Responding to the Health Vulnerabilities of the Urban Poor in the “New Urban Settings” of Asia

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Abstract
Rapid and unplanned urbanization in Asia has profound implications for population health. With globalization, failure of governance has resulted in inequities that translate into health impacts that are most severe for the urban poor. Urban poverty and the growth of slums, informal settlements and squatter areas pose obvious hazards and risks to health. Asia is one of the most rapidly urbanizing areas of the world with 60% of the global population or an estimated 550 million people who exist in deprived, unsafe and unhealthy living conditions. This paper reviews the literature on health in the urban settings of Asia and identifies examples of interventions and innovations that reverse unfair health opportunities. Multiple sources of information and a broad range of indicators (covering governance, health systems, environmental health, political development and community participation) are used to complement existing knowledge on health impacts. Key innovations are summarized under six themes: 1) the urban poor as key drivers and decision-makers in community upgrading; 2) local governments holding themselves accountable for healthy urban settings; 3) using infectious disease outbreaks as opportunities for strengthening public health infrastructure; 4) improving efficiency in health promotion financing in cities; 5) applying information technology to population health activities; and 6) optimizing social determinants of health in urban settings. Within an evolving notion of “healthy urban governance”, principles of good governance need to be continuously applied to the promotion and protection of health. There is no “one-size-fits-all” solution, and actors will need to continuously navigate a fast-changing environment in order to achieve results. Change is best facilitated through nodes of power and influence among the urban poor, local governments and the public health sector that are growing and establishing cross-linkages beyond geopolitical regions. National decision-makers can create more supportive and enabling environments for achieving fairer health opportunities for all by rendering visibility to the health vulnerabilities of the urban poor through the skillful framing of public policy issues.

Executive Summary
Asia is home to 60% of the world's population. In the next few decades, estimates are that more than 60% of the increase in the global urban population will also be in Asia. In a rapidly urbanizing environment, different groups of people may be exposed to a wide range of risks from communicable and noncommunicable disease as well as violence and injuries. Different groups exhibit varying degrees of vulnerability or exposure despite the fact that they “live in the same city”. These varying vulnerabilities are translated into unequal physical and mental health outcomes. The most extreme end of the health inequity gradient in cities includes people in low-income informal settlements (“slums”). Currently, it is estimated that 60% of the world’s informal settlers and slum dwellers are in Asian cities. In South Asia, slums and squatter settlements constitute 58% of the total urban population, compared to 36.4% in East Asia and

1 There is no universal agreement on the definition of what a “slum” is, but for purposes of this paper, the general definition used by UN-HABITAT is “a wide range of low-income settlements and/or poor human living conditions.” (UN-HABITAT, 2003). These deprived areas are further characterized by the following attributes: a) lack of basic services; b) substandard housing or illegal and inadequate building structures; c) overcrowding and high density; d) unhealthy living conditions and hazardous locations; e) insecure tenure, irregular or informal settlements; and f) poverty and social exclusion.
28% in Southeast Asia. In absolute figures this translates to more than 550 million people.

This paper reviews the literature on health in the urban settings of Asia and proposes a closer examination of how unfair health opportunities can be overcome by addressing social determinants of health and improving urban governance. Evidence of improved health outcomes (using health and/or disease indicators) is considered only one of several sources of information on the effectiveness of innovations. Using a social and development framework, we have considered a wide range of other health-related indicators, such as governance indicators (participation, political commitment, enforcement of laws, protection of human rights, decency and fairness), health systems indicators (efficiency, capacity and institution-building, sources and uses of funds for health), environmental health indicators (better quality of housing, cleaner indoor air, less pollution) and political and community indicators (public perception, community participation, social cohesion, support for policy, adherence to public health policies, e.g., quarantine measures) as equally valid evidence of the impact of innovations in urban health.

We therefore propose that a platform for the evolving notion of “healthy urban governance” seeking to improve the social, political, physical and economic environment in cities is crucial to improving the health of the urban poor and may be considered as a strategic pathway for healthy urbanization.

The role of key players – the urban poor, local governments and urban health systems – are noted throughout the paper. Innovations in population health that impact the urban poor in Asia have been driven by agents and stakeholders who have been able to shape the new political space created by globalization, urbanization, decentralization, democratization and advances in information technology to create opportunities, build capabilities, achieve greater security, empower, engage and mobilize support for policy and action to improve the urban living environment for vulnerable populations.

The key innovations are summarized as follows:

1) **The urban poor as key drivers and decision-makers in community upgrading** (Examples: Society for the Promotion of Area Resources Centre (SPARC), India; Asian Coalition for Housing and Rights (ACHR); Shack/Slum Dwellers International and its members, the Women’s Development Bank Federation, Nepalese National Squatters Federation, Philippines Homeless People’s Federation, National Slum Dwellers Federation/Mahila Milan and Homeless International; Community Organization Development Institute (CODI), Thailand; Self-Employed Women’s Association (SEWA), India; Orangi Pilot Project, Pakistan).

2) **Local governments holding themselves accountable for healthy urban settings** (Examples: Alliance for Healthy Cities – “twinning” of Marikina City, Philippines and Ichikawa City, Japan; Asian Network of Major Cities; “Asian Infectious Disease Project” – New Delhi, Hanoi, Jakarta, Singapore, Taipei, Tokyo and Yangon; WHO Collaborating Centre on Healthy Cities and Urban Health, Tokyo Medical and Dental University, Japan; Community participation research project on communities living in boats, Hue City, Viet Nam and research on drug abuse.

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3 “Healthy urbanization”, as defined by the WHO Centre for Health Development, refers to the process of enabling cities to achieve health and equity through eight key principles, the “8Es”: environmental sustainability, empowerment of communities, engagement of all sectors, energy efficiency, elimination of extreme urban poverty, enforcement of security and safety, equity-based health systems and expression of cultural diversity.
Vientiane, Laos; WHO Centre for Health Development – action-research on healthy urbanization – Bangalore, India, Suzhou, China and Kobe, Japan; Healthy Cities, Kuching Malaysia; Mongolian Association of Urban Centres, Ulaanbaatar, Mongolia; Confederation of Indian Industry (CII) and the Indian Business Coalition on AIDS (IBCA); the Thailand Business Coalition, an alliance of more than 100 companies; Corporate Social Responsibility Asia Magazine, Asian Institute of Management).

3) Using infectious disease outbreaks as opportunities for strengthening public health infrastructure (Examples: Coordinated city and national action on SARS and avian flu in Hong Kong, Viet Nam, China and Singapore, resulting in improvements in surveillance, hospital infection control, public hygiene, quarantine and risk communication; healthy marketplace initiatives in Viet Nam; health promotion and public education on HIV/AIDS in train stations in Beijing; compassionate care for survivors of HIV/AIDS in Thailand).

4) Improving efficiency in health promotion financing in cities (Examples: Social insurance coverage for prevention and health promotion in Japan; tobacco and alcohol taxes used for health promotion by Thai Health; the Korean Health Promotion Fund).

5) Applying information technology to population health activities (Examples: Village phone systems in Bangladesh peri-urban areas; strategic communication and use of mass media entertainment to deliver family planning and reproductive health messages in urban and rural Indonesia, Bangladesh and the Philippines; use of geographic information systems for health planning, mapping and programme monitoring, Cebu, Philippines).

6) Optimizing social determinants of health in urban settings (Examples: Tobacco-free sports (World Cup Series, Olympics and Southeast Asian Games) in the host cities in Republic of Korea, Japan, China and Viet Nam; walking for health in Singapore; life skills and pre-employment training in Marikina City; fuel regulation policy on compressed natural gas in India).

Healthy urban governance, as an evolving approach to reducing the health vulnerabilities of the urban poor in Asia, is achievable. Principles of good governance need to be continuously applied to the promotion and protection of health. There is no “one-size-fits-all” solution, and actors will need to continuously navigate a fast-changing environment in order to achieve results. Nodes of power and influence among the urban poor, local governments and the public health sector are growing and cross-linkages between geopolitical regions are being discovered. In Asian cities, as in other cities around the world, there are countless examples of living networks of people, communities, organizations and institutions that have the knowledge, skills and resources for scaling up change. They could certainly benefit from a more supportive and enabling environment for achieving fairer health opportunities for all. Rendering visibility to the health vulnerabilities of the urban poor through the skilful framing of public policy issues seems to be an effective starting point.
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I. Introduction

Asia is home to 60% of the world’s population. In the next few decades, estimates are that more than 60% of the increase in the global urban population will be in Asia, mostly in China and India, but also in Pakistan, Bangladesh, the Philippines and Viet Nam. Three major sources contribute to urban growth in Asia: natural growth (the excess of births over deaths) and net in-migration (where population inflow exceeds outflow) as well as growth due to administrative changes or the redrawing of boundaries due to sprawl from urban centres. In each country, these sources of urban growth have different implications for urban administration and national policy.

Unlike other regions, usually the growth of Asian cities and municipalities has been accompanied by economic prosperity. There is no doubt that the Asian economic miracle was one of the most significant global developments of the twentieth century and has brought many positive benefits to the East Asian “tiger economies” as well as many other countries in South and Southeast Asia through higher incomes, better education, better health outcomes, declines in infant mortality rates and longer life expectancies. The drawing power of Asian cities for rural migrants seeking more economic opportunities is evident in that the per capita GDP of cities is often higher than the per capita national GDP. In the future, this will continue to drive the rural-to-urban population shift as well as the high level of migration between countries. These migrations are an important part of the economic transformation of countries, but they demand a sharper focus on population and development policies.

Where urbanization has been unplanned and has progressed at an unmanageable pace, existing public infrastructure, the urban environment and the traditional social fabric deteriorates and the growth and wealth of cities cease to translate into “an urban advantage”. In the developing countries of Asia, where national and municipal authorities have been unable to cope with the speed of change, the net effect is failure of governance, increased and unabated inequity and the urbanization of poverty. In developed

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6 Ooi Giok Ling and Kai Hong Phua. 2006. Urbanization and Slum Formation. Thematic paper for the Knowledge Network on Urban Settings, WHO Centre for Health Development.
4 Cities and municipalities are used interchangeably in the paper to refer to local government jurisdictions in the urban setting. There are no universally accepted definition of what constitutes a city or an urban area. A city implies a sizeable conglomeration and concentration of dwellings, businesses and their workplaces and infrastructure; it usually implies some administrative status, for instance as a district or provincial capital. Of course, it implies urban status, but in most nations, the definition of “urban areas” means that there are many urban centres too small to be considered cities. Many national definitions of “urban” consider all settlements with 1,000, 1,500 or 2,500 or more inhabitants as urban. A large proportion of the world’s “urban” population lives in urban centres that lack the size or economic or political importance to be considered cities. For instance, many nations have more than a fifth of their population living in urban centres with fewer than a fifth of their population living in urban centres, with fewer than 50,000 inhabitants (Satterthwaite 2006).
countries, inequities exist along other determinants such as ethnicity, gender and age.

In a rapidly urbanizing environment, different groups of people may be exposed to a wide range of risks and exhibit varying and extreme degrees of vulnerability or exposure despite that fact that they “live in the same city”. These different vulnerabilities are translated in unequal health risks and outcomes and may not be easily gleaned from routine health statistics. In order to unmask these differences and develop relevant interventions to reduce health inequity, risks and vulnerabilities, as well as to address underlying drivers of these conditions, new ways of looking at and evaluating health vulnerability and creating fairer opportunities for health must be established.

The most extreme end of the health inequity gradient in cities includes the people in low-income and informal settlements (“slums”\(^\text{13}\)).\(^\text{14}\) To date, it is estimated that 60% of the world’s informal settlers and slum dwellers are in Asian cities. In South Asia, slums and squatter settlements constitute 58% of the total urban population, compared to 36.4% in East Asia and 28% in Southeast Asia. In absolute figures this translates to more than 550 million people.\(^\text{15}\)

It has been pointed out by Wratten, Rakodi, Satterthwaite, Sen, Kawachi and Wamala and the Knowledge Network on Urban Settings of the WHO Commission on Social Determinants of Health\(^\text{16}\) that poverty is not only a question of financial or material resources, but needs to be considered in other dimensions with strong links to social conditions. In turn, these social conditions determine health risks and outcomes:

- lack of opportunities (for employment and access to productive resources);
- lack of capabilities (access to education, health and other public services);
- lack of security (vulnerability to economic risks and violence);
- lack of empowerment (absence of voice, power and participation); and the
- lack of 2a health-supporting physical living environment (poor housing, unsafe working conditions, unnecessary exposure to biological, chemical and physical threats to health).

This applies to both the rural and urban settings, but may tend to be severe in the urban living environment.\(^\text{17}\)

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\(^\text{13}\) There is no universal agreement on the definition of what a “slum” is, but for purposes of this paper, the general definition used by UN-HABITAT denotes “a wide range of low-income settlements and/or poor human living conditions” (UN-HABITAT, 2003). These deprived areas are further characterized by the following attributes: a) lack of basic services; b) substandard housing or illegal and inadequate building structures; c) overcrowding and high density; d) unhealthy living conditions and hazardous locations; e) insecure tenure, irregular or informal settlements; and f) poverty and social exclusion.

\(^\text{14}\) WHO Centre for Health Development 2005, “A Billion Voices: Responding to the Health Needs of Slum Dwellers and Informal Settlers in the Urban Setting” Strategic and analytic paper for the Knowledge Network on Urban Settings, WHO Commission on Social Determinants of Health.

\(^\text{15}\) Ooi Giok Ling and Kai Hong Phua. 2006. Urbanization and Slum Formation. Thematic paper for the Knowledge Network on Urban Settings, WHO Centre for Health Development


\(^\text{22}\) WHO Centre for Health Development. 2007. Report of the Knowledge Network on Urban Settings
The urban poor who live in deprived urban settings, informal settlements and slums constitute the single largest group of vulnerable populations in today’s Asian cities. Sub-groups within this population include women, children, the disabled, minority groups of different ethnic origins or countries, street children, commercial sex workers, survivors of HIV/AIDS, “dalits”, indigenous peoples, sexual minorities, transient workers and hawkers among others.

A key constraint to responding to the needs of these vulnerable populations is systematic social and political exclusion that renders them “invisible” and powerless.

The knowledge and means to achieve fairer health opportunities for these vulnerable groups are available. Overcoming the social and political barriers to fairer health opportunity is the more formidable challenge. The vulnerability of these groups is related to place, people and time (or life course) events. In this context, health vulnerability per se is reversible. Hence, public health interventions need to address two problems: lack of access to health services and information and social determinants of “the causes behind the causes of ill-health” in the urban setting. In relation to informal settlements and health of the urban poor, a high priority should be placed on stopping the development of new slums. This is aptly summarized by the challenge posed by Sir Michael Marmot, Chair of the WHO Commission on Social Determinants of Health: “Why do we keep treating people, only to send them back to the conditions that made them ill in the first place?”

How can we change the urban conditions that make people ill?

Most governments recognize the benefits of urbanization but with this recognition often comes ambivalence about the process. It is widely believed that the urban poor can fend for themselves and that better job opportunities will erase social inequity in cities. On the contrary, despite economic prosperity in many Asian cities, slums and informal settlement growth has escalated.

In Asia, as in other parts of the world, urban centres are the “engines of growth” as well as power and wealth, but they are also the centres of opposition and dissent. This has given rise to conflicting policies and hesitancy in addressing the underlying structural determinants of health for the urban poor. The political reality is that uneven power structures, incomplete decentralization and weak local government capacity coupled with cultural bias and social discrimination against the urban poor remain deeply embedded in health systems and the larger governance systems. This needs to change if the half-billion people who live in slums in Asia are to have better lives in the near future.

This paper reviews the literature on health in the urban settings of Asia and proposes a closer examination of how unfair health opportunities can be overcome by addressing social determinants of health and improving urban governance.

Innovations that have been included in the paper were selected with a governance lens. The paper also attempts to show how the actors in innovations in population health are using a wide range of indicators of upstream (socio-ecological drivers such as poverty, education, employment, poor housing, unsafe environments) and downstream (access to quality health care, quality services, social insurance coverage) determinants of health to

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23 WHO Commission on Social Determinants of Health. “The President of Chile and the WHO Director-General launch global commission to tackle the ‘causes behind the causes of ill-health.’” Press release by the CSDH, 18 March 2005.


advance action on health in cities in general and of the urban poor in particular.

Throughout this paper, evidence of improvement of health outcome (using health or and disease indicators) is considered as only one of several sources of information on effectiveness of innovations. Using a social and development framework, we have considered a wide range of other health-related indicators, such as governance indicators (participation, political commitment, enforcement of laws, protection of human rights, decency and fairness), health systems indicators (efficiency, capacity and institution-building, sources and uses of funds for health), environmental health indicators (better quality of housing, cleaner indoor air, less pollution), and political and community indicators (public perception, community participation, social cohesion, support for policy, adherence to public health policies, e.g., quarantine measures), as equally valid evidence of the impact of innovations in urban health.

We therefore propose that a platform for the evolving notion of “healthy urban governance” seeking to improve the social, political, physical and economic environment in cities is crucial to improving the health of the urban poor and may be considered as a strategic pathway for healthy urbanization.

Figure 1. Healthy urban governance as a critical pathway for equity in new urban settings. (Modified from a model for “Health in New Urban Settings” developed by Ilona Kickbusch for the WHO Kobe Centre, 2005.)
II. A model for understanding health vulnerability in new urban settings as “spheres of high socio-ecological stress”

Ill-health is brought about by the interaction of humans with their environment within “socio-ecological spheres”

A model for understanding different outcomes in urban settings is presented to characterize linkages and pathways that result in “spheres of high socio-ecological stress” resulting in the vulnerability of population groups in new urban settings. (Figure 1)

Country specific contexts, e.g., economic, social and political factors interact with the forces of globalization and rapid and unplanned urbanization in countries to affect human communities. The intersection between the global and the local may produce both positive and negative effects. In cities, an aggregate of attributes of urban living or “the urban factor” – mobility, density, connectivity, opportunity, anonymity, viability, privacy, proximity and diversity – determine lifestyles and social environments and affect the way in which people live, work, learn and play.

Where social and political institutions are unable to adapt, manage and contain the tensions created by urban living, spheres of high socio-ecological stress emerge. High socio-ecological stress gives rise to health vulnerabilities that manifest in a range of health and social outcomes, differentials and inequities. Some of these are context-specific, but in some cases, cross-national trends may be noted.

Within this model, the well-being and quality of life of human communities in turn affect urbanization and globalization; the cycle continues and may be mediated by the speed of change. The types of health problems that arise in spheres of high socio-ecological stress are characterized by disempowerment and the accompanying loss of control, choice and autonomy over circumstances, situations and conditions that normally help individuals, families and communities protect themselves when faced with threats or hazards.

A syndemic approach helps us to appreciate how multiple causalties converge to create disease patterns that may be linked to unequal health opportunities: 1) place-related: high stress and vulnerability is related to the confluence of biological, chemical, physical or psycho-social and behavioral risks linked to characteristics of the place of residence, work, learning or play, e.g., children living in a squatter area in Manila, Philippines are nine times more likely to have tuberculosis than non-squatter children in the city; 2) people-related: high stress and vulnerability related to discrimination based on gender, race, ethnicity or socio-economic status, e.g., in China, the “floating population” (liudong renkou) is considered to be at high risk of contracting HIV/AIDS because of higher mobility rates, transient residence and limited access to knowledge of the disease or how condom use prevents infection; and 3) time-related: high stress and vulnerability related to changes during the developmental stages of the life cycle and the inability to cope with rapid social change, such as the rise in solitary deaths (kodoku-shi in Japanese) among elderly and relatively poor individuals who survived the Great Hanshin Awaji earthquake in Kobe, were relocated, and lived alone with almost no social contact with neighbours or family, and whose

28 “Syndemic” is a term invented to describe a set of linked health problems. The first syndemic to have been named and analysed in professional public health literature was reported by Merrill Singer. Comprised of substance abuse, violence, and AIDS, the “SAVA” syndemic conveyed what he saw as inextricable and mutually reinforcing connections between three conditions that disproportionately afflict those living in poverty in U.S. cities.


bodies have gone unnoticed for as long as a month after dying alone at home.\textsuperscript{31}

A framework for better urban governance is needed to change the socio-ecological phenomena in the urban setting that cause health inequity and unnecessary vulnerability

Using the WHO definition of health as a “state of complete mental and physical well-being and not just the absence of disease” and the notion of health as a “resource for living” as stated in the Ottawa Charter on health promotion, a governance perspective helps locate nodes of influence and power that can be mobilized and engaged to effect changes in the social, political and economic environments of the urban poor to enable them to gain greater control of their life circumstances and the determinants of their health.\textsuperscript{32, 33}

In this paper, governance is defined as “the management of the course of events within a social system”\textsuperscript{34} and involves a wide range of actors beyond those who are in positions of authority in government. In the previous section, the proliferation of informal settlements and slum growth has been attributed to “failure of governance”, meaning current governance systems may be inefficient, corrupt or unresponsive and irrelevant to the needs of the governed. The importance of “good governance” in achieving better health for vulnerable groups is underscored. Some key principles that are used to characterize good governance in the urban setting include:

1) \textit{participation}, the degree of ownership and involvement that stakeholders have in the political system;
2) \textit{fairness}, the degree to which rules are applied equally to everyone;
3) \textit{decency}, the degree to which rules are formed and implemented without humiliating or harming particular groups of people;
4) \textit{accountability}, the extent to which those with governing power are responsible and responsive to those who are affected by their actions;
5) \textit{sustainability}, the extent to which current needs are balanced with those of future generations; and
6) \textit{transparency}, the extent to which decisions are made in a clear and open manner.\textsuperscript{35}

We refer to “healthy urban governance” as the systems, institutions and processes that promote a higher level and fairer distribution of health in urban settings as a critical pathway for improving population health in cities. Key features of healthy urban governance\textsuperscript{36} include:

- Putting health and human development at the centre of government policies and actions in relation to urbanization;
- Recognizing the critical and pivotal role of local governments in ensuring adequate basic services, housing and access to health care as well as healthier and safer urban environments and settings where people live, work, learn and play;

\textsuperscript{31} WHO Centre for Health Development 2006. Scoping paper for Japan Healthy Urbanization Field Research Site, Healthy Urbanization Project

\textsuperscript{32} Barten, Francoise, Catherine Mulholland et al. 2006. Healthy governance/ Participatory governance: towards an integrated approach of social determinants of health for reducing health inequity. Thematic paper for the Knowledge Network on Urban Settings, WHO Centre for Health Development

\textsuperscript{33} Burris, Scott, Vivian Lin, Andrew Herzog and Trevor Hancock. 2006. Emerging Principles of Healthy Urban Governance. Thematic paper for the Knowledge Network on Urban Settings, WHO Centre for Health Development


\textsuperscript{35} Hyden, Goran, Julius Court and Kenneth Mease. 2003. \textit{Making Sense of Governance: The Need for Involving Local Stakeholders.} Overseas Development Institute, London

\textsuperscript{36} WHO Centre for Health Development. 2007. Report of the Knowledge Network on Urban Settings to the WHO Commission on Social Determinants of Health (unpublished)
• Building on and supporting community grassroots efforts of the urban poor to gain control over their circumstances and the resources they need to develop better living environments;
• Developing mechanisms for bringing together private, public and civil society sectors, and defining roles and mechanisms for international and national actors to support local governance capacity.
• Winning and using resources – aid, investment, loans – from upstream actors to ensure a balance between economic, social, political and cultural development and establishing governance support mechanisms that enable communities and local governments to partner in building healthier and safer human settlements in cities.

III. Health in the “new urban settings” of Asia
As early as 300 BC, the development of cities in Asia was linked to the development of trade. Cities on both ends of the Silk Road flourished as gold, silver, ivory, silk, precious stones and exotic animals and plants were traded across the area that once separated the East from the West. In those days, the largest Asian cities were the capitals of the medieval empires: Pataliputra (India), Constantinople (later Istanbul) and Chang-An (now Xian, China). In the 1300s, the same Silk Road that fostered trade, commerce and cultural exchange along its eastern and western borders also brought one of the most devastating epidemics in human history: the plague or “black death” that spread across Europe from China, killing what some historians claim as a third of the entire population of the continent, an estimated 20 million people.

Then as now, the connectedness of Asian cities to the rest of the world through trade and commerce makes them strategic hubs for economic growth across the continents. Recent developments point to how this trend will continue through proposed land bridges to connect Europe through China (Tianjin-Beijing-Ulaanbaatar-Ulan-Irkutsk) or a Trans-Korean Railway linking Japan with Eurasia through the Korean peninsula. In the near future, Bangladesh may become the transport hub of South Asia and the Southeast Asian region and also may become the gateway for countries like Nepal, Bhutan, India and Myanmar through the Bangla Bandha land port and the Chittagong seaport. Recently, Malaysia has positioned itself to compete with Singapore as the key Southeast Asian shipping hub for the region through the Port of Tanjung Pelepas on the southern tip of the Malay Peninsula facing the Strait of Malacca, one of the world’s most important international shipping channels.

Then as now, these lines of connectedness generate great potential for economic growth and prosperity. But as recent history has shown, high city-to-city connectedness also presents risks for the spread of infectious diseases, harmful products and social tensions across highly dense populations elsewhere in the world.

So what is different about Asian cities today?
Five interrelated conditions of the current Asian urban context make it different from any other point in history: 1) the unprecedented rate of urban growth and its effect on municipal governments; 2) faster and continuing growth of market economies in “primate cities” accompanied by both marked improvement in

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40 Mark Jefferson in 1939 described the primate city in a country as one that is four to ten times as large as the second city and dominates all urban life. This is especially true in the smaller developing countries. In Laos, for example, half the urban population resides in the capital of Vientiane. That city has been 3–10 times the size of the next two cities. Rangoon has a third (29%) of all Myanmar’s urban population and is five times the size of the next city, Mandalay. Kathmandu in Nepal has 18% of the country’s urban population.
quality of life and living conditions in some places but with an upsurge in poverty, slums, informal settlements and inequity in others; 3) regrouping of marginalized and socially excluded groups along ethnic, cultural and religious lines within cities, e.g., sub-communities of Nepalese refugees in the slums of New Delhi; 4) sustained city-to-city interconnectedness through trade, commerce, industry and international travel; and 5) new and emerging health vulnerabilities brought about by a confluence of biological, social, political and environmental tensions and risks.

Combined, these give rise to what the WHO Centre for Health Development refers to as “new urban settings” or urban areas characterized by a radical process of change with positive and negative effects, increased inequities, greater environmental impacts, expanding metropolitan area, the proliferation of slums and informal settlements and new and increasing health vulnerability across the social gradient.

Understanding the social pathways of health inequity and vulnerability of the urban poor

The inequities of 21st century globalization play out vividly in the cities of Asia. In relation to the urban poor, health vulnerability may be linked to place, people and time, though cross-linkages are obvious. The places where people live, work, learn and play; the people and their socioeconomic status, and specific conditions in relation to time, developmental stages of the life cycle or life course events define how inequities are heightened. In all instances, inequity is compounded by disempowerment and the inability to gain access to nodes of power or influence. At the level of the individual, this is manifest in loss of control, choice or autonomy over one’s life circumstances. At the social level, rapid changes such as overnight economic opportunities in boom cities may create income inequalities that drive deeper wedges into communities and result in the loss of trust and respect between sub-groups, and may result in increasing inability to co-exist harmoniously. In Mumbai for example, street violence and “winning back the street” or control over certain parts of a neighborhood is divided by lines of distrust drawn along socio-economic and religious differences between Hindus and Muslims. Extremism is created when citizens are not invited into and have not grown to trust in institutions but rather rely on the ties of blood or religion or systems of patronage to gain a sense of control over their circumstances. High levels of inequity result in the fragmentation of cities, with certain areas attracting businesses and high-income earners at the expense of others who have none and suffer from high unemployment, little or no access to essential services, and infrastructure in need of maintenance or repair. The multifaceted effects of globalization on the health of poor and low-income populations in all cities need to be better understood in this context, both at the individual level and within the city and community.

What is reported in the next section is by no means an exhaustive survey of evidence and knowledge on health in new urban settings in Asia. Instead we attempt merely to highlight strategic issues and offer illustrative examples. It must be stated up front that there is an overall paucity of data on informal settlers, slums and health conditions of the urban poor. The lack


45 Saskia Sassen, one of the preeminent scholars on globalization and urbanization, underlines that the “decoding of globalization” can only be undertaken at a local level (Sassen, 2001).
46 Sassen (2005:30) states that MDG 7 strongly influences many of the other MDGs, and the need for international coordination to realize environmental sustainability is an important factor in the realization of other development objectives.
47 David, Annette, Susan Mercado, David Becker, Kati Edmundo, Fredrich Mugisha. 2006. The prevention and control of HIV/AIDS, TB and vector-
of disaggregated urban data (such as from intra-urban health differential studies, urban surveys, or routinely reported data on urban health) is a key constraint and limitation of this paper and is a challenge that must be overcome if future action and policy change is to be meaningful. In the future, investments in developing capacity and systems to generate and analyse urban health data specifically intra-urban differentials, will be critical for leveraging policy, action and research to unmask health vulnerability across the social gradient.

**Places**

Unsound living conditions (e.g., unsafe water, unsanitary conditions, poor housing, overcrowding and high density, hazardous locations and exposure to extremes of temperature) are a major intermediate determinant of health inequity in Asian urban settings and invariably linked to poverty both in developed and developing countries. The lack of shelter and the poor quality of housing are major threats to health in urban slums and more than half a billion people in Asia. There is compelling evidence to link different communicable and noncommunicable, injuries and psychosocial disorders to risk factors related to unhealthy living conditions, such as faulty building, defective water supplies, substandard sanitation, poor fuel quality and ventilation, non-existent refuse storage and collection, improper food and storage preparation, as well as poor/unsafe location, such as near traffic hubs, dumpsites and polluting industries.

Unequal access to water and sanitation needs to be highlighted as a persistent and major preventable underlying pathway for many diseases and conditions in Asian cities. These pathways may be further classified as being waterborne, water-washed (or water scarce), water-based or linked to water-related insect vectors. Privatization of water in cities has been shown to heighten inequity in access and has led to disease outbreaks. In many instances, the urban poor pay much more for water as they rely on informal vendors, compared to the better off who have house connections. In Vientiane, these vendors charge US$ 14.6.8/m3 compared to 11 cents/m3; in Mandalay $11.33/m3 compared to 81 cents/m3; in Phnom Penh $1.64/m3 compared to 9 cents/m3.

Industrialization and the proximity of the urban poor to factories and manufacturing zones and further compounded by weak regulatory and pollution control measures and enforcement at national and municipal levels, result in a wide range of other types of environmental risks to health. These include exposure to chemicals and biological agents that pollute the ambient air, as well as indoor air pollution, extremes of noise and temperatures, and industrial pollution of land and water. For example, Minamata disease, caused by methyl mercury poisoning from eating shellfish and fish where the toxic

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56 http://www.unu.edu/unupress/unupbooks/uu35ie/uu3_5ie0c.htm (accessed on 21 May 2007).
chemical bioaccumulated, affected more than 2,000 city residents in Minamata, Kumamoto Prefecture, Japan and resulted in 1,784 deaths and more than 10,000 claims for financial compensation since 1956. More recently, official reports from China state that there are now more than 200,000 enterprises engaged in the production, transportation and treatment of hazardous chemicals. Many of these are located in urban areas. Last year, China reported 142 chemical accidents, resulting in 229 deaths. In the biggest disaster yet, a spill of nitrobenzene and other chemicals into the Songhua River in 2006 forced Harbin, the biggest city in the northeast, to suspend running water to 3.8 million people for five days.57

Cities can become both breeding grounds and gateways for emerging and reemerging infectious diseases. Migration and increased mobility bring new opportunities for otherwise marginal and obscure microbes.58 Other contributory factors include changes in the ecology of urban environments, crowding and high population density, international travel and commerce, technology and industry, microbial adaptation to changes and breakdowns in public health measures59. The recent outbreak of severe acute respiratory syndrome (SARS) that was spread globally from city to city by airline passengers is a case in point.60 Other examples are the threat of a global pandemic of H5N1, the resurgence of tuberculosis through homeless populations and transients in cities like Osaka61 and the spread of multi-drug-resistant strains of tuberculosis that place the urban poor at a higher risk India, Indonesia, Nepal and Myanmar.62 Vector-borne diseases such as dengue and urban malaria63 have also been found to be increasing in many towns and cities due to migration, climate change, stagnant water, insufficient drainage, flooding and improper disposal of solid waste.64

People

Stigma and social exclusion must be cited as important intermediate determinants of health.65 Slum dwellers and informal settlers suffer from the stigma associated with not having a street address66 – just one example of how they are excluded from “full citizenship” within cities. Slum dwellers and informal settlers are usually not counted in regular municipal census activities. These are key social determinants that limit slum dwellers’ ability to take action to improve their living environment. Other factors with detrimental impacts on slum dwellers’ health are lack of transportation, exposure to crime and violence and the stress created by living in constant fear of one’s safety. This creates high levels of mistrust and low social capital.


It is reported that the “floating population” of China now numbers 140 million. These are migrants who are not counted as part of the population of the cities where they work, but who may spend several months in the city in deprived living conditions and suffer from a wide range of disparities, including unequal treatment in relation to crime and punishment in Beijing as well as other cities.

It is important to point out that among the urban poor in Asia, gradients of disadvantage exist. Gender is a major cross-cutting structural determinant. For example, tuberculosis causes more deaths among women of reproductive age than any other infectious disease, yet for example, all factors being equal, the health care system in Viet Nam is less likely to test and treat women for TB than men.

Time

Globalization and urbanization have profound effects on lifestyles in cities and thereby the health of urban populations. Modernization, the globalization of food culture, unhealthy diets, and increasing dependence on motorized vehicles for transport, less physical activity and stress from the speed of change affect all age groups in urban settings. Some of these factors have been linked to risks to health that contribute to increasing morbidity and mortality rates from noncommunicable diseases, obesity and injuries even among vulnerable groups and the urban poor.

Tobacco use is a major risk factor for cardiovascular disease and cancer in Asian cities and is an underlying factor that contributes to household level poverty in cities. Alcohol and other forms of substance abuse are also a leading public health challenge. Marketing and promotion of harmful products usually target adolescents and youth.

Road injuries and violence also contribute to a high burden of disease in Asian cities and youth are at higher risk. The total mortality from road traffic injuries of the regions of Southeast Asia and the Western Pacific account for more than half of the world deaths (50.7%) and about half of the disability adjusted life years (DALYS) lost. China has a high country rate at 15.6 road deaths per 100,000. Thailand and the Republic of Korea have worse rates still, at 20.9 and 22.7 deaths per 100,000, respectively. While these figures are not disaggregated as rural or urban, increasing motorization and the inability to cope with

72 Campbell, Tim and A Campbell. 2006. Emerging health challenges in cities of developing countries. Thematic paper for the Knowledge Network on Urban Settings, WHO Centre for Health Development.
75 http://www.searo.who.int/LinkFiles/Alcohol_and_S substance_abuse_7-Gaining.pdf (accessed on 2 May 2007).
76 Campbell, Tim and A Campbell. 2006. Emerging health challenges in cities of developing countries. Thematic paper for the Knowledge Network on Urban Settings, WHO Centre for Health Development.
77 http://www.searo.who.int/EN/Section1243/Section13 10/Section1343/Section1344/Section1836/Section183 7.htm (accessed on 22 May 2007).
higher levels of mobility have been identified as underlying factors.

At the extremes of age, infants and very young children along with older persons are particularly vulnerable to social and environmental change in urban settings. And with slums and informal settlements often hives of informal economic activity, working conditions also constitute major intermediate determinants of health for men, women and children (child labourers, street children). Globalization and urbanization may also affect child health in an indirect, generally ignored, manner: through an increase in women’s participation in the labour force. In East and Southeast Asia, up to 80% of the workforce in export-processing zones is female.

In Bangladesh, the number of garment factories increased from four in 1978 to 2400 in 1995, when they employed 1.2 million workers, 90% of whom were women below 25 years of age. While female employment results in better family incomes and more bargaining power for women in the family, if economic activity by women is not accompanied by the development of adequate child care institutions, there may be an increase in injury and malnutrition among children despite a rise in family incomes.

It is evidence that multiple and multi-leveled policy and action interventions on social determinants of health in the urban settings of Asia are needed to address a wide range of issues, structures and value systems that influence population health. Though the challenges seem daunting, there is strong evidence to show how Asia is mustering political will at many levels to confront the issues of inequity.

IV. Methodology

Examples of innovations were identified by the authors based on their work related to Healthy Cities in the WHO Western Pacific Region and the South-East Asian Region, the Alliance for Healthy Cities, and the Knowledge Network on Urban Settings of the WHO Commission on the Social Determinants of Health, of which the WHO Kobe Centre is the hub. More than a hundred case studies and reports were reviewed. Where documentation was insufficient or outdated, the authors commissioned the writing of case reports through the Southeast Asian Press Alliance, an independent network of Asian journalists.

The authors decided to review and consider innovations that tackle upstream (socio-ecological drivers) as well as downstream (access to quality health care, information, services and programmes) determinants of health. We are mindful of how inequitable access to research funds in the developing world may skew the results in favor of reports that have been published, i.e., innovations that are funded externally by players who are interested in capturing immediate impact on specific diseases or groups at risk, rather than addressing intermediate and structural determinants as they give rise to syndemics in the urban setting.

As mentioned previously, we have cast a wide net on evidence effectiveness on health and health determinants of the urban poor and did not limit ourselves to health indicators. Using a social determinants of health approach, we considered a wider data set including social, political and economic indicators on how innovations brought about changes in the enabling and reinforcing conditions for action to shape political space, advance health agendas, mobilize support for health, and modify power relationships and governance mechanisms over the resources and requisites for health and decent living. To further validate the results, triangulation was achieved through informal interviews that provided insight into the values

of the stakeholders as reported in the case studies that were developed by the Southeast Asian Press Alliance.\textsuperscript{83}

The following criteria for selection were used: a) effectiveness in reducing the health vulnerability of the urban poor (although in some examples gradient approaches do not target the urban poor per se but the poor in general\textsuperscript{84}) in relation to place, person or time; b) attention paid to overcoming social barriers to health through interventions that are clearly consistent with principles of good governance, i.e., participation, fairness, decency, accountability, sustainability, transparency in the urban setting; and 3) reasonably sufficient documentation to derive lessons learned but preferably with availability of tools, guidelines and methodology for cross-national application of the innovations.

V. Innovations responding to health vulnerabilities of the urban poor in Asia

The following is a summary table of innovations that address and respond to health vulnerabilities of the urban poor in Asia. These are described in greater detail in the succeeding part of the report and in the annex as case studies. The governance principles that these innovations demonstrate are mentioned. The types of vulnerabilities addressed are also cited. Types and examples of indicators that are used by the actors and stakeholders are included.

\textsuperscript{83} Refer to Case Studies in Annex 1.

\textsuperscript{84} In the cases of the Village Phone Operators and Grameen Bank, the use of information technology and microfinancing for health is basically rural; however it is clear that these types of measures prevent further migration to cities and the urbanization of poverty.
<table>
<thead>
<tr>
<th>Innovations</th>
<th>Examples</th>
<th>Analysis of health vulnerabilities addressed</th>
<th>Types of indicators currently used by players and stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The urban poor as key drivers and decision-makers in community upgrading</td>
<td>Society for the Promotion of Area Resources Centre (SPARC), India</td>
<td>Lack of security</td>
<td>Rights to secure tenure, housing and property</td>
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<tr>
<td></td>
<td>Asian Coalition for Housing and Rights (ACHR)</td>
<td>Lack of opportunities</td>
<td>Better homes and living conditions, e.g., stronger construction materials in homes, efficient drainage systems, less flooding, more footpaths</td>
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<td></td>
<td>Slum Dwellers and its members, the Women’s Development Bank Federation, Nepalese National Squatters Federation, Philippines Homeless People’s Federation, National Slum Dwellers Federation/Mahila Milan and Homeless International</td>
<td>Lack of capabilities</td>
<td>Community process indicators, i.e., participation, empowerment of women, viable local organizations, skilled local leaders, social cohesion</td>
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<tr>
<td></td>
<td>Community Organization Development Institute (CODI), Thailand</td>
<td>Lack of empowerment</td>
<td>Access to resources, e.g., microfinancing, water, health services, electricity</td>
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<tr>
<td></td>
<td>Self-Employed Women’s Association (SEWA), India</td>
<td>Lack of a safe living environment</td>
<td>Self-reported health and well-being</td>
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<td></td>
<td>Oranji Pilot Project, Pakistan</td>
<td></td>
<td>Health outcome indicators – e.g., decrease in morbidity from diarrhoeal diseases after water supply is introduced.</td>
</tr>
</tbody>
</table>

2. Local governments holding themselves accountable for healthy urban settings

<table>
<thead>
<tr>
<th>Relevant governance principles: accountability, transparency, participation,</th>
<th>Alliance for Healthy Cities – “Twinning” of Marikina City and Ichikawa City</th>
<th>Lack of opportunities</th>
<th>General good local governance indicators, e.g., commitment of mayors and other political leaders to put health high on the city agenda, better city policies on health, willingness of business and industry to comply with health, occupational and safety regulations, business-led community projects on health and environment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>WHO Collaborating Centre on Healthy Cities and Urban Health, Tokyo Medical and</td>
<td>Lack of capabilities</td>
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<td></td>
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<td>Lack of empowerment</td>
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</table>
**Improving Urban Population Health Systems**

**CENTER FOR SUSTAINABLE URBAN DEVELOPMENT | JULY 15-20, 2007**

<table>
<thead>
<tr>
<th>Fairness, Sustainability</th>
<th>Improvements in municipal services, city planning and public infrastructure – better sanitation, waste management, cleaner and safer marketplaces, well-lit streets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental University, Japan – Community participation research project on communities living in boats, Hue City, Viet Nam and research on drug abuse, Vientiane, Laos</td>
<td>Healthy city process/governance indicators, e.g., multi-sectoral participation, investments and support from the private sector, community participation in health projects, strong community interest in health activities, sustained action, social cohesion</td>
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<tr>
<td>WHO Centre for Health Development – Action – research on Healthy Urbanization – Bangalore, India; Suzhou, China and Kobe, Japan</td>
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<tr>
<td>Healthy Cities, Kuching Malaysia</td>
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<td>Mongolian Association of Urban Centres, Ulaanbaatar City Mongolia</td>
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<tr>
<td>Confederation of Indian Industry (CII) and the Indian Business Coalition on AIDS (IBCA) in India, the Thailand Business Coalition, an alliance of more than 100 companies.</td>
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<td>Corporate Social Responsibility Asia Magazine</td>
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<td>Asian Institute of Management</td>
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</tbody>
</table>

3. **Using infectious disease outbreaks as opportunities for strengthening public health infrastructure**

<table>
<thead>
<tr>
<th>Relevant governance principles: transparency, accountability, decency, fairness</th>
<th>Lack of security</th>
<th>Lack of opportunities</th>
<th>Lack of capabilities</th>
<th>Lack of a safe living environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordinated city and national action on SARS and avian flu in Hong Kong, Viet Nam, China, Singapore, resulting in improvements in surveillance, hospital infection control, public hygiene, quarantine and risk communication.</td>
<td>Health systems improvement indicators, e.g., capacity of health workers and hospitals improved through training, activation of infection control committees</td>
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<tr>
<td>Healthy marketplace initiatives in Viet Nam</td>
<td>Updated public health policies for infectious disease prevention, control and response, e.g., quarantine ordinances</td>
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<tr>
<td>Health promotion and public education on HIV/AIDS in train stations in Beijing</td>
<td>Enforcement of health protection laws and food safety regulations</td>
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<td>4. Improving efficiency in health promotion financing in cities</td>
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<tr>
<td><strong>Relevant governance principles:</strong> participation, fairness, decency, accountability</td>
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<tr>
<td>Social insurance coverage for prevention and health promotion in Japan</td>
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<td>Tobacco and alcohol taxes used for health promotion by Thai Health, Thailand and the Korean Health Promotion Fund</td>
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<tr>
<td>Lack of opportunities</td>
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<td>Lack of capabilities</td>
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<td>Lack of empowerment</td>
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<td>Lack of a safe living environment</td>
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<tr>
<td>Health financing indicators, e.g., increase in coverage of benefits of health financing, i.e., health promotion; new sources of finance, increase in levels of financing for health promotion</td>
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<tr>
<td>Health sector reform indicators, e.g., more efficient mechanisms for funding Healthy Cities projects from tobacco taxes</td>
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<tr>
<th>5. Applying information technology to population health activities</th>
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<tbody>
<tr>
<td><strong>Relevant governance principles:</strong> participation, decency, accountability, sustainability</td>
</tr>
<tr>
<td>Village phone systems in Bangladesh peri-urban areas</td>
</tr>
<tr>
<td>Strategic communication and using mass media entertainment to deliver family planning and reproductive health messages in urban and rural Indonesia, Bangladesh, Philippines</td>
</tr>
<tr>
<td>Use of geographic information systems for health planning, mapping and programme monitoring, Cebu, Philippines</td>
</tr>
<tr>
<td>Health communication indicators, e.g., higher awareness of health messages, endorsement of healthy behaviours and practices by celebrities who influence youth and women through popular culture, i.e., movie stars, athletes, artists</td>
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<tr>
<td>Behavioural change indicators, e.g., increase in contraceptive prevalence rates</td>
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<td>Changes in social perceptions, social support systems and social cohesion</td>
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<tr>
<td>Health service utilization indicators, e.g., more women go for prenatal check-ups; teenagers seek counselling on</td>
</tr>
</tbody>
</table>
### Descriptions of innovations

1. **The urban poor as key drivers and decision-makers in community-upgrading**

Linking the right to health of the urban poor to the requisites of a decent life – secure housing, land rights and micro-financing – is the most important innovation in population health for Asia.

Progress in advancing these issues to the arena of healthy public policy has not been due to actions of ministries of health or housing, but by the urban poor themselves who have the desire, the political will and the capacity to negotiate, dialogue and manage funds and projects for community-upgrading, as an issue of social justice.

At the forefront of this social movement are organizations and groups that have steadily reshaped perceptions about the role of the urban poor in the process of community-upgrading, from “targets” and “beneficiaries” to “key drivers” and "decision-makers". These organizations and groups demonstrate how incremental and hard-won gains in participation, decency, fairness and accountability result in meaningful change in their day-to-day existence. Examples of organizational nodes that have enabled this process include the Society for the Promotion of Area Resources Centres (SPARC), India, the Asian Coalition for Housing and Rights (ACHR), Slum Dwellers International and its member groups, the Women’s Development Federation, Nepalese National Squatters Federation, Philippines Homeless People’s Federation, National Slum Dwellers Federation/Mahila Milan, and Homeless International.

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<table>
<thead>
<tr>
<th>6. Optimizing social determinants of health in urban settings</th>
<th>STDs</th>
<th>More efficient implementation of public health programmes in urban areas</th>
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</thead>
<tbody>
<tr>
<td>Relevant governance principles: participation, fairness, decency, accountability</td>
<td>Tobacco-free sports (World Cup Series, Olympics and Southeast Asian Games) in the host cities of Korea, Japan, China and Viet Nam</td>
<td>Lack of opportunities</td>
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<td>Walking for health in Singapore</td>
<td>Lack of capabilities</td>
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<td></td>
<td>Life skills and pre-employment training in Marikina City</td>
<td>Lack of empowerment</td>
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<td></td>
<td>Fuel regulation policy on compressed natural gas in India</td>
<td>Lack of a safe living environment</td>
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<td></td>
<td>Changes in social norms and acceptance of regulations on harmful products – bans on advertising of tobacco at major sports events; bans on smoking in public places, higher visibility of anti-smoking messages</td>
<td>Changes in social norms in relation to vulnerable groups, e.g., older persons</td>
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<td></td>
<td>Decline in unemployment rates among the urban poor</td>
<td>Air quality improvement</td>
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85 WHO. 1986. The Ottawa Charter on Health Promotion.

86 CODI prefer to use the phrase “community-upgrading” instead of “slum-upgrading” to denote continuing improvements in the community in relation to the social, economic and political environment and not just improving the “slum” as a physical entity.
Power relations need to change

What the urban poor federations have done is to show that an effective housing policy for low-income groups is actually about changing the relationships of “slum shack” and “pavement” dwellers with official agencies – not about physical improvements. The physical improvements – in housing, housing tenure and basic services – come from these changing relationships.

Such was the conclusion of David Satterthwaite in a recent paper presented at a social policy conference in Arusha, Tanzania. Together with five other organizations, he singled out the Community Organization Development Institute (CODI) in Thailand as one organization that demonstrates change for slum and squatter settlers through upgrading using participatory and inclusive processes that ensure good services, including health, through enforcing good governance. The “network of networks” approach used by CODI was able to mobilize neighbourhood groups of slum dwellers, networks of sectors and networks of important stakeholders and leaders able to make a difference. This initiative has now reached 415 communities and 30,000 households in 140 Thai cities.

What has been the backbone of this success? Somsook Boonyabancha, Director of CODI, explains that the horizontal linkages between individuals (bonding social capital) and peer groups (bridging social capital) are key factors in the development of new power bases (nodes). When urban poor communities have the possibility of looking at their city in its entirety, they find that they are no longer isolated within their individual settlement – they have allies, friends with similar difficulties, similar fates, and similar ways of doing things. They are not alone – instead they are building links dozens of communities facing similar problems in the same city. When communities expand, the fora for negotiating change also grow. Thus communities gain access to more responsive audiences. Forum-shifting leads to better information and opportunities to enlist support for structural changes. However, linkages in themselves are not sufficient for sustained change. Almost all political systems have vertical structures linked to status, power and wealth that influence key decisions affecting all people in society. Therefore, the emergence of horizontal platforms or networks to balance and tap into those vertical strings (linking social capital) are very important. Communities and development actors in the city can work together and start processes that provide a chance to think and understand their own situation and harness their power and support to engage and gain greater access to power and influence decision-making. This process can result in the creation of new “nodes” of governance and power structures that can be fairer, more responsive, accountable and transparent.

Confronting patronage politics and moving toward democratization

Municipalities – and municipal politicians from various parties – always have their own intermediaries that link with urban poor communities. Urban poor communities in any given city tend to be divided into camps – for instance, one community might “belong” to the ruling party while another might belong to the opposition. Politicians like to have bilateral relationships with community leaders and often lead with a “divide and rule” mentality in order to control their constituents and maintain power. But if this kind of patron-client relationship and its division between the “benefactor” and the “petitioner” is to be changed, such bilateral ties

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89 Boonyabancha S. 2004.
have to be challenged by development interventions that encourage poor communities in a city to work together. Such city-wide processes enable communities to gain both independence from and to tap into these vertical strings of patronage which control them.

**A sharper focus on social cohesion:**

“community-upgrading” vs. “slum-upgrading”

Communities, even poor communities, always have a mix of rich and poor, helpless and super-active people, people with particular problems such as disabled, unemployed, elderly, orphans, drug addicts, the sick and people in crisis or emergency. In the market system, only those who can afford to pay can fully enjoy society’s benefits. But in a collective community process, everybody can be taken care of if the process is sufficiently inclusive and if social cohesion-building has been adequate.

Community processes must also seek to work at scale, finding solutions for all urban poor groups, including those with very low incomes and very limited capacity to pay. If reconceived in this way, “community-upgrading” (as opposed to “slum-upgrading”) upholds the processes of participation, engagement, decency, fairness and accountability through social processes that are inclusive. Community-upgrading refers to restoring the notion of shared space, resources and public goods. This can be a powerful intervention for rebuilding or reinforcing social cohesion and capital from bonding via bridging to linking, thus addressing structural determinants of health and establishing a basic safety net for the urban poor. These processes may further reduce poverty and support decentralization processes. CODI has done all this by having cross-subsidiaries and financial incentives built into the project through a communal welfare fund and communal welfare facilities and called it “collective equalizing”.

CODI is just one of several community organizations that have worked through networks. Another success story has been documented by the Self Employed Women’s Association (SEWA) in Gujarat, India. Not only was SEWA successful in its own right, but the Association joined other like-minded organizations to form a trust specifically dedicated to promoting housing for self-employed women. The trust aims to provide technical support, research and advocacy to its members. These services enable the members to access better housing and have demonstrated improvements in health and declines in morbidity as a result.

The Orangi Pilot Project in Pakistan is another organization that has used networking for improving water and sanitation for the urban poor through “networks of networks” of community organizations that manage and supervise the water and sanitation systems. Begun in Karachi’s Orangi squatter community in the 1980s, one “lane manager” would represent 15 households on a “lane committee” representing a total of 600 households. These networks or organizations gradually gained control and applied pressure to hold their municipalities’ policy-makers to account. This resulted in the release of municipal funds for construction of primary and secondary sewers servicing over 600,000 people in Karachi.

These network processes require social cohesion. If cohesion is absent, it has to be created, and if it exists, it has to be strengthened. All communities have a need for social cohesion, but in the urban setting this need is greater than ever due to the increased pressure of globalization and the rapid and radical changes that result in the unraveling of the traditional social fabric and the breakdown of social bonds. The caveat is that there are two sides to the coin. Whereas social cohesion can have a positive effect on health if the processes are inclusive and participatory, some cities have sought cohesion in negative ways, classically by glorifying the sense of belonging as citizens and

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92 Ibid.
inciting mistrust of foreigners, immigrants and floating populations.

2) Local governments holding themselves accountable for healthy urban settings

Many countries in Asia are decentralizing, meaning they are transferring decision-making and spending powers from national to local governments. This entails a transformation of political power, increasing the importance of cities in the conduct of public business. In public health, the drama is one of balancing priorities, allocation of resources, and personnel issues between central governments and local communities, as city and community leadership—mayors, elected officials, health sector professionals and administrators—play a growing role in health care.

Local government officials (in what were highly centralized systems) holding themselves accountable for healthier cities has been a major innovation in population health for Asian cities. When empowered mayors and governors encounter WHO's concept of health, referring to a state of “complete physical, mental, and social well-being and not merely the absence of disease”, and see evidence that a wide range of their actions influence health outcomes in the population, they too can play more active roles as effective health governors.

An understanding of how health is a requisite of productivity and economic development can be a strong motivator for putting health on the agenda of local governments. WHO's Healthy Cities movement over the past 25 years has produced countless examples of how this has happened. And once local governments see health as an outcome with both social and political value, the achievement of better health is more likely to be linked to democratization processes.

Local government support for health goals builds social cohesion and helps mobilize different sectors for health. Local leaders are also in a better position to articulate health goals as social goals, as opposed to narrow health sector goals. However, many local and municipal institutions are ill-equipped to respond to population health challenges, especially where decentralization is recent and, more often than not, incomplete.

Democratization is relatively new in some parts of Asia. Coupled with decentralization, it is a process that poses daunting challenges for the unprepared. Popular elections in scores of countries around the world subject public sector decision-makers to a scrutiny and a clamour for participation with which they have limited or no experience and poor or underdeveloped tools. Participatory democracy requires new levels of sophistication in structuring decisions, informing the public, and channeling feedback on the implementation of programmes in the public sector.

Capacity building, therefore, is critical for enabling local governments to hold themselves accountable for healthier cities. Rathor addressed capacity building in urban public health programmes as:

...a health and welfare promotion system applied with a 'bottom up and inside out' approach; as a continuous process of

94 Campbell, Tim and A Campbell. 2006. Emerging health challenges in cities of developing countries. Thematic paper for the Knowledge Network on Urban Settings, WHO Centre for Health Development.
96 Barten, Françoise, Catherine Mulholland et al. 2006 "Healthy governance/ Participatory governance: towards an integrated approach of social determinants of health for reducing health inequity. Thematic paper for the Knowledge Network on Urban Settings, WHO Centre for Health Development.
97 Campbell, Tim and A Campbell. 2006. Emerging health challenges in cities of developing countries. Thematic paper for the Knowledge Network on Urban Settings, WHO Centre for Health Development.
98 Ibid.
enhancing the ability (capability) of all the key stakeholders to perform their core functions to reach the ultimate goal of overall health and quality of life in a city, where its environment is suitable and sustainable for present and future generations.

City-to-city learning
As emerging health issues take on distinctly urban features, cities themselves have much to offer each other as they develop approaches and solutions to reduce health risks. Many cities have already engaged in city-to-city exchanges in areas such as trade, economic development, environmental sustainability and finance. “Horizontal assistance” is a phenomenon that already likely amounts to a shadow economy of knowledge. UNDP asserts that links between cities over the past several decades number in the range of 15,000 to 20,000. City-to-city cooperation has become a recognized field of development assistance. Anecdotes and systemic hard data for specific cities suggest a very large latent demand and a strong willingness to pay: it is clear that the formation of knowledge markets could be of great utility for cities as they invent or look for ways to solve emerging health problems.

Learning through international networks of cities
The Alliance for Healthy Cities is an international organization aiming to protect and enhance the health and quality of life of city dwellers through the Healthy Cities approach. It is an autonomous organization with, as of April 2007, 67 members from Cambodia, China, Japan, Republic of Korea, Malaysia, Singapore and Vietnam, and it has a close relationship with WHO. It started with 26 members in 2004 and the steady growth of its membership indicates how cities themselves value city-to-city learning through international networks. Evaluation of impact of Healthy City projects are on-going and part of the work of the individual cities as well as the network itself.

The network provides many processes for learning and capacity building. Cities receive practical advice on programmes for health. Sub-networks or “national chapters” have been initiated in some countries to help promote a country level understanding of geo-culturally relevant programmes in the local language. Exposure to a wide range of interventions across the diverse cultures of Asia stimulates creativity in approaches to health and helps expand the understanding of health determinants in a global world.

“Twinning activities” have been pursued through the network. For example, since 2005, Marikina City, Philippines and Ichikawa City, Japan have worked together for the promotion of healthy diets and physical activity through urban planning. WHO supported a one-week study visit of four Marikina City officers to Ichikawa and another week-long study visit by four Ichikawa City officers to Marikina to encourage understanding of the diverse contexts of these two cities. City officials reaffirmed the value of health in cities and the relevance of local social

As studies on urban health determinants indicate (Takano, 2001a), there are wide-range factors influencing on health of urban dwellers. Frameworks of participatory-style research using quantitative and qualitative methods were proposed to evaluate comprehensive programs aiming better health of the urban population (Takano, 2001b, Baum, 2003, Nakamura 2003). An example of more practical guideline for evaluation is also available (Technical Secretariat, 2003). There are some qualitative evaluations (Harpham, 2001; Kiyu, 2006), results of needs assessments (Hashim, 1996), and baseline quantitative evaluations of health of urban dwellers (Quang, 2005) from initiatives related to Healthy Cities and Villages in Asia.
health determinants. Study visits provided different sectors of both cities a chance to share their respective visions through participation in Healthy Cities activities in both sites. City senior officers, technical officers, practitioners, community group leaders, teachers and children in the cities also gained a greater understanding of the challenges of urban public health.

The “Asian Infectious Disease Project” is another example of how city-to-city learning has taken place through an international network of cities. This project was launched in November 2004 with the participation of 11 megacities in Asia as a health project of the Asian Network of Major Cities 21. New Delhi, Hanoi, Jakarta, Singapore, Taipei, Tokyo, and Yangon are among the network members. These cities share the view that the rapid spread of infectious diseases including SARS and avian influenza have had serious effects on Asian economies and national livelihoods. This project directly links health information among participating cities without necessarily passing through the channels of individual cities’ central governments. Participating cities also accept clinicians and researchers for study visits and training. The establishment of a mechanism of formal and informal information networking allows the prompt exchange of information and skills. Such a mechanism further allows technical collaboration between cities. This project represents fairer opportunity for local governments to access strategic information for emergencies without having to be at the mercy of national bureaucratic processes. The project provides capacity building for technical and management personnel who are at the frontline of infectious disease control in major cities.

Using participatory action research to derive local knowledge
To develop effective health programmes for vulnerable urban communities, evidence from


these communities is essential. Health inequity may be recognized within cities, but the potential entry points for improving health opportunities vary from place to place. The participation of the community and local research practitioners is crucial in identifying these highly localized entry points and opportunities and in developing approaches that are socially and culturally acceptable and appropriate. In particular, participatory action research encourages the production of evidence reflecting locally perceived needs, felt needs and perceived solutions. Participatory action research also promotes communication and management skills among particular communities and stakeholders including local authorities and research institutions. Community participation in a research project on the health of communities living on boats in Hue, Vietnam, and research on drug abuse in Vientiane, Laos shows importance of community capacity. Within the WHO Centre for Health Development’s Healthy Urbanization Project, participatory action research is a key strategy for mapping health inequities in six urban sites, three of which are in Asia, namely Bangalore, Suzhou, and Kobe. Through “Healthy Urbanization Learning Circles” at each site, learning environments are created where social accountability is put into practice. Since the project started in 2006, documentation of results are still on-going.

109 WHO Centre for Health Development. 2006. The Core Project: Optimizing the impact of social determinants of health on exposed populations in urban settings. Information brochure.
Benchmarking against a Healthy City demonstration site

Kuching City in Sarawak, Malaysia, is a Healthy City demonstration site that first applied the Healthy City concept to its communities in 1994 and has since received more than 800 visitors from around the world, each keen to study how it became a “Healthy City”. Process indicators and improvements in local living conditions as well as the establishment of elemental settings (healthy marketplaces, health promoting schools) demonstrate the effectiveness of this approach. The city also sends out senior officers to other cities to attend seminars, meetings, and consultations on healthy settings including Healthy Cities. All of these opportunities have strengthened Kuching’s local resolve to be a model for health- and environment-centred urban development. City-to-city learning activities with Kuching have stimulated Healthy City projects in southeast Asian countries and beyond.

National city-to-city learning mechanisms bridge language barriers

While international networking and exchange has many benefits, in some countries, local officials may be unable to learn from cities in other countries because of language barriers. National city-to-city mechanisms can help bridge such gaps. In small countries, primary cities may be the sole beneficiaries of international exchange and while this creates a starting point within a country, it may also create new inequities between the primary city and other cities that do not have the same level of access to international knowledge. Domestic networks of healthy cities give secondary and smaller cities and municipalities a fairer chance at gaining access to knowledge on healthy urban governance. For example, the Mongolian Association of Urban Centres (MAUC) established in 2003 is a nongovernmental organization that demonstrates how cities can learn from each other within Mongolia. Emerging from an agreement made at the first meeting of mayors in the capital, Ulaanbaatar, the vision of MAUC is to support exchanges of experiences in urban planning and good governance and has made decentralization a key concern. MAUC covers urban planning, urban services and environmental issues. Within-country study visits by groups of mayors and governors have also created learning opportunities for decision-makers. Through this process for example, a plan to encourage sanitary practices in ger (traditional tents for living) areas has been developed.

The hub of the network is Ulaanbaatar City Office, where the Association secretariat is based; a full-time coordinator facilitates information dissemination and capacity building.¹¹⁰

Working with the private sector to promote health in cities

In the Asia-Pacific region, corporate social responsibility efforts directed toward improving health and reducing the vulnerability of groups in the urban setting is on the rise. Some examples of corporate social responsibility, public-private partnerships and the private and corporate sector sponsorships have been applied to the prevention, care and support activities for HIV/AIDS, such as the initiatives by the Confederation of Indian Industry (CII) and the Indian Business Coalition on AIDS (IBCA) in India, and the work of the Thailand Business Coalition, an alliance of more than 100 companies.¹¹¹

In response to public protest in the early 1990s against sweatshops in Asia operated by big foreign firms, labour compliance has become a mainstay on the agenda of many corporate boardrooms. Independent media groups such as the Corporate Social Responsibility Asia Magazine provide a clearing house of information, news and reports that are relevant to business-initiated and supported projects on labor law compliance, occupational health, environment, health and poverty alleviation. In China, for example, a partnership between academics and NGOs, and a consortium of export-processing companies including Ford Motor, Gap, HP, Liz Claiborne, Pfizer, ¹¹⁰ Mongolian Association of Urban Centres [http://www.mauc.org.mn/] (accessed on 27 April 2007).
¹¹¹ [http://www.youandaids.org/Themes/Corporate%20Social%20Responsibility%20(CSR)/index.asp].
MeadWestvaco, Motorola and Target launched the Global Supplier Institute to offer training on management, health and safety, and HIV/AIDS, amongst other compliance curricula.\textsuperscript{112}

In 2002, the first Asian Forum on Corporate Responsibility (AFCR) was convened by the Asian Institute of Management-Ramon del Rosario, Sr. Center for Corporate Responsibility and included presentations from groups like Koalisi Indonesia Setasi (Coalition for a Healthy Indonesia) and discussions on corporate giving as social investment, corporate responses in the delivery of low-income housing, corporate/sectoral partnerships with health professionals and corporate partnerships in delivering health services.\textsuperscript{113}

3. Using infectious disease outbreaks as opportunities for strengthening public health infrastructure

“Seizing opportunity in crisis” best describes how Asian national and local governments have responded to the outbreaks of SARS, avian influenza and HIV/AIDS in their jurisdictions. These crises have served as triggers for refurbishing failing public health infrastructure. Effective and sophisticated management of information, skill in risk communication and engagement with global media to control the outbreak and mobilize governments and society to take action are highlighted.

SARS, a wake-up call for governments to pay attention to public health and hygiene

In his overview in the book SARS: How an global epidemic was stopped,\textsuperscript{114} Dr Shigeru Omi, Regional Director of the WHO Western Pacific Region, notes:

SARS shook the world. By some standards, the first emerging and readily transmissible disease of the 21st century was not a big killer, but it caused more fear and social disruption than any other outbreak of our time. … More than 95% of the SARS cases took place in the WHO’s Western Pacific Region. … I don’t know if one can decently say that SARS had a silver lining, but if it did, it was that it awakened the global public-health community from a kind of slumber. … since those days many countries and cities have invested extensively in public health. … Health care workers have been drilled in infection-control measures. Better surveillance systems are in place. And research has been intensified. SARS, for all the fear and suffering it caused, has left public-health systems greatly improved.

The role of communication and media in achieving transparency

Surveillance (defined as “close observation, especially of suspected persons”\textsuperscript{115}) during the SARS outbreak went beyond the usual mechanisms of public health in terms of the level of detail and the speed of information gathering and dissemination. Early in the outbreak, when little was known about the disease, rumours spread through the news and Internet. During the outbreak, in-country teams, usually in the Asian capital cities, gathered information through both “official” (reports sent to WHO by ministries of health) and “unofficial” channels (unconfirmed rumours). WHO handled these two types of information differently. Interestingly, two thirds of rumours were later confirmed.\textsuperscript{116}

Global electronic media played a critical role in providing the public with timely information and sounding the alarm to restrict movement in high-risk areas through 24-hour news coverage of WHO travel advisories. WHO, by talking directly to the global public through global electronic media, held governments accountable for controlling the epidemic and heightened...
awareness on the need for transparency in reporting cases at all levels.

**National and local officials closed ranks to control the SARS outbreak**

National governments and affected cities throughout Asia, despite tremendous political pressure and often adverse public opinion, mustered the political will to enforce stronger surveillance, quarantine and isolation measures to control SARS. In Beijing, for example, at least 30,000 people were quarantined and 20–30% of the population isolated themselves. In Guangxi, gatherings of more than 50 people were banned.

In Hong Kong, the designation of the Princess Margaret Hospital as the SARS hospital was a difficult yet crucial decision. At the end of the epidemic, 62 staff were infected, 25 from the intensive care unit. In late March 2003, Hong Kong’s Quarantine and Prevention of Disease Ordinance of 1936 was revised to include SARS and required medical practitioners to report SARS to the Ministry of Health. This ordinance required SARS contacts to report to medical authorities within 10 days of exposure. The ordinance also enabled quarantine and later evacuation of the residents of Block E, Amoy Gardens when evidence increasingly pointed to an environmental source of spread. Hong Kong’s health promotion sector immediately seized the opportunity to launch a Hygiene Charter that put forward suggestions and guidelines on hygiene practices for more than 10 sectors: the personal and family, management, buildings, catering, education, finance and commercial, industrial, medical and health, public transportation, social welfare, sports and culture and tourism.

In Singapore, cases were identified and isolated promptly at Tan Tock Seng Hospital. Hospitals improved infection control measures. Contact tracing was intensified. The Infectious Disease Act was amended to allow the Government to compel contacts of suspected SARS cases to be quarantined at home and mandated fines for those who refused to comply.

**Avian influenza prevention: a rallying point for Healthy Marketplaces and safer food systems**

The lessons learned from SARS are currently helping countries in the region to deal with the ongoing epidemic of H5N1 avian influenza. Both diseases have drawn attention to how traditional cultural practices, higher population density and increased mobility of human beings have created contexts for animal viruses to cross over and attack humans. In particular, Dr Shigeru Omi cites the risks that come from:

…the way animals are raised for food in Asia, where increasing prosperity has led to a greater demand for meat, and, in some cultures, a taste for the flesh of exotic animals. In markets where wild animals are sold for the table, creates that would never meet in their natural habitat are kept in proximity to one another, setting the conditions for the emergence of new viruses. A similar threat lies in the ways that chickens, ducks, and pigs are raised together, often in unhygienic conditions and usually with no barriers between them and humans. Such husbandry practices must change, or more viruses are likely to emerge from the animal world.

Furthermore, the spread of the H5N1 virus in Viet Nam and Hong Kong was linked to unrestricted poultry movement within and between countries and the role of wet markets in this process was highlighted. Because marketplaces in Asia have multiple economic, cultural, social, religious and political functions, closure of marketplaces was not an option. Countries such as Viet Nam managed to use the


118 WHO WPRO. 2006. SARS: how a global epidemic was stopped. World Health Organization.


avian influenza epidemic as a rallying point to implement a Healthy Marketplaces initiative and safer food systems. Prior to the avian influenza outbreak, most Vietnamese markets did not have separate areas for different types of food. Fresh meat and poultry and cooked food were often sold in the same stall. Sellers' hands tended to be unclean due to the lack of basic infrastructure for hygiene.

Under the Healthy Marketplaces initiative with WHO, poultry sellers were given gloves, boots, and aprons to protect them from the virus and prevent them from handling live chickens with their bare hands as they had done before. They also underwent monthly health checkups as a preventive measure. More importantly, they were told to keep the sick poultry out of the stalls; it was well known that sick or dead poultry were often secretly sold for a profit. Since the opening of the new stalls, no poultry can be sold without a stamp of approval by food safety officials. Local veterinarians have also been closely monitoring poultry suppliers in an effort to stop any smuggling or other illegal means of selling poultry from bird flu-infected areas.

Both the sellers and consumers accepted the changes (no live chicken sales at the market, among other new regulations) when it became obvious that cleaner markets and improved market practices were absolutely necessary.

After the success in setting up Healthy Marketplaces in the famous tourist area of Ha Long, officials from Quang Ninh and Thai Binh provinces have publicly stated their admiration of the initiative and are considering duplicating the measures when they build new markets.

**Reaching out to migrants and floating populations at risk for HIV/AIDS in Asian cities**

Asia is one of two regions with the most rapid growth in new HIV infections, even though sub-Saharan Africa remains the region with the greatest HIV prevalence. Of the 4.8 million new HIV infections worldwide in 2003, Asia accounted for one in four. UNAIDS estimates that more than seven million Asians are living with HIV, and that high-risk behaviors fuel the spread of the virus. Unsafe drug injections and unprotected commercial sex are reported to be responsible for most of the new infections in Asia. HIV/AIDS is predominantly urban in Asia, though there is a paucity of data on intra-urban differentials.

Every year, one billion people ride on China’s gigantic railway system. Beijing’s West Station alone services 70,000 passengers daily and up to 300,000 a day in peak holiday seasons. Many are migrant workers seeking jobs and considered to be at high risk of contracting HIV/AIDS but who have little knowledge of the disease or of how condom use prevents infection. On average, passengers spend two hours in the station and 20 hours on trains.

Since 2003, Beijing’s West Station has run an information campaign on HIV prevention. The organizers target waiting and traveling times, during which they believe passengers are receptive to hearing and accepting information about HIV prevention. The Beijing West Station is one of nine stations participating in a groundbreaking project initiated by the Ministry of Railways, supported by UNFPA. The programme taps into the railway’s massive networks in reaching out to a vast audience, especially the floating population of migrants. Evaluation on knowledge, attitudes and skills is on-going.

The Ministry of Railways hopes to scale up the HIV/AIDS prevention efforts and expand the programme to its 5,700 railway stations across the country, a challenge that would require continued political and economic support.

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Cultivating social solidarity and compassion for survivors of HIV/AIDS
In predominantly Buddhist Thailand, the application of the Four Noble Truths: Dukkha (suffering); Samudaya (the origin of suffering); Nirodha (the cessation of suffering); and Magga (the path leading to the cessation of suffering) in HIV/AIDS education and intervention has profoundly improved communities’ ability to mitigate the suffering caused by the disease and raised people’s awareness about their power in face of the scourge.

Since 2002, monks under the Sangha Metta Project have been conducting community HIV/AIDS workshops that begin with one basic exercise: a reflection on the Four Noble Truths that replaces “Dukkha” – suffering – with “HIV/AIDS”.

Initiated by monks themselves, the project was a direct response to inadequacies in the formal health response and resources of the national government. That leaders were quick to acknowledge that the formal structure was insufficient and that they needed community leaders from various sectors to step forward.

It was in this context that community-based interventions such as the Sangha Metta Project provided a breakthrough. The first workshops were held by abbots of temples in northern Thailand. Those abbots then brought along monks from their respective temples, who in turn extended invitations to lay community leaders, including village headmen, members of village development committees, and representatives of the Tambon Administrative Council.

The impact was immediate and has been sustained, demonstrating the power of building social cohesion for addressing the social dimensions of the HIV/AIDS epidemic. These interventions help survivors from urban centres who return to their villages and may be ostracized. Using Buddhist ethics as their starting point and guide, the community leaders teach about high-risk behavior, set up support groups, provide training for livelihood, and help to take care of AIDS orphans. Meanwhile, notes the Buddha Dharma Education Association, “because local people are accustomed to telling monks their troubles, the latter have become a conduit for identifying many undocumented HIV-positive people who…can be referred to support groups and public assistance programs. ‘HIV-friendly’ temples encourage these people to participate in community activities.”

4. Improving efficiency in financing health promotion in cities
In Asia and the Pacific, it is estimated that less than 10% of national health expenditures go to public health services that carry out both prevention and promotion. Considering the magnitude of public health challenges that could benefit from prevention and promotion, the funds available for population health are a pittance compared to what is spent on hospital services, treatment and cure.

In this section, innovations in national financing mechanisms that enable the promotion and protection of health across the social gradient including cities are highlighted.

Preventive health check-ups for all as part of social health insurance coverage in Japan
Health inequity studies in a predominantly urban country like Japan clearly indicate that socioeconomically disadvantaged populations are less likely to attend health checkups. Though this example comes from a developed country, it demonstrates how social health insurance can become more than a “sickness fund” for the poor, the elderly, the disabled and other disadvantaged groups and can be used to promote health and prevent disease among vulnerable groups.

Currently, almost all medical treatments are included in social health insurance benefits in

123 Email exchange with Dr D Bayarsaikhan, Regional Adviser for Health Financing, WHO Western Pacific Region on 27 April 2007.
Japan. However, health promotion activities such as health checkups and counseling are not. In response to the growing health expenditure, following an increase in the burden of noncommunicable diseases, the Health Insurance Law and Medical Care for the Aged has been amended to incorporate a health checkup package programme into the social health insurance system from April 2008.

The plan obliges insurers to provide effective packages of health education, checkups and counseling to their insured members aged between 40 and 74. Insurers are also obliged to set specific targets to be achieved over five years by measuring the health outcomes of their client groups. Insurers who meet their targets will be rewarded with a reduced contribution requirement to the Medical Fee Payment Fund as a part of the joint payment system for medical fees for the elderly.

By initiating this obligatory health checkup programme, it is hoped that inequities in access to health promoting services will reduce. Financial incentives to the insurers would facilitate the development of effective and efficient programmes and would lighten the burden for health promotion among socioeconomically disadvantaged groups. While this is an example in a developed and high-income country, there are many lessons and insights that are useful for developing countries that are undergoing health sector reform and looking for ways to achieve greater efficiency in social health insurance packages.

**Upping the ante for tobacco and alcohol taxes to promote health in Thailand**

In 2006, the Thai government approved a Baht 5 billion (US$ 125 million) budget to support sports and cultural events, but that was only half of the story. On the other side of this programmed spending for health, much of that earmark was sourced from a 2% annual “sin tax” on tobacco and alcohol.

Thailand already has one of the strictest tax and anti-tobacco regimes in Asia, and is considering enforcing new measures to address health issues related to alcohol consumption. High taxes, strict marketing restrictions and aggressive health communication strategies helped to bring down smoking from 35% of the 15-and-over population in 1981 to 22% in 2001.

What truly sets the Thai model apart is its provisions for sustainability, by drawing revenue and budgets from the targeted industries themselves. Two percent of annual state revenue from tobacco and liquor tariffs is deducted as a contribution to a national health promotion fund.

Today ThaiHealth spends 6% of its budget on raising awareness of health issues and conducting an annual “Cigarettes vs. National Health” seminar to facilitate regular exchanges among researchers, campaigners and the general public. It also encourages the formation of networks and an academic centre on smoking control will be established to undertake further training and research on cigarettes and health, and to support legal and economic measures that will help expose unethical practices by the tobacco industry.

ThaiHealth’s breakthrough has been a source of inspiration for other countries in the region that are at different stages of setting up autonomous infrastructure and financing for the promotion of health such as the Malaysian Health Promotion Board. Similar initiatives for securing tobacco taxes for health have been seen in Mongolia, the Philippines and Tonga.125

**Financing Healthy Cities projects from tobacco taxes in the Republic of Korea**

125 A health promotion leadership and training programme for strengthening infrastructure and financing for health using the health promotion foundation models of Vic Health, Thai Health and the Swiss Health Promotion Foundation was first established by the WHO Western Pacific Regional Office in 2002 under the name of “Prolead”. Prolead, as a regional capacity-building template, continues in the Western Pacific Region as “Prolead plus”, and has now been adapted by the Eastern Mediterranean Region through the WHO Centre for Health Development and WHO Health Promotion Unit, Geneva.
Article 22 of the Korean Health Promotion Act, 1995 specifies that tobacco taxes are to be allocated to the Korea Health Promotion Fund (KHPF), the primary funding organization for national and regional health promotion programmes. It is estimated that the KHPF collected US$ 1.429 billion in 2005 from this tax, and allocated 65% to national health insurance, 5% to cover the administrative costs and 25% to fund projects specifically focused on the health promotion topics of nutrition, physical activity, tobacco and alcohol.\(^{(126)}\)

While total sales of cigarettes are decreasing, the government is gradually raising the tobacco tax and successfully maintaining the health promotion fund. Utilization of tobacco taxes for health promotion projects exceeds its value over the social compensations of polluters – it is helping smokers quit, protecting non-smokers from secondhand smoke and helping all the citizens to promote their health. Moreover, this large, secured fund is allowing close, continuous attention to helping the poor in a predominantly urban country – 82% of the Republic of Korea’s population is urban and its slum to urban population is 37%\(^{(127)}\).

In addition to the national tobacco tax that accounts for 14.2% of the total package price, local governments are allowed to further place taxes on tobacco (up to 25.6% per package) under the Local Tax Law, another article of the Health Promotion Act. Wonju City is one of the cities that has moved to enforce this law. In 2005, the local tobacco tax accounted for 19.6% of all revenue, the second largest among all the local taxes of the city, and the money was used for promoting housing supply, clean water supply, as well as free health care projects for low-income families.

5) Applying information technology to population health activities

5) Applying information technology to population health activities

The macro-social environment in both urban and rural settings – specifically, new (relative) affluence, technological innovation, and commercialization – can help create fairer health opportunities for vulnerable groups. Technological advances and media reach both rural and urban populations, but are nonetheless influential among the urban poor.

Village phone systems improve health opportunities in Bangladesh

In Bangladesh, the peri-urban “villages” maintain rural features but are slowly becoming more concentrated and closely linked to communication infrastructure of the city. In this context, the degree of mobility was one of eight indicators used in a study to assess the degree of women’s empowerment.\(^{(128)}\) Having a telephone in the house may therefore be not only a profitable business opportunity for a woman operator, but also make it a space that is acceptable for other village women to access. Findings indicate clearly that when women are Village Phone Operators, they are more likely to feel comfortable using a phone and are likely to have more equitable access to telecommunications. There is evidence of increased social status that Village Phone Operators have gained in their villages. For example, the fact that better-off villagers now come to a poorer woman’s house to use the phone is significant.\(^{(129)}\) These factors, plus the added income, contribute to the increased status of women in the village.\(^{(130)}\) Women’s empowerment is closely related to maternal and child health. In other words, this technological advance could be a model for improving health equity in village settings.

Empowerment through electronic media


\(^{(130)}\) Ibid.
Another example of how technological transfer has improved women’s health comes from India, where the unmet need for reproductive health care requires a wide demand net. In addition to the supply of oral contraceptives, condoms and IUDs, a “non-supply” approach for increasing contraceptive prevalence is recommended through education. The expansion of education through innovative technology in urban areas is partly responsible for the recent decline in fertility in India. The community can – through technologies such as radio and television – become a key force in knowledge-sharing for greater contraceptive prevalence and also to support its service sector.

In other countries, USAID has supported family planning programmes that utilize strategic communication principles, including the integration of entertainment and education (“enter-educate”) to promote family planning, increase social acceptance of artificial contraceptives, and generate public demand for higher quality of reproductive services in the public and private sector. These types of interventions have been documented by the Johns Hopkins Centre for Communication Programmes and include success stories from Indonesia (“the Blue Circle”), Bangladesh (“the Green Umbrella”) and the Philippines (“Sentrong Sigla – centres of vitality).

Other examples of using innovative technology for health improvements in urban settings are: promotion of literacy and health issues such as HIV/AIDS awareness through radio soap operas in Cambodia; using bikes as innovative billboards and motorcycles for the disabled in China; use of telephones to provide health information and easier access to health services in Mongolia, and use of SMS text messages in the Philippines for national health campaigns. All of these have brought empowerment and strengthened social cohesion within those societies.

Geographic Information Systems (GIS) for city health programmes

In the Visayas region of the Philippines, a number of local governments are leading the way in exploiting Geographic Information Systems (GIS) technology to improve urban centers. In the province of Capiz, for example, a “Backyard GIS” system – built on the backs of low-end computers and using existing data from previous government surveys – was used to help policymakers and community members to take part in what was billed a “Participatory Planning Budgeting Workshop”. With leaders and their constituents looking at the same picture and standing over the same page, GIS helped to identify the community’s infrastructure and investment plans and projects, and helped develop a list of priorities for funding.

In the larger Visayan metropolis of Cebu City, GIS technology is used by the city government to quickly identify “disparity areas” or to undertake “poverty mapping” that can more compellingly call officials’ attention to problem areas. In health care, for example, GIS maps give city planners the ability, in one glance, to monitor the spread and distribution of Cebu’s programmes for maternal and child health. Through colour-coded representations of the city’s various barangays (villages), for example, they can immediately see where there are too few health workers, or where there are higher or lower incidences of infant mortality. This ability to quickly analyse in turn allows the local government to formulate policies and/or direct its limited resources. Cebu officials credit GIS technology with helping them to narrow the gap between the health realities of “disparity areas” and that of the larger region and country. GIS,

136 WHO. Choosing the Channels of Communication: a review of media resources for 11 countries in the Western Pacific Region. Manila: WPRO; undated.
for example, shortened the working time it took for officials to check areas where immunization was not being delivered and/or is still urgently needed.

So impressed and rewarded has Cebu been in its experience with GIS that the city’s own GIS Center now assists local government departments on questions such as how to improve tax collection and how to prevent fires in the community. They also help the city’s Urban Poor Division in seeking options for providing shelter and tenure to the urban poor. The technology, in other words, has now become a standard support service provided by the city government to all its departments.

6) Optimizing social determinants of health in urban settings

Changing the norm for citizens’ enforcement of smoke-free policies

Since the Olympic Games were declared tobacco-free in 1988, international tobacco-free sports events have helped boost host country and city efforts to curb tobacco use in other sports events as well. In 2002, the FIFA World Cup championship events held in the Republic of Korea and Japan were declared smoke-free. In the same year, FIFA received a tobacco control award from the World Health Organization.137

Recently, Beijing has banned smoking in restaurants and popular tourist spots in the lead-up to a smoke-free Olympic Games. Olympic venues, hotels and restaurants located inside the Olympic village will be smoke-free before June 2008. The smoking ban was jointly issued by the city’s health bureau, tourism bureau and bureau of commerce. Beijing started working to reduce smoking in public places a few years ago. As early as 2004, Chinese Premier Wen Jiabao said China would make creating a smoke-free Olympics a priority in its preparations for a green Olympics, and last year, Ministry of Health official Zhang Bin said the ministry was working with the Beijing Organizing Committee for the 2008 Olympics to ensure the games are smoke-free. Smoking will also be banned at all hospitals serving the games by the end of 2007. The no-smoking rule will also apply to public areas like public transport depots and offices. Places that serve children will be a priority.

Viet Nam’s laws already ban smoking in public places. But getting people to respect the law remains a problem. Culture and lack of knowledge about tobacco-related laws and health issues prevent non-smokers from speaking up next to or in the face of smokers in public places. Nor is there widespread practice of tolerating such requests to stop smoking in this nation where 52% of men (but just 1.8% of women) are still smokers. At the Hanoi railway station, some guards reported having been threatened by smokers with a beating.

To introduce and promote the notion that smokers can and should be reminded not to light up in public places, Vietnam declared the 2003 Southeast Asian Games in Hanoi and Ho Chi Minh City tobacco-free – then let volunteers set the example by stubbing out all cigarettes at the venues. Uniformed volunteers approached smokers in the stadiums and politely asked to put out their cigarettes. It was a simple act, repeated thousands of times throughout the days and venues of the games; Vietnamese officials believe it has had a lasting impact and support the long-term efforts of the Vietnam Committee on Smoking and Health (VINACOSH). “Anti-smoking is not a priority for Vietnamese because we are still facing a lot of other (economic) hardships,” said Do Thi Phi, who used to work for the International Development Enterprise NGO, a partner of the government and the WHO in the anti-smoking push in Vietnam. “The SEA Games was the biggest event so far to attract people’s attention to the issue, and it became an important venue to raise their awareness.”

“Intergenerational” walking for health creates caring cities

Statistics show the Asian population is ageing, presenting the challenge of how a smaller, younger generation will care for a much larger,
older generation. The United Nations projects the number of Asians aged 65 and older will increase more than 300% between the years 2000 and 2050 – from 207 million to 857 million. In Asia, governments’ long-term responses to demographic change and population ageing in urban centres are critical even at this stage.

Singapore has started to prepare for the future through activities such as brisk walking and mass Qigong exercises initiated by its Health Promotion Board (HPB) and implemented via the City’s five Community Development Councils (CDCs). To date, the five CDCs offer 37 programmes to assist special segments of the population, including the elderly, the young, and the handicapped. Senior Minister Goh Chok Tong says CDCs have “touched the lives of 180,000 needy Singaporeans.”

The Brisk Walking Clubs represent just one outreach activity. The HPB and CDCs also provide basic health screening in the community for people over 50, charging them a token S$2. But it is the walking clubs, the organized exercises, and the community activities that reach people on any given day. Social cohesion, decency, respect and trust are built through these interventions. In Singapore, the elderly do not walk alone.

Life skills and pre-employment training programmes provide a fairer chance for employment of the urban poor

Marikina City, Philippines has been a Healthy City for more than 10 years and is recognized locally and internationally. In 2004, it embarked on a human resource development project called “The Marikina City Volunteer Corps” that sought to overcome social barriers to formal employment among the urban poor. Encouraging the urban poor to participate in the network, the programme doubles as emergency employment as well as providing “transformation and preparation of the poor for regular employment”. The “volunteers” are engaged in life-skills training programmes on how to budget a minimum wage for nutritious meals for a family of five, how to write a curriculum vitae, how to prepare for a job interview and so forth. Volunteers also receive health training and are able to serve as volunteer health workers. They are also given job experience to rebuild confidence in their ability to take on productive work – as clerks, community health workers or as greeters for the local tourist programme. For four hours a day, individuals receive a wage of 100 pesos (roughly $2).

Through the programme, more than 4,000 volunteer health workers have been added to the city’s health workforce. The impact on health systems was immediate. And while it is difficult to attribute reduction in diarrheal disease or lower dengue prevalence rates to this single intervention, the approach demonstrates the importance of local government accountability for human resource development at the municipal level. But even beyond this, Mayor Marides Fernando says the programme was also about “creating opportunities for the people.” The volunteerism is just a start. After the volunteers’ stints are over, their names and qualifications are added to an employment pool that where both private and public entities can try to match organizational needs with individual skills. Mayor Fernando says the volunteer program gives her constituents added capacity and capability to compete in the job market. The Marikina government allots some 15 million pesos ($300 000) a year to maintain the programme. From the perspective of the local government, the dividends, clearly, far outweigh the cost.

Fuel regulation policy results in healthier city air for all

“New Delhi was choking to death,” says Sunita Narain, director of India’s Center for Science and Environment. “Air pollution was taking one life per hour.” Adds Bhure Lal, 63, then a senior government administrator: “The capital was one of the most polluted on earth. At the end of the day, your collar was black, and you had soot all

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138 Brick, Gabrielle/Hong Kong. Asia - home to half the world population - is graying. Voice of America. 11 July 2006.
over your face. Millions had bronchitis and asthma.”

For the past decade, local advocates and champions from civil society have worked toward regulations to force Delhi’s buses, taxis and rickshaws to convert to cleaner-burning compressed natural gas (CNG). In July 1998, the Supreme Court ruled largely in favor of the proposal and ordered a ban on leaded fuel, conversion of all diesel-powered buses to CNG and the scrapping of old diesel taxis and rickshaws. But the powerful lobbying of busmakers and oil companies – supported by government ministers – created obstacles to implementation. Bus companies took vehicles off the road, stranding angry commuters. Endless queues of rickshaws formed at the handful of gas stations with CNG pumps. Oil companies trotted out scientists who claimed that CNG was just as polluting as diesel. But Narain and Lal fought back. By December 2002, the last diesel bus had left Delhi, 10,000 taxis, 12,000 buses and 80,000 rickshaws were powered by CNG, and now, the city stands as the world’s best test case for CNG.

Narain estimates that Delhi’s air pollution would be 30% higher now but for the introduction of CNG. Although air pollution in Delhi has stabilized, the fight for clean air is far from won. Some 400 to 600 new private cars roll onto the city’s streets every day. Recent evaluation of the impact of fuel-switching in New Delhi shows that the conversion of buses from diesel to CNG has helped to reduce PM10, CO and SO2, but that conversely, no gains have been realized from the conversion of three-wheelers from petrol to CNG, possibly because of poor technology. The gains are also being undermined by the increase in the proportion of diesel-fuel cars and rising distances traveled by all types of vehicles, pointing to the need for more aggressive promotion of public transport policy.

Narain and Lal don’t claim to have slowed global warming. But their efforts have attracted requests for advice from as far away as Kenya and Indonesia.

VI. Synthesis, strategic entry points for scaling up action and conclusions

Synthesis of findings and some thoughts on opportunities for building on current innovations

Innovations in population health that impact the urban poor in Asia have been driven by players and stakeholders who have been able to shape the new political space created by globalization, urbanization, decentralization, democratization and advances in information technology to create opportunities, build capabilities, achieve greater security, empower, engage and mobilize support for policy and action to improve the urban living environment for vulnerable populations.

Within the set of examples used for this report, it is clear that a social movement exists to confront the stark inequities in cities that create and perpetuate inequity and vulnerability that result in poor health.

The primary stakeholders of this movement are organized groups of the urban poor prepared to negotiate for the requisites of a decent life and better health: secure housing, land rights and micro-financing. These groups have discovered the power of their numbers and have shown how networked and “asymmetric” governance nodes operate in a global environment. They demonstrate how once-marginalized groups can bring powerful gatekeepers and interests to the negotiating table.

City and municipal officials who must deal with the political implications of rising inequity in cities are feeling the heat and becoming increasingly responsive to the needs of the urban.

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140 Alex Perry/New Delhi.
142 Alex Perry/New Delhi.
poor. They are less threatened and more open to engaging with them to find solutions that will work as a means to achieving both economic and their political goals and the social goals of their city. Increasingly, local governments of cities and municipalities (exemplified by the Healthy Cities champions) are holding themselves accountable for health and its determinants and there are examples in every country of how local leaders are using intersectoral approaches and more participatory approaches to governance over health, the environment and social development. Local governments are also using city-to-city connectedness (that has evolved through trade and business) as a means of learning and building capacity for health. Partnership between the business sector and local governments within a framework of corporate social responsibility is on the rise. In order for healthy urban governance to flourish, enabling conditions need to be created and sustained at the national level.

Decentralization policies have enabled local governments to break free from the stranglehold of national bureaucracies and hierarchies, even if in many countries this process is incomplete and poorly supported. In this respect, national governments need to develop clear policies and strategies to manage rapid urbanization and health, and human development should be at the centre of this agenda.

Recent outbreaks of infectious disease in Asia have prompted national authorities and ministries of health to pay closer attention to health risks and vulnerabilities created by the urban dimensions of communities: density, crowding, increased mobility, connectivity and diversity. Promoting health and hygiene in the different elemental settings of the city – marketplaces, restaurants, schools, ports, airports – is now higher on national health agendas and creates a gateway of opportunity for public health infrastructure development, be it surveillance, quarantine, isolation, hospital preparedness, emergency response, or outbreak regulations and laws. This should be sustained and must be extended gradually to pursue the unfinished agenda for water, sanitation and waste management in urban informal settlements.

Asia is also showing how it can use its wealth for health. Innovations in the financing of health promotion (social health insurance and tobacco and alcohol taxes) and the uptake of modern information technology in health planning and public health education have been noted. Investments need to be made on healthy systems at all levels, but more so in urban areas. Training, leadership development urban health information systems and new and innovative ways of financing health promotion, protection, treatment, cure and emergency services are needed.

Last but not least, interventions are needed that build social cohesion and address the social determinants of health point to a growing recognition of the links between social norms and fairer health opportunities, as demonstrated by tobacco-free sports, pre-employment capacity building for the urban poor and urban policies for cleaner air. Again, social health issues need to recognized and addressed in many different types of urban activities.

**Strategic entry points for scaling up action**

1) **Engage with the key actors of the existing social movements.** As in any social movement, there are political leaders at all levels (local, national, global) who are recognized and have gained credibility over many years of staying focused on issues. Engagement with these key actors requires an appreciation of the asymmetry of the movements and skill in maneuvering through networked or nodal governance. One cannot go to the front of the parade and expect to lead it.

2) **Support the creation of “global knowledge markets” for healthier cities.** In many instances, effective sharing of knowledge of municipal policy options may be all that is needed to change what seem to be intractable problems. Previous work done by UN-HABITAT and UNDP demonstrate how urban governance tools, systems for recognition for good practices and city-to-city learning mechanisms can bring
about a critical level of change. Global coalitions and alliances of cities such as UCLG, Metropolis and the Cities Alliance can strengthen their focus on health as part of their current agenda. There is clearly a demand and willingness among cities to pay for understanding of how practical interventions can be applied to specific contexts. These knowledge markets need not be confined to Asia and could have a global reach.

3) **Partner with global media to define more “responsive fora” that can help the actors reach a tipping point together.** Engaging with other stakeholders who have a natural interest in transparency and accountability i.e. global media, creates opportunities for reaching a wider audience for political mobilization. The SARS and avian flu threats demonstrated the power of global media as a means of controlling an epidemic, albeit indirectly.

Conclusions
We referred to “healthy urban governance” at the start of this paper and reiterate the need for a broad perspective on urban health in development:

Put health and human development at the centre of government policies and actions in relation to urbanization;
Recognize the critical and pivotal role of local governments in ensuring adequate basic services, housing and access to health care, as well as healthier and safer urban environments and settings where people live, work, learn and play;
Build on and support community grassroots efforts of the urban poor to gain control over their circumstances and the resources they need to develop better living environments;
Develop mechanisms for bringing together private, public and civil society sectors, and defining roles and mechanisms for international and national actors to support local governance capacity;
Win and use resources – aid, investment, loans – from upstream actors to ensure a balance between economic, social, political and cultural development, and establish governance support mechanisms that enable communities and local governments to partner in building healthier and safer human settlements in cities.

Healthy urban governance, as an evolving approach to reducing the health vulnerabilities of the urban poor in Asia, is achievable. Principles of good governance need to be continuously applied to the promotion and protection of health. There is no “one-size-fits-all” solution, and actors will need to continuously navigate a fast-changing environment in order to achieve results. Nodes of power and influence among the urban poor, local governments and the public health sector are growing and discovering their cross-linkages across geopolitical regions. In Asia, as in other cities in the world, there are countless examples of living networks of people, communities, organizations and institutions who have the knowledge, skills and resources for scaling up change. They could certainly benefit from a more supportive and enabling environment for achieving fairer health opportunities for all. Rendering visibility to the health vulnerabilities of the urban poor through skillful framing of public policy issues seems to be an effective starting point.

References


Beall, Jo. From the culture of poverty to inclusive cities: re-framing urban policy and politics. *Journal of International Development* 12, no. 6 (August 2000): 843.


Burris S et al., (2006) Emerging principles of healthy urban governance. Thematic paper for KNUS second meeting (a shorter paper is published in the *Journal of Urban Health* in June 2007, with similar title and the same authors).

Research and Policy Review 21, no. 3 (June 2002): 159.

Campbell T and Campbell A (2006): Emerging health risks in cities of the developing world. Thematic paper for KNUS second meeting (a shorter paper is published in the Journal of Urban Health in June 2007, with similar title and the same authors).

Campbell-Lendrum D and Corvalan C (2007): Climate change and developing country cities: implications for environmental health and equity (a shorter paper is published in the Journal of Urban Health in June 2007, with similar title and the same authors).


Celine D'Cruz and David Satterthwaite. Building homes, changing official approaches: the work of the urban poor organizations and their federations and their contributions to meeting the Millennium Development Goals in urban areas. IIED Working paper 16, Poverty Reduction In Urban Areas Series, IIED, 2005.


David AM, Mercado SP, Becker D and Edmundo K (2006): Approaches to prevention and control of HIV/AIDS, TB and vector-borne diseases in slums and informal settlements. Thematic paper for KNUS second meeting (a shorter paper is published in the Journal of Urban Health in June 2007 with similar title and the same authors).


Dixon J et al. (2006): The health equity dimension of urban food systems. Thematic paper for KNUS second meeting (a shorter paper is published in the Journal of Urban Health in June 2007, with similar title and the same authors.)


Hien TT, Liem NT, Dung NT, et al. Avian influenza A (H5N1) in 10 patients in
Improving Urban Population Health Systems
CENTER FOR SUSTAINABLE URBAN DEVELOPMENT | JULY 15-20, 2007


Leitmann J (2006) Learning from post-disaster response in Indonesia. Thematic paper for KNUS second meeting (a shorter paper is published in the *Journal of Urban Health* in June 2007, with similar title and the same authors).


Li, Xiaoming et al. HIV/AIDS knowledge and the implications for health promotion programs among Chinese college students: geographic, gender and age differences. *Health Promotion International* 19, no. 3 (September 2004): 345.


Luo W, Zhang Y, Li H. Children’s blood lead levels after the phasing out of leaded gasoline in Shantou, China. *Archives of Environmental Health* 58, no. 3 (March 2003): 184-7.


Ompad DC, Galea S, Caiapia WT and Vlahov D (2006) Social determinants of the health of urban populations: Implications for interventions. Thematic paper for KNUS second meeting (a shorter paper is published in the Journal of Urban Health in June 2007, with similar title and the same authors).

second meeting (a shorter paper is published in the Journal of Urban Health in June 2007, with similar title and the same authors).


Pan, Zhenfeng. Socioeconomic predictors of smoking and smoking frequency in urban China: evidence of smoking as a social function. Health Promotion International 19, no. 3 (September 2004): 309.


Sheuya S, Patel S, and Howden-Chapman P (2006) The design of housing and shelter programmes. Thematic paper for KNUS second meeting (a shorter paper is published in the *Journal of Urban Health* in June 2007, with similar title and the same authors).


Takano T. 2001b. Practical methodologies for the evaluation of Healthy Cities projects. WHO/WPRO.


UN-HABITAT (2006a) State of the world’s cities 2006/7. The Millennium development goals and urban sustainability. Nairobi, UN-HABITAT.

UN-HABITAT (2006b) Meeting development goals in small urban centres. Water and sanitation in the world’s cities 2006. The Millennium development goals and urban sustainability. Nairobi, UN-HABITAT.


USAID (2005) www.USAIDmakingcitieswork.org.access


Annexes

Annex 1: CASE STUDIES

Case study: Bangladesh

Microcredit in urban setting: Grameen Bank and BRAC

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Summary
The Grameen and BRAC microcredit initiatives in Bangladesh have reported success in reducing vulnerability and enhanced social networks and empowerment among its village members. As a result, villages have been prevented from falling deeper into poverty. However, there is no clear-cut conclusion as to whether microcredit has succeeded in addressing social gradients among the poor or the wider socioeconomic and cultural determinants of health.

Description
Through the scope and outreach of their microcredit efforts, the Grameen Bank and the Bangladesh Rural Advancement Committee (BRAC) have found fame in the international setting. Both have generated an international wave of interest and been the main source of inspiration for the microcredit movement, which was launched in 1997 as a “global movement to reach 100 million of the world’s poorest families, especially the women of those families, with credit for self-employment and other financial and business services, by the year 2005” (MCS, 1997). Muhammad Yunus, the “Father of the Grameen Bank”, was recently awarded a Nobel Peace Prize for his efforts in providing access to funds to the poor.

In Bangladesh, 16 million people are clients of a microcredit institution. More than 2.3 million are involved in the programme of Grameen Bank and more than 2.7 million in the programme of BRAC (CDF, 1999). The roots of Grameen Bank and BRAC go back to the early seventies when, after the independence of Bangladesh from Pakistan, a huge influx of refugees caused a grinding famine. It was in this context that Grameen Bank and BRAC started their programmes. Whereas BRAC was set up as a support and rehabilitation programme, the Grameen Bank was established as a purely microcredit institution. BRAC expanded and increased its attention to education and skills training; eventually, microcredit was also added as one of the major pillars of the programme. Today, BRAC is still refining this holistic “credit-plus” approach. The broader ambition of BRAC is stated succinctly in the “Seventeen Promises”, something of a credo for BRAC and its members. Grameen Bank has added some

143 The seventeen promises are the following: 1) We shall not do malpractice and injustice; 2) We will work hard and bring prosperity to our family; 3) We will send our children to school; 4) We will adopt family planning and keep our family size small; 5) We will try to be clean and keep our house tidy; 6) We will always drink pure water; 7) We will not keep our food uncovered and will wash our hands and face before we take our meal; 8) We will construct latrines and will not leave our stool where it doesn’t belong; 9) We will cultivate vegetables and trees in and around our house; 10) We will try to help others under all circumstances; 11) We will fight against polygamy and injustices to our wives and all women; 12) We will be loyal to the organization and abide by its rules and regulations; 13) We will not sign anything without having a good understanding of what it means (we will look carefully before we act); 14) We will attend weekly meetings regularly and on time; 15) We will always abide by the decisions of the weekly group meeting; 16) We will regularly deposit our weekly savings; 17) If we receive a loan, we will repay it on time.

144 1) We shall follow and advance the four principles of Grameen Bank – Discipline, Unity, Courage and Hard Work – in all walks of our lives; 2) Prosperity we shall bring to our family; 3) We shall plan to keep our families small. We shall minimise expenditures. We shall look after our health; 7) We shall educate our children and ensure that we can earn to pay for their education; 8) We shall always keep our children and
training and education to its programme over the years but overall, BRAC represents a more holistic approach to development through microcredit. Both credit schemes work through peer pressure and group solidarity where members of groups of five take solidary responsibility for the loans. Social networks are therefore of vital importance for the implementation of the microcredit schemes and their sustainability. The repayment rate rarely falls below 90% — a figure that commercial banks in Bangladesh have not reached (Develtere and Huybrechts, 2002). Although the group mechanism has always been considered the key factor of Grameen Bank's success, not everybody is in agreement on this front. Jain (1996) sees strong decentralization, combined with an extensive information and communication system, as the source of success for both Grameen Bank and BRAC. The specific organizational structure makes good management and transparency possible. On decentralization, Grameen Bank goes even further than BRAC by employing members in the head office and giving everybody the opportunity to become shareholders.

One success story: village phone operators
Degree of mobility is one of eight indicators used in a study to assess the degree of women's empowerment (Hashemi, Schuler and Riley, 1996). Having a telephone in the house may therefore not only be a profitable business opportunity for a woman operator, but may also provide a space that is acceptable for other village women to access. Our findings indicate clearly that when women are village phone (VP) operators, female Grameen Bank members are more likely to feel comfortable using a phone and will likely have more equitable access to a phone. There is evidence of increased social status that Village Phone operators have gained in their villages. For example, the fact that better-off villagers now come to a poorer woman's house to use the phone is significant (Bayes, von Braun and Akhter, 1999). The woman's house is a centre of activity, with people waiting to make or receive calls. Moreover, the woman becomes very aware of the private and personal matters of many villagers. These factors, plus the added income, contribute to her increased status in the village (Bayes, von Braun and Akhter, 1999).

During interviews it was related how the phone is integrated into a woman's busy routine, both day and night. When the phone is mobile, the operator has the ability to keep it with her while she is doing household chores or operating another business enterprise. While there is clearly an inconvenience with phone calls and errands, most women operators we interviewed felt that the benefits overrode the limitations. The average income earned contributes 30–40% of the household income (Bayes, von Braun and Akhter, 1999). It is therefore not surprising that many family members of Village Phone operators are also involved in the business. When a phone call is received, children are sent off as messengers to inform a village member. Husbands, sons and daughters of VP operators that we met proudly confirmed that they knew how to operate the phone. Adolescent children were able to easily tell us the international dialling codes for countries such as Saudi Arabia and Kuwait.

Conclusion
Several assessments (Develtere and Huybrechts, 2002) have shown that access to microcredit in the villages of Bangladesh has definitely succeeded in reducing members' vulnerability and therefore prevented them from falling even further into poverty. The direct and indirect effects on health are clear, such as improving children's health and welfare as well as food
consumption and promoting health knowledge (Hadi, 2001).

Assessment of the social impact of these initiatives has been done through an examination of the situation of poor women in the patriarchal society of Bangladesh. Several authors shared the opinion that Grameen Bank and BRAC have a positive influence on their female members. Women’s increased involvement in family decisions, expanding knowledge, awareness and an improved situation for children were the most important ways in which membership helped boost their status.

First of all, the social inputs of the programmes in terms of individual empowerment and capabilities (knowledge, awareness, health) would also affect non-members in the community. Secondly, an increase in the supply of credit would lead to a decline in interest rates. Wages may also be positively affected by microcredit programmes. However, it is also clear that the poor are not a homogeneous group; social gradients play a big role leading to self-selection and self-exclusion, due often to ill-health on the part of female-headed households. It is indicative that these microcredit schemes alone cannot eliminate vulnerability but that more is needed. Poor people who do not have the needed assets, social relations or self-confidence have to be reached differently.

Finally, it is not clear what impact Grameen Bank and BRAC – or other microcredit programmes – have on the wider social, economic and political environment. While on the one hand religious leaders see Grameen Bank and BRAC as endangering traditional values, on the other hand local and national leaders have tried to work together with them. Grameen Bank and BRAC have continued to mobilize their members around very sensitive issues such as the ones retained in the “sixteen decisions” of Grameen Bank and the “seventeen promises” of BRAC. However, no research has been done on the impact of this sensitization and mobilization on the ideas and practices of members, nor on the way family members and other villagers react to them. The same applies for the advocacy work done by both institutions. Increasingly, Grameen Bank and BRAC voice their opinions on national and international development issues. However, what effect and impact their advocacy strategies have is not known.

References
Case study: China

HIV/AIDS prevention in Beijing, China

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Summary
Innovative approaches to fighting HIV/AIDS in China have shown that certain key interventions, combined with an enabling environment, must be present for success. This is apparently more so in urban settings due to the concentration of intravenous drug users, commercial sex workers and the urban setting as a departure, arrival and transit point, men having sex with men and plasma donors. Four factors have driven China’s response to the HIV/AIDS pandemic: 1) building of social capital (bonding, bridging and linking) among people within the government system; 2) creating and dissemination of scientific information; 3) external influence – partly provoked by the SARS epidemic; and 4) political will to act created by the three other factors.

Description
In 2002 it was predicted that China could have 10 million infected HIV-infected individuals by 2010. The following year, the emerging SARS epidemic further challenged the effectiveness of existing HIV/AIDS interventions by putting stress on the health sector’s capacity. But instead of compromising resources and technical inputs, this motivated the government to take aggressive action on HIV-related issues. SARS not only showed how infectious diseases could threaten economic and social stability but also how a health security risk could affect China’s policies. Policy-makers announced a change of focus from purely economic goals to more focus on health and social well-being with an increased resource envelope. The fact that controlling SARS created contact within and between government offices at a different level as well as linking the government with international agencies such as the WHO and other UN agencies and the US Center for Disease Control stimulated stronger networks, communication and collaboration. This also led to applying measures used in controlling SARS to HIV/AIDS prevention.

For the city of Beijing, as for the country as a whole, the culmination of the control of HIV/AIDS was a legislative framework to control the pandemic. Major initiatives are currently being implemented: 1) case detection through surveillance, such as Voluntary Counseling and Testing, which is free for the poor and 2) educating the public through community campaigns and social marketing with the aim of raising awareness and reducing stigma. National legislation has outlined requirements for local governments, educational institutions, ministries, businesses, health providers, custom and border control and the media. One example is given below from the Ministry of Railways. It has addressed the floating population in Beijing in view of the sheer size and broad movement of this population, and its work may well prove a “tipping point” in AIDS prevention and control in China.146

Beijing
One billion passengers ride China’s vast railway system each year. Millions are rural migrants seeking jobs in the cities. A significant number may engage in behavior that puts them at risk of acquiring HIV, but many know next to nothing about how the virus spreads or how to prevent infection.

Train travel offers a unique opportunity to educate this large floating population about HIV. Since 2002, an innovative campaign has mobilized Chinese railway workers for this task. (See a video on this campaign: http://www.unfpa.org/video/2006/china_railway_06.htm)

“On average passengers will spend two hours in the station and 20 hours on the train,” notes Han Shu Rong, Deputy Director General in the Ministry of Railways’ Department of Labour and Health. “There is a lot of time to conduct

activities on AIDS prevention. It’s easy for people to accept it.”

On the 44-hour journey from Beijing to Panzhihua, a city located in the south of Sichuan province, two half-hour prevention messages are broadcast over the train’s video screens, one in the morning and one in the evening. Staff also hand out flyers, and they have been trained to answer questions about HIV. “We pay special attention to providing information to the passengers,” says conductor Jiang Xiao Ying.

“The main target group is men between 25 and 40,” Han states. “Rural people are shy talking about sexual issues. We conducted research on the effectiveness of different approaches to shape messages for migrants and it seemed that HIV/STD prevention activities are acceptable among rural-to-urban migrants146 and that there is an urgent need for HIV/STI prevention programs that address the cultural, social, and economic constraints facing the migrant population in China.147”

“In a limited time, we try to get across information about the three HIV transmission routes and prevention. Our research indicates that passengers learn a lot.”

Besides educating the passengers, the Ministry of Railways undertakes HIV awareness efforts aimed at protecting the 2.2 million Chinese railway workers and their families.

Education is also underway in nine major transit hubs as part of a pilot effort started by the Ministry with support from the United Nations Population Fund (UNFPA). Officials hope they will eventually be able to expand the programme to many more of the country’s 5,700 train stations. Some 70,000 people pass through the Beijing West Station each day. Electronic boards flash messages about HIV and in the waiting rooms large screens televisive instructive videos. Station workers often distribute brochures. During busy travel periods, such as the annual spring holiday when up to 300,000 passengers a day use the station, workers staff tables to give out information face-to-face. In the station’s clinic, health personnel provide counseling. People who want to know their HIV status are referred to testing facilities.

Condom promotion, once a sensitive topic in China, is an explicit part of the railway campaign. Information materials stress the effectiveness of condoms in preventing HIV infection. Condom vending machines have been installed in station toilets, but Han acknowledges that they are often out of order, adding, “We are trying to procure better machines.”

To Siri Tellier, former UNFPA Representative in China, the railway campaign is indicative of a high level of official commitment to fighting the epidemic. “I think it’s quite clear and widely recognized that the Chinese Government has really taken much stronger steps to prevent HIV in the last three years.” (http://www.unfpa.org/news/news.cfm?ID=831&Language=1, last accessed 25th of April, 2007).

Thirdly, a free anti-retroviral therapy programme was piloted in late 2002 in Shanghai and scaled up in 2003. At the same it became a policy that the urban poor was provided with free anti-retroviral therapy under the “Four Free and One Care policy”. However, a high dropout rate mainly due to drug side-effects has led the government to explore options with the pharmaceutical industry for alternative regimes.

The last intervention the government addressed was mother-to-child transmission. After initial pilot testing that was done simultaneous with the anti-retroviral treatment trial, the government decided that it was necessary to develop national guidelines that stipulate that mothers who test positive be offered counseling, the option of abortion or anti-retroviral therapy, and where feasible, a Caesarian section delivery take place to reduce the likelihood of transmission. Free

formula milk is also provided to infants for 12 months.

**Achievements**
The prevalence of HIV/AIDS in China is about 0.05% and the number of detected cases 840,000. It is evident that the prevalence as well as the total number of HIV/AIDS cases peaked in 2004 with the onset of active testing. So what has caused this turnaround? From the literature it seems that a combination of events such as the SARS epidemic in 2003 combined with a gradual consensus and social capital-building among various levels of the government and administrative structure. Personal relationships were formed that facilitated the consideration and examination of previous unrecognized policy options for detection, prevention and care. This was combined with timely access to information on effective intervention strategies that could change the course of the epidemic. The incremental approach to intervention made the scaling up of “best practice” approaches more effective. Policy recommendations with regard to mass health education campaigns were preceded by small pilot projects that showed their feasibility or efficacy among populations at high risk. Once the evidence was collected, an iterative process of involving the press and garnering political support gathered momentum. Legislation was passed and enforcement ensured through a comprehensive media campaign.

With prevalence rates still low, the success does not come without critical warning, for, as stated by UNAIDS executive director Peter Piot at the opening speech of the National AIDS/STD Conference in Beijing in 2001, “What happens in China will determine the global burden of HIV/AIDS.”

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Case study: Japan

Healthy Japan 21

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Summary
Healthy Japan 21 is a health promotion strategy to enable the citizens of Japan to live a happy and fulfilling life and contribute to the sustainability of society.

This strategy has nine major areas of intervention and is implemented from national to municipal and village level through an iterative planning process involving local intersectoral teams of authorities and citizens. Progress is monitored through regular surveys and the results fed back to the communities through the media.

Description
The aim of this initiative is to enable people to lead a happy and fulfilling life, as well as contribute to a sustainable society.

Healthy Japan 21 has set specific health-related goals that relate to mortality, morbidity and lifestyle-related risk factors. Access to information and the establishment of proper environments is also part of the plan. All refer to national health promotion activities based on new concepts to help all individuals living in Japan in the 21st century to achieve good health.

The health promotion activities are realized through the activities of individuals based on their own vision of health, and supported by a variety of health-related organizations (WHO, 2005).

The Health Promotion Law was passed in 2003. The law established targets to help prevent lifestyle-related disease. It set nine areas of intervention: nutrition intake and eating habits; physical activity and exercise; rest and mental health; tobacco; alcohol; dental health; diabetes mellitus; cardiovascular disease, and cancer.

Figure 1: Outline of the Health Promotion Law

1. Basic policies for health promotion in place;
2. Systems for health promotion developed in prefectures and municipalities;
3. Guides for medical checkups developed;
4. Guides for national surveys on health and nutrition available;
5. Guides for health promotion in place;
6. Guideline for preventing passive smoking in place;
7. Guidelines for labeling of nutritional value of food in place.

The strategy of Healthy Japan 21 is being implemented through national guidelines that will direct the municipality and prefectural administrative systems in promoting healthy lifestyles, together with intersectoral and multilevel interventions based on scientific evidence with predefined indicators and targets.

From national to local level: each level of government in Japan must play a key role in the implementation of Japan 21, and each level is delegated its own roles and responsibilities. For example:

1) National government is directed to develop implementation strategies, set up targets and monitor implementation.
2) Prefectures must support cities and municipalities in implementing Healthy Japan 21 and ensure intersectoral and multilevel collaboration. Through a participatory planning process, local strategies and targets are defined in each prefecture, such as the Action Health Index for Hyogo Prefecture. Local organizational structures are put in place to ensure effective and efficient implementation. The media are involved to ensure that the population is aware of the strategies and targets as well as progress achieved. Furthermore,
progress is reported via the internet to ensure accountability.

3) Cities, municipalities and villages develop local plans in specific areas, such as the ones related to mother and childcare and services for the elderly. These plans are aligned with the prefectural and national plans through an iterative process and widely disseminated through the Internet (http://www.city.kobe.jp/cityoffice/18/menu03/h/hoken/) and press.

For nutrition: the traditional Japanese diet, high in carbohydrates and salt and low in animal protein, has gradually improved, but these improvements have been counteracted by an increase in lifestyle-related diseases related to “environmental impact”. The outcome is seen in behaviors such as skipping breakfast and eating fast food of unbalanced nutritional value. Healthy Japan 21 addresses this problem not only through individual health education but also through promotion of environments that are conducive to healthy eating habits.

For physical activity and exercise: prevention of lifestyle-related diseases is related to the level of physical activities that a person engages in. Lifestyle changes such as decreased walkability in the elderly, adults and children have contributed to the increased morbidity of noncommunicable diseases. Health education about the importance of keeping fit and healthy is currently ongoing for preschoolers, schoolchildren and adults.

For mental health and rest: according to the 1996 Attitude Survey on Good Health, 54.6% of the population experienced stress during the month prior to the survey; men cited work-related stress and women cited family-related and work-related stress. Stress is a predisposing factor for hypertension, diabetes and sleep disorders – up to 23% of the population was found to suffer from sleep disorders, often addressed through alcohol consumption, leading to a high prevalence of accidents.

For tobacco control: the trend of smoking in Japan shows that the prevalence among males is increasing, especially young women in their teenage years. Smoking is a known risk for noncommunicable diseases such as cancers, ischemic heart diseases and for low birth weight and premature delivery.

For alcohol control: alcohol is a traditional stimulant during social events in Japan, and a survey from 2002 showed that 50% of men and 10% of women regularly consume alcohol. Japan’s significant consumption is facilitated by easy access such as alcohol sold from vending machines. Healthy Japan 21 has put legal and regulatory frameworks in place for reducing alcohol consumption.

For dental health: dental care is part of the agenda of Healthy Japan 21, with particular focus on the elderly, as the effect of odontopathy on the elderly is worse than on the younger generation. Not only do elderly people have problems chewing their food without teeth, they are also at higher risk of pneumonia. Healthy Japan 21 has put a movement known as “8020 (Hachimal Niimaru)” in place, aiming at keeping 20 teeth throughout the lifespan and maintaining the ability to chew, thus preventing tooth decay and periodontitis from early life on.

For diabetes mellitus: diabetes is on the increase in Japan and is associated with obesity, ageing, reduced physical activity and impaired glucose tolerance, as well as family history of diabetes. Healthy Japan 21 is campaigning for preventive measures that address obesity through physical activity and nutrition.

For cardiovascular diseases: these will be addressed indirectly through nutrition, physical exercise, tobacco control and alcohol reduction, as well as reduction in stress-inducing environments.

For cancer prevention: Healthy Japan 21 has emphasized early detection of cancer through screening as well as healthy lifestyles (see above). However Fukuda et al. 2007 have shown that there are notable socioeconomic differences in cancer-screening participation in Japan depending on marital status, rural-urban setting, income and employment.
The evaluation takes place at local and national levels. In Kobe, the city has set up a system for registering citizens who wish to participate in Healthy Japan 21. This participation not only involves following the set health guidelines but also ensuring that the participants have a voice in the development of strategies and can be part of the monitoring process. This system has been expanded to shops, restaurants and hotels. Healthy Kobe 21 aims to register 1,000 convenience stores and supermarkets as well as hotels and restaurants by 2010. Each registered enterprise receives the Healthy Kobe 21 sticker that can then be featured on its website or displayed on the premises (http://www.city.kobe.jp/cityoffice/18/menu03/h/hoken/hp21do/sapoitiran.htm).

Conclusion
The social issues that postwar Japan has faced resulting from globalization, industrialization, rapid economic growth, technological innovation and not least rapid urbanization have been vast. Policy and research have been combined to develop effective strategies to improve health and decrease inequity. The lesson learned is that urban communities have become interdependent and share issues in ways that transcend local, national and international borders. Japan and its cities have an important role in sharing their scientific approach and knowledge as exemplified by the Healthy Japan 21 approach. This can be further enhanced through policy solutions based on scientific evidence and participatory action research. The first type of research will be through specialized studies that support environmental factors for improving health, and the second type of studies will be through reflective participatory action research that addresses multiple determinants of health and promotes skills in human relations (Takano, 2007).

Case study: Pakistan

Orangi Pilot Project in Pakistan

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How and when poor people demand sanitation services, and how to meet these: the case of the Orangi Pilot Project in Karachi

In the early 1980s, Dr Akhtar Hameed Khan, a world-renowned community organizer, began working in the Orangi slum of Karachi. Instead of telling the people what to do, or what they needed to do, he went asking what issues they had that he could help resolve. While community members had a relatively satisfactory supply of water, they faced "streets that were filled with excreta and wastewater, making movement difficult and creating enormous health hazards.” What did the people want, and how did they intend to get it? he asked. What they wanted was clear: “people aspired to a traditional sewerage system...it would be difficult to get them to finance anything else.” And how they would get it, too, was clear – they would have Dr Khan to persuade the Karachi Development Authority (KDA) to provide it for free as it had done (in their eyes, at least) in the richer areas of the city.

Dr Khan then spent months going with representatives from the community to petition KDA to provide the service. Once it was clear that this would never happen, Dr Khan was ready to work with the community on finding alternatives. (He would later describe this first step as the most important thing he did in Orangi – liberating, as he put it, the people from the demobilizing myths of government promises.) With a small amount of core external funding, the Orangi Pilot Project (OPP) was started. The services that people wanted were clear; the task was to reduce the costs so that these were affordable and to develop organizations that could provide and operate the systems. On the technical side, the achievements of the OPP architects and engineers were remarkable and
innovative. Coupled with an elimination of corruption, and the provision of labour by community members, the costs (in-house sanitary latrine and house sewer on the plot, and underground sewers in the lanes and streets) are less than US$ 100 per household.

The related organizational achievements are equally impressive. The OPP staff has played a catalytic role, explaining the benefits of sanitation and the technical possibilities to residents, conducting research and providing technical assistance. The OPP staff never handled the community’s money. The total costs of OPP’s operations amounted, even in the project’s early years, to less than 15% of the amount invested by the community. The households’ responsibilities include financing their share of the costs, participating in construction, and election of a “lane manager”, who typically represents about fifteen households. The lane committees, in turn, elect members of neighbourhood committees (typically around 600 houses) who manage the secondary sewers.

The early successes achieved by the Project in the 1980s created a “snowball” effect, in part because of increases in the value of property where lanes had installed a sewerage system. As the power of the OPP-related organizations increased, so they were able to bring pressure on the municipality to provide funds for the construction of secondary and primary sewers. The Orangi Pilot Project has led to the provision of sewerage to over 600,000 poor people in Karachi and to attempts by at least one progressive municipal development authority in Pakistan to follow the OPP method and, in the words of Arif Hasan, “to have government behave like an NGO.” Even in Karachi, the mayor has now formally accepted the principle of “internal” development by the residents and “external” development (including the trunk sewers and treatment) by the municipality. The experience of Orangi demonstrates graphically how peoples’ demands move naturally from the provision of water to removal of waste from their houses, then their blocks and finally their neighbourhoods and towns (See page 121 – http://siteresources.worldbank.org/INTGENDER/Resources/toolkit.pdf).

A report on the Orangi Pilot Project in Pakistan mentions how it was discovered that wives were often more concerned than husbands about disease and sanitation, as the burden of caring for the sick often fell to them. Project staff saw many examples of women forcing their reluctant husbands to pay their contribution to the project’s low-cost sanitation component. (Khan, Akthar Hameed. Orangi Pilot Projects Programs. Orangi Pilot Project – Research Training Institute. 1992, p. 22.) It was also noted that mothers saw most clearly the connection between filth and disease, although they did not always know the specific causes or methods of prevention. However, they were the ones with the job of caring for sick family members and for ensuring household cleanliness, thus managing hygiene at the household level. The project therefore was intended to reach them with messages on proper hygiene and sanitation. Since it is customary for women to stay inside their homes, sessions could not be held at clinics. Instead, the project introduced mobile training teams composed of a lady health visitor and a social organizer. An activist family or “contact lady” was chosen for each 10–20 lanes in the area. Meetings were held at these homes. The contact lady activists became trusted advisors and conveners for their neighbours, providing a means for the health extension teams to hold discussions with neighbourhood women to spread learning about good sanitation practices.
Case study: Philippines

Cebu City’s Geographic Information Systems

Ira Pedrasa
Manila, Philippines

Geographic Information System (GIS) technology has long been used to improve governance efforts in such concerns as land use, traffic management, and even tax collection. The ubiquity of computers (and the explosion of computing power) has allowed planners and policy-makers to translate demographics and statistics into graphical representations of specific communities’ realities, concerns, resources, and needs. GIS technology has thus made planning and resource allocation easier and more efficient. Planners could literally see trends pictured on computer monitors, and that has allowed them to more concretely discuss problems and point out possible solutions.

In the Philippines’ Visayas region, a number of local governments are leading the way in exploiting the technology to improve urban centers. In the province of Capiz, for example, a “Backyard GIS” system – built on the backs of low-end computers in the city, and using existing data from previous government surveys – was used to help policy-makers and community members to take part in what was billed a “Participatory Planning Budgeting Workshop”. With leaders and their constituents looking at the same picture and standing over the same page, GIS helped Capiz folk to identify the community’s infrastructure and investment plans and projects, and develop their list of priorities for funding.

In the larger Visayan metropolis of Cebu, GIS technology is used by the city government to, among other things, quickly identify “disparity areas”, towns and villages that need help the most. Engineer Nicesoro Iroy of Cebu’s Planning and Development Office says GIS technology gave them “a poverty mapping system” that could more compellingly call officials’ attention to problem areas.

In healthcare, for example, GIS maps give city planners the ability to, in one glance, monitor the spread and distribution of Cebu’s programs for maternal and child healthcare. Through colour-coded representations of the city’s various barangays (villages), for example, they can immediately see where there are too few health workers, or where there are higher or lower incidences of infant mortality.

Such ability to quickly analyse and understand in turn allows the local government to formulate policies and/or direct its limited resources. Cebu officials credit GIS technology with helping them to narrow the gap between the health realities of “disparity areas” and that of the larger region and country to which the city belongs.

GIS, for example, shortened the working time it took for officials to check areas where immunization was not being delivered and/or is still urgently needed. So impressed and rewarded has Cebu been in its experience with GIS that the city’s own GIS Center now assists local government departments on problems such as how to improve tax collection and how to prevent fires in the community. They also help the city’s Urban Poor Division in seeking options for affording shelter and tenure for the urban poor. GIS, in other words, has now become a standard support service provided by the city government to all its departments.
Case study: Philippines

Human resource development through the volunteers programme of Marikina City and implications for local governments in the Philippines

Ira Pedrasa
Manila, Philippines

With nearly half a million people living in their territory, the officials of Marikina City know that, much like any other municipality in the Philippines, the formal health care systems are far from fully equipped to deliver everything their residents need. The ideal situation for example, says city health chief Dr Alberto Herrera, is to have at least one health worker for every 20 families in the city. Yet Marikina only has around 200 barangay health workers for its more than 450,000 people.

Spread out over 15 barangays that each have 20,000 to 30,000 residents, the number of health workers could hardly be expected to rise, given Marikina’s limited resources. As it stands, the city can only afford to give an official barangay health workers a monthly allowance of 500 pesos (around $10).

And yet Marikina has augmented its health force over the past three years, thanks to a bold volunteer programme that targets health and unemployment issues at the same time. The Marikina City Volunteer Corps started operations in 2004, with the aim of promoting the spirit of volunteerism and creating a network of free helpers in city programs. Among other things, it has added 4,000 people to the local healthcare system and the actual workforce.

“We teach them primary health care and preventive medicine,” Dr Herrera says. The volunteer health workers are skilled enough to take people’s blood pressure, for example, as well as to teach families the ways and virtues of basic hygiene. The requirements for joining Marikina’s volunteer corps are simple. The city government’s official website says one needs only be a resident of Marikina, be at least 17 years old, and have a “willingness to serve the community for free.”

To both the volunteers and the city, of course, there were more compelling motivations. Mayor Marides Carlos-Fernando, who started the volunteer program, says it was also an intervention for “emergency employment” – something to provide “transformation and preparation for people for the real work.”

Each batch of volunteers in Marikina is asked to augment public work for three to six months before another wave of volunteers takes its place. During this period, the volunteers (mostly from the population’s urban poor) each work four hours a day for a wage of 100 pesos (roughly $2). They do as much as there is to be done, from clerical jobs to health-related work.

The impact on the city’s health systems was immediate. But even beyond this, Mayor Fernando says the program was also about “creating opportunities for the people.” The volunteerism is just a start. After the volunteers’ stints are over, their names and qualifications are added to an employment pool where both private and public entities can try to match organizational needs with individual skills. Mayor Fernando says the volunteer program gives her constituents added capacity and capability to compete in the job market. “We have a success rate of 75%” in terms of placement of their former volunteers, she says. “The remaining 25% mostly come from the older sets whose employability is unfortunately lower. But even they can still find opportunities in odd jobs such as cleaning the surroundings.”

The Marikina government allots some 15 million pesos ($300,000) a year to maintain the program. The dividends, clearly, are much higher than that.
Improving Urban Population Health Systems
CENTER FOR SUSTAINABLE URBAN DEVELOPMENT | JULY 15-20, 2007

Case study: India

Self-Employed Women’s Association (SEWA)

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SEWA – India

In 1971, Mrs Ela Bhatt organized a small group of women workers in the cloth markets of Ahmedabad in Gujarat, India, to demand fair treatment of women by the merchants. Their victory triggered more groups to start organizing themselves in different sectors. In response to an appeal from the women and at the initiative of Mrs Ela Bhatt, the Self-Employed Women’s Association (SEWA) was born on 3 December 1971. SEWA’s success in Gujarat inspired other regions, and SEWA organizations were started for unorganized women workers in other states. Together, ten member organizations form SEWA Bharat, with the mandate to highlight the issues of women working in the informal sector and to strengthen the capacity of these women and the organizations that serve them. SEWA considers itself the largest membership-based organization in India and advocates on issues concerning women workers by carrying their voices to policymakers at the national level. SEWA also supports its member organizations to build and strengthen their own capacities. SEWA considers itself “both an organization and a movement, with each strengthening and carrying forward the other.”

In 2004, SEWA reported that more than 93% of all workers in India were considered self-employed, and more than half of were women. SEWA has concentrated much of its work on gaining access to water for productive enterprises. In addition, as women are often responsible for providing water for their household, the lack of adequate sanitation undermines needs to be taken into consideration, as the relative benefits of having safe water supply in a community can be jeopardized if there are no safe sources of sanitation. In addition, according to a report from the United Nations, “Women play a crucial role in influencing the hygiene behaviours of young children, and men can – and should – also serve as role models in sustaining changes in habits.” (United Nations Department of Economic and Social Affairs, Commission on Sustainable Development. A gender perspective on water resources and sanitation. Background Paper No. 2. February 2005.)

According to case studies outlined by the One World Action campaign (online 2007), one of the union leaders of SEWA Bharat, Sanjay Kumar, noted:

There is much to be done in terms of strengthening women’s leadership, their bargaining power within and outside their homes and their involvement in policy-making and decision-making. It is their issues, their priorities and needs which should guide and mould the development process in our country.

Quoted from SEWA website:

Over the last fifty years there has been considerable urbanization in India as rural migrants both rich and poor came to the cities and towns in search of employment. One of the outcomes of the laws, regulations and approaches to urban management that have prevailed over this period is that slum communities have come to constitute a large and growing percentage of the population in cities and towns. Almost 28% of the Indian population live in the urban areas (2001 census), of these, approximately 67% do not have access to toilet facilities, 52% are uncovered by sanitation and sewerage infrastructure and 20% do not get safe drinking water.

The slum population in urban areas consists of families working primarily in the informal sector where there is no well-defined employer-employee relationship and the workers and producers tend not to be covered by social security provisions of any kind. In India, as in most developing countries, the informal sector is very large and growing. Although informal sector workers are a major part of the urban workforce, due to lack of infrastructure facilities, the
productivity of this sector is much lower than it could be. This is especially true of women, who bear the bulk of the cost associated with the lack of basic infrastructure. The major cost of poor infrastructure is in terms of the health of the slum population, which leads to continuous physical degradation and low productivity.

The lack of sanitation, clean drinking water and unhygienic surroundings has led to poor morbidity and mortality indicators among the slum populations. Morbidity patterns among the slum populations are high and reveal a preponderance of disease relating to water pollution. In a study of women who have accessed SEWA’s health insurance scheme, it was found that 62.6% of women suffered from water-related complaints. Gastric problems including dysentery and typhoid affected 20%, followed by malaria (12%) and skin diseases (10%). Such high levels of morbidity not only decrease the productivity and the quality of life of the slum populations but also lead to heavy expenditures on health care which often result in the family trapped in a vicious cycle of poverty.

SEWA Bharat’s sister organization, Mahila Housing SEWA Trust, runs the Ahmedabad Parivartan project, which transforms the physical environment in which informal sector workers live by providing a package of seven infrastructure services, including paved roads, individual toilets, water and drainage connections and street lighting. The package is provided on an equitable cost-sharing basis, with community residents contributing one third of the cost. The project is implemented by registered bodies known as “Community Based Associations”, which represent the interests of the residents as well as maintain the newly acquired infrastructure. More information about the project is available at www.sewahousing.org. SEWA Bharat works towards promoting such projects in its member organizations and providing the most basic services such as water sanitation and health to the women of the urban slums of India. These aims are achieved in a demand-driven and financially sustainable way.

The Gujarat Mahila SEWA Housing Trust: women see housing as a basic need next only to work and food. Because a house offers safety to them and their families, it is perhaps their only asset and often it is also their workplace. SEWA and SEWA bank have been providing various housing services to their members, including housing finance worth Rs 8,262,000 to 1,162 women, along with technical assistance. In Ahmedabad, 158 women received their own plots under the Urban Land Ceiling Act, and a scheme was set in place to build houses in one consolidated plot.

However, in order to strengthen these efforts, SEWA has joined with other like-minded organizations to form a trust specifically dedicated to promote housing for self-employed women. The founders of the Gujarat Mahila SEWA Housing Trust are SEWA, SEWA Bank, Gujarat Mahila Co-operative Federation, Friends of Women’s World Banking, Foundation for Public Interest and the Banaskantha DWCRA Association.

The Trust aims to provide technical, research and advocacy support to its members to enable “better provision of all types of housing services to self-employed women”. (http://www.gdrc.org/icm/akiko/sewaE6.html)
Case study: Singapore

Health programs for urban elderly

Divine Salvador
Singapore

Any given day in Singapore finds its elderly citizens walking in groups, as if keeping pace with the city-state’s professionals. But unlike those harried workers, these senior citizens are not in any hurry to get anywhere. They hustle along neighbourhood sidewalks or through city parks, but the destination is the journey itself: the exercise and good health provided and organized for them by the government.

Whether through mass qigong exercises or organized walks, Singapore’s Health Promotion Board (HPB) sees itself as “the main driver for national health promotion and disease prevention programmes.” Among other things, therefore, the HPB helps to promote and support brisk walking clubs throughout the city. There are monthly brisk walks organized to pass through various parks and reserves. Many parks also have fitness stations where people can get together and enjoy mass exercises like qigong.

Established in 2001 and currently headed by Executive Officer Designate Lam Pin Woon, the HPB implements its projects via the Lion City’s five Community Development Councils (CDCs).

The CDCs, established in 1997, consist of 12 to 80 appointed members headed by a mayor. These councils, along with other grassroots organizations, are the main conduit for across-the-board government policies. To date, the five CDCs offer 37 programmes to assist special segments of the population, including the elderly, the young, and the handicapped. Senior Minister Goh Chok Tong says CDCs have “touched the lives of 180,000 needy Singaporeans.”

The elderly represent a special beneficiary sector. “Aside from physical health concerns, there’s the stress and loneliness. You know, empty nest syndrome,” Lam says. “So we are spending a lot of time with them so that they’re not too lonely.”
Case study: Singapore

Food safety among street vendors/hawker stalls

Divine Salvador
Singapore

Hawkers’ centres in Singapore, like the one in popular Bugis Square, are always teeming with people. The smells wafting in and out of the centers are testament to Singapore’s cultural diversity.

It is also, of course, testament to two other things the city-state is best known for: food and cleanliness.

The foods sold at Singapore’s hawkers’ centres are much like street foods sold in other countries – cheap, accessible, and a great introduction to the local culture. Almost everywhere else, however, the term “street food” is also equated with hygienic risk. The lack of running water, exposure to the elements, improperly cleaned utensils, and often the very absence of business permits and regulations place both street vendors and their patrons at risk for disease.

Singapore, however, has long rejected the formula that street food necessarily equals a lack of quality and safety standards, and therefore actively intervenes to not only apply standards but help the vendors meet such standards.

Running water and electricity for heating and refrigeration are two necessities for food hygiene. Because vendors of street foods usually have little or no access to either, what with food carts parked along sidewalks, hygiene suffers in the preparing and preserving of food, and connoisseurs of street food often run the risk of contracting gastrointestinal diseases.

The Singapore government solved this problem when it decided to organize street food vendors into designated locations and provided them with water and electricity. Today, both vendors and customers enjoy heat, refrigeration, potable water, and, of course, a roof to shelter them as they enjoy their laksa.

In Singapore, one cannot just park a food cart by the side of the road or set up a food stand along the sidewalk. Stalls and stores that sell street food are subject to the same strict food safety regulations as other food establishments.

The National Environment Agency (NEA), which is tasked to ensure sanitation of hawkers’ markets, employs strict rules and regulations in giving out – and revoking – food licenses. But the agency also regularly offers seminars on food safety and hygiene to both vendors and consumers. It also comes out with advisories on food safety and hygiene, and announces which establishments have had their licenses suspended or revoked.

Even with the SARS outbreak, the safety of street foods remained unquestioned. Singapore’s response to the SARS threat has been hailed as successful and exemplary by different agencies and organizations, both local and international.

If anything, food safety regulations have become stricter and more effective. Beyond SARS, reports of food poisoning remain very rare, according to Mr Lam Pin Woon of the Health Promotion Board (HPB), allowing Singapore to retain its title as the best place to enjoy street food in the region.
Case study: Thailand

Innovation in community-upgrading among the urban poor through CODI

With reporting from Jeerawat Na Thalang and SEAPA
Bangkok, Thailand

The canals that once earned Bangkok its billing as “The Venice of the East” have also inevitably represented the precariousness and vulnerability of living in this urban jungle. Water represents life anywhere in the world, but pollution in Thailand’s famed waterways and cramped settlements along their banks have in the past decades also made the canals – or klongs – symbols of illness and potential demise.

However, the city’s tributaries now also represent the fight to survive, and the promise of winning. Current attempts to revive not just the klongs, but also the neighbourhoods clinging to them, provide compelling models for rehabilitating entire communities.

In recent years, for example, the once problematic squatters along Bangkok’s Klong Hualampung have seen their communities cleaned, decongested, and repainted – and legitimized. The squatters have become organized and their properties are now properly leased. To get to this point, no less than five distinct neighbourhoods along the klong were somehow motivated to band and work together, and then learned to coordinate with NGOs, local governments, financial institutions and other concerned sectors, such as volunteer professionals.

Around Bangkok’s network of canals, in other words, a network of neighbourhoods, a network of sectors, and then a “network of networks” were all instigated and nurtured to bring together this inspiring picture of community empowerment.

The one government intervention crucial to spurring this model of urban development was the formation of the Community Organisation Development Institute (CODI) by the Thai government.

Brought together from two Thai offices dealing with urban and rural development, CODI is at once a lending institution and an instigator – a catalyst – for uniting once-frayed communities into more formal, organized and empowered sectors.

CODI itself provides soft state loans to organized communities, augmenting international development assistance and, crucially, rewarding local counterpart funds that the community members themselves raise from their own networks.

As CODI Director Somsook Boonyabancha notes, “CODI is an organization that [believes in and encourages] people’s management through local organizations that collect savings, offer loans and collectively make decisions and implement projects.”

CODI invests in networks. Networks after all give communities courage as well as shared skills and capacities for managing projects and funds, the institute believes. Such skills and capacities spiral upwards towards greater aspirational initiatives, Somsook notes, further empowering the communities.

One of CODI’s first interventions on water pollution and urban settlements ran from 1996 to 2002 and saw communities “organized to identify needs and encouraged to take greater control over their environment and development,” noted Donovan Storey in a presentation on CODI in 2005. “Through small loans of a few thousand US dollars CODI supported hundreds of poor communities to become involved in identifying environmental threats, developing low-cost community-driven responses to these needs, and organizing themselves into viable collectives to manage funds and projects and to network with other communities facing similar challenges. This often acted as a catalyst for canal-cleaning projects and in some cases involved communities scaling up their actions to focus on tenure, livelihoods and wider recognition over their rights and existence.”
This effect has been refined into a template that CODI has applied in other stories around Thailand.

In Klong Mekhaa, Chiang Mai, northern Thailand, a project involving approximately 1,000 households of an “informal settlement” threatened with eviction saw CODI loans helping to push residents to clean up the canal, network with other Chiang Mai sectors (they got architects to volunteer their services, for example) and be rewarded with 30-year leases where their houses stood. Encouraged, the network again turned to CODI for more community loans, this time for community enterprises, income generating activities, and a credit-saving scheme.

“Poverty reduction cannot be achieved simply through financial mechanisms,” Somsook said in a paper co-authored with Diana Mitlin of the Institute for Development Policy and Management. “The change that is required means that people need to learn about possible strategies, to have more confidence, to negotiate and to work together as a group. Then they can change their relations with the city managers and with other stakeholders that influence access to resources.”

Case study: Thailand
Community-based care and interventions for HIV/AIDS in Thailand

With reporting from Jeerawat Na Thalang and SEAPA
Bangkok, Thailand

Buddhist teachings regularly remind followers of the Four Noble Truths: Dukkha (Suffering); Samudaya (the origin of suffering); Nirodha (the cessation of suffering); and Magga (the path leading to the cessation of suffering). In predominantly Buddhist Thailand, the application of the Four Noble Truths in HIV/AIDS education and intervention has had profound effects on communities’ ability to mitigate the suffering caused by the disease, as well as raised people’s awareness about their power in face of the scourge.

Since 2002, Thai Buddhist monks under the Sangha Metta Project have been conducting community HIV/AIDS workshops that begin with one basic exercise: a reflection on the Four Noble Truths that replaces “Dukkha” – suffering – with “HIV/AIDS.” Ultimately, because Buddhist teachings say that understanding the Noble Truths leads to Parinna (comprehension of suffering), Pahana (eradication of the cause of suffering), Sacchikiriya (the cessation of suffering), and Bhavana (the development of the path to enlightenment), the Sangha Metta Project uses a shared value – that of religion – to make Thais more aware and involved in HIV/AIDS care and intervention, particularly at the level where the alternatives – ignorance and apathy – are the most dangerous: the community level.

Initiated by monks themselves, the project was a direct response to inadequacies in the formal health response and resources of the national government. Though one of the first Asian countries to acknowledge HIV/AIDS in its local population, Thailand’s response was long hampered by management and resource issues in the public health sector. Documentation of cases was itself problematic, and, beyond medical help, any thought given to counselling and home care
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for persons living with HIV/AIDS (PLWHAs) was limited by a lack of resources and standardized training for health workers or even volunteers. Efforts on the community level were also severely hampered by stigmatization and misconceptions about HIV/AIDS transmission. Thai leaders were quick to acknowledge that they couldn’t do it on their own. They needed community leaders from various sectors to step forward.

Thailand has now made significant strides in addressing the concerns of PLWHAs since HIV/AIDS first took hold in the country in the 1990s. But the tasks remain daunting. The United Nations Program on HIV/AIDS (UNAIDS) estimates that 570,000 Thais or 1.5% of the country’s adult population are still infected. Condom use is declining and a high number of intravenous drug users in urban areas are HIV-positive. Only 1% of these drug users benefit from HIV prevention services.

It was in this context that community-based interventions such as the Sangha Metta Project provided a breakthrough. The first workshops were directed by abbots at temples in northern Thailand. Those abbots then brought along monks from their respective temples, who in turn extended invitations to lay community leaders, including village headmen, members of village development committees and representatives of the Tambon Administrative Council.

The impact was immediate and has been sustained. Using Buddhist ethics as their starting point and guideline, the community leaders teach about high-risk behavior, set up support groups, provide training for livelihood and help to take care of AIDS orphans. Meanwhile, notes the Buddha Dharma Education Association, “because local people are accustomed to telling monks their troubles, the latter have become a conduit for identifying many undocumented HIV-positive people who can be referred to support groups and public assistance programs.” HIV-friendly temples encourage these people to participate in community activities. The example set by the Sangha Metta Project is now the subject of replication efforts by Thailand’s neighbours in Laos, Myanmar, Cambodia, Southern China, Vietnam, and even Mongolia and Bhutan.
Case study: Thailand

Health projects from tobacco and alcohol taxes

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In 2006, the Thai government approved a Bt5 billion (US$ 125 million) budget to support sports and cultural events, but that was only one half of the story. On the other side of this programmed spending for health, much of the earmarked fund was sourced from a 2% annual “sin” tax share from levies on tobacco and alcohol. Thailand already has one of the strictest tax and anti-tobacco regimes in Asia and it is considering enforcing new measures to address health issues related to alcohol consumption. High taxes, strict marketing restrictions, and aggressive health communication strategies helped to bring down smoking from 35% of the 15-and-over population in 1981 to 22% in 2001.

Graphic and morbid pictures of people dying and debilitated cover more than half cigarette packs — much more powerful than the typical text-based health warnings seen almost everywhere else in the world. When Thailand first considered raising cigarette taxes from 55 to 60% in 1993, opponents of the tax feared that the government would lose revenue while failing to make a dent in the problem of smoking. In 1994, however, Thailand’s Excise Department showed that revenue from cigarette excise taxes in fact jumped from 15 billion baht (US$ 0.576 billion) to 20 billion baht (US$ 0.769 billion). Since then, the tax has been increased six times and currently stands at 75% of the retail price.

Meanwhile, the resulting higher prices for cigarettes have corresponded to immediate declines in smoking.

Beyond what is required of tobacco companies, the Thai Health Promotion Foundation (ThaiHealth) has in the past five years also actively produced and conducted awareness programs promoting healthy living.

What truly sets the Thai model apart, however, is its provisions for sustainability, by drawing revenue and budgets from the targeted industries themselves. Two percent of annual state revenue from tobacco and liquor tariffs are deducted as contributions to a national health promotion fund.

Tobacco products in Thailand now have the highest taxes in the region: there is an excise tax equivalent to 75% of retail price, an import duty equal to 5% of value and a VAT (sales tax) of 7%. Then there are municipal taxes. Of the revenue generated from all this, 2% is earmarked for health promotion.

Today, ThaiHealth spends 6% of its budget on promoting health issues and for conducting an annual seminar on “Cigarettes vs. National Health” to facilitate regular exchanges among researchers, campaigners, and the general public. It also encourages the formation of networks on smoking control, and an academic centre on smoking control will be established to undertake further training and research on cigarettes and health, and to support legal and economic measures that will help expose unethical practices of the tobacco industry.

For all its progress, though, Thailand’s war on smoking remains a formidable challenge. There are still more than 10 million smokers in the country, and enforcement of the 1992 Tobacco Products Control Act and the 1992 Non-smokers’ Health Protection Act — both of which target the illegal marketing and sale of tobacco products to minors, limit marketing strategies for tobacco companies and compel the full disclosure of tobacco product components — are still pocked with loopholes.

But by tapping big tobacco’s own revenue stream, the Thai government has at least given itself a fighting and sustainable chance — even when it comes to taking over sponsorship of large events.
Case study: Viet Nam

Healthy marketplace in Thai Binh province

Tran Le Thuy
Hanoi, Viet Nam

Poultry sellers in the open market of De Tham were apprehensive about the new stalls built for them. They were not used to the sparkling stones and private water pipes and sewage – too clean and luxurious compared to the old and dirty wooden stalls they had been using for years.

But when they were told how low the rental fees for the stalls were, they went for it.

“Most Vietnamese markets don’t have separate areas for each kind of food. Fresh meat and poultry stalls are often mixed with cooked food. Also, the sellers’ hands are not clean since there is no basic infrastructure for hygiene,” says Dr Do Manh Cuong of Vietnam’s Administration of Preventive Medicine under the Ministry of Health.

“Therefore, markets are at the highest risk of transmitting diseases to a large population, and it would be very dangerous if it happens to be H5N1 – bird flu.”

De Tham market in Thai Binh province, which is located along the Red River delta, suffered heavily from the outbreak of the deadly virus that took the lives of several people two years ago.

It was for this reason that WHO chose to pioneer its Healthy Marketplace initiative in 2005 in this province, in parallel with similar market in the famous tourist district of Ha Long.

The poultry sellers were given gloves, boots, and comforters, to protect them from the virus, instead of handling live chicken with their bare hands as they did before. They also underwent monthly health checkups as a preventive measure against the transmittable disease.

More important, they were told to keep sick poultry out of the stalls; it is commonly known that sick or dead poultry were often secretly sold for a profit. Since the opening of the new stalls, no poultry can be sold without a stamp of approval by food safety officials.

Local veterinarians have also been closely monitoring poultry suppliers in their move to stop any smuggling or other illegal means of selling poultry from the bird-flu-infected areas.

“The sellers said their business has been better. Clients are more confident in buying their products, even during the epidemic outbreaks, because of the strict procedures and lower risk of contact,” says Dr Cuong, who helped lead the implementation of WHO’s urgent project.

Huge and colourful posters were put up at the gates of the markets urging people to wash their hands constantly and warning them against eating sick poultry. The project also organized classes to teach sellers about H5N1 and methods to stop or prevent its spread.

“We are looking for new sources of support to continue and expand the model to other provinces,” says Dr Cuong.

“The officials from Quang Ninh and Thai Binh provinces said publicly that they appreciate what has been done and will consider duplicating such healthy marketplaces when they build new markets.”
Case study: Viet Nam

Tobacco control

Tran Le Thuy
Hanoi, Viet Nam

Vietnam’s laws already try to make it tough on smokers in public places. But getting people to respect the law remains a problem. Culture and ignorance about tobacco-related laws and health issues prevent non-smokers from speaking up next to or in the face of smokers in public places. “Enforcement of such policy is difficult,” said Do Thi Phi, former IDE staff who contributed to smoke-free SEA Games project.

Nor is there widespread practice of tolerating requests to stop smoking in this nation, where 52% of men and 1.8% of women are still smokers.” At the Hanoi railway station, says anti-tobacco advocate Do Thi Phi, “some guards reported having been threatened with beatings by smokers.”

To introduce and promote the notion that smokers can and should be reminded to refrain from lighting up in public places, Vietnam declared the 2003 Southeast Asian Games in Hanoi and Ho Chi Minh City tobacco-free – then let volunteers set the example by stubbing out all cigarettes at the games.

Uniformed volunteers approached smokers in the stadiums and politely asked them to put out their cigarettes. It was a simple act, repeated thousands of times throughout the days and venues of the games, and Vietnamese officials believe it’s had a long-term impact.

“Anti-smoking is not a priority for Vietnamese because we are still facing a lot of other (economic) hardships,” said Do Thi Phi, who used to work for the International Development Enterprise, an NGO and partner of the government and the WHO in the anti-smoking push in Vietnam. “The SEA Games was the biggest event so far to attract people’s attention to the issue, and it became an important venue to raise their awareness.”

For the SEA Games, WHO provided technical assistance and financial support in developing the regulations and training workshops for volunteers, on-site officials and key staff members. It also supported the Vietnam Committee on Smoking and Health (VINACOSH) in producing and providing crucial information about the harmful effects of tobacco for a nationwide health campaign that included television spots, billboard publicities, and press features.

The overall aim was not only to implement laws, but to change behaviours – of smokers and non-smokers alike.

Together the consortium for a smoke-free SEA Games called for “no tobacco sales, sponsorship, advertising, or any form of promotion permitted at any games site.” Smoking was permitted only in designated areas, and substantial efforts were made to provide useful and accurate information about tobacco use to athletes, spectators, and staff – while actively asking smokers to stamp out their cigarettes.