One of the challenges of the 21st century is managing the accelerating pace of urbanization. Projections suggest that by the year 2030, six out of ten people all over the world will live in cities. By 2050 this proportion is likely to reach 70 per cent. Most of the growth in urban population will occur in Asia, Africa and Latin America. Currently, the urban population in South-East Asia is estimated to be about 600 million, of about 150 million are estimated to be poor. In the whole wake of the often unplanned and unregulated urbanization, the urban poor face physical, environmental, social and psychological problems. These impose a heavy burden of disease and inequity on the urban poor. There is an urgent need to identify biological, socio-cultural and financial determinants of health inequity in the urban poor in order to mount a multisectoral effort to address the health concerns of this burgeoning disadvantaged section of the population.

To deliberate on the various facets of the health of the urban poor including the health status and determinants of the health of the urban poor and to discuss a framework of strategic actions to improve health and health care services for this segment of society, the WHO Regional Office for South-East Asia organized a Regional Consultation on Health of the Urban Poor in Mumbai, India, in October 2010. In addition, policy makers, programme managers, experts and representatives of civil society and academia from the Member States of the WHO South-East Asia Region, participants from UNICEF, World Bank, USAID and Population Foundation of India attended the consultation. This publication is an account of the proceedings of the Regional Consultation.
Regional Consultation on Health of the Urban Poor

Mumbai, India, 13-15 October 2010
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Introduction

Over half of the world’s population is now urban. This compels a focus on the living conditions, challenges and opportunities in urban health. Urban health was the theme of World Health Day, April 7, 2010; aptly captured in the slogan “urban health matters”.

In view of the rapid increase in urbanization in the South-East Asia Region, attention to the health and well-being of vulnerable urban populations is called for. In this context the World Health Organization Regional Office for South-East Asia (WHO-SEARO) organized the Regional Consultation on Health of the Urban Poor with representatives from Member States of the Region to deliberate on the health status and determinants of health of the urban poor, discuss barriers to health improvement, share the lessons learnt from urban health interventions in Member States and agree on potential solutions for the Region.
Objectives of the consultation

The overarching objective of the consultation was to agree on a strategic framework for improving health of the urban poor in South-East Asia.

The specific objectives were:

(i) To review the health status and its determinants among urban poor in South-East Asia.

(ii) To share experiences in improving health and health care services for the urban poor in the Region.

(iii) To discuss a draft strategic framework for improving health and health care services for the urban poor.
Proceedings of the consultation

Day 1

Inaugural session

The consultation was inaugurated with addresses by Mr S. H. Shetty, Minister of Environment, Family Welfare, Protocol and Public Health, Government of Maharashtra, Dr Poonam Khetrapal Singh, Deputy Regional Director, WHO South-East Asia Regional Office, and Mr Ghulam Nabi Azad, Minister for Health and Family Welfare, Government of India.

Mr S. H. Shetty welcomed all the delegates to Mumbai, and congratulated the Ministry of Health, Government of India, and the World Health Organization for organizing the regional consultation. He called attention to several issues that merit consideration, particularly in the current trends of demographics, economics and health status of the population. He emphasized the fact that urbanization needs to be
factored into every government strategy. Among the urban problems that he listed were insufficient housing, poor sanitation, unavailability of safe drinking water, inadequate waste management, and lack of accessibility of the poor to healthcare services, all of which he acknowledged as the foundation of poor urban health. He cautioned against implementing health programmes without addressing these health determinants.

Dr Poonam Khetrapal Singh read out the message from Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region. In his message Dr Samlee stated that history would record the 21st century as the century of transition. Health systems would have to gear up to face the challenges posed by this transition, including climate change, globalization, as well as epidemiological and demographic shifts.

He mentioned the rapid growth in urban populations, and highlighted the associated problems, such as disruptions in the physical and social ecology; increase in communicable and non-communicable diseases; stress as people compete for resources; and social alienation, crime and health-endangering behaviour.

Dr Samlee acknowledged the impressive world-class health infrastructure in many parts of the South-East Asia Region, and drew attention to the fact that accessibility to those services was not optimum in the Region. He cited the Bangkok Declaration on Urbanization and Health, and urged a holistic and multidisciplinary approach to eliminate the health equity gaps in the urban population. He called for all forces to join hands to address health issues, and reduce health inequities through the primary health care approach.

He congratulated the Indian government on the gains made in the National Rural Health Mission, and hoped that the National Urban Health Mission would do the same for urban health. He also hoped that the consultation would lead to an effective and efficient framework to improve the health of the urban poor, through strategies based on community participation and accountability. The text of the message is at annex 1.

Mr Ghulam Nabi Azad, the Hon’ble Minister of Health and Family Welfare, Government of India, avowed that democracy is thriving in India only because of the poor and downtrodden, and that it behoves public representatives to know and improve the status of the poor. He observed that the consultation was extremely contextual and timely, and emphasized the disadvantages faced by the urban poor, who compare unfavourably with their rural counterparts in terms of facilities available.
Mr Azad listed the initiatives of the Indian government in rural and urban health systems, in particular the National Urban Health Mission (NUHM) and its partnership-based, city-specific, urban local body-administered, health literacy-oriented model. He explained that the shortfall of human resources was the reason that the NUHM had not been implemented so far. He detailed the government’s strategies to build and upgrade the public health workforce in the country, such as the expansion of educational institutions all over the country. His address concluded with a call for cooperation and pooling of resources to accomplish the common goal of improved urban health.

**Office bearers**

Mr P.K. Pradhan, Addl. Secretary and Mission Director, Ministry of Health and Family Welfare, India; Dr Dorji Wangchuk, Director-General, Department of Medical Services, Bhutan; and Dr L. Chandradasa, Sarvodaya Movement, Sri Lanka, served as Chairperson, Co-Chairperson and Rapporteur respectively for the regional consultation.
Technical session 1

Global overview of urban health: challenges and promises

Dr Jacob Kumaresan, WHO Kobe Centre

The presentation highlighted characteristics of the global urban population and their health indicators. Of the 1 billion slum-dwellers worldwide this year, 170 million have no access to a latrine, and 1.2 million will die from urban air-pollution. Traffic injuries claim 1.2 million lives every year, and physical inactivity leads to 1.9 million deaths per year and a loss of 19 million years of healthy life.

Urbanization is accelerating: It is projected that 6 out of 10 people will live in cities by the year 2030, and 7 out of 10 by the year 2050. Most of this growth will occur in Asia, Africa and Latin America. The population in developed countries will either stabilize or reduce. An examination of the new cities (small, intermediate and big) in developing countries across the globe reveals that Asia has outstripped both Africa and Latin America in urban growth.

Strategies for urban development and for the alleviation of urban poverty include:

(i) Enhancing the productivity of the urban poor
(ii) Improving the living conditions of the poor
(iii) Providing security of tenure
(iv) Empowering the urban poor

Cities are confronted by the triple threat of infectious diseases exacerbated by poor living conditions; noncommunicable diseases and conditions fueled by tobacco use, unhealthy diets, physical inactivity, and the abuse of alcohol; and injuries, road accidents, violence and crime.

Energy-dense diets, and less active lifestyles, forced reliance on local corner stores, and over-reliance on fast food restaurants are spread across socio-economic strata. Studies show that the causes of death among the urban poor are similar to those among the non-poor, including cardiovascular diseases and cancer among those over 40 years of age, and TB, respiratory infections, and diarrhoea among children under 5 years of age. Significant health inequities exist within urban areas. Estimations of the progress towards the Millennium Development Goals suggest a marked lagging behind of the poorest urban residents compared to the richest.
Figure 1: Trends and projections towards achieving MDGs in urban areas of India

Universal coverage: skilled birth attendance  Halving stunting by 2015 (in relation to 1990 levels)

Source: WHO calculations based on data from Demographic and Health Surveys (DHS).

A tool to assess health equity and response, called “urban HEART”, has been developed by the WHO Centre for Health Development at Kobe, Japan. This tool is geared towards key local government executives and civil society, and measures a city’s health using health outcomes and determinants as indicators and movers of policy change.

The World Health Day 2010 focused on urbanization and health. Other initiatives to increase awareness about urbanization and health include the organization of the Global Forum on Urbanization and Health (Kobe, Japan, 15-17 November 2010 and the release of the WHO/UNHABITAT report on Urbanization and Health (Hidden cities: unmasking and overcoming health irregularities in urban settings). The ‘1000 cities’ initiative surpassed its target of getting 1000 cities to enroll to improve urban health: Of the 1543 cities that participated, 217 were in South-East Asia. Mention was made of regional committees, fora and partnerships among organizations to address the challenges of urban health.

The presentation concluded with the observation that global poverty is concentrated in cities, and improved urban health is the need of the hour.

Strategic framework for addressing the health of the urban poor

Dr Poonam Khetrapal Singh, Deputy Regional Director, WHO South-East Asia Region

Dr Singh prefaced her talk with a statement that the urban population in SEAR approximates 600 million, of which a quarter (150 million) are estimated to be poor.
These numbers are large and growing. Of the urban poor in the SEA Region, 80 million live in India, 27 million in Indonesia, and 11 million in Bangladesh.

The advantages of urbanization, such as the ability to provide facilities to be provided cost-effectively to large numbers of people are known. However, unplanned and unregulated urbanization brings in its wake several problems – physical, environmental, social and psychological. These environmental and civic problems impose a heavy burden of disease and inequity on the urban poor. There is a lack of availability of good quality healthcare in urban areas, and there are barriers to access for the urban poor.

Nutritional status, reproductive health indicators such as teenage pregnancy, total fertility rate (TFR), maternal mortality, communicable and noncommunicable disease (including injuries) general mortality and child mortality are all worse among the urban poor than the urban non-poor. The poor spend considerable out-of-pocket expenses for quality health care, which they believe comes from private rather than government healthcare providers. Also, people throng secondary and tertiary facilities, where primary facilities would serve better. The utilization of healthcare services by the poor is low owing to livelihood concerns, distance from health facilities, inappropriate health facility operating hours, as well as financial and cultural barriers.

Challenges to improving the health of the urban poor were categorized as:

(i) Socio-cultural – low health awareness and inadequate social support leading to low prevalence of health-promoting behaviours.

(ii) Low accessibility to basic infrastructure – sanitation, water, housing and health care facilities.

(iii) Economic – daily wages, and transport expenses.

(iv) Time – owing to livelihood pressures.

(v) National policy lacunae:
   - Low participation of the poor in policy formulation and implementation
   - Unbalanced resource allocations for primary care
   - Inadequate intersectoral collaboration
   - Inadequate emphasis on health in policies and strategies in sectors other than “health”
Table 1: Service utilization of urban poor and urban non-poor women in India and Bangladesh

<table>
<thead>
<tr>
<th>Selected indicators</th>
<th>India</th>
<th>Bangladesh</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban poor</td>
<td>Urban non-poor</td>
</tr>
<tr>
<td>Having at least 3 ANC visits (%)</td>
<td>54.3</td>
<td>83.1</td>
</tr>
<tr>
<td>Taking IFA at least 90 days (%)</td>
<td>18.5</td>
<td>41.8</td>
</tr>
<tr>
<td>Received at least 2 tetanus toxoid (%)</td>
<td>75.8</td>
<td>90.7</td>
</tr>
<tr>
<td>Mothers received complete ANC (%)</td>
<td>11.0</td>
<td>29.5</td>
</tr>
<tr>
<td>Births in health facilities (%)</td>
<td>44.0</td>
<td>78.5</td>
</tr>
<tr>
<td>Births assisted by skilled health personnel (%)</td>
<td>50.7</td>
<td>84.2</td>
</tr>
</tbody>
</table>

Dr Singh declared that healthy public policy, wherein every sector is called upon to address the health of the population, is the need of the hour.

Community education was acknowledged as vital in view of the weak social networks and social support in urban slums; the transient and migratory population; and the need for self-care, particularly in the event of non-availability of healthcare providers. The need for comprehensive and accurate data was also emphasized: The information available on the urban poor and the research done on this segment of the population is inadequate, with much of the work based on presumptions.

Dr Singh then presented the Strategic Framework proposed by WHO-SEARO to improve the health of the urban poor. This framework focuses on the following domains:

(i) Healthy public policy
(ii) Community education and empowerment
(iii) Improving availability of and accessibility to health services for the urban poor
(iv) National health policy and plans
(v) Information systems and research.

The framework recommends the inclusion of health education into formal educational curricula at all levels; the harnessing of children, community health workers and volunteers as effective communication agents.
The necessity of establishing preventive and promotive healthcare as the foundation of urban health programmes was reiterated by the presenter. National health policies and plans need to make a special provision for interventions especially aimed at improving health of the urban poor. It is especially important to ensure that the principles of primary health care – universal access and health equity, community participation, intersectoral coordination and use of appropriate technology – are followed in health interventions designed for the urban poor. Policies and plans for urban health should be evidence-based; focus on decentralization of health care services to local bodies; and be inclusive of the participation of the urban poor and all other relevant sectors, in addition to the health sector.

Re-engineering of schedules and facilities offered by the public sector, e.g., the institution of a pay-clinic after working hours in a government set-up, may be a way to improve the access of the urban poor to healthcare. Public-private partnerships could be explored as effective strategies to circumvent the constraints of tight budgets, harnessing private entities not only for infrastructure, but also for the provision of services. The lacunae in information systems and research call for much work in ensuring data collection, management and communication.

Based on the concept of the healthy city, programmes to improve the health and living conditions of the urban poor have been developed in Bangladesh, India, Indonesia, Sri Lanka, and Thailand.
In a recent meeting held in September 2010 the health ministers of the 11 Member States of the South-East Asia Region adopted the landmark Bangkok Declaration on Urbanization and Health. The commitments made by the health ministers include a focus on pro-poor policies to reduce the health equity gap.

**Discussion points**

The discussion following this session brought out the following insights:

- There are no shortcuts to ensuring health of the urban poor.
- **Economics:** The GDPs of most SEAR countries are increasingly becoming “urban”, e.g. 60% to 70% of the GDP of India is urban in origin. The urban poor contribute greatly to the economy, and it is the obligation of the affluent citizens of the cities to address the disadvantages that the poor face.
- Poverty is an accident of birth. Not all in urban slums are poor. There has been a relative decrease in poverty. However, there is an increase in absolute poverty owing to the natural increase in the urban poor (60%) and rural migration to urban slums.
- **Health services:** Health is not a priority for the poor. Nearly all health facilities, e.g., institutions and hospitals, are in urban areas. It is not only utilization, but also access and reach that need to be considered. Health services and governments need to reach out, and not wait for people to come and utilize services. Mechanisms need to be set up to enhance the access of the poor to these services. The education system needs to be changed. In view of the need for health promotion and disease prevention, physicians should harness the opportunity provided by a visit to a clinic to counsel patients about health promotion.
- **Governance and policy:** Accountability is part of good governance, and needs to be inculcated at all levels. Budgets are often not spent in an optimal manner; the focus should be on the best way of spending the available resources.
- It is the elected representatives who understand their constituents. Different constituencies need to be approached to raise awareness of the importance of inclusion of health into all policies.
- The responsibilities of community health workers should be explored to modify any unrealistic expectations. Despite the expenditure of innumerable man-hours on uncoordinated and unfocused data collection, there is no clear guarantee that it informs policy.
Data: The health sector needs to ensure comprehensive data collection and management. The private sector and nongovernmental organizations (NGOs) need to be involved in this endeavour. The medical associations in each country could play an important role in advocating good data collection and communication. Underreporting may lead to a fallacious picture of decrease in the numbers of slums. Data need to be disaggregated, particularly into urban poor and non-poor sections to identify where the problems lie, and formulate specific solutions.

**Technical session 2**

**Meeting the health challenges of the urban population with a focus on the urban poor: National Urban Health Mission, India**

*Amit Mohan Prasad, Joint Secretary, Ministry of Health and Family Welfare, Government of India*

The presentation began with a description of the distribution and projections of the population of the urban poor in India. Extrapolation from the census data available to date indicates an almost seven-fold increase in urban India in seven decades. The urban population, which was 350 million in 2010 is projected to reach 535 million by 2026. Some states that lag behind with regard to health parameters (the Empowered Action Group states) are home to 41% of the urban poor of India.

Urban public health services suffer from inadequate manpower, infrastructure and supplies, weak referral systems, and sub-optimal allocation of resources. There is a diversity of services for primary healthcare, and no standards for regulation. Physical proximity to healthcare infrastructure does not guarantee access; legal, social and economic barriers are faced by the urban poor.

Health indicators are consistently inferior among the urban poor compared to the urban average and the non-poor. Under-5 mortality at 72.7 among the urban poor is significantly higher than the urban average of 51.9. Fifty-six per cent of deliveries among the urban poor take place at home. Similarly, data on complete immunization, and nutritional status among children, and anaemia among women reveal that the urban poor are worse off than their non-poor counterparts.

The National Urban Health Mission (NUHM) is a strategy to address these lacunae. It covers all state capitals and cities with a population of over 100,000, and focuses on vulnerable populations such as rag-pickers, street children and
migrants. Towns with less than one lakh urban population are covered under the National Rural Health Mission.

The National Urban Health Mission is not prescriptive about details: States are expected to customize their own plans based on their perceptions, needs and disease burden. NUHM promotes innovations for improved service delivery and public health, including collaboration with nongovernmental providers. The monitoring and evaluation plan includes community monitoring, web-based
programmes and tracking through health cards at the individual level. Processes (e.g., number of city plans developed), outcomes (e.g., immunization coverage), and impacts (e.g. IMR) will be assessed.

**Second Urban Primary Health Care Project, Bangladesh**

*Md. Abu Bakr Siddique, Project Director, Second Urban Primary Health Care Project*

The presentation began with a description of Bangladesh, and a statement that it is the most densely populated country in the world. Its health indicators, particularly child health indicators (e.g., IMR of 41.3, and under-5 underweight prevalence of 41%), were detailed. The range of health facilities, from community clinics and medical college hospitals to private facilities, was described.

Bangladesh’s urban population is projected to reach 89.5 million by 2030. The 2001 census revealed that 7.8% of the urban population resides in slums. Although rural poverty is overall more severe than urban, the condition of the urban poor is far worse than that of their rural counterparts, with respect to housing and sanitation.

Dhaka, the capital, accounts for 40% of the urban population of the country, and is the fastest-growing megacity of the world, estimated to rise from the ninth-ranking megacity today to the fourth-ranking in 2025.

The Local Government Division of Bangladesh, the ADB and UNFPA have come together in one of the largest public-private partnerships (PPP) for the delivery of urban healthcare services in South Asia. It aims to improve the health of the urban population, particularly the poor in the project areas including six city corporations and five municipalities. It is planned to enhance access to high quality primary healthcare services, with at least 30% being provided free to the poor.

The essential services package comprises reproductive health care; child health care; communicable disease control; limited curative care; behaviour change communication; (addressing) violence against women; selected pathological tests; and drugs at low cost. Additional services include primary eye care; TB control and treatment; and HIV/AIDS services.

Service delivery structures are health centre based, outreach based, and community based. There are also special observances, camps, and media campaigns within the project. Between 2005 and 2010, 6.35 million clients, of
whom 76% were female, attended clinics in this project. Poor families have been identified and issued “red cards” that entitle them to numerous free and subsidized services.

Health facilities have been placed in geographical proximity to slums, and community mobilization programmes implemented to enhance the accessibility of healthcare services. In addition, doorstep services, media promotions, and free ambulance services are available. The project works to alleviate poverty via the provision of free or affordable healthcare.

The challenges faced by Bangladesh are the lack of a clear urban health strategy, inadequate resource allocations, and the absence of uniformly applied standards. A clear lesson from this project is that the PPP model is an effective one for the provision of primary healthcare services to the urban population, especially the poor. Local governance, social commitment, and intersectoral collaboration have been demonstrated to be valuable contributors to the success of the project. The presentation concluded with the assertion that analysis of problems and solutions is not enough, and that investment is very important.

**Discussion points**

The discussion at the end of the session focussed on the need for separate rural and urban health systems, and included the following explanations and insights:

- Urban local health bodies in Bangladesh are autonomous in many places. They are allowed to raise revenue. Their functioning as well as context is different from health bodies of rural areas.

- The epidemiology of rural and urban health is different, to necessitating two distinct healthcare strategies. Urbanization is driven by industrialization, which brings with it problems associated with exposure to industrial emissions and effluents, and sedentary living, and poses risks, e.g., to cardiovascular health. The idea behind a separate urban health mission is that the structured system in rural areas is absent in urban areas. When a comparably systematized set up is in place in urban areas, integration can be achieved.

- Accessibility – both physical and economic – needs to be considered. The disparity between services available in urban and rural areas is an important driver of rural-urban migration. A concern was expressed that the creation of further urban services, without commensurate rural services, might stimulate more rural-urban migration, which may not be sustainable.
Nepal urban health policy

Dr Praveen Mishra, Health Secretary, Ministry of Health and Population, Nepal

The presentation began with a broad description of the proportion and demographics of the urban population of Nepal. Fifteen percent of the country’s population is urbanized. Over 60% of the urban population is composed of internally displaced persons and labourers, who live in unauthorized colonies and slums. Access to piped drinking water, sanitation and garbage disposal services is limited to around 50% of the population.

Selected maternal and child health indicators were presented. They revealed a picture of consistently better health indicators among urban residents compared to rural.

The urban public health delivery system is not well-developed, and the private sector is the main provider, although not uniformly accessible and affordable. The low priority accorded to public health is demonstrated by the allocation of only 1% of the municipality’s budget (and only 7% of the central government’s budget) to healthcare. About 81% of the municipalities do not have a public health department. The health workforce is inadequate. The female community health volunteers are insufficiently trained. The urban health delivery system calls for considerable resources and planning to adequately address the needs of the population.

The urban health policy of Nepal will be developed by 2012. Its basic principles are the acknowledgement of health as a basic right; universal coverage; equity; the primary health care approach; and partnerships. Services planned to be provided include immunization; safer motherhood; family planning; control of TB, leprosy, malaria, kala-azar, and HIV/AIDS; and disease-preventive and health-promotive services. It is proposed that municipalities allocate 10% of their budget to health, and that health indicators be incorporated into performance measures.

Challenges to be overcome include the incorporation of health into all levels of planning and implementation, resource mobilization and upscaling community activities to city-wide activities.

In response to a question on how female community health volunteers are selected, the presenter responded that the educational level of candidates was usually between 8th and 10th class. The government has very limited incentives; community health volunteers are largely self-motivated, and deserve credit
for lowering the mortality rates in Nepal. They are being included to a larger extent in community health and being given greater responsibilities, including educational.

Migrants and urban health in Thailand

Dr Chanvit Tharathep, Director of Health Administration Bureau, Ministry of Public Health, Thailand

The presentation described an unprecedented, progressive initiative by the Thai government to assimilate illegal migrants into mainstream society and provide them essential services. The speaker expressed the spirit behind this initiative thus: “Providing services for migrants is not an option. If you want a healthy Thailand, a healthy region, a healthy world, it is a must.”

Migration, mostly from neighbouring Laos, Cambodia and Myanmar, is associated with heightened health risks for the Thai population. To address this, various departments of the government, in collaboration, formulated a strategy to acknowledge the reality of illegal migration, and address the needs of the migrants and residents of Thailand, taking into account the health and human rights of all. The procedure involves identifying illegal migrants, administering health check-ups and appropriate treatment (e.g., for HIV) to them, and instituting legal measures in agreement with the migrants’ countries of citizenship to render the illegal migrants semi-legal, and then legal, residents of Thailand with work permits. Appropriate ‘migrant health workers’ are assigned to communities of migrants. This task involves several ministries (e.g., Public Health, Law) of the government of Thailand; NGOs and global organizations, and the community.

Healthcare security as a specified amount of money per year, and access to various healthcare centres, are provided to the migrants. Migrant health workers, matched to communities on the basis of country of origin and language, educate the community on self-care and community participation in improved health. The strategies employed are tailored to the context, resulting in different activities in different regions of Thailand.

The presentation was followed by several complimentary remarks from the audience on the progressive, proactive stance of Thailand in addressing the health issues of illegal migrants.
Discussion points

The following points were elaborated in response to questions from the audience:

- Everyone in Thailand has health insurance. Thai people are provided identity cards by the ministry of the interior, and can access health services using them. Voluntary health workers, nearly 1 million at present, are in constant contact with the Ministry of Public Health.

- The Thai government has set up home shelters in every province, to help victims of domestic violence, and their families. Policies to provide housing for the poor are beginning to be instituted.

Figure 4. Self-care and community participation: migrant health workers

- Every country has the problem of illegal immigration. Thailand recognizes it and has formulated progressive policies, including bilateral agreements with neighbouring countries to identify their citizens for Thailand to provide them with visas. Although the Thai government has such agreements with its neighbours, since this migration is illegal, there is not much formal support (financial or personnel) from the countries of origin of the illegal migrants. Negotiations are underway. Cambodia has set up
anti-retroviral clinics on the border for Cambodian migrants to receive anti-retroviral therapy. There is a small proportion of migrants classified as “prohibited”: They are people who are too sick to work, or test positive for certain drugs. They are not granted work permits.

- The number of Thai workers migrating to other countries is reducing every year.

Multisectoral approach to the health of the urban poor in Sri Lanka

*Dr Lalith Chandradasa, Sarvodaya Movement, Sri Lanka*

Sri Lanka’s urban population, 22% at present, is projected to increase to 40% by 2031. In Colombo, 60% to 65% of the population of lives in underserved settlements, facing inadequacies in housing, water supply, food safety, sanitation, and schooling; as well as social, health, and gender inequities and drug abuse.

Public health issues include communicable diseases, rising levels of malnutrition and anaemia, environmental pollution, substance abuse and stress-related diseases. It is observed that the accessibility to healthcare services is declining.

Substance abuse is found to be a predominant problem among the youth, teenagers and unemployed men. Women face social and health disadvantages due to unemployment, lack of advocacy, early marriage and domestic violence.

Sri Lanka’s health indicators, particularly the low mortality statistics among infants, children and mothers, and the high rates of literacy and life expectancy, are remarkable for a low-income country, and attest to the effectiveness of healthy public policy. The municipal health system includes public health services, such as maternal healthcare and laboratory services; dispensaries for curative care; veterinary services; and the Ayurvedic department, which encompasses traditional systems of medicine.

The presenter described the following major campaigns undertaken in urban underserved settlements by the Sarvodaya programme: (i) Community involvement in TB control and prevention; (ii) Establishment of an emergency response system for the city of Colombo; and (iii) Strengthening of life skills for positive youth behaviour.

Partnerships among the government, local urban body, and NGOs were the backbone of these campaigns. Lessons learnt included the importance of specifying
the roles and responsibilities of all partners at the outset, funding for sustainability, and coordination of skills, schedules and services for optimal impact.

The programme that promoted skills for positive youth behaviour was described in great detail. The model used was ‘peer leader outreach’. Sensitization of opinion leaders was the first step. This was followed by the training of trainers to build capacity for positive skills among community youth. Health information was incorporated into numerous popular, informal, recreational activities, such as cricket matches and festivities.

Examples of health promotion interventions included:

- Provision of musical instruments to schools, leading to the formation of bands.
- Teaching of media literacy.
- Persuading married women to play cricket, after which they reported improved rapport with families.

Supportive policy includes banning smoking and alcohol abuse scenes in movies in Sri Lanka.

**Discussion points**

The discussion that followed the presentation clarified that underserved communities, which also have lower levels of education, tended to demonstrate gender biases, such as viewing married women who play badminton as “promiscuous”. This is not true of the whole society of Sri Lanka, which has a high level of literacy and is more gender-egalitarian.

In summary, the sessions stressed the strong need for intersectoral convergence and coordination; and commitment led by local leadership and backed by national policies.

**Day 2**

**Recapitulation of the sessions on day 1**

*Dr Kumara Rai, WHO-SEARO*

With the strategic framework as a background, the principal messages from the discussions on the first day were:
(i) Technology should be cost effective, socially acceptable, and appropriate for the setting.

(ii) It would be better to focus on health promotion and disease prevention, i.e. primary care, rather than to increase facilities of tertiary care, e.g., beds in ICUs.

(iii) Urbanization should be considered seriously in the formulation of national policy. There is a need for a distinct plan for urban health, rather than an expansion of the rural health set up to urban areas.

Technical session 3

Protecting the health of informal sector waste workers in Delhi

Rohini Rangarajan, Manager Outreach, Chintan Environmental Research and Action Group, New Delhi, India

The presentation was prefaced with a brief on the work done by Chintan, an environmental research and action group. They mobilize wider public support for environmental sustainability and ‘green’ jobs for the urban poor through research, campaigns, building capacity, demonstrating models on the ground and scaling them up; and increase environmental justice through systemic change.

The informal waste processing sector works like a pyramid. The first tier comprises several hundred thousand men, women and children in urban pockets who “mine” garbage heaps and bins for recyclable waste like plastics, paper and metals. The second tier includes the middle men, often marginalized in many ways themselves, who buy waste from the waste pickers. They, in turn, sell the waste to the third tier, comprising large buyers who own huge godowns. Finally, at the top are the actual recyclers themselves. Most of the city’s population interacts with the first and second layer whose labour actually propels recycling. Approximately 1% of a city’s population, mostly women, children and members of disadvantaged communities, depends on waste processing for their livelihood. Their work, devoid of official recognition, is virtually free for the city’s municipality.

Delhi generates 8000 tons of waste per day and 6000 tons go to landfills. 2000 tons (25%) get recycled by waste-pickers. The informal waste workers in Delhi recycle up to 20% of the waste generated by households, and almost 60% of the waste generated by commercial complexes. The work done by the waste-pickers saves Rs.1.2 million per day in terms of waste-collection and transportation expenses to be incurred by the municipality.
Despite serving a vital environmental role, informal waste recyclers suffer health hazards, stigma and economic hardship, and receive no institutional support. For instance, the police routinely confiscate vehicles of the informal waste workers.

Occupational hazards include exposure to pathogens and vectors in and around the waste, injuries from sharp objects and animal bites, inhalation and contact with toxic chemicals. The low level of education, health literacy, and affordability and access to healthcare services further disadvantage this population.

The presenter called for policies for the formalization of the waste-collection sector, thus eliminating the economic hardship and stress related to informal work. This would entail the collection of data relating to the waste-workers, best practices in waste-processing, and new categories of waste, e.g., e-waste and new plastics.

The presenter mentioned ‘extended product responsibility’, which places the responsibility for the entire life-cycle of a product with the producer. This would account for the work done to process the waste and protect against hazardous exposure related to the product.

**Discussion points**

The discussion following this presentation focussed on two issues, viz., child protection and waste management. It included descriptions of some work done by NGOs.

- In the areas of Delhi where the NGO Chintan works, houses are provided with twin bins to facilitate source-segregation of waste. Wastepickers get a fee from the household for collecting the waste. They segregate the waste and sell the recyclables. The rest of the waste goes to the dustbins of the municipality. The authority that the uniforms and identity cards give the wastepickers reduces the institutional harassment that they are subject to.
- Chintan runs a school to educate children of wastepickers and to bring them to the level of their same-age counterparts. Children between 3 and 5 years of age have begun to pay far more attention to hygiene now than they used to before attending school. Health checkups sponsored by Chintan are conducted twice a year for wastepickers. It is difficult to get data on the numbers of wastepickers because the numbers keep fluctuating.
- The municipality has provided identity cards to some waste-pickers in Mumbai. Most unidentified wastepickers are children 8-14 years of
age. The most frequent health problems that they face are asthma and injuries. Some of these children earn Rs.150-200 per day, and spend it on trinkets. The NGO ‘Niramaya’ is trying to send them to school. Change is happening, but it takes a long time.

- Counselling and therapy for learning disabilities for children who pick waste, often working with their parents, who may also be illiterate, are issues that demand attention, in addition to the physical hazards that the occupation poses.

Addressing maternal, neonatal and child health in urban Bangladesh

Taskeen Chowdhary, Senior Sector Specialist, Manoshi Project, BRAC Health Programme, Dhaka, Bangladesh

The presentation provided a brief description of Bangladesh and the organization BRAC (Bangladesh Rural Advancement Committee), which started in 1972 as a post-war relief organization and has grown to serve a population of over 110 million in Bangladesh since. Maternal and neonatal health indicators were highlighted: 85% of deliveries in Bangladesh take place at home, and only 18% of women have skilled birth attendants. The alarming increase in the urban population, particularly that of the urban poor, and the unsanitary living conditions in slums led to a collaboration between the Gates Foundation and BRAC, with the goal of improving maternal and child health among the urban poor.

Figure 5. Innovative initiatives of Manoshi
A five-year, community-based intervention called “Manoshi”, intended to reduce maternal, neonatal and child mortality in urban slums, was described in detail. The workforce of Manoshi comprises Urban Birth Attendants (UBA), Shasthya Kormis, Shasthya Shebikas (SS), and midwives. The principal strategy of Manoshi is community empowerment, through performance-based incentives for behaviour change communications by community health workers.

One of the innovative initiatives of Manoshi is the delivery centre – a small rented house in every slum, to provide a clean, safe, private venue for childbirth, and skilled attendants to help with the process and make referrals to hospitals if necessary. Referral officers stationed in hospitals help incoming women get through the hospital procedures and receive care promptly. Women are also provided physical and financial support. Better preventive care and better emergency response contribute to reductions in maternal, neonatal and child mortality. Technology is used to facilitate prompt documentation and communication, for instance, mobile phones are used to update records and to communicate with link personnel.

Manoshi has scaled up from one city corporation in 2007 to six in 2009, with corresponding increases in the workforce and infrastructure. The improvements in maternal, neonatal and child health in Manoshi city corporation areas include a drop in maternal deaths from 294 in 2008 to 157 in 2009. A decrease in the neonatal mortality rate has also been recorded. Institutional delivery utilization has also gone up in Manoshi areas.

**Figure 6: Neonatal mortality reduction in Manoshi areas in Dhaka**
Discussion points

The discussions that followed elaborated the roles and services in the initiatives of BRAC, and included insights on the changing patterns of perinatal care.

- The thinking that women prefer home delivery is not true. If institutional services are provided, they will be used. Manoshi’s workers, UBAs and SSs, are trained for newborn care. Midwives supervise the work of the other workers. Refresher training is provided for all staff every month. The thrust of the programme is to promote skilled birth attendance, not simply to avoid home delivery. The numbers of trained skilled birth attendants is too small for the population of the urban areas, particularly the urban poor.

- The view that BRAC is working parallel to the government rather than in a complementary role raises the issue of sustainability, and calls into question the fulfilling by the government of its responsibility towards the citizens. The government extends educational and financial support to BRAC’s programme. BRAC is attempting to link up with existing organisations for greater efficiency and to avoid duplication of services. A good referral system is a vital component of any maternal and neonatal care programme.

Healthy cities – Bangaluru

Dr Kameshwari Devi, Local Coordinator, Bengaluru Healthy Urbanization Programme, India

The presentation detailed an action research project implemented to improve health and promote health equity in urban settings in Bangaluru, India, one of six healthy urbanization field research sites in a global healthy urbanization project. The WHO Kobe Centre, WHO and the Bangaluru Municipal Corporation are partners in the Bangaluru Healthy Urbanization Project (BHUP).

BHUP involves capacity-building, for instance, training in the local language, field research methodology, community diagnosis, and project management. Preliminary research yielded themes such as ‘lack of physical exercise’, ‘change in lifestyle’, ‘lack of awareness of non-communicable diseases’, ‘irregular treatment’, ‘increase in pollution’, ‘(lack of utilization of) health centre facilities’, and ‘(increase in) respiratory (illnesses) and anaemia in migrant populations’.

Recommendations implemented include health education and screening using mobile vans; extension of bus services to enhance access to healthcare
facilities; improving waste-processing and sanitation facilities; and advocacy against domestic violence.

The project was developed into a formal programme in 2009, and executives appointed to coordinate and implement it. Components of the programme include health and nutrition camps, HIV awareness campaigns, school health camps, and anganwadi awareness events. Entertaining methods, such as Yakshagana (a traditional dance-drama form) and yoga events, were used to attract and sustain participants. The media support the dissemination of information on the various initiatives of the municipal corporation.

Future plans include establishment of counselling centres, in collaboration with students of medicine and social work; support to orphanages; and improvement of sanitation services in slums.

City without slums

Dr. M.H. Baysir Ahmad, Mayor, Pekalongan, Indonesia

This talk, by the mayor of Pekalongan, Indonesia, described the eradication of slums by local urban government action in the area. The premise of the slum-eradication project was community empowerment in the spirit of “Baiti Jannati”, which translates to ‘my home my heaven’. The local government actively sought out the poor, and instituted housing and sanitation programmes to improve their living conditions. The thrust of the project was the provision of safe and hygienic housing and toilet facilities for the urban poor to achieve far-reaching positive impacts on their health and well-being.

Several regulations, viz. smoke-free zones, tree-plantation, vehicle-free zones, and formation of committees to monitor various aspects of community development, were described. Total budget allocations for the city, as well as the proportion allocated to poverty-eradication, the latter rising from 0.62% in 2005 to 2.98% in 2010, were presented.

The method used to achieve poverty-eradication was described as the “Sapu Lidi” or ‘broomstick system’, which is predicated on contributions from various sectors (including the target population, NGOs, donors and various levels of government) to strengthen and realize the project. Community participation was led by the head of the community, and included representatives from community organizations, including women’s organizations at the hamlet and subdistrict levels, and of the Poverty Eradication Coordination Team, Housing and Environment Working Group Team, and the Healthy City Forum at the city level.
Numerous environment conservation and enrichment initiatives were introduced, for instance, reduction in garbage-generation; waste-segregation at source; recycling; and wastewater reutilization. In addition, numerous steps to address climate change related threats were taken, for instance, disaster-resilient housing for fishermen; tree-plantation in slums; cleaning up rivers and beaches; protection of biodiversity; and harnessing biogas as an energy source.
The implementation of this programme is associated with a positive change in several health indicators, such as infant mortality and child mortality rates, and maternal mortality ratio. Other indicators, such as the prevalence of tuberculosis and diabetes morbidity, although not showing steady improvement within the area over the duration of the project, are nevertheless placed at favourable levels with respect to the MDG targets. The project has garnered much popularity, and the mayor leading it has been re-elected for the next term.

Discussion points

- The discussion that followed this presentation included elaboration on the specific policies and actions employed to achieve slum-eradication in Pekalongan, and insights on the value of political will and good leadership.
- Slum-eradication in the city began with work in the small slums, which had the effect of encouraging emulation by neighbouring slums. The number of migrants to Pekalongan is not very large. There are regulations to prevent the development of new slums. Another important factor is the encouragement of continued stay in the city for its dwellers (i.e., prevention of migration outside Pekalongan) by providing education and employment in situ.
- Outcomes need to be demonstrated in order to encourage governments and others to invest funding in such projects, and interventions need to be scalable.

Intersectoral approach to address the health of the urban poor: Panel discussion

Moderator: Professor Mala Rao

Members: Dr Dorji Wangchuk (Bhutan), Dr Manohar Agnani (India), Mr Mahmood Ahmed (India), Dr Armida Fernandez (India), Dr M.H. Basyir Ahmed (Indonesia), Dr Lalith Chandradasa (Sri Lanka), Miss Ladda Jitwatanapataya (Thailand)

The accounts from the panel members, on governance and collaboration, are summarized as follows:

- Governance: From the perspective of the head of an urban local body (ULB), the principal challenges are from local legislators who need to work hard to prove themselves. Personal and professional association
with community members and opinion leaders, such as religious leaders, aids ULBs in community building and advocacy for better health.

- The ULBs take a major share of the responsibility for the ramifications of inadequate responses to disasters. They function under the Ministry of Urban Development, which has a multifaceted role. The widespread understanding of the importance of urban development needs to be translated to action, through the Ministry of Urban Development. Policymakers and planners feel the need for convergence, cooperation, collaboration, and coordination.

- The health impacts of policies in various sectors are not sufficiently considered. They are rarely factored in during discussions of projects. Ministries of social welfare, labour, employment, and women and child development need to work together with urban development. It is crucial that in collaborative efforts, one of the sectors provides leadership and coordinates the work done by the other sectors.

- Urban development is a state subject in India. The national government can persuade, but it is the state that has the authority to act. Reforms have to be delivered at the state level. As urbanization proceeds, more opportunities present themselves. More institutions of education and health develop. The role of NGOs and community-based organizations (CBOs) in building capacity is considerable.
Some strategies undertaken by the government of Bhutan in decelerating migration were described, e.g., all health services are totally free; employment is being encouraged through skill-development. These strategies notwithstanding, the net migration to cities remains high.

Collaboration: In an emergency, everybody works together. But there is no system in place for collaboration among government, NGOs and private bodies during normal times. In most countries they are only called to action in an ad hoc manner. Mechanisms should be put in place for collaboration during non-emergency periods as well, to enhance the effectiveness and efficiency of work for public good. The government needs the inputs of the private sector, particularly at the lowest, local, levels of government. A framework to include the private sector as well as donor agencies is required.

Most NGOs work to fill the gaps of the government. Their role is supplementary and complementary, e.g., with most at-risk populations. They often work closely with the government, e.g. in outreach work and receive support from the community, e.g., volunteers. Many NGOs report excellent experiences in working with the government by using the latter’s infrastructure and institutions. There is often some “red tapism”, e.g., inordinate delays in work getting sanctioned. Also, there may be problems of trust, especially in the initial phase of collaboration.

Communication and participatory planning: One of the principal barriers experienced in government functioning is the lack of communication among programmes and departments. Greater involvement of community members in policy making as well as intersectoral convergence is important in planning and implementation.

The audience voiced inputs on administration, leadership, planning, scaling up, and evaluation, as summarized below:

Decentralization and coordination are important principles in the provision of urban health services. In addition, disaster management should be considered as a priority in planning for urban health.

An effective model from Timor-Leste was described: The country has already approved an intersectoral action for health and well-being policy using the primary health care model. The roles and responsibilities of different ministries are clear. This is an ideal way of working, which provides a forum for representatives of different ministries to come together in planning. Governments should create clear legislative frameworks. The place of NGOs should mainly be to support projects.
• NGOs endorse the imperative of participatory planning. An example was described of the participatory planning between the NGOs in Mumbai and the government: Action group committees were formed from among the government employees and the NGOs helped them fill the gaps identified in services. The NGOs did not fill the gaps in service themselves.

• Scaling up is important to ensure that models do not remain islands of excellence. Documentation and maintenance of data is the foundation for the continuity of a system. Sharing of information, and success, is important. Flexibility rather than territoriality about models is called for. A successful framework should be able to be proffered for trial and adoption in other areas.

• Planning should include provisions for regulation. If departments and officers can be evaluated on a multisectoral basis, the health situation is more likely to improve. If evaluation is unidimensional, the focus will be unidimensional. E.g. water supply only focuses on water supply, not on health impacts.

• The appropriate unit of planning in the urban context is the ward, usually the unit of the elected representative. Links among the government, NGOs, community leaders and elected representatives help the community forward applications for various services to the implementers. The primary health centre can be used as the unit of intersectoral convergence.

• Individual leaders have made a great difference: How to develop such leaders is what needs to be considered. Mid-level officials are the bridge between policy and action. They need to be sensitized to enable the implementers to work effectively. Convergence is tougher to achieve at higher levels owing to interpersonal factors.

Field visits

Briefing for field visits

The field visit was intended to provide a glimpse of some initiatives and interventions undertaken by both local government and nongovernmental organizations focusing on the health needs of the urban poor in Mumbai. Participants were urged to explore the nature of the work undertaken, the major health initiatives and programmes, the target groups, the challenges faced, and the key lessons learned.
The participants were divided into nine groups, each of which visited one site that had a health facility run by the Bombay Municipal Corporation and one NGO working in the area to improve the health of the urban poor. The work done by the organizations covered child nutrition; community development; tobacco; violence against women; maternal health; human development; HIV/AIDS; reproductive health; and vulnerable groups like commercial sex workers and their children, homeless youth and street children. Details of the field visit sites were provided in a booklet that formed part of the participant’s information kit.

Day 3

Reflections from the field visits

Facilitator: Dr Monir Islam

The major points that emerged from the “reflections” are summarized below:

- The needs of the urban poor call for multisectoral collaboration, sustainability, and scaling up. The government needs to coordinate and steward services, not necessarily provide everything itself.

- The infrastructure and cleanliness in some of the field visit sites were better than expected by some of the participants. Even people from outside the slum were welcome to access services in the slum. The picture was a gratifying one of collaboration rather than competition.

- NGOs need to mobilize communities to ensure that government services are properly utilized. An example of an initiative that boosted the utilization of government services is the Janani Suraksha Yojana (JSY) in India, which worked as a trigger to increase utilization of maternal and child health (MCH) services. Despite the improved services, infrastructure and supplies, people were not coming forward to utilize maternity services. Then, under the JSY, link workers started motivating the community. The JSY is not simply a conditional cash transfer scheme; it is an enabler. It covers some incidental expenses, such as transport and some drugs, that may not be affordable for the poor.
• NGOs in the slums are few. The major players providing services in the slums are private providers. Their value lies in the fact that they provide services when required, and sometimes on credit. Such services may be poor in quality, but they are available on time.

• The urban poor are not confined to the slums. A proportion of those living in apparently middle-class dwellings and localities are poor in terms of their ability to afford services and put aside funds as buffers.

• Many NGOs provide an important service in the field. But there is some duplication in the work. When NGOs are working in an area, there need not be government workers in the same area. Work can be outsourced to NGOs who know local needs well, and are well accepted by communities. Public sector funding may be utilized to enable NGOs to provide services valued by the community.

• The urban population is heterogenous, and has a variety of needs. When there are programmes and activities in place, a mechanism needs to be established to bring all the facilities together in a ‘one-stop-shop’. Financing is key to sustainability. The concept of primary health care is ideal; it needs to be underpinned by identification of needs ahead of time and a combination of all solutions for each area. Ideally, the government could focus on health promotion and disease prevention (public goods) and the private providers on the curative aspects of healthcare.
• Timor-Leste has a system in place, with health posts and referral systems that link health posts and hospitals. It is the government’s responsibility to coordinate the different actors involved in the provision of health services. NGOs take part in community mobilization, based on their specialization. In Timor-Leste, in mid-June, the government invites NGOs, private entities and international agencies to a meeting convened by the health minister to work for one objective. Services are then contracted out suitably.

Health staff at a participating community hospital.

• Approaching issues in a holistic manner ensures that solutions can be health-oriented instead of problem-oriented. People with a health problem do not necessarily have decision-making power. It is important to educate and empower them, not just to provide healthcare services.

• A successful model is the initiation of services by an NGO to address violence against women; the service has now been taken up by the local government. Another model is the provision of services entirely by a private group (NGO) where the government is unable to reach the community.

• Inordinate focus on health services’ provision fails to address the root of the problem. Starting with primary care and then fanning out into more advanced therapeutic services will not provide solutions. We can solve health problems only by improving living conditions, and including primary care as part of the solution. Quality of life should be the focus.
Panel discussion: Building partnerships

Moderator: Dr Monir Islam

Members: Dr Pavitra Mohan (UNICEF), Mr Anand Rudra (USAID), Mr Rajiv Ahuja (World Bank), Dr Sanjay Pandey (Population Foundation of India), Dr D.S. Dhakure (India), Dr Jai P. Narain (WHO)

The discussion emphasized the vital need for partnerships, particularly among non-“health” sectors and the health sector. The following points were made:

- Urban health brings out inequities more starkly than any other area. It makes partnerships more important, and opportunities more abundant. Essential components of the provision of urban health services are data on distribution and determinants of disease; delivery of services and ensuring access to these services; and evaluating the impacts of problems and solutions. There is a need to go beyond just clinically approached services to services that improve the living conditions and well-being of the people. Short-term projects can provide evidence, but sustainability is important.

- Steps in using partnerships to improve the health of the urban poor may include:
  - Identifying the purposes of partnerships
  - Forming partnerships at the top, middle and grassroots levels
- Setting the policy and the targets
- Ensuring accountability
- Filling gaps in services
- Complementing capacity
- Facilitating access, e.g. facilitation counters in health facilities.

- There should be a clear-cut policy on partnerships. Each partner has a mandate and a modality and operates at different times in an endeavour. Stewardship should be the role of the government. Development agencies can play an effective facilitatory role. NGOs and CBOs, and the private sector can complement the government in capacity-building and provision of services.

- The essentials of partnerships were encapsulated in the following “Cs”:
  - collaboration on equal terms
  - commitment
  - consistency on time
  - creativity for local solutions to local problems
  - contribution (rather than competition and credit-seeking)
  - commonality of the vision and mission of the partners
  - clarity of roles and responsibilities of all partners
  - communication (seamless) among partners.

- Ensuring the success of partnerships requires:
  - Understanding the scope of the partnership, inclusiveness and respect – egos may come into the picture; when this happens, the parties serve themselves at the expense of the cause.
  - Re-engineering the mechanics – top-down work may be necessary to empower each level. The bottom-up approach, which is equally essential, will be facilitated by an enabling environment created top-down. Partnership happens at the point of action – that level should be empowered.
  - Accountability and transparency – in their absence, some players may adopt morally inappropriate practices.
Gender biases are deep-rooted in culture. Education and negotiation are the ways to change this, although it is often seen that people not exposed to modern education may be more gender-equal than those in modern societies. It is important to work with women in urban areas to address gender discrimination. Gender inequality and discrimination are based on convenience, not culture. Affluent, educated, urban societies are demonstrating worse sex ratios and other indicators of discrimination. Health indicators are better in regions with higher literacy and participation in governance by women, than in the more prosperous neighbours.

There is a huge, unregulated profit-making private sector. At the same time, there are inefficiencies in the public health services. It is important to reach out and take the initiative to address this. Social health insurance that engages the private sector, and the use of technology to bring about greater transparency, have the potential to prevent corruption. The government has the ultimate responsibility to ensure health, and good governance. Governance needs to be strengthened, and a grievance redressal mechanism provided, to curb corruption.

Group work

The participants were divided into three groups for in-depth discussions on the proposed strategic framework for addressing the health of the urban poor. They discussed the following aspects:

(i) Intersectoral action to improve health of the urban poor.
(ii) Empowering the urban poor for better health.
(iii) Addressing inequities in access to health care for the urban poor.

The following is a summary of the deliberations in each group:

Group presentations

Group 1: Intersectoral action to improve the health of the urban poor

Chair: Dr Armida Fernandez

Key factors for success:

The group listed the following as key factors for successful intersectoral actions:
(i) a framework for planning and implementation
(ii) decentralization
(iii) interdepartmental co-ordination institutionalized
(iv) political commitment and support
(v) mechanism for collaboration
(vi) empowerment of people
(vii) universal health coverage
(viii) bottom-up planning
(ix) community volunteerism and participation
(x) quality-of-life improvement approach
(xi) accountability of both NGOs and government organizations
(xii) empowered urban local bodies
(xiii) monitoring and evaluation
(xiv) demand generation
(xv) capacity building, and behaviour and attitude change of the service providers

**Challenges in intersectoral collaboration:**

Problems related to intersectoral collaboration were identified as:

(i) achieving consensus among the various sectors
(ii) implementation of plans
(iii) advocacy with political leaders
(iv) capacity of individuals and agencies
(v) team accountability, i.e., allocation of rewards and credit
(vi) monitoring of co-ordination
(vii) (suboptimal) political will on health issues
(viii) (lack of) flexibility at the ULB level for implementation
(ix) (uncooperative) mindset of some persons in charge of implementing the programmes.

The creation of a legal framework for intersectoral collaboration was suggested as being possible by the group. The methods proposed were:
(i) by law of parliament (as in the National Health Bill of Thailand) and by executive order
(ii) by creating an authority for intersectoral actions
(iii) by involving people in formulating policy and legislation.

Finally, the group recommended the formation of regional alliances for the health of the urban poor. Their expectations from WHO-SEARO were:

(i) guideline development
(ii) documentation of best practices
(iii) sharing and cross-learning experiences
(iv) advocacy with the governments of Member States.

Group 2: Empowering the urban poor for better health

Chair: Mr Amit Mohan Prasad

To the question “What can the municipality do to enhance awareness on health and participation in health programmes of the urban poor?”, the group’s response was as follows:

(i) make effective use of existing structures of municipality including campaigns and propaganda with a focus on preventive and promotive care, e.g., using ration depots and religious places as health communication centres
(ii) establish multisectoral committees, which include community representation
(iii) employ a rights-based approach, and place it on the political agenda
(iv) poverty mapping
(v) expand the roles of health officers
(vi) involve non-“health” players, e.g., town planners
(vii) use technology such as mobile phones for health communication
(viii) upgrade health facilities, and institute flexible timings and mobile services to ensure increased utilization
(ix) map NGOs working in the area and ensure their participation together as partners
(x) allocate resources appropriately for community mobilization and participation
(xi) ensure implementation of prevailing and new laws, such as the community participation law, to engage people
(xii) make people aware of the benefits of central and state schemes that follow reform-linked or result-based financing, e.g. the JNNURM
(xiii) pro-poor planning
(xiv) ensure quality health services (preventive, curative and supportive) before generating awareness, so that people may not be denied the facilities to improve their health after they are sensitized to their needs
(xv) recognize community groups (e.g. youth, women) and engage them
(xvi) engage local bodies, including the sensitization of local corporators
(xvii) offer co-financing options, such as poor-sensitive loans and contribution-matching for the provision of basic health services
(xviii) formulate occupational safety standards for the urban poor employed in the informal sector.

**Health volunteers:**

The topic of health volunteers for urban areas was debated at length. It was agreed that urban and rural areas cannot be equated, and that the role of urban health volunteers needs to be defined. Potential role definitions include:

(i) bridge for outreach and facilitation
(ii) interface with community for awareness-raising, i.e., information, education and communication (IEC)
(iii) provider of specific services, e.g., first aid.

It was recognized that the profile of health volunteers and their training would differ according to the setting, e.g. big cities and smaller towns.

Health volunteers, while needed everywhere, are indispensable in hard-to-reach areas within and outside the city. A payment mechanism, such as incentives or performance-based payment, is essential to encourage the work of health volunteers. Existing informal groups such as youth groups and women’s groups which can be utilized for community mobilization should be capitalized on.

**Corporate social responsibility:**

Deliberations on the role of the private sector in improving the health of the urban poor led to the acknowledgement that health should be made a common concern
for all. Corporate social responsibility (CSR) among private companies should be encouraged and more corporate entities mobilized. Lessons to be learnt from the private sector were enumerated as follows:

(i) creation and management of widespread distribution channels  
(ii) making services more user-friendly  
(iii) result-based or target-oriented management.

Further, it was recommended that the expertise and reach of the private sector be harnessed for public health via:

(i) skill transfer to government and NGOs, e.g., training in human resource management and finance management  
(ii) effective mass communication, e.g. placing a health message on commercial products.

**Differences between urban and rural poor:**

The following differences between the urban and rural poor were highlighted:

(i) The urban poor are often employed seasonally and largely in the informal system, as domestic help and construction labourers.  
(ii) The sense of belonging and community in rural areas is often absent in urban areas.  
(iii) The urban poor are more deprived than their rural counterparts, even with similar incomes, as they are subject to higher prices for the services that they use and have fewer financial and social buffers.

The role of the government in this endeavour was described as:

(i) harnessing political will  
(ii) stewardship and facilitation  
(iii) enabling policy framework and guidelines  
(iv) ensuring good regulations and enforcement  
(v) inclusive planning.

The role of NGOs was summarized as:

(i) complementary  
(ii) reaching out
(iii) facilitative and interfacing
(iv) forging links between the community and the public sector.

Group 3: Addressing inequities in access to healthcare for the urban poor

Chair: Dr Chanvit Tharathep

To the question “What should be done to enhance equity?”, the group’s response was “improve social and health determinants”. This was detailed as improvements in:

(i) health
(ii) education
(iii) living conditions
   - housing
   - safe drinking water
   - sanitation
   - electricity
   - cooking fuel.

Equitable access was described as access to the full range of healthcare services, viz., preventive and promotive care; primary care to fulfill basic needs; and secondary and tertiary care, irrespective of ability to pay. Increasing accessibility was put forward as a way to reduce inequity. The necessity of recognizing slums, i.e., identifying and mapping the habitations of the urban poor, in order to improve the services available to them was emphasized.

The following challenges experienced in improving access to healthcare services were listed:

(i) lack of space to establish services within slums
(ii) lack of knowledge of services available
(iii) poor quality of services in slums
(iv) reliance of the urban poor on information from community members, who may not be well-informed
(v) compulsion among the urban poor to use nearby healthcare providers of questionable credentials because of lack of access to more distant but better qualified providers.
Ways suggested to improve access were improving quality and responsiveness; providing holistic services; enhancing health literacy and health promotion; and regulating the quality of services in the public sectors and cost of services in the private sector.

**Underutilization of services:**

The following factors related to underutilization of services were recorded:

(i) (limited) availability
(ii) (inconvenient) timing of services
(iii) high cost
(iv) the service mix in primary care
(v) fragmented organization of services – public and private
(vi) heterogenous private sector
(vii) non-availability of drugs, leading to high out-of-pocket expenditure
(viii) (intimidating) attitude of service providers.

The recommendations made to enhance the utilization of services were:

(i) bridging supply and demand
(ii) setting up a formal structure of healthcare services in urban areas, in line with the system in rural areas
(iii) formulating integrated strategies, which are multi-sectoral, link private and public actors, and specify a clear role and funding mechanism for NGOs and CBOs.

**Role of community-based health workers**

The roles and functions of a community-based wealth worker (CBHW) were conceptualized as follows:

(i) representative of the community
(ii) guides people through the healthcare system
(iii) creates awareness and provides information regarding improving living conditions and the rights of community members
(iv) currently focuses on disease and not on health; should focus on quality of life and health literacy
(v) should engage in pro-active inquiry regarding the health of community members.

In summary, the concrete strategies presented by the group were:

(i) identification of social and health problems

(ii) improvement of data-collection (and management) about the urban poor, listed and unlisted

(iii) multisectoral networking, including formulation of an integrated strategy for the structure and function of healthcare services in urban areas

(iv) health communication to enhance health literacy and improve healthcare utilization, via the work of CBHWs, and the use of technology and media

(v) regular monitoring and evaluation of equity.
Conclusions and recommendations

The conclusions from the consultation, including the presentations, panels, group deliberations and plenary discussions on urbanization, social determinants of health, basic health services, health inequities, and institutional and multisectoral partnerships, were as follows:

- The Strategic Framework to improve health of the urban poor was unanimously accepted.
- Urbanization is an inevitable process. About 600 million people in South-East Asia live in urban areas.
- About 25% of the urban population is poor and this proportion is likely to increase if concerted actions are not taken urgently.
- The urban poor make a significant contribution to the economy of Member States.
- Health of the urban poor is recognized as a major public health issue in South-East Asia.
- About 50%-60% of the increase in the urban population is due to natural population growth. The remaining is due to migration (both internal and external) and reclassification of newer areas as urban.
• The social determinants of health are the root cause for inequities in health. Hence, focusing efforts on the health sector alone will not yield significant improvement in health equities.

• There is limited availability of disaggregated information related to urban health in general and the urban poor in particular. There is a need to take steps to include health information in HMIS from the private sector. Attention needs to be accorded to improve quality and standardization of data.

• It is acknowledged that governments have accorded priority to setting up a structured health care delivery system based on PHC in rural areas. There is an urgent need to establish/strengthen a similar structure in urban areas.

• The NGO sector plays a significant role in health care delivery in urban areas in several countries of the Region. In addition, the Region has many successful experiences with PPP for improving access to health care services for the urban poor.

• Evidence suggests that in addition to the high burden of communicable disease and issues related to maternal and child health the urban poor bear a high burden of noncommunicable diseases, mental health problems as well as accidents and injuries.

• The private sector (formal and informal) plays a significant role in providing health care to the urban poor. There is evidence from some countries that the urban poor prefer private care due to social factors, geographic access and issues related to quality of care.

• Urban areas are heterogeneous. The urban poor are marginalized with little political clout. Local specific strategies depending upon the social ecology and epidemiology are needed to address urban health issues, including health of the urban poor.

• Data suggests that while the upper quintiles of the urban population in some countries will achieve the health MDGs the poorer segments may not. In addition to pointing towards health inequities this indicates the need for targeted approaches for the urban poor for accelerating overall progress to achieve the health MDG goals.

• There was agreement that national health policies, strategies and plans should include specific attention to urban health with the focus on the urban poor.
It was agreed that the PHC approach can be adapted to meet the health needs of people in urban settings.

Recommendations for Member States

- Strengthen national and sub-national health policies to give further attention to urban health and develop strategies for the urban poor based on local specific social ecology and epidemiology.
- To address social determinants of health that affect health of the urban poor ensure mechanisms and processes to ensure that all public policies include attention to health issues (healthy public policy).
- Establish and strengthen mechanisms for ensuring health impact assessment of urban development projects.
- Strengthen HMIS to include disaggregated information about the urban poor. Professional organizations of health care delivery personnel may be approached to ensure adequate private sector contributions to the HMIS. Examine strengthening the regulatory framework for private sector contributions to HMIS.
- Strengthen community empowerment and education for health for the urban poor to ensure greater participation by them in self-care, policy formulation, programme implementation and monitoring of health programmes.
- Increase capacity of planners and implementers of municipalities and local bodies in stewardship, designing, implementing and monitoring integrated multi-sectoral initiatives for the urban poor.
- Implement operational research projects to improve the efficacy and effectiveness of interventions for the urban poor.

Recommendations for WHO-SEARO

- Provide technical support to Member States in policy formulation for urban health and in their efforts for developing and strengthening urban health programmes. This may include training on Urban HEART.
- Facilitate exchange of information, disseminate global experiences and best-practices for improving health of the urban poor.
- Support Member States in operational research for urban health
- Collaborate with development partners to further strengthen advocacy for PHC-based health systems strengthening.
Almost two years ago we met in Jakarta to lay down a roadmap for revitalizing PHC in the WHO South-East Asia Region. And at that meeting, we resolved to redouble our efforts to strengthen health systems based on the primary healthcare approach. We are here now to examine how far we have gone towards the revitalization of PHC. Certainly, however, a lot more remains to be done to ensure a robust PHC approach in supporting the functioning of health systems. We will be able to achieve the health-related MDGs only when we have health systems that are functioning efficiently and effectively. Only five years are left before the target date for the world to achieve MDGs. Therefore, we need to exert all our efforts to further explore innovative avenues to accelerate progress towards health systems based on primary health care.

There is evidence that countries have gained considerable experience in their efforts to reduce health inequities; and in their endeavours towards universal healthcare coverage.

On the basis of the principles of PHC, different intervention models have been developed to address prevailing health problems. Consequently, substantial improvements in people’s health have been made possible. Life expectancy has increased further. Infant and child mortality has been significantly reduced. Countries in the SEA Region have recorded substantial success in improving access to safe water and sanitation. The coverage of immunization and antenatal care services have increased. Significant progress has been made in controlling and eliminating communicable diseases such as guineaworm, leprosy and tuberculosis. The incidence of vaccinepreventable diseases such as diphtheria, pertussis and measles has significantly declined. Neonatal tetanus has been eliminated from a large part of the Region and we are very close to eradication of poliomyelitis. These are significant contributions of the PHC approach.
The WHO South-East Asia Region is undergoing demographical and epidemiological transitions. We are facing challenges of a double burden of diseases (communicable and noncommunicable). We are also facing threats from:

- epidemics of new and emerging pathogens;
- the ageing population;
- lifestyle changes;
- rapid urbanization; and
- impact of climate change, etc.

The list is very long indeed.

These and other challenges mandate a fresh examination by countries of strategic options in their health development efforts. We have to believe that revitalization of PHC with innovative actions to address these issues is a vehicle through which health systems can be effectively strengthened to meet the old, new and emerging health challenges in an equitable, efficient and effective manner.

There is widespread consensus on the validity of the overarching principles of PHC, which particularly encompass:

- Equity
- Universal coverage
- Social justice.

The PHC principles need to be applied through multidisciplinary/multisectoral actions. The application of the PHC principles must be done with the full participation and involvement of people in the community. What is needed is a fresh look as to how health problems and issues can be practically addressed through the PHC approach. In the process we need to keep in mind that health outcomes are influenced by a complex interplay among sociocultural, economic, political and environmental factors.

“Health for All” is predicated by actions of multiple players and multiple stakeholders. We all know very well that to address the current health issues effectively, we need to go far beyond the confines of the health sector. Coordinated multisectoral and multidisciplinary actions are imperative. With these requisites as the background, revitalization of PHC should, therefore, adopt a developmental approach. This approach must incorporate innovative new ideas from evaluation.
and research. Primary health care must not only focus its activities on the delivery of health services but also has to be research-oriented and research-based.

The international community is committed to achieving the Millennium Development Goals by 2015. We, in South-East Asia, have to think of strategies that can help us reach the goals within the remaining five years. I believe that our Region has sufficient resources to pursue these goals; especially MDGs 4, 5 and 6. These goals relate to:

- reducing child mortality;
- improving maternal health; and
- combating HIV/AIDS, malaria, tuberculosis and other diseases.

What is needed is a strategy to harness the available resources in the most cost-efficient and cost-effective manner. There are several examples from within the Region and elsewhere to demonstrate that adoption of innovative PHC interventions can help accelerate the pace of progress towards MDGs.

This consultation will provide a platform for exchange of such experiences from some countries and will also provide an opportunity to explore how best we can optimize the use of our available resources for the purpose.

On the other hand, some contemporary issues are affecting the functioning of health systems. Among others, health services today have become overwhelmingly commercialized with the increased involvement of the market mechanism. Out-of-pocket expenditure for health care in the Region has skyrocketed. Catastrophic expenditure on health is recognized as a major cause for people to become impoverished.

This phenomenon can be effectively countered through the development of health systems based on the PHC approach whereby equitable access to healthcare services is promoted within the spirit of equity and social justice. Such healthcare places primary emphasis on promoting healthy growth and development, maintaining healthy status and preventing ill health. During the past two years, WHO in the South-East Asia Region has actively collaborated with countries in their initiatives to revitalize PHC. These include, among others:

- The Strategic Roadmap (SRM) in Thailand.
- Development of community health clinics in Bangladesh.
- ASHA (Accredited Social Health Activists) scheme in India.
- Integrated Development of Community Health Services (SISCA) in Timor-Leste.

A number of regional consultations and meetings were organized to offer suitable platforms for Member States to deliberate upon different aspects of the PHC approach such as:

- Self-care in the context of PHC;
- Use of herbal medicines in PHC;
- Application of sociocultural approaches within the context of PHC to accelerate achievement of MDGs 4 and 5;
- Health Care Reform for the 21st Century with emphasis on strengthening health systems based on PHC;
- Decentralization of health care services delivery to ensure health equity and universal coverage; and
- Most recently, the development of national health policies and strategies in support of strengthening of health systems based on PHC.

Several important recommendations emerged from these meetings. WHO will continue to work with Member States to ensure the implementation of these recommendations. Later this year, WHO plans to organize at least two more important regional meetings on related topics. These are:

- Regional Meeting on PHC Approach in Emergencies; and
- Regional Consultation on Health of the Urban Poor, with particular attention to the application of PHC principles in urban settings.

These regional events will provide further guidance on the use of the PHC approach.

WHO will continue promoting the exchange of experiences that contribute towards the PHC revitalization process. The South-East Asia PHC Innovations Network has been established with the initiative of the Foundation for Quality of Life. The first meeting of the network will be held immediately after this consultation.

We need to focus our attention, especially on the “thrust areas” that will effectively contribute to revitalize PHC in our countries. It is imperative that people in the community must be educated and empowered to enable them to take informed health decisions. Towards this end, and among others, equipping the community
for “self-care” assumes great importance. In this connection, we need to redouble our efforts to strengthen the community-based health workforce.

We need to equip community health workers adequately to ensure that they are able to face today’s community health challenges in the most efficient and effective manner. We also need to ensure that these workers are capable to perform as change agents in the community through educating and empowering the people.

Furthermore, innovative approaches to “healthcare financing” need to be explored to ensure that people will not fall into the poverty trap due to the high cost of health care. We need to advocate for the correction of the “imbalance” in health resource allocation at the national level to ensure a fair share of national health resources for promotive and preventive care.

We not only have to ensure that national health policies adequately reflect PHC principles but also that health matters are adequately taken care of in other sectoral development policies. There is a reason why PHC has not succeeded to its full potential. It is due to the relatively weak “referral support” from the “higher levels of care”. Innovative approaches to strengthening referral systems need special attention.

In this connection, the role of a vibrant private sector, which is growing rapidly in our Region, needs urgent attention.

I am sure our deliberations over the next three days will provide further and tangible guidance on the various issues involved. The recommendations from the consultation will provide a blueprint for accelerating action towards the strengthening of health systems based on PHC. WHO will make every effort to collaborate with all Member States in developing innovations to their PHC.
1. Introduction

The urban areas in the developing countries are witnessing explosive growth. Around 3 million people are added to the urban population of the developing countries every week. By the year 2030, 60% of the world population will live in towns or cities. Most of this growth will take place in Asia and Africa (1).

Presently, around one-third of urban dwellers, or nearly one billion people, live in urban slums. This number is likely to swell to 1.4 billion by 2020. This mandates a proactive attention to infrastructure development, pro-poor housing, land tenure policies and social sector infrastructure including that for health services (2).

This fast pace of urbanization has posed adverse effects on health of urban population, especially the poor. It causes tremendous pressure on all public services including health care services, transport systems, water supply, sanitation and electricity. Consequently, basic human needs such as clean air, water, food and housing are becoming difficult to meet. Inadequate water supply and sanitation is a fertile ground for disease-transmission. Un-segregated domestic, marketplace and industrial solid waste and untreated sewage pose grave risks to urban health. Insect and rodent pests abound, enhancing the incidence of vector-borne diseases, and respiratory and skin infections. The problem is compounded by the deficiency of the urban built environment, particularly in plumbing and paving.

Adverse weather events such as unseasonal or heavy rains lead to urban flooding and water-logging, disrupting daily life in cities and raising the risks of diseases as leptospirosis, dengue, diarrhoea, and dysentery. Climate change is reinforcing these challenges undermining rural development and spurring rural-urban migration (3, 4).
The rapid pace of urban life leads to neglect of nutrition; sedentary jobs invite lethargy and provide little physical stimulation; crowded living conditions, as well as social tensions and stress; and heavy road traffic, a part and parcel of the city’s bustling life, put them at risk of communicable, non communicable and chronic diseases, accident and injuries, especially, among the urban poor.

The consequences of poverty and ill health, including mental health, are significant in a city setting. They are detrimental to all city dwellers. Urban poverty and squalor are strongly linked to social unrest, mental disorders, crime, violence, and outbreaks of disease associated with crowding and filth. These threats can easily spread beyond a single neighborhood or district to endanger all citizens.

Recognizing that the rapid growth of urbanization and urban slums has posed new health challenges that go far beyond the health sector and require action at all levels, World Health Organization, on the World Health Day 2010, has called for collaboration and cooperation from all sectors concerned to address such challenges. Later this year, WHO and UN-HABITAT will launch a report on urban health inequities and how to address them. This report is aimed at unmasking and overcoming health inequities in urban settings. In addition, a global forum on urbanization and health will be held in Kobe, Japan in November 2010 to bring together municipal authorities and decision makers across multiple sectors to promote inter-sectoral action to reduce urban health inequities.

2. Urbanization and health of the urban poor in South-East Asia Region

South-East Asia is home to more than 1.6 billion people, 32% of which or 600 million people live in urban areas. Of this number, 25% are poor. Poverty is conventionally defined in terms of incomes that are inadequate to permit the purchase of necessities, including food and safe water in sufficient quantity. India, alone, is home to 80 million urbanites living below the poverty line, while 27 million people and 11 million people in Indonesia and Bangladesh, respectively, are urban poor (4,5). Despite a plethora of information on urban and mega cities in the region, specific information on urban poor is quite limited. Only a few countries have data on aspects such as health, social, cultural, and economic conditions of the urban poor. However, it has been well documented that the poor, including those living in the urban, are socially, economically, physically, politically, environmentally, and psychologically disadvantaged.
2.1 Maternal and child Health and nutrition

In India and Bangladesh children born to the urban poor have higher neonatal, infant, and under-five mortality rates than those born to urban non poor (6). Sepsis, peri-natal asphyxia and prematurity are some of the principal causes of neonatal deaths among slum dwellers (7,8,9). 16.7% of children living in households without improved water and sanitation in India and 17% of children living in slums in Nepal suffered from diarrheal diseases (8).

Studies reveal that urban poor women tend to marry at younger ages; use contraception less, receive less antenatal care, and have poor access to skilled care at delivery. Teenage pregnancy rates among urban poor in India and Bangladesh are 25.9% and 21.0%, respectively, as compared to 8.3% and 11.0%, respectively, of urban non poor. The total fertility rates among the urban poor in India and Bangladesh are high, 2.8 and 2.46, respectively, as compared to the urban non poor populations, 1.84 and 1.85, respectively (10,11).

Nutritional status of children in slums of India is poor; stunting and wasting is higher among children belonging to households with no safe drinking water supply and without any improved sanitation facility (12,13). Around 17% of children in slums of Bangladesh are wasted; and 46% are underweight, against 28% in non-slums areas. 25% of pre-school children living in the slums of Bangkok were underweight for their age (14).

A higher proportion of urban poor women is thinner and suffers from anemia as compared to other women. Urban poor populations often rely on street food, fast food, processed and cheap food leading to nutritional problems such as vitamin/mineral deficiencies, obesity, diabetes, cardiovascular problems, and dental problems. It has been found that slum dwellers consume less diverse (15) and energy dense and highly processed foods, which lead to a rapid rise in the prevalence of non communicable diseases (NCDs) (16).

2.2 Communicable diseases

Vector borne diseases such as malaria and dengue hemorrhagic fever were twice as high in slum areas than general population (10). Poor access to safe drinking water and insanitary conditions coupled with consumption of unhygienic street food, fast food, processed and cheap food contributes to spread cholera, typhoid, and diarrheal diseases.
Financial instability/insecurity, low autonomy, and social vulnerability among the urban poor raise their risks of contracting and spreading STD and HIV/AIDS which have already highly prevalent in the region. TB is also still prevalent in the region. The disease is closely related to poverty and living conditions of the poor raise their risk of TB infection. Five of the member countries are classified as high burden countries, with India bearing 20 per cent of the global burden of TB (17). The disease continues to be a major health threat in the region, with new challenges in the way of drug-resistant forms such as multi-drug resistant TB (MDR-TB) and extensive drug resistant TB (XDR-TB).

2.3 Noncommunicable diseases and injuries

Slum dwellers suffer from a heavy burden of lifestyle associated diseases. Low income among slums dwellers can lead to high proportion of tobacco and alcohol consumption leading to high expenditure on these products, violence and diseases. In the Urban Health Survey of Bangladesh, it was found that 60% of men were involved in smoking cigarettes or bidis or both. The use of alcohol or drug was same in slums and non-slum areas (11). In the Demographic Health Survey of Indonesia, tobacco smoking was high among men from lowest wealth quintile as compared to men from highest wealth quintile (18).

Alcohol consumption not only affects individual health but also affects health of other individuals and children in the family due to second hand smoking. Slums have become loci of socio-economic deprivation and increasing social ills. Communities with high rates of violence and crime generally have high rates of consumption of tobacco, alcohol and substance abuse. Alcohol addiction among slum dwellers can lead to crime, domestic violence, loss of earning and further impoverishment. Both alcohol and drug use are co-related to the increased violent crimes. A study in India found that 20 percent of slum dwellers are alcohol drinkers (5,19).

Prevalence of coronary heart disease has increased in urban areas in India, from 2.0% in 1960 to 11.0% in 2000. The increase was also found in other countries like Myanmar and Thailand. It is also evident that the urban poor have significant increased risks to chronic and metabolic diseases such as coronary heart diseases, hypertension, and diabetes mellitus. These risks include obesity, high LDL cholesterol, and lack of exercise (20,21,22,23). There is evidence in SEAR countries that slum dwellers have higher prevalence of psychiatric, behavioral anxiety, conduct, and oppositional defiant disorders than those residing in more affluent areas (24,25,26,27,28).
Domestic violence, injuries and accidents, especially among children, are found to be higher among the urban poor (29,30). Urban poor also experience injuries from hazardous road structure and traffic accidents (13).

3. Availability and accessibility of urban poor to health care services

In most countries of the Region a well-structured rural health care infrastructure has been developed. In contrast, the public health system in urban areas has many gaps and weaknesses. Most cities in the region have a thriving health private health sector. The urban poor encounter difficulties in access to quality health care services due to economic, social, psychological, and geographic factors.

3.1 Availability of health care services

The urban poor face lack of access to health care services in spite of reasonable or good availability of health care facilities in towns and cities. Economic, social and geographic factors adversely impact the access of the urban poor to these facilities.

Public health facilities are generally available in the center of the city, hence the poor living at the peripheral parts find it time consuming to travel to these public health facilities for services. They might find it extremely difficult to take out time or take a day off from their daily work when it is linked to the daily food and existence. Lack of public health services is further reinforced by lack of cheap public transport and unfavorable timings.

According to the National Family Health Survey in India in 2005-2006, health care service utilization among women living in urban slums was low due to lack of adequate public health facilities in the areas. The majority of them resorted to private health care services. In Vellore, India, only one-third of these women went to government facilities, more than half of which went to secondary and tertiary hospitals, the rest of them went to private providers (13). Not surprisingly, SEAR has the highest rate out-of-pocket expenditure for health in the world.

3.2 Quality of health care services

One of the reasons cited for non-utilization of public health facilities is the poor quality of services. In Rajkot, India, one of the reasons women living in slum areas attributed to their not using family planning services was poor quality of services.
In Bangladesh, urban poor women mostly visit a low level qualified health care providers like community worker for their ante natal care (11,13).

### 3.3 Health care service utilization

It is evident that health service utilization among the urban poor is low compared to the non poor. It has been observed that immunization coverage is low in the slum population of India and Bangladesh (6, 31).

National Family Health Survey of India showed that women living in urban slums are less likely to have all the antenatal care visits and to use contraceptive services. In Bangladesh, about 62% of urban poor women get antenatal services as compared to 85% among urban women. It was also observed that fewer proportions of deliveries in slum population are attended by skilled birth attendant, 50.7% vs. 84.2% in India and 18.0% vs. 56.0% in Bangladesh, and slum women are proportionately delivering more at home. Similar evidence was found in Bangkok, Thailand where 18.0% of deliveries among the urban poor were attended by skilled health personnel as compared to 56.0% among non urban poor.

### 4. Programmes improving lives of urban poor in WHO/SEAR

Based on the concept of Healthy City, countries such as Bangladesh, India, Indonesia, Sri Lanka, and Thailand have developed programmes to improve health and living conditions of the urban poor in their country. These include, for example, Healthy Bengaluru Urbanization Project and Slum-Free India in India, Urban Primary Health Care Project in Bangladesh and Urban Heart in Indonesia and Sri Lanka, and Baan Mekong in Thailand, just to mention a few.

### 5. Challenges in improving health of the urban poor

There are a multitude of factors that affect the health of the urban poor. These include among others, socio-cultural determinants, availability of social sector services including health services, environmental factors, availability and access to information and so on. Figure 1 attempts to depict the interplay between different factors that can contribute to equity in health and health outcomes in the urban populace.
5.1 Socio-cultural issues

Cultural and traditional beliefs play an important role in health and healthcare practices of individuals. These beliefs influence health behaviors of slum dwellers as well as treatment seeking attitude for their illnesses (18). Slum populations are generally low in education, health literacy, and economic status; and have less family or social supports (32). They lack awareness on health and concern more on economic well-being rather than health. Due to this they are less likely to adopt healthy behaviors and practices for health promotion and disease prevention. Women living in slums often work and are less likely to seek healthcare services and to pay proper attention towards health and environmental sanitation.

5.2 Accessibility to basic infrastructures and services

The urban poor are in a distinctly inferior position compared with urban non-poor residents in accessing piped water, flush toilets and electricity (33). In India, only 18.5% and 47.2% of urban poor households accessed to piped water at home and used a sanitary facility for disposal of excreta, respectively, as compared to 62.2%
and 95.5%, respectively, among urban non-poor households (10). Only 2.8% of the population of Jakarta is connected to municipally operated sewers (18).

More than 2 million Mumbai residents have no sanitary facilities, and most sewerage collected is discharged untreated or partially treated into creeks or coastal waters.

Solid waste disposal services are also unsatisfactory in poor urban settings since most slums do not benefit from municipal services. As a result, residents live among mountains of garbage and the associated vermin. Trash burning causes air pollution, and in some communities, scavenged hospital or medical waste poses a particularly dangerous health hazard. Garbage, however, can be a source of income and many urban poor are rag pickers or informal garbage collectors and recyclers. This exposes them further to risk of infectious disease.

High densities of population, industrial, commercial and residential structures, and traffic in urban areas, and the often lenient standards of emission regulations in developing countries, in combination with low awareness of harms from environmental pollutants and constrained access to health services put the urban poor at the double disadvantage of high exposure and sensitivity, and low ability to cope with challenges.

5.3 National health policy

The special needs of the urban poor remain unrecognized in the national health policies and strategies. The major challenge in health programmes for urban poor is to get recognized by the governing bodies and voice their needs.

Urban poor are hardly consulted by the authorities regarding the kind of problems faced by them and the kind of services they need to improve their health and daily living. There is no representation in the planning process of the city to voice the needs of the urban poor. The Healthy Settings concept that calls for a multidimensional and multisectoral approach to health needs to be reflected in national health policies. This will address health issues of the entire urban population including the health of the urban poor.

Another policy dimension that needs consideration is the allocation of resources for primary care as compared to provision for secondary and tertiary care. In most countries the health budgets are skewed towards secondary and tertiary health care services.
The need of the hour is to promote Healthy Public Policies which implies that health issues need to be reflected and addressed in the policies and strategies of every sector including education, urban development, agriculture, industry, and so on.

5.4 Community education and empowerment for health

The sense of community, typically strong in rural neighborhoods and to some extent in economically stable urban ones, is vulnerable to the increased mobility and transitory nature of urban poor habitations. Although access to formal aid networks in urban areas may be better owing to physical proximity, informal social aid networks may be weaker. Social support systems in big cities are becoming weak and are leading to social alienation and crime, and to health risk behaviors such as sexual misconduct, alcohol and drug addiction.

Transient migratory slum population generally lives at construction sites, pavements or near industries. This population might move continuously from place to place within the city as they shift from one construction site to another. Organizing and supplying health service and health information for such population is difficult.

Due to their low level of health literacy and autonomy, socially, economically and politically, they are less likely to take part in health and health care services. In the absence of traditional support systems, concerted efforts are needed to educate and empower the urban poor to enable them to take informed decisions and actions for promoting and preserving their health. A special emphasis on promoting Self Care is needed.

5.5 Information about the urban poor

To make the improvement of health of the urban poor effective and sustainable, good policies and plans must be in place. This requires current and correct information on the situations related to health of the urban poor. Currently, information on health outcomes of the urban poor in the SEAR countries is limited, if not at all exist. Few countries have current information on health and health related issues of the urban poor. These include the National Family Health Survey of India and Urban Health Survey of Bangladesh which provide comprehensive information regarding health outcomes of the slums dwellers. But there is lack of such information from other SEAR countries.
6. Strategic framework to improve health of the urban poor

Taking into account the current situation, factors and determinants of health of the urban poor, the following model has been proposed as a regional strategic framework to improve health and health services of the urban poor.

Figure 2: Strategic Framework to improve health of the urban poor

To address the health issues related to the urban poor, the following strategies are proposed:

6.1 Healthy Public Policy: towards inter-sectoral cooperation and collaboration

It must be stated upfront that addressing the health of the urban poor is the responsibility of multiple sectors. Unless the social, economic, environmental are addressed in a holistic and coordinated manner meaningful progress may not be possible in improving the health status of the urban poor.

The cooperation and collaboration among all sectors concerned, both government and non-government, should be developed to reduce poverty, provide good housing, safe drinking water, sanitation facilities and safe working places to the urban poor. These sectors include, for example, education, finance, urban
planning, social and welfare, employment, women and children welfare, public work services, NGOs, and other related private organizations.

It is important to assimilate health information into the formal educational curriculum at all levels, and to have a strong policy support for the creation of supportive environments to enable improved health choices, e.g., safe and regular physical activity; freedom from injury; safe and healthy food procurement and preparation. This will have a major impact on the health and well-being of the urban poor. Providing these services will be a cost-effective preventive measure for the urban poor.

Healthy urban planning should be used to plan, design and re-design cities built environment to improve social and physical determinants of health. Health sector should take a leader role for inter-sectoral collaboration to ensure that all related sectors include health issues in their policy and plans, and that health impact assessment should be carried out before launching any development projects that can potentially pose health threat.

To ensure health and social equity in the urban areas Governments need to develop and strengthen Healthy Public Policy. This implies that structures and mechanisms need to be put in place that ensure that health and health related issues are appropriately addressed in policies and strategies of all sectors. Depending upon the country context a review of national, sub-national and local policies/strategies is necessary to make these compliant with the Healthy Public Policy concept.

6.2 Community education and empowerment

The urban poor should be adequately educated and empowered to actively practice self care and take part in health care services. Awareness is an important determinant of health behaviors and actions to avoid health risks, injury and death. Evidence shows that the urban poor lack awareness on health and, as a result improperly take care of themselves and their environment. This is due to inadequate health literacy. This can be effectively addressed through appropriate health education and empowerment interventions including promoting strong community organizations and networks.

Community health workers and volunteers can play an important role in health education and empowerment of the urban poor. Strong community organizations and social network must be established through the supports of NGOs and related government organizations.
6.3 **Improve availability of and accessibility to healthcare services to the urban poor**

A comprehensive, need-based and people-centered urban healthcare service system should be promoted and strengthened. Community health workers and volunteers should play important roles in motivating and empowering the urban poor to adopt self care practices and actively take care of their environment. Preventive and promotive healthcare should be the foundation of urban health programmes.

Affordable good quality Primary Care is essential for the urban poor. In addition to strengthening public sector primary care health facilities the role of private providers, NGOs and CBOs is critical in providing healthcare services. Governments may like to explore appropriate public private partnership models for this.

To effectively facilitate the accessibility of the urban poor to public health care services, the quality of primary care and referral services from community to higher levels of health care services should be strengthened.

Alternative and innovative health financing, including social health insurance need to be explored to reduce out-of-pocket and catastrophic expenditures on health.

Operational research for developing effective health care service models at the community level is needed to find local specific solutions to ensure equitable access to health care services for the urban poor.

6.4 **National Health Policy and Plans: towards equitable health for the urban poor**

The urban poor are financially, socially, psychologically, and physically distant from public health care services. For these and other reasons many resort to private health care providers.

National health policies and plans need to make a special provision for interventions especially aimed at improving the health of the urban poor. It is especially important to ensure that the principles of Primary Health Care – universal access and health equity, community participation, intersectoral coordination and use of appropriate technology are enshrined in health interventions designed for the urban poor.
The policies and plans should focus on decentralization of health care services to local bodies; inclusive, good governance health programmes planning with the participation of urban poor and other sectors concerned.

The policies and plans should be based on evidence. This requires accurate and up-dated evidence and information. Accurate information is also needed for political advocacy and for effective policy and programme planning. The information collection and monitoring of urban development and urban health indicators such as health outcomes, health and health seeking behaviors among the urban poor should be strengthened.

6.5 Information system and research

Urban health information system should be developed and operated. Timely, accurately and comprehensively data collection and analysis will help to investigate urban health issues and inform policy makers and other organizations to develop relevant policies and programmes to deal with urban health issues.

Operational research is needed to find effective and efficient situation specific solutions. Appropriate research to answer questions like what roles community based health workers and volunteers can play, how best to build channels for multisectoral implementation of urban health programmes, exploring best models for public-private partnerships and so on needs to be conducted.

Studies on appropriate health care financing mechanism for the urban poor should be carried out and resources should be mobilized to ensure universal access to healthcare for the urban poor.

7. Conclusion

Urbanization in WHO/SEAR is increasing rapidly, so is the number of urban poor population. This trend will continue. This population is socially, economically, politically, environmentally, and psychologically disadvantaged. They live in poor housing condition and unsanitary environments; are low in health literacy to properly take care of themselves, low in power to negotiate for their rights and low in economic power to purchase the necessities and services. Low health literacy has affected their health behaviors, personal hygiene, and health care choices. Such conditions put them at higher risks of triple burden of diseases-communicable and non communicable diseases and accidents and injuries.
To improve health of the urban poor, a multi level or an ecological approach, which includes individual, community or societal, and policy levels needs to be applied. The urban poor must be empowered to increase their health literacy and actively participate in health development and services in their community through effective health education and community organization. Social network and social support must be strengthened.

Health should be an integral policy of all agencies concerned. Inter-sectoral cooperation and collaboration among Government, NGOs, local organizations, private sectors, and civil society must be in place to improve their quality of life through poverty reduction; improvement of housing conditions, safe water supply, environmental sanitation, road and transportation, food supplies, health education and health care services.

To make quality health care services available and accessible to the urban poor, the national health policy and plan must be informed by research on the urban poor. Their social, cultural, economical, and physical environments must be taken into account.

Referral systems for continuity of care, both to and from family, community, primary to tertiary care must be strengthened. Self care among the urban poor, including health promotion and disease prevention, must also be strengthened. Community-based health workers and volunteers must be good role models and change agents for good health behaviors for the community. Tasks and competencies of health workforce including community health workers and community health volunteers must be reviewed, revised, and re-oriented according to the needs of the community; and this requires good health information system and operational research.

References


(7) UN-HABITAT. State of World Cities 2010/11: Cities for All: Bridging the Urban Divide. UN-HABITAT, March 2010.


(20) Gupta, R. Recent trends in coronary heart disease epidemiology in India. Indian Heart J, 2008: 60, B4-18.
Regional Consultation on Health of the Urban Poor


## Annex 3
### Programme

<table>
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<tr>
<th>Day/Date/Time</th>
<th>Topic</th>
<th>Responsible person(s)</th>
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<tr>
<td><strong>DAY 1:</strong></td>
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<td><strong>09.00 - 10.00</strong></td>
<td><strong>Inaugural Session</strong></td>
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<td>• Ceremonial lighting of lamp</td>
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<td></td>
<td>• Welcome address by the Hon’ble Minister of Environment, Family Welfare, Protocol and Public Health, Government of Maharashtra</td>
<td>H.E. Mr S.H. Shetty</td>
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<td></td>
<td>• Message from the Regional Director, WHO-SEAR</td>
<td>Dr Poonam Khetrapal Singh</td>
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<tr>
<td></td>
<td>• Inaugural Address by the Hon’ble Minister of Health and Family Welfare, Government of India</td>
<td>H.E. Mr Ghulam Nabi Azad</td>
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<tr>
<td><strong>10.30 – 11.00</strong></td>
<td><strong>Group Photograph</strong></td>
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<td><strong>10.30 – 11.00</strong></td>
<td><strong>Business Session</strong></td>
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<td></td>
<td>• Objectives of the Consultation</td>
<td>Dr Poonam Khetrapal Singh (in Chair)</td>
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<td>• Introduction of Participants</td>
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<td>• Nomination of Chairperson, Co-Chairperson and Rapporteur</td>
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<td>• Announcements</td>
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<td><strong>11.00 – 12.30</strong></td>
<td><strong>Technical Session - I</strong></td>
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<tr>
<td><strong>11.00 -11.30</strong></td>
<td><strong>Global overview of urban health: challenges and promises</strong></td>
<td>Dr Jacob Kumaresan</td>
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<tr>
<td><strong>11.30 -12.00</strong></td>
<td><strong>Strategic Framework for addressing health of the urban poor</strong></td>
<td>Dr Poonam Khetrapal Singh</td>
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<tr>
<td><strong>12.00 - 12.30</strong></td>
<td><strong>Technical Session - II</strong></td>
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<tr>
<td><strong>12.00 - 12.30</strong></td>
<td><strong>Proposed National Urban Health Mission, India</strong></td>
<td>Mr Amit Mohan Prasad</td>
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<tr>
<td><strong>14.00 - 15.30</strong></td>
<td><strong>Technical Session – II (contd...)</strong></td>
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<tr>
<td><strong>14.00 - 14.30</strong></td>
<td><strong>Urban primary health care project, Bangladesh</strong></td>
<td>Dr Md. Abu Bakr Siddique</td>
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<tr>
<td><strong>14.30 - 15.00</strong></td>
<td><strong>Nepal urban health policy</strong></td>
<td>Dr Praveen Mishra</td>
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<tr>
<td><strong>15.00 - 15.30</strong></td>
<td><strong>Migrants and urban health in Thailand</strong></td>
<td>Dr Chanvit Tharathep</td>
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<td><strong>16.00 - 16.30</strong></td>
<td><strong>Technical Session – II (contd...)</strong></td>
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<tr>
<td><strong>16.00 - 16.30</strong></td>
<td><strong>Multisectoral approach to health of urban poor in Sri Lanka</strong></td>
<td>Dr Lalith Chandradasa</td>
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### DAY 2:
**Thursday, 14 October 2010**

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<tr>
<th>Time</th>
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<tr>
<td>08.30 - 08.45</td>
<td>Recap of Day 1</td>
<td>Dr Kumara Rai</td>
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<tr>
<td>08.45 - 10.45</td>
<td>Technical Session - III</td>
<td>Ms Rohini Rangarajan</td>
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<tr>
<td>08.45 - 09.15</td>
<td>Addressing health of the street children / waste handlers</td>
<td>Ms Taskeen Chowdhury</td>
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<tr>
<td>09.15 - 09.45</td>
<td>Addressing maternal and child health in urban poor – Manoshi-Urban MNCH Project</td>
<td>Dr M.H. Basyir Ahmad</td>
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<tr>
<td>09.45 - 10.15</td>
<td>City without slums</td>
<td>Dr Kameshwari Devi C</td>
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<td>10.15 - 10.45</td>
<td>Healthy Cities – the Bengaluru Project</td>
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<tr>
<td>11.15 – 12.15</td>
<td>Panel Discussion: <em>Intersectoral approach to addressing health of the urban poor</em> (India, Indonesia, Nepal and Thailand)</td>
<td>Moderator: Dr Mala Rao,</td>
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<td>12.15 - 12.30</td>
<td>Briefing for field visit</td>
<td>Mr Sunil Nandraj</td>
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**DAY 3:**
**Friday, 15 October 2010**

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<th>Time</th>
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<tr>
<td>08.30 - 09.00</td>
<td>Reflections from the Field Visit</td>
<td>Moderator: Dr Monir Islam</td>
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<td>09.00 - 10.00</td>
<td>Round Table with Partners: <em>Building partnerships for promoting health of the urban poor</em> (UNICEF, USAID, DFID, World Bank, Population Foundation of India)</td>
<td>Moderator: Dr Monir Islam, and Dr Jacob Kumaresan</td>
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<tr>
<td>10.00 - 13.00</td>
<td>Group Work</td>
<td>Dr Boosaba Sanguanprasit</td>
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<td>• Guidance for Group Work</td>
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<td>• Group 1: Intersectoral action to improve health of the urban poor</td>
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<td>• Group 2: Empowering urban poor for better health</td>
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<td>• Group 3: Addressing inequities in accessing health care</td>
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<td>14.00 - 15.30</td>
<td>Group Work Presentations</td>
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<td>16.00 – 17.00</td>
<td>Concluding Session</td>
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<td>• Conclusions and Recommendations</td>
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<td>- Recommendations for Member States</td>
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## Annex 4

### List of participants

<table>
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<tr>
<th>BANGLADESH</th>
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</table>
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<thead>
<tr>
<th>BHUTAN</th>
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</table>
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<table>
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<tr>
<th>INDIA</th>
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</table>
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One of the challenges of the 21st century is managing the accelerating pace of urbanization. Projections suggest that by the year 2030, six out of ten people all over the world will live in cities. By 2050 this proportion is likely to reach 70 per cent. Most of the growth in urban population will occur in Asia, Africa and Latin America. Currently, the urban population in South-East Asia is estimated to be about 600 million, of about 150 million are estimated to be poor. In the whole wake of the often unplanned and unregulated urbanization, the urban poor face physical, environmental, social and psychological problems. These impose a heavy burden of disease and inequity on the urban poor. There is an urgent need to identify biological, socio-cultural and financial determinants of health inequity in the urban poor in order to mount a multisectoral effort to address the health concerns of this burgeoning disadvantaged section of the population.

To deliberate on the various facets of the health of the urban poor including the health status and determinants of the health of the urban poor and to discuss a framework of strategic actions to improve health and health care services for this segment of society, the WHO Regional Office for South-East Asia organized a Regional Consultation on Health of the Urban Poor in Mumbai, India, in October 2010. In addition, policy makers, programme managers, experts and representatives of civil society and academia from the Member States of the WHO South-East Asia Region, participants from UNICEF, World Bank, USAID and Population Foundation of India attended the consultation. This publication is an account of the proceedings of the Regional Consultation.