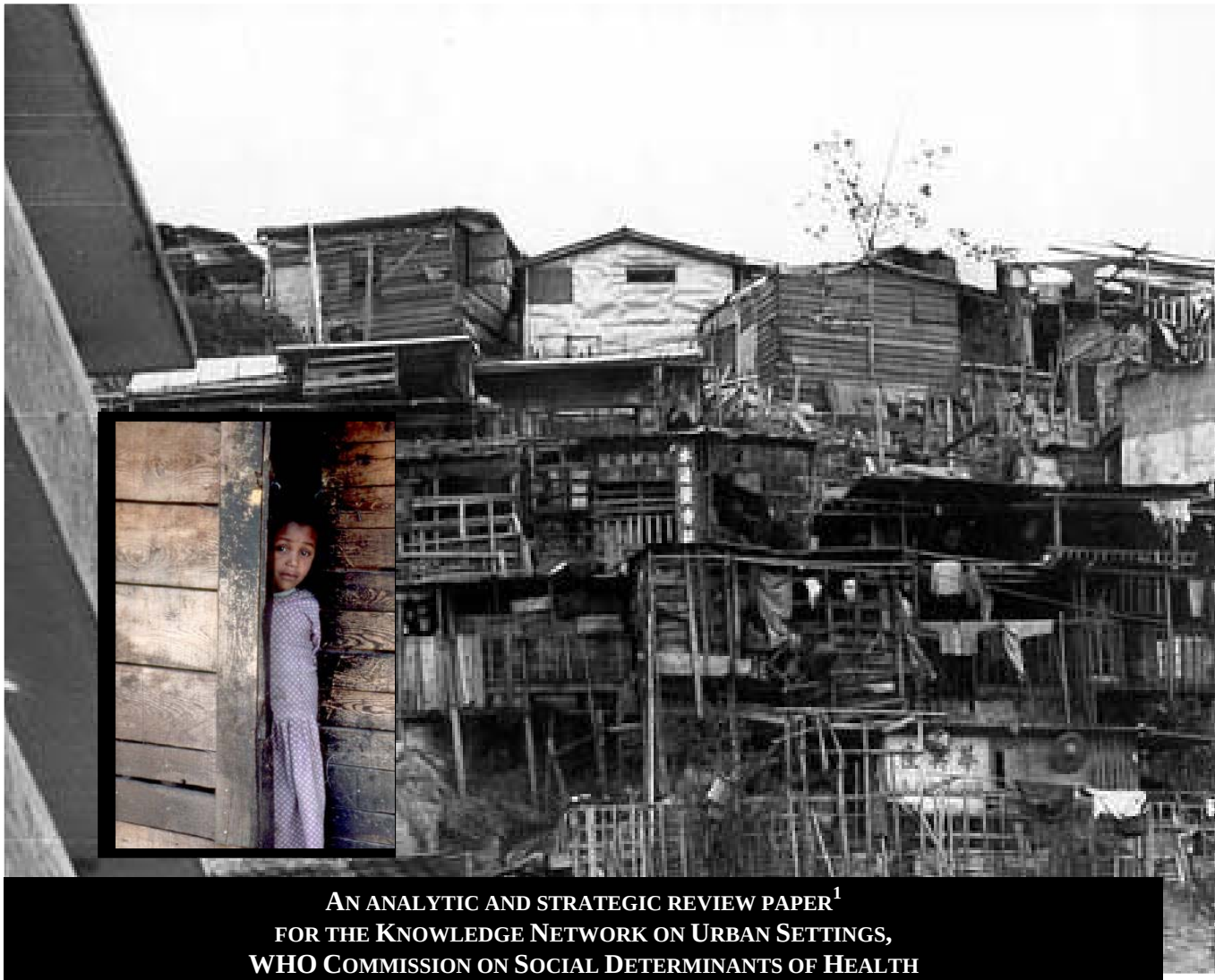
A Billion Voices:

Listening and Responding to the Health Needs of Slum Dwellers and Informal Settlers in New Urban Settings[1]



AN ANALYTIC AND STRATEGIC REVIEW PAPER[1]
FOR THE KNOWLEDGE NETWORK ON URBAN SETTINGS,
WHO COMMISSION ON SOCIAL DETERMINANTS OF HEALTH
PREPARED BY THE WHO KOBE CENTRE, JAPAN
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[1] The notion of "new urban settings" was first introduced by the Research Ad Hoc Advisory Group of the WHO Centre for Health Development (WHO Kobe Centre) in a document entitled *Health in Development: Healthier people in healthier environments , a proposed research framework for the WHO Centre for Health Development, (WHO Kobe Centre*) *Recommendations to the World Health Organization, 2004.*

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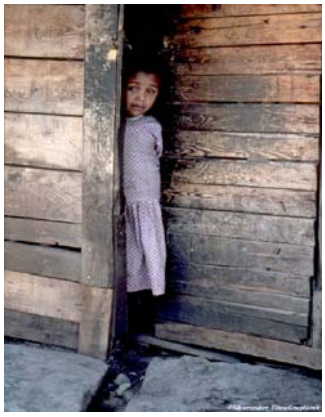
New urban settings

The urban setting as we know it today is a complex and dynamic environment that has a profound impact on the health of the human community. Three interrelated characteristics of urbanization make it different from what it was in the past: 1) the rapid rate of urban growth and its effect on municipal governments; 2) the upsurge in poverty and its effect on the urban economy; and, 3) the proliferation of slums and their impact on the urban environment and the environment's impact on slums.



Combined, these conditions give rise to "new urban settings" [5]characterized by a radical process of change with positive and negative effects, increased inequities, greater environmental impacts, expanding metropolitan areas and fast-growing slums. In order to meet the health challenges that new urban settings create, it is important to grasp the nature and scale of urbanization, the various driving forces[6] that affect it and the factors and determinants[7] of health that are linked to this process.

Rapid urbanization

Over the last 50 years, urban populations have grown dramatically. While in 1950 approximately 29.1% of the world's population was living in urban areas, by 1975 this figure had reached around 37.3%. In 2006/07 this figure is expected to nudge 50%, with 60.8% of the people living in cities by 2030 (UN, 2003: 5).

Africa had the highest annual rate of urban growth over the period 1975-2000 at 4.21%, compared to Asia at 3.47%, Latin America and the Caribbean at 2.76%, Europe at 0.68% and North America at 1.32%. The projected rate of urban population growth (2000-2030) in the less developed regions is 2.3% per annum, in contrast to that of developed countries at 0.5% (UN, 2004: 3). The causes of urban growth in each of these regions vary.

As more people continue to be displaced from rural areas, and as the number of people born in cities increases, the urban population will only continue to grow. The current average annual population increase in developing world cities is estimated to be 60 million, a rate of 163 000 people per day. Over half of this increase is caused by natural population growth within these cities. The most spectacular outcome will be the burgeoning of megacities with populations in excess of 10 million inhabitants (25 in 2020). But if megacities are the prominent feature of the urbanization process, second tier cities will host three quarters of population growth (UN-HABITAT, 2005:5). Overall, the largest share of the increase in the

[6] "Driving forces" are defined within the framework of the WHO DPSEEA model for environmental health that delineates the interaction between driving forces, pressures, state, exposures, effects and actions when analyzing the effects of the environment on human health. (WHO, Health, Environment and Sustainable Development: Five years after the Earth Summit, 1997.)

[7] "Determinants" are defined as the 'range of personal, social, economic and environmental factors which determine the health status of individuals and populations'. (WHO, Health Promotion Glossary, 1998.)

world urban population will be attributed to urban settlements with fewer than 500 000 inhabitants and cities with populations of 1-5 million.[8]

Despite the different causes of urban growth, cross-national continuities are noted. An example would be the dynamic between push-pull factors where pull factors of the urban environment and push factors at the local and national level (e.g. government policy on land tenure and use); and at a global level (e.g. the globalization of agricultural production, new agrarian structure, retrenchment of agricultural jobs) are driving urban growth.

The urbanization of poverty

The acceleration in the rate of urbanization has been accompanied by an equally alarming increase in urban poverty. At this time there are approximately three billion people living in urban areas, and approximately a billion now living in slums. Slums are the most visible manifestation of poverty.

Slums are characterized by:

- **Lack of basic services**
- **Substandard housing or illegal and inadequate building structures**
- **Overcrowding and high density**
- **Unhealthy living conditions and hazardous locations**
- **Insecure tenure, irregular or informal settlements**
- **Poverty and social exclusion**
- **Minimum settlement size**

Urban poverty is severe, pervasive and largely unacknowledged. According to the latest Global Report on Human Settlements, 43% of the urban population in developing regions lives in slums. In the least developed countries, 78% of urban residents are slum-dwellers. Many countries do not welcome urbanization and urban poverty remains largely unaddressed.[10] In most instances, national and municipal governments are not prepared from multiple perspectives to manage urban development in support of the poor.

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 in a recent report denotes 'a wide range of low-income settlements and/or poor human living conditions.'[11] Slums are further characterized by the following attributes[13]: 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[14]; f) poverty and social exclusion; and, g) minimum settlement size.

These attributes are associated or linked with ill-health, the details of which are discussed later in this paper. As the urban slum population is expected to grow to approximately two billion by 2030 (from 32% to 41% of the world's urban population), and to around three billion by 2050, the scale and speed of this phenomenon poses serious and compelling risks and challenges to health. Of course, the greatest impact will be felt in the developing world.

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[8] United Nations Secretariat. World Urbanization Prospects 2001, Revision, Data Tables and Highlights.
[10] United Nations Millennium Project. *A Home in the City – Task Force on Improving the Lives of Slum Dwellers*. Earthscan, United Kingdom, 2005.
[11] UN Habitat. *The Challenge of Slums: Global Report on Human Settlements*. Nairobi, 2003.
[13] UN Habitat. *The Challenge of Slums: Global Report on Human Settlements*. Nairobi, 2003.
[14] The main focus of this paper is on slums as defined above, but where appropriate the text refers to slum dwellers and informal settlers as vulnerable populations in new urban settings as they are affected by social determinants of health.

Globalization as a driver of rapid urbanization and urban poverty

Globalization, a dominant force in the 20th century's last decade, is shaping a new era of interaction amongst national economies and people, characterized by increasing contacts between people across national boundaries in economy, technology, culture and governance. While this is not a totally new phenomenon, the present era has distinctive features. Shrinking space, shrinking time and disappearing borders are linking peoples (and territories) more deeply and more intensely than ever before.[15] Rapid urban population growth, the urbanization of poverty and the proliferation of slums are being driven to a great extent by this dynamic form of globalization. At the same time, globalization also drives economic and cultural growth and urban culture in megacities.

The inequities of globalization play out most vividly in cities of the developing world. Such cities become fragmented, with certain areas attracting businesses and high-income earners at the expense of others which have none and suffer from high unemployment, little or no access to essential services, and infrastructure in need of maintenance or repair.[16] 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[17,18].

In this interconnected world, cities have become gateways for infection. Migration, crowding and increased mobility bring new opportunities for otherwise marginal and obscure microbes.[19] The recent outbreak of severe acute respiratory syndrome (SARS) that was spread from city to city by airline passengers is a case in point.[20]

Cities with high population density are not only gateways for infection but are breeding grounds for emerging and reemerging diseases. Factors that can contribute to these 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 measures[22]. Vector-borne diseases such as dengue, malaria, yellow fever, plague, leishmaniasis, filariasis, lyme disease and schistosomiasis have also been found to be increasing in many urban areas due to stagnant water, insufficient drainage, flooding and improper disposal of solid waste.[23]

Globalization has also affected lifestyles in cities. It has been suggested that the increase in the incidence of obesity may be linked to several aspects of urban life such as

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[15] Tipping DC, Adom D, Tibaijuka AK (2005). *Achieving Healthy Urban Futures in the 21st Century: New Approaches to Financing and Governance of Access to Clean Drinking Water and Basic Sanitation as a Global Public Good*. Helsinki Process Publication Series 2, Ministry of Foreign Affairs of Finland, Helsinki.

[16] International Institute for Environment and Development (IIED) (2002:1)

[17] 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).

[18] 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.

[19] Wilson ME. Infectious diseases: an ecological perspective. *British Medical Journal*, 1995, 311: 1681-1684.

[20] WHO. Healthy Cities and SARS. A presentation made at the meeting on a regional mechanism for Healthy Cities, Western Pacific Region, 2003.

[22] Morse Stephen Factors in the Emergence of Infectious Diseases, http://www.cdc.gov/ncidod/eid/vol1no1/morse.htm

[23] McMichael AJ (2000). The Urban Environment and Health in a World of Increasing Globalization: Issues for Developing Countries. *Bulletin of the World Health Organization*, 78:1117 - .

increased intake of manufactured food with calories drawn from sugars and saturated fats, or food products with high salt content. Meanwhile, increasing reliance on motorized transport in cities can lead to decreased levels of physical activity. Combined, these contribute to higher risk factors for diabetes, cancer and cardiovascular disease. These noncommunicable diseases have been noted to be increasing in urban areas in different countries.[24] High levels of stress from city life have also been associated with mental health problems such as depression, anxiety, tobacco use, alcoholism and substance abuse.

There are a wide range of environmental risks to health that can be found in cities. These include exposure to chemicals and biological agents that pollute the air, land and water, as well as physical agents such as noise and extremes of temperature. Accidents in industrial sites, hazardous land sites, poor waste disposal, toxic wastes, poor drainage, water shortages, fires and landslides are also sources of health risks and hazards in cities.

Urban violence, including homicide, assault, rape sexual abuse and domestic violence, has continued to rise in cities worldwide. Although there are large variations between countries and cities, urban violence has grown on average by 3-5% over the past 20 years.[25]

Health inequity in urban settings

Globally, the poor bear a heavy burden from both communicable and noncommunicable diseases[26] and slum dwellers and informal settlers are the most vulnerable groups in the urban setting. There is strong evidence to show how the health inequities observable in urban settings can be associated with economic, social and political disparities.

Structural determinants

Based on the conceptual framework of the Commission on Social Determinants of Health, urban poverty in slums and informal settlements constitutes the most dominant structural determinant of health affecting all individuals regardless of age or gender. Gender is also a dominant structural determinant, as women-headed households constitute 30% or more of total households in slums. In slums, women compared to men, tend to stay home more, increasing their exposure to hazards and risks to health from squalid environments. They also carry the burden and responsibility of fetching water, securing food and caring for other members of the family with their meager resources. They are also more vulnerable to violence and crime. They rely on public transport, this affects their safety. Ethnicity is another key structural determinant within slums. Discrimination, intolerance and stigma create steeper barriers to health and increase vulnerability of minority groups within

STRUCTURAL DETERMINANTS
Poverty
Gender
Ethnicity
Education and health literacy

[24] *The World Health Report 2002: Reducing Risks, Promoting Healthy Life*. World Health Organization, Geneva, 2002.
[25] United Nations Millennium Project. *A Home in the City – Task Force on Improving the Lives of Slum Dwellers*. Earthscan, United Kingdom, 2005.
[26] Ibid.

slums and informal settlements. Low levels of education resulting in low health literacy are also structural determinants of health in slums. Health literacy, defined as the cognitive and social skills which determine the motivation and ability to gain access to, understand and use information in ways which promote and maintain good health[27] is dependent on basic literacy and plays a crucial role in enhancing or reducing individual vulnerability to health problems in slums and informal settlements.

Intermediate determinants

Living conditions (e.g. unsafe water, unsanitary conditions, poor housing, overcrowding and high density, hazardous locations and exposure to extremes of temperature) are intermediate determinants of health that are invariably linked to poverty. Extremes of age, the infants and very young children, and older persons are particularly vulnerable to these determinants. Working conditions (as informal economic activity may be based in slums and informal settlements) also constitute intermediate determinants of health for men, women and children (i.e. child laborers, street children).

INTERMEDIATE DETERMINANTS
Living and working conditions
Social and political exclusion
Social capital
Access to quality health care
Violence and crime
Transportation
The environment

Urban slum dwellers and informal settlers are vulnerable and excluded from many of the benefits of urban life[28]. Stigma and social exclusion must be cited as important intermediate determinants of health. Slum dwellers and informal settlers suffer from the stigma associated with not having a street address[29] – 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. They may be ostracized or discriminated against when applying for jobs or seeking licenses to operate small business activities. They may be highly mobile and may move from one city to the next without public records. At some point, the line between social exclusion and political exclusion begin to blur. All these deny slum dwellers of a 'political voice' and create obstacles to participation in decision-making processes that affect the determinants of their health.

Lack of access to quality health services is singled out as a critical intermediate determinant of health for slum dwellers and informal settlers. Women of reproductive age and children below the age of 5, bear the heaviest burden for being unable to access health care services. While health service resources (human, financial and material) tend to gravitate toward urban centres where more advanced and sophisticated medical care and facilities are found, more often than not, these are inaccessible to these groups.

Exposure to crime and violence and the stress created by living in constant fear of one's safety, creates high levels of mistrust and low social capital. This is an intermediate determinant that has more far-reaching effects on youth and adolescents who live in slums and informal settlements who eventually take-up hostile and violence behaviour as a means of coping with their surroundings.

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[27] Health Promotion Glossary, World Health Organization, 1998

[28] UNDP states that these attributes are critical to full citizenship, though remain a monopoly of a privileged minority. They include: political voice, secure and good quality housing, safety and the rule of law, good education, affordable health services, decent transport, adequate incomes, and access to economic activity and credit.

[29] United Nations Millennium Project. *A Home in the City – Task Force on Improving the Lives of Slum Dwellers*. Earthscan, United Kingdom, 2005.

Transportation and its impact on the physical environment as well as on individual behaviour and social interaction must be considered as another intermediate determinant of health. Lack of access to good, safe and reliable transport is a barrier to welfare services, employment, education and child care as well.

Slums as a failure of governance

The role of municipal governance in mitigating and modulating the negative impact of urban poverty and slum growth cannot be overemphasized. Governance[30], defined as "the management of the course of events in a system consisting largely in the policing of social relations, environmental conditions and the allocation of resources essential to well-being", is a critical pathway for addressing determinants of health, especially in the urban setting.

Slums represent a failure of governance. Exponential population growth is taking place without the corresponding ability of many cities in the developing world to expand public provision of adequate shelter, basic infrastructure and services, and gainful employment. As a result, in nearly all urban centers, there are neighborhoods with little or no provision of the basic needs for public health and well-being (Cheru and Bradford, 2005:).

In order to address the conditions that create poor health for slum dwellers and informal settlers, the political relationship between government and all citizens, particularly the urban poor, may need to be redefined.[31] New and more effective ways of working with local communities, people's organizations, the private sector and other stakeholders is an underpinning theme of modern urban municipal governance. [See Appendix I: Approaches to Governance]

Slum dwellers and informal settlers must acquire a voice in the process of governance. This does not happen in a vacuum. Neither is it achieved overnight. Values and principles that underpin more sustainable forms of urbanization may prove to be useful in this process.

Slum dwellers and informal settlers must acquire a political voice in this process. Their participation in decision-making processes that affect their lives is critical. But engaging slum dwellers in governance does not happen in a vacuum. Neither can it be achieved overnight. High levels of participation in governance are usually enabled by system-wide reforms and changes that shape policy and institutional practices toward greater responsiveness to "felt needs" of vulnerable groups in the long term. Values and principles that underpin more sustainable forms of urbanization may prove to be useful in this process.

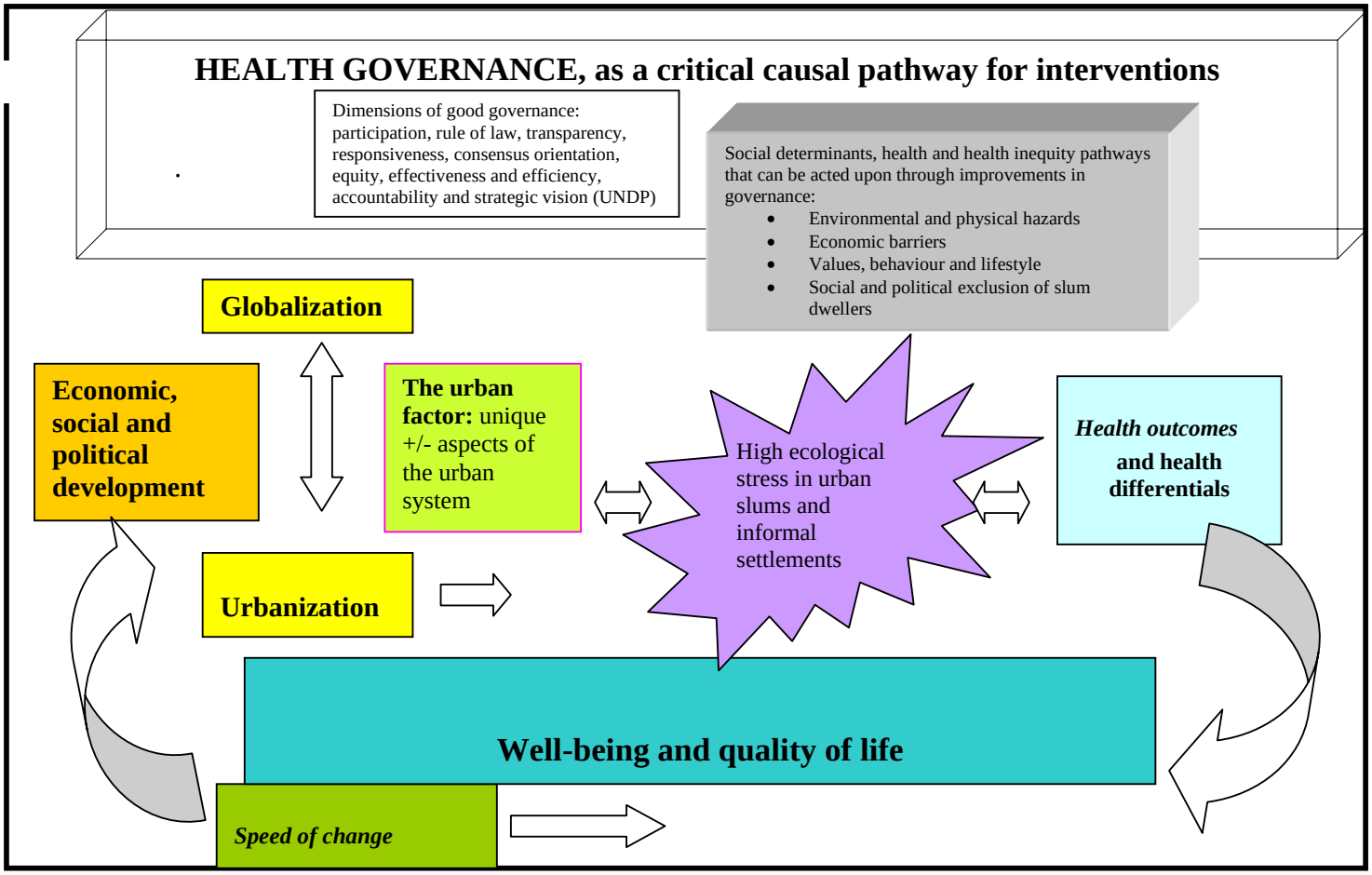
While the role of government in the process of governance must be viewed as a continuum where authority is distributed between national (or federal), provincial, and municipal administrative tiers, mid-level government (provincial/state) may be more actively engaged in balancing urban and rural policy (often with a pronounced urban bias (Lipton, 1977)), while municipal government may be able to be more responsive to local needs.

[30] Burris S. Governance, *Micro-governance and Health Conference on SARS and the Global Governance of Public Health*. Temple University Beasley School of Law, Philadelphia PA, USA, March 2004.
[31] United Nations Millennium Project. *A Home in the City – Task Force on Improving the Lives of Slum Dwellers*. Earthscan, United Kingdom, 2005.

There are many examples of how principles of good governance as articulated by the UNDP and demonstrated by various projects of the Urban Governance Initiative (TUGI)[32] [participation, rule of law, transparency, responsiveness, consensus orientation, equity, effectiveness and efficiency, accountability and strategic vision] can be brought to bear upon urban health and environment problems. Over recent decades, good urban governance for health has also been implicitly developed through city multi-sectoral health planning processes that are a core component of Healthy Cities projects, Local Agenda 21 sites, Cities without Slums, slum-upgrading projects (HABITAT), urban basic services projects (UNICEF) among others. Several associations and networks of mayors and local officials at international and local levels have also taken this forward. Despite this, the scale of uptake of good governance has been limited. The resources needed to achieve a critical mass of local governments that can impact on the health of a billion slum dwellers around the world are clearly insufficient at municipal and national levels. Global vision, policy and programmes to guide this complex process are also deficient.

WHO Kobe Centre model for "Health in New Urban Settings"

Model for "Health in New Urban Settings" developed by Ilona Kickbusch for the WHO Kobe Centre, Japan (2005)



[32] The Urban Govenance Initiative closed down in 2004, but was able to popularize urban health governance principles through "Report Cards" that enabled cities and municipalities to critically assess their responsiveness to the needs of their constituents in urban areas. TUGI also a good database on good practices.

The conceptual framework provided shows how driving forces of urbanization and social determinants of the urban setting affect health. This framework is based on an ecological model that emphasizes how the conditions of the social, cultural, political, built and natural environments strongly affect human health (Lawrence, 1999 & 2000; Tsouros, 2000 in OPHA, 2003). The ecological model is based on the hypothesis that individuals are more susceptible to certain illness because of their exposure to environmental, economic, social or political factors that can either promote or endanger health and well-being.

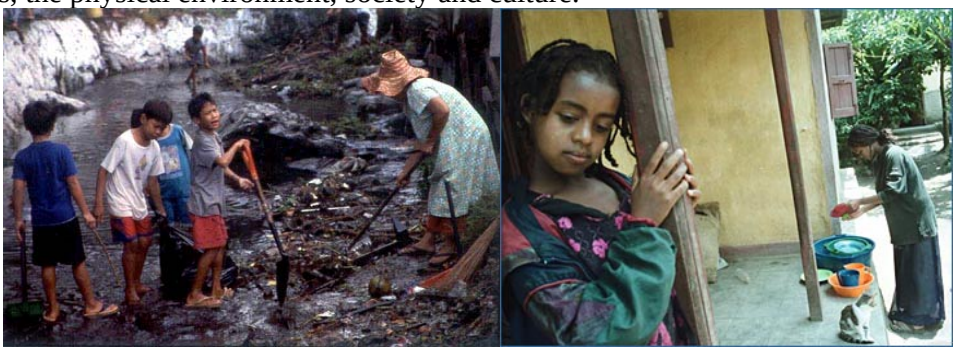
In this conception, the city represents a center or concentration of urban traits, collectively characterized as the urban factor. The urban factor encompasses all dimensions of the urban setting that either promote or endanger health. Until recently the urban factor was seen as mostly contributing to better health, particularly in comparison to health levels in rural areas. However, this is no longer the case for a large number of urban dwellers, particularly those in slums and informal settlements who live under the most life- and health-threatening circumstances anywhere (UNDG, 2005:1).

While common causal pathways give rise to these traits, there are also significant differences in urbanization processes in different regions of the world and within countries. These differences need to be taken into account. In Africa, for example, most of the urban growth that is taking place is in the absence of significant industrial expansion. As a consequence, the *urban factor* and the associated determinants of health need to be delineated in the context of new urban settings in different locations.

Glocalization[33]

The starting point on the left of the model recognizes that, at present, a significant number of economic, social and political factors find their expression in two major trends of global restructuring: globalization and urbanization. These two major forces are intertwined, leading some analysts to speak of a "glocal" phenomenon. Therefore, as urbanization and its impacts on health are analyzed, the related global dimension and its impact cannot be neglected.

In slums and informal settlements, these traits culminate in *"high ecological stress"* for populations, with a range of manifestations relating to physical, mental and social health, well-being and quality of life. Health outcomes and well-being or ill-health and premature death are therefore the result of a complex web of causation where risks are related to individual behavior, the family, neighborhood and community, access to health facilities and services, the physical environment, society and culture.



[33] *Health in Development: Healthier people in healthier environments* A proposed research framework for the WHO Centre for Health Development, (WHO Kobe Centre) Recommendations of the Ad Hoc Research Advisory Group to the World Health Organization, 2005

SECTION II: Reviewing evidence, exploring opportunities for synergy

Using the CSDH's conceptual framework to: a) critically and if possible systematically review evidence on the robustness of associations between SDH and health/health inequity across different country contexts; b) identify and prioritize associations that can be acted upon and thus used as the basis upon which to outline policies and programmes on SDH at country, regional or global level; and c) develop an inventory of key individuals, institutions, civil society organizations and global processes that includes those soh are researching, implementing and evaluating interventions and policies on SDH.

This section assesses the evidence of associations between slum life, health and health inequity. It is collated from published and grey literature as well as government sources.

Limitations of the review

The results presented are by no means exhaustive, but provide a starting point for a more systematic review of evidence. While methods for deriving differentials between urban-rural, intra-urban and intra-slum populations are available, they are not widely used.

Other limitations of this review include:

1. Slum dwellers and informal settlers, despite their growing number, are invisible. Usually they are illegal residents in a city or are highly mobile and may not be included in regular census activities and may not use public health facilities. If they are homeless, their status and needs are not captured by household surveys either.[34]

2. Disaggregation of urban-rural[35], intra-urban or intra-slum health statistics is not routinely done at the level of ministries of health or municipalities. The extent to which countries routinely disaggregate data is not known and should be reviewed. Health inequities at the municipal level are masked and/or hidden because local government organizations and their policies, procedures and regulations are determinants of what services are provided and who can access them (Satterthwaite, 2005:87)[36]. These then become part of the inherent limitations of traditional health information systems.[37] The absence of routine data is a major factor that has held back action on improving health in slums. In developing and least developed countries, this limitation is related to weaknesses in surveillance and health information systems in general.

3. Information on communicable diseases and environmental health seem to be more accessible than information on noncommunicable diseases, including mental health and injuries.

4. Shifting definitions of what constitutes "poverty" or "slums" or "informal settlers" at the national level and between countries vary. In operational terms, there are problems in identifying who the urban poor are and where exactly the slums are within specific local communities.

[34] USAID Making Cities Work: Urbanization, poverty and health http://www.usaidmakingcitieswork.org
[35] Worldwide epidemiological and demographic information suggests that health, health services and survival rates are better in cities than in rural areas. However, intra-urban differentials suggest that poor and low-income urban populations are worse off in terms of communicable and noncommunicable diseases than the poor in rural areas (UN-HABITAT, 2001).
[36] Satterthwaite (2005) states that local governments have great relevance in the progress towards most of the MDGs. It is not a simple issue of whether local government has the resources and capacity support the achievement of the goals, rather a fundamental question of what they choose to prioritize and ignore in policy contests. It is a question of political will, and choosing not to address the problem is equated to lack of capacity and resources.
[37] USAID Making Cities Work: Urbanization, poverty and health.http://www.usaidmakingcitieswork.org

5. For local political leaders, there are obvious political disincentives to deriving exact data on the magnitude and extent of health problems of slum dwellers if the resources and capacity to respond to this growing problem are not immediately available.

Complex associations between determinants of health: subfocus on housing

In the analysis of the associations between social determinants, health and health inequity in urban settings, it is clear that structural and intermediate social determinants interact to cause multiple and interrelated hazards, threats, exposures, risks, diseases and mortality associations. Housing as an intermediate determinant of health is a good example to show how these interactions converge in slums. Within the context of new urban settings, housing is a determinant that is a critical entry point for health improvement.

The following table shows how specific risk factors related to sub-standard housing are associated with different disease entities or risks to health.

Indicators of unhealthy living conditions (adapted from the work of Mara and Alabaster, 1995)[38]

Principal risk factor	***Communicable diseases***	***Noncommunicable diseases***	***Psychosocial disorders***
Defects in buildings	Insect vector diseases Rodent vector diseases Geohelminthiases Diseases due to animal faeces Diseases due to animal bites Overcrowding-related diseases	Dust and damp and mould-induced diseases Injuries Burns	Neuroses Violence Delinquency and vandalism Drug and alcohol abuse
Defective water supplies	Faecal-oral (waterborne and water-washed) disease Non-faeco-oral water-washed diseases Water-related insect-vector diseases	Heart disease Cancer	
Defective sanitation	Faecal-oral diseases Geohelminthiases Taeniases Water-based helminthiases Insect-vector diseases Rodent-vector diseases	Stomach cancer	
Poor fuel/defective ventilation	Acute respiratory infection	Perinatal defects Heart disease Chronic lung disease Lung cancer Fires/burns Poisoning	
Defective refuse, storage and collection	Insect vector diseases Rodent vector diseases	Injuries Burns	
Defective food storage and preparation	Excreta-related diseases Zoonoses Diseases due to microbial toxins	Cancer	
Poor location (near traffic, waste sites, industries, etc)	Airborne excreta-related diseases Enhanced infectious respiratory disease risk	Chronic lung disease Heart disease, cancer Cancer Neurologic/reproductive diseases Injuries	Psychiatric organic disorders due to industrial chemicals Neuroses

Major pathways for associations that may be considered

The following associations between social determinants, health and health inequity have been reviewed and may be considered by the Knowledge Network on Urban Settings

[38] World Health Organization. *Health and Environment in Sustainable Development: Five years after the Earth Summit.* WHO, Geneva, 1997.

(KNUS) as starting points for discussions on priority associations. [A summary of findings and evidence to illustrate the interactions are included in APPENDIX III]

- Living and working conditions in slums, low status of women, low health literacy, lack of access to quality health care, >>>>infants and under-5 mortality rates

- Unsafe water, poor sanitation, low health literacy, lack of access to quality health care>>>>diarrheal diseases in slums

- Poverty, food insecurity, unsafe water and poor sanitation, low health literacy, lack of access to quality health care>>>>malnutrition and parasitic infections among slum dwellers

- Hazardous location of slums >>>>> exposure to multiple environmental hazards and respiratory illness, road traffic injuries among urban populations

- Crowding, poor housing conditions, unemployment, lack of access to welfare or social services, poor transportation systems >>>>>stress, violence and injuries among slum dwellers

- Poverty, stress, crowding, unemployment, lack of access to health, welfare and social services, low health literacy>>>>>behavioural risks to health, mental illness and substance abuse (including alcoholism and drug abuse) in urban populations

- Poor housing, extremes of temperature, low health literacy>>>>>heat stroke and respiratory illness in urban populations

- Poverty, crowding, poor housing conditions, unsafe water, poor sanitation, hazardous locations (flooding), lack of access to quality health care, low health literacy>>>> > communicable diseases among slum dwellers

- Poverty, social exclusion, low status of women, low health literacy, lack of access to quality health care>>>>>maternal mortality, maternal morbidity, sexually transmitted disease, other reproductive health risks, among slum dwellers

A possible approach to prioritizing action

Social determinants, health and health inequity pathways that can be acted upon through improvements in governance:

- Environmental hazards and threats
- Economic barriers
- Values, behaviour and lifestyle
- Social and political exclusion

The abovementioned pathways may be approached in several ways. One approach would be to group these interactions according to the predominant types of risks that they create for slum dwellers. For example:

- Social determinants and interactions that cause ***environmental hazards and threats*** to health – unsafe water, sanitation, exposure to pollution, exposure to extremes of temperature and noise, exposure to traffic, poisoning, burns, accidents and injuries;

- Social determinants and interactions that create and interact with ***economic barriers*** to health – poverty, unemployment, education, food insecurity, cost of medical care;

- Social determinants and interactions that influence ***values, behaviour and lifestyle*** – low health literacy, poor health seeking behaviour, poor access to health information, stigma, exposure to crime and violence, unregulated access to dangerous and addictive substances;

- Social determinants and interactions that create and influence the ***social and political exclusion of slum dwellers and informal settlers*** from community decision-making processes that could alter their health – hazardous locations of homes, legal status, inability to access basic health care, education, lack of access to welfare or social support services, violations of human rights.

Governance as a critical causal pathway for addressing social determinants in the urban settings

The key responsibility in achieving better health outcomes in urban settings lies with local governments and their partners at the local level. There is a wealth of experience to show how improved health outcomes can be achieved and more importantly, sustained when driven from the municipal level. Efforts are now needed to enable local governments to understand and respond to how the rate of urban growth, the upsurge of poverty and the proliferation of slums affect resources for health and health as a resource of the city.

Municipal level interventions that have worked have been characterized by approaches to health that are broad and involve cross-disciplinary perspectives that usually have one or a combination of these features:

1) Ecological and population-based – responsive to multiple upstream determinants of health for entire communities in relation to social, political, cultural and physical environments;

2) Integrative – coherent within specific "healthy settings" and yet able to incorporate a wide range of interventions (promotive, preventive, curative, protective) that are context-specific and responsive to local felt needs;

3) Systems-based – and clearly linked to principles of good governance as well as ongoing health system reform processes (decentralization, health financing, quality improvement, reducing health inequity).

Municipal-level action cannot be disengaged from the national and global governance issues that drive the urbanization process and the social determinants that arise in the process. Hence, a combination of strategic (long-term) and tactical (short and medium-term) actions within the framework of good governance, are needed to improve the health of the urban poor and modulate the driving forces of urbanization. Delineating tactical interventions at the local level is especially relevant where municipal political leaders have 3-5 year terms of office and may be anxious to demonstrate immediate results to their constituencies.

Five strategic actions that may be more closely considered

Here some strategic areas for action to stimulate discussion on interventions that work and show promise for making a difference in the lives of slum dwellers. There is a wealth of evidence to show how these individual interventions are being pursued independently. One of the challenges for the Knowledge Network will be to see how these are being linked or integrated in countries or how these can be scaled up to benefit a critical mass of slum populations.

5 strategic actions that may be more closely considered:

- **Slum-upgrading**
- **Improving access to quality health care**
- **Targeted health promotion**
- **Integration of health, welfare and education services**
- **Sustainable urban development**

1. Slum upgrading

Slum upgrading offers a realistic opportunity for rapid scale-up of concrete action. It is a programmed approach to physical, social, economic, organizational and environmental improvements in slums, undertaken through partnerships with families, community groups, businesses and municipal authorities. The aim is to actively enhance local governance, empower communities to improve their health, well-being and quality of life, strengthen the capacity of municipal actors to support the provision of housing and infrastructure in slums, and enrich the overall livelihoods of people living and working in informal settlements.

Slum upgrading is making life better for those who can't get out of slums. Upgrading is conducted through concerted strategies that respond to poor conditions and services in existing slums, and involves self-help and local ownership of the programme. It consists of improving security of tenure (often through regularization of land rights) and improving the existing infrastructure up to a satisfactory and affordable standard. These improvements also focus on introducing or improving basic service provision (e.g. water services, storm drainage systems, security lighting), improvement of housing, mitigation of environmental hazards, provision of incentives for community management and maintenance, improved access to health care and education and enhancement of livelihoods through training and micro-credit.

Many national and local governments have been unable to cope with urbanization, and are unable to provide shelter, infrastructure or basic services for poor and low-income neighborhoods in cities. However, they can create an enabling environment that encourages slum upgrading through a variety of actors, the foremost being the urban poor who are often not considered as a resource. Some important government actions that can facilitate slum upgrading include:

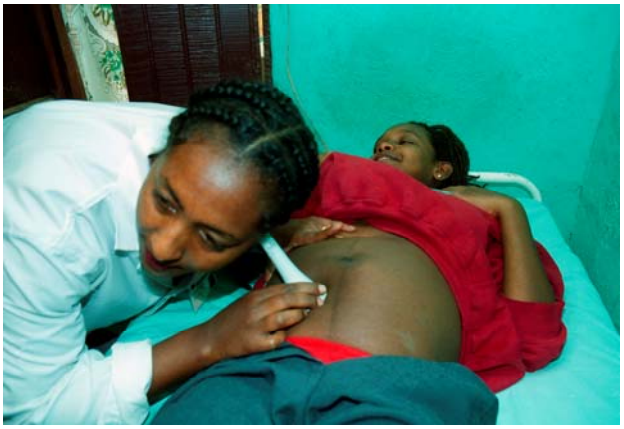
- "the explicit provision of secure tenure to slum residents;
- an improved low-cost, user-friendly system for land titling;
- community contracting to implement small infrastructure works in slums;
- the reform of building codes to enable incremental building by slum dwellers and to facilitate their access to micro-credit for progressive building;
- well-targeted incentives to encourage the local private sector to move down market and begin serving the credit needs of the poor;
- consistent implementation of policy that is enforceable at the local and national levels; and public-private partnerships with slum dwellers to improve community living conditions, open lines of

communication, and build trust and accountability among government authorities, local businesses, and the urban poor" [41]

2. Improving access to quality health care

Despite the concentration of health-care facilities in urban areas, the access of the urban poor to basic health services is hampered by several factors. The cost of travel may be prohibitive. Women may not have anyone to leave young children with. Slum dwellers may be treated shabbily or discriminated against in health centres. Where free health care services are not available, the cost of care may be unaffordable. Access must therefore be broadly defined to encompass its physical, social, cultural and economic dimensions. Transportation for example, though outside of the health care system is a critical determinant of access to health care. Improvement of access may be led by the health sector, but it is apparent that the role of other sectors is equally important.

Within the health sector, reforms that have focused on reducing inequity, sustaining adequate health care financing, improving quality care, strengthening local accountability for health through decentralization or devolution and improving city and municipal regulatory capacity, have proven to be effective in changing health outcomes. These same reform processes may need to be focused more sharply on improving health of slum-dwellers and informal settlers. For example, efforts could focus on ensuring that targeted subsidies or social health insurance programmes do in fact cover the poorest of the poor. While there are mixed reviews on the impact of outreach services (such as mobile clinics or missions), where these have been linked to mainstream public health programmes of cities (e.g. expanded programme of immunization [EPI]or directly observed short course chemotherapy [DOTS]), lower morbidity and mortality rates have been reported.



Improving access to care can also be achieved through reforms in policy and practice that widen the range of health care providers who can provide services to vulnerable groups. For example, enabling midwives to operate small out-patient facilities in communities has shown to improve coverage for reproductive health services. The role of private health providers can also be further explored. It must be pointed out, that widening the range of providers usually require strengthening of regulatory capacity at the municipal level. As far as the public sector is concerned, it is important to build on the infrastructure of primary health care to ensure sustainability of programmes. In this context, community-based health programmes and training of health workers in slums can in better access to care.

Improving access to care has been demonstrated through various quality improvement programmes[42] in several countries. Quality improvement initiatives may also be expanded to include treatment and care for conditions that are not included in traditional primary health care programmes. Examples of these include pain relief for cancer patients, medical treatment of mental illness, sexually transmitted diseases, diabetes, hypertension and HIV-

[41] Online at www.USAIDmakingcitieswork.org,access on 9/7/05
[42] Oneline at http://www.jhuccp.org/quality/index.shtml

AIDS ---if these are causes of high disease and economic burden for families in slum areas. Community groups, non-government organizations and the private sector may be key partners for such new initiatives.

3. Targeted health promotion for specific risks to health

A risk management approach to health is critical to improving the health of the urban poor. A risk is defined as "a probability of an adverse outcome, or a factor that raises this probability". It is now known that a third of all mortality in the world could be prevented by modifying ten leading risks to health: underweight, unsafe sex, high blood pressure, tobacco consumption, alcohol consumption, unsafe water, sanitation and hygiene, iron deficiency, indoor smoke from solid fuels, high cholesterol and obesity.[43]

Health promotion directed at improving health literacy of slum dwellers and informal settlers could significantly reduce vulnerabilities and improve health-seeking behaviour for a wide range of risks, diseases and debilitating conditions that are communicable and non-communicable and can significantly reduce costs of care and treatment if done efficiently and effectively.

Programmes that are specifically designed to address the psycho-social context of slum dwellers need to be developed. Specifically, "boosting strategies" that help build self confidence and self-esteem may be needed to overcome stigma and social exclusion.

Programmes for empowering women have proven to be an effective entry point for further promotion of health. Community-organizing and the creation of support groups, women's networks and cooperatives, mothers clubs and volunteer health worker programmes have encouraged participation in health issues and been shown to help build social capital and strengthen social cohesion. Health promotion programmes in slums and informal settlements could be further linked to livelihood and micro-credit financing programmes as well as slum-upgrading programmes.

The role of electronic media in modifying behavioural risks to health has already been demonstrated in relation to reproductive health, tobacco, road injuries and violence prevention in urban areas in many parts of the world. Targeted campaigns may be considered in slum areas where television and radio usage is high.

4. Integration of health, welfare and education services

Health problems in slum and informal settlement areas cannot be addressed by health sector interventions alone. There is often a need to provide assistance and support for other services that address social determinants more directly. Malnourished children, for example, may be given deforming medications and supplementary feeding, but if there are no opportunities for early childhood education and care, or if their mothers are not provided with information and the means or capacity to care

[43] *The World Health Report 2002: Reducing Risks, Promoting Healthy Life.* Geneva, World Health Organization, 2002.

for them, the benefits of the medical interventions will be short-lived. In the case of mental illness, halfway homes and family support services are needed. Where there is chronic illness such as cancer in the family and additional income is needed to compensate for unemployment, alternative livelihood programmes are necessary to prevent families from suffering complete financial catastrophe. There are countless examples of how health, welfare and education services can be integrated within the context of 'healthy settings' (particularly Healthy Cities programmes) and through various types of public-private partnerships[44] [See APPENDIX V]. Non-government organizations and foundations have pioneered in such approaches and could be tapped to expand these to slum areas and informal settlements in partnership with local governments.

Violence prevention programmes at the community level, in particular, also show how health, education and welfare must converge. Health facilities are usually the entry point for identification of problems related to violence as survivors of injuries from domestic violence, child abuse, rape or crime will go to an emergency room before they go to the local police or the local welfare department. Emergency care facilities in cities could be linked to comprehensive strategies that include referral for counselling, community violence prevention programmes, school based intervention programmes (i.e. health-promoting schools), as well as expansion of welfare and legal service support services and further collaboration with local authorities.

Other vulnerable groups, such as street children, disabled persons, refugees and migrants could also benefit from comprehensive programmes that integrate health, education and welfare programmes. The deaf or blind who live in slums for example may need special types of assistance to reduce their risks for various health hazards and diseases.

5. Sustainable urban development

It is apparent that city-wide approaches to improving the whole urban environment will be critical to improving the health and quality of life of vulnerable populations such as slum dwellers and informal settlers. There are many examples of how vulnerable populations suffer the heaviest burden of environmental hazards that affect cities. For example, ambient air quality is worse in slums and settlements that are located near major thoroughfares, dumpsites or industries. Landslides are more likely to occur in sites of informal settlements. The urban poor may have to pay more for water (and may be asked to shoulder the costs of water pipes and drainage systems) than residents in more well-off parts of the city. Poorly designed waste management systems within a city result in dumping of garbage in poorer parts of the city, usually close to informal settlements and slums.

[44] The San Lazaro Extended Child Care Centre is an example of a public-private partnership in a tertiary hospital in Manila, Philippines provides extended child care for families where a parent is debilitated by chronic infectious disesase (HIV-AIDS, tuberculosis).

Integrating the principles and values of sustainable urban development has shown how upstream determinants of health can be better addressed. Experiences around Local Agenda 21 and Healthy Cities show how this can be successfully achieved. Institutionalizing consultation, participation and ensuring local stakeholder engagement are examples of city-wide interventions to address environmental health concerns and improve health of slum dwellers and informal settlers. Other relevant interventions include the integration of environment and development concerns, ensuring coordination and cooperation between and among local agencies, and between national and local authorities. Harmonizing national and local policy in relation to land use, for example, would be crucial. Environmental impact assessments as well as health impact assessments can support policy and decision-making processes at multiple levels.

Inventory of resources and opportunities

The KNUS may consider a closer review of ongoing initiatives related to improving the lives of slum dwellers. These include but are not limited to the following:

On-going initiatives related to urbanization, health and slums

- The *United Nations Millennium Project*, in particular the work of Task Force 8 on "Improving the Lives of Slum Dwellers," as well as the work of Task Force 1 (Poverty and Economic Development) and Task Force 7 (Water and Sanitation).
- The work of the *United Nations Human Settlements Programme* (UN-HABITAT), particularly in relation to the Slum Upgrading Programme, the Global Campaign on Good Urban Governance, the Monitoring of Urban Inequities Programme, the Best Practices and Local Leadership Programme, and the Slum Upgrading Financing Facility. [See APPENDIX II]
- The *Cities Alliance* initiative launched by UN-HABITAT and the World Bank in 1999.
- *United Cities and Local Governments* (UCLG) created in 2004 through the merger of the World Federation of United Cities, the International Union of Local Authorities, and Metropolis (the World Association of Major Metropolises).
- *Shack/Slum Dwellers International*, a network of people's organizations working to improve the lives of the urban poor.
- National slum upgrading initiatives in countries such as Albania, Brazil, Ethiopia, India, Nicaragua, Pakistan, South Africa, and Thailand.

Some of key global and regional processes that are addressing urban poverty issues [See APPENDIX IV]

- *Parliamentarians for Global Action*
- *International Chamber of Commerce*
- *International Confederation of Free Trade Unions*
- *World Social Forum*
- *Third World Network*
- *G8*
- *Helsinki Process on Globalization and Democracy - Finland and Tanzania*
- *ASEAN*
- *Economic Commission for Latin America and the Caribbean*

Some regional initiatives that are linking local poverty reduction strategies and health improvement within the healthy settings framework

- *Healthy Settings Programme - WHO-AFRO*
- *The urban initiative -Healthy Municipalities and Communities Initiative in the Americas – AMRO*
- *The Health Investment Project, WHO Venice*
- *European Network of Healthy Cities – WHO European Region*
- *Healthy Cities - WHO-Arab Gulf Programme for United Nations Development Organization (AGFUND) and countries of the Gulf Cooperation Council*

- *Healthy settings – WHO Southeast Asian Regional Office*
- *Alliance for Healthy Cities in collaboration with the WHO Western Pacific Regional Office*

Some key organizations that are working on urbanization issues

- *International Union for Health Promotion and Education*
- *International Institute for Environment and Development*
- *International Development Research Center*
- *Women's Environment and Development Organization*
- *Habitat International Coalition Organization*
- *International Society of City and Regional Planners Organization*
- *World Association of the Major Metropolises*
- *Environnement et Developpement Dans Le Monde Arabe*
- *Globalization Research Network*
- *Centre for African Settlement Studies and Development*
- *Huairou Commission*

Some key individuals working on implementation of projects on slum upgrading, housing and urban renewal

Mouhtque Chowhury (Bangladesh)
Arif Hasan (Pakistan)
Charles Kiyu (Kenya)
Bayani and Maria Lourdes Fernando, Noli de Castro (Philippines)
Elizabeth Lule (India)
Olivio de Oliveira (Brazil)
Somsook Boonyabancha (Thailand)

Some key individuals who are working on evaluation and research on urbanization and health

Jo Beal (UK), Patrick Bond (South Africa), Salma Burton (UK), Cathy Campbell (UK), Mike Douglas (USA), Joe Flood (Australia); Sandro Galea (USA),Lucy Gilson (South Africa) Lawrence Green (USA), Nelson Gouveia (Brazil), Trudy Harpham (UK), Minu Hermatti (Germany), Fu Hua (People's Republic of China), Ken Judge (Scotland), Nkuruma Kalakuka (Tanzania); Lawrence Kincaid (USA), Andrew Kiyu (Malaysia), Davidner Lamba (Kenya), Albert Lee (Hong Kong SAR, People's Republic of China), Vivian Lin (Australia), Sharon Long (USA), Martin McKee (UK), David McQueen (USA), Keiko Nakamura (Japan), Louise Potvin (Canada), Victor Rodwin (USA), David Satterthwaite (UK),Shoshanna Sofaer (USA), Alfredo Stein (Sweden), Carolyn Stephens (UK), Ralph Straton (Australia), Irving Rootman (Australia), Alfred Rutten (Germany), Reg Warren (Australia), John Williamson (USA).

Some key academic institutions with programme/initiatives on urbanization and health

***Australia**- Australian National University/ La Trobe University/ University of New South Wales Australia*
***Brazil**- Federal University of Minas Gerais, Belo Horizonte/ University of Sao Paolo*
***Canada** -University of British Columbia/ Center for Health Evaluation and Outcome Sciences, British Columbia, Canada*
***China**-Chinese University of Hong Kong/ Fudan University*
***Colombia** – Universidad del Valle*
***Israel**-Yeshiva University*
***Japan** – Tokyo Medical and Dental University*
***Philippines** - Ateneo de Manila University/ De la Salle University/ University of the Philippines*
***United Kingdom** - Imperial College London*
***United States** - Boston University/ City University of New York/ Columbia University/ Cornell University/ Emory University/ Fordham University/ Harvard University/ Johns Hopkins University/ New York Medical College / Northeastern University/ University of California, Berkeley/ University of North Carolina*

Non government organizations, foundations and civil society groups
Save the Children
Medecins sans Frontieres

International agencies
African Development Bank, Asian Development Bank, UNAIDS, UNCDF, UNICEF, UNDP, UNEP, UNIFEM, UNHCR, UNU, World Bank,

SECTION III: Positioning for action

Propose priority areas of KN work for 2005-06, mechanisms for taking this forward and specific country country, regional and global institutional and individual participants to engage in this work.

The KNUS could examine the wide range of environmental, service, commercial and social drivers of public health in specific slum areas taking into account available evidence and delineating needs for better and new knowledge. Particular attention will be paid to developing a better understanding of the widening inequities in health in slums. The KNUS would propose policy options and interventions[48] drawing from existing good practice for improving health in slum areas and establish an analytical framework to examine the macro-environment and upstream issues of urban development, the mediating policies and services that influence health outcomes, and the modulating influence of governance on both the urbanization process and areas of high ecological stress.

Priority areas of KNUS work

It is proposed that the KNUS would closely examine existing evidence, policies and demonstration sites relevant to the four associations[49]. The table below outlines priority areas of work and key questions for each areas:

Priority area of work	*Key question*
Delineating "best practice"	What approaches and methodologies are effectively influencing social processes to enhance health and well-being?
Identifying challenges and opportunities	What are the organizational and institutional barriers that limit the effective application of these approaches and methodologies? How might these be overcome?
Developing an interdisciplinary framework for collecting evidence	What is the evidence that these approaches and methodologies work?
Validation and measurement	What comprises evidence in relation to social processes?
Delineating action-research options and alternatives	What types of research are needed to drive public health-related policy and practice in ways that enhance health and well-being?
Moving from knowledge to action	What priority actions might WHO undertake, in partnership with others, to ensure effective scaling-up of ongoing initiatives and maximize health benefits for a critical mass of people living in new urban settings?

Linking with the Knowledge Network on Measurement

The area of validation and measurement is given special attention, as conceptual and methodological issues that have been raised in other parts of this paper may need to be discussed in depth. Since the WHO Kobe Centre is also involved in the work of the Knowledge Network on Measurement through a special research project on the development

[49] Social determinants that cause and interact with environmental hazards to health, social determinants that create and interact with economic barriers to health, social determinants that influence values, behaviour and lifestyle and social determinants that create and interact with social and political exclusion of slum dwellers.

of a conceptual framework of indicators on SDH and their testing in Asian countries with Evidence for Policy, WHO Headquarters, close collaboration between the two networks is expected. A combination of qualitative and quantitative methods will need to be employed and should include but not be limited to the following:

- compilation of programme policies and good practices;
- anchoring vignettes or other methods for evoking stories by ordinary people and people's associations – "the voices of slum dwellers";
- good practice models explaining the interface between urbanization and globalization in the context of actual experiences;
- conceptual models and associated research that captures the reality of the health-environment interaction in new urban settings, as well as the changing nature of the urban-rural interface;
- action research that delineates the changing nature of cities and the communities that comprise cities, with a particular focus on the urban factor, areas of high ecological stress and slums, and
- applied research on health and good governance.

Pilot projects on scaling up

Subject to availability of funds, the KNUS may opt to conduct pilot studies in certain cities. The overarching goal would be to apply key strategies and interventions for scaling up an existing model or demonstration site in the aim of modifying social determinants of health. Relevant tools and methods for these pilot projects could include but not be limited to:

- a policy analysis phase at the municipal level;
- city development index delineation;
- city socioeconomic surveys;
- development of an urban health development plan with strategic and tactical interventions, and
- evaluating results and gaining insight into issues and challenges related to scaling up.

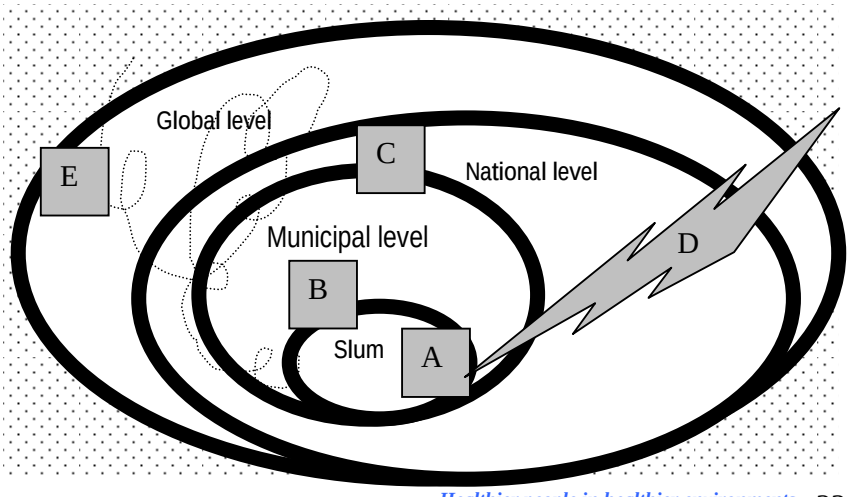
Linking with the Knowledge Networks on Globalization, Social Exclusion and Health Services

The links between urbanization and globalization, slums and informal settlements and social exclusion and health services will be pursued through collaboration with the other Knowledge Networks.

Starting points for deriving new and better knowledge

A cursory review of existing work on improving health in slum areas point to five "intervention zones" where knowledge, experience and data may be derived. These intervention zones are not discrete, nor are they necessarily continuous. Clearly, from the experience of countries where these interventions have taken place, there is wide variability in the way in which they are constructed. As illustrated by the schematic diagram below, the intervention zones are at the:

1) slum level (A);
2) interface between slums and municipal stakeholders, i.e. local governments, NGOs and/or civil society groups (B);
3) interface of slums, municipal stakeholders and national players (C);
4) interface of slums and municipal, national and global players (D), or



5) various combinations of levels as listed above (E).

Role of the members of the Knowledge Network on Urban Settings

Individual members of the KNUS may opt to focus their review on one of these intervention zones. Case studies, policy calculations, systematic reviews of literature and pilot projects may be conducted to derive insight into what works and what can be scaled up.

Preliminary listing of potential stakeholders for 2005-06

The following is a preliminary attempt to collate country-level information on effective interventions that have shown potential for scale-up. Countries have been selected based on the following criteria:

1. Case studies on characteristics, features, attributes and challenges of slums in key cities of the country are available through UN-HABITAT;[50]
2. The issue of slums and health is addressed at multiple levels, although there is usually a dominant entry point, at the slum, municipal, national or global level;
3. The approach used to address slums and health is a combination of interventions that include preventive, promotive and protective measures to improve population health and are linked to broader health initiatives such as Healthy Settings, Healthy Cities, City Development Plans, Sustainable Cities, Local Agenda 21 cities, etc.
4. Policies and programmes to address slums and health are embedded in broader policy directions usually related to good urban governance and health systems development such as decentralization, health care financing, health regulation reforms and municipal health systems development;
5. Features of good urban governance are apparent (participation, accountability, rule of law, strategic vision, etc.), and
6. Tangible results are available for further review and evaluation.

Preliminary list of countries [See APPENDIX VI]

Country	***Cities where UN HABITAT case studies are available***	***Documentation on good practices related to urbanization and health; slum-upgrading, decentralization are immediately available***
Bangladesh		The Green Umbrella [health quality improvement];"Pro Poor Service Delivery Initiatives "[Project of Bengalore Mahanagara Palike, ADB]
Brazil	Rio de Janairo, Sao Paolo	Participatory budgeting [Porto Alegre]; Slum-upgrading for 250,000 households [Sao Paolo];Slum-upgrading [Fortaliza]; model public transport [Curitiba]; constitutional provision on 'urban policy'[national government, 1988]; Cities and Health research projects [WHO Kobe Centre]; Secretariat for Housing and Urban Development [Sao Paolo]
Cambodia	Phnom Penh	Solidarity for the Urban Poor Federation;
Colombia	Bogota	Profamilia [private sector reproductive health program]; decentralization; social health insurance
Egypt	Cairo	The Gold Star [health quality improvement]
Ecuador	Quito	Local governance improvement [with Association of Dutch municipalities]
India	Ahmedabad, Kolkata	India Family Welfare Urban Slums Project [Andhra, Pradesh, Karnataka and West Bengal]; Slum Networking Project (Parivartan)linked with Self-employed Women's Activities (SEWA) [Ahmedabad Municipal Corporation, Gujarat]; Alliance of National Slum Dwellers and the Mahila Milan; the Society for the Promotion of Areas Resource Centres; Community-Led Infrastructure Financing Facility
Indonesia	Jakarta	The Blue Circle [health quality improvement]; Kampung Improvement Programs (KIPs)[national slum upgrading for 15 million people]; decentralization of health services
Jordan	(-)	Slum upgrading [Amman and Aqaba]
Kenya	Nairobi	Muungano wa Wanavijiji federation of slum and informal open-air markets; Kenya Urban Poor Federation

[50] These case studies have comprehensive data on slums and take a close look at municipal and national-level drivers of slum growth The themes covered by the case studies are: origin of slums, definition of "slum", types of slums, tenure types, slum dynamics, slum socio-political characteristics, policy actions proposed or taken, policy impacts of development prospects.

[78] WHO, World No Tobacco Day 2004 (advocacy materials from the WHO Western Pacific Regional Office)

Lebanon	Beirut	
Mexico	Mexico	Decentralization of health services [national policy]; social health insurance
Nigeria	Ibadan	
Pakistan	Karachi	The Oranji Pilot Project Research Training Institute ; Cities and Health research projects [WHO Kobe Centre]; Slum upgrading without donor assistance – [Sidh Katchi Abadis Authority and Hyberabad Development Authority]
People's Republic of China	Chengdu	Comprehensive Revitalization of Urban Settlements for 30,000 households [Chengdu]; Transfer of social welfare administration to municipal level and other decentralization efforts [Shengyang]; Decentralization of health services [national policy]; Cities and Health research projects [WHO Kobe Centre]; Healthy Cities projects [Souzhou, Shanghai, Macao, Hong Kong with Alliance for Healthy Cities and WHO-WPRO]
Philippines	Manila	Sentrong Sigla [health quality improvement]; San Lazaro Extended Child Care Centre [public-private partnership model with WHO]; Healthy Cities demonstration site [Marikina City and WHO];Community Mortgage Program [national programme]; "Empowering the poor: key to effective pro poor services [Naga City and ADB]; Well Midwife Clinics [national project with USAID]; Cities and Health research projects [WHO Kobe Centre]; Homeless People's Federation;
Russian Federation	Moscow	
Thailand	Bangkok	Urban Community Development Office [national agency];Baan Makong Programme [national programme]; Wat Chonglom project [private-community-government partnership for slum upgrading]; The Community Organizations Development Institute [national programme for slum-upgrading and secure tenure]
South Africa	Durban	Consultative process includes actors in the informal economy [Durban]; Healthy homes project in inner cities [with WHO-AFRO]; "Embedding poverty reduction into local government transformation: the case of Johannesburg"[Johannesburg with University of Birmingham]; Mafikeng Development Programme; South African Homeless People's Federation
Sri Lanka	Colombo	Million Houses Program [national initiative]; "Promoting Service Delivery by the Colombo Municipal Council through Effective Partnerships [Colombo and ADB]; Cities and Health research projects [WHO Kobe Centre]
Tanzania	Dar Es Salam	Healthy Cities project uses geographic targeting [WHO EMRO]; local governance improvement [with Association of Dutch Municipalities]; Cities and Health research projects [WHO Kobe Centre]

Activities to take the work forward

1) A meeting of regional advisers and focal points on Healthy Settings, including Healthy Cities was convened by the WHO Kobe Centre in Bangkok on 12 August 2005. Regional focal points will contribute to the development of a global database on Healthy Settings, including Healthy Cities as a contribution to the work of the KNUS.

2) KNUS will take place on October 20-22, 2005 at the WHO Kobe Centre, Japan. The network will agree on an analytic framework and will further develop a workplan based on this strategy document.

3) WHO Kobe Centre and UNEP will jointly create an internet-based portal for sharing information about the work of the KNUS.

4) A communication and advocacy strategy will be further developed and implemented by the WHO Kobe Centre after the meeting in October to engage a wide range of possible stakeholders for 2006.

5) The workplan of the WHO Kobe Centre for 2006-07 will have a core project that focuses on optimizing social determinants for vulnerable populations in urban settings and will provide opportunities for interventions in "urban health field research sites" in selected cities.

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APPENDIX I: APPROACHES TO GOVERNANCE

Box 2.1: Approaches to Governance:

World Bank: Good governance is epitomised by predictable, open, and enlightened policy making (that is, transparent processes); a bureaucracy imbued with a professional ethos; an executive arm accountable for its actions; a strong civil society participating in public affairs; and all behaving under the rule of law.

UNDP: Governance can be seen as the exercise of economic, political and administrative authority to manage a country's affairs at all levels. It comprises mechanisms, processes and institutions through which citizens and groups articulate their interests, exercise their legal rights, meet their obligations and mediate differences. Good governance is, amongst other things, participatory, transparent and accountable. Good governance ensures that political, social and economic priorities are based on a broad consensus in society and that the voices of the poorest and the most vulnerable are heard in decision-making over the allocations of development resources.

Habitat: Good governance can be defined by how well a population, its representatives and agents, identify and deal with major social, economic and environmental issues that stand in the way of improved quality of life for all citizens. Urban governance can be defined as an efficient and effective response to urban problems by democratically elected and accountable local governments working in partnership with civil society.

(UMP, 2000)

APPENDIX II: INFORMATION ABOUT UN HABITAT

The UN-HABITAT Strategic Vision

'The problem of slums is a dynamic one. At any point in time and in any one place it may present itself as a cluster of symptoms that might be dealt with sector-by-sector until the problem begins to dissolve. There are, however, economic, social and political forces behind urban poverty that cause slums to form at a rate that overwhelms every effort to fight them. It is those forces that must be challenged and channeled, not just within the slums but also in the wider urban and regional context. Fundamentally, urban poverty and slums are not just a matter of local improvement but of region-wide and national development policy.

Facing the growing magnitude of the slum problem thus requires a three-part, integrated strategy that is both corrective and pre-emptive:

a) **Slum upgrading:** physical upgrading of housing, infrastructure, environment; social upgrading through improved education, health and secure tenure; governance upgrading through participatory processes, community leadership and empowerment;

b) **Urban development:** stimulation of job creation through city-wide advance land use planning, development and management of the revenue base, infrastructure improvement, amenities provision, city management and urban governance practices, community empowerment, vulnerability reduction and better security;

c) **Regional development:** reduction and diffusion of urbanization impacts through national urban policies and enabling laws that support secondary/tertiary cities, metropolitan governance and the planning/management of integrated urban-rural economic and lifeline systems. (UN-HABITAT, 2003c:4)

Global Campaign on Urban Governance

"The campaign promotes accountable and transparent urban governance which responds to and benefits all sectors of society, particularly the urban poor, and which works to eradicate all forms of exclusion. By linking operational and normative activities, the campaign focuses on mechanisms to promote inclusion. By supporting consensus-building governance processes between local governments and civil society, the campaign helps establish priorities for socio-economic development" (UN-HABITAT, 2003c:10).

One of the strengths of the Branch is pro-poor urban governance toolkit development (city, town, village). Approaches used include anti-corruption, efficiency and revenue enhancement. Categories include tools to support participative urban decision-making, tools to support transparency in local governance and participative budgeting (final stages). If the statistical correlation between UN-HABITAT's "process"-orientated urban governance index and population health output data could be assessed to judge whether health is improving, then it would be feasible to develop an urban health governance toolkit.

Monitoring Systems Branch

The Global Urban Observatory (GUO) addresses the urgent need to improve the world-wide base of urban knowledge by helping governments, local authorities and civil society organizations to develop and apply policy-oriented urban indicators, statistics and other urban information.

The GUO works closely with Best Practices and Local Leadership programme (BLP) which was established to make use of information and networking in support of the Habitat Agenda Implementation. Both programmes operate under the Monitoring Systems Branch, which has the overall mandate to monitor progress on the Habitat Agenda and the Millennium Development Goals.

Current activities are based on the development of an integrated network of national and local urban observatories. The beneficiaries are policy-makers at all levels and civil society organizations participating in sustainable urban development. The three main areas of

work include assistance to governments, local authorities and organizations of local civil society to amplify their ability to collect, manage, maintain and use information on urban development; enhance the use of knowledge and urban indicators for policy formulation, planning and urban management through a participatory process; and collection and dissemination of results of global, national and city level monitoring activities, as well as disseminating good practices in the use of urban information worldwide.

Monitoring of Urban Inequities Programme

"The Monitoring Urban Inequities Programme is the study of social inequities within human settlements regarding access to essential services such as water; sanitation; shelter; sufficient living space and security of tenure. The programme, however, will not be limited to these five indicators but goes a few steps beyond into other social conditions in health, education, employment and access to credit to name a few. The goal is to collect and analyze urban indicator data in a global representative sample of cities (350+ cities), synthesize the results and disseminate them at global, national and city levels.

Along with the Urban Indicators Programme and other current monitoring activities, the MUIP aims to provide globally representative knowledge on the actions taken by the governments to improve the lives of slum dwellers and to measure the impact of these actions, by monitoring the magnitude of urban inequities. The MUIP aims to develop capacity among multiple national stakeholders on policy analysis and implementing multi-stakeholder programme frameworks in favor of the urban poor. This will enhance policy formulation and dissemination at the local level, based on solid evidence and information." (http://www.unhabitat.org/programmes/guo/muip.asp).

At the global level, UIP will thus respond to Habitat's monitoring and reporting mandate, and will be used to analyze global trends and develop advocacy actions for policy development. The Branch will make comparisons between regions, sub-regions, countries and cities, and build capacities at the local level to use urban indicators as a policy decision tool. But they have a long way to go and the Commission may need reliable data and proven tools in a timely manner. (pers. comm.)

It needs to be clarified with MSB how the use of national census data and development of additional locally relevant information (global household level data on slums settlements, for example) is used for policy formulation at the city and slum levels. This approach is an improvement on the City Development Index (which it is believed is no longer produced), and will enhance monitoring and evaluation in the future. However, the robustness of the data sets at this time needs to be further clarified. Given the short-term nature of the KNUS's work, it is suggested that the City Development Index could possibly be used for case studies. Data is easy to collect and the process is relatively cheap, and it could raise the red flag at the city level if used in one of the original CDI cities. The KNUS will in any case need to be aware of the strengths of the UIP as it may have bearing on recommendations made to the Commission.

Best Practices and Local Leadership Programme

"The Best Practices and Local Leadership Programme (BLP) was established in 1997 in response to the call of the *Habitat Agenda* to make use of information and networking in support of its implementation. It is a global network of government agencies, local authorities and their associations, professional and academic institutions and grassroots organisations dedicated to the identification and exchange of successful solutions for sustainable development. BLP partners are specialised in such areas as housing and urban development, urban governance, environmental planning and management, architecture and urban design, economic development, social inclusion, crime prevention, poverty reduction, women, youth, cultural heritage, municipal finance and management, infrastructure and social services.

The objective of the BLP is to raise awareness of decision-makers on critical social, economic and environmental issues and to better inform them of the practical means and policy options for improving the living environment. It does so by identifying, disseminating and applying lessons learned from Best Practices to ongoing training, leadership and policy development activities. Best Practices are actions that have made a lasting contribution to improving the quality of life and the sustainability of our cities and communities.

BLP products include: documented and peer-reviewed best practices, examples of good policies and enabling legislation, case studies and briefs and transfer methodologies. These products are destined for decision-makers and practising professionals at all levels of government and organised civil society. Media products, including videos and newspaper articles are developed for the general public."
(http://www.unhabitat.org/programmes/bestpractices/)

The Cities Alliance

The Cities Alliance was created as a global alliance of cities and their development partners committed to improve the living conditions of the urban poor through action in two key areas:

- ***City development strategies*** (CDS) which link the process by which local stakeholders define their vision for their city, analyse its economic prospects and establish clear priorities for actions and investments, and

- ***Citywide and nation-wide slum upgrading*** to improve the living conditions of at least 100 million slum dwellers by 2020 in accordance with the Cities Without Slums action plan.

The alliance was launched in 1999 with initial support from the World Bank and UN-HABITAT, the political heads of the four leading global associations of local authorities and 10 governments—Canada, France, Germany, Italy, Japan, the Netherlands, Norway, Sweden, the UK and the US. The Asian Development Bank joined the Cities Alliance in March 2002. UN-HABITAT is active in the Cities Alliance at both the policy level, as a member of the Consultative Group, and in the field where its regional offices are instrumental. The Executive Director of UN-HABITAT is co-chair of the Cities Alliance, along with the World Bank.

UN-HABITAT, as a founding member of the Cities Alliance, has influenced the work of the Cities Alliance on preparation of City Development Strategy guidelines and strategies. UN-HABITAT was involved in preparing the initial action plan for CDS and has prepared

guidelines for undertaking the CDS exercise. The CDS is seen by UN-HABITAT as an Urban Poverty Reduction Strategy Paper (UPRSP) that needs to be integrated within the overall framework of national PRSP efforts. A slum upgrading strategy has to be developed within the overall framework of a pro-poor CDS. As a result of UN-HABITAT's efforts, the Cities Alliance has now defined a CDS as "an action-plan for equitable growth in cities, developed and sustained through participation, to improve the quality of life for all citizens."

The participatory approach to city consultation for preparation of a CDS is also now recognized. The CDS guidelines state that, "the goals of a City Development Strategy include a collective city vision and action plan aimed at improving urban governance and management, increasing investment to expand employment and services, and systematic and sustained reductions in urban poverty. The Slum Upgrading and City Development Strategy are seen as complementary activities in concert with the UN-HABITAT campaigns on secure tenure and good governance. The follow-up activities to these campaign launches have been supported by Cities Alliance to prepare participatory pro-poor strategies. Through the Urban Management Programme (UMP), seven CDS exercises have been completed and a synthesis and lessons study has been prepared. Beside the UMP related CDS activities, UN-HABITAT has been involved in a number of Slum Upgrading and City Development Strategy activities for the Cities Alliance.

Report on Inception Phase (March 2002)
Urban Poverty and Livelihoods - Annex B
DFID Research project R7963
Localising the Habitat Agenda for Urban Poverty Reduction

A livelihoods approach attempts to provide a holistic and people-centered framework for considering access to resources, including those that depend on human development and non-economically-based social relationships. One of the sources of the livelihoods approach is the critique of the use of quantitative indicators of absolute poverty, the narrow focus of the policy responses to poverty so defined, and the advocacy of a more multi-dimensional approach (Chambers, 1995). In the urban context, work on the household strategies of people living in poverty has contributed to the development of a livelihoods perspective.

The concept of sustainable livelihoods involves environmental sustainability – less relevant in urban areas where the livelihood activities of the poor are generally less damaging to the wider environment than those of the better off. However, ‘sustainability’ is also used in the sense of durability and relative absence of risk and uncertainty. A ‘right to a sustainable livelihood’ (as in Oxfam’s approach to sustainable livelihoods) means that people should have the opportunity to access livelihood activities and opportunities to provide for their security and minimize their vulnerability over the long term. The emphasis is on attacking the four dimensions of
poverty, income-poverty, poor health and education, vulnerability and voicelessness.
Social exclusion recognizes both the problems of lack of material resources as well as including the social and political processes that lead to poverty.

DFID’s sustainable livelihoods approach (SLA) and sustainable livelihoods framework recognises that policies, institutions and processes provide the context in which people can utilise their assets in responding to shocks in order to achieve sustainable livelihoods (see: http://www.livelihoods.org). The SLA helps to explore the processes through which local, national and international policies and institutions

interrelate. Secure rights and good governance are critically important to the livelihoods of the poor. The framework is an attempt to include these factors in the analysis of the many factors, which influence people's livelihoods. These contextual factors can have a major impact on the livelihoods strategies of poor people and their vulnerability (the Vulnerability Context) and the policy and organizational factors than constrain or increase their livelihood opportunities (Policies, Institutions, Processes).

The sustainable livelihoods framework identifies five types of 'capital' that help to keep people out of poverty, described as the 'asset pentagon':

- Human capital: skills, knowledge, ability to work and health
- Natural capital: access to land, forests, water and clean air,
- Financial capital: savings, credit, and other sources of investible resources, including migrants remittances
- Physical capital: infrastructure such as roads, buildings, water supplies, equipment and transport,
- Social capital: friends, family, social organisations and other people who can offer support.

The sustainable livelihoods approach looks at the building blocks of people's lives, at how policies, institutions and processes affect the way that those building blocks are used to construct livelihood strategies and how external factors can increase or decrease a person's vulnerability to poverty. On this basis, priorities for action can be determined, based on the views and interests of poor people and which reflects their perceptions of poverty and well being.

These priorities may revolve around which assets are crucial for people and the critical relationships between these, for example, is the use of natural resources dependent on access assured through social networks? Is one asset the most important? Do those who escape from poverty tend to start with a particular combination of assets? Are people poor because of a deficiency such as land, or do they have inadequate knowledge to use an asset effectively? To which asset is access weakest, thus making people more vulnerable?

A household strategy-based approach gives a greater emphasis to human capabilities and non-income based assets. Central to the livelihoods approach is asset-building as expressed in an assets framework. Assets provide benefits that can be realized over time and these are the key to increasing security and reducing the vulnerability aspects of poverty. They provide the basis on which people can escape poverty on a permanent basis. Non-income based factors which can reduce poor people's vulnerability or increase their own capacity to escape poverty, as well as those that relate to income are given concrete representation in this way, i.e. different types of human capability and tangible or non-tangible assets.

What is a City Development Strategy?

Accessed online at: www.citiesalliance.org

A rapidly increasing share of the world's population is living in cities. In the next 15 years the population of many cities in Asia and Africa will nearly double. In order to confront the challenges posed by this unprecedented rate of urban growth and increasing urban poverty, cities need to plan ahead in order to make more informed choices about the future and they need to act now. A city development strategy supports cities in this critical decision making

process and is focused on implementation. It is an action-plan for equitable growth in cities and their surrounding regions, developed and sustained through participation, to improve the quality of life for all citizens.

The output of a city development strategy includes a collective city vision and a strategic action plan aimed at policy and institutional reforms, increased economic growth and employment, and implementation and accountability mechanisms to ensure systematic and sustained reductions in urban poverty.

Because "cities are made up of people and their hopes – not of buildings and streets" (Augustin, 400 A.D.) , there is no universally applicable best practice for the implementation of a city development strategy. Each city needs to recognize and to identify its own opportunities and problems, which may vary considerably according to its location, level of economic, social and institutional development and many other factors.

Initial results from Cities Alliance supported city development strategies underscore the importance of city officials themselves taking the lead, while actively involving the urban poor and local business leaders within a wider participatory process. Thorough assessments of the city and its region, which include the assets and knowledge of the urban poor, have proven to be an essential starting point for a city development strategy. However the success of the strategy also seems to depend on its ability to mobilise and engage not only the public, but also the business and community sector.

Other key building blocks of a city development strategy include creating a shared strategic understanding among all stakeholders (vision building); the focus on points of leverage and results (strategy); and the focus on implementation and monitoring mechanisms.

The Slum Upgrading Facility (SUF) is a new global facility located within UN-HABITAT. SUF is designed to lead and coordinate technical cooperation and seed capital initiatives established to develop bankable projects that promote affordable housing for low-income households, the upgrading of slums, and the provision of urban infrastructure in settlements in cities of the developing world. The key clients of SUF are municipal authorities, CBOs, NGOs, and relevant departments of central government, as well as the local, private sector, including retail banks, property developers, housing finance institutions, service providers, micro-finance institutions, and utility companies. A central objective of SUF is to mobilize domestic capital for upgrading activities by facilitating links among these local actors and by packaging the financial, technical and political elements of development projects. This will entail identifying projects, building local capacities, networking, and providing direct technical assistance and seed capital. A second objective of SUF is to ready local projects for potential investment by international donor facilities, international financial institutions and, potentially, investors in the global capital markets – with the specific intent of leveraging further, domestic capital for slum upgrading.

SUF will be executed by Human Settlements Financing, the Sub-Programme 4 of UN-HABITAT in conjunction with the Cities Alliance, the collaborative initiative of the World Bank Group and UN-HABITAT set up to advance strategies to improve conditions of cities in the developing world. SUF will be advanced in cooperation with international donor facilities such as the Private Infrastructure Development Group, international financial

institutions including the World Bank Group, International Bank for Reconstruction and Development (IBRD), International Finance Corporation (IFC), Asian Development Bank (ADB), etc.as well as the United Cities and Local Governments, Slum and Shack Dwellers International, and the UN-HABITAT Governing Council. A UN-HABITAT Programme Manager and a contracted Management Support Team will together manage the operations and technical activities of SUF. UN-HABITAT and its partners seek to capitalize the facility with USD 30 million for an initial 3-Year Pilot. The Department for International Development (DFID) and Swedish International Development Cooperation Agency (Sida) have pledged support towards the 3-Year Pilot with a contribution of USD 20 million.

UN-HABITAT and its partners, in consultation with DFID and Sida, are adopting a staged approach to the SUF 3-Year Pilot, by providing additional support of USD 1.8 million towards an initial 10-month start up period, referred to as the SUF Design Phase. UN-HABITAT will recruit a design team of five persons: senior urban advisor, investment finance adviser, project finance adviser, Africa regional advisor, and a program management adviser. The design team will undertake a number of activities to ready the 3-Year Pilot for full implementation. These include fund raising, establishment of inter-institutional relations among key SUF partners, and a number of management arrangements such as the tendering of the contract for the management support team, recruitment of programme manager, and the development of a one-year action plan. The SUF Design Team will in parallel identify a pipeline of prospective field pilots in cities of Sub-Saharan Africa and South and Southeast Asia, developing in greater detail four projects selected from among the initial pipeline. Further work will be undertaken in the four projects including consultation with local partners, initiation of capacity building activities, and the design and initial field-testing of financial mechanisms to mobilize domestic capital for slum upgrading.

APPENDIX III: Review of Literature, SDH, health and health inequities

SUMMARY OF MAJOR ASSOCIATIONS

Slums, low status of women, low health literacy, lack of access to quality health care, >>>>infants and under-5 mortality rates

There is strong and conclusive data to show that infant and child mortality rates are higher in slum areas. Data to show urban-rural, intra-urban and intra-slum differentials is available.

Unsafe water, poor sanitation, low health literacy, lack of access to quality health care>>>>diarrheal diseases in slums

The associations between unsafe water, poor sanitation and diarrheal diseases in slum areas are strong and conclusive. Higher incidence and prevalence rates for diarrheal diseases are consistently reported in studies that review urban-rural, intra-urban and intra-slum differentials. Water and food-borne disease outbreaks in slum areas are also well-documented.

Poverty, food insecurity, unsafe water and poor sanitation, low health literacy, lack of access to quality health care>>>>malnutrition and parasitic infections among slum dwellers

The associations between poverty, food insecurity, malnutrition and parasitic infections are also strong and conclusive. Poverty is a strong underlying determinant of underweight as it contributes to household food insecurity, poor childcare, maternal undernutrition, unhealthy environments and poor health care. All ages are at risk for malnutrition, but underweight is more prevalent among children under 5 years of age, especially in the weaning and post-

weaning period. Underweight and malnutrition is also linked to poor sanitation and intestinal parasitism. Higher prevalence rates for chronic malnutrition resulting in stunting and wasting among slum children are shown in studies involving urban-rural, intra-urban and intra-slum populations. Intestinal parasitism among slum dwellers has been shown to be higher than other urban groups. Intestinal parasitism is not routinely reported at country level. However, special surveys are available in slum areas and through school health programmes.

Hazardous location of slums >>>>> exposure to multiple environmental hazards and respiratory illness, road traffic injuries among urban populations

Associations between poor air quality (outdoor and indoor pollution) and respiratory illnesses such as asthma and acute bronchitis, as well as chronic lung diseases such as cancer, are well established, but data is usually available at city level only. Comparative analysis of air quality among cities is readily available and quite up to date. Data to show intra-urban differentials in exposure or vulnerability to disease was not encountered. Special studies on blood lead levels in children may be able to show higher risk factors for slum dwellers who may be exposed to lead through air, land and water pollution. Higher risk of slum dwellers from road safety injuries are implied, but no studies to show intra-urban differentials were encountered.

Crowding, poor housing conditions, unemployment, lack of access to welfare or social services>>>>>stress, violence and injuries among slum dwellers

There is strong and compelling evidence to show that exposure to violence and crime is higher in urban areas. Despite wide variability in rates and types of violence in urban settings, this has reported to be constantly increasing in cities over recent decades. Evidence for the association between crowding and stress as underlying factors for violent behaviour is ample. Strong and compelling evidence shows the associations between youth violence, stress, frustration, poverty and crowding. Intimate partner violence and child abuse are strongly associated with poverty and larger family size, although urban-rural differentials show varying results. Comparison of suicide rates between urban and rural areas show mixed results. Homicide risks are reported to be higher in slum areas. Witnessing of violent acts and crimes is reported to be higher in slums. The effects of fear and anxiety on social capital in unsafe neighborhoods has also been studied.

Poverty, stress, crowding, unemployment, lack of access to health, welfare and social services, low health literacy>>>>>behavioural risks to health, mental illness and substance abuse in urban populations

There is ample evidence to show the relationship between behavioural risks and poverty, crowding and poor living conditions in urban areas and slums. Compulsive behaviours such as gambling and substance abuse --- alcoholism, drugs and tobacco --- are widely reported to be increasing in cities and among the urban poor, though these problems are also prevalent in rural areas. It is known that gambling and substance abuse can drive families into deeper poverty. Recent studies for example show how tobacco use in poor families uses up 10-17% of household income. [78] Loneliness, anomia, stress-related disorders (hypertension) as well as various forms of antisocial behaviour (e.g. violence) are seen as typical in cities. There are more lonely chronically ill in cities than in villages.[79] Mental health and psycho-social problems in cities have reported to be increasing, but there is no agreement on urban-rural differences or their causes.

[79] Goldberg D and Thornicroft G Mental Health in our Future Cities Psychology Press, United Kingdom 1998.

Poor housing, extremes of temperature, low health literacy>>>>>heat stroke and respiratory illness in urban populations

Heat waves and mortality related to increases in temperature have been reported as underlying causes of death, morbidity and/or severe dehydration in major cities such as Chicago, Paris, and recently in Shanghai and Beijing. There is ample evidence to show that the groups at risk are in extremes of age, particularly older persons of low socioeconomic status living in poor housing conditions. Climate change, poor housing that does not provide protection from extremes of temperature and the built environment are contributory factors. Urban populations are at greater risk than rural populations. Data to show intra-urban or intra-slum differentials was not available.

Poverty, crowding, poor housing conditions, unsafe water, poor sanitation, hazardous locations (flooding), lack of access to quality health care, low health literacy>>>> communicable diseases among slum dwellers

There is strong evidence to show that communicable diseases that are spread through droplet transmission or inhalation such as tuberculosis and leprosy are higher among slum dwellers than other urban populations. Increasing incidence and prevalence rates of vector-borne diseases in cities and slums have been reported. Scabies and other louse-borne diseases have been reported to be higher in some slum areas.

Poverty, social exclusion, low status of women, low health literacy, lack of access to quality health care>>>>reproductive health risks among slum dwellers

There is strong and compelling evidence to show high and alarming rates of conditions related to reproductive health risks and threats among women in slums. Women of reproductive age, especially pregnant women, who have no access to quality health care and with low health literacy are particularly at risk for disease and premature death. Unaddressed risks and complications related to unplanned pregnancies, sexually-transmitted infections and other reproductive health disorders such as cancers of the reproductive tract result in still high and unacceptable levels of maternal mortality and morbidity in many parts of the world, especially in slums of the least developed countries. Special attention is drawn to dangerously high rates of HIV/AIDS rates among pregnant women in slums in some cities of Africa.

EVIDENCE ON THE INTERACTION BETWEEN SOCIAL DETERMINANTS, HEALTH AND HEALTH INEQUITIES IN SLUMS AND URBAN SETTINGS

The following are examples of evidence to show health and health inequities in urban settings, specifically in slums.

Slums >>>>Child and infant mortality rates

Diarrhea and many other water-related diseases also often combine with under-nutrition, serving to weaken the defenses of infants and young children, making them susceptible to diseases such as measles and pneumonia, and stunting their physical growth and cognitive development. These two diseases alone are among the leading causes of death in infants and children worldwide (WHO 1992).

Infant mortality rates

The Nairobi Slum Cross-Sectional Survey (NCSS) was a two-stage stratified sample survey which canvassed 7% of Nairobi's slum population. These surveys show the dramatic

difference between mortality rates for infants and children (under5 years) in the Nairobi slums and the national, rural, other urban and Nairobi rates.80

Basta (1977) reported that the IMR for Manila overall was 76/1000 while it was 210/1000 for the Tondo squatter area. Neonatal mortality for Manila was 40/1000, but 105/1000 for Tondo.

Breihl et al (1983) reported that IMR in upper-class districts was 5/1000, while it was 129/1000 in manual labour squatter districts.

Gwatkin et al (2000) reported an infant mortality rate in India of 121 in the poorest urban quintile (most likely to be residing in slums), compared to 43 in the richest urban quintile, 109 in the poorest rural quintile and a population average of 86.3. Researchers reported that high levels of stunting (69.3%) and underweight (74.3%) among children in poorest urban quintile, in contrast to 55.2% and 59.5% in the poorest rural quintile.

USAID (2002) reported IMR for slums in Ahemadabad, India of 123, compared to 76 for the whole city.

Cassim et al (1982) reported that IMR in squatter settlements was significantly higher than in the better-off districts.

Guimaraes and Fischmann (1985) reported that IMR in non-squatter areas in Porto Alegre, Brazil was 25/1000 compared to 75.5/1000 in squatter settlements.

IGBE (1986) report that in northeast urban Brazil, the infant mortality rates in the poorest families and among children of the least-educated mothers were 8.3 and 7.2 times higher than those for the richest and for the best-educated mothers. In southeast urban Brazil the corresponding ratios were 3.3 and 2.6 respectively.

Timaeus and Hill (1985) reported from Andana, Turkey that elevated infant and child mortality was found in households with poor overall dwelling quality (as measured by building material).

Under-5 child mortality

Poor children (under-5s) in slums suffer and die more often from diarrhea and acute respiratory infections than rural children (USAID).

AHRHS (in Caldwell, 49:60) also found elevated mortality rates among under5s in both poor areas and slums in Dakar, Bangladesh. The key factors identified were social composition, household and community environment, access to public services and health facilities. From a population perspective, key factors were poverty (lack of food security, cost of access to health care and treatment, cost of time off work, cost of crowded unhygienic housing), lack of

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[80] *Slum health differentials: the case of Nairobi*

The Nairobi Slum Cross-Sectional Survey (NCSS) was a two-stage stratified sample survey which canvassed 7% of Nairobi's slum population. A total of 5463 households, 3661 women aged 12-49 years, and 1807 adolescent boys were successfully interviewed for the survey. Most of the data collected by the NCSS is comparable to that of the Kenya Demographic and Health Surveys (KDHS). NCSS data shows that school enrolment rates are lower and mortality rates are higher in the slums than in other parts of Kenya.

education (personal hygiene, when to seek health care), and the fact that these areas were favored by migrants (lower social capital).

Caldwell et al (2002) reported mortality rates of 165 in bostie slums and 115 in nonbostie poor areas in Dhaka, Bangladesh compared to the reported urban average 96.7 and a rural average of 112.6. Respondents noted positive factors (the presence of good doctors, availability of health services) and negative factors (very poor environment) as reasons their health had been better in Dhaka. Researchers also reported that the mortality rate was 30% higher in the poorest households, while another study reported an 88% difference. Education of the mother was reported as a more important predictor of child mortality than income or possessions.

Unsafe water, poor sanitation and diarrheal diseases in slums

Unsafe water and poor sanitation
At any one time, close to half the urban population in Africa, Asia and Latin America is said to be suffering from one or more of the main diseases associated with inadequate provision for water and sanitation (WHO 1999). The reported global estimates of the burden of disease attributed to inadequate water, sanitation and hygiene provision in 1992 was at least 2.2 million deaths and 82.2 million "disability-adjusted life years" (DALYs) each year; this is 4% of all deaths and 5.7% of all DALYs.

Diarrheas
Higher incidence rates of diarrheal diseases among children have been reported in slums compared to other parts of the city in Ethiopia (Kloos et al 1987 in UMP, 1992), Panama City (Kourany and Vasquez, 1979), and Sao Paulo (Benicio et al 1987 in UMP, 1992).

Cholera
Coll et al (1989 in UMP, 1992) reported on 139 cases of cholera in Dakar, Senegal. It was found that 41% were unemployed, with a further 18% of cases in irregular employment. The majority of cases originated from houses containing over 30 residents. Only 18% of cases houses had running water and 36% had sanitation.

Poverty, food insecurity >>>>malnutrition and intestinal parasitic infections
Malnutrition – It is estimated that 27% of children under 5 are underweight. Underweight children are at increased risk of mortality from infectious diseases such as diarrhea and pneumonia. As much as 50-70% of the burden of diarrheal diseases, measles, malaria and lower respiratory infections of childhood are attributable to underweight. Underweight is estimated to have caused 3.7 million deaths in 2000. This accounted for 1 in 15 deaths globally. Since deaths from underweight occur mostly in children, the loss of healthy life years is substantial and estimated at 138 million DALYs, or 9.6% of the global total. Deficiencies in iron, Vitamin A and zinc and the lack of breastfeeding also contribute to the high global burden from malnutrition.81

Stunting, wasting and micronutrient deficiency
Higher rates of stunting and wasting in slum children have been reported in Dhaka (Pryer et al 2003), Guatemala (Bogin and Macvean 1981), Delhi (Datta and Banik 1977 in UMP,

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1992), Zaire (Franklin et al 1984 in UMP, 1992), Sao Paulo (Monteiro et al 1986 in UMP, 1992; Gomez I, II, III) and India (Gwatkin et al 2000 in UMP, 1992).

Intestinal parasitism
Higher prevalence rates for hookworm among slum dwellers have been reported in Singapore (Kleevens 1966), Guatemala (Pierce et al 1962) and Malaysia (Yan et al 1978). Higher prevalence rates for ascaris among slum dwellers were reported in Cato Manor, Durban, South Africa (Elsdon-Dew 1953 in UMP, 1992), Singapore (Kleevens 1966) and Tanzania (McCullough 1972). Higher trichuris rates among the urban poor in Guatemala have also been reported (Pierce et al 1962).

Environmental hazards >>>>risks to health in slums
Hazardous location of slums in highly congested parts of the city where traffic converges may predispose slum dwellers to higher risks from exposure to environmental hazards.

The following offers a summary of environmental factors that are major risks to health:

Risk factor	Theoretical minimum exposure	Measured adverse outcomes of exposure
Urban air pollution	7.5 ug/m3 for PM	Cardiovascular mortality, respiratory mortality, lung cancer, mortality from acute respiratory infections in children
Indoor smoke from solid fuels	No solid fuel use	Acute respiratory infections in children, chronic obstructive pulmonary disease, lung cancer
Lead exposure	0.016 ug/dl blood lead levels	Cardiovascular disease, mild mental retardation
Climate change	1961-1990 concentrations	Diarrhea, flood injuries, malaria, malnutrition

Outdoor air pollution is associated with a broad range of acute and chronic health effects that may vary with the pollutant constituents. Indoor air pollution is associated with 35.7% of lower respiratory tract infections, 22% of chronic lung infections and 1.5% of cancer of the trachea, bronchus and lung. It is also associated with asthma, tuberculosis and cataracts.

Outdoor air pollution from both mobile (vehicular) and stationary (industrial) sources have in recent decades been responsible for over 130,000 premature deaths and 50-70 million episodes of respiratory illness each year in developing countries, half of them in East Asia.82

Hazardous location of slums increases exposure levels to environmental hazards from air pollution and increases risks for respiratory diseases. High levels of air pollution in cities are well-documented. There are, however, few attempts to document differential exposure levels to outdoor or indoor air pollution in slums compared to other city areas.

Special mention is made of lead poisoning. Lead, because of its multiplicity of uses, is present in air, dust, soil and water. Environmental contamination is related to industrial development and the use of leaded petrol. Housing settlements that are adjacent to industries

[82] Maddison D. *A meta-analysis of air pollution epidemiological studies*. London, Centre for Social and Economic Reseearh on the Global Environment, University College London, 1997.

that use lead or dumpsites where lead may seep into the soil are particularly at risk. Worldwide, 120 million people are estimated to have lead levels of 5-10ug/dl. Forty percent of children have blood lead levels of 5Ug/dl.83 High concentrations of lead in the blood of residents of Bangkok, Jakarta, Taipei, Santiago and Mexico have been reported.

Ambient lead concentrations in Dhaka are some of the highest in the world. The lead content of petrol in Africa is the highest in the world and is associated with high concentrations in the atmosphere as well as dust and soil. In recent surveys, more than 90% of children in Cape Province, South Africa had lead concentrations of over 10ug/d84l.

Crowding, stress >>>>violence and injuries

There is strong evidence to show that exposure to violence and crimes is higher in urban areas (Krug et al 1998; Millner 1998; Zvekic and Alvazzi del Frate 1995). Urban violence has been reported to be increasing at a rate of 3-5% over recent decades (Vanderschueren, 1998). Evidence of the association between crowding and stress as underlying factors for violent behaviour is ample.

Globally, in 2000, an estimated 1.6 million people worldwide died as a result of self-inflicted, interpersonal or collective violence, for an overall age-adjusted rate of 28.8 per 100 000. The vast majority of these deaths occurred in low-middle income countries. Nearly half of these violence-related deaths were suicides. Almost one third were homicides and one fifth were war casualties.85

Suicides
There are frequently large disparities in suicide rates between urban and rural areas. This has been reported in the United States, Australia, England and Wales and China.86 Feelings of isolation, hopelessness and loneliness have been linked to suicide and may be an increasing factor in urban areas, although evidence to support this is limited.

Youth violence
Rapid demographic changes in the youth population, modernization, emigration, urbanization and changing social policies have all been linked with an increase in youth violence. These have been associated with school-based and student revolts in Africa.87 Reports from Algeria and Papua New Guinea ("raskolism" – criminal gangs) also show how unemployment and grossly inadequate housing lead to extreme frustration, anger and pent-up tensions among youth. Young people as a result are more prone to turn to petty crime and violence, particularly under the influence of peers.88

Injuries
In 1990, injuries in 15-44 year-old men accounted for 55 million disability-adjusted life years (DALYs) lost – one third of the total (Swi and others 1996; Montgomery and others 2003).

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[83] World Health Report on Risks, 2002.
[84] McMichael Anthony. *The urban environment and health in a world of increasing globalization:issues for developing countries*, World Health Organization Bulletin 2000.
[85] *World Report on violence and health*, 2002

[86] ibid.
[87] ibid.
[88] ibid.

Accidental injuries in the home are a significant health burden (Barlett 2002). Currently, however, there is no evidence to show that injuries are higher in slum areas.

Homicide

Latin America has the world's highest homicide burden – more than double the world average of 3.5 per 1000 people. In Sao Paulo between 1991 and 1993, 15-24 year-old men in low-income urban areas were five times as likely as their high income counterparts to be victims of homicide (Barata and others 1998; Grant and Slowing 1999; Montgomery and others 2003).

Intimate partner violence

Studies from a wide range of settings show that women living in poverty are disproportionately affected. It is unclear why poverty increases the risk of violence – whether it is the stress of surviving on a low income itself or because of other factors that accompany poverty such as overcrowding or hopelessness.89

Child abuse

Information on numbers of children who die from child abuse come primarily from death registries or mortality data. Global estimates of child homicide suggest that infants and very young children are at greatest risk. Physically abusive parents are more likely to be young, single, poor and unemployed. Family size can also increase the risk of child abuse. In Chile, for example, it has been shown that families with four or more children were three times more likely to be violent towards their children. Data from a range of countries shows that household overcrowding increases the risk of child abuse.90

<u>Poverty, stress, crowding, unemployment and behavioural risks to health, including mental illness</u>

The nature of modern urbanization may have deleterious consequences for mental health due to the influence of increased stressors and adverse life events such as overcrowded and polluted environments, poverty and dependence on a cash economy, high levels of violence and reduced social support (Desjarlais et al 1995).

Mental illness

The relationship between poverty and mental health is complex and multidimensional. The poor and the deprived have a higher prevalence of mental and behavioural disorders, including substance abuse disorders. This higher prevalence may be explained by both higher causation of disorders among the poor and by the drift of the mentally ill into poverty.91

Mari (1987) reported the prevalence of minor psychiatric morbidity was 56% in Brasilandia, a poor slum area with a high proportion of migrants in Sao Paulo, Brazil, versus 50% in Funda (a civil servant community) and 47% in Barra (a more stable slum area). Women and those on low incomes were more vulnerable.

Iyun (1989 in UMP, 1992) reports on clinic-based data for 478 mental patients in Ibadan, Nigeria. The bulk of patients in mental ill-health were found to be 16-35 years (67%) with the age group 21-25 most affected (21% of cases). Males comprised 50.2% of cases, females 49.8%. Men suffer more from organic psychosis, alcoholism, drug abuse and neuroses. A

[89] World Report on Violence and Health, 2002
[90] ibid.
[91] World Health Report 2001 – Mental Health: New Understanding, New Hope, 2001.

higher proportion of females suffer from senile psychosis. Spatially, Iyun identified the low income, deteriorated housing areas as a source of cases. The high income outer city area was another dominant source of cases. Mental stress in high income areas is associated with socioeconomic frustration.

Poverty, crowding, low status of women, and sexual and reproductive health
Reproductive health risks

HIV/AIDS
High rates of HIV/AIDS are becoming are increasingly a distressing fact of urban life in developing countries. Studies of pregnant urban women in sub-Saharan African capitals have shown particularly high HIV/AIDS rates: nearly 12% in Rwanda, 18% in Malawi, 22% in Zambia, and 24% in South Africa, nearly 33% in Botswana, and 39% in Swaziland (Sclar et al 2005)

Sexually transmitted diseases
Sabin et al (2003) reported that 13% of the slum population was harboring a sexually or perinatally-transmissible infection, mainly syphilis and hepatitis B. The current syphilis infection rate of 6% was much higher than earlier rural population-based studies of 0-1 %. [However, it was reported that urban/peri-urban biased samples found prevalence ranging from 1–84 %.] The gonorrhea infection rate of 1.7% was double that of the earlier rural population-based studies. Researchers did not report any HIV cases in the sample, but they reported that behaviors that put persons at risk were evident.

Caldwell (1999) stated that Dhaka had all the characteristics for explosive HIV transmission except sufficient prevalence to begin the epidemic.

Noncommunicable diseases
Six of the ten leading causes of death worldwide are non-communicable diseases whose risk factors can be modified. It is no longer the case that cardiovascular disease, cancer and diabetes are problems of developed countries alone.

Slums and communicable diseases
Tuberculosis
Bianco (1983, in UMP, 1992) reports that mortality due to TB was three times higher in aperipheral areas than in the city.

Leprosy
Ganapati (1983) reported leprosy in squatter settlements in Bombay, India was 22/1000 compared to 6.9/1000 for the city as a whole.

Vector-borne diseases
Filariasis, yellow fever, lyme disease, schistosomiasis, leishmaniasis, malaria, dengue are all reported to be increasing in urban areas and find fertile breeding grounds in slums.

APPENDIX IV: KEY PROCESSES

Process	**Aims**
Helsinki Process on Globalization and Democracy - Finland and Tanzania	The agenda of the Helsinki Conference, to be held in September 2005, is to discuss what is needed to design global health actions that build on linkages and promote health as a pivotal issue for multisectoral development policies. New forms of governance and financing of access to water and sanitation will be key items of debate.
Parliamentarians for Global Action	Addressing global problems that cannot be solved by any one government or parliament. Works on an expanded list of global issues including international law and human rights, population and sustainable development. Takes action in advancing national agendas: legal review, reform and the enactment of progressive laws and policies.
International Chamber of Commerce	Voice of world business championing the global economy as a force for economic growth, job creation and prosperity. Health gains can be shown to improve productivity and facilitate economic growth.
International Confederation of Free Trade Unions	Areas of work include child labour, equality in gender relations, maintenance of public services, creating awareness of HIV/AIDS and its impact on labor, globalization and corporate social responsibility.
World Social Forum	Provides an open meeting place where social movements, networks, NGOs and other civil society organizations opposed to neoliberalism and a world dominated by capital or by any form of imperialism come together.
World Economic Forum	Independent, non-profit international organization committed to improving the state of the world by engaging leaders in partnerships to shape global, regional and industry agendas. The Global Health Initiative's mission is to increase the quantity and quality of business programmes fighting HIV/AIDS, tuberculosis (TB) and malaria.
Third World Network	Independent, non-profit international network of organizations and individuals involved in issues relating to development, the developing world and North-South issues. Conducts research on economic, social and environmental issues; publishes books and magazines; organizes and participates in seminars, and provides a platform representing broad South interests and perspectives.

APPENDIX V: AN EXAMPLE OF A PUBLIC PRIVATE PARTNERSHIP

Box 1: Extended child care in the Philippines as a mechanism for integrating health, welfare and education services

In the Asia-Pacific setting, hospitals have been traditionally seen as the cornerstone of the system that provides health care services to the community. In practice, however, hospital services are often heavily focused on providing technical solutions to the problems of ill health. Less effort and time is spent on preventive interventions, health promotion and health protection. An area that receives little, if any, emphasis is the non-clinical, health related needs of the patients and their extended families (which are, in practice, seen as a natural support system in Asian and Pacific cultures). This is particularly problematic in situations where recovering or terminally ill patients require extended care. Among the most adversely affected are children experiencing long-term illness or whose parents are ill.

At San Lazaro Hospital, Manila, Philippines, an extended childcare centre [which began operations in 2002] is part of an innovative program approach that recognizes the need of children to receive on-going stimulation, nurture, education and protection while they are in the hospital environment. It enables the child and parent to remain together during times of crisis and illness. The Centre also serves as the catalytic mechanism for extended interaction among programs in the hospital (e.g., mental health, maternal and child health, communicable diseases and health promotion) and between the hospital and the community in relation to a broad range of public health and social concerns.

In the Philippines, the San Lazaro Hospital, because of its patient clientele, its unique relationship with the Philippine Department of Health (DOH) and its proximity to the WHO Western Pacific Office, offers an excellent setting for piloting such an approach. The non-government, faith-based organization Precious Jewels Ministry, Inc. (PJM) has extensive and unique experience in the Philippines in providing care and support for HIV infected children and their families, in cooperation with the DOH, the Department of Social Welfare and Development, and others. This project builds on the DOH's emerging effort to have the hospital seen as a centre of wellness with extended outreach to and involvement with the community. The San Lazaro Hospital Extended Childcare Centre reflects a public-private partnership approach to "extended childcare" involving the Philippine DOH, WHO, PJM and San Lazaro Hospital.

In addition to the direct impact on the children and families served by the Centre, included among the outcomes of the first three years of operation of the Extended Childcare Centre and the associated programmes are the following:

- The laying of a foundation for the development of a national policy on extended childcare;
- The first phase of expansion of the programme approach to three additional hospitals;
- The development and publication, in collaboration with UNICEF, of *Ang Tulay* ["The Bridge"] – *A Training Guide and Workbook for Children in Grief;* and, as a related spin-off,
- The development of a 5-year Memorandum of Agreement called "Crossing Borders – Towards Integrated Care of HIV/AIDS Affected Children" among PJM, San Lazaro Hospital, Philippine General Hospital, the Philippine Research Institute for Tropical Medicine, the Philippine Department of Health and UNAIDS.

APPENDIX VI: INVENTORY OF COUNTRY LEVEL INITIATIVES

BANGLADESH

- The Green Umbrella – Quality improvement programmes for reproductive health and family planning that have extended into slum areas (developed with Johns Hopkins University Center for Communication Programs)
- Experimentation, learning-by-doing and new policies on services, partnership and participation supported by the Asian Development Bank: Pro-poor Service Delivery Initiatives by the Bangalore Mahanagara Palike

BRAZIL

- Rio de Janairo and Sao Paulo –case studies carried out by Habitat, 2003/are partner cities of the WHO Kobe Centre
- Porto Alegre, Brazil – developed a model for participatory budgeting at the municipal level. Has a municipal budget forum where the council of representatives set the agenda for municipal spending based on district priorities. Final decisions are made in three-way meetings at city hall. Has a case study on urban governance and poverty with the International Development Department of the University of Birmingham: "Giving Voice to the Grassroots Movements and Infrastructure for the Poor: the Experience of Porto Alegre's Participatory Budgeting".
- Sao Paulo, Brazil – upgrading, legalizing land tenure, and inner city redevelopment that reached 250 000 low income households from 2000-2004 with new legislation, more effective coordination between different government agencies, new financial instruments, a modernized administrative system, partnerships with the private sector, and more scope for citizen participation in decision-making and implementation processes.[92]
- Fortaliza – has a slum upgrading project
- Curitiba – has developed a model public transportation and road system that has reduced air pollution and encouraged walking.
- In 1988, the new Brazilian constitution introduced a chapter entitled "On Urban Policy" with specific provisions that enable urban policy councils to take action through various interventions including participative budget management.

EGYPT

- Cairo – has a case study by Habitat, 2003
- The Gold Star – quality improvement programmes for reproductive health and family planning that have extended into slum areas (developed with Johns Hopkins University Center for Communication Programs)

ECUADOR

- Quito – hosted a case study by Habitat, 2003

[92] (Budds and Teixiera)

- Has been engaged in local governance improvement with the Association of Dutch Municipalities.

INDIA
- Ahmedabad and Kolkata - hosted a case study by Habitat, 2003
- India Family Welfare Urban Slums Project (Andhra, Pradesh, Karnataka and West Bengal) – community outreach as well as facility-based reproductive health services. Trained over 17 000 neighborhood health workers for immunization, family planning and other basic services. Included women's empowerment initiatives, vocational skills training and other urban slum improvement programmes. Focal persons are Elizabeth Lule and G.N.V. Ramana Sr.
- Slum Networking Project (Parivartan), Gujarat - linked with an NGO of women (Self-employed Women's Association, SEWA) that extends microfinancing for housing and economic activities.

INDONESIA
- Jakarta - hosted a case study by Habitat, 2003
- The Blue Circle – quality improvement programmes for reproductive health and family planning that have extended into slum areas (developed with Johns Hopkins University Center for Communication Programs)
- Kampung Improvement Programs (KIPs), Indonesia –implementation of slum upgrading and housing in more than 500 urban areas since 1968, benefitting almost 15 million people by providing sanitation, potable water and garbage removal. Based on a strong partnership between urban communities and local governments.
- Decentralization of health services is high on the health policy reform agenda
- Aguablanca district of Cali and El Mezquital settlement in Guatemala City

JORDAN
- Amman and Aqaba – have slum upgrading programmes.

KENYA
- Nairobi - case study by Habitat, 2003
- Has a case study on the Muungano wa Wanavijiji on a federation of slum and informal open-air markets in Kenya to assist slum-dwellers access permanent, decent and affordable shelter.

LEBANON
- Beirut - case study by Habitat, 2003/is a partner city of WHO Kobe Centre

MEXICO
- Mexico City - case study by Habitat, 2003
- Decentralization of health services and social health insurance are high on the policy agenda

PAKISTAN
- Karachi - has a case study by Habitat, 2003
- The Oranji Pilot Project-Research Training Institute (Karachi, Pakistan) – low-cost sanitation programme linked to self-financed, self-managed neighborhood sanitation programmes. Has been replicated through training NGOs and/or community activities.

Identified four barriers to overcome: psychological barriers, economic barriers, technical barriers and sociological barriers. Focal person is Arif Hasan.
- Islamabad and _____are partner cities of the WHO Kobe Centre.
- The Sidh Katchi Abadis Authority a semi-autonomous body under the Department of Local Government and the Hyberabad Development Authority have examples of programmes for slum upgrading without donor assistance.

PEOPLE'S REPUBLIC OF CHINA
- Chengdu - case study by Habitat, 2003
- Chengdu is the site of the Comprehensive Revitalization of Urban Settlements project where participation and partnership was improved for the re-housing of 30,000 households. Scale–out to surrounding towns and districts is currently being done.
- Shenyang, People's Republic of China – transfer of social welfare administration to the municipal level, joint financing and pooling of social insurance by employees, employers and municipal government, transfer of schools and utilities to municipal government, privatization of the housing market.
- Decentralization of health services is high on the health policy reform agenda.
- Shanghai City is a partner city of the WHO Kobe Centre.

PHILIPPINES
- Manila - case study by Habitat, 2003
- Marikina – is a model for Healthy Cities for the Western Pacific Region on emergency preparedness and safe environments for children. Has upgraded slums and redeveloped drainage systems that were once the cause of constant flooding. Has also developed innovative training and temporary employment for the urban poor to open up options for gainful employment and prevent petty crime. Bicycle and walking lanes have been introduced. Food safety measures have been developed within the framework of Healthy Marketplaces. Marikina is also the head of the national chapter of the Alliance for Healthy Cities and a partner city of WHO Kobe Centre.
- Sentrong Sigla – quality improvement programmes for reproductive health and family planning that have extended into slum areas through local health centres and have certified over 500 public health facilities in Mindanao to meet basic quality standards. (Developed with Johns Hopkins University Center for Communication Programs)
- National policy and programme initiative to improve human settlements through the Community Mortgage Programme
- Naga City – has done work on improving services delivery, partnerships, and participation supported by the Asian Development Bank: a) Empowering the poor: key to effective pro-poor services, and b) The Politics of Service Delivery Improvement.
- Makati City – Healthy Cities project site and has been involved in a Asian Development Bank project, "Management Innovations in the City of Makati".
- Well Midwife Clinics is a model for social enterprise, allowing midwives to own and manage outpatient clinics for family planning and maternal and child health services(USAID)
- San Lazaro Extended Child Care Centre

RUSSIAN FEDERATION
- Moscow - case study by Habitat, 2003

THAILAND

- Bangkok - case study by Habitat, 2003/is a partner city of WHO Kobe Centre
- Baan Mankong Programme (secure housing)
- Wat Chonglom project – demonstrates private sector, community-based organizations, NGOs and government agencies working together on slum upgrading.
- The Community Organizations Development Institute headed by Somsook Boonyabancha supports networks of community organizations tha work with local governments in implementing a national programme for slum-upgrading and secure tenure.

SOUTH AFRICA

- Durban - case study by Habitat, 2003
- Johannesburg, South Africa – healthy home projects carried out in the inner city where overcrowding was a major concern; case study on urban governance and poverty completed in collaboration with the International Development Department of the University of Birmingham: "Embedding poverty reduction into local government transformation: the case of Johannesburg, South Africa"
- Mafikeng Development Programme focuses on training and building local capacity for integrated programmes that address city and river clean-up, safe water, improvement in traffic, enterprise and tourism development.
- Has demonstrated consultative processes to address issues in relation to the informal economy and entrepreneurial development in slums.
- South African Homeless People's Federation lobbied for direct subsidies for low-income households resulting in the People's Housing Programme, a self-help development programme.

SRI LANKA

- Colombo - case study by Habitat, 2003/is a partner city of WHO Kobe Centre
- The nationwide Million Houses Program
- Urban health policy development programme supported by the Asian Development Bank: Promoting Service Delivery by the Colombo Municipal Council through Effective Partnerships

TANZANIA

- Dar Es Salam, Tanzania –Healthy Cities project that uses geographical targeting for healthy settings for urban poor communities and underserved groups. Is a partner city of the WHO Kobe Centre.
- Has been working on local governance with the Association of Dutch Municipalities
- Is a partner city of the WHO Kobe Centre