusion of RUP needs in the Health Investment Plan

### Desired Outputs
1. Improved individual health seeking behavior
2. Service network delivery established from the primary (private-public) level
3. City ordinance supporting implementation of RUP
4. Health center staff capable of training health center staff of new RUP sites
5. Pilot health center sites per Health Center
6. Additional RUP sites per Health Center
7. Health Center staff of pilot sites managing their own health agenda or concerns
8. At least one (1) major health issue or concern, managed from planning, implementation, to evaluation, by health center and community

### Structure
**Phase 1: Engagement**

**Phase 2: Piloting and Modeling**

**Phase 3: Scaling Up and Sustainable Expansion**

### Table 4.1: Summary of the Phases of RUP: Roles of the CHD and the Local Government
Monitoring and evaluation of health services provided to the urban poor can be measured qualitatively by direct consultations, focused group discussions or client satisfaction surveys. Indicators of good services rendered will include patient satisfaction, appropriateness of health services, privacy and sensitivity to client needs, regularity or predictability of services, and financial security to cite a few.

**Definition of supervision, monitoring, and evaluation (MSE):**

**Monitoring** is the process of tracking the implementation of the planned activities. During this process, issues and constraints may be identified and early corrective actions will have to be instituted.

*The CHD in coordination with partner agencies will monitor the city. Initially, this is done monthly and then at least quarterly. The city health office with the assistance of the city/municipal TWG will monitor the communities. The communities should also review, analyze and use the data. Records must not be only filed but used.*

**Supervision** is a process of ensuring that the health care providers and community volunteers are providing the appropriate health services or are doing things in accordance with established policies, standards, and guidelines.

*The assigned medical officer &/or public health nurse in the specific area supervises the midwife in the delivery of health services. Midwife supervises the BHWs or volunteers in the conduct of their activities. The frequency of the supervision will depend on the following:*
*duration of service*
*level of accomplishment*
*feedback from the monitors and clients*

**Evaluation** is a process of ensuring that the health care providers and community volunteers are providing the appropriate health services or are doing things in accordance with established policies, standards, and guidelines.

*This will be done by the city/municipal health office with the assistance of the TWG and the CHD. All stakeholders must participate. This is done at least annually.*
Importance of MSE

Conducting Supervision, Monitoring, and evaluation will help the Steering Committee, Technical Working Group and Implementers in the following:

a. Determining the effectiveness and feasibility of interventions and strategies;

b. Ensure that processes are undertaken according to the agreed action plan, policies, and guidelines; and

c. Identification of problems, issues, and concerns arising in the community and the possible solutions and interventions.

Principles of MSE

- It should be participatory.
- It should be evidence-based.
- There should be a mechanism for community validation and feedback.
- Data quality (timely, complete, accurate and valid) should be ensured.

Monitoring, Supervision and Evaluation Process

Supervision

Visit health center and community and observe how they perform their tasks.

Monitoring

Monitoring shall be done by a Joint Monitoring Team, composed of the following:

1) City health office (RUP point person, City TWG)
2) CHD staff (DOH Rep) when needed
3) Other Partners (NGOs, Peoples Organizations)
4) Representative of the community (community volunteers, BHWs, barangay captains, purok/ sitio leaders)

Process of monitoring by Joint Monitoring Team:

1) Review previous findings and recommendations
2) Visit the health center and review the HC records and reports
3) Validate the data collected by the health staff with those collected by community volunteers
   a. Review records such as the notebooks / diaries of CV
   b. Talk with community volunteers Look into the performance (quantitative) and quality of services
   c. Interview some clients regarding their feedback on the quality of services
   d. Note the discrepancies if both sources and discuss reasons / problems
Monitoring, Supervision and Evaluation Process

Monitoring

4) Feedback to the community members and volunteers and health center staff
5) HC staff with the community plans how to address issues and concerns. Actions taken to address them will be monitored on the subsequent visit
6) Prepares the report and submit to CHO/TWG.

Process of community monitoring:

1) Community volunteers go to the health center weekly and discusses their data with the staff
2) Staff meets with all volunteers monthly:
   a. Volunteers present and discuss data including problems encountered
   b. Other participants ask questions and also give suggestions.
   c. HC summarizes the findings and agreements
   d. HC consolidates and finalize all monthly reports of the RUP sites and submit to CHO

Evaluation Methods

A. Annual Program Implementation Review – focus will be assessing status of program indicators and RUP processes and outputs. This will be organized by the CHO and participated by the implementers and partners. The outputs will be an annual plan including on how to address problems / issues to improve RUP implementation.

B. External Evaluation

1. Team:

   Evaluation can also be done by members of a third-party as organized by the CHO. This is a possibly rich venue to get unbiased and highly critical reviews. However, care must be exercised when such method is employed to always validate the collected data with the community and to feedback the results of the evaluation to the CHO and the implementers.

2. Evaluation by an external consultant

   Assess achievements of the RUP through;
   a. Analyzing the data using the tools and methodologies of URBAN HEART and LGU score cards
   b. Analyzing trends of performance to see whether they are increasing, stagnating, or decreasing
   c. Performance of RUP and non-RUP sites will be compared to see the effect of the strategy on program performance.
   d. Factors affecting performance are identified and solutions proposed.
Monitoring, Supervision and Evaluation Process

Possible Ways of doing evaluation

Accomplishment trends analysis within RUP Site (baseline versus actual accomplishment after one year)

Comparing two (2) urban poor areas: urban poor area (baseline) and RUP site (terminal)

Comparing RUP site versus an affluent area (within barangay if RUP is implemented in one sitio or with other affluent barangay with full implemented RUP)

Compare RUP site accomplishment with barangay / city average accomplishment

Monitoring, Supervision and Evaluation Framework

Figure 5.1: The Monitoring and Evaluation Framework of RUP

A. Inputs:

- Assess the inputs as planned - 7 Ms (manpower, money, mansion, messages, materials, machine, management structure)
- Assess readiness of health center to respond to additional demand

B. Process:

Review planned processes by phase

(See Annex 1: Process and Outcome Indicators pp. A.1—A.15)
Monitoring, Supervision and Evaluation Framework

C. Output:

- Compare accomplishment with the minimum outputs by phase
- NGO: based on the expected roles/outputs of NGOs per phase
  
  Extent of participation
  
  Added value e.g. technology transfer

D. Outcome:

The following are the outcome indicators for RUP (see Annex 1: Process and Outcome Indicators, pp. A.1—A.16 for complete details and definition of terms):

1. Improved access to quality continuum of care and services for mothers and newborns in selected geographically isolated or depressed areas of RUP site

1.1 Maternal Care

1.1.1 Percentage of pregnant women first seen at the HC
1.1.2 Percentage of pregnant women seen in other health facilities
1.1.3 Percentage of women with complete prenatal visits
1.1.4 Percentage of pregnant women with dental check-up
1.1.5 Percentage of pregnant mothers given complete IFA supplementation
1.1.6 Percentage skilled health professional assisted deliveries
1.1.7 Percentage of births in EmONC facilities
1.1.8 Health facility delivery rate
1.1.9 Caesarian delivery rate
1.1.10 Percentage of women with adequate post-partum care visits
1.1.11 Percentage of post partum mothers given complete IFA supplementation
1.1.12 Percentage of PP mothers given Vitamin A supplementation
1.1.13 Low birth weight (LBW) rate*

1.2 Newborn Care

1.2.1 Percentage of newborns with early initiation of breastfeeding
1.2.2 Percent coverage for Hepa B at birth
1.2.3 Newborn screening coverage rate

2. Improved access and utilization to child health services among underfive year old children in selected geographically isolated or depressed areas of RUP sites

2.1 Percent coverage for 1st dose of DPT
2.2 Percent coverage for 3rd dose of DPT
2.3 Percent AMV (Anti-Measles Vaccine) coverage
2.4 Exclusive breastfeeding rate (EBFR)
2.5 Percentage of children (6-11 mos) given Vit. A capsules
2.6 Percentage of children (12-59 mos) given Vit. A capsules
Monitoring, Supervision and Evaluation Framework

2.7 Percentage of children (0-59 mos) with diarrhea given ORS
2.8 Percentage of children (0-59 mos) with pneumonia given complete treatment
2.9 Deworming rate for 12-59 months old children
2.10 Percentage malnourished pre-schoolers 0-59 months

3. Increased utilization of core RH services in selected geographically isolated or depressed areas of RP sites

3.1 Percentage of pregnant adolescents seen at HC
3.2 Adolescent pregnancy rate
3.3 Percentage of reproductive age women with unmet needs for FP
3.4 Contraceptive prevalence rate (CPR)

4. Improved access to quality TB services by the urban poor

4.1 Indicators to be gathered by the Community
   4.1.1 No. of TB symptomatics / suspects successfully referred to health center
   4.1.2 No. of TB symptomatics/ suspects referred who were diagnosed as TB case and initiated treatment
   4.1.3 No. of TB patients whose treatment is being supervised by volunteer
   4.1.4 No. of TB patients who transferred-out, died or lost

4.2 Indicators to be monitored by HC and TWG
   4.2.1 Symptomatic identification rate
   4.2.2 TB Case notification rate, all forms
   4.2.3 Case notification rate, new smear positive cases
   4.2.4 Community contribution to total TB cases
   4.2.5 Treatment success rate of new smear positive cases

5. Increase in urban poor participation in local health governance bodies (e.g. Local Health Board) and/or mechanisms (e.g. annual operating plan)

5.1 Number of urban poor community actions to respond to identified community needs
5.2 Number of urban poor community appeals responded to by C/BLGU
5.3 Number of barangays/ cities with plans and policies to support priority health needs
5.4 No of C/BLGUs with increased budget for MNH and TB programs for poorest of the population

6. Enhanced inter-sectoral actions on environmental and social determinants for health*

6.1 Percentage of urban poor households with access to safe water
6.2 Percentage of households with access to sanitary toilets
6.3 Percentage of RUP households with PhilHealth cards
6.4 Proportion of CCT households in RUP communities with 100% compliance in a period of 3 months
Monitoring, Supervision and Evaluation Framework

E. Impact:

E.1 **Health status:** mortality / morbidity, over-all and by disease, IMR, MMR, under 5, nutritional status
E.2 **Health inequities:** RUP performance vs. non-RUP sites, vs. city average
E.3 **Financial risk protection:**
   a. Proportion of population who are enrolled in PhilHealth
   b. Utilization / availment rate of PhilHealth benefit
   c. Availability of other funding sources
   d. Proportion of barangay budget for health
   e. Availability of city / barangay ordinance
E.4 **Responsive Health System**
   % satisfied clients

Reporting and Recording

Flow of Documents

Table 5.1: Details of RUP Reporting System

<table>
<thead>
<tr>
<th>Level</th>
<th>Documents/ Records</th>
<th>Reports for Submission</th>
<th>Person/s-In-Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community/ Barangay</td>
<td>• Notebook/ logbook containing daily narration of activities</td>
<td>Monthly report of per sitio/purok containing: • Monthly updates of indicators • Key activities and results</td>
<td>• Community Volunteers • Barangay Health Workers • Peoples’ Organizations</td>
</tr>
<tr>
<td></td>
<td>• RUP Monitoring forms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health center level</td>
<td>• TCL of RUP site</td>
<td>Monthly barangay/community report on RUP: • Monthly updates of indicators per barangay • Key activities and results</td>
<td>• HC health care providers headed by HC physician or PHN • Barangay RUP coordinator (if applicable)</td>
</tr>
<tr>
<td></td>
<td>• Annual Urban health report</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Database (from baseline survey conducted)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Masterlists (e.g. maternal, children 0-5 years old, FP CU)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• RUP monitoring tool (process and outcome indicators)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Reporting and Recording

#### Flow of Documents

<table>
<thead>
<tr>
<th>Level</th>
<th>Documents/ Records</th>
<th>Reports for Submission</th>
<th>Person/s-In-Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>City Health Office</td>
<td>• Annual Urban health report</td>
<td>quarterly city report</td>
<td>• TWG</td>
</tr>
<tr>
<td></td>
<td>• RUP Database (city level)</td>
<td>on RUP</td>
<td>• City RUP coordinator/ CHO</td>
</tr>
<tr>
<td></td>
<td>• RUP monitoring tool (city level)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• M1 or Sumtab (FHSIS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Center for Health Development</td>
<td>• Annual Urban health report</td>
<td>Quarterly regional report on RUP</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• RUP Database (regional level)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• RUP monitoring tool (regional level)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• FHSIS</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Reporting process

1. Community volunteers/ community health workers/ barangay health workers or People’s Organizations collect data from the community;
2. Community volunteers/ community health workers/ barangay health workers or People’s Organizations submits the sitio/ purok monthly summary of activities and indicators to the HC;
3. HC verifies sitio/ purok data or report with the community volunteers/ community health workers/ barangay health workers or People’s Organizations through meetings, informal discussions and data quality checking activities;
4. HC verifies/ validates data with the community through data quality checking activities;
5. HC prepares and submits barangay/ community monthly report (with accomplishment of objectives and indicators) to the City Health Office/ City Health Department and CHO validates/ verifies data with the HC;
6. CHO verifies the data with the HC service providers and prepares and submits the city quarterly report to the Center for Health Development
7. CHD verifies/ validates the city quarterly reports with the CHOs then prepares and submits the regional quarterly report to the DOH-central office and the partner agency or funding organization.
8. The DOH Central Office and the partner agency or funding organization may verify and validate the reports with the community, the HC service providers or the CHOs.
If the CHO decides to partner with a Non Government Organization; the NGO can provide technical assistance to the CHO/ HC or build the capability of the service providers in terms of conducting baseline surveys and developing reports. The Peoples’ Organizations can also help the volunteers and Barangay Health Workers to collect data and prepare their reports.

Figure 5.2: Diagram of Reporting Process for RUP: The Reporting Process of RUP involves validation and community feedback at all levels
REFERENCES


ii. NSO, NCSB (Philippine Figures)


v. DOH briefer on Urban Systems Health Development


viii. NDHS. 2008 Survey


ANNEXES

ANNEX 1: Process and Outcome Indicators

ANNEX 2: Guidelines for Improving Access to TB Care in the Urban Poor Areas under Reaching the Urban Poor Initiative


ANNEX 4: List of Participants to RUP MOP Workshops
## PROCESS INDICATORS

Table A.1.1: RUP Process Indicators Monitoring form

### REACHING THE URBAN POOR

#### PROCESS INDICATORS

City: ____________________________
Health Center: ________________________________
Name of Community/ies: _____________________________________________________________
Total Population: _________________________________________________________________
Period: __________________________________________________________________________

<table>
<thead>
<tr>
<th>Process</th>
<th>Indicators</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase 1: Engagement and Stewardship</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Site Selection</td>
<td>1.1. CTWG reviewed the HC data for site selection based on set criteria</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.2 CTWG visited/conducted ocular inspection on the proposed sites</td>
<td></td>
</tr>
<tr>
<td>Management structure</td>
<td>1.3 RUP Management Structure, established</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.3.1 Management arrangement defined</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.3.2 Financial management plan, formulated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.3.3 Reporting flow defined</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.4 City LGU and other key people in the City RUP Management Structure orientated on the RUP program</td>
<td></td>
</tr>
<tr>
<td>Health Situation Assessment</td>
<td>1.5 City with baseline data on community health status and other socio-demographic data</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.6 City using the URBAN HEART to collect and analyze data for decision-making</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.7 Community assessment conducted</td>
<td></td>
</tr>
<tr>
<td>Problem definition and prioritization</td>
<td>1.8 Community assembles/ sessions to identify key issues in their community, conducted</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.9 Communities have identified their priority health concern</td>
<td></td>
</tr>
<tr>
<td>Community Action Planning</td>
<td>1.10 Communities with plans and strategies to address the identified key issues</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.11 Communities with plans on how to address priority health concern</td>
<td></td>
</tr>
</tbody>
</table>
### ANNEX 1: Process and Outcome Indicators

#### PROCESS INDICATORS

<table>
<thead>
<tr>
<th>Process</th>
<th>Indicators</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase 2: Piloting and Modeling</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health service delivery strengthening</td>
<td>2.1 Health service providers (HC and CHO/CHD) trained on MNCHN (and TB)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.2 Volunteers trained on MNCHN (and TB)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.3 Number of persons reached by volunteers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(see outcome indicators)</td>
<td></td>
</tr>
<tr>
<td>Community organizing</td>
<td>2.4 Urban poor PO's/ local organizations established or mobilized</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.5 Community assemblies and other venues to discuss community concerns,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>conducted</td>
<td></td>
</tr>
<tr>
<td>Social mobilization</td>
<td>2.5 Brgy/ community volunteers and leaders, identified/recruited and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>mobilized</td>
<td></td>
</tr>
<tr>
<td>Linking with other relevant agencies</td>
<td>2.6 Barangays linked to external agencies/resources that could assist the</td>
<td></td>
</tr>
<tr>
<td></td>
<td>communities in dealing with priority concerns</td>
<td></td>
</tr>
<tr>
<td>Addressing social determinants of health</td>
<td>(see outcome indicators 5.1 to 5.4 and 6.1 to 6.4)</td>
<td></td>
</tr>
<tr>
<td><strong>Phase 3: Scaling up and Sustainable expansion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leadership and governance strengthening</td>
<td>3.1 Cities with policies in support of its priority health programs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>identified by the project</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.2 Health Center staff assisted in conducting advocacy session on RUP</td>
<td></td>
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<tr>
<td></td>
<td>with the Local Chief Executive and local legislators (chair of brgy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>council on health) and other partners or stakeholders at the community</td>
<td></td>
</tr>
<tr>
<td></td>
<td>level</td>
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<tr>
<td></td>
<td>3.3 City incorporated the RUP approach into their CIPH and AOP</td>
<td></td>
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<tr>
<td></td>
<td>3.4 Barangays/ communities with resolution/ ordinance in support of its</td>
<td></td>
</tr>
<tr>
<td></td>
<td>priority health programs identified by the project</td>
<td></td>
</tr>
</tbody>
</table>
### ANNEX 1: Process and Outcome Indicators

#### OUTCOME INDICATORS

Table A.1.2-A: RUP Outcome Indicators Monitoring form (MNCHN)

<table>
<thead>
<tr>
<th>INDICATORS</th>
<th>BASELINE</th>
<th>IMPLEMENTATION (Month)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 Maternal Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1.1 Percentage of pregnant women first seen at the HC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1.2 Percentage of pregnant women seen in other health facilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1.3 Percentage of women with complete prenatal visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1.4 Percentage of pregnant women with dental check-up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1.5 Percentage of pregnant mothers given complete IFA supplementation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1.6 Percentage skilled health professional assisted deliveries</td>
<td></td>
<td></td>
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<tr>
<td>1.1.7 Percentage of births in ImCI facilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1.8 Health facility delivery rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1.9 Cesarian delivery rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1.10 Percentage of women with adequate post-partum care visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1.11 Percentage of post-partum mothers given complete IFA supplementation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1.12 Percentage of PP mothers given Vitamin A supplementation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1.13 Low birth weight (LBW) rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2 Newborn Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2.1 Percentage of newborns with early initiation of breastfeeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2.2 Percent coverage for Hep B at birth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2.3 Newborn screening coverage rate</td>
<td></td>
<td></td>
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<tr>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1</td>
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<tr>
<td>3.3</td>
<td></td>
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</table>
## OUTCOME INDICATORS

### Table A.1.2-B: RUP Outcome Indicators Monitoring form (SDH and Governance)

<table>
<thead>
<tr>
<th>INDICATORS</th>
<th>BASELINE</th>
<th>IMPLEMENTATION (Month)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>4. Increase in urban poor participation in local health governance bodies (e.g. Local Health Board) and/or mechanisms (e.g. annual)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1 Number of urban poor community actions to respond to identified community needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.2 Number of urban poor community appeals responded to by CiUBLU</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.3 Number of barangay/towns with plans and policies to support priority health needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.4 No. of CiUBLUs with increased budget for MNH and TB programs for poorest of the population</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Enhanced inter-sectoral actions on environmental and social determinants for health*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.1 Percentage of urban poor households with access to safe water</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.2 Percentage of households with access to sanitary toilets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.3 Percentage of RUP households with PhilHealth cards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.4 Proportion of CCT households in RUP communities with 100% compliance in a period of 3 months</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Table A.1.2-C: RUP Outcome Indicators Monitoring form (TB)

<table>
<thead>
<tr>
<th>INDICATORS</th>
<th>BASELINE</th>
<th>IMPLEMENTATION (Month)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>1. Improved access to quality TB services by the urban poor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 Indicators to be gathered by the Community</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1.1 No. of TB symptoms / suspects successfully referred to health center</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1.2 No. of TB symptoms / suspects referred who were diagnosed as TB case and initiated treatment</td>
<td></td>
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<tr>
<td>1.1.3 No. of TB patients whose treatment is being supervised by volunteer</td>
<td></td>
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<tr>
<td>1.1.4 No. of TB patients who transferred-out, died or lost</td>
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<tr>
<td>1.2 Indicators to be monitored by HC and TWG</td>
<td></td>
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<tr>
<td>1.2.1 Symptomatic identification rate</td>
<td></td>
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</tr>
<tr>
<td>1.2.2 TB Case notification rate, all forms</td>
<td></td>
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<tr>
<td>1.2.3 Case notification rate, new smear positive cases</td>
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<tr>
<td>1.2.4 Community contribution to total TB cases</td>
<td></td>
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<tr>
<td>1.2.5 Treatment success rate of new smear positive cases</td>
<td></td>
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<tr>
<td>INDICATORS</td>
<td>DEFINITION</td>
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</tr>
<tr>
<td>1.1 Maternal Care</td>
<td>Percentage of pregnant women who had their first prenatal visit at the health center, indicator of maternal access to health facility</td>
<td>Numerator: Number of pregnant women who had their first prenatal visit at the health center&lt;br&gt;Dominator: Total number of pregnant women identified in the community</td>
</tr>
<tr>
<td>1.1.2 Percentage of pregnant women seen in other health facilities</td>
<td>Percentage of pregnant women who sought consultation in health facilities other than the health center (private clinics of MDs, midwives, hospital OPD, etc)</td>
<td>Numerator: Number of pregnant women seen in other health facilities&lt;br&gt;Dominator: Total number of pregnant women identified in the community</td>
</tr>
<tr>
<td>1.1.3 Percentage of women with complete prenatal visits</td>
<td>Complete prenatal visits means that 4 or more prenatal visits had occurred with at least one visit during the first trimester, one during the second trimester and at least 2 visits during the third trimester. If visits occurred outside the catchments PHU, the visit should be counted as part of the minimum requirements. Prenatal services include: (1) complete physical examination of pregnant women (pregnancy status) (2) check for pre-eclampsia (3) check for anemia (4) check for syphilis (5) check/screen and treatment for STI and HIV status (6) respond to observed signs or volunteered problems (7) give preventive measures (8) advice and counsel on family planning (9) check on both and emergency plan (10) check for nutritional status and (11) advocacy on breastfeeding</td>
<td>Numerator: Number of pregnant women with 4 or more prenatal visits&lt;br&gt;Dominator: Total number of pregnant women identified in the community</td>
</tr>
<tr>
<td>1.1.4 Percentage of pregnant women with dental check-up</td>
<td>Percentage of pregnant women with at least 1 visit to the dentist</td>
<td>Numerator: Number of pregnant women with at least 1 visit to the dentist on this pregnancy&lt;br&gt;Dominator: Total number of pregnant women identified in the community</td>
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<tr>
<td>INDICATORS</td>
<td>DEFINITION</td>
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</tr>
<tr>
<td>1.1 Maternal Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1.1 Percentage of pregnant mothers given complete IFA supplementation</td>
<td>Prenatal complete IFA supplementation refers to at least 60 mg of iron with at least 400 mcg folate acid supplements given for 6 months (1 tablet once a day for 6 months to start at most on the 2nd trimester for a total of 180 tablets)</td>
<td>Numerator: Number of pregnant women given complete IFA supplementation Denominator: Total number of pregnant women identified in the community</td>
</tr>
<tr>
<td>1.1.2 Percentage of skilled health professional assisted deliveries</td>
<td>Percentage of skilled health professional assisted deliveries is defined as deliveries attended by health professionals such as midwife, doctor or nurse—who has been educated and trained to proficiency in the skills needed to manage normal ( uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns. This definition excludes traditional birth attendants whether trained or not, from the category of skilled health</td>
<td>Numerator: Number of deliveries assisted by skilled health professional Denominator: Total number of deliveries</td>
</tr>
<tr>
<td>1.1.3 Percentage of births in EmONC facilities</td>
<td>Percentage of births that occurred in Emergency Obstetrics and Newborn Care (EmONC) capable facilities</td>
<td>Numerator: Total number of births in EmONC facilities Denominator: Total number of livebirths</td>
</tr>
<tr>
<td>1.1.4 Health facility delivery rate</td>
<td>Percentage of women who delivered in health facilities such as hospitals (all levels, both public and private); and birthing facilities manned by skilled health professionals</td>
<td>Numerator: Number of livebirths delivered in health facilities Denominator: Total number of livebirths in a certain period or year</td>
</tr>
<tr>
<td>1.1.5 Cesarian delivery rate</td>
<td>Percentage of women who delivered through Ca- section</td>
<td>Numerator: No. of women who delivered through C-Section Denominator: Total Number of women who delivered in a certain period or a year</td>
</tr>
<tr>
<td>INDICATORS</td>
<td>DEFINITION</td>
<td>FORMULA</td>
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</tr>
<tr>
<td>1.1.10</td>
<td>Percentage of women with adequate post partum care visits</td>
<td>Adequate post-partum visits refers to visits seen by the midwife/PHN/MD at home or at the clinic twice or more than twice after delivery such that first visit should be within 24 hours upon delivery and the second visit within one week after delivery. Pregnant women who delivered in the hospital is already considered seen in the first visit which is 24 hours upon delivery. Note: Pregnant women who delivered in the hospital is already considered seen in the first visit which is 24 hours upon delivery.</td>
</tr>
<tr>
<td>1.1.11</td>
<td>Percentage of post-partum mothers given complete IFA supplementation</td>
<td>Post-partum complete IFA supplementation refers to at least 80 mcg of Fe with at least 400 mcg Folic acid, once a day for 3 months or a total of 90 tablets. If postpartum mother did not take full course of 90 tablets, she will not be considered.</td>
</tr>
<tr>
<td>1.1.12</td>
<td>Percentage of PP mothers given Vitamin A supplementation</td>
<td>Vitamin A supplementation refers to 200,000 I.U. of Vitamin A capsule given within 4 weeks after delivery.</td>
</tr>
<tr>
<td>1.1.13</td>
<td>Low birth weight (LBW) rate</td>
<td>Percentage of infants who were delivered with a weight of less than 2500 grams</td>
</tr>
<tr>
<td>1.2</td>
<td>Newborn Care</td>
<td></td>
</tr>
<tr>
<td>1.2.1</td>
<td>Percentage of newborns with early initiation of breastfeeding</td>
<td>Early initiation of breastfeeding is putting the newly delivered baby to the mother’s abdomen in prone position and allowing the newborn to feed the mother’s breast (skin to skin contact) with sign of nipple sucking</td>
</tr>
<tr>
<td>1.2.2</td>
<td>Percentage coverage for Hepatitis B at birth</td>
<td>Percentage of infants who received 1st dose of Hepatitis B vaccine within 24 hours after birth</td>
</tr>
<tr>
<td>1.2.3</td>
<td>Newborn screening coverage rate</td>
<td>Percentage of newborns (0-27 days old) screened for metabolic disorders</td>
</tr>
<tr>
<td>INDICATORS</td>
<td>DEFINITION</td>
<td>FORMULA</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
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<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2.1 Percent coverage for 1st dose of DPT</td>
<td>Percentage of infants who received the 1st dose of DPT antigens before reaching one year of age.</td>
<td>Numerator: Number of infants under 1 year old who received 1st dose of DPT Denominator: Total number of infants less than 1 year of age</td>
</tr>
<tr>
<td>2.2 Percent coverage for 3rd dose of DPT</td>
<td>Percentage of infants who received a 3rd dose of DPT before reaching one year of age.</td>
<td>Numerator: Number of infants under 1 year old who received 3rd dose of DPT Denominator: Total number of infants less than 1 year of age</td>
</tr>
<tr>
<td>2.3 Percent AMV (Anti-Measles Vaccine) coverage</td>
<td>Percentage of infants who received one dose of anti-measles vaccine before reaching one year old.</td>
<td>Numerator: Number of under 1 year old infants who received AMV before reaching one year old Denominator: Total number of infants less than 1 year of age</td>
</tr>
<tr>
<td>2.4 Exclusive breastfeeding rate (EBFR)</td>
<td>Exclusive breastfeeding means no other food (including water) other than breast milk is given to an infant steadily up to 6 months of age. Infants given vitamin drops or any prescribed medication while breastfeeding is still &quot;exclusively breastfed.&quot;</td>
<td>Numerator: Number of infants exclusively breastfed up to 6 months of age Denominator: Total number of infants 6 months or less of age seen at the health center or community</td>
</tr>
<tr>
<td>2.5 Percentage of children (6-11 mos) given ViA capsules</td>
<td>Percentage of infants 6-11 months old given vitamin A supplementation. Vitamin A supplementation refers to 1 dose of 60,000 I.U. vitamin A capsule. It can be given anytime during the 6-11 months age of the infant but usually given at 9 months during routine measles immunization at the health center.</td>
<td>Numerator: Number of infants 6-11 months old given Vitamin A capsule Denominator: Total number of infants 6-11 months old</td>
</tr>
<tr>
<td>Indicator</td>
<td>Definition</td>
<td>Formula</td>
</tr>
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</tr>
<tr>
<td>Improved access and utilization of child health services among under-five year old children in selected geographically isolated or depressed areas of RUF sites</td>
<td>Percentage of infants 12-59 months old given vitamin A supplementation. Vitamin A supplementation refers to 1 dose of 200,000 IU vitamin A capsule. It is given every 6 months to infants 12-59 months of age.</td>
<td>Numerator: Number of infants 12-59 months old given vitamin A capsule. Denominator: Total number of infants 12-59 months old at the health center or in the community.</td>
</tr>
<tr>
<td>Percentage of children (0-59 mos) with diarrhea given ORS</td>
<td>Percentage of children 0-59 months old seen by a health worker for the past 3 months, diagnosed with diarrhea and given oral rehydration solution (ORS).</td>
<td>Numerator: Number of children 0-59 months old seen. Denominator: Actual number of 0-59 months old seen.</td>
</tr>
<tr>
<td>Percentage of children (0-59 mos) with pneumonia given complete treatment</td>
<td>Percentage of children (0-59 mos) diagnosed with pneumonia by the health worker and given complete antibiotic treatment (at least 5 days duration).</td>
<td>Numerator: Number of children 0-59 months old diagnosed with pneumonia. Denominator: Total number of 0-59 months old diagnosed with pneumonia.</td>
</tr>
<tr>
<td>Deworming care for 12-59 months old children</td>
<td>Percentage of children 12-59 months given deworming drugs.</td>
<td>Numerator: Total number of children 12-59 months old given deworming drug for the past 6 months. Denominator: Total number of children 12-59 months old.</td>
</tr>
<tr>
<td>Percentage of malnourished preschoolers 0-59 months</td>
<td>Malnourished children refers to children whose weight are classified as below normal - low or below normal - very low.</td>
<td>Numerator: Number of children with weight of below normal - low or below normal - very low. Denominator: Total number of children 0-59 yrs old.</td>
</tr>
<tr>
<td>INDICATORS</td>
<td>DEFINITION</td>
<td>FORMULA</td>
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</tr>
<tr>
<td>3.1 Increased utilization of core RH services in selected geographically isolated or depressed areas of RUP sites</td>
<td>Percentage of pregnant adolescents seen at HC</td>
<td>Numerator: No. of pregnant adolescents who sought consultation in the health center at least once; indicator of access to health facility by adolescent clients. Denominator: Total number of adolescents who are currently pregnant.</td>
</tr>
<tr>
<td>3.2 Adolescent pregnancy rate</td>
<td>Percentage of adolescents (10-19 yrs old) who are confirmed to be pregnant; indicator of unmet needs for RH among the young people</td>
<td>Numerator: Number of adolescents (10-19 yrs old) who are pregnant. Denominator: Total number of adolescents (10-19 yrs old).</td>
</tr>
<tr>
<td>3.3 Percentage of reproductive age women with unmet needs for FP</td>
<td>Number of women 15-49 yrs old (married or with permanent partner) who want to postpone pregnancy or want to stop having children, but who are not using any modern method of contraception.</td>
<td>Numerator: Number of women (15-49 yrs old) not using any modern method. Denominator: Total number of women (15-49 yrs old) who expressed their current need for any modern method of contraception but is not actually using it.</td>
</tr>
<tr>
<td>3.4 Contraceptive prevalence rate (CPR)</td>
<td>The proportion of reproductive age married women or with partner who are currently using (or whose partner is using) a FP method at a given point in time.</td>
<td>Numerator: Number of reproductive age women or with partner who are currently using (or whose partner is using) a FP method at a given point in time. Denominator: Number of women of reproductive age at risk of pregnancy (married or with partner)</td>
</tr>
<tr>
<td>INDICATORS</td>
<td>DEFINITION</td>
<td>FORMULA</td>
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</tr>
<tr>
<td>4.1</td>
<td>Number of urban poor community actions to respond to identified community needs</td>
<td>Number of actions/activities or interventions that were implemented by other local NGOs, People's Organizations, the Philippines Health Department, or other government line agencies and private organizations to address the community needs that were identified during the community planning sessions.</td>
</tr>
<tr>
<td>4.2</td>
<td>Number of urban poor community appeals responded to by C/BLGUs</td>
<td>Number of actions/activities or interventions that were implemented by the barangay or city government and to address the community needs that were identified.</td>
</tr>
<tr>
<td>4.3</td>
<td>Number of barangays/cities with plans and policies to support priority health needs</td>
<td>Barangays or cities that have developed plans and policies that support the priority health needs identified during the community planning sessions.</td>
</tr>
<tr>
<td>4.4</td>
<td>No. of C/BLGUs with increased budget for MNHI and TB programs for poorest of the population</td>
<td>LOUs that have increased their budget for MNHI and TB programs to the identified poorest of the population in their cities.</td>
</tr>
</tbody>
</table>

5 Enhance inter-sectoral actions on environmental and social determinants for health

5.1 Percentage of urban poor households with access to safe water | Refers to households covered by or have access to the following types of water sources: | Numerator: Total No. of households with access to improved or safe water supply | FHBS report | Annual | FHBS report |
<p>| | household water system | • Level I: • Level II | LOU household survey | | |
| | • Level III: | Level II | | | |
| | | Demonominator: Total Number of Households | | |</p>
<table>
<thead>
<tr>
<th>INDICATORS</th>
<th>DEFINITION</th>
<th>FORMULA</th>
<th>SOURCE OF DATA</th>
<th>FREQUENCY OF REPORTING</th>
<th>MOV</th>
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<tbody>
<tr>
<td>Enhanced inter-sectoral actions on environmental and social determinants</td>
<td></td>
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<tr>
<td>for health</td>
<td></td>
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</tr>
<tr>
<td>5.2 Percentage of households with access to sanitation toilets</td>
<td>Refers to households with flush toilets connected to septic tanks and/or sewage</td>
<td>Numerator: Total no. of households with Sanitary toilet</td>
<td>FHSIS</td>
<td>annual</td>
<td>FHSIS report</td>
</tr>
<tr>
<td></td>
<td>treatment system, sanitary pit latrine or ventilated improved pit latrine.</td>
<td>Denominator: Total Number of Households</td>
<td></td>
<td></td>
<td>LGU scorecard</td>
</tr>
<tr>
<td>5.3 Percentage of RUP households with PhilHealth cards</td>
<td>Refers to households enrolled in PhilHealth through sponsorship programs</td>
<td>Numerator: Total number of households enrolled in PhilHealth in the target community/ies</td>
<td>baseline and endline survey, project files/documents, LGU files, CSWDs, DOH</td>
<td>baseline and endline (start and end of project)</td>
<td></td>
</tr>
<tr>
<td>5.4 Proportion of CCT households in RUP communities with 100% compliance</td>
<td>The Philippines is implementing a Conditional Cash Transfer program, which is</td>
<td>Numerator: No of CCT households in RUP communities with 100% compliance</td>
<td>baseline and endline survey, project files/documents, LGU files, CSWD</td>
<td>baseline and endline (start and end of project)</td>
<td>CSWD CCTI 4P’s records</td>
</tr>
<tr>
<td>INDICATORS</td>
<td>DEFINITION</td>
<td>FORMULA</td>
<td>SOURCE OF DATA</td>
<td>FREQUENCY OF REPORTING</td>
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</tr>
<tr>
<td>1.1.1 No. of TB symptomatic/suspects successfully referred to health center</td>
<td>TB symptomatic/suspect (a) with cough of more than 2 weeks with or without fevers, hemoptysis, chest pain, weight loss (b) with cough less than two weeks and high risk group such as smoker, diabetic, malnourished (c) contacts of a registered TB case successfully referred -- with feedback from health center staff that patient consulted them</td>
<td>Count</td>
<td>Community health volunteer record</td>
<td>monthly</td>
<td>Community health volunteer record</td>
</tr>
<tr>
<td>1.1.2 No. of TB symptomatic/suspects referred who were diagnosed as TB case and initiated treatment</td>
<td>Refers to TB cases who were referred, diagnosed and initiated treatment</td>
<td>Count</td>
<td>Community health volunteer record</td>
<td>monthly</td>
<td>Community health volunteer record</td>
</tr>
<tr>
<td>1.1.3 No. of TB patients whose treatment is being supervised by volunteers</td>
<td>Refers to clients who have volunteered as treatment partners, supervising their treatment and ensuring that the regimen is followed</td>
<td>Count</td>
<td>Community health volunteer record</td>
<td>monthly</td>
<td>Community health volunteer record</td>
</tr>
<tr>
<td>1.1.4 No. of TB patients who transferred-out, died or lost</td>
<td>Total number of TB cases detected and initiated treatment</td>
<td>TB registry</td>
<td>Monthly (barangay to city and city to region)</td>
<td>Quarterly (BU to next higher)</td>
<td>TB Registry</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OUTCOME INDICATORS: DEFINITION OF TERMS</th>
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<tbody>
<tr>
<td><strong>1.1.2 Symptomatic Identification rate</strong></td>
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<tr>
<td><strong>1.1.3 Case notification rate, all forms</strong></td>
</tr>
<tr>
<td><strong>1.1.4 Case notification rate, new smear positive cases</strong></td>
</tr>
<tr>
<td><strong>1.1.5 Treatment success rate of new smear positive cases</strong></td>
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</table>
ANNEX 2: Guidelines for Improving Access to TB Care in the Urban Poor Areas under Reaching the Urban Poor Initiative

BACKGROUND:

The CATCH TB Cases Project is managed by the Infectious Disease Office, National Center for Disease Prevention and Control of the Department of Health with support from WHO and the Canadian International Development Agency. This is a three-year project with the aim of helping the National TB Control Program (NTP) improve program performance specifically TB case detection through various strategies. One of the three components is focusing on the high risk groups such as the urban poor. Based on the 1997 national prevalence survey done in Metro Manila, TB prevalence in this group is 2–3 times than the general population. Paradoxically, despite the availability of TB care services in the health centers, urban poor have difficulties in accessing TB care services.

Reaching the Urban Poor (RUP) is a program initiated by the Center for Health Development- National Capital Region in four cities in 2005 with the assistance of WHO and was endorsed by DOH in 2010 as one of the programs needed to improve the urban health system. Initially, the initiative focused on improving access to Maternal and Child Health services specifically the Expanded Program of Immunization. Implementation of the RUP by the City Health Offices (CHO) was guided by four principles namely (a) community participation, (b) empowerment of the community and health service providers, (c) social cohesion and (d) intersectoral action. Communities were involved in all phases of implementation. Results showed substantial improvement in the program coverage, hence, it was expanded to seven cities in 2011 with the support of AUSAID. In three cities of MM namely Caloocan, Malabon and Quezon City, interventions will be expanded to include improving access to TB services by the urban poor with support of the CATCH TB cases project. This will run from July – December 2011 with possibility of extension to 2012 and beyond. NGOs have been engaged by WHO to support the CHO and a manual on RUP is being finalized.

The guidelines below will serve as starting point for implementation of TB interventions under the Reaching the Urban Poor initiative. CHO and NGOs could implement some or all of the suggested approaches depending on the existing situation in the area, status of local TB control program, available resources and agreements among stakeholders.

OBJECTIVES AND LOGICAL FRAMEWORK:

Objective:
To improve access to quality TB services by the urban poor.

Targets:
1. Increased number of TB symptomatics/suspects seeking TB care services.
2. Increased number of TB patients detected and initiated treatment.
3. Improved treatment outcome.
4. Model for accessing TB services among the urban poor developed
ANNEX 2: Guidelines for Improving Access to TB Care in the Urban Poor Areas under Reaching the Urban Poor Initiative

SITES FOR IMPLEMENTATION:

<table>
<thead>
<tr>
<th>SITES</th>
<th>BARANGAY/ COMMUNITY</th>
<th>POPULATION (NSO, 2007)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.) Caloocan City</td>
<td>Barangay 28</td>
<td>29,812</td>
</tr>
<tr>
<td></td>
<td>Barangay 34</td>
<td>6,046</td>
</tr>
<tr>
<td></td>
<td>Barangay 35</td>
<td>21,023</td>
</tr>
<tr>
<td></td>
<td>Total-Caloocan City</td>
<td>56,881</td>
</tr>
<tr>
<td>2) Malabon</td>
<td>Catmon</td>
<td>36,804</td>
</tr>
<tr>
<td></td>
<td>Longos</td>
<td>51,113</td>
</tr>
<tr>
<td></td>
<td>Tonsuya</td>
<td>40,221</td>
</tr>
<tr>
<td></td>
<td>Total-Malabon</td>
<td>128,138</td>
</tr>
<tr>
<td>3) Quezon City</td>
<td>Pansol</td>
<td>24,246</td>
</tr>
<tr>
<td></td>
<td>Tatalon</td>
<td>57,930</td>
</tr>
<tr>
<td></td>
<td>Total-QC</td>
<td>82,176</td>
</tr>
<tr>
<td></td>
<td>GRAND TOTAL</td>
<td>267,000</td>
</tr>
</tbody>
</table>

LOGICAL FRAMEWORK

- Reduced TB mortality and prevalence
- Increased TB case notification rate and improved treatment outcome
- Increased number of TB symptomatics and high risk groups identified and who consulted a health care provider
- Better TB services (supply-side)
- Better health practices of the communities (demand-side)
  - Enhance quality collaboration of TB services
  - Establish referral network among TB care providers
  - Intensify case finding esp among high risk group
  - Intersectoral Collaboration
  - Expanded community participation
  - Communication for behavior change

Reaching the Urban Poor Initiative
MANUAL OF OPERATIONS 67
ANNEX 2: Guidelines for Improving Access to TB Care in the Urban Poor Areas under Reaching the Urban Poor Initiative

APPROACHES FOR IMPROVING ACCESS TO QUALITY TB CARE BY THE URBAN POOR:

Using the logical framework above and based on local and international experiences, below are some recommendations on how to make TB services accessible;

1) Ensure that the health center (HC) serving the urban poor areas has the capacity to provide quality TB care.
   a. With key staff such as the physician and nurse who had been trained on basic TB-DOTS.
   b. Has a capacity to diagnose TB based on NTP policies. It has TB microscopy that is providing quality-assured direct sputum smear microscopy (DSSM) or with access to DSSM of another health facility and with access to a TB Diagnostic Committee (TBDC).
   c. Has adequate anti-TB drugs – available stock for at least five TB patients.
   d. Has a mechanism to do supervised treatment of TB patient (thru health center staff or community volunteer)
   e. Has a system for monitoring of TB patient and TB control program activities including proper recording and reporting.

2) Establish or strengthen the system of TB referral among health care providers in the area, specially those being utilized by the poor such as the health center, private practitioners, hospitals, other government clinics, NGOs, etc. The public-private mix DOTS (PPMD) is the approach adopted by NTP to engage other non-NTP providers.

3) Enhance the community’s knowledge on the basic facts about TB, such as the cause, signs and symptoms, diagnosis and treatment, prevention and availability of TB services in the health center and influence their health-seeking behavior. This could be done through mass health education, dissemination of information, education and communication (IEC materials), individual or small group counselling.

4) Engage the community and other stakeholders in addressing the TB problem;

   4.1 During the health situational assessment, involve community members in assessing the status of TB control in the area specifically the factors that affect access to TB care. Baseline data to be collected will include; (a) local TB control program performance in terms of case notification rate and treatment success rate, number of TB symptomatics who underwent DSSM and TB patients currently enrolled from the areas, (b) available resources, (c) knowledge and practices on TB, (d) problems and issues, etc.
ANNEX 2: Guidelines for Improving Access to TB Care in the Urban Poor Areas under Reaching the Urban Poor Initiative

APPROACHES FOR IMPROVING ACCESS TO QUALITY TB CARE BY THE URBAN POOR:

Common problems among the urban poor are:
- lack of money to consult a health care provider
- people do not know that HC has free services on TB
- non-accommodating attitude of health care provider
- stigma
- no time to consult a health care provider due to work or school
- perceived poor quality services by HC

4.2 During planning phase, facilitate the surfacing of possible solutions to these problems.

4.3 If there is low utilization of health services based on the level and trend of the TB case notification rate, health center must decentralize some TB services to the community. Instead of waiting for TB patients to visit a health center (called passive case finding), there is need to intensify case finding. Some of these approaches are:

a. Conduct of TB contact investigation
   a.1 Studies show that 5% of household contacts have TB.

   a.2 Household contact investigation
      - Review the TB register of the health center and identify those who are from the area specially the smear positive
      - Health center staff and community volunteer advise the household members of the TB case to go to the HC.
      - HC staff make the necessary assessment of contacts.

a.3 Community / neighbourhood contact investigation
   - Get a spot map of the community.
   - Mark the houses where TB patient resides
   - If there is clustering of TB cases in adjacent houses or if TB cases per thousand population identified is more than 10, do community contact investigation
   - Advise household members of houses in the affected area of the community to report to HC for evaluation

b. Search for TB cases through house-to-house
   - This could be done simultaneously with other house-to-house activities such as household enumeration or census, information dissemination or door-to-door immunization campaign, etc. Or it could be done as a stand alone activity;
APPENDIX 2: Guidelines for Improving Access to TB Care in the Urban Poor Areas under Reaching the Urban Poor Initiative

APPROACHES FOR IMPROVING ACCESS TO QUALITY TB CARE BY THE URBAN POOR:

- The purpose is to find TB symptomatics (persons with signs and symptoms of TB specially those with cough of two week duration) and TB high risk group. The latter are predisposed to develop TB more than others.
- TB high risk group with cough of any duration should also be evaluated. These are the (a) smokers, (b) affected with disease that facilitate development of TB such as diabetes, HIV/AIDS, (c) malnourished, and (d) elderly
- Guide question is in Annex 1
- Advise these TB symptomatics or suspects to go to the health center for DSSM.
- If they could not go the HC for some reasons such as lack of money or time, the microscopist or volunteer should ask for sputum specimen from the TB symptomatic/suspect and bring these to the TB microscopy center. Sputum specimen must be sent to TB laboratory within a week after collection.
- Smear negative but with symptoms must be referred for x-ray examination

c. Community cough surveillance
   - Community may designate members to monitor those with cough. Source of information could be the storekeepers, vendors, debt collectors, head of community organizations such as the tricycle drivers etc...

d. Conduct of regular outreach visit by the HC staff or of an itinerant team from the Health Center
   - The health center staff including the TB microscopist may schedule monthly visit to the community to conduct sputum collection from the TB symptomatics or suspect. Information prior to the activity must be done through announcement during community meetings, dissemination of flyers, poster or thru “bandillo” (mobile van).
   - to attract more people, include a package of services including screening tool such as peak flowmetry, mobile xray or portable spirometry

e. Integration of TB case finding with other programs such as the Integrated Management of Childhood Illness, pre-natal visit of mothers, diabetic clinic, smoke cessation program, etc.

5) Ensure that enrolled TB patient has completed treatment based on the prescribed duration (minimum of six months). HC provides anti-TB drugs for free.
ANNEX 2: Guidelines for Improving Access to TB Care in the Urban Poor Areas under Reaching the Urban Poor Initiative

APPROACHES FOR IMPROVING ACCESS TO QUALITY TB CARE BY THE URBAN POOR:

This could be done through
- Daily supervision of treatment at the community by the HC staff or community volunteer and weekly visit to the health center.
- Continuous counselling by staff or community volunteer of TB patient and family
- Recording of the intake of drugs and evaluation of treatment outcome (cured, completed, failed, died, defaulted, transferred-out)

6) Address other social determinants of TB. Some examples are;
- Lack of money to pay for X-ray or to go to health center– coordinate with hospitals for free or subsidized x-ray fee or through the Conditional Cash transfer of DSWD; transportation subsidy; PhilHealth
- Hunger – coordinate with DSWD or other NGOs
- Housing congestion – coordinate with city government, HULRB or NGOs involved in shelter such as Habitat for Humanity or Gawad Kalinga.

MONITORING AND EVALUATION

Definition of Terms:

(1) Successfully referred – with feedback from health center staff that patient consulted them
(2) TB symptomatic/suspect
   (a) with cough of more than 2 weeks with or without fever, hemopthysis, chest pain, weight loss
   (b) with cough less than two weeks and high risk group such as smoker, diabetic, malnourished
   (c) contacts of a registered TB case
(3) TB case – (a) two positives on DSSM, (b) one positive plus x-ray suggestive of TB, (c) with x-ray suggestive of TB and with decision by a DOTS trained health care provider to treat, (d) culture positive
(4) Notification – listed in the TB registry and notified to NTP
(5) Cured – with smear negative result at the end of treatment and one negative result during maintenance phase
(6) Completed – without sputum result or with one smear negative result
## MONITORING AND EVALUATION

<table>
<thead>
<tr>
<th>Indicators to be monitored by the Community</th>
<th>Source</th>
<th>Formula</th>
<th>Frequency of reporting</th>
<th>Venue of reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. No. of TB symptomatics / suspects successfully referred to health center</td>
<td>Community health volunteer record</td>
<td>Count</td>
<td>Monthly</td>
<td>Monthly meeting of volunteers</td>
</tr>
<tr>
<td>2. No. of TB symptomatics / suspects referred who were diagnosed as TB case and initiated treatment</td>
<td>Community health volunteer record</td>
<td>Count</td>
<td>Monthly</td>
<td>Monthly meeting of volunteers</td>
</tr>
<tr>
<td>3. No. of TB patients whose treatment is being supervised by volunteer</td>
<td>Community health volunteer record</td>
<td>Count</td>
<td>Monthly</td>
<td>Monthly meeting of volunteers</td>
</tr>
<tr>
<td>4. No. of TB patients who transferred-out, died or lost</td>
<td>Community health volunteer record</td>
<td>Count</td>
<td>Monthly</td>
<td>Monthly meeting of volunteers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicators to be monitored by HC and TWG</th>
<th>Source</th>
<th>Formula</th>
<th>Frequency of reporting</th>
<th>Venue of reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Symptomatic identification rate</td>
<td>Consolidated CHVs monthly report for the quarter Area Census</td>
<td>No. of TB's/suspects successfully referred by CHVs to health center / 100,000 population</td>
<td>Quarterly</td>
<td>TWG meeting</td>
</tr>
<tr>
<td>6. Case notification rate, all forms</td>
<td>TB register Area Census</td>
<td>(No. of TB patients registered, all forms / area population) x 100,000</td>
<td>Quarterly</td>
<td>TWG meeting</td>
</tr>
<tr>
<td>7. Case notification rate, new smear positive cases</td>
<td>TB register Area Census</td>
<td>(No. of TB patients registered, new smear positive cases / area population) x 100,000</td>
<td>Quarterly</td>
<td>TWG meeting</td>
</tr>
<tr>
<td>8. Community contribution to total TB cases</td>
<td>CHV record TB register</td>
<td>No. of TB cases identified by the CHVs / total TB cases</td>
<td>Quarterly</td>
<td>TWG meeting</td>
</tr>
<tr>
<td>9. Treatment success rate of new smear positive cases</td>
<td>TB register</td>
<td>No. cured plus completed / Total cohort evaluated</td>
<td>Quarterly</td>
<td></td>
</tr>
</tbody>
</table>

Purpose and Scope of the Manual of Operations

A. It aims to **guide LGUs as well as national agencies** in the LGU-wide implementation of AO 2008-0029 also known as the MNCHN Strategy.

B. The **Manual of Operations (MOP)** is an:
   - also in accordance with
     ⇒ AO 2009-0025 known as Adopting New Policies and Protocol on Essential Newborn Care
     ⇒ AO 2010-0001 known as Policies and Guidelines for the Philippine National Blood Services (PNBS) and the Philippine Blood Services Network (PBSN),
     ⇒ AO 2010-0010 and AO 2010-0014 known as Administration of Life Saving Drugs and Medicines by Midwives to Rapidly Reduce Maternal and Neonatal Morbidity and Mortality.

C. The MOP provides for the
   - **steps in identifying at risk and priority populations** in given locality,
   - **service packages** essential to addressing the MNCHN needs of the target population
   - steps in establishing a **functional MNCHN service delivery network**,
   - steps to ensure **quality of care in delivering MNCHN services**,
   - the various **financing options** to sustain implementation of the strategy,
   - the mechanisms by which to **monitor and evaluate** performance
   - the **roles** of the DOH central office units, the CHDs, LGUs and other partners in implementing the strategy.

D. The MOP also serves as a roadmap in navigating through the various technical guidelines and tools produced by the DOH and its partners for the implementation of the MNCHN strategy.

The MNCHN Strategy

The systems and strategies that are presented in the Manual of Operations could be summed up into a framework (figure 1). The framework depicts how DESIRED HEALTH OUTCOMES are the results of the utilization of health services. On the other hand, utilization of health services can only come about when there is DEMAND FOR HEALTH CARE among households and the health service providers through the government health facilities are able provide the SUPPLY OF QUALITY HEALTH CARE. Both SUPPLY and DEMAND are, in turn, the results of HEALTH INPUTS, mainly from the LOCAL GOVERNMENT UNITS (LGU) ACTIONS. LGU actions over health are informed and supported by **ISSUANCES, ACTIONS AND INFLUENCE OF NATIONAL AGENCIES**.

The MNCHN Strategy

**MNCHN Strategy Framework**

- Demand for health care
- Desired health outcomes
- Actions by LGUs
- Supply of quality health care
- Issuances, actions and influence by CHD & national agencies

Figure A3.1: The MNCHN Strategy Framework

A. Achieving Desired Health Outcomes:

**FINAL OUTCOME:**
Rapid reduction of maternal and child mortality by half in 2015

**INTERMEDIATE OUTCOMES**
- Every pregnancy is wanted, planned and supported
- Every pregnancy is adequately managed throughout its course
- Every delivery is facility-based and managed by skilled birth attendants/skilled health professionals
- Every mother and newborn pair receives proper post-partum and newborn care with smooth transitions to the women’s health care package for the mother and child survival package for the newborn

**INDICATORS**
- Contraceptive Prevalence Rate (CPR)
- 3 antenatal care visits - ANC
- Skilled birth attendance (SBA)
- Facility-based delivery (FBD)
- Essential Newborn Care (ENC)
- Fully Immunized Child (FIC)
- Vitamin A Supplementation
- Exclusive Breastfeeding

Figure A3.2: MNCHN Strategy Outcomes and Major Indicators
B. Strategic Responses to the MNCHN Problem: Ensuring Supply of Quality Health Care

B.1 MNCHN Core Packages

The MNCHN Core Package of Services consists of interventions that will be delivered for each life stage: pre-pregnancy, pregnancy, delivery, and the post-partum and newborn periods.

<table>
<thead>
<tr>
<th>Pre-Pregnancy</th>
<th>Provision of iron and folate supplementation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Advice on family planning and healthy lifestyle</td>
</tr>
<tr>
<td></td>
<td>Provision of family planning services</td>
</tr>
<tr>
<td></td>
<td>Prevention and management of infection &amp; lifestyle-related diseases</td>
</tr>
</tbody>
</table>

Most of these services require minimal cost and can be delivered by health workers as part of their routine functions with some that may require additional training and minimal investments in facilities.

The intervention in the MNCHN core package of services that were found effective in preventing deaths and in improving the health of mothers and children include the following:

Figure A3.3: MNCHN Core Package of Services throughout the Life Span
### The MNCHN Strategy

#### SERVICE PACKAGES

| Pregnancy | First prenatal visit at first trimester, At least 4 prenatal visits throughout the course of pregnancy to detect & manage danger signs and complications of pregnancy, Provision of iron & folate supplementation for 3 months, Iodine supplementation & 2 tetanus toxoid immunization, Counselling on healthy lifestyle and breastfeeding, Prevention and management of infection. |
| Delivery/ Birth | Skilled birth attendance/skilled health professional-assisted delivery Facility-based deliveries including the use of partograph, Proper management of pregnancy and delivery complications and newborn complications, Access to BEmONC or CEmONC services |
| Post Partum | Visit within 72 hours and on the 7th day postpartum to check for conditions such as bleeding or infections, Vitamin A supplements to the mother, Counselling on family planning and available services. |
| Neonatal/ New Born - till first week of life | Interventions within the first 90 minutes: immediate drying, skin to skin contact between mother and newborn, cord clamping after 1 to 3 minutes, non-separation of baby from the mother, Early initiation of breastfeeding, as well as essential newborn care after 90 minutes to 6 hours Newborn screening and newborn care prior to discharge, Newborn care after discharge as well as additional care thereafter as provided for in the “Clinical Practice Pocket Guide, Newborn Care until the First Week of Life. |
| Infancy/ Child Care | Immunization Micronutrient supplementation (Vitamin A, iron) Exclusive breastfeeding up to 6 months Sustained breastfeeding up to 24 months with complementary feeding Integrated management of childhood illnesses Injury prevention Insecticide-treated nets for mothers and children in malaria endemic areas |
The MNCHN Strategy

B.1 MNCHN Service Delivery Network (SDN)

The MNCHN SDN can be a province or city-wide network of public and private health care facilities and providers capable of giving MNCHN services, including basic and comprehensive emergency obstetric and essential newborn care. It also includes the communication and transportation system supporting this network.

There are three levels of care in the MNCHN SDN: (1) Community level service providers; (2) Basic Emergency Obstetrics and Newborn Care (BEmONC)-capable network of facilities and providers; and (3) Comprehensive Emergency Obstetrics and Newborn Care (CEmONC) - capable facility or network of facilities.

B.2.1. Community level providers give primary health care services. These may include outpatient clinics such as Rural Health Units (RHUs), Barangay Health Stations (BHS), and private clinics as well as their health staff (i.e., doctor, nurse and midwife) and volunteer health workers (i.e., barangay health workers, traditional birth attendants).

For the MNCHN Strategy, the Community Health Team (CHT) shall be organized and deployed to implement the MNCHN Core Package of Services identified for the community level. CHTs should be present in each priority population area to improve utilization of services, ensure provision of services as well as follow-up care for post-partum mothers and their newborn.
The MNCHN Strategy

<table>
<thead>
<tr>
<th>Navigation Functions of CHTs</th>
<th>Basic Service Delivery Functions of CHTs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• assisting families in health risks and needs assessment</td>
<td>• advocating for birth spacing</td>
</tr>
<tr>
<td>• assisting families in developing individualized health use plans such as birth plan, Well-child plan, RH plan</td>
<td>• counselling on family planning services</td>
</tr>
<tr>
<td>• facilitating access by families to critical health services (e.g. emergency transport and communication as well as outreach) and financing sources (e.g. Phil-Health)</td>
<td>• tracking and master listing of pregnant women, women of reproductive age, children below 1 year of age</td>
</tr>
<tr>
<td></td>
<td>• early detection and referral of high-risk pregnancies</td>
</tr>
<tr>
<td></td>
<td>• reporting maternal and neonatal deaths.</td>
</tr>
<tr>
<td></td>
<td>• The team shall also facilitate discussions of relevant community health</td>
</tr>
</tbody>
</table>

### B.1.2 Basic Emergency Obstetric and Newborn Care (BEmONC)-capable.

**Hospital-Based BEmONCs should have:**

- blood transfusion services which may or may not include blood collection and screening
- operate on a 24-hour basis
- complement of skilled health professionals such as doctors, nurses, midwives and medical technologists.

<table>
<thead>
<tr>
<th>.....as a stand-alone facility</th>
<th>.....as a network of facilities &amp; skilled health professionals capable of delivering the 6 signal functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>typically an RHU with the complement of skilled health professionals such as doctors, nurses, midwives and medical technologists</td>
<td>can be RHUs, BHS, lying-in clinics, or birthing homes operated by skilled health professionals</td>
</tr>
<tr>
<td></td>
<td>At the minimum, can be operated by a midwife, either under supervision by the RHP or has referral arrangements with a hospital or doctor trained in the management of maternal &amp; newborn emergencies.</td>
</tr>
<tr>
<td></td>
<td>Under this arrangement, a midwife can provide lifesaving within the intent of A. O. 2010-0014.</td>
</tr>
</tbody>
</table>

BEmONCs shall be supported by emergency transport and communication facilities. The provision of blood transfusion services in non-hospital BEmONCs shall be dependent on presence of qualified personnel and required equipment and supplies.
The MNCHN Strategy

B.1.3 Comprehensive Emergency Obstetric and Newborn Care (CEmONC)-capable facility or network of facilities are end-referral facilities capable of managing complicated deliveries and newborn emergencies.

CEmONC should be able to:
- perform the six signal obstetric functions
- provide: 1) caesarean delivery services, 2) blood banking and transfusion services, and 3) other highly specialized obstetric interventions.

- It is also capable of providing newborn emergency interventions, which include, at the minimum, the following:
  (a) newborn resuscitation
  (b) treatment of neonatal sepsis/infection
  (c) oxygen support for neonates
  (d) management of low birth weight or preterm newborn
  (e) Other specialized newborn services.

CEmONC - capable facility or network of facilities:
- could be private or public;
- could be secondary or tertiary hospital/s;
- should be capable of performing caesarean operations and emergency newborn care;
- should be ideally less than 2 hours from the residence of priority populations or the referring facility;
- could serve as high volume providers for IUD and VSC services, especially tubal ligations and no-scalpel vasectomy.

Human resource of typical CEmONC facility:
- 3 doctors preferably obstetrician/surgeon or General Practitioner (GP) trained in CEmONC (1 per shift);
- at least 1 anaesthesiologist or GP trained in CEmONC (on call);
- at least 1 pediatrician (on call);
- 3 Operating Room nurses (1 per shift), maternity ward nurses (2 per shift), and
- 1 medical technologist per shift.

There can be inter-CEmONC-capable network of facilities cooperation for specific services

The CEmONC capable facility or network of facilities should organize an itinerant team for the conduct of out-reach services to remote communities. A typical itinerant team is composed of at least 1 doctor (surgeon), 1 nurse and 1 midwife.
C. Improving Client’s Utilization of Services: Increasing Demand for Health Care

The MNCHN MOP suggests that in order to improve the utilization of health services by the clients, it is important to do FOCUSED TARGETING, which means that vulnerable or marginalized and underserved populations have to be identified and profiled. The next step is to identify the gaps to the utilization of services. Gaps are usually dependent on the current situation, cultural practices and beliefs and other socio-economic factors in an area. Thus, the following factors have to be assessed: Information, Cultural Preferences, Time, Distance and Capacity to Pay for the services and other incidental costs. The interventions to improve the utilization of services are then identified based on the gaps; and implementation plans are formulated accordingly.

The MOP emphasizes the importance of establishing Community Health Teams as the core intervention in increasing demand for quality health care through its navigation function or role.

The MOP specifically states that "Community Health Teams (CHTs) are instrumental in assisting priority population groups in assessing health risk and needs, preparing health plans such as reproductive health plan, birth plan, well-baby or sick-baby plan, providing information on available services including the cost of these services and information on available support from the community like transportation and communications systems. The CHT could also facilitate the conduct of regular outreach services for remote areas and organize the emergency transportation and communication systems in a community.”

With the support of the Local Government Unit and the assistance of the CHTs, the following are some specific activities that can be implemented to increase the demand for MNCHN health services:

1) Focused Targeting – prioritizing population groups
   - actively master list women of reproductive age especially those with unmet need for family planning,
   - women who are pregnant or post-partum, and
   - children 0 to 11 months old and those 6 to 59 months old

2) Assessment of Gaps/Needs and Tracking Utilization
   - Help families assess health risk and needs
   - Reports maternal and neonatal deaths to RHU and participate in maternal death reviews
   - assessing clients’ utilization of services
3) Preparation of Health Plans and Providing Information

- assist in preparing reproductive health plan, birth plan, well-baby or sick-baby plan
- providing information on available services including the cost of these services and information on available support from the community like transportation and communications systems.
- Inform families of the need to know their registration status with PhilHealth and the benefits of being covered by the National Health Insurance Program
- Advocate for prenatal care, facility-based deliveries, postpartum and newborn care
- Guide women in choosing the appropriate providers of the MNCHN Core Package of Services
- Provide health information such as self-care to address common health problems during pregnancy

The MOP also recommends some strategies to increase the utilization of health services:

Transportation and Communication Systems

The availability of transportation and communications system to support the functionality of the MNCHN SDN especially in remote areas is critical considering the terrain and distance to facilities. Mapping out of all available transportation and communication facilities, even those that are privately-owned is crucial, as well as collaboration and partnership with all stakeholders.

Outreach Services

Outreach services should be regular and targeted towards hard-to-reach communities. Since these areas are not frequently visited by health providers and health facilities are not available, outreach activities can bring the needed services closer priority population groups, ensuring their accessibility to health services and adherence of the families to their health use plans. In some provinces, outreach activities are also used by the LGU to
Local Implementation of the MNCHN Strategy

A. Establishing the MNCHN Team

The MOP suggests that in order to begin the process of implementing an LGU-wide MNCHN Strategy, an MNCHN Team, key people from the LGU, health offices (Provincial/Municipal/City), DOH Center for Health Development as well as hospitals both from the public and private. Members from partners, non-government organizations (NGOs) and civil society may be invited to be part of the team. The team shall lead the assessment of the MNCHN situation and strengthening the service delivery network. The LGU does not have to organize a new team for MCNHN but ensure that issues and concerns of women, mothers and children are tackled by the existing body.

The MOP suggests the following steps in implementing the MNCHN strategy in the Local Government Unit:

a. Prioritize Population Groups
   - Know the MNCHN Situation in the LGU – the MNCHN team can lead the assessment of the MNCHN situation in the locality. Existing data sources such as the FHSIS or monitoring and evaluation systems such as the LGU scorecard or the URBAN HEART can be used.
   - Identify Priority Population Groups – the results of the assessment can be used to identify communities that have high maternal deaths or low performance in terms of MNCHN indicators.

b. Designate the Service Delivery Network for the MNCHN Core Package of Services
   - Define the MNCHN Service Delivery Network – The MOP states that defining the MNCHN SDN would involve organizing the Community Health Team (CHT) as part of the Community-Level Health Providers, designating the CEmONC-capable facility or network of facilities, and designating the BEmONC-capable network of facilities and providers.
   - Verify Services – there is a need to verify services that can be delivered by the service delivery network since these services will also require a certain level of competency by providers.

c. Strengthen the MNCHN Service Delivery Network
   - Increase client’s utilization of services – the LGU should assess gaps in the utilization of health services, identify and implement interventions accordingly
   - Improve the capacity of the MNCHN Delivery Network - the LGU should also assess the capacity of the Service Delivery Network to implement the level and quality of health services required by the MNCHN strategy. Interventions along this component include the establishment and capacitating to CHTs, training and skills improvement for service providers and the improvement of designated BEmONC and CEmONC facilities.
Local Implementation of the MNCHN Strategy

- Improve local health systems - the MNCHN Strategy should be supported by health system instruments (governance, regulatory and financing) to sustain its implementation. Some of these instruments include:

**Governance**
- MNCHN plans
- Coordinating mechanisms among local leaders and among health care providers
- Capability program for health care providers
- Logistics management and information system
- Monitoring system
- Strengthen Health Information System
- Strengthen Private-Public Partnership

**Regulatory/ Policy Issuances:**
- Issuance of a Policy Directive on the Adoption of the MNCHN package of interventions to be made available to clients at appropriate levels of care with adherence to standards of quality
- Engagement of different health facilities as members of the MNCHN service delivery network from the community level up to the province/city level, and across private and public facilities
- Organization of community-based MNCHN team in every community, and formally engage their services

**Financing:**
- Generate Resources for One-time Investments – local budget, special loans for health from the Municipal Development Fund Office and Development Banks, MNCHN and Health Facility Grants from the DOH, Health Facility Grants from development partners, grants from the Philippine Charity Sweepstakes office (PCSO)
- Generate resources for operational expenses – PhilHealth reimbursements, cost recovery schemes, revolving drug fund/Botika ng Barangay/P100 Program or minimize costs of the provision of services

**d. Monitor the LGU-wide Implementation of the MNCHN Strategy**

The LGU has to define the monitoring and reporting process of the implementation of the MNCHN strategy:

(a) identify needed information to track progress – service coverage indicators for MNCHN; number of maternal, neonatal and infant deaths and process indicators based on the MNCHN plan
(b) determine activities that should be some to collect information – FHSIS, maternal death reviews (MDR), client feedback, progress review and Program Implementation Review (PIR)
(c) define the roles of the MNCHN team (or the Local Health Board) and other stakeholders in monitoring
Monitoring and Evaluation

The DOH shall use the following indicators to in achieving target health indicators:

- **Health Outcome Indicators:** Maternal Mortality Ratio, Neonatal Mortality Rate, Infant Mortality Rate, Under Five Mortality Rate
- **Service Coverage Indicators:** Contraceptive Prevalence Rate, Antenatal Care, Facility-Based Deliveries, early initiation of breastfeeding, Fully Immunized Children

**Maternal Death Tracking**

Reduction of maternal mortality is one of the goals of the MNCHN Strategy. The DOH shall track maternal deaths by having CHDs report occurrence of deaths in their localities.

The CHDs should ensure that the province and involved providers conduct Maternal Death Reviews (MDR) of all deaths occurring in the region. MDR shall be the venue for providers and managers find local solutions and share resources for the reduction of maternal mortalities.

**Process Indicators**

The DOH supports LGUs in establishing capable MNCHN service delivery networks. Progress in the implementation of the MNCHN Strategy shall use the following indicators:

1) Number of Community Health Teams organized, trained and deployed
2) Number of CEmONCs designated, capacitated, made functional and accredited
3) Number of BEmONCs- designated, capacitated, made functional and accredited
4) Number of Facilities for Safe Blood Supply designated/established
5) Number of Transportation and Communication Systems established
ANNEX 4: List of Participants to the RUP MOP Workshops

Workshop on RUP Manual of Operations Development  
March 9-11, 2011  
List of Participants

A. Local Government Units – City Health Offices

1. Carl Abelardo T Antonio  
2. Dalisay B Bulacan  
3. Edita L Capiral  
4. Nelia T Chavez  
5. Emma Ruth B Cuevas  
6. Ma. Socorro Delos Santos  
7. Erinda D Rayos del Sol  
8. Loida N Gaba  
9. Josephine I Gallardo  
10. Alma Gammad  
11. Wilma S Gonzales  
12. Joselito Heyres  
13. Teresita G Hilario  
14. Fe Justimbaste  
15. Myrna Lapuz  
16. Armando C Lee  
17. Sonia F Timbang-Majus  
18. Elizabeth B Marcelo  
19. Amelia C Medina  
20. Rosanna S Miciano  
21. Cynthia L Sampol  
22. Rosalind G Vianzon  
23. Olga Z Virtuso

National Capital Region, Center for Health Development

24. Dr. Irma L Asuncion  
25. Ms. Rosalie A Espeleta  
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ANNEX 4: List of Participants to the RUP MOP Workshops

RUP MOP Finalization Workshop  
July 21-22, 2011  
List of Participants

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2. Loida N Gaba  
3. Elizabeth B Marcelo  
4. Josephine I Gallardo  
5. Olga Z Virtuzio  
6. Cynthia L Sampol  
7. Nelia T Chavez  
8. Teresita G Hilario  
9. Carl Abelardo T Antonio  
10. Emma Ruth B Cuevas  
11. Dalisay B Bulacan  
12. Wilma S Gonzales

B. Department of Health

Bureau of Local Health Development  
13. Teresita C Guzman

Health Policies Development and Planning Bureau  
14. Clarissa B Reyes

National Center for Disease Prevention and Control  
15. Rosalind G Vianzon

C. Center for Health Development-National Capital Region  
16. Rosalie A Espeleta  
17. Ruben S Siapno  
18. Reinhard M Dalumpines  
19. Milagros T Reyes  
20. Marilyn P Ebuen

D. Civil Society Organizations
22. Evelyn L Felarca, Adolescent Friendly Reproductive Health Services (AFRHS) Network  
23. Gari R Lazaro, Institute of Politics and Governance (IPG)  
24. Roberto O Nebrida, Philippine NGO Support Program, Inc (PHANSuP)  
25. Ruthy D Libatique, Simbayanan ni Maria Community Foundation, Inc  
26. Rodelio S Abilir, Samahang Mamamayan Zone One Tondo (SM-ZOTO)

E. World Health Organization
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This manual was a collaborative effort of:

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