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Healthy Urbanization Learning Circles (HULC)

Healthy Urbanization Learning Circles are networks of multisectoral and interdisc that will undertake action research projects at the city level through a guided process introduce public health methodologies for action to improve governance, optimize the social determinants and promote health equity in the urban settings.

Healthy Urbanization Learning Circles will undertake capacity-building activities c 9-12 month period that is organized around four modules:

- Module 1: Overview of Healthy Urbanization: Situation analysis
- Module 2: Healthy Urbanization Challenges: Strategy development and project writing
- Module 3: Healthy Urbanization Opportunities: Social mobilization for intersect
- Module 4: Mainstreaming Healthy Urbanization: Sustaining action through adv

Healthy Urbanization Learning Circles will be guided by the following principles:

- Emphasizing applied skills, not just theoretical knowledge;
- Training in a highly interactive manner, drawing on personal experience to reinforc learning;
- Encouraging strategic thinking on the promotion of healthy urbanization;
- Emphasizing the use of good governance principles in decision-making;
- Using action research projects to reinforce classroom learning, multiply training be generate results;
- Providing opportunities for mentoring and technical support through national and i networking; and
- Soliciting feedback as a means of improving the learning process.

General criteria for participants in the ***Healthy Urbanization Learning Circles*** are preliminary guidance, but local groups are strongly encouraged to develop appropriat meet the needs of their own site. It is proposed that participants are:

- Recognized as being committed to the improvement of health in the city;
- Known to value social justice and equity;
- Respected as influential members of the community;
- Engaged in work that promotes positive social values;
- Highly motivated and will exercise leadership in their sphere of influence;
- Representatives of different gender and sectors who are stakeholders in social health.

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Developing strategies (Project Objective 1)

Two frameworks for assessing Healthy Urbanization are presented here.

A Framework for Assessing Healthy Urbanization - The WHO Regional Office for has developed an ***urban health assessment framework*** to function as a practical-t to provide reliable and comprehensive information for decision-makers, local governn researchers, local communities, and public and private sectors to effectively and appr address the challenges and opportunities to improve the health conditions in cities.

As urban health is a relatively new concept, there is little consensus on definitions an Yet there is a common understanding that health and quality of life are influenced by conditions as well as lifestyles. Cities are facing great challenges in dealing with the u its consequences, such as increasing health inequities and the emergence and deteric and informal settlements; health inequities are observed within the city, from block t household to household. It is argued that the inequalities among individuals and citie of local dynamics relating to economic, political, social and health conditions. The mu act on these matters but effective intersectoral collaboration is needed.

The Healthy Urbanization Spidergram - This simple, powerful tool has been devel WKC experience as a mean to measure social perceptions about the **eight elements urbanization**. It can be appropriate for use at the municipal level to:

- understand "felt needs" of a group in relation to urbanization as a social deterr
- define a baseline on social perception within groups from the same setting and one group feels about urbanization as a social determinant in relation to anot.
- identify key areas for intervention based on subjective perceptions of lopsided within an urban setting;
- provide a basis for analyzing a social gradient in perceptions about the urbaniz
- measure how group perceptions can be used as a variable that can be linked t outcomes;
- Serve as a starting point for complementary quantitative measurement.

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Capacity building (Project Objective 3)

The capacity-building component, called the "**Healthy Urbanization Learning Circl** provides a structure for implementation of activities at the Healthy Urbanization Field

Participants are expected to carry out projects that will address social determinants o health promotion approaches* and tools introduced during the didactic portion of the programme is flexible, dynamic and can be adapted to local contexts by including ap training and capacity-building materials, methods and approaches that are most suite needs. It aims to enhance practical skills among teams across five categories (intra-p qualities, interpersonal qualities, cognitive skills, communication skills and task-speci Opportunities for cross-regional sharing and learning are also provided.

In addition to training, activities may include action research projects, technical assis monitoring group learning, technology transfer, field visits and international exchang

*The curriculum and training materials of the Healthy Urbanization Learning Circles w materials that have been developed and tested through "Prolead", a health promotior training template that was initiated at the WHO Western Pacific Regional Office in 20(further expanded by the WHO Centre for Health Development in collaboration with th offices of the Eastern Mediterranean Region and the Southeast Asian Region.

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Policy advocacy (Project Objective 4)

Activities will be undertaken to ensure that new knowledge and good practices are lin integrated with national health systems development and wider social and political pr project will create opportunities to advocate for healthy public policy and more respoi systems, particularly in relation to:

- Effective management of intersectoral collaboration to ensure maximum impact an judicious use of limited resources for health;
- Decision-making that harmonizes competing interests to achieve the higher goal of equity as a social good;
- Empowerment of communities to ensure:
  - Identification of real problems and needs;
  - Judicious use of available resources;
  - Ownership and sustainability;
  - Timely action for improvement; and
  - Community-based management.

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World Health Organization Centre for Health Development

PRESS RELEASE
Tel: 078 230 3130/3128,
URL: **http://who.or.jp/**
29 October 2006

Mayors pledge action on social determinants of healt

Suzhou -- Mayors from six cities around the world are gathered in Suzhou to pledge the emerging theme of "healthy urbanization". The leaders will speak at the Symposi Urbanization held by the WHO Centre for Health Development today under the subhe "Optimizing the impact of social determinants of health on exposed populations in urt

In recent decades, economic globalization has pushed rapid and often unplanned u·5ı serious consequences. The mayors of Kobe, Japan, Suzhou, China, Bangalore, India, Chile, Ariana, Tunisia and Nakuru, Kenya will address key issues that have emerged f research and scoping papers under the Healthy Urbanization Project. Findings include

- In Bangalore, around 25% of the population lives in slums, while some 40% of greater Bangalore are part of info rmal settlements. One-fifth of slum dwellers noncommunicable diseases, with 15-20% dying from injury – suicide, road ac violence. .
- In San Joaquin, Santiago, Chile, a strong correlation between income and mort observed, with men in San Joaquin losing 123.4 years of life between 1999 an compared to 45.7 years in the wealthy nearby borough of Lo Barneachea.
- In Japan, home to the WHO Centre for Health Development, despite economic working hours are up and wages are down. Of workers visiting health centres i had hypertension, 67% had high cholesterol and 53% had diabetes.

Dr Soichiro Iwao, Director of the Centre, will speak on the theme, "From Healthy Citi Urbanization in the 21 st Century" on Saturday, 28 October, at 2.00 pm on the emer required for healthy urbanization in a city.

During this event, the mayors will sign a statement to pledge their commitment to su Healthy Urbanization Project.

More on the Healthy Urbanization Project can be found at **http://www.who.or.jp**

For further info rmation, journalists can contact: Ms Susan Loo, Policy Advocacy, WH Health Development Telephone: +81-078-230-3131 (direct) E-mail: **chungs@wkc.v**

Mr Richard Bradford, Public Information, Telephone: +81-078- 230-3136 (direct) E-m **bradfordr@wkc.who.int**.

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Priority Project B: The effect of urbanization on risk factors for noncommur diseases

Swelling cities

Urbanization is now a truly global phenomenon, with a stream of rural-urban migrat in the developing world. The percentage of the world's population residing in urban from 38% in 1975 to 47% by 2002. Over three billion people now live in towns and notion that better opportunities for health and other lifestyle improvements can alw in an urban setting is under challenge.

Driven by globalization, many cities are today characterized by rapid urbanization, r expansion, increased environmental impact and deeper inequity. Cities and municip not equipped to cope with the rate of change and its social, political and environme ramifications.

The role of inequitable and unsustainable urban settings in promoting stress and otl and environmental risks for disease is not well understood. Hence, urbanization anc human health in relation to chronic noncommunicable diseases (NCDs) needs to b examined.

Chronic NCDs – global burden rising

The rising global burden of disease is mainly due to noncommunicable diseases (NC **cardiovascular diseases**, **cancer**, **chronic respiratory disease**, **diabetes** and **h** They are now responsible for 60% of deaths worldwide and 48% of the burden of d are related to lifestyle as well as to the physical and social environment – all of whi rapidly, especially in fast-urbanizing developing countries. In fact, the change to hig

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Research Programme 2006-2007

Priority Project A: Preparing Health Facilities for Disaster ir

Health facilities in urban areas with high population densities play a special role in r containing emergencies and responding to disasters. On the other hand, health faci affected or exposed to risks, emergencies and disasters and are unprepared may pc and more serious risks to the communities they serve. The project contributes to th and dissemination of scientific knowledge on how health facilities in cities can best b into emergency preparedness policies and the programmes of selected health facilit eventually throughout health systems.

Objective 1 - Conduct a situational analysis on the preparedness of selecte facilities to withstand and respond to disasters

Approach 1.1. Build an information base of health facilities that are structu programmatically prepared for withstanding and responding to disasters

Product 1.1.1. Report findings of an analytical literature review on the pre health facilities to withstand and respond to disasters in selected settings

Objective 2 - Characterize the features and attributes of effective health fa preparedness policies and programmes

Approach 2.1. Develop, field-test and validate one or more methodologies t the preparedness of health facilities to withstand and respond to disasters

Product 2.1.1. A methodology for assessing health facility preparedness to respond to disasters

Approach 2.2. Assess selected disaster preparedness policies and programi characterize their features and attributes

Product 2.2.1. Report on assessment of selected disaster preparedness pol programmes, and associated good practice guidelines

Product 2.2.2. An inventory of health facilities that are structurally and pro prepared to withstand and respond to disasters

Objective 3 - Advocate effective health facility disaster preparedness polici programmes within the context of health systems development using the d reduction framework

Approach 3.1. Develop a database of experts and resource centres for heal disaster preparedness and response

Product 3.1.1. A database of experts and resource centres for health faciliti preparing for and responding to disasters

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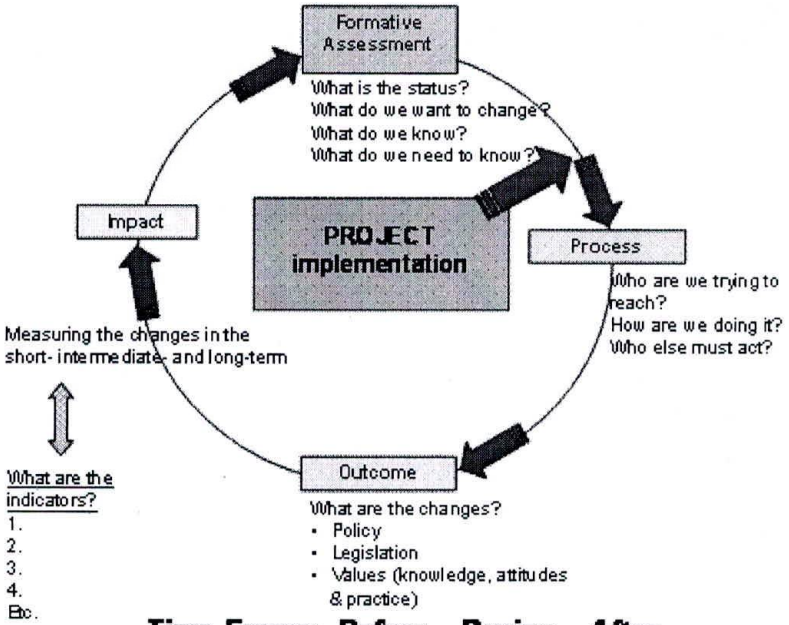
Monitoring and evaluation

Monitoring, assessment and evaluation in relation to the Healthy Urbanization Field R will be approached from a co-learning perspective, mindful of the "learning-by-doing' underpins project implementation. From this perspective, judgment is suspended as v with our partners, how to improve health and reduce health inequity, particularly amo populations. In this process, the timely gathering, documentation and dissemination o critical — before, during and after the project.

Evidence Gathering, Documentation and Dissemination Cycle



Time Frame: Before – During – After

This framework is a work in progress developed in collaboration with the W *Office for South-East Asia.*

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Demonstrating the applicability of strategies (Project Object

Strategies that are developed through the project will be applied in Healthy Urbanizat Research Sites through several methods, all with an emphasis on action research to c needs. Monitoring and evaluation of the strategies and methodologies will also take p

Action research - Action research consists of research methodologies which pursue research outcomes simultaneously. Action research tends to be:

- cyclic -- similar steps tend to recur, in a similar sequence;
- participative -- the clients and informants are involved as partners, or at least acti participants, in the research process;
- qualitative -- it deals more often with language than with numbers; and
- reflective -- critical reflection upon the process and outcomes are important compo cycle.

Monitoring and evaluation - Participatory methods will be emphasized in assessing and evaluating the effectiveness of strategies in Healthy Urbanization Field Research

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Research Framework

In 2004-2005, the WHO Centre for Health Development undertook a process of con partners and the scientific community to gain perspective on its future work for the 2015. A Research Advisory Group and associated Sub-Groups were convened to del important research questions related to Ageing and Health; Urbanization and Healtl Technological Innovation and Environmental Change and Health. The product of th.s Proposed Research Framework for the WHO Centre for Health Development." This F served as an important scientific reference in the development, by WHO and the Ko ten-year (2006-2015) extension of the Memorandum of Understanding and the Cen plans for the future.

A fundamental idea embodied in the Framework is that health is essential to develo forces such as ageing and demographic change, urbanization, environmental char.g technological innovation create conditions for both health improvement and impairn development goals, health and welfare systems must respond in timely and creativ concept of "health in development" captures the notion that health is central to soci development and vice-versa. The inter-relatedness of health and the development p throughout the span of development; hence, "health in development" applies to bot and developed countries.

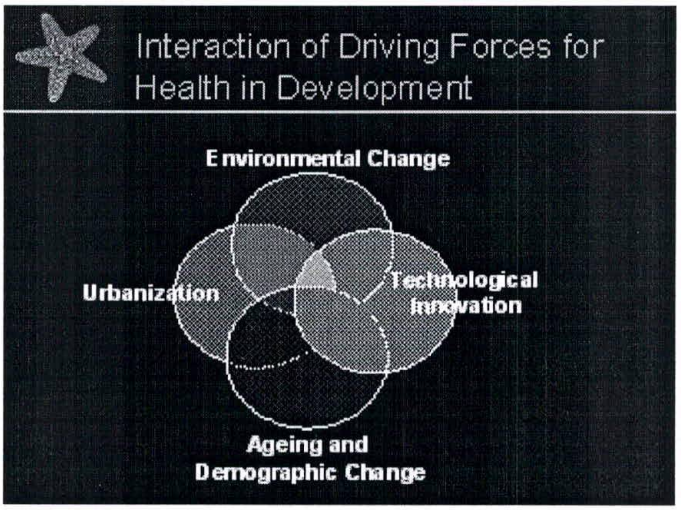
From this perspective, the complex interdependency of increasing pressures on hea systems and the effects of specific driving forces shape the research framework of t Centre. The search for appropriate and practicable solutions to related priority publi problems provides the focus for the Centre's work. With this in mind, the Research proposed the following vision statement for the Centre:

"Healthier People in Healthier Environments"

The Centre adopted this vision statement with a view of health as a resource for livi context of sustainable development. The Centre is positioned to undertake multidisc research to optimize the determinants of health by generating, analyzing and comm evidence base that drives health-related policy and programme development and in

From this perspective, the complex interdependency of increasing pressures on hea systems and the effects of specific driving forces shape the research framework of t Centre.

Figure 1: The intersection of driving forces for health in development

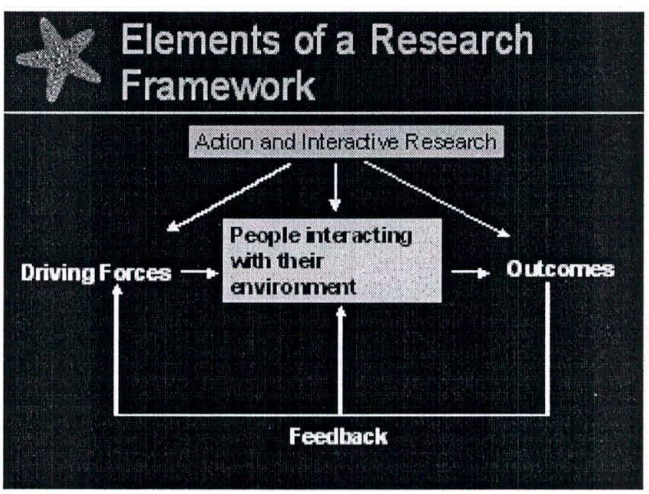


The priority areas of research identified by the Research Advisory Group and the as Groups cluster in five critical research arenas:

- Characterizing the determinants of health and health infrastructure;
- Assessing the existing situation;
- Projecting into the future;
- Providing solutions; and,
- Evaluating outcomes, programmes, models, needs and capacities, and measurinç

These five critical research arenas comprise the sequential steps of an integrated, it that is necessary to generate the evidence base for driving health-related policy an development and implementation in relation to the challenges associated with the d While this dynamic process can be entered at any of the steps, successfully meetinç posed by a particular driving force requires strategic cycling through the complete p ensure that the outcomes of research initiatives lead to viable and sustainable solut problems.

Figure 2: Elements of a research framework



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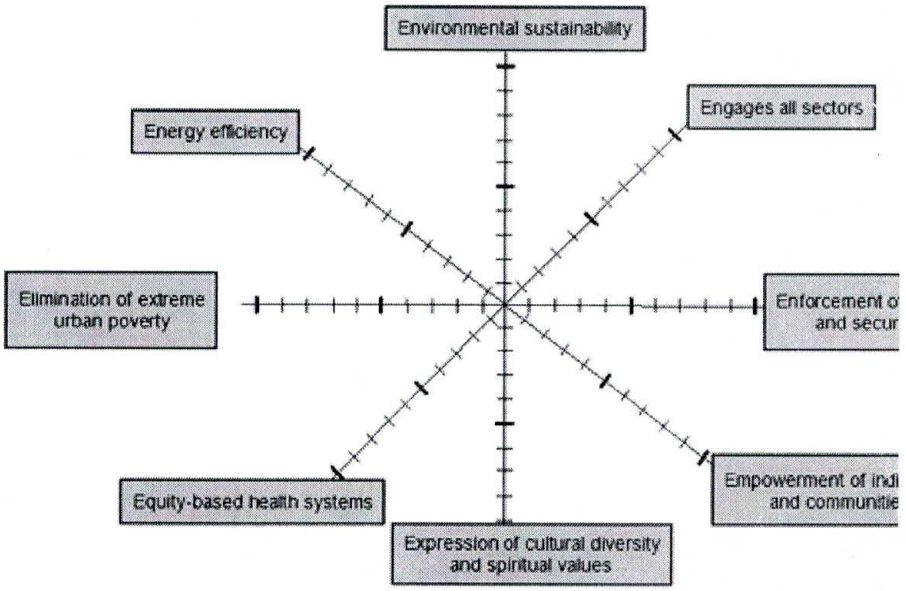
The Healthy Urbanization Project proposes eight elements of healthy urbaniza guide local, municipal and global action on social determinants of health in th setting.

The eight elements represent key action areas for multisectoral stakeholders.

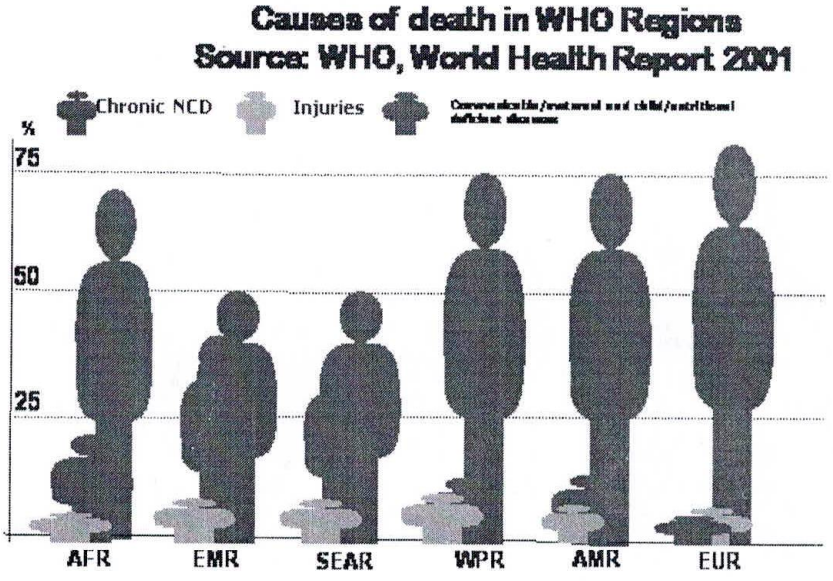


The Healthy Urbanization Spidergram is being field-tested as a tool for assessing social pe urbanization and health in the Healthy Urbanization Field Research Sites.

Healthier People in Healthier Environments

nutrient fast food diets and sedentary lifestyles is happening much more quickly in t
than was the case in the developed countries, bringing a double burden of commun
and NCDs.

The extent to which these risk factors are linked to urban living and the urban envir
to be better understood.



Background in Depth

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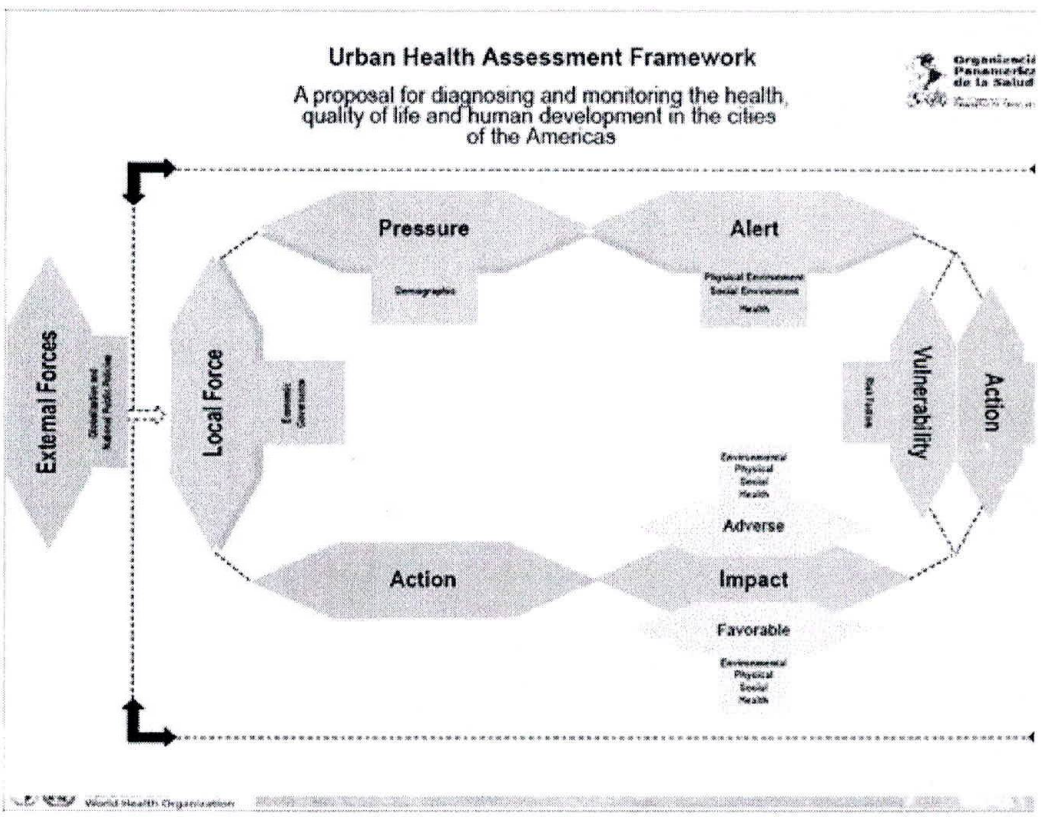
The Urban Health Assessment Framework

The ultimate purpose of the Urban Health Assessment Framework (UHF) is to provide comprehensive information for decision and policy-makers, local governments and au researchers, local communities, and public and private sectors. Functioning as a strat the UHF aims to effectively and appropriately identify and address strength, weaknes and opportunities to improve urban health conditions.

The UHF is considered a work in progress. It consists of conditioning phases such as **external forces, local forces, pressure, alert, action/vulnerability, impact and** conditioning phase is represented by macro determinants of urban health such as der economic, governance, social and physical environments as well as health. Each dete denoted by major factors according to its respective conditioning phase.

The framework starts with *external forces* represented by the effects of globalization policies that affect local decision-making and ultimately the health of people in the cit external forces impact on *local forces*, represented by the economic and governance turn exert *pressure* on the demographic pattern in the city, provoking an *alert* situati the various macro determinants. The outcomes of urbanization depend on the level o the actions taken. Yet if these *actions* are deficient or absent, the city might face *vulr* represented by the risk factors. This will eventually *impact* on the physical, social anc environments of the city and its population.



PAHO/WHO Urban Health Assessment Framework

THE CORE PROJECT
PLAN OF WORK

WHO Centre for Health Development
Kobe, Japan

1.0 Introduction

1.1 Background

In 2004–2005, the Centre undertook a process of consultation with its partners and the scientific community to gain perspective on its future work for the period 2006–2015. An Ad hoc Research Advisory Group (RAG) and associated Sub-groups were convened to delineate the most important research questions related to Ageing and Health, Urbanization and Health, and Technological Innovation and Environmental Change and Health. The product of this process was "A Proposed Research Framework for the WHO Centre for Health Development."[1] This Framework served as an important scientific reference in the development, by WHO and the Kobe Group, of the ten-year extension of the Memorandum of Understanding to 2015 and the Centre's research plans for the future that are reflected in the Plan of Work for 2006–2007.

The Ad hoc Research Advisory Group process highlighted the growing importance of urbanization as a cross-cutting driving force and the central role that **cities and urban municipalities** are beginning to play as key drivers of modernization and social change. There was consensus on the need for inter-disciplinary, applied research into priority public health issues affecting urban settings, particularly in relation to exposed populations. It was recognized that the character of these settings in the 21st century is changing rapidly, and that the increasing complexity of the factors affecting change and their impact on health and well-being is not well understood.

Emphasis was also placed on the need to focus on the health and well-being of **exposed populations** including the poor, the elderly, women and children. In the context of urbanization and globalization, the problem of **health inequity**, particularly in relation to exposed populations, was noted in all of the discussions. For example, of the three billion people who live in urban areas today, one billion live in slums. As the number of people born in cities increases and as people continue to be displaced from rural areas, the urban slum population is expected to grow to approximately two billion by 2030, resulting in a continuing and rapid urbanization of poverty and ill health whose greatest impact will be felt in the developing world.

A significant amount of discussion in the Ad hoc Research Advisory Group process in general, and in the Urbanization and Health Sub-group in particular, revolved around the importance of **the social determinants of health** in relation to health inequity and the role of **health governance** as a critical pathway by which social conditions translate into health impacts.

Based on deliberations during the Ad hoc Research Advisory Group process, related discussions with members of the Kobe Group[2] and others, and the selection of the WHO Kobe Centre as the Hub for the Commission on Social Determinants of

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[1] The World Health Organization Centre for Health Development. *Health in Development – Healthier People in Healthier Environments. A Proposed Research Framework for the WHO Centre for Health Development.* Kobe, Japan, August 2004.

[2] Comprising: Hyogo Prefecture, Kobe City, Kobe Chamber of Commerce and Industry, and Kobe Steel, Ltd.

Health's Knowledge Network on Urban Settings, the future work of the Centre will have the following strategic foci:

- **Monitoring and responding to "felt needs"** – aiming to complement the findings of epidemiological and public health research with information about the needs felt by exposed populations.

- **Packaging knowledge from a health equity perspective to inform policy and practice** – Aiming to reduce health inequity by improving health governance.

- **Developing new knowledge to address existing and emerging areas of vulnerability** – Aiming to identify and advocate effective responses and interventions in relation to driving forces.

The work will be carried out with a major emphasis on **urban settings**, mindful of the "globalization-urbanization interface" that exists in these settings, with **the overall aim of reducing health inequity by optimizing the impact of social determinants of health on exposed populations.**

1.2 The presentation

The Core Project is organized around four areas of emphasis:

1. **Developing strategies:** Building an evidence base, generating policy ideas, evaluating current experiences and interventions, developing public health methodologies for health inequity assessment and evaluation and deriving new knowledge on social determinants and health inequity.

2. **Demonstrating the applicability of strategies:** Demonstrating how "generic" municipal strategies can be applied and combined with tactical and context-specific interventions to reduce health inequity.

3. **Capacity building:** Building capacity at the level of the individual, the organization and the system through leadership training and applied projects.

4. **Policy advocacy:** Developing and applying principles of strategic communication and advocacy to influence health governance at all levels and enhance understanding of how the impact of social determinants can be optimized to reduce health inequity.

Staff will work in and across these areas of emphasis in a multi-disciplinary fashion to develop specific products. In addition, to provide effective liaison with other WHO programmes and offices, as well as with other organizations, they will serve as designated Focal Points for the following Areas of Work:

- Surveillance, prevention and management of chronic, noncommunicable diseases
- Health promotion
- Tobacco

- Health and environment
- Gender, women and health
- Policy-making for health in development
- Health system policies and service delivery
- Human resources for health
- Health information, evidence and research policy
- Emergency preparedness and response
- Mental health and substance abuse
- Ageing and life course

2.0 Plan of Work Details

2.1 The Core Project - Optimizing the Impact of Social Determinants of Health on Exposed Populations in Urban Settings

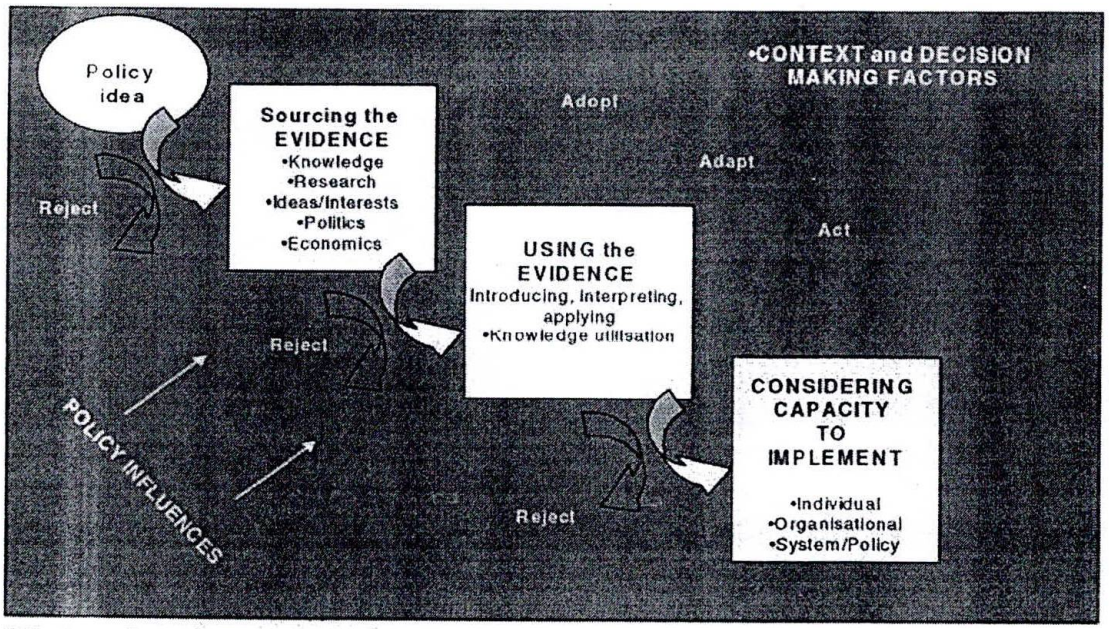
2.1.1 Objectives

Within the overall purpose of the project – to reduce health inequity in urban settings – the specific objectives for 2006–2007 are to:

1. Develop strategies to reduce health inequity in urban settings;
2. Demonstrate the applicability of strategies for reducing health inequity among exposed populations in urban settings;
3. Build capacity for reducing health inequity in urban settings;
4. Advocate the reduction of health inequity in urban settings.

The model of the "Evidence-Informed Policy and Practice Pathway"[3] (Brown and Zwi, 2005) provides the basis for the research design of the Core Project. According to this model, policy ideas, evidence, use of evidence and capacity to implement evidence-based policies are interlocked in a series of decision-making steps that are characteristic of how events unfold in practice. Policy ideas provide the starting point for the sourcing of evidence. Sources of evidence are multiple and varied. Using the evidence includes interpreting and applying knowledge in specific contexts. Capacity to implement is considered from the perspective of the individual, the organization and the system.

[3] From the PowerPoint presentation of the Knowledge Network on Measurements, given at the Meeting of the Knowledge Networks, 10-12 September 2005, Ahmedabad, India.



DOI: 10.1371/journal.pmed.0020166.g001

2.1.2 Present plans, 2006–2007

Objective 1 – Develop strategies to reduce health inequity in urban settings

Approaches and products

Building the evidence base

Closer examination of existing evidence will be a key component for developing strategies to reduce health inequity in urban settings. Knowledge will be collated, analyzed, synthesized and organized to enable researchers, implementers and decision-makers to gain easy access to information on the associations and pathways between social determinants and health inequity in urban settings. In particular, the evidence base will try to capture the policy ideas emanating from attempts to bridge equity gaps through municipal health governance. Materials to be included in the evidence-base will come from published and grey literature and from the worldwide experience of Healthy Cities, Local Agenda 21 cities, Sustainable Cities, Cities without Slums, the Urban Governance Initiative and other initiatives where the city/municipality is both the entry point and setting for achieving sustainable change and improvement in health.

From the evidence base, research teams will systematically review evidence and select good examples of strategies and interventions that are promising or proven to be effective in reducing health inequities in urban settings. A glossary of terms and concepts will be developed to promote wider discourse on the subject in the scientific community, as well as to supplement advocacy efforts in the political domain.

Ensuring local participation and ownership of research

Research activities will emphasize principles of community and stakeholder participation and ownership. People's participation in planning, implementation and evaluation of research activities will be ensured. Thus, at the early stages of the project, participatory and consultative processes will guide the identification of exposed populations, prioritization of issues and concerns and the pursuit of opportunities and imperatives for influencing health governance at the local level. Multiple pathways of causality and associations may necessitate a wide range of interventions for enhancing health governance. The emphasis in Objective 1 however, will be on creating enabling environments for municipal-level action.

The project will develop generic municipal-level strategies for reducing health inequity but will also construct a framework for tactical actions that facilitate achieving rapid results in relation to the specific and unique contexts of urban settings through collaborative research and other means. For this reason, selected urban areas are initially proposed as field research sites for 2006-2007, where these will be applied in: China, Chile, Japan and India. Sites in African and the Eastern Mediterranean regions will follow. Project steering committees will be organized for each urban health field research site and will include representatives from regional and country offices of WHO, national and local representatives and stakeholders as well as key partner research institutions from the local community. Other sites will be involved in subsequent biennia.

Strengthening public health at the local level

The role of the public health sector at the city and municipal level in enhancing health governance will be highlighted in the project. As both social and environmental determinants of health necessitate action and responsibility from many actors (e.g. transportation, housing, education, welfare, finance, police and law enforcement), public health officers may need to play a more important role as **catalysts** for change than as implementors in the locality and will need to steer highly complex political processes toward healthy public policy. While the research objective is focused on reduction of health inequity, the key products of the project will be public health methodologies that enhance the performance of local health officials in the new role they must play in the face of rapid urbanization.

In particular, tools will be developed to **derive the "felt needs"** of exposed populations who may otherwise be excluded from regular census activities or routine public health reporting systems. Felt needs can then be used as a reference point for assessing the responsiveness of public health policies, programmes and practices in contexts where health inequity is manifest.

In conjunction with public health methodologies for deriving felt needs, checklists to ensure that health equity principles are embedded in public policies, programmes and practices will be developed, field-tested and pilot-tested in the field research sites. These checklists will demonstrate how municipal development decisions may affect human, social, economic and ecological capital (together

referred to as "community capital"[4]) and what possible impacts these would have on exposed populations such as disaster survivors, women and children exposed to abuse, violence and HIV-AIDS, workers suffering from depression or individuals predisposed to suicide.

Highlighting the interaction between local and national determinants

The project will also develop tools to assist municipal planners in assessing long-term development decisions. In particular, work will be initiated to develop models that render visible the impact of broad determinants on the health of exposed populations in future scenarios, using projections and trends of urbanization in the first instance, and demographic and environmental change as well. An example of this might be the effect of heat waves on exposed populations in urban settings.

Work will also be initiated for the development of a core set of indicators that countries, cities and municipalities can use to assess how socioeconomic factors and rapid urbanization are interacting to produce changes in health and quality of life in their cities through the development of a Poverty-Health-New Urban Settings Index.[5]

Contributing to global action on social determinants of health

As WHO Kobe Centre is the hub of the Knowledge Network on Urban Settings (KNUS) of the Commission on Social Determinants of Health, the Project and the KNUS will work in tandem to develop new knowledge on slum dwellers as a priority exposed urban population. The Project will collaborate with the KNUS to produce new knowledge on interventions to address the health conditions of people who live in slums and informal settlements. The KNUS will convene meetings to draw on the knowledge of international experts on this subject. Some of the activities of the network will include the writing of historical and analytic narratives on countries that have demonstrated success and the scaling up and documentation of interventions in one field project sites. The KNUS will also forward policy recommendations to the Commission.

Approach	Product
Build an evidence base of experiences and current interventions	An evidence base on how health inequity is reduced through municipal level interventions that address social determinants of health
Evaluate selected experiences and current interventions against existing theoretical frameworks and conceptual models that describe the relationship between social	A review of grey and published literature on promising and successful interventions
	A glossary of terms and key concepts

[4] Hancock T. People, partnerships and human progress: building community capital. *Health Promotion International,* September 2001, 16, 3.

[5] The notion of "New Urban Settings" (NUS) was introduced by the Sub-group on Urbanization of the Ad hoc Research Advisory Group. It refers to urban settings that are characterized by a radical process of change with positive and negative effects, increased inequities, greater environmental impacts, expanding metropolitan areas and fast-growing slums.

determinants of health and health inequity in urban settings	Strategies to enable municipal level action to reduce health inequity in urban settings
Develop methodologies to determine health needs of exposed populations in urban settings	Checklists for assessing and evaluating health equity in urban settings using "felt needs" of exposed populations as reference
Develop methodologies for projecting future scenarios in relation to determinants of health and their impact on exposed populations in urban settings	Models for forecasting and scenario building on the future of cities and municipalities based on demographic and environmental change, urbanization and health with reference to "felt needs"
Develop methodologies for evaluating health inequity at the city or municipal level	Core set of indicators to evaluate health inequity in cities and municipalities (Poverty-Health-New Urban Settings Index)
Develop new knowledge on reducing health inequity in urban settings	Syntheses of evidence on effective interventions for reducing health inequity in urban settings

Objective 2 – Demonstrate the applicability of strategies for reducing health inequity among exposed populations in urban settings

Approaches and products

Urban Health Field Research Sites will be established in selected urban settings[6] to create learning environments for local decision-makers to apply generic municipal- level strategies and further evolve localized and context-specific and tactical interventions to reduce health inequity. Local project steering committees will be organized and workshops will be conducted. Social, community and political mobilization will be done to ensure multi-sector stakeholder participation in the application of strategies.

Research units will be set up in offices of WHO Representatives with full-time staff under special services agreements. The research units will coordinate research activities but will also play a coordinating role in the implementation of local projects to reduce health inequity. Technical advice and support will be provided for local projects.

[6] China, Chile, Japan and India.

Approach	Product
Establish Urban Health Field Research Sites that will serve as learning environments for local decision-makers and communities for the application of strategies for reducing health inequity	Three Urban Health Field Research Sites where the strategies for reducing health inequity will be applied
	Three research units based in WR offices with capacity to coordinate stakeholder activities and oversee implementation of the strategies at the local level
Apply the strategies for reducing health inequity	Application of the strategies in three Urban Health Field Research Sites

Objective 3 – Build capacity for reducing health inequity in urban settings

Approaches and products

Capacity building,[7] or the "development of sustainable skills, organizational structures, resources and commitment to health improvement in health and other sectors, to prolong and multiply health gains many times over", will be a critical part of the project. Teams of leaders who are key players in health governance at the local level will be organized and engaged in a health promotion leadership training programme using the WHO ***Prolead*** model.[8] Each team will design and implement a specific project to optimize the impact of social determinants and reduce health inequity in urban settings. Projects will also emphasize strengthening infrastructure and financing for the promotion of health in the city/municipality in order to ensure the sustainability of interventions to reduce health inequity. The course is conducted over a nine-month period with 160 hours of group learning sessions. The learning sessions are organized into three modules featuring didactics, workshops and field visits. Topics covered by the training will include leadership principles, communication and social mobilization skills, health sector reform, total quality management, governance, social determinants and health inequity, management of change and organizational development, among others.

Prolead III aims to enhance the practical skills of teams across five categories that may be needed to improve governance for the promotion of health: intra-personal qualities; inter-personal qualities; cognitive skills; communication skills; and, task-specific skills.

[7] Hawe P, King L, Noort M, Jordens C & Lloyd B. *Indicators to help with capacity building in health promotion.* NSW Health: 1999

[8] *Prolead III: A Health Governance Initiative* builds on a leadership development model that started in 2003 in the WHO Western Pacific Region as a collaborative effort between the WHO Western Pacific Regional Office, the Southeast Asian Ministers of Education Organization Tropical Medicine Network (SEAMEO-TROPMED Network), the School of Public Health at La Trobe University (Australia), and the Field Epidemiology Training Program Alumni Foundation, Inc., with the support of the Japan Voluntary Fund.

Prolead III guiding principles include:

- Emphasizing applied skills, not just theoretical knowledge;
- Training in a highly interactive manner, drawing on personal experience to reinforce team learning;
- Encouraging strategic thinking in the promotion of health;
- Emphasizing the use of good governance principles in decision-making;
- Using applied field projects to reinforce classroom learning, multiply training benefits, and generate results;
- Providing opportunities for mentoring and technical support;
- Soliciting feedback as a means of improving the learning process.

Approach	Product
Conduct leadership development, mentoring and training on using the strategies to reduce health inequity in urban settings	Trained teams of leaders who are undertaking projects to reduce health inequity in the three urban health field research sites

Objective 4 – Advocate the reduction of health inequity in urban settings

Approaches and products

A strategic communication and advocacy plan will be developed to ensure that different audiences and stakeholders will have a clear understanding of the goals and objectives of the project. For the biennium, project advocacy materials will be developed in English, Spanish and Japanese.

In collaboration with the United Nations University (UNU), video documentation of strategies for reducing health inequity will be conducted at one project site. The video documentation will be converted into a case study using methods and techniques developed by UNU. The video will be made available to a wider audience through different distance education programmes at regional and country levels.

A range of advocacy activities will be implemented at global, regional, national and local levels. For example, advocacy campaigns by the Knowledge Network on Urban Settings may be directed at global, regional or national audiences. Regular town meetings and scientific seminars will be conducted in the local community.

Partnerships will be established, nurtured and sustained. A framework for developing and evaluating effective partnerships to reduce health inequity will be demonstrated through a historical and analytical narrative of the public-private partnership model for health of Hyogo–Kobe City, Japan.

Finally, educational materials, checklists and rapid assessment guidelines on emerging models and innovative strategies that seek to reduce health inequity will be developed. These materials will contribute to enabling municipal-level decision-makers in health and other sectors to generate innovative policy ideas and options for

reducing health inequity. Examples of these include: tobacco and alcohol tax measures for health promotion foundations; alliances between industries, the community and academia; community-based programmes for older persons and mental health promotion in the workplace.

Approach	Product
Develop and implement a communication and advocacy plan for the strategies.	Communication and advocacy plan for the strategies.
	Video documentation of projects of the Urban Health Field Research Sites.
	Profiles of promising approaches.
	Information exchange, networking, meetings and other advocacy activities.
Establish and sustain partnerships for reducing health inequity	A framework for developing effective partnerships to reduce health inequity
Develop education materials and rapid assessment guidelines on reducing health inequities	A set of educational materials, checklists and rapid assessment guidelines on how health inequity may be reduced

2.1.3 Future directions

It is anticipated that these Core Project objectives will serve to guide the work of the WHO Centre for Health Development over its next ten years of life. It is recognized that from biennium to biennium the approaches to achieving these objectives may vary somewhat and the products associated with them may vary significantly. For example, new methodologies and tools will be developed; tools will be added, adapted, or enhanced. Urban health field research sites may be expanded to cover adjacent urban areas or new countries. Other foundational mechanisms such as the ***Prolead*** initiative will continue to be an integral part of the project.

Healthy Urbanization Project of WKC center for Health and Development

Background

Following a decision by the Executive Board of the World Health Organization in 1995, a Memorandum of Understanding between the World Health Organization (WHO) and the Kobe Group1 established the WHO Centre for Health Development (WKC). As an integral part of the Secretariat of WHO, the WKC has a global mandate to conduct research into the health consequences of social, economic, environmental and technological changes and their implications for health policy development and implementation.

In 2004–2005, the Centre undertook a process of consultation with its partners and the scientific community to gain perspective on its future work for the period 2006–2015. An Ad hoc Research Advisory Group (RAG) and associated Sub-groups were convened to delineate the most important research questions related to Ageing and Health, Urbanization and Health, and Technological Innovation and Environmental Change and Health.

These consultation lead to development of a research framework for the WHO Centre for Health Development. This framework served as an important scientific reference in the development, by WHO and the Kobe Group, of the ten-year extension of the Memorandum of Understanding to 2015 and the Centre's research plans for the future that are reflected in the Plan of Work for 2006–2007.

The Memorandum of Understanding (MOU) between WHO and the Kobe Group for 2006–2015 was signed on 15 June 2005. This MOU ensures the Centre's programmatic and financial future for the next ten years, providing a stable budget for its scientific work that averages about US$ 5.4 million per year.

About Kobe Center

As WHO Kobe Centre is the hub of the Knowledge Network on Urban Settings (KNUS) of the Commission on Social Determinants of Health, the Project and the KNUS will work in tandem to develop new knowledge on slum dwellers as a priority exposed urban population. The future work of the Centre will have the following strategic foci:

Monitoring and responding to "felt needs" – aiming to complement the findings of epidemiological and public health research with information about the needs felt by exposed populations.

Packaging knowledge from a health equity perspective to inform policy and practice – Aiming to reduce health inequity by improving health governance.

Developing new knowledge to address existing and emerging areas of vulnerability – Aiming to identify and advocate effective responses and interventions in relation to driving forces.

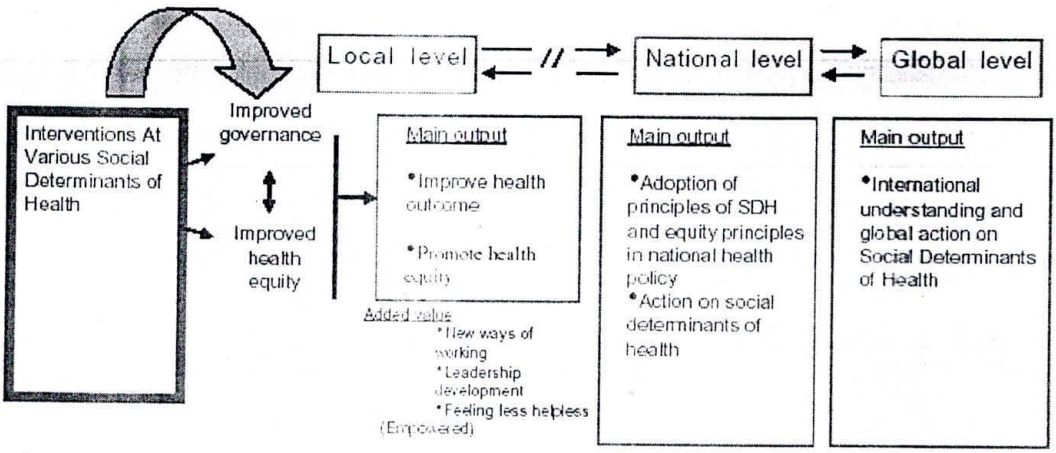
The work will be carried out with a major emphasis on **urban settings**, mindful of the "globalization-urbanization interface" that exists in these settings, with **the overall aim of reducing health inequity by optimizing the impact of social determinants of health on exposed populations**.

The WHO Centre for Health Development, in collaboration with WHO Regional and Country Offices, and through its project on "Healthy Urbanization," aims to integrate evidence-based good practices and public health methods that optimize the impact of social determinants on health and promote health equity in national policies and health systems of Member States.

Rationale

At the local level, the project will bring added value through new ways of working between and among sectors, leadership development and community participation and empowerment. At the national level, the project will provide new knowledge and evidence that may accelerate the adoption of principles of social determinants of health and health equity in national policy, programmes and practice. At the global level, the project will contribute to international understanding and strengthen the imperative for action on social determinants of health.

Figure 2: Expected outputs from action research interventions



Goal

The overall goal of the project is to promote health equity in urban settings, particularly among exposed populations through actions in areas that relates to the project objectives:

Objectives

1. **Developing strategies:** Building an evidence base, generating policy ideas, evaluating current experiences and interventions, developing public health methodologies for health inequity assessment and evaluation and deriving new knowledge on social determinants and health inequity.

2. **Demonstrating the applicability of strategies:** Demonstrating how "generic" municipal strategies can be applied and combined with tactical and contextspecific interventions to reduce health inequity.

3. **Capacity building:** Building capacity at the level of the individual, the organization and the system through leadership training and applied projects.

4. **Policy advocacy:** Developing and applying principles of strategic communication and advocacy to influence health governance at all levels and enhance understanding of how the impact of social determinants can be optimized to reduce health inequity.

Staff will work in and across these areas of emphasis in a multi-disciplinary fashion to develop specific products. In addition, to provide effective liaison with other WHO programmes and offices, as well as with other organizations, they will serve as designated Focal Points for the following Areas of Work:

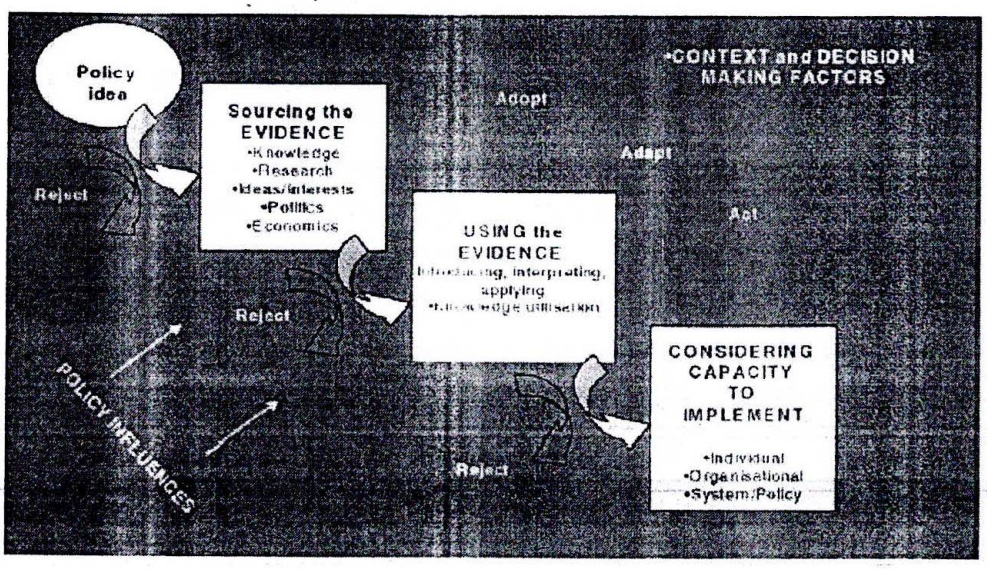
1. Surveillance, prevention and management of chronic, non-communicable
2. Diseases
3. Health promotion
4. Tobacco and environment
5. Gender, women and health
6. Policy-making for health in development
7. Health system policies and service delivery
8. Human resources for health
9. Health information, evidence and research policy
10. Emergency preparedness and response
11. Mental health and substance abuse
12. Ageing and life course

Project partners –

The Healthy Urbanization Project will be implemented in partnership with a wide range of stakeholders at global, regional, national and local levels. The proposed institutional partners of the project at the global level will include the Alliance for Healthy Cities, International Network of Health Promotion Foundations, the SEAMEOTROPMED Network and the La Trobe University School of Public Health. Partners at the regional level will include the different Regional offices of the World Health Organization and other international agencies. Partners at the country level will include Ministries of Health, transportation, education, welfare, civil society and other stakeholders. Partners at the local level will include local governments, non governmental organizations, communities, people's organizations and others that will emerge as the site-specific projects are developed and implemented.

Model

The model of the "Evidence-Informed Policy and Practice Pathway"3 (Brown and Zwi, 2005) provides the basis for the research design of the Core Project. According to this model, policy ideas, evidence, use of evidence and capacity to implement evidence-based policies are interlocked in a series of decision-making steps that are characteristic of how events unfold in practice. Policy



Guiding principles and approaches

The project will be guided by the following principles:
1. "Learning by doing," in particular the use of participatory and action-research methods to optimize social determinants and promote health equity;

2. Respect for local contexts and responsiveness to local needs in the design, development and adoption of project interventions and strategies;

3. Community participation and the involvement of beneficiaries and stakeholders at all stages of the project (i.e. planning, implementation and evaluation);

4. Empowerment of beneficiaries and stakeholders through capacity building;

5. Integration with existing initiatives that strengthen health systems at the national and local level;

6. Linkage to initiatives in support of global imperatives such as Health for All, the Millennium Development Goals, the Commission on Social Determinants of Health, the Commission on Macroeconomics and Health and Sustainable Development;

7. Utilization of vulnerability assessment and reduction approaches to address health issues that result from the convergence of social and environmental determinants; and

8. Cost-sharing and resource mobilization at all levels to complement fixed budgets that are provided by the WHO Kobe Centre.

Present plans, 2006–2007
Objective 1 – Develop strategies to reduce health inequity in urban settings
Approaches and products

Building the evidence base
Closer examination of existing evidence will be a key component for developing strategies to reduce health inequity in urban settings. Knowledge will be collated, analyzed, synthesized and organized to enable researchers, implementers and decision-makers to gain easy access to information on the associations and pathways between social determinants and health inequity in urban settings. In particular, the evidence base will try to capture the policy ideas emanating from attempts to bridge equity gaps through municipal health governance.

Ensuring local participation and ownership of research

Research activities will emphasize principles of community and stakeholder participation and ownership. People's participation in planning, implementation and evaluation of research activities will be ensured. Thus, at the early stages of the project, participatory and consultative processes will guide the identification of exposed populations, prioritization of issues and concerns and the pursuit of opportunities and imperatives for influencing health governance at the local level.

Strengthening public health at the local level
The role of the public health sector at the city and municipal level in enhancing health governance will be highlighted in the project. As both social and environmental determinants of health necessitate action and responsibility from many actors (e.g. transportation, housing, education, welfare, finance, police and law enforcement), public health officers may need to play a more important role as catalysts for change than as implementers in the locality and will need to steer highly complex political processes toward healthy public policy.

Highlighting the interaction between local and national determinants

The project will also develop tools to assist municipal planners in assessing long-term development decisions. In particular, work will be initiated to develop models that render visible the impact of broad determinants on the health of exposed populations in future scenarios, using projections and trends of urbanization in the first instance, and demographic and environmental change as well. An example of this might be the effect of heat waves on exposed populations in urban settings.

Contributing to global action on social determinants of health

the Project and the KNUS will work in tandem to develop new knowledge on slum wellers as a priority exposed urban population. The Project will collaborate with the KNUS to produce new knowledge on interventions to address the health conditions of people who live in slums and informal settlements.

Approach	Product
Build an evidence base of experiences and current interventions	An evidence base on how health inequity is reduced through municipal level interventions that address social determinants of health
Evaluate selected experiences and current interventions against existing theoretical frameworks and conceptual models that describe the relationship between social determinants of health and health inequity in urban settings	A review of grey and published literature on promising and successful interventions
	A glossary of terms and key concepts
	Strategies to enable municipal level action to reduce health inequity in urban settings
Develop methodologies to determine health needs of exposed populations in urban settings	Checklists for assessing and evaluating health equity in urban settings using "felt needs" of exposed populations as reference
Develop methodologies for projecting future scenarios in relation to determinants of health and their impact on exposed populations in urban settings	Models for forecasting and scenario building on the future of cities and municipalities based on demographic and environmental change, urbanization and health with reference to "felt needs"
Develop methodologies for evaluating health inequity at the city or municipal level	Core set of indicators to evaluate health inequity in cities and municipalities (Poverty-Health-New Urban Settings Index)
Develop new knowledge on reducing health inequity in urban settings	Syntheses of evidence on effective interventions for reducing health inequity in urban settings

Objective 2 – Demonstrate the applicability of strategies for reducing health inequity among exposed populations in urban settings

Approaches and products

Urban Health Field Research Sites will be established in selected urban settings6 to create learning environments for local decision-makers to apply generic municipal- level strategies and further evolve localized and context-specific and tactical interventions to reduce health inequity. Local project steering

committees will be organized and workshops will be conducted. Social, community and political mobilization will be done to ensure multi-sector stakeholder participation in the application of strategies. Local project steering committees will be organized and workshops will be conducted. Social, community and political mobilization will be done to ensure multi-sector stakeholder participation in the application of strategies.

Approach	Product
Establish Urban Health Field Research Sites that will serve as learning environments for local decision-makers and communities for the application of strategies for reducing health inequity	Three Urban Health Field Research Sites where the strategies for reducing health inequity will be applied
	Three research units based in WR offices with capacity to coordinate stakeholder activities and oversee implementation of the strategies at the local level
Apply the strategies for reducing health inequity	Application of the strategies in three Urban Health Field Research Sites

Objective 3 – Build capacity for reducing health inequity in urban settings
Approaches and products

Capacity building, or the "development of sustainable skills, organizational structures, resources and commitment to health improvement in health and other sectors, to prolong and multiply health gains many times over", will be a critical part of the project. Teams of leaders who are key players in health governance at the local level will be organized and engaged in a health promotion leadership training programme using the WHO ***Prolead*** model

The learning sessions are organized into three modules featuring didactics, workshops and field visits. Topics covered by the training will include leadership principles,

Prolead III aims to enhance the practical skills of teams across five categories that may be needed to improve governance for the promotion of health: intrapersonal qualities; interpersonal qualities; cognitive skills; communication skills; and, task-specific skills.

Prolead III **guiding principles include:**

a. Emphasizing applied skills, not just theoretical knowledge;
b. Training in a highly interactive manner, drawing on personal experience to reinforce team learning;
c. Encouraging strategic thinking in the promotion of health;
d. Emphasizing the use of good governance principles in decision-making;
e. Using applied field projects to reinforce classroom learning, multiply training benefits, and generate results;
f. Providing opportunities for mentoring and technical support;
g. Soliciting feedback as a means of improving the learning process.

Approach	Product
Conduct leadership development, mentoring and training on using the strategies to reduce health inequity in urban settings	Trained teams of leaders who are undertaking projects to reduce health inequity in the three urban health field research sites

Objective 4 – Advocate the reduction of health inequity in urban settings
Approaches and products

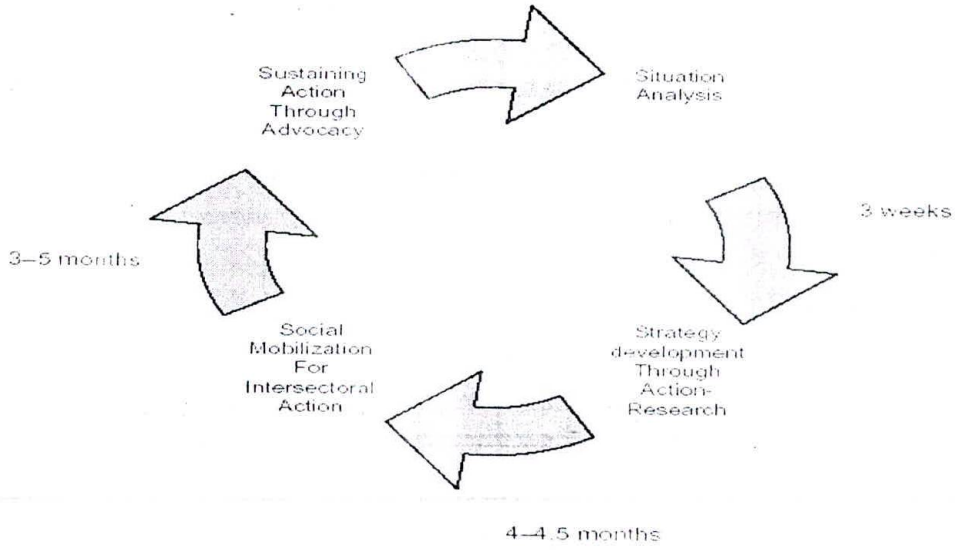
A strategic communication and advocacy plan will be developed to ensure that different audiences and stakeholders will have a clear understanding of the goals and objectives of the project. For the biennium, project advocacy materials will be developed in English, Spanish and Japanese.

In collaboration with the United Nations University (UNU), video documentation of strategies for reducing health inequity will be conducted at one project site. A range of advocacy activities will be implemented at global, regional, national and local levels. For

Approach	Product
Develop and implement a communication and advocacy plan for the strategies.	Communication and advocacy plan for the strategies.
	Video documentation of projects of the Urban Health Field Research Sites.
	Profiles of promising approaches.
	Information exchange, networking, meetings and other advocacy activities.
Establish and sustain partnerships for reducing health inequity	A framework for developing effective partnerships to reduce health inequity
Develop education materials and rapid assessment guidelines on reducing health inequities	A set of educational materials, checklists and rapid assessment guidelines on how health inequity may be reduced

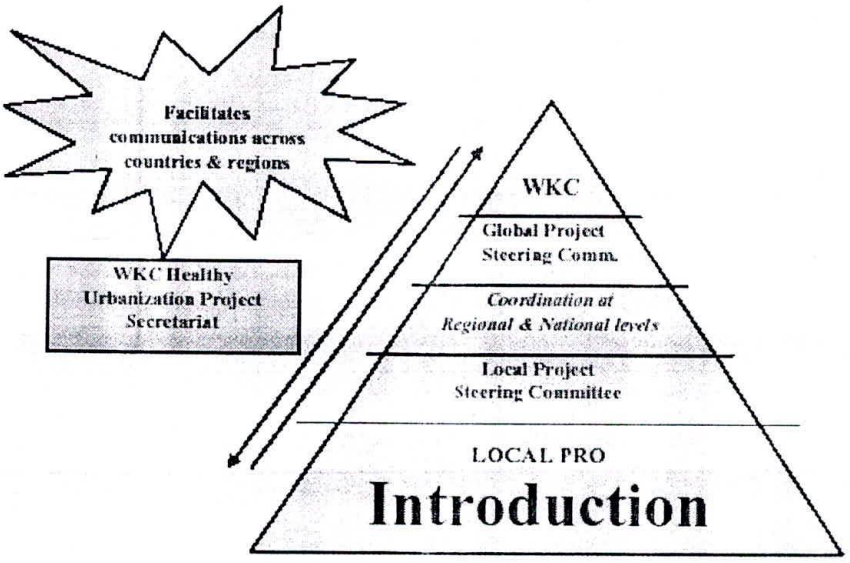
PROJECT IMPLEMENTATION

2006–2007 Timeframe



PROJECT MANAGEMENT

Management and support structure



It is anticipated that these Core Project objectives will serve to guide the work of the WHO Centre for Health Development over its next ten years of life.

Project Steering Committee Meeting
30 May – 2 June 2006

India: In Bangalore, access to quality health care, safe water and sanitation, and proper garbage disposal, as well as the provision of ample parks and play areas, safe roads and transportation, and a city free of crime, violence and drugs, are all being addressed by the municipality using an inter-sectoral participatory approach.

Dr Muthukrishnan Vijayalakshmi, Health Officer, Bangalore City Corporation, Bangalore, presented a paper on Health Promotion in Bangalore, India. Although this was not a scoping paper, it did provide the audience with a sense of the important social determinants in Bangalore. Dr. Vijayalakshmi started her presentation arguing that urbanization in Bangalore happens because citizens are looking for a better life. The pace, scope and depth of urbanization was resulting in inadequate food and shelter, overcrowding, insufficient water and sanitation facilities and pollution, which again pushed the population into use of harmful substances, and insecurity.

Bangalore has adopted the healthy cities approach and identified six main intervention areas:

1) Access to quality health care – especially urban poor; 2) Safe water supply & proper sanitation;
3) More organized disposal of waste (collection, segregation & transportation);
4) Ample public parks & play areas;
5) Safe roads & safe transportation; and
6) Freedom from crime, violence and drugs.

The six issues are being addressed through environmental health interventions, preventive health measures, health promotion approaches, education and training. These initiatives are proving successful and are being implemented using an intersectoral and participatory approach. However, there are still major challenges such as solid waste management, which consume the majority of the budget, and HIV/AIDS with its high prevalence among the working class.

The ensuing discussion concentrated on environmental health issues and how Bangalore had managed to sustain a recycling initiative and build on already existing initiatives. In responding to a question related to resettlement, Dr Vijayalakshmi described how the government was constructing houses and the importance that development initiatives in other sectors be aligned with those of the Ministry of Health. The important success factors included education, good housing and employment as well as strong political will reflected in a commitment to the healthy cities approach.

Following on the regional presentations, a major question for the participants was:
What have we learned and what can we transplant into the Healthy Urbanization Project?

Bangalore, India

The group from India started their work by defining the characteristics of future Prolead participants. These participants must be individuals who are working with health related issues, known to have demonstrated leadership potential, currently employed and engaged in a technical or professional area of work such as finance, planning, transport, housing, health policy, law enforcement, working at a level where policy and practice are reinforcing each other. It is advisable that Prolead participants come from the following three domains: WHO, government or nongovernmental organizations. The Bangalore research site will have 4-6 research teams with three members per team. Each team will be encouraged to have an appropriate gender and age balance. There should also be a sense of continuity with the work of the three previously trained Prolead fellows. The activity timeline for the Bangalore project was outlined as follows:

- 30 June 2006: Completion of appointment of SSA.
- 4-6 July 2006: WKC Focal Point (Ms Loo) visits Bangalore to
    - Review the interim scoping paper/meet with stakeholders;
    - Gain an understanding of BMP;
    - Present the Project to the Commissioner;
    - Orient SSA staff (project document, work and financial plans, office supplies,
    - Communications, recording and reporting, etc);
    - Catalyze establishment of a Bangalore working body at the local level, comprised of BMP (two clinical and public health), SSA, training institution,

one from an NGO, one former Prolead fellow and the Commissioner.

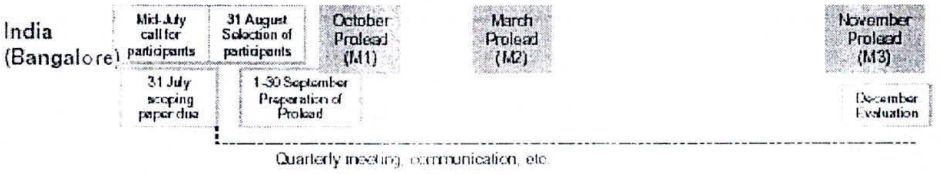
- Mid-July 2006: call for expression of interest for Project participants.
- 31 July 2006: deadline for submission of scoping paper.
- 31 August 2006: deadline for selection of Prolead participants; and training institution identified
- 1-30 September 2006: Preparations for Prolead, Module 1 (training venue, food, materials, programme, etc).
- October 2006: Prolead, Module 1.
- Commencement of city projects.
- March 2007: Prolead, Module 2.
- Continuation of city projects.
- November 2007: Prolead, Module 3.
- Phasing out/closure of city projects.
- December 2007: Bangalore core project evaluation.

Annex 5, Plan of Action, Bangalore

Objective: Optimizing the social determinants of health in urban settings
Site: Bangalore, India **Total budget:** 110 500 USD

Items	Activity compo nente	Timeframe (Quarters) 2006				Timeframe (Quarters) 2007				Mile stone	Maxim um funds from WKC (USD)	Additional funds required and source (USD)		Officer in charge	Suggestions
		1	2	3	4	1	2	3	4			Amt	source		
Capacity building	Proleed modules				Revised		mid Mar	Nov		Proleed curr dona Plan identified	30 000	0		Working group including SSA	Module starts from 4th quarter 06
Project development and implementation	City projects									Conduct of Proleed Module 1	10 500			Working group Proleed participants	4~6 city projects to optimize SDH
•Special service agreement	Recruit ment national staff		Jan							Subject to n No and to WR	54 000	0		WKC and WR-India	•Smooth coordination of activities between WKC and country teams
Local cost and project mobilization	quarterl y meeting, commu nication, transpo ...										5 000			SSA	Regular report on progress
•Supplies and equipment	Office supplies										8 000	0		SSA	N/A
•Scoping paper	Researc h										3 000	0		NIMHANS (Dr Gururaj)	N/A

Proposed dates for Training



Dr Davison Munodawafa, Regional Adviser in Health Promotion and Education, WHO Regional Office for South-East Asia (SEARO)

Healthy Urbanization Learning Circles will undertake capacity building activities over a 9–12-month period that is organized around four modules9:

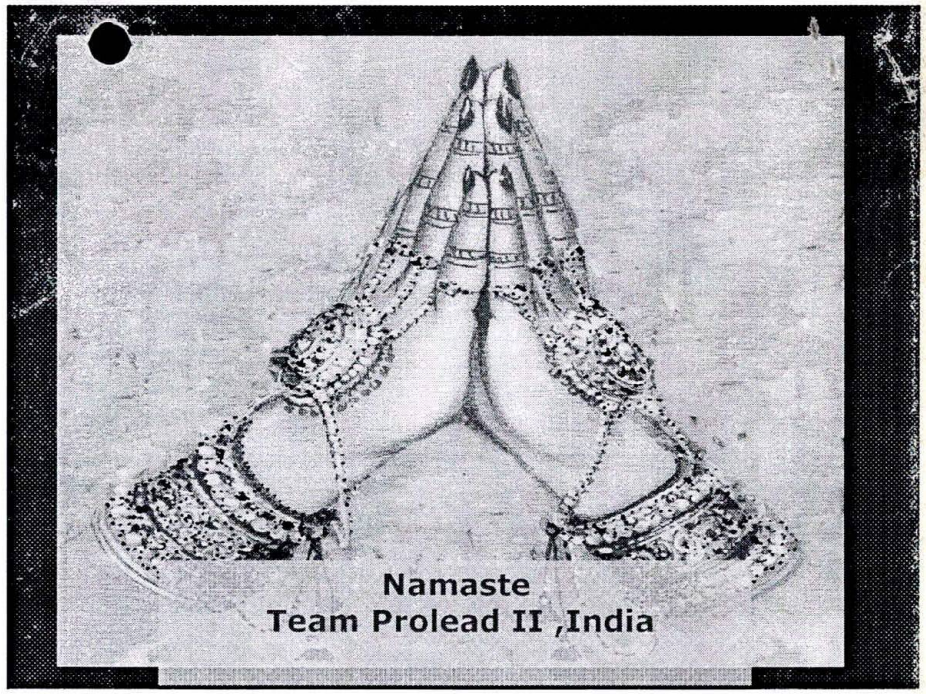
- Module 1: Overview of Healthy Urbanization: Situation Analysis
- Module 2: Healthy Urbanization Challenges: Strategy Development and Project Proposal Writing
- Module 3: Healthy Urbanization Opportunities: Social Mobilization for Intersectoral Actions.
- Module 4: Mainstreaming Healthy Urbanization: Sustaining Action through Advocacy

Research sites - BHUP

- Will work through 7 centres allocated in 14 low resource settings:
  - Pobbathi MH
  - Vasanthnagar Disp.
  - Vidyapeeta HC
  - Robertson Road HC
  - Moodalapalya HC
  - Mathikere HC
  - Shanthinagar MH

INDIA

- Population :1,080,264,388[July 2004]
  1 billion,80 million
- 7th largest country:Geographical area:3,287,590 sq kms
- GDP:603.3 billion$



Bangalore city

- Geographical area spread over 225 kms
- Bangalore metropolitan area has a population of 6.5 million[census 2001]
  [present estimates:8 million]
- Urban poor constitutes 30% of the population[2.1 million][present estimates 2.4 million]
- Estimated 1 million floating population

Prolead II :Module 1 :
A Health Governance Initiative
[WHO Center for Health Development,Kobe, Japan.]

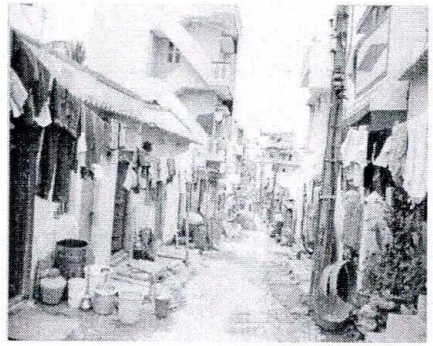
Country report: India

13:00 to 13:20 ,Day 1,Monday,25th July, Bangkok,Thailand

Team: Mr. P R Ramesh, Dr A G Harikiran , Dr Srinivasan.v

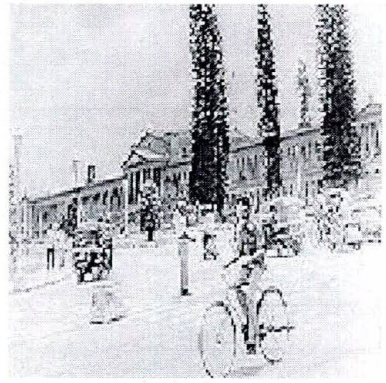
Bangalore:now:the other face

- Overcrowding
- Overpopulation
- Slums/urban poor
- Inadequacy of Infrastructure
- City struggling to cope



Bangalore: then

- Garden city
- Pensioners paradise



Bangalore Health Infrastructure

- 250 large hospitals and nursing homes
- 5000 family practitioners
- 10 Tertiary care hospitals
- Bangalore city corporation

  48 UFWCS/health centers,6 referral hospitals and 24 maternity homes

Bangalore:now

- Silicon valley of India
- Information technology capital
- Bio technology capital
- Service industry center
- Education center for medicine,engineering
- Rapid infrastructure development

Key Health Challenges in Bangalore City

Leading causes of death in Bangalore

1. Cardiovascular diseases:16212
2. Injury /external causes:8723
3. Infections/parasitic diseases:7887
4. Perinatal complications:6649
5. Genito urinary diseases:4007

Bangalore-Health Infrastructure-Medical/allied Teaching Institutions

Rajiv Gandhi university of health sciences

- 5 Medical Colleges
- 16 Dental Colleges
- 86 Nursing Colleges
- 23 Physiotherapy Colleges
- 2 Unani Colleges
- 2 Ayurvedic Colleges
- 2 Homeopathy Colleges.

Regional occupational health center[south]

Health Challenges/ Health Issues Priority in Trisector Dialogue Workshop[11th January 2003]

- Air pollution
- Accidents and trauma
- Violence against senior citizens
- Violence against women
- Cardiovascular diseases
- Toilets,underground drainage systems,solid waste management
- Substance abuse
- Child labor
- HIV aids
- Primary health care

Bangalore existing health system: Government and Private Sector Role

- Government hospitals[free service,paid for higher socio economic strata people]
- Private sector hospitals and clinics provide major part of the service
- Insurance:role and use steadily increasing
- Welfare services/health benefits/hospitals for employees present and limited:these services face many challenges

Health promotion action in Bangalore:Bangalore healthy city initiative trisector dialogue

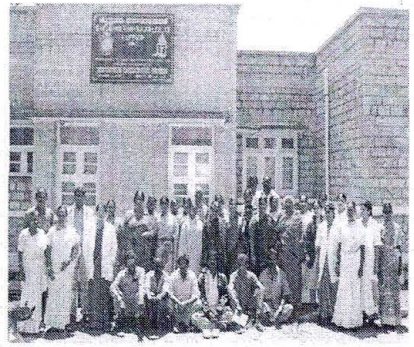
'Citizens and governance program:tri sector dialogue':a collaborative effort of CAMHADD [NGO],Bangalore city corporation, Sri Jayadeva institute of cardiology ;January 2003

Broad determinants/Underlying causes to health challenges to Bangalore city

- LIFESTYLE CHANGES
- Political factors
- Population
- Financial limitations:low budgetary allocation for health[low priority for health promotion or preventive activities.]
- Inadequate prioritization and long term planning
- Lack of multisectoral coordination and utilization and orientation of available resources.

Health Promotion Activities:Bangalore: Preventive Cardiology Center at Shantinagar: BMP,CAMHADD, SJIC,RVDC:November 2003

- First of Three Centers Of Trisector Partnership
- Target group:4000 Pourakarmikas [Sanitary workers]
- Unique challenges
- Services provided
  Health promotion activity and health education
  Screening and referral services.
- *Services :free for the employees*



Broad determinants/Underlying causes to health challenges to Bangalore city

- Poverty

Nobel laureate:Amartya Sen said ' the great Bengal famine was not caused by shortage of food but the lack of paying capacity among the masses"

Health Promotion Actions:Bangalore:

Preventive Medicine and Healthy Lifestyle Clinic:
Karnataka state police, CAMHADD :November 2005

- Third Center of Trisector Partnership
- Target group: Employees of 'Karnataka State Police'
- Services

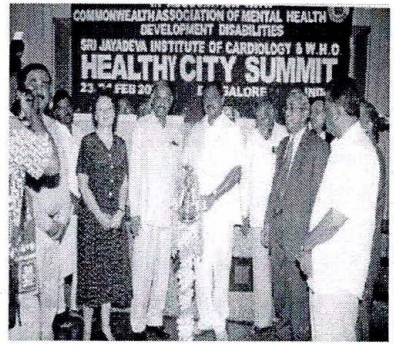
  Health promotion activity and health education

  Screening and referral services.
- Services :free for the employees

BANGALORE HEALTHY CITY SUMMIT :FEBRUARY 2004

BMP,CAMHADD AND SJIC

- Development of centers of excellence
- Promotion of healthy environment
- To promote school and community based health initiatives
- Preventive health care through ' healthy lifestyle clinic'



Health Promotion Actions:Bangalore City Corporation: Parks and Playgrounds

- One Park - each Ward
- Over 250 Parks redeveloped
- Adopt A Park Scheme'
- Government-Citizen partnerships Bangalore Agenda Task Force (BATF)
- 360 Play Grounds developed

Health Promotion Actions:Bangalore:

Preventive Medicine and Healthy Lifestyle Clinic:
KSRTC, CAMHADD :January 2005

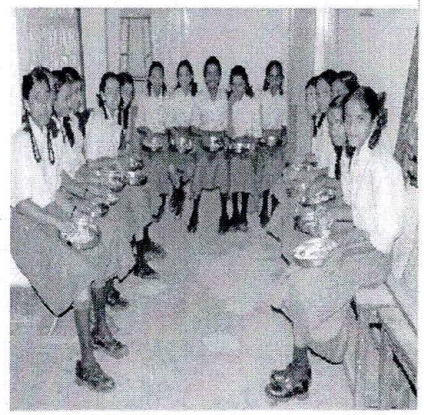
- Second Center of Trisector Partnership
- Target group:16000 employees of 'Karnataka State Road Transport Corporation

Health Promotion Actions:Bangalore City Corporation: Yoga Classes at schools

- Yoga classes are conducted in all Corporation schools
- Physical Trainers or Trained Teachers will conduct ½ hr Yoga classes everyday
- Over 8500 High school students and 2800 Primary school students

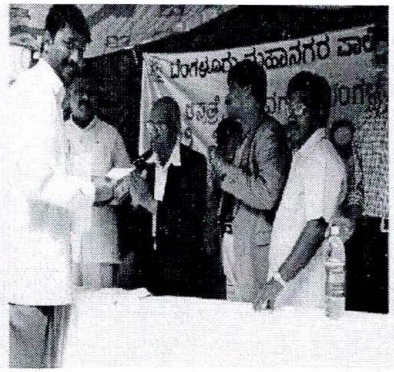
Health Promotion Actions:Bangalore City Corporation: Mid Day Meal Programme

- Mid Day Meal from ISCKON temple for about 22,000 students.
- Budget : Rs.1 crore
- Completed 3 successful years
- Cost:3-6 rupees per meal
- Outcome: Drop out rates have come down



Health Promotion Actions:Bangalore City Corporation: Trinity smart card

- Smart card :A unique Trinity smart card has been issued to all families of V.V.Puram ward [PILOT]
- Gradually this facility will be made available to all Other 99 wards of Bangalore city corporation
- Access not only to treatment facilities but a range of health promotion activities/screening programs.



Health Promotion Actions:Bangalore City Corporation: Day Care Facility for underprivileged Elders

- "Sandhya kirana" a unique day care facility exclusively for the low income elders :19th feb 2004 at 2 centers in Bangalore:BMP and nightingales medical trust, an NGO.
- A support system for the unprivileged elders .

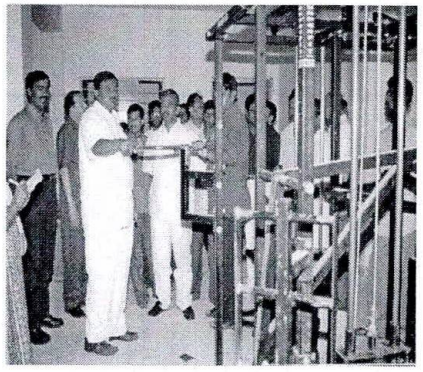
Health promotion activity:Bangalore:CVD risk management program

WHO "CVD risk management premise study in Bangalore"

At 10 primary health centers of the Bangalore city corporation

Health Promotion Actions:Bangalore City Corporation: Gymnasium

- One fitness center/ Gymnasium at each ward
- One Trained professional is been appointed as coach



Health Promotion Actions in Bangalore:Finance

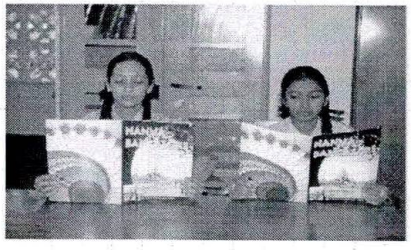
Primary funding:organization employing the target population[Bangalore city corporation,KSRTC,police department]

Additional support:other participating institutions,NGO [CAMHADD.etc]

- Lack of earmarked budgetary allocations for health promotion activity,donor funds,corporate sponsorship or social health insurance.

Health Promotion Actions:Bangalore City Corporation: Health Education Programmes:

- **Voluntary organizations like Freedom Foundation/ Samraksha and KSAPS are counseling and screening pregnant mothers in 15 BMP Hospitals for HIV/AIDS**
- **'NAMMA BENGALURU': A Health education program**



Scope for improvement

- Development of a system for integration and coordination between participating stake holders[government ,private sector and civil society]towards common goals
- Training and skill upgradation towards utilization of non traditional funding options.
- Development and integration of present efforts towards sustainable programs
- Evaluation
- Infrastructure and systems development
- Integration between health care delivery and medical education

Research Programme 2006-2007

Healthy Urbanization Project: Optimizing the impact of social determinants of health on exposed populations in urban settings

In the context of urbanization and globalization, the problem of health inequity in cities and urban municipalities must be confronted. **The Healthy Urbanization Project** is an integrated, interdisciplinary, multi-sector initiative that will frame the WHO Kobe Centre's work over the next ten years, and anchor the development of specific products in the immediate 2006-2007 biennium. This core project for the Centre for 2006-2015 will be carried out with a major emphasis on urban settings, mindful of the "globalization-urbanization interface" that exists in these settings, with the overall aim of reducing health inequity by optimizing the impact of social determinants of health.

Objective 1 - Develop strategies to reduce health inequity in urban settings

Approach 1.1. Build an evidence base of experiences and current interventions.

Product 1.1.1. An evidence base on how health inequity is reduced through municipal-level interventions that address the social determinants of health

Approach 1.2. Evaluate selected experiences and current interventions against existing theoretical frameworks and conceptual models that describe the relationship between social determinants of health and health inequity in urban settings

Product 1.2.1. A review of grey and published literature on promising and successful interventions

Product1.2.2. A glossary of terms and key concepts

Product 1.2.3. Strategies to enable municipal level action to reduce health inequity in urban settings

Approach 1.3. Develop methodologies to determine the health needs of exposed populations in urban settings

Product 1.3.4. Checklists for assessing and evaluating health equity in urban settings using the "felt needs" of exposed populations as a reference

Approach 1.4. Develop methodologies for projecting future scenarios in relation to determinants of health and their impact on exposed populations in urban settings

Product 1.4.1. Models for forecasting and scenario building on the future of cities and municipalities based on demographic and environmental change, urbanization and health with reference to "felt needs"

Approach 1.5. Develop methodologies for evaluating health inequity at the city or municipal level

Product 1.5.1. Core set of indicators to evaluate health inequity in cities and municipalities (a poverty-health-new urban settings index)

Approach 1.6. Develop new knowledge on reducing health inequity in urban settings

Product 1.6.1. Syntheses of evidence on effective interventions for reducing health inequity in urban settings

Objective 2 - Demonstrate the applicability of strategies for reducing health inequity among exposed populations in urban settings

Approach 2.1. Establish Urban Health Field Research Sites that will serve as learning environments for local decision-makers and communities for the application of strategies for reducing health inequity

Product 2.1.1. Three Urban Health Field Research Sites where the strategies for reducing health inequity will be applied

Product 2.1.2. Three research units based in WR offices with capacity to coordinate stakeholder activities and oversee implementation of the strategies at the local level

Approach 2.2. Apply the strategies for reducing health inequity

Product 2.2.1. Application of the strategies in three Urban Health Field Research Sites

Objective 3 - Build capacity for reducing health inequity in urban settings

Approach 3.1. Conduct leadership development, mentoring and training on using the strategies to reduce health inequity in urban settings

Product 3.1.1. Trained teams of leaders who are undertaking projects to reduce health inequity in the three urban health field research sites

Objective 4 - Advocate the reduction of health inequity in urban settings

Approach 4.1. Develop and implement a communication and advocacy plan for the strategies

Product 4.1.1. Communication and advocacy plan for the strategies

Product 4.1.2. Video documentation of projects at the Urban Health Field Research Sites

Product 4.1.3. Profiles of promising approaches

Product 4.1.4. Information exchange, networking, meetings and other advocacy activities

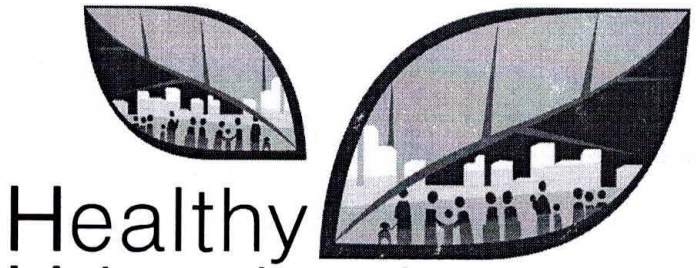
Approach 4.2. Establish and sustain partnerships for reducing health inequity

Product 4.2.1. A framework for developing effective partnerships to reduce health inequity

Approach 4.3. Develop education materials and rapid assessment guidelines on reducing health inequities

Product 4.3.1. A set of educational materials, checklists and rapid assessment guidelines on how health inequity may be reduced

Healthier People in Healthier Environments



Healthy Urbanization

Guidelines for Action

HEALTHY URBANIZATION:
Optimizing the Impact of Social Determinants of Health on Exposed Population in Urban Settings

WHO Centre for Health Development
I.H.D. Centre Building, 9th Floor, 5-1, 1-Chome
Wakinohama-Kaigandori, Chuo-ku, Kobe, 651-0073, Japan
Tel +81 78 230 3100 Fax: +81 78 230 3178
URL: http://www.who.or.jp/

World Health Organization

TO EP from CMC
re: follow up + recall
from Dr V. Jayalakshmi last week
(CMO - BMP)
JW
25/1/01.

TABLE OF CONTENTS

Annexes:

FOREWORD

Following a decision by the Executive Board of the World Health Organization in 1995, a Memorandum of Understanding between the World Health Organization (WHO) and the Kobe Group[1] established the WHO Centre for Health Development (WKC). As an integral part of the Secretariat of WHO, the WKC has a global mandate to conduct research into the health consequences of social, economic, environmental and technological changes and their implications for health policy development and implementation.

The 2004–2005 biennium was pivotal for the WHO Centre for Health Development. It was a period of transition and transformation that afforded the opportunity to reflect and build on the Centre's past achievements, learn from its shortcomings and chart a course for the next decade in response to the WHO Director-General's call for a Centre that stands for excellence in research on health in development. A participatory process was used to chart the research future of the Centre. This process reflected the views of the Centre's Kobe Group partners and the 2004 Ad Hoc Research Advisory Group in developing a Research Framework focused on understanding the complex dynamics of the driving forces that shape health in development.

In 2005, the Centre focused on consolidating the key elements of the transition and transformation process that started in 2004. A new Memorandum of Understanding (MOU) between WHO and the Kobe Group for 2006–2015 was signed on 15 June 2005. This MOU ensures the Centre's programmatic and financial future for the next ten years, providing a stable budget for its scientific work that averages about US$ 5.4 million per year. New strategic directions for research work were developed and agreed to. A detailed Plan of Work for 2006–2007 was prepared consistent with these new directions. The staffing and management of the Centre were streamlined to develop a sharper focus on stakeholder needs and interests.

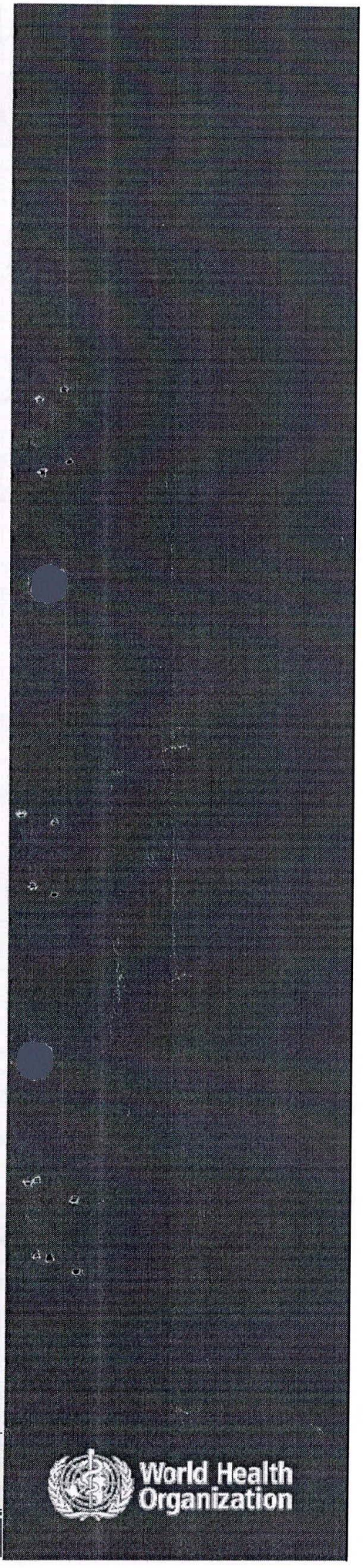
In November 2005, the Advisory Committee of the WHO Kobe Centre enthusiastically endorsed the ongoing work of the Centre and its plans for the future. They recommended to the late Director-General, Dr J. W. Lee, hat he approve the recommendations of the 2004 Ad Hoc Research Advisory Group, the strategic directions for future research proposed by the Centre for the period 2006–2015, and the proposed Plan of Work for 2006–2007. In December 2005, the Director-General approved the recommendations of the Advisory Committee.

These Guidelines for Action will inform the work of the WHO and its project partners who are involved in the Centre's project on *"Healthy Urbanization: Optimizing the Impact of Social Determinants of Health on Exposed Populations in Urban Settings."* The workplan for 2006–2007 completes the transitional and transformational processes that began in 2004–2005 and frames the research activities for implementation over the period 2006–2007. The manual is intended to provide strategic direction and implementation guidance. It is a dynamic document that should be informed and improved upon by experience.

Dr Soichiro Iwao
Director
WHO Kobe Centre

[1] The Kobe Group is comprised of Hyogo Prefecture, Kobe City, the Kobe Chamber of Commerce and Industry and Kobe Steel, Ltd.

The WHO Centre for Health Development, in collaboration with WHO Regional and Country Offices, and through its project on "Healthy Urbanization," aims to integrate evidence-based good practices and public health methods that optimize the impact of social determinants on health and promote health equity in national policies and health systems of Member States.



Healthy
Urbanization
Learning
Circle

Introduction

1.0 INTRODUCTION

1.1 Background

Following a decision by the Executive Board of the World Health Organization in 1995, a Memorandum of Understanding between the World Health Organization (WHO) and the Kobe Group established the WHO Centre for Health Development (WKC). As an integral part of the Secretariat of WHO, the WKC has a global mandate to conduct research into the health consequences of social, economic, environmental and technological changes and their implications for health policy development and implementation. In this context the vision of the WHO Kobe Centre is:

Healthier People in Healthier Environments

In pursuing this vision, the Centre's mission is to nurture, sustain and promote innovation and excellence in public health research on health in development.

Over the next ten years, the research programme of the WHO Kobe Centre is focused on urbanization and health equity. Through its project on "*Healthy Urbanization: Optimizing the Impact of Social Determinants of Health on Exposed Populations in Urban Settings*", the Centre hopes to contribute to the generation of new knowledge and stimulate action to confront the issue of health inequity in urban settings in both developing and developed countries. The overall goal of the project is to promote health equity in urban settings, particularly among exposed populations through actions in areas that relates to the project objectives:

- **Developing strategies:** Building an evidence base, generating policy ideas, evaluating current experiences and interventions, developing public health methodologies for health equity assessment and evaluation and deriving new knowledge on social determinants and health inequity.

- **Demonstrating the applicability of strategies**: Demonstrating how "generic" municipal strategies can be applied and combined with tactical and context-specific interventions to promote health equity.

- **Capacity building**: Building capacity at the level of the individual, the organization and the system by creating a learning environment for stakeholders, leadership training, applied projects and international exchange of experience.

- **Policy advocacy**: Developing and applying principles of advocacy, communication and social mobilization to influence health governance at all levels and enhance understanding of how a social determinants approach can integrated in national health systems.

1.2 Purpose

These "Guidelines for Action" are intended for use by the Centre and its stakeholders in developing and implementing action research at the local level related to "Healthy Urbanization" objectives for the period 2006–2007. This phase of the project will test approaches in Healthy Urbanization Field Research Sites to inform a wider group of stakeholders in the future. Included among the Centre's partners are:

- Local stakeholders in selected urban sites [e.g., city health officers, civil society partners, government, non-governmental organizations and other agencies and organizations at the local and national level]; and,
- WHO Country and Regional Offices.

Action research projects aimed at strategic problem-solving will focus on governance-related interventions that optimize social determinants in ways that improve health and promote health equity as shown in Figure 1. New knowledge will be generated through research activities that will be embedded at several points in the process as indicated by the red circles.

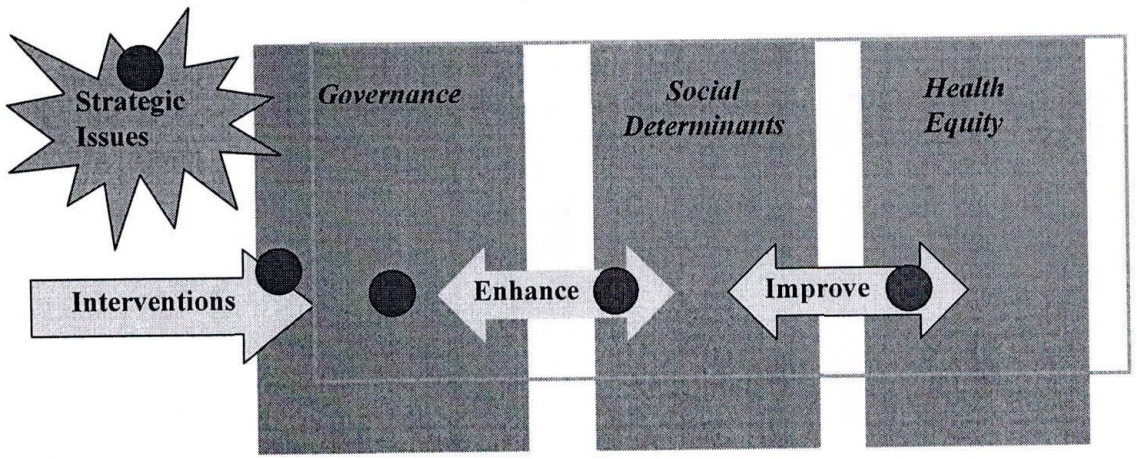


Figure 1: The focus of action research interventions

These are where action research interventions will be focused.

1.3 Structure of the Guidelines

These Guidelines present the reader with a step-wise approach to the implementation of the Healthy Urbanization Project. The document has four sections that emphasize different aspects of action on the project. In order to suite the needs of specific audiences, Section 1 may be combined with any of the other sections as appropriate.

Section 1 – Provides the **purpose** of the Guidelines; the **background** of the project; and **guiding principles** to be followed in implementing the project.

Section 2 – Provides definitions of key **terms and concepts**; the overall **rationale** for the project; a summary of the **project partners 2006–2007;** and suggested **methodologies and approaches** to implementation.

Section 3 – A **2006–2007 timeframe** for project activities; a brief description of **Project capacity building modules**; **site-specific project details**; and selected issues related to **advocacy and the future.**

Section 4 – A description of the project **management and support structure**; and considerations related to **monitoring, evaluation and reporting.**

Annexes – Providing **templates for planning and reporting.**

1.4 Guiding principles and approaches

The project will be guided by the following principles:

1. **"Learning by doing,"** in particular the use of participatory and action-research methods to optimize social determinants and promote health equity;

2. **Respect for local contexts and responsiveness to local needs** in the design, development and adoption of project interventions and strategies;

3. **Community participation** and the involvement of beneficiaries and stakeholders at all stages of the project (i.e. planning, implementation and evaluation);

4. **Empowerment of beneficiaries and stakeholders** through capacity building;

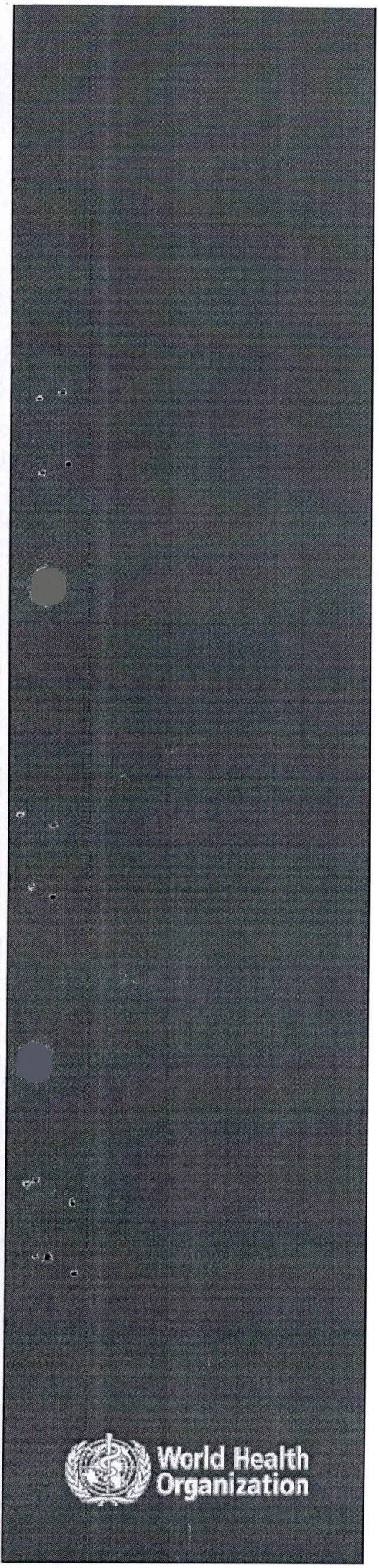
5. **Integration with existing initiatives that strengthen health systems** at the national and local level;

6. **Linkage to initiatives in support of global imperatives** such as Health for All, the Millennium Development Goals, the Commission on Social Determinants of

Health, the Commission on Macroeconomics and Health and Sustainable Development;

7. **Utilization of vulnerability assessment and reduction approaches** to address health issues that result from the convergence of social and environmental determinants; and

8. **Cost-sharing and resource mobilization** at all levels to complement fixed budgets that are provided by the WHO Kobe Centre.



Operational Framework

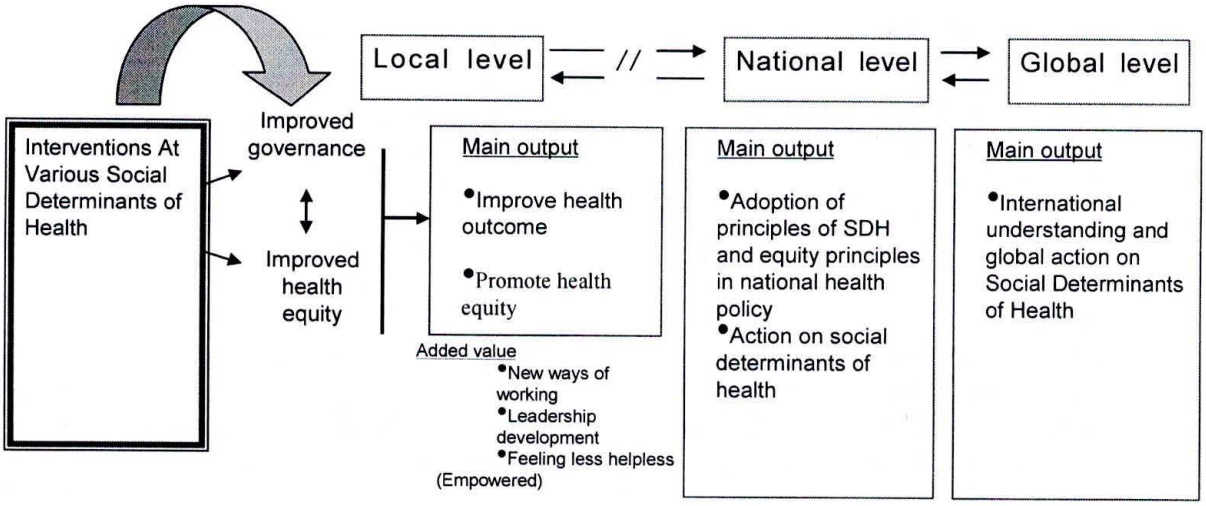
2.0 OPERATIONAL FRAMEWORK

2.1 Rationale[2]

The Healthy Urbanization Project will address strategic local health issues in urban settings through action research projects with a focus on governance-related interventions that optimizes the impact of social determinants in ways that improve health and promote health equity. Outputs of the project are expected at local, national and, later, global levels. At the local level, the project will bring added value through new ways of working between and among sectors, leadership development and community participation and empowerment. At the national level, the project will provide new knowledge and evidence that may accelerate the adoption of principles of social determinants of health and health equity in national policy, programmes and practice. At the global level, the project will contribute to international understanding and strengthen the imperative for action on social determinants of health (Figure 2).

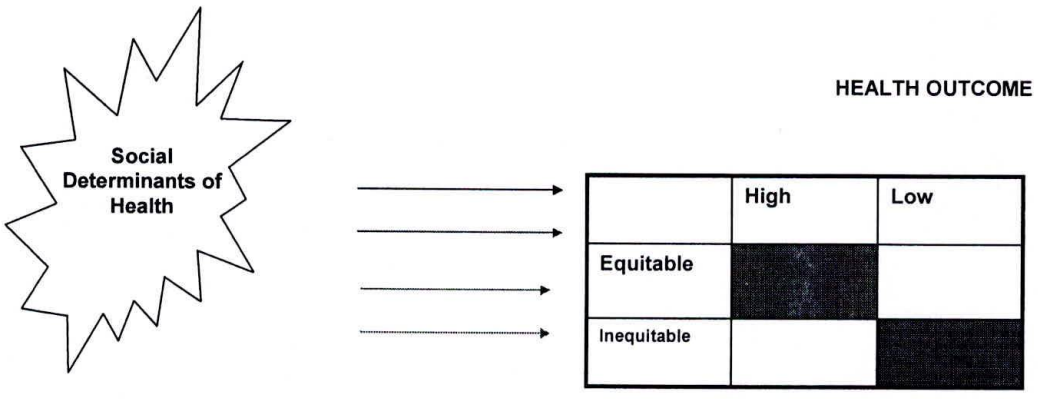
[2] A more in-depth discussion of the concepts underlying the Healthy Urbanization Project can be found in the WKC document *Concepts underlying the Healthy Urbanization Project: Optimizing the Impact of Social Determinants of Health on Exposed Populations in Urban Settings,* 2006.

Figure 2: Expected outputs from action research interventions



Social determinants of health can be modified and influenced, resulting in different health outcomes as noted in Figure 3. In any particular situation, the overall goal is to optimize the impact of social determinants in ways that result in high and equitable outcomes (indicated by the green box) and minimize impacts that result in poor health outcomes and low equity (indicated by the red box).

Figure 3: Impact of social determinants on health outcomes



2.2 Project partners - 2006–2007

The Healthy Urbanization Project will be implemented in partnership with a wide range of stakeholders at global, regional, national and local levels. The proposed institutional partners of the project at the global level will include the Alliance for Healthy Cities, International Network of Health Promotion Foundations, the SEAMEO-TROPMED Network and the La Trobe University School of Public Health. Partners at the regional level will include the different Regional offices of the World Health Organization and other international agencies. Partners at the country level will include Ministries of Health, transportation, education, welfare, civil society and other stakeholders. Partners at the local level will include local governments, non governmental organizations, communities, people's organizations and others that will emerge as the site-specific projects are developed and implemented.

2.3 Methodologies and approaches

2.3.1 Developing strategies (Project Objective 1)

Two frameworks for assessing Healthy Urbanization are presented here. While the Urban Health Assessment Framework show in figure 4 below is recommended for national level assessment, we propose the spider diagram shown in figure 5 as an assessment tool for municipal level assessment of healthy urbanization.

A Framework for Assessing Healthy Urbanization – The WHO Regional Office for the Americas has developed an *urban health assessment framework* (Figure 4) to function as a practical-theoretical tool to provide reliable and comprehensive information for decision makers, local governments, researchers, local communities, and public and private sectors to effectively and appropriately address the challenges and opportunities to improve the urban health conditions in cities. [3]

As urban health is a relatively new concept, there is little consensus on definitions and frameworks. Yet there is a common understanding that health and quality of life are influenced by urban living conditions as well as lifestyles. Cities are facing great challenges in dealing with the urbanization and its consequences, such as increasing health inequities and the emergence and deterioration of slums and informal settlements; health inequities are observed within the city, from block to block and household to household. It is argued that the inequalities among individuals and cities are the result of local dynamics relating to economic, political, social and health conditions. The municipal level can act on these matters but effective intersectoral collaboration is needed.

This framework emerges from the following underlying assumptions:

[3] This framework was developed by the WHO Regional Office for the Americas (the Pan American Health Organization) – Ms Katia de Pinho Campos, Regional Adviser in Urban Health, based in Mexico.

1. Cities may impact positively or negatively on the health and quality of life of the population. We need to identify HOW (policies and programs), WHY (factors and conditions) and WHERE (neighbourhood, areas) in order to take effective action;
2. Health is not merely the absence of the disease. It is a positive and holistic concept that means a complete state of well-being, physical and mental health; therefore, a multisectorial approach is required.
3. The concepts represented in this framework are not new. The framework allows for putting together the evidence that is known, and organizing it in such a way that authorities, decision-makers, civil society, the community and the private sector can have a comprehensive picture of the dynamics of the city and understand what , why, where and how decisions are taken;
4. Local authorities may lack comprehensive yet localized diagnostics to make informed decisions and to monitor and evaluate actions;
5. This framework has been developed for the Americas Region and adaptations are necessary both within and outside the Region.

Figure 4 shows the framework presented for assessing the determinants of health and quality of life in urban settings[4].

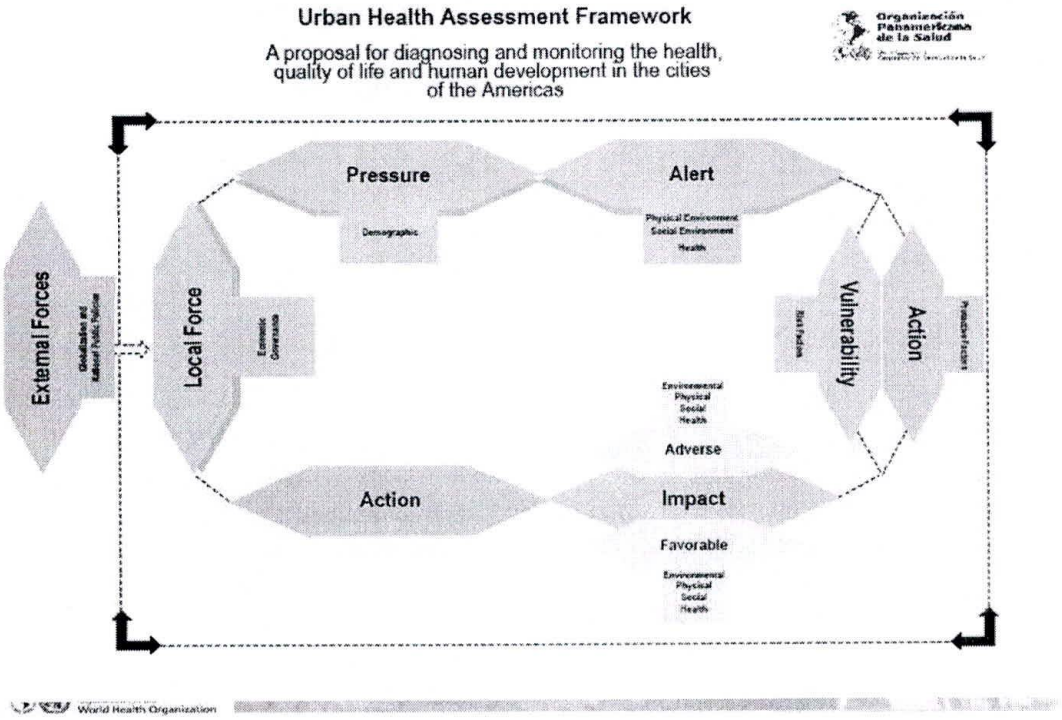


Figure 4: PAHO/WHO Urban Health Assessment Framework (A work in progress)

[4] See Annex 2 for explanation of the different factors: local force, pressure, alert, action/vulnerability, impact and action.

The ultimate purpose of the Urban Health Assessment Framework (UHF) is to provide reliable and comprehensive information for decision and policy makers, local governments and authorities, researchers, local communities, and public and private sectors. Functioning as a strategic framework, the UHF aims to effectively and appropriately identify and address strength, weakness, challenges and opportunities to improve the urban health conditions in cities.

The UHF is a considered as a work in progress. It consists of conditioning phases such as external forces, local forces, pressure, alert, action/vulnerability, impact and reaction. Each conditioning phase is represented by macro determinants of urban health such as demographic, economic, governance, social and physical environments as well as health. Each determinant is denoted by major factors according to its respective conditioning phase.

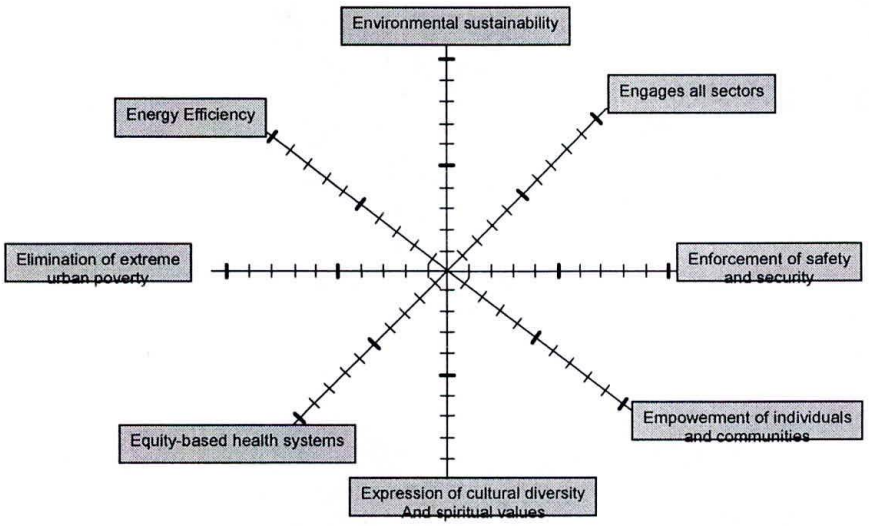
The framework starts with *external forces* represented by the effects of globalization and national policies that affect local decision-making and ultimately the health of people in the city. These external forces impact on *local forces*, represented by the economic and governance factors. These in turn exert pressure on the demographic pattern in the city, which provokes an alert situation in relation to various macro determinants such as the physical environment, the social environment and health. The outcomes of urbanization depend on the level of response and the actions taken. Yet if these actions are deficient or absent, the city might face a vulnerability condition, represented by the risk factors. This will eventually impact on the physical, social and health environments of the city and its population.

The Healthy Urbanization Spidergram – This simple, powerful tool has been developed based on WKC experience[5] as a mean to measure social perceptions about the eight elements of healthy urbanization. It can be appropriate for use at the municipal level to:

- understand "felt needs" of a group in relation to urbanization as a social determinant;
- define a baseline on social perception within groups from the same setting and to compare how one group feels about urbanization as a social determinant in relation to another;
- identify key areas for intervention based on subjective perceptions of lopsided development within an urban setting;
- have a basis for analyzing a social gradient in perceptions about the urbanization process;
- measure how group perceptions can be used as a variable that can be linked to health outcomes;
- Serve as a starting point for complementary quantitative measurement.

[5] *The Healthy Urbanization Project : Optimizing the impact of social determinants of health on exposed populations in urban settings*. Kobe, WHO Centre for Health Development, 2006.

Figure 5: Healthy Urbanization Spider Diagram



2.3.2 Demonstrating the applicability of strategies (Project Objective 2)

Action research – "Action research consists of … research methodologies which pursue action and research outcomes at the same time … It also has some characteristic differences from most other qualitative methods. Action research tends to be:

- cyclic -- similar steps tend to recur, in a similar sequence;
- participative -- the clients and informants are involved as partners, or at least active participants, in the research process;
- qualitative -- it deals more often with language than with numbers; and
- reflective -- critical reflection upon the process and outcomes are important parts of each cycle."[6]

Monitoring and evaluation – In relation to the Healthy Urbanization Field Research Sites, monitoring and evaluation is expected to have a distinct participatory flavor. "One of the negative connotations often associated with evaluation is that it is something done to people. One is evaluated. Participatory evaluation, in contrast, is a process controlled by the people in the program or community. It is something they

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[6] Dick, B. (2000) *A beginner's guide to action research* [On line]. http://www.scu.edu.au/schools/gcm/ar/arp/guide.html, accessed 2 June 2006.

undertake as a formal, reflective process for their own development and empowerment."[7]

2.3.3 Capacity building (Project Objective 3)

The capacity building component of the Healthy Urbanization Project provides a structure for implementation of activities at the healthy urbanization field research sites. In addition to training, activities may include action research projects, technical assistance, monitoring group learning, technology transfer, field visits and international exchange. The proposed capacity building component is composed of three modules on healthy urbanization. Participants are expected to carry out projects that will address social determinants of health using health promotion approaches and tools introduced during the didactic portion of the course. The programme is flexible, dynamic and can be adapted to local contexts by including appropriate training and capacity-building materials, methods and approaches that are most suited to local needs. It aims to enhance practical skills among teams across five categories (intra-personal qualities, interpersonal qualities, cognitive skills, communication skills and task-specific skills). Opportunities for cross-regional sharing and learning are also provided.

2.3.4 Policy advocacy (Project Objective 4)

Activities will be undertaken to ensure that new knowledge and good practices are linked and integrated with national health systems development and wider social and political processes. The project will create opportunities to advocate for healthy public policy and more responsive health systems, particularly in relation to:

- **Effective management of inter-sectoral collaboration to ensure maximum impact and the judicious use of limited resources for health;**
- **Decision-making that harmonizes competing interests to achieve the higher goal of health equity as a social good.**
- **Empowerment of communities to ensure:**
    - Identification of real problems and needs;
    - Judicious use of available resources;
    - Ownership and sustainability;
    - Timely action for improvement; and
    - Community-based management.

[7] M Patton. *Qualitative Evaluation Methods, (2nd ed).* 1990, p. 129.

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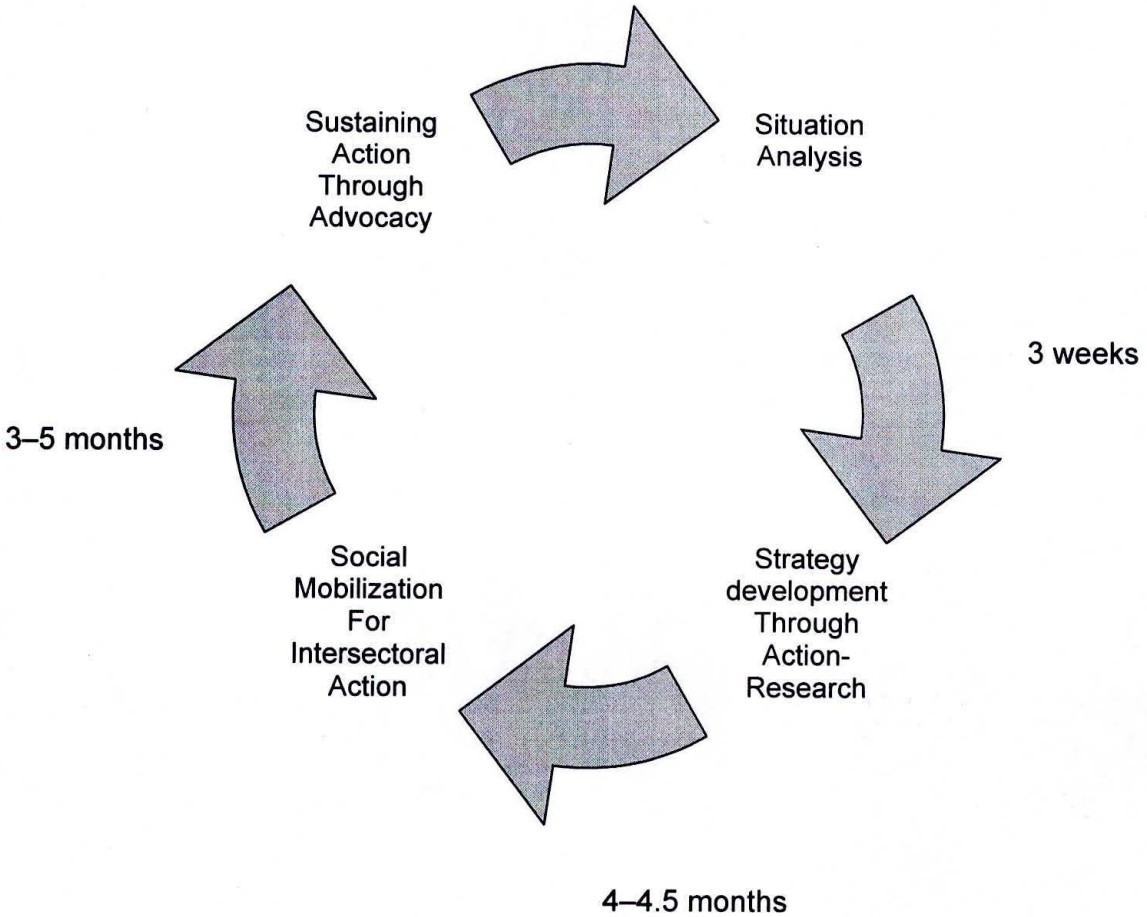
3.0 PROJECT IMPLEMENTATION

3.1 2006–2007 Timeframe



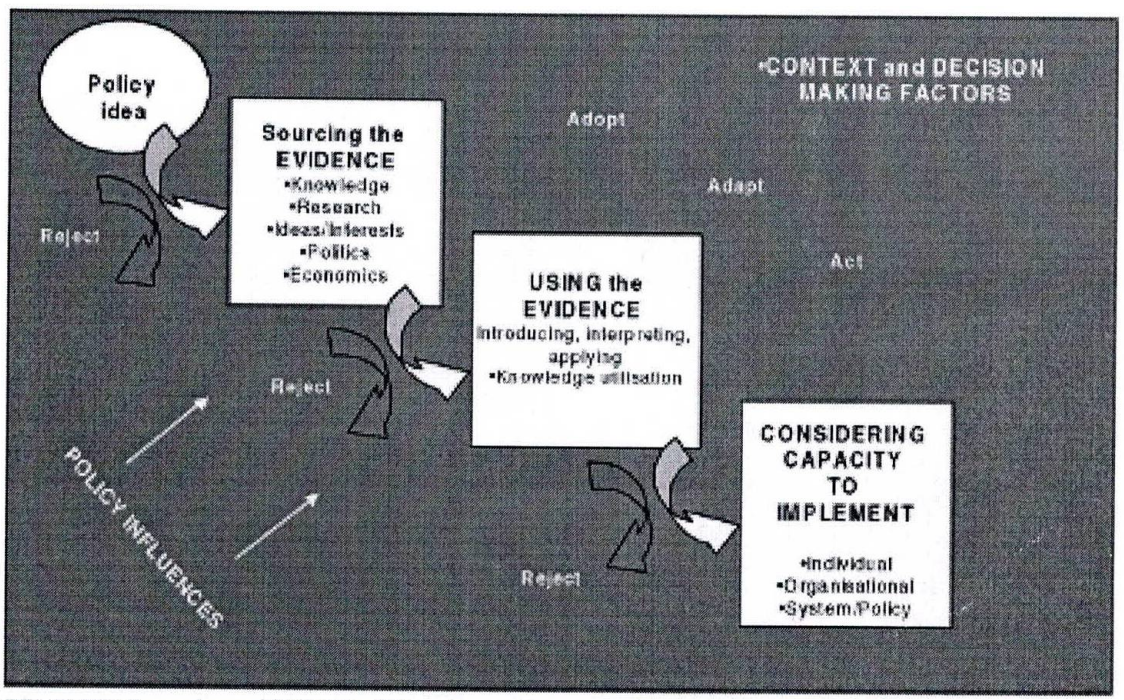
3.2 Capacity building modules

Capacity building in the ***Healthy Urbanization Project*** will be undertaken through the organization of "***Healthy Urbanization Learning Circles***".

Healthy Urbanization Learning Circles are networks of multi-sectoral and interdisciplinary teams that will undertake action research projects at the city level through a guided process that will introduce public health methodologies for action to improve governance, optimize the impact of social determinants and promote health equity in the urban settings.

Healthy Urbanization Learning Circles will use the "Evidence-Informed Policy and Practice Pathway[8] (see figure 6) as a model for influencing policy and practice throughout municipal decision-making processes. Policy ideas provide the starting point for the sourcing of evidence. Sources of evidence are multiple and varied. Using the evidence includes interpreting and applying knowledge in specific contexts. Capacity to implement is considered from the perspective of the individual, the organization and the system.

Figure 6: Evidence-Informed Policy and Practice Pathway



DOI: 10.1371/journal.pmed.0020166.g001

[8] Bowens, Zwi AB (2005). Pathways to "Evidence-Informed" Policy and Practice: A Framework for Actions. PLOS Med 2(7):e166

Healthy Urbanization Learning Circles will undertake capacity building activities over a 9–12-month period that is organized around four modules[9]:

- Module 1: Overview of Healthy Urbanization: Situation Analysis
- Module 2: Healthy Urbanization Challenges: Strategy Development and Project Proposal Writing
- Module 3: Healthy Urbanization Opportunities: Social Mobilization for Intersectoral Actions.
- Module 4: Mainstreaming Healthy Urbanization: Sustaining Action through Advocacy

Healthy Urbanization Learning Circles will be guided by the following principles:

- Emphasizing applied skills, not just theoretical knowledge;
- Training in a highly interactive manner, drawing on personal experience to reinforce team learning;
- Encouraging strategic thinking in the promotion of healthy urbanization;
- Emphasizing the use of good governance principles in decision-making;
- Using action research projects to reinforce classroom learning, multiply training benefits and generate results;
- Providing opportunities for mentoring and technical support through national and international networking; and
- Soliciting feedback as a means of improving the learning process.

General criteria for participants in the ***Healthy Urbanization Learning Circles*** are provided as preliminary guidance, but local groups are strongly encouraged to develop appropriate criteria to meet the needs of the sites. It is proposed that participants are:

- Recognized as having a commitment to the improvement of health in the city;
- Known to value social justice and equity;
- Respected as influential members of the community;
- Engaged in work that promotes positive social values;
- Highly motivated and will exercise leadership in their sphere of influence;
- Representatives of different gender and sectors who are stakeholders in social determinants of health.

[9] The curriculum and training materials of the Healthy Urbanization Learning Circles will include materials that have been developed and tested through "Prolead", a health promotion leadership training template that was initiated at the WHO Western Pacific Regional Office in 2002 and was further expanded by the WHO Centre for Health Development in collaboration with the Regional offices of the Eastern Mediterranean Region and the Southeast Asian Region.

3.3 Advocacy and the future

Healthy Urbanization builds on a wide range of health and development initiatives that link health to broad determinants that are social, political, cultural and political as shown in the Figure 7. The project hopes to advance the agenda of Healthy Cities, strengthen the health equity perspective in cities and municipalities and create a critical mass of urban stakeholders who are better prepared to promote health in a rapidly urbanizing and globalized world.

In March 2005, the Director-General launched the WHO Commission on Social Determinants of Health. Over the next two years, the work of the Commission will be supported by a number of Knowledge Networks that focus on various social determinants-related themes. In this regard, the WHO Centre for Health Development has been selected as the hub of the Knowledge Network on Urban Settings (KNUS). The work of the KNUS has been made an integral part of the Healthy Urbanization Project in 2006–2007. The focus of the KNUS' work lies at the heart of promoting health equity in urban settings, particularly among exposed populations. This work will inform and enhance on-going activity in the Healthy Urbanization Field Research Sites, as well as the related work of identifying, assessing, adapting and developing tools and models to influence health governance decision-making in ways that promote health equity. Correspondingly, the action research carried out in the Healthy Urbanization Field Research Sites will inform the work of the KNUS, providing examples and relevant experience aimed at influencing social determinants of health to promote health equity. The Sites will also serve to directly connect selected KNUS members to key urban settings as a possible mechanism for enriching the related thematic papers that are being developed for the Commission on Social Determinants of Health.

3.4 Allocation of funds

Funding in the amount of about US$ 114 500 for each Healthy Urbanization Field Research Site will be available from the budget of the WHO Centre for Health Development. An indicative allocation of these funds is shown in Table 4. It is also expected that some in-kind support will be provided by the local project stakeholders. In addition, Local Project Steering Committees are encouraged to mobilize funds from other sources and partners with shared local interests.

Managing the release of funds

WKC will issue a "HQ Fund Authorization to Charge" for the funds agreed in the budget for the implementation of each Healthy Urbanization Field Research Site. This authorization will be issued from WHO/HQ Geneva to the WHO Country Representative (WR) through the Regional Office. The authorization of funds will not necessarily be for the full budgeted amount but divided into appropriate portions. As the amounts will exceed US$20 000, only the Allotments and AMS codes will be provided and the WR will be responsible for the creation of obligating documents (APWs and Internal

communication) and issuance of sticker numbers in accordance with WHO procedures. Disbursal of funds will follow normal WHO procedures applicable in each Country Office. A copy of all obligation documents must be provided to WKC as soon as approved.

Table 4: Resource allocation for each Healthy Urbanization Field Research Site in 2006–2007

BUDGET ITEM	**BUDGET AMOUNT (US$)**
Recruitment of Local Project Research Coordinator (18 months)	54000
Team research projects (APW) X 1,500/team	10 500 [10]
Supplies and equipment	8 000 [11]
Local costs and social mobilization	5000 [12]
Capacity building	30 000 [13]
WKC Country Team Advisers	00 [14]
Agreements for Performance of Work	4000 [15]
ESTIS websites	In collaboration with UNEP
Project Scoping Paper	3000 [16]

[10] It is estimated that site research teams will be comprised of about 3-4 members each and that there will be about 4-6 teams per site. It is recognized that this may vary somewhat from site to site depending on local circumstances.

[11] To support the establishment of a local project office (located in the WHO Country Representative's offices where possible).

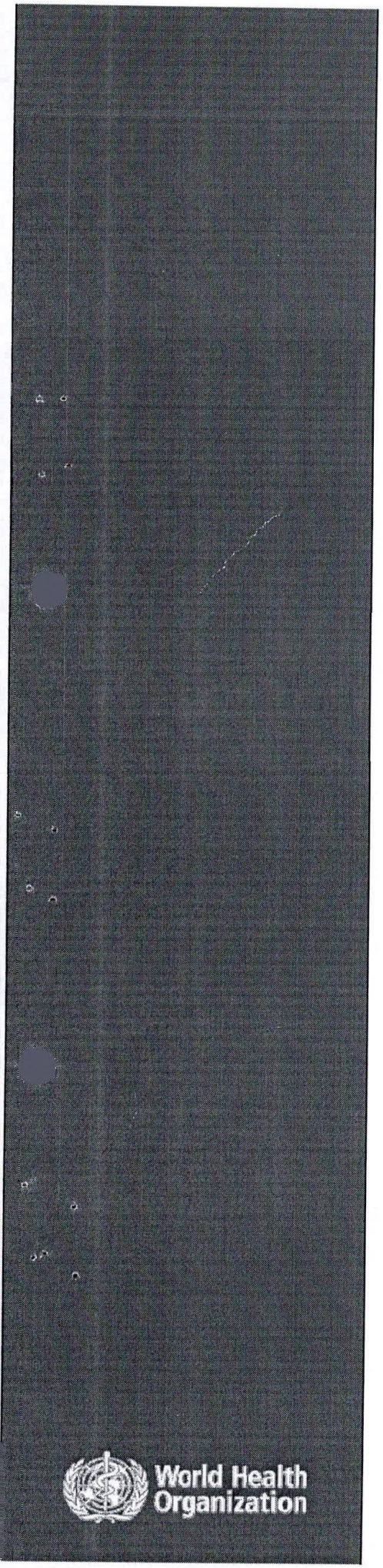
[12] For communications costs, videoconferences, meetings, etc.

[13] This estimate is based on three training sessions over the course of the project. The participants in these sessions will be the research teams. As indicated in Footnote 15, this will involve about 20 or so participants per Site.

[14] A WKC Country Team Adviser(s) will visit the site about three times. Interim communications and advisory services will also be provided.

[15] Local contract(s) to support project work.

[16] Local contract(s) to support project work.



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Project management

World Health
Organization

4.0 PROJECT MANAGEMENT

4.1 Management and support structure

The general relationship between the various levels of project management is depicted in Figure 6.

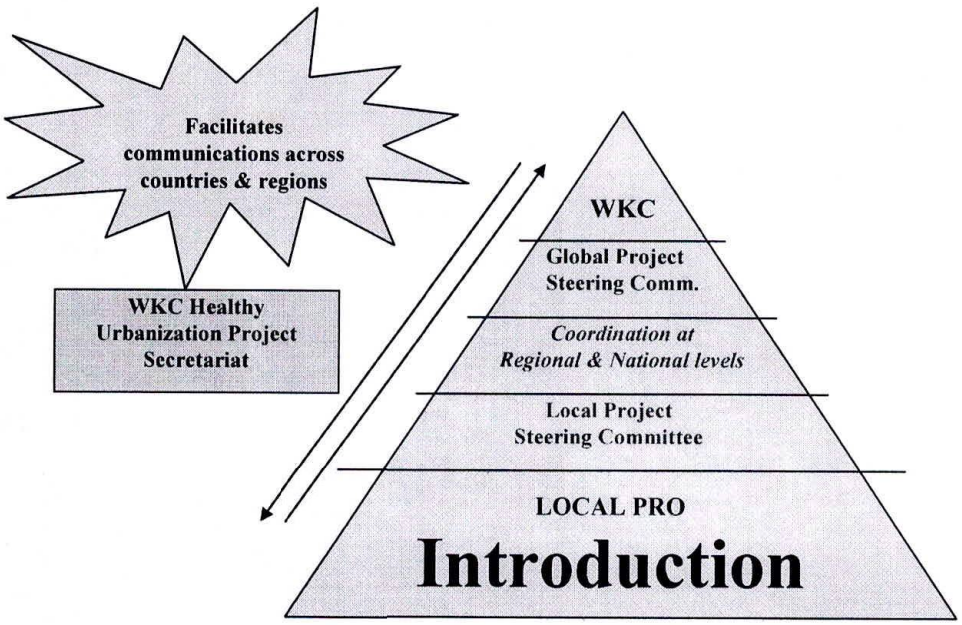


Figure 6: The general relationship between levels of project stakeholders

The Terms of Reference and composition of the WKC Healthy Urbanization Project Secretariat, the Global Project Steering Committee and the Local Project Steering Committee are shown in Tables 5.

Table 5: Membership and responsibilities of committees and teams

COMMITTEE/TEAM	MEMBERSHIP	TERMS OF REFERENCE
WKC Healthy Urbanization Project Secretariat	1. Director, WHO Kobe Centre 2. Team Leader, Urbanization and Health Equity 3. Technical Officer, Health Governance Research 4. Technical Officer, Best Practice Research 5. Technical Officer, Knowledge Management 6. Technical Officer, Policy Advocacy 7. WKC Country Team Advisers to the Healthy Urbanization Field Research Site projects 8. Responsible Officer, Information and Communications Support 9. Administrative Officer	1. Oversee project implementation 2. Develop technical, organizational, political and financial guidelines for project implementation 3. Raise and manage human and financial resources for the project. 4. Undertake planning processes related to further development and implementation of the project. 5. Coordinate activities between the WHO Kobe Centre, the WHO Regional Offices (and Country Offices, as appropriate), the Healthy Urbanization Field Research Sites and local project teams. 6. Engage partners in collaborative research and capacity-building activities. 7. Document processes and activities, and 8. Assess, monitor and evaluate the project.
Global Project Steering Committee	1. The WHO Regional Advisers designated as Healthy Urbanization Project Focal Points 2. The WHO Country Representatives from countries with Healthy Urbanization Field Research Sites 3. The City Focal Points from Research Sites 4. The Local Project Research Coordinators	1. Provide leadership and strategic guidance to the development of the Healthy Urbanization Project. 2. Create opportunities for sharing of research results and lessons learned among the Healthy Urbanization Field Research Sites.

Table 5: Membership and responsibilities of committees and teams (Cont'd)

COMMITTEE/TEAM	MEMBERSHIP	TERMS OF REFERENCE
Global Project Steering Committee (Cont'd)	5. Members of the WKC Healthy Urbanization Project Secretariat	3. Provide leadership and strategic guidance to the development & implementation of the Healthy Urbanization Project. 4. Create opportunities for & facilitate the sharing of research results and lessons learned among the Healthy Urbanization Field Research Sites. 5. Critically assess the work and financial plans for the Healthy Urbanization Field Research Sites. 6. Explore global and regional opportunities to enhance the work of the Healthy Urbanization Project, and 7. Agree on common inputs, targets and indicators for monitoring, assessment and evaluation of projects and outcomes of the Healthy Urbanization Field Research Sites. 8. Review and enrich the implementation guidelines as prepared by the Healthy Urbanization Project Secretariat, particularly in relation to Healthy Urbanization Field Research Sites

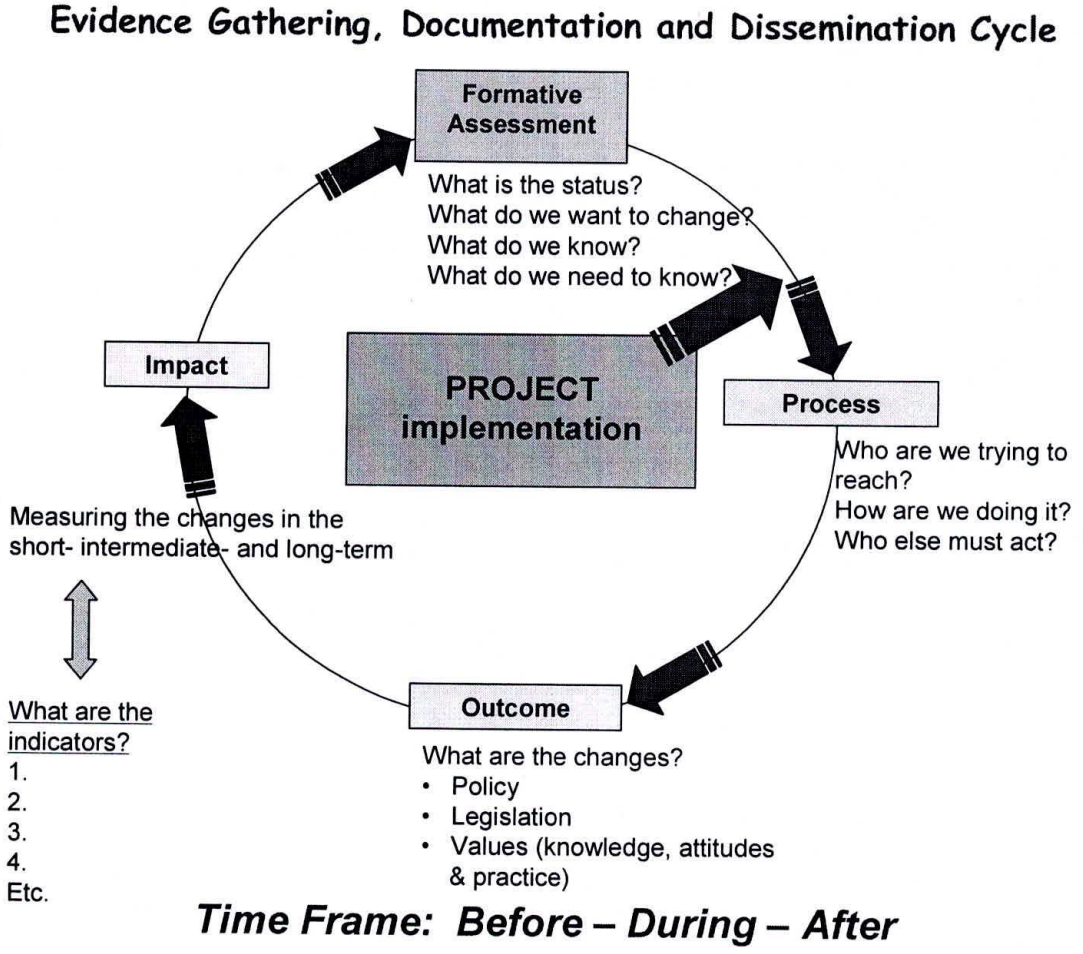
Table 5: Membership and responsibilities of committees and teams (Cont'd)

COMMITTEE/TEAM	MEMBERSHIP	TERMS OF REFERENCE
Local Project Steering Committee	1. Designated WKC Healthy Urbanization Project Secretariat Focal Point 2. WHO Regional Adviser designated as Healthy Urbanization Project Focal Point 3. WHO Country office focal point 4. Local Research Project Coordinator 5. WKC Country Team Adviser 6. Ministry of Health Focal Point for the WKC Healthy Urbanization Project 7. The City Focal Point 8. Other local stakeholders as the Committee may deem appropriate	1. Ensure timely implementation of the local project action plans. 2. Explore other sources of funding and resources to enhance project implementation. 3. Assess and report on project outcomes to the Global Project Steering Committee and the WKC Healthy Urbanization Project Secretariat, as appropriate. 4. Engage local academic and other institutional partners to participate in the project as required. 5. Oversee implementation of the local projects. 6. Collaborate with local stakeholders in development of detailed work and financial plans for the Healthy Urbanization Field Research Site. 7. Prepare project activity and implementation plan reports as required. 8. Mobilize local and national stakeholders to support the project.

4.2 *Monitoring, evaluation and reporting*

Monitoring, assessment and evaluation in relation to the local projects will be approached from a co-learning perspective, mindful of the "learning-by-doing" philosophy that underpins project implementation. From this perspective, judgment is suspended as we jointly learn, with our partners, how to improve health and reduce health inequity, particularly among exposed populations. In this process, the timely gathering, documentation and dissemination of information is critical – before, during and after the project (Figure 7).

Figure 7: Process, Outcome and Impact framework for the Healthy Urbanization Learning Circles.[17]



[17] Dr. Davison Munodawafa, Regional Adviser for Health Promotion & Education, WHO Regional Office for South-East Asia, June 2006.

Reporting

In general, it is expected that report authors will discuss major findings and conclusions of all reports with the Local Project Team Leader, the City Focal Point and the Country Focal Point at the time of their submittal. Copies of all reports will be provided to the Regional Focal Points.

- Country Team Adviser – An initial assessment report to the Project Steering Committee and the Team Leader, Urbanization and Health Equity, based on the first Site visit; a progress report based on the second Site visit (format included as Annex 3); and an end-of-project evaluation report following the third Site visit (format included as Annex 4).

- Local Project Research Coordinator – The Local Project Research Coordinator will submit short quarterly progress reports, through the WHO Country Representative, with copies to the Regional Focal Points, to the Team Leader, Urbanization and Health Equity (format included as Annex 5).

- Local Project Team – A bi-annual (June and December) progress report, including assessment and evaluation components, to the Project Steering Committee, through the WHO Country Representative, on project implementation, and an end-of-project evaluation report (formats included as Annex 6 and Annex 7 respectively).

- Team Leader, Urbanization and Health Equity, WKC – Based on the above submissions, the Team Leader will prepare an overall Healthy Urbanization Project Evaluation Report for the Director, WKC, and relevant Healthy Urbanization Project stakeholders.

- WHO Country Representative (WR) - The WR, with the assistance of the Local Project Research Coordinator, will be responsible for providing WKC with necessary financial reports on the funds obligated and disbursed on regular basis as per agreed on each sites.

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Annex 1: Terms and concepts

A common understanding of a number of terms and concepts is important to the successful implementation of the Healthy Urbanization Project and effective cross-cultural communications about its components. Among others, these include the following:

- **Social determinants** - Broadly defined as "the causes behind the causes" of poor health outcomes as they relate to both social and environmental consequences of human actions. The "causes behind the causes" of poor health outcomes are often social in nature and include housing, education, employment conditions, access to transportation, access to health care and early childcare. These in turn are driven by structural determinants such as gender, age, socioeconomic status, ethnicity and belief systems and faltering social support systems that underpin family and community life. These are the outcomes of the wider economic and political structures and systems such as globalization and rapid, unplanned urbanization that influence social and community networks as well as well as individual lifestyle factors.

- **Governance** - Governance is defined as the management of the course of events in a system.[18] In relation to health, it can be seen as the process of allocating health resources and promoting, protecting and expanding health assets. The power to decide how health resources and assets are allocated may rest in multiple 'nodal' systems. There is a wide array of state, (national, regional and local) and non-state (civil society, non-profit organizations, media, business and industry) players that influence health governance.

- **Exposed populations** – This term refers to a population at risk of unfavorable social conditions over a designated period of time in a specific geographical area.

- **Health equity** – "...equity in health can be defined as the absence of disparities in health (and in its key social determinants) that are systematically associated with social advantage/disadvantage... Equity in health means equal opportunity to be healthy, for all population groups. Equity in health thus implies that resources are distributed and processes are designed in ways most likely to move toward equalizing the health outcomes of disadvantaged social groups with the outcomes of their more advantaged counterparts." [19]

- **Urbanization** – is defined as "the social process whereby cities grow and societies become more urban". Different countries have different definitions of what a city, a town or an "urban area" is using parameters such as density or population size. 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 slums and informal

[18] Burris S (2004). Governance, microgovernance and health. *Temple Law review*. 77: 335-358
[19] Braveman and Gruskin, http://jech.bmjjournals.com/cgi/content/full/57/4/254, accessed 1 June 2006.

settlements and the effect on the urban economy; and, 3) the proliferation of informal settlements and their impact on the urban environment and the environment's impact on slums and informal settlements. Combined, these conditions give rise to settings characterized by a radical process of change with positive and negative effects, increased inequity, greater environmental impacts, expanding metropolitan areas and fast-growing slums and informal settlements.

- **Millennium Development Goals (MDGs)** – "The eight Millennium Development Goals (MDGs) … form a blueprint agreed to by all the world's countries and all the world's leading development institutions. They have galvanized unprecedented efforts to meet the needs of the world's poorest."[20]

  1. Eradicate extreme poverty and hunger.
  2. Achieve universal primary education.
  3. Promote gender equality and empower women.
  4. Reduce child mortality.
  5. Improve maternal health.
  6. Combat HIV/AIDS, malaria and other diseases.
  7. Ensure environmental sustainability.
  8. Develop a global partnership for development.

- **Optimizing impacts** – How people interact with their social and physical environments results in pressures, changing status of health and quality of life and exposure to positive and negative factors that have a direct impact on health. In the context of the Healthy Urbanization Project, "optimizing impacts" of social determinants refers to modifying the way in which people interact with their social and physical environments to achieve optimum health outcomes.

[20] http://www.un.org/millenniumgoals/, accessed 1 June 2006.

Annex 2: Site-specific project details

San Joaquin, Santiago, Chile

The main health problems noted are mistreatment of children, ageing, obesity, poor housing conditions, tobacco, alcohol and a poverty-drugs cycle, mental health disorders, pollution and a growing sense of insecurity. This had led to inequities in areas such as education and gender, as well as inter-generational inequities. Despite these, the scoping paper noted certain opportunities that could be further explored. These opportunities are related to strengthening the demand side of governance and services, and include political will and stability, effective participation by all relevant stakeholders, including children, which is shown by the recent initiatives of an effective life skills program for children and participatory budgeting and planning that has happened in 10 municipalities in the health sector. In addition there are both national and local programs to promote these initiatives. For social inequities to diminish there must be effective and sustainable intersectoral collaboration.

Suzhou City, China

TO BE ADDED

Bangalore, India

Bangalore has adopted the healthy cities approach and identified six main intervention areas:

1) Access to quality health care – especially urban poor;
2) Safe water supply & proper sanitation;
3) More organized disposal of waste (collection, segregation & transportation);
4) Ample public parks & play areas;
5) Safe roads & safe transportation; and
6) Freedom from crime, violence and drugs.

The six issues are being addressed through environmental health interventions, preventive health measures, health promotion approaches, education and training. These initiatives are proving successful and are being implemented using an intersectoral and participatory approach. However, there are still major challenges such as solid waste management which consumes the majority of the budget, and HIV/AIDS with its highest prevalence among the working class.

Hyogo Prefecture-Kobe City, Japan

This paper directly contextualised four major identified social determinants of health.

1) Eating environment with a focus on children and the elderly,
2) Ageing of people displaced by disasters,
3) Working environment, and
4) Social support for parenting.

For each social determinant of health, relevant stakeholders and actions underway or proposed to remedy these problems were identified and the final conclusion was that more attention needs to be given to exposed population sub-groups based on evidence emerging from the health sector on health disparities as well as to strengthening intersectoral collaboration between stakeholders.

Annex 3: Description of factors of the Healthy Urbanization Framework

External Forces						
Globalization and National Public Policies		**Alert**	**Action**		**Impact**	
Local Force	**Pressure**	**Physical Environment**	**Protective factors**	**Vulnerability Risk factors**	**Adverse**	**Favorable:**
Economic: 1.GDP 2.Income distribution 3.Employ,ment by Industry 4.Government revenue and expenditure	**Demographic:** Migration Immigration Sub-urbanization Urbanization Population density Dependent population Ethnicity Age and sex Gender Culture Religion Fertility Rate Age structure	Housing deficit Unsafe housing Vehicular fleet Use and condition of public transportation Access to potable water and basic sanitation Energy consumption Poor green and recreational spaces Polluted industries	**Environment:** Land use and soil protection Emergency disaster preparedness Environmental literacy	**Environmental:** Water, air and soil contamination	**Environmental:** Disasters Polluted urban run-off and storm Water runoff	**Environmental:** Clean water, air and soil Available green and recreational spaces Clean industries
Governance Type of		**Social Environment:**	**Physical:** Land-use	**Physical:** Noise exposure	**Physical:** Urban slums and	**Physical:** Traffic safety

[21] Elderly, women, children, disabled and chronically ill.

External Forces						
Globalization and National Public Policies		**Alert**	**Action**		**Impact**	
Local Force	**Pressure**	**Physical Environment**	**Protective factors**	**Vulnerability Risk factors**	**Adverse**	**Favorable:**
government Citizen's perception of political will Community Participation in public policies Community perception of the use of public resources Corruption perception Index Qualities of public policies Level of intersectoral collaboration of public policies		Unemployment Poor solidarity and thrust High rates of community transition Segregation Discrimination Vulnerable groups[21] Informal jobs Number of schools Enrolment in early child care and education Enrolment in primary and secondary education Out-of-school children Distance house to school Teaching staff in primary and	planning Traffic signs Traffic laws Safe housing	Mobility	informal settlements Vehicular traffic	Healthy housing

External Forces						
Globalization and National Public Policies		**Alert**	**Action**		**Impact**	
Local Force	**Pressure**	**Physical Environment**	**Protective factors**	**Vulnerability Risk factors**	**Adverse**	**Favorable:**
		secondary education Trained teachers				
		Health: Urban un-insured Access and quality of primary, secondary and tertiary care Emergency care Number of health professionals per inhabitant Morbidity Food security	**Social:** NGOs and community councils Participatory programs Partnership between public and private sectors[22] Community support programs[23] Family and community support Policy	**Social:** Poor job condition Drop-outs Primary and secondary school completion rates	**Social:** Violence[24] Child labor Poverty Education[25] Inequality[26] Human Development Index	**Social:** Healthy schools Safety well-being High social capital Tertiary education completed Reduction of urban poverty High HDI Personal satisfaction Expectation of future growth

[22] This partnership can be expanded to cover civil society, community and educational institutions.
[23] Jobs, food security and education.
[24] Theft, kidnapping, domestic violence, abuse of elderly, women and children.
[25] Literacy, and school completion rates (primary, secondary and tertiary).
[26] Social and income.

External Forces						
Globalization and National Public Policies		**Alert**	**Action**		**Impact**	
Local Force	**Pressure**	**Physical Environment**	**Protective factors**	**Vulnerability Risk factors**	**Adverse**	**Favorable:**
			enforcement			
			Health: Health literacy Preventative health services and programs Immunization	**Health:** Unsafe sexual behavior Teenage pregnancy Substance and alcohol abuse Tobacco use Lack of exercise Diet Health inequalities	**Health:** Mortality rates Malnutrition External causes Infant and maternal mortality	**Health:** Equity in health Healthy life expectancy Healthy life style

Annex 4: Proposed Template for Planning

Agreed Objective:

No.	Objective	Who	Target/Indicator	Budget	Expenses	Balance	Q1	Q2	Q3	Q4	Critical Assumption/ Comments
1.	*Output 1*										
	Activities										
1.1											
1.2											
1.3											
1.4											
1.5											
2	*Output 2*										
2.1	Activities										
2.2											
2.3											
2.4											
2.5											
	Output 3										
3.1	Activities										
3.2											
3.3											
3.4											
3.5											

Annex 5: Proposed Template for reporting – First visit (Country Team Adviser)

Initial Assessment Report:

Contents

Annexes:

Annex 6: Proposed Template for reporting – Third visit (Country Team Adviser)

Evaluation report:

Annex 7: Proposed Template for reporting – Quarterly Progress Report (Local Coordinator)

Heading:

Date:

To: Team Leader, Urbanization and Health Equity

Through: the WHO Country representative

Copy: Regional Focal Point (Name and position)

Name and position of the writer

Progress Report: Healthy Urbanization Project, Country: _____

Report No.

---

1. Purpose Statement:

2. Background:

3. Work Completed:

4. Strengths, Weaknesses, Opportunities, Constraints and Challenges:

5. Planned Next Work Scheduled:

(Specify the dates of the next segment of time in the project and line out a schedule of the work you expect to get accomplished during the period. It is often a good idea to arrange this section by dates which stand for deadlines. To finish the progress report, you might add a sentence evaluating your progress thus far).

Annex 8: Proposed Template for reporting – Bi-annual Progress Report (Local Project Team)

Heading:

Date:

To: Project Steering Committee

Through: the WHO Country representative

Copy: Regional Focal Point (Name and position)

Name and position of the writer

Progress Report: Healthy Urbanization Project, Country: _____

Report No.

---

1. Purpose Statement:

2. Background:

3. Work Completed:

4. Strengths, Weaknesses, Opportunities, Constraints and Challenges:

5. Conclusion:

5. Recommendation:

Annex 9: Format for reporting – End-of-Project Evaluation Report (Local Project Team)

Project Title

1. Executive Summary

2. List of Abbreviations

3. Introduction and Background

4. Country context

5. The 8 Healthy Urbanization components

6. Preconditions and Benchmarks

7. Programme Achievements

8. Programme review and summary of progress

9. Lessons Learned
    - 9.1 General Context
    - 9.2 Design and Formulation
    - 9.3 Stakeholders
    - 9.4 Selected activities

10. Conclusion
11. Recommendation
12. List of reference

Annex 10: "Terms of Reference" for Country Team Adviser

Scope and Purpose
for
Country Team Adviser, _____

Background

In consultation with its Kobe Group partners, WHO recently completed a two-year transformation of the WHO Centre for Health Development, resulting in an agreed vision of "Healthier People in Healthier Environments". The main operational feature of this vision is action research aimed at improving health and promoting health equity in urban settings in the face of rapid urbanization. The Centre's Healthy Urbanization Project (HUP) for 2006-2015, *Healthy Urbanization: Optimizing the impact of social determinants of health on exposed populations in urban settings*, takes a collaborative approach that informs and enhances WHO regional and country efforts to support Member States. The Healthy Urbanization Project confronts health equity issues by developing an evidence base of effective strategies and interventions; demonstrating the applicability of these strategies in various settings, and building public health leadership capacity to promote health equity through governance and policy interventions. In collaboration with WHO regional and country offices, the HUP is engaging six field research sites in 2006-2007: Santiago, Chile; Bangalore, India; Kobe, Japan and Suzhou, China. Additional sites are expected to be included in late 2006 and 2007.

Scoping papers have been prepared at each site. Three such papers have already been written and were presented at the Healthy Urbanization Project Steering Committee meeting held in Kobe from 30 May to 2 June 2006. The HUP is embarking on a capacity-building and leadership project which will involve major stakeholders from each selected site.

Country description: _____

Objective

Under the general guidance of the Team Leader, Urbanization and Health Equity (UHE), and under the direct supervision of the WKC focal point, the Country Team Adviser in close collaboration with WHO Country Representative and city focal point, will support and guide the design, implementation, evaluation and documentation process of the Healthy Urbanization Project in the municipality of _____.

Outputs

- Technical advice provided to the WKC team (the Team Leader and WKC focal point in particular) on international experiences (e.g. best practices, examples of local policy initiatives, opportunities for networking) that may be applicable to the Healthy Urbanization Field Research Site during the conduct of the different training modules;

- Technical support through the identification of strategies and opportunities for linking local action to national, regional and global initiatives, as well as WHO and other UN initiatives, that could facilitate greater international exchange and collaboration;
- Progress reports on the issues, challenges and opportunities for improving; implementation of activities of the local Healthy Urbanization Learning Circle after each training module;
- A final report (20-25 pages) for the WHO Kobe Centre with the following format:
  1. Summary of the project including a brief description of the outcome of project activities
     (4-5 pages)
  2. National context and opportunities for linking local action to national policy and action
     (3-4 pages)
  3. Opportunities for synergy with current WHO country and regional programmes as well as the work of other agencies in the country (3-4 pages)
  4. Lessons learned (5-6 pages)
  5. Implications and key recommendations toward the development of a global platform for action on Healthy Urbanization (5-6 pages)

Scope of work

- Assisting in the identification of best practice examples that are relevant to the training programme for the Healthy Urbanization Learning Circle;
- Ensuring that governance issues are highlighted in projects and interventions;
- Mentoring the WKC focal point and participants of the Healthy Urbanization Learning Circle;
- Providing insight and recommendations on the conduct of local training activities;
- Acting as a resource person on technical matters and areas of expertise for the site as well as other Healthy Urbanization Field Research Sites;
- Preparation of progress and end of project reports;
- Performing other duties from time-to-time as agreed by the Director, WHO Kobe Centre, the Team Leader and the WKC focal point.

In addition to the tasks related to the research sites the Country Team Adviser is expected to:

- Promote the Healthy Urbanization Project among key stakeholders;
- Prepare for and participate in the meeting of the Global Project Steering Committee;
- Distill what is of true international value and provide feedback to KNUS on best practices and potential membership in the Breakthrough Circle.

Timing and reporting

The Country Team Adviser will perform the work and be contracted on ad hoc basis between September 2006 and December 2007, a total of 16 months. For each designated assignment the Country Team Adviser will be issued with a specific task and output sheet for the specific project period. The Country Team Adviser is expected to submit a soft copy and three hard copies of the final report together with any photographs taken in accordance with the standard operating procedures required from the funding mechanism undertaken. The final report shall be delivered not later than three weeks after the completion of the last assignment.

Personal Qualifications

- Advanced University Degree (Master's Degree or equivalent) in health or related fields.
- Minimum 10 years of work experience in implementing health projects.
- Minimum of 5 years of experience in doing social science research.
- Excellent skills in written and oral English and the language spoken at the Healthy Urbanization Field Research Site.
- Excellent writing skills.
- Strong capacity to relate to and interact with a large number of actors at regional, national and local levels.

Duration of Assignment

The Healthy Urbanization Field Research Country Team Adviser for _____ is engaged on an ad hoc basis from September 2006 until December 2007. Separate contracts with specific terms of reference will be prepared for each period.

Submission of Reports to WKC

The Country Team Adviser is expected to submit three hard copies of the report together with any photographs taken at the site(s) and soft copies upon completion of each assignment in accordance with the standard operating procedures required from the funding mechanism undertaken.

Specific Terms of Reference for Country Team Adviser's first visit to _____
Date: _____

Reference is made to the agreement during the Steering Committee Meeting for the Healthy Urbanization Project (former Core Project) held in Kobe from 30 May to 2 June 2006. It was agreed that Country Team Advisers would be assigned to assist the

WKC focal point person at each of the four research sites. This person is expected to accompany and backstop the WKC focal point for the leadership capacity building course (Healthy Urbanization Learning Circles – HULC) over each of the four modules. The first visit by the Country Team Adviser to _____ is expected to take place from _____ to _____, during which period the following are planned for the organization and implementation of activities of the Healthy Urbanization Learning Circle (HULC):

1. consult with national counterparts and the Ministry of Health and other line agencies to discuss linking local action and results of local research to national policy;
2. develop and formulate a framework for all team sites on integrating health equity in health sector reform policy at national level with specific suggestions per site for Chile, China, India and Japan;
3. provide technical advice to the WKC (Team Leader for the Urbanization and Health Equity and the focal point in particular) on international experiences (e.g. best practices, examples of local policy initiatives, opportunities for networking) that may be applicable to the Health Urbanization Field Research Site during the conduct of the different training modules;
4. manage technical support through the identification of strategies and opportunities for linking local action to national, regional and local initiatives, as well as WHO and other UN initiatives, that could facilitate greater international exchange and collaboration;
5. submit progress reports on the issues, challenges and opportunities for improvement; implement activities of the local HULC after each training module; and
6. undertake other tasks as assigned.

Annex 11: "Terms of Reference" for Local Coordinator

Background

In consultation with its Kobe Group partners, WHO recently completed a two-year transformation of the WHO Centre for Health Development, resulting in an agreed vision of: "Healthier People in Healthier Environments". The main operational feature of this vision is action research aimed at improving health and promoting health equity in urban settings in the face of rapid urbanization. The Centre's core project for 2006-2015, *Healthy Urbanization: Optimizing the impact of social determinants of health on exposed populations in urban settings*, is taking a collaborative approach that informs and enhances WHO regional and country efforts to support Member States. The project confronts health equity issues by developing an evidence base of effective strategies and interventions; demonstrating the applicability of these strategies in various settings; and building public health leadership capacity to promote health equity through governance and policy interventions. In collaboration with WHO Regional and Country Offices, the Healthy Urbanization Project (HUP) is engaging four field research sites in 2006-2007: Santiago, Chile; Bangalore, India; Kobe, Japan; and Suzhou, China. Two additional sites are being negotiated with WHO AFRO and WHO EMRO. Scoping papers are first prepared at each site. Three such papers have already been written and were presented at the Healthy Urbanization Project Steering Committee meeting held in Kobe from 30 May to 2 June 2006. The HUP involves a capacity building and leadership project which will involve major stakeholders from each selected site.

Country specific description: _____

Objective

Under the general guidance and direction of the Team Leader, Urbanization and Health Equity (UHE), WHO Kobe Centre and the supervision of the WHO Country Representative, the Healthy Urbanization Field Research Site (HUFRS) Local Coordinator will coordinate, facilitate and undertake action research in _____.

Outputs

- facilitation of the Healthy Urbanization Learning Circle (HULC);
- well-executed action research in _____ (see workplan);
- quarterly progress reports in English describing both technical and administrative progress and shortcomings;
- one final report in English which will include background information, objectives, research design, data collection methods and tools, data analysis, research results and recommendations for further actions;
- effective intersectoral collaboration between relevant stakeholders in _____ (see workplan);
- effective and efficient project management and administrative systems (see workplan).

Scope of work

The work shall comprise but not necessarily be limited to:

- Coordinate and undertake research on health inequity at the field research sites;
- Support, facilitate and help coordinate HUP-related activities with the WKC-designated focal point;
- Set up, maintain and promote the use of communication systems and mechanisms that facilitate clear and timely dialogue among key stakeholders;
- Coordinate project work with other relevant organizations, groups and individuals having shared interests in urbanization and health equity issues;
- Represent the WHO Kobe Centre at local and national meetings as required;
- Develop and foster a team approach to the work of the project;
- Assist in the translation of documents and text;
- Provide general administrative (including that of obtaining necessary clearances) and logistical support to the project; and
- Perform any other duties that arise from the implementation of HULC as agreed with the WHO Country Representative and the focal point of the HUFRS;

Local Coordinator will also

- be responsible for updating the ESTIS website for HULC projects
- coordinate the selection process of HULC participants
- review any translations
- coordinate with the designated local contractual partner undertaking the capacity-building project

Timing and reporting

The Healthy Urbanization Field Research Site Local Coordinator will perform the work and be employed between 1 September 2006 and 31 December 2007, a total of 16 months. The final report shall be delivered by the end of the contract.

Personal Qualifications

- Advanced University Degree (Master's Degree or equivalent) in health or related fields.
- Minimum 3 years of work experience in participatory social science research.
- Excellent skills in written and oral English and the language spoken at the urban health field research site.
- Excellent writing skills.
- Strong capacity to relate to and interact with a large number of actors at regional, national and local levels.

Compensation

The level remuneration of the Local Coordinator should be determined according to local market conditions in _____. The type of contractual arrangement should be determined locally according to needs. The total cost of the contract should not exceed the budgeted US$ 3000 including remuneration and all associated costs.

Annex 12: "Letter of exchange" (Draft under discussion with HQ Legal)

Letter of Exchange

Between

[Name of city] Field Research Site

and

WKC center for Health Development

1. The WHO Kobe Centre for Health Development's vision of "Healthier People in Healthier Environments" will be achieved through a research programme that focuses on urbanization and health equity. The Centre's Healthy Urbanization Project (HUP) for 2006-2015, Healthy Urbanization: Optimizing the impact of social determinants of health on exposed populations in urban settings, is taking this vision forward in a collaborative approach that confronts health equity issues in urban settings. This will be done through development of effective strategies and municipal level public health interventions; demonstration of the applicability of these strategies in field research sites; building capacity among stakeholders and advocacy for health equity.

2. In collaboration with WHO Regional and Country Offices, Healthy Urbanization Field Research Sites are to be established. These field research sites will conduct action-research projects to derive local knowledge to inform global, national and local policy and action. In each field research site, multi-sectoral teams will work together through a 'learning by doing' approach to address social determinants of health through improving health governance. These teams will be part of a "Healthy Urbanization Learning Circle" that will be engaged in capacity building activities, training and action-research.

2. The city of [name of city] was chosen after extensive consultations between the WHO regional and country offices and with other relevant stakeholders. In order to define the parameters for research and action, the WHO Kobe Centre for Health Development has collaborated with a relevant institution to develop a scoping paper that outlines the current situation and local context in preparation for project operations.
[name of city] has agreed to partner with WKC in implementing this project in order to reduce health equity in the urban setting.

The specific objectives of the project are to:

1) Derive evidence of effective strategies and interventions through action research;
2) Select and train change agents to support action on social determinants of health;
3) Integrate and link local knowledge on health governance with national policy and action;
4) Strengthen capacity to undertake inter and intrasectoral collaboration;

5) Develop a comprehensive and realistic plan of action that will include target-setting, monitoring and evaluation of activities; and
6) Support the development and financing of systems and institutions that will ensure sustainability of efforts.

3. To achieve these objectives WKC agrees to provide [name of city] field research site with the relevant in-kind support over a period of 18 months.

WKC will not be responsible for any fees or payment other than in-kind support or mutually agreed upon between [name of city] research site, the WHO country and regional office and WKC.

Any problems or discrepancies in the implementation of this letter of agreement along with alterations deemed to be necessary for the success of the project before or during the implementation will be assessed and solved jointly by the Project Steering Committee and the WKC as necessary and appropriate.

This letter of agreement will take effect from the date of its signature by all appropriate partners. Any modification or revision must be approved in writing both by the WHO country and regional offices as well as WKC.

Agreement

Today, _____, 2006, we:

Healthy Urbanization Field Research Site, represented by

_____

and
WKC, represented by

_____

Attachments:
Scope of work and responsibilities

Consistent with the overall goal and objectives of this initiative [name of city] field research site and WKC agree to the following responsibilities:

WKC will:

In relation to the project management and technical services,

- provide the project deliverables in collaboration with the WHO country and regional offices and other partners such as the MoH;
- collaborate with local project partners in the development, review and evaluation as well as updating of progress, as required, of a detailed work plan; and

coordinate its implementation;

- provide technical support to government and municipal agencies and other project stakeholders in implementing and monitoring of progress of specific social determinants of health;
- establish, in consultation with the project partners, a Project Steering Committee to provide local technical advice, as necessary and appropriate, and to serve as advocate for the project in both the public and private sectors;
- build working relationships and network with relevant Government agencies and international organizations and external support agencies to share project experiences and learn from these experiences of others.

In relation to project administration, finances and reporting:

- Ensure that project funds are used in accordance with the agreed work plan;
- Recruit and hire qualified and trained project staff;
- Prepare project documentation, reports and updates for the local research sites on regular agreed upon interval;
- Facilitate co-learning visits from time to time.

Local research Site will:

- provide local resources, such as human resources, transport and equipment as required and appropriate to support the project for:
- develop a project plan of work;
- implement the project activities as agreed in the plan of work, and assess, on a co-learning basis, the project implementation and outcomes;
- technically and administratively support project related capacity building initiatives;
- build working relationships and networks at the local level agencies, including the government, local and international organizations, to share project experiences and learn from the experiences of others.

THE CORE PROJECT
PLAN OF WORK

WHO Centre for Health Development

Kobe, Japan

1.0 Introduction

1.1 Background

In 2004–2005, the Centre undertook a process of consultation with its partners and the scientific community to gain perspective on its future work for the period 2006–2015. An Ad hoc Research Advisory Group (RAG) and associated Sub-groups were convened to delineate the most important research questions related to Ageing and Health, Urbanization and Health, and Technological Innovation and Environmental Change and Health. The product of this process was "A Proposed Research Framework for the WHO Centre for Health Development."[1] This Framework served as an important scientific reference in the development, by WHO and the Kobe Group, of the ten-year extension of the Memorandum of Understanding to 2015 and the Centre's research plans for the future that are reflected in the Plan of Work for 2006–2007.

The Ad hoc Research Advisory Group process highlighted the growing importance of urbanization as a cross-cutting driving force and the central role that **cities and urban municipalities** are beginning to play as key drivers of modernization and social change. There was consensus on the need for inter-disciplinary, applied research into priority public health issues affecting urban settings, particularly in relation to exposed populations. It was recognized that the character of these settings in the 21st century is changing rapidly, and that the increasing complexity of the factors affecting change and their impact on health and well-being is not well understood.

Emphasis was also placed on the need to focus on the health and well-being of **exposed populations** including the poor, the elderly, women and children. In the context of urbanization and globalization, the problem of **health inequity**, particularly in relation to exposed populations, was noted in all of the discussions. For example, of the three billion people who live in urban areas today, one billion live in slums. As the number of people born in cities increases and as people continue to be displaced from rural areas, the urban slum population is expected to grow to approximately two billion by 2030, resulting in a continuing and rapid urbanization of poverty and ill health whose greatest impact will be felt in the developing world.

A significant amount of discussion in the Ad hoc Research Advisory Group process in general, and in the Urbanization and Health Sub-group in particular, revolved around the importance of **the social determinants of health** in relation to health inequity and the role of **health governance** as a critical pathway by which social conditions translate into health impacts.

Based on deliberations during the Ad hoc Research Advisory Group process, related discussions with members of the Kobe Group[2] and others, and the selection of the WHO Kobe Centre as the Hub for the Commission on Social Determinants of

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[1] The World Health Organization Centre for Health Development. *Health in Development – Healthier People in Healthier Environments. A Proposed Research Framework for the WHO Centre for Health Development.* Kobe, Japan, August 2004.

[2] Comprising: Hyogo Prefecture, Kobe City, Kobe Chamber of Commerce and Industry, and Kobe Steel, Ltd.

Health's Knowledge Network on Urban Settings, the future work of the Centre will have the following strategic foci:

- **Monitoring and responding to "felt needs" – a**iming to complement the findings of epidemiological and public health research with information about the needs felt by exposed populations.

- **Packaging knowledge from a health equity perspective to inform policy and practice** – Aiming to reduce health inequity by improving health governance.

- **Developing new knowledge to address existing and emerging areas of vulnerability** – Aiming to identify and advocate effective responses and interventions in relation to driving forces.

The work will be carried out with a major emphasis on **urban settings**, mindful of the "globalization-urbanization interface" that exists in these settings, with **the overall aim of reducing health inequity by optimizing the impact of social determinants of health on exposed populations**.

1.2 The presentation

The Core Project is organized around four areas of emphasis:

1. **Developing strategies:** Building an evidence base, generating policy ideas, evaluating current experiences and interventions, developing public health methodologies for health inequity assessment and evaluation and deriving new knowledge on social determinants and health inequity.

2. **Demonstrating the applicability of strategies:** Demonstrating how "generic" municipal strategies can be applied and combined with tactical and context-specific interventions to reduce health inequity.

3. **Capacity building:** Building capacity at the level of the individual, the organization and the system through leadership training and applied projects.

4. **Policy advocacy:** Developing and applying principles of strategic communication and advocacy to influence health governance at all levels and enhance understanding of how the impact of social determinants can be optimized to reduce health inequity.

Staff will work in and across these areas of emphasis in a multi-disciplinary fashion to develop specific products. In addition, to provide effective liaison with other WHO programmes and offices, as well as with other organizations, they will serve as designated Focal Points for the following Areas of Work:

- Surveillance, prevention and management of chronic, noncommunicable diseases
- Health promotion
- Tobacco

- Health and environment
- Gender, women and health
- Policy-making for health in development
- Health system policies and service delivery
- Human resources for health
- Health information, evidence and research policy
- Emergency preparedness and response
- Mental health and substance abuse
- Ageing and life course

2.0 Plan of Work Details

2.1 The Core Project - Optimizing the Impact of Social Determinants of Health on Exposed Populations in Urban Settings

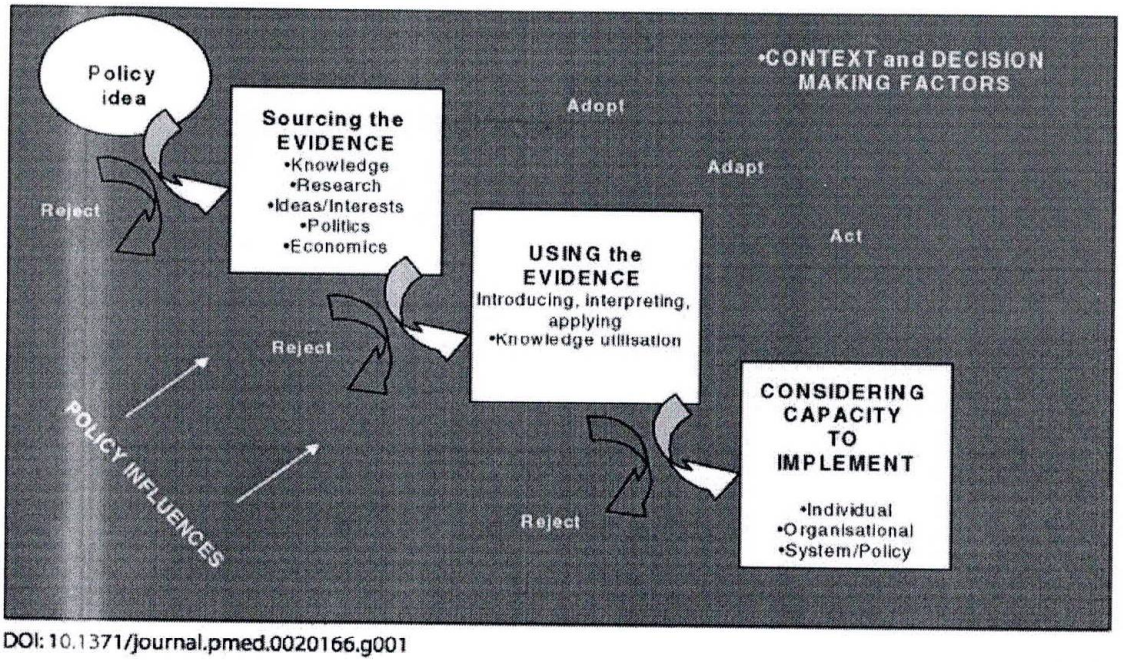
2.1.1 Objectives

Within the overall purpose of the project – to reduce health inequity in urban settings – the specific objectives for 2006–2007 are to:

1. Develop strategies to reduce health inequity in urban settings;
2. Demonstrate the applicability of strategies for reducing health inequity among exposed populations in urban settings;
3. Build capacity for reducing health inequity in urban settings;
4. Advocate the reduction of health inequity in urban settings.

The model of the "Evidence-Informed Policy and Practice Pathway"[3] (Brown and Zwi, 2005) provides the basis for the research design of the Core Project. According to this model, policy ideas, evidence, use of evidence and capacity to implement evidence-based policies are interlocked in a series of decision-making steps that are characteristic of how events unfold in practice. Policy ideas provide the starting point for the sourcing of evidence. Sources of evidence are multiple and varied. Using the evidence includes interpreting and applying knowledge in specific contexts. Capacity to implement is considered from the perspective of the individual, the organization and the system.

[3] From the PowerPoint presentation of the Knowledge Network on Measurements, given at the Meeting of the Knowledge Networks, 10-12 September 2005, Ahmedabad, India.



DOI: 10.1371/journal.pmed.0020166.g001

2.1.2 Present plans, 2006–2007

Objective 1 – Develop strategies to reduce health inequity in urban settings

Approaches and products

Building the evidence base

Closer examination of existing evidence will be a key component for developing strategies to reduce health inequity in urban settings. Knowledge will be collated, analyzed, synthesized and organized to enable researchers, implementers and decision-makers to gain easy access to information on the associations and pathways between social determinants and health inequity in urban settings. In particular, the evidence base will try to capture the policy ideas emanating from attempts to bridge equity gaps through municipal health governance. Materials to be included in the evidence-base will come from published and grey literature and from the worldwide experience of Healthy Cities, Local Agenda 21 cities, Sustainable Cities, Cities without Slums, the Urban Governance Initiative and other initiatives where the city/municipality is both the entry point and setting for achieving sustainable change and improvement in health.

From the evidence base, research teams will systematically review evidence and select good examples of strategies and interventions that are promising or proven to be effective in reducing health inequities in urban settings. A glossary of terms and concepts will be developed to promote wider discourse on the subject in the scientific community, as well as to supplement advocacy efforts in the political domain.

Ensuring local participation and ownership of research

Research activities will emphasize principles of community and stakeholder participation and ownership. People's participation in planning, implementation and evaluation of research activities will be ensured. Thus, at the early stages of the project, participatory and consultative processes will guide the identification of exposed populations, prioritization of issues and concerns and the pursuit of opportunities and imperatives for influencing health governance at the local level. Multiple pathways of causality and associations may necessitate a wide range of interventions for enhancing health governance. The emphasis in Objective 1 however, will be on creating enabling environments for municipal-level action.

The project will develop generic municipal-level strategies for reducing health inequity but will also construct a framework for tactical actions that facilitate achieving rapid results in relation to the specific and unique contexts of urban settings through collaborative research and other means. For this reason, selected urban areas are initially proposed as field research sites for 2006-2007, where these will be applied in: China, Chile, Japan and India. Sites in African and the Eastern Mediterranean regions will follow. Project steering committees will be organized for each urban health field research site and will include representatives from regional and country offices of WHO, national and local representatives and stakeholders as well as key partner research institutions from the local community. Other sites will be involved in subsequent biennia.

Strengthening public health at the local level

The role of the public health sector at the city and municipal level in enhancing health governance will be highlighted in the project. As both social and environmental determinants of health necessitate action and responsibility from many actors (e.g. transportation, housing, education, welfare, finance, police and law enforcement), public health officers may need to play a more important role as **catalysts** for change than as implementors in the locality and will need to steer highly complex political processes toward healthy public policy. While the research objective is focused on reduction of health inequity, the key products of the project will be public health methodologies that enhance the performance of local health officials in the new role they must play in the face of rapid urbanization.

In particular, tools will be developed to **derive the "felt needs**" of exposed populations who may otherwise be excluded from regular census activities or routine public health reporting systems. Felt needs can then be used as a reference point for assessing the responsiveness of public health policies, programmes and practices in contexts where health inequity is manifest.

In conjunction with public health methodologies for deriving felt needs, checklists to ensure that health equity principles are embedded in public policies, programmes and practices will be developed, field-tested and pilot-tested in the field research sites. These checklists will demonstrate how municipal development decisions may affect human, social, economic and ecological capital (together

referred to as "community capital"[4]) and what possible impacts these would have on exposed populations such as disaster survivors, women and children exposed to abuse, violence and HIV-AIDS, workers suffering from depression or individuals predisposed to suicide.

Highlighting the interaction between local and national determinants

The project will also develop tools to assist municipal planners in assessing long-term development decisions. In particular, work will be initiated to develop models that render visible the impact of broad determinants on the health of exposed populations in future scenarios, using projections and trends of urbanization in the first instance, and demographic and environmental change as well. An example of this might be the effect of heat waves on exposed populations in urban settings.

Work will also be initiated for the development of a core set of indicators that countries, cities and municipalities can use to assess how socioeconomic factors and rapid urbanization are interacting to produce changes in health and quality of life in their cities through the development of a Poverty-Health-New Urban Settings Index.[5]

Contributing to global action on social determinants of health

As WHO Kobe Centre is the hub of the Knowledge Network on Urban Settings (KNUS) of the Commission on Social Determinants of Health, the Project and the KNUS will work in tandem to develop new knowledge on slum dwellers as a priority exposed urban population. The Project will collaborate with the KNUS to produce new knowledge on interventions to address the health conditions of people who live in slums and informal settlements. The KNUS will convene meetings to draw on the knowledge of international experts on this subject. Some of the activities of the network will include the writing of historical and analytic narratives on countries that have demonstrated success and the scaling up and documentation of interventions in one field project sites. The KNUS will also forward policy recommendations to the Commission.

Approach	Product
Build an evidence base of experiences and current interventions	An evidence base on how health inequity is reduced through municipal level interventions that address social determinants of health
Evaluate selected experiences and current interventions against existing theoretical frameworks and conceptual models that describe the relationship between social	A review of grey and published literature on promising and successful interventions
	A glossary of terms and key concepts

[4] Hancock T. People, partnerships and human progress: building community capital. *Health Promotion International,* September 2001, 16, 3.

[5] The notion of "New Urban Settings" (NUS) was introduced by the Sub-group on Urbanization of the Ad hoc Research Advisory Group. It refers to urban settings that are characterized by a radical process of change with positive and negative effects, increased inequities, greater environmental impacts, expanding metropolitan areas and fast-growing slums.

determinants of health and health inequity in urban settings	Strategies to enable municipal level action to reduce health inequity in urban settings
Develop methodologies to determine health needs of exposed populations in urban settings	Checklists for assessing and evaluating health equity in urban settings using "felt needs" of exposed populations as reference
Develop methodologies for projecting future scenarios in relation to determinants of health and their impact on exposed populations in urban settings	Models for forecasting and scenario building on the future of cities and municipalities based on demographic and environmental change, urbanization and health with reference to "felt needs"
Develop methodologies for evaluating health inequity at the city or municipal level	Core set of indicators to evaluate health inequity in cities and municipalities (Poverty-Health-New Urban Settings Index)
Develop new knowledge on reducing health inequity in urban settings	Syntheses of evidence on effective interventions for reducing health inequity in urban settings

Objective 2 – Demonstrate the applicability of strategies for reducing health inequity among exposed populations in urban settings

Approaches and products

Urban Health Field Research Sites will be established in selected urban settings[6] to create learning environments for local decision-makers to apply generic municipal- level strategies and further evolve localized and context-specific and tactical interventions to reduce health inequity. Local project steering committees will be organized and workshops will be conducted. Social, community and political mobilization will be done to ensure multi-sector stakeholder participation in the application of strategies.

Research units will be set up in offices of WHO Representatives with full-time staff under special services agreements. The research units will coordinate research activities but will also play a coordinating role in the implementation of local projects to reduce health inequity. Technical advice and support will be provided for local projects.

[6] China, Chile, Japan and India.

Approach	Product
Establish Urban Health Field Research Sites that will serve as learning environments for local decision-makers and communities for the application of strategies for reducing health inequity	Three Urban Health Field Research Sites where the strategies for reducing health inequity will be applied
	Three research units based in WR offices with capacity to coordinate stakeholder activities and oversee implementation of the strategies at the local level
Apply the strategies for reducing health inequity	Application of the strategies in three Urban Health Field Research Sites

Objective 3 – Build capacity for reducing health inequity in urban settings

Approaches and products

Capacity building,[7] or the "development of sustainable skills, organizational structures, resources and commitment to health improvement in health and other sectors, to prolong and multiply health gains many times over", will be a critical part of the project. Teams of leaders who are key players in health governance at the local level will be organized and engaged in a health promotion leadership training programme using the WHO ***Prolead*** model.[8] Each team will design and implement a specific project to optimize the impact of social determinants and reduce health inequity in urban settings. Projects will also emphasize strengthening infrastructure and financing for the promotion of health in the city/municipality in order to ensure the sustainability of interventions to reduce health inequity. The course is conducted over a nine-month period with 160 hours of group learning sessions. The learning sessions are organized into three modules featuring didactics, workshops and field visits. Topics covered by the training will include leadership principles, communication and social mobilization skills, health sector reform, total quality management, governance, social determinants and health inequity, management of change and organizational development, among others.

Prolead III aims to enhance the practical skills of teams across five categories that may be needed to improve governance for the promotion of health: intra-personal qualities; inter-personal qualities; cognitive skills; communication skills; and, task-specific skills.

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[7] Hawe P, King L, Noort M, Jordens C & Lloyd B. *Indicators to help with capacity building in health promotion.* NSW Health: 1999

[8] *Prolead III: A Health Governance Initiative* builds on a leadership development model that started in 2003 in the WHO Western Pacific Region as a collaborative effort between the WHO Western Pacific Regional Office, the Southeast Asian Ministers of Education Organization Tropical Medicine Network (SEAMEO-TROPMED Network), the School of Public Health at La Trobe University (Australia), and the Field Epidemiology Training Program Alumni Foundation, Inc., with the support of the Japan Voluntary Fund.

Prolead III guiding principles include:

- Emphasizing applied skills, not just theoretical knowledge;
- Training in a highly interactive manner, drawing on personal experience to reinforce team learning;
- Encouraging strategic thinking in the promotion of health;
- Emphasizing the use of good governance principles in decision-making;
- Using applied field projects to reinforce classroom learning, multiply training benefits, and generate results;
- Providing opportunities for mentoring and technical support;
- Soliciting feedback as a means of improving the learning process.

Approach	Product
Conduct leadership development, mentoring and training on using the strategies to reduce health inequity in urban settings	Trained teams of leaders who are undertaking projects to reduce health inequity in the three urban health field research sites

Objective 4 – Advocate the reduction of health inequity in urban settings

Approaches and products

A strategic communication and advocacy plan will be developed to ensure that different audiences and stakeholders will have a clear understanding of the goals and objectives of the project. For the biennium, project advocacy materials will be developed in English, Spanish and Japanese.

In collaboration with the United Nations University (UNU), video documentation of strategies for reducing health inequity will be conducted at one project site. The video documentation will be converted into a case study using methods and techniques developed by UNU. The video will be made available to a wider audience through different distance education programmes at regional and country levels.

A range of advocacy activities will be implemented at global, regional, national and local levels. For example, advocacy campaigns by the Knowledge Network on Urban Settings may be directed at global, regional or national audiences. Regular town meetings and scientific seminars will be conducted in the local community.

Partnerships will be established, nurtured and sustained. A framework for developing and evaluating effective partnerships to reduce health inequity will be demonstrated through a historical and analytical narrative of the public-private partnership model for health of Hyogo–Kobe City, Japan.

Finally, educational materials, checklists and rapid assessment guidelines on emerging models and innovative strategies that seek to reduce health inequity will be developed. These materials will contribute to enabling municipal-level decision-makers in health and other sectors to generate innovative policy ideas and options for

reducing health inequity. Examples of these include: tobacco and alcohol tax measures for health promotion foundations; alliances between industries, the community and academia; community-based programmes for older persons and mental health promotion in the workplace.

Approach	Product
Develop and implement a communication and advocacy plan for the strategies.	Communication and advocacy plan for the strategies.
	Video documentation of projects of the Urban Health Field Research Sites.
	Profiles of promising approaches.
	Information exchange, networking, meetings and other advocacy activities.
Establish and sustain partnerships for reducing health inequity	A framework for developing effective partnerships to reduce health inequity
Develop education materials and rapid assessment guidelines on reducing health inequities	A set of educational materials, checklists and rapid assessment guidelines on how health inequity may be reduced

2.1.3 Future directions

It is anticipated that these Core Project objectives will serve to guide the work of the WHO Centre for Health Development over its next ten years of life. It is recognized that from biennium to biennium the approaches to achieving these objectives may vary somewhat and the products associated with them may vary significantly. For example, new methodologies and tools will be developed; tools will be added, adapted, or enhanced. Urban health field research sites may be expanded to cover adjacent urban areas or new countries. Other foundational mechanisms such as the ***Prolead*** initiative will continue to be an integral part of the project.

Healthy Urbanization Project of WKC center for Health and Development

Background

Following a decision by the Executive Board of the World Health Organization in 1995, a Memorandum of Understanding between the World Health Organization (WHO) and the Kobe Group1 established the WHO Centre for Health Development (WKC). As an integral part of the Secretariat of WHO, the WKC has a global mandate to conduct research into the health consequences of social, economic, environmental and technological changes and their implications for health policy development and implementation.

In 2004–2005, the Centre undertook a process of consultation with its partners and the scientific community to gain perspective on its future work for the period 2006–2015. An Ad hoc Research Advisory Group (RAG) and associated Sub-groups were convened to delineate the most important research questions related to Ageing and Health, Urbanization and Health, and Technological Innovation and Environmental Change and Health.

These consultation lead to development of a research framework for the WHO Centre for Health Development. This framework served as an important scientific reference in the development, by WHO and the Kobe Group, of the ten-year extension of the Memorandum of Understanding to 2015 and the Centre's research plans for the future that are reflected in the Plan of Work for 2006–2007.

The Memorandum of Understanding (MOU) between WHO and the Kobe Group for 2006–2015 was signed on 15 June 2005. This MOU ensures the Centre's programmatic and financial future for the next ten years, providing a stable budget for its scientific work that averages about US$ 5.4 million per year.

About Kobe Center

As WHO Kobe Centre is the hub of the Knowledge Network on Urban Settings (KNUS) of the Commission on Social Determinants of Health, the Project and the KNUS will work in tandem to develop new knowledge on slum dwellers as a priority exposed urban population. The future work of the Centre will have the following strategic foci:

Monitoring and responding to "felt needs" – aiming to complement the findings of epidemiological and public health research with information about the needs felt by exposed populations.

Packaging knowledge from a health equity perspective to inform policy and practice – Aiming to reduce health inequity by improving health governance.

Developing new knowledge to address existing and emerging areas of vulnerability – Aiming to identify and advocate effective responses and interventions in relation to driving forces.

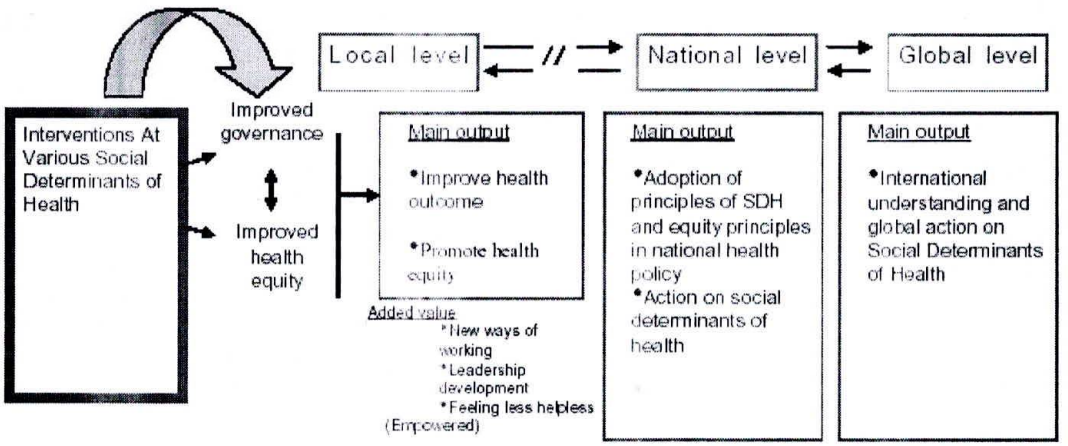
The work will be carried out with a major emphasis on **urban settings**, mindful of the "globalization-urbanization interface" that exists in these settings, with **the overall aim of reducing health inequity by optimizing the impact of social determinants of health on exposed populations**.

The WHO Centre for Health Development, in collaboration with WHO Regional and Country Offices, and through its project on "Healthy Urbanization," aims to integrate evidence-based good practices and public health methods that optimize the impact of social determinants on health and promote health equity in national policies and health systems of Member States.

Rationale

At the local level, the project will bring added value through new ways of working between and among sectors, leadership development and community participation and empowerment. At the national level, the project will provide new knowledge and evidence that may accelerate the adoption of principles of social determinants of health and health equity in national policy, programmes and practice. At the global level, the project will contribute to international understanding and strengthen the imperative for action on social determinants of health.

Figure 2: Expected outputs from action research interventions



Goal

The overall goal of the project is to promote health equity in urban settings, particularly among exposed populations through actions in areas that relates to the project objectives:

Objectives

1. **Developing strategies:** Building an evidence base, generating policy ideas, evaluating current experiences and interventions, developing public health methodologies for health inequity assessment and evaluation and deriving new knowledge on social determinants and health inequity.

2. **Demonstrating the applicability of strategies:** Demonstrating how "generic" municipal strategies can be applied and combined with tactical and contextspecific interventions to reduce health inequity.

3. **Capacity building:** Building capacity at the level of the individual, the organization and the system through leadership training and applied projects.

4. **Policy advocacy:** Developing and applying principles of strategic communication and advocacy to influence health governance at all levels and enhance understanding of how the impact of social determinants can be optimized to reduce health inequity.

Staff will work in and across these areas of emphasis in a multi-disciplinary fashion to develop specific products. In addition, to provide effective liaison with other WHO programmes and offices, as well as with other organizations, they will serve as designated Focal Points for the following Areas of Work:

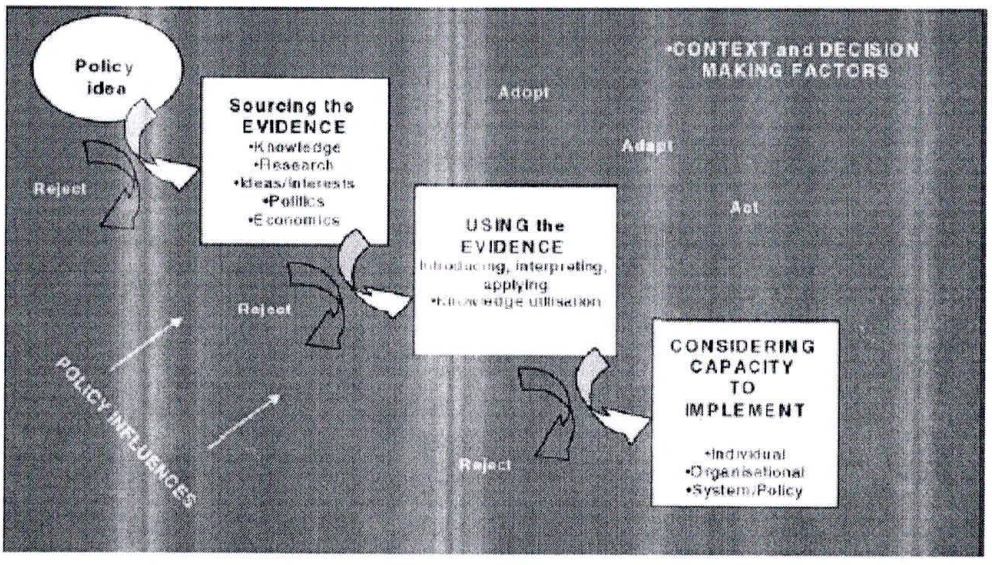
1. Surveillance, prevention and management of chronic, non-communicable
2. Diseases
3. Health promotion
4. Tobacco and environment
5. Gender, women and health
6. Policy-making for health in development
7. Health system policies and service delivery
8. Human resources for health
9. Health information, evidence and research policy
10. Emergency preparedness and response
11. Mental health and substance abuse
12. Ageing and life course

Project partners –

The Healthy Urbanization Project will be implemented in partnership with a wide range of stakeholders at global, regional, national and local levels. The proposed institutional partners of the project at the global level will include the Alliance for Healthy Cities, International Network of Health Promotion Foundations, the SEAMEOTROPMED Network and the La Trobe University School of Public Health. Partners at the regional level will include the different Regional offices of the World Health Organization and other international agencies. Partners at the country level will include Ministries of Health, transportation, education, welfare, civil society and other stakeholders. Partners at the local level will include local governments, non governmental organizations, communities, people's organizations and others that will emerge as the site-specific projects are developed and implemented.

Model

The model of the "Evidence-Informed Policy and Practice Pathway"3 (Brown and Zwi, 2005) provides the basis for the research design of the Core Project. According to this model, policy ideas, evidence, use of evidence and capacity to implement evidence-based policies are interlocked in a series of decision-making steps that are characteristic of how events unfold in practice. Policy



Guiding principles and approaches

The project will be guided by the following principles:
1. "Learning by doing," in particular the use of participatory and action-research methods to optimize social determinants and promote health equity;

2. Respect for local contexts and responsiveness to local needs in the design, development and adoption of project interventions and strategies;

3. Community participation and the involvement of beneficiaries and stakeholders at all stages of the project (i.e. planning, implementation and evaluation);

4. Empowerment of beneficiaries and stakeholders through capacity building;

5. Integration with existing initiatives that strengthen health systems at the national and local level;

6. Linkage to initiatives in support of global imperatives such as Health for All, the Millennium Development Goals, the Commission on Social Determinants of Health, the Commission on Macroeconomics and Health and Sustainable Development;

7. Utilization of vulnerability assessment and reduction approaches to address health issues that result from the convergence of social and environmental determinants; and

8. Cost-sharing and resource mobilization at all levels to complement fixed budgets that are provided by the WHO Kobe Centre.

Present plans, 2006–2007
Objective 1 – Develop strategies to reduce health inequity in urban settings
Approaches and products

Building the evidence base
Closer examination of existing evidence will be a key component for developing strategies to reduce health inequity in urban settings. Knowledge will be collated, analyzed, synthesized and organized to enable researchers, implementers and decision-makers to gain easy access to information on the associations and pathways between social determinants and health inequity in urban settings. In particular, the evidence base will try to capture the policy ideas emanating from attempts to bridge equity gaps through municipal health governance.

Ensuring local participation and ownership of research

Research activities will emphasize principles of community and stakeholder participation and ownership. People's participation in planning, implementation and evaluation of research activities will be ensured. Thus, at the early stages of the project, participatory and consultative processes will guide the identification of exposed populations, prioritization of issues and concerns and the pursuit of opportunities and imperatives for influencing health governance at the local level.

Strengthening public health at the local level
The role of the public health sector at the city and municipal level in enhancing health governance will be highlighted in the project. As both social and environmental determinants of health necessitate action and responsibility from many actors (e.g. transportation, housing, education, welfare, finance, police and law enforcement), public health officers may need to play a more important role as catalysts for change than as implementers in the locality and will need to steer highly complex political processes toward healthy public policy.

Highlighting the interaction between local and national determinants

The project will also develop tools to assist municipal planners in assessing long-term development decisions. In particular, work will be initiated to develop models that render visible the impact of broad determinants on the health of exposed populations in future scenarios, using projections and trends of urbanization in the first instance, and demographic and environmental change as well. An example of this might be the effect of heat waves on exposed populations in urban settings.

Contributing to global action on social determinants of health

the Project and the KNUS will work in tandem to develop new knowledge on slum wellers as a priority exposed urban population. The Project will collaborate with the KNUS to produce new knowledge on interventions to address the health conditions of people who live in slums and informal settlements.

Approach	Product
Build an evidence base of experiences and current interventions	An evidence base on how health inequity is reduced through municipal level interventions that address social determinants of health
Evaluate selected experiences and current interventions against existing theoretical frameworks and conceptual models that describe the relationship between social	A review of grey and published literature on promising and successful interventions
	A glossary of terms and key concepts
determinants of health and health inequity in urban settings	Strategies to enable municipal level action to reduce health inequity in urban settings
Develop methodologies to determine health needs of exposed populations in urban settings	Checklists for assessing and evaluating health equity in urban settings using "felt needs" of exposed populations as reference
Develop methodologies for projecting future scenarios in relation to determinants of health and their impact on exposed populations in urban settings	Models for forecasting and scenario building on the future of cities and municipalities based on demographic and environmental change, urbanization and health with reference to "felt needs"
Develop methodologies for evaluating health inequity at the city or municipal level	Core set of indicators to evaluate health inequity in cities and municipalities (Poverty-Health-New Urban Settings Index)
Develop new knowledge on reducing health inequity in urban settings	Syntheses of evidence on effective interventions for reducing health inequity in urban settings

Objective 2 – Demonstrate the applicability of strategies for reducing health inequity among exposed populations in urban settings

Approaches and products

Urban Health Field Research Sites will be established in selected urban settings6 to create learning environments for local decision-makers to apply generic municipal- level strategies and further evolve localized and context-specific and tactical interventions to reduce health inequity. Local project steering

committees will be organized and workshops will be conducted. Social, community and political mobilization will be done to ensure multi-sector stakeholder participation in the application of strategies. Local project steering committees will be organized and workshops will be conducted. Social, community and political mobilization will be done to ensure multi-sector stakeholder participation in the application of strategies.

Approach	Product
Establish Urban Health Field Research Sites that will serve as learning environments for local decision-makers and communities for the application of strategies for reducing health inequity	Three Urban Health Field Research Sites where the strategies for reducing health inequity will be applied
	Three research units based in WR offices with capacity to coordinate stakeholder activities and oversee implementation of the strategies at the local level
Apply the strategies for reducing health inequity	Application of the strategies in three Urban Health Field Research Sites

Objective 3 – Build capacity for reducing health inequity in urban settings
Approaches and products

Capacity building, or the "development of sustainable skills, organizational structures, resources and commitment to health improvement in health and other sectors, to prolong and multiply health gains many times over", will be a critical part of the project. Teams of leaders who are key players in health governance at the local level will be organized and engaged in a health promotion leadership training programme using the WHO ***Prolead*** model

The learning sessions are organized into three modules featuring didactics, workshops and field visits. Topics covered by the training will include leadership principles,

Prolead III aims to enhance the practical skills of teams across five categories that may be needed to improve governance for the promotion of health: intrapersonal qualities; inter-personal qualities; cognitive skills; communication skills; and, task-specific skills.

Prolead III **guiding principles include:**

a. Emphasizing applied skills, not just theoretical knowledge;
b. Training in a highly interactive manner, drawing on personal experience to reinforce team learning;
c. Encouraging strategic thinking in the promotion of health;
d. Emphasizing the use of good governance principles in decision-making;
e. Using applied field projects to reinforce classroom learning, multiply training benefits, and generate results;
f. Providing opportunities for mentoring and technical support;
g. Soliciting feedback as a means of improving the learning process.

Approach	Product
Conduct leadership development, mentoring and training on using the strategies to reduce health inequity in urban settings	Trained teams of leaders who are undertaking projects to reduce health inequity in the three urban health field research sites

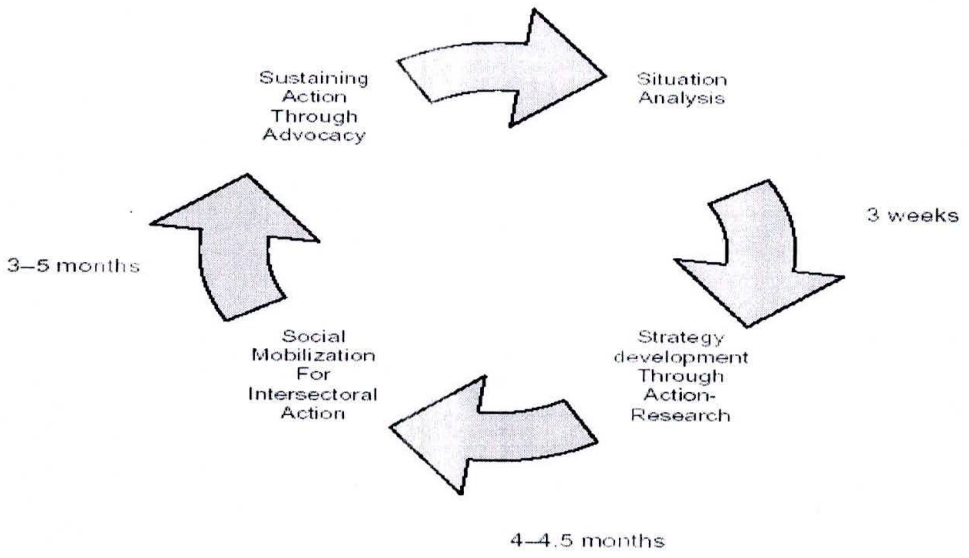
Objective 4 – Advocate the reduction of health inequity in urban settings
Approaches and products

A strategic communication and advocacy plan will be developed to ensure that different audiences and stakeholders will have a clear understanding of the goals and objectives of the project. For the biennium, project advocacy materials will be developed in English, Spanish and Japanese.

In collaboration with the United Nations University (UNU), video documentation of strategies for reducing health inequity will be conducted at one project site. A range of advocacy activities will be implemented at global, regional, national and local levels. For

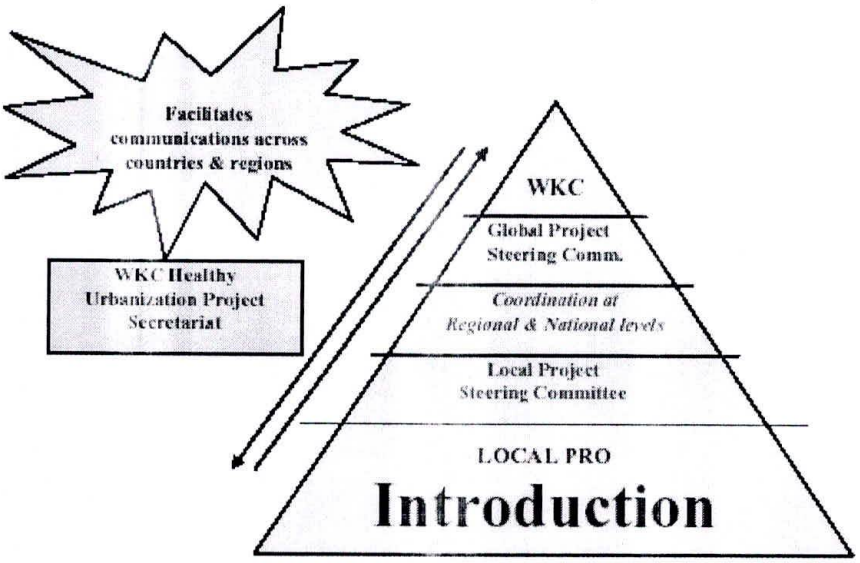
Approach	Product
Develop and implement a communication and advocacy plan for the strategies.	Communication and advocacy plan for the strategies.
	Video documentation of projects of the Urban Health Field Research Sites.
	Profiles of promising approaches.
	Information exchange, networking, meetings and other advocacy activities.
Establish and sustain partnerships for reducing health inequity	A framework for developing effective partnerships to reduce health inequity
Develop education materials and rapid assessment guidelines on reducing health inequities	A set of educational materials, checklists and rapid assessment guidelines on how health inequity may be reduced

PROJECT IMPLEMENTATION
2006–2007 Timeframe



PROJECT MANAGEMENT

Management and support structure



It is anticipated that these Core Project objectives will serve to guide the work of the WHO Centre for Health Development over its next ten years of life.

Project Steering Committee Meeting
30 May – 2 June 2006

India: In Bangalore, access to quality health care, safe water and sanitation, and proper garbage disposal, as well as the provision of ample parks and play areas, safe roads and transportation, and a city free of crime, violence and drugs, are all being addressed by the municipality using an inter-sectoral participatory approach.

Dr Muthukrishnan Vijayalakshmi, Health Officer, Bangalore City Corporation, Bangalore, presented a paper on Health Promotion in Bangalore, India. Although this was not a scoping paper, it did provide the audience with a sense of the important social determinants in Bangalore. Dr. Vijayalakshmi started her presentation arguing that urbanization in Bangalore happens because citizens are looking for a better life. The pace, scope and depth of urbanization was resulting in inadequate food and shelter, overcrowding, insufficient water and sanitation facilities and pollution, which again pushed the population into use of harmful substances, and insecurity.

Bangalore has adopted the healthy cities approach and identified six main intervention areas:

1) Access to quality health care – especially urban poor; 2) Safe water supply & proper sanitation;
3) More organized disposal of waste (collection, segregation & transportation);
4) Ample public parks & play areas;
5) Safe roads & safe transportation; and
6) Freedom from crime, violence and drugs.

The six issues are being addressed through environmental health interventions, preventive health measures, health promotion approaches, education and training. These initiatives are proving successful and are being implemented using an intersectoral and participatory approach. However, there are still major challenges such as solid waste management, which consume the majority of the budget, and HIV/AIDS with its high prevalence among the working class.

The ensuing discussion concentrated on environmental health issues and how Bangalore had managed to sustain a recycling initiative and build on already existing initiatives. In responding to a question related to resettlement, Dr Vijayalakshmi described how the government was constructing houses and the importance that development initiatives in other sectors be aligned with those of the Ministry of Health. The important success factors included education, good housing and employment as well as strong political will reflected in a commitment to the healthy cities approach.

Following on the regional presentations, a major question for the participants was:
What have we learned and what can we transplant into the Healthy Urbanization Project?

Bangalore, India

The group from India started their work by defining the characteristics of future Prolead participants. These participants must be individuals who are working with health related issues, known to have demonstrated leadership potential, currently employed and engaged in a technical or professional area of work such as finance, planning, transport, housing, health policy, law enforcement, working at a level where policy and practice are reinforcing each other. It is advisable that Prolead participants come from the following three domains: WHO, government or nongovernmental organizations. The Bangalore research site will have 4-6 research teams with three members per team. Each team will be encouraged to have an appropriate gender and age balance. There should also be a sense of continuity with the work of the three previously trained Prolead fellows. The activity timeline for the Bangalore project was outlined as follows:

- 30 June 2006: Completion of appointment of SSA.
- 4-6 July 2006: WKC Focal Point (Ms Loo) visits Bangalore to
    - Review the interim scoping paper/meet with stakeholders;
    - Gain an understanding of BMP;
    - Present the Project to the Commissioner;
    - Orient SSA staff (project document, work and financial plans, office supplies,
    - Communications, recording and reporting, etc);
    - Catalyze establishment of a Bangalore working body at the local level, comprised of BMP (two clinical and public health), SSA, training institution,

one from an NGO, one former Prolead fellow and the Commissioner.

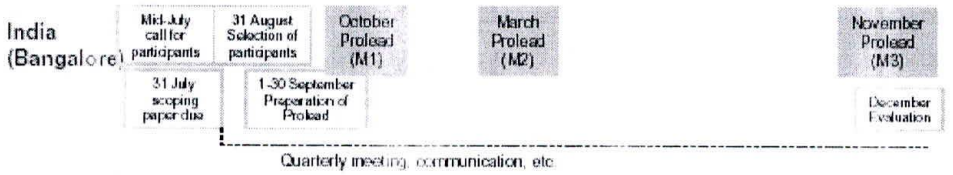
- Mid-July 2006: call for expression of interest for Project participants.
- 31 July 2006: deadline for submission of scoping paper.
- 31 August 2006: deadline for selection of Prolead participants; and training institution identified
- 1-30 September 2006: Preparations for Prolead, Module 1 (training venue, food, materials, programme, etc).
- October 2006: Prolead, Module 1.
- Commencement of city projects.
- March 2007: Prolead, Module 2.
- Continuation of city projects.
- November 2007: Prolead, Module 3.
- Phasing out/closure of city projects.
- December 2007: Bangalore core project evaluation.

Annex 5, Plan of Action, Bangalore

Objective: Optimizing the social determinants of health in urban settings
Site: Bangalore, India **Total budget:** 110 500 USD

Items	Activity components	Timeframe (Quarters) 2006				Timeframe (Quarters) 2007				Milestone	Maximum funds from WKC (USD)	Additional funds required and source (USD)		Officer in charge	Suggestions
		1	2	3	4	1	2	3	4			Amt	source		
Capacity building	Prolead modules				Early Oct		mid Mar	Nov		Prolead curr done Pax identified	30 000	0		Working group including SSA	Module starts from 4th quarter 06
Project development and implementation	City projects									Conduct of Prolead Modules 1	10 500			Working group Prolead participants	4~6 city projects to optimize SDH
•Special service agreement	Recruitment national staff		June							Objective info and to WR	54 000	0		WKC and WR-India	•Smooth coordination of activities between WKC and country teams
Local cost and project mobilization	quarterly meeting, communication, transpo										5 000			SSA	Regular report on progress
•Supplies and equipment	Office supplies										8 000	0		SSA	N/A
•Scoping paper	Research										3 000	0		NIMHANS (Dr Gururaj)	N/A

Proposed dates for Training



Dr Davison Munodawafa, Regional Adviser in Health Promotion and Education, WHO Regional Office for South-East Asia (SEARO)

Healthy Urbanization Learning Circles will undertake capacity building activities over a 9–12-month period that is organized around four modules9:

- Module 1: Overview of Healthy Urbanization: Situation Analysis
- Module 2: Healthy Urbanization Challenges: Strategy Development and Project Proposal Writing
- Module 3: Healthy Urbanization Opportunities: Social Mobilization for Intersectoral Actions.
- Module 4: Mainstreaming Healthy Urbanization: Sustaining Action through Advocacy

Slums selected for Healthy Urbanization Project

	Name of health center	Name of the medical officer & contact number	Name of the slum
1	Shanthi Nagar Maternity Home	Dr. Sandhya 9845244350	Vinayaka nagar ~~slum~~ J.K. nagar, Satyavelnagar (Gulbarga slum)
2	Pobbathi Materniry Home	Dr. Chethana 22975673	Parvathipura
3.	Mathikere Health Center	Dr.Parimala 9845184942	BK Nagar Akkyappa garden
4.	Vidyapeth Health Center	Dr. Usha Deve 22975776	Hittimaduve, slum near Ayappa temple
5.	Moodlepalya	Dr. Parimala 9844031180	Kanakanagara slum
6.	Roberson road	Dr. Nayantara Patil 22975890	Netaji Hut Near Ashoka theatre.
7.	Vasanthnagar Dispensary	Dr.Sathish 9448244888	Ambedkar Salum, Harijan slum, Gulberga slum

Jalakanteshwara nagar

Bangalore, India

The group from India started their work by defining the characteristics of future Prolead participants. These participants must be individuals who are working with health-related issues, known to have demonstrated leadership potential, currently employed and engaged in a technical or professional area of work such as finance, planning, transport, housing, health policy, law enforcement, working at a level where policy and practice are reinforcing each other. It is advisable that Prolead participants come from the following three domains: WHO, government or nongovernmental organizations. The Bangalore research site will have 4-6 research teams with three members per team. Each team will be encouraged to have an appropriate gender and age balance. There should also be a sense of continuity with the work of the three previously trained Prolead fellows.

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  - present the Project to the Commissioner;
  - orient SSA staff (project document, work and financial plans, office supplies, communications, recording and reporting, etc); Headquarters Political TechnicalRegional level Political TechnicalLocal/ Municipality level Political TechnicalCommunity level Participatory Learning, Planning, Budgeting and Action processes Social marketing Validation Social marketing Validation
  - Catalyze establishment of a Bangalore working body at the local level, comprised of BMP (two clinical and public health), SSA, training institution, one from an NGO, one former Prolead fellow and the Commissioner.
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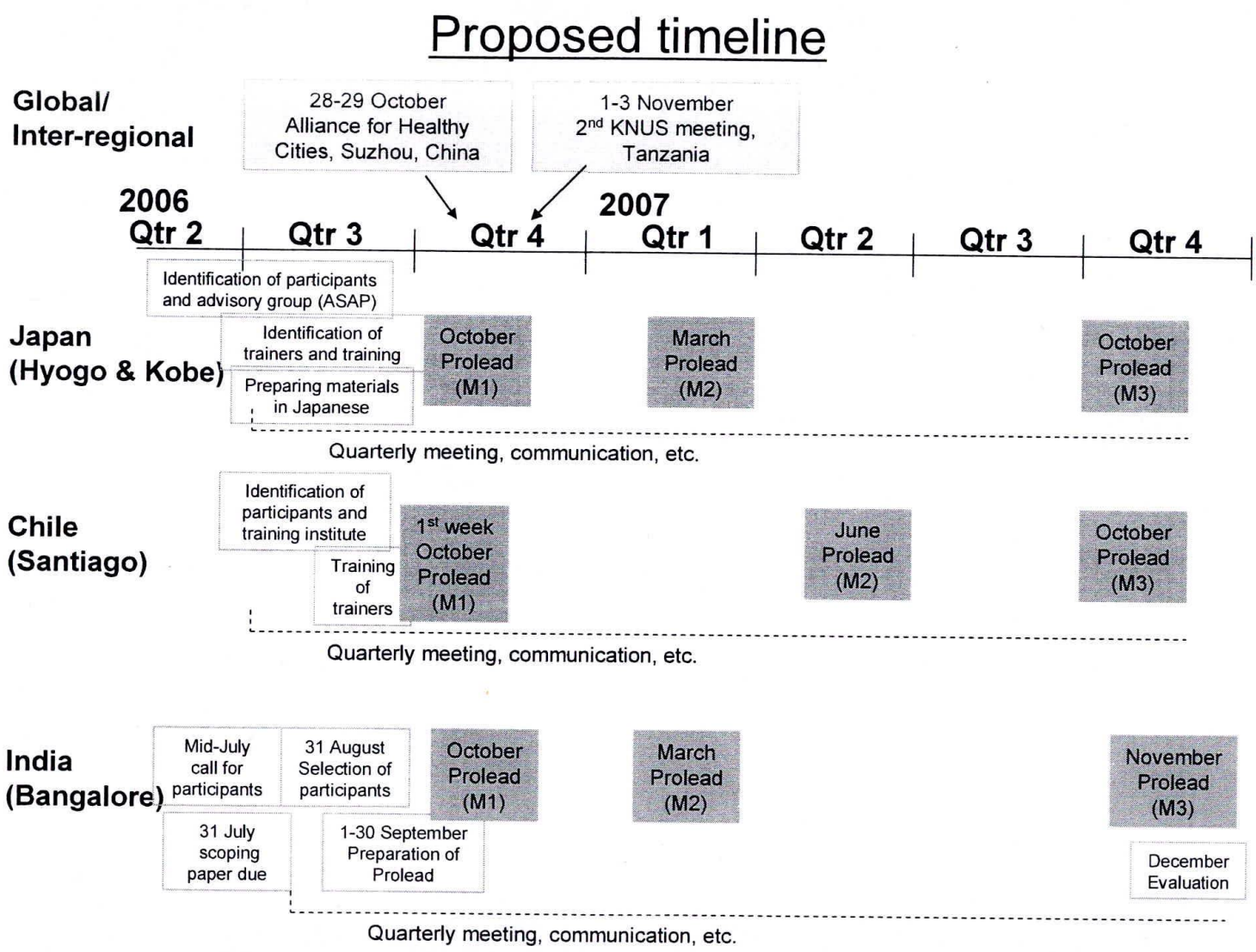
- 1-30 September 2006: Preparations for Prolead, Module 1 (training venue, food, materials, programme, etc).
- October 2006: Prolead, Module 1.
- Commencement of city projects.
- March 2007: Prolead, Module 2.
- Continuation of city projects.
- November 2007: Prolead, Module 3.
- Phasing out/closure of city projects.
- December 2007: Bangalore core project evaluation.

Annex 8, Proposed dates for Training



Annex 5, Plan of Action, Bangalore

Objective: Optimizing the social determinants of health in urban settings
Site: Bangalore, India **Total budget:** 110 500 USD

Items	Activity components	Timeframe (Quarters) 2006				Timeframe (Quarters) 2007				Mile stone	Maximum funds from WKC (USD)	Additional funds required and source (USD)		Officer in charge	Suggestions
		1	2	3	4	1	2	3	4			Amt	source		
Capacity building	Prolead modules				Early Oct		mid Mar	Nov		Prolead curr done; Pax identified	30 000	0		Working group including SSA	Module starts from 4rd quarter 06
Project development and implementation	City projects									Conduct of Prolead Module 1	10 500			Working group Prolead participants	4~6 city projects to optimize SDH
▪Special service agreement	Recruitment national staff		June							Obligation No. sent to WR	54 000	0		WKC and WR-India	▪Smooth coordination of activities between WKC and country teams
Local cost and project mobilization	quarterly meeting, communication, transpo ...										5 000			SSA	Regular report on progress
▪Supplies and equipment	Office supplies ...										8 000	0		SSA	N/A
▪Scoping paper	Research										3 000	0		NIMHANS (Dr Gururaj)	N/A

Bangalore Healthy Urbanization Project
an urban health research site
A partnership project of
BMP, WKC Japan, WHO India and SEARO

Dear Sir,

Thankyou for attending the launching of Healthy Urbanisation project on 4th December .We will be too happy if you can attend a meeting on the day mentioned below to have a detailed discussion on the same so that we can implement it effectively in Bangalore.

Time: 3 P.M
Date: Thursday,14th December 2006
Venue: Pobbathi Maternity Home,1st floor,
Sajjan Rao Circle.

Your's Sincerely,
C. Kameshwari
Dr.P.S.Thandavamurthy,
Local coordinator.

Dr. Thelma Narayana
#359, Srinivasa Nilaya
Jakkasandra
1st main, 1st Block
Koramangala
Bangalore-34
Ph. 25531518,25525372

810
13/12/06

Notes of BHUP Meeting on January 16th, 2007 at 3.00 p.m., Dassappa Maternity Home

1) Agenda: Further clarification about the project with Jostacio Merno Lapitan of the Urbanisation and Emergency Preparedness Programme, WHO Centre for Health Development (WHO Kobe Centre).
2) 2) The meeting started one hour late at 4.00 p.m. as Dr. Lapitan (a Filipino, working with WKC) had just arrived. Dr. Thandava Murthy (TM) introduced the project, by again saying that it was not a BMP project and repeated the same details as in the earlier meetings. After the introduction, the floor was thrown open for questions.
3) We raised the following issues:
    a. If it is not a BMP project, why is there so much BMP involvement? Also the brochure says that it is a "partnership project of BMP with WKC, Japan WHO (SEARO & India). TM accepted that it was a BMP project.
    b. Methodology used for selection of seven areas for the project. TM replied that the BMP Commissioner chose one area from different directions.
    c. The logic behind composition of HULC members (NGO, BMP Dr., Suchimitra and PG student). Dr. Lapitan said that it was based on previous projects' experience in developing countries.
    d. The ethicality of burdening link workers and other community workers (who themselves are from "low-resource settings") to do additional work without compensation. (Earlier a BMP doctor had confided in us that link workers had not been paid their honorariums from last August). Dr. Lapitan said that BMP informed them that voluntary agencies were already working in the area and would provide voluntary service for the project. But regarding payment to field workers, he said that it could be reconsidered. USD 1500 was kept aside for each HULC and some of that money could be used for it.
    e. HULC members have been requesting for communication stating the nature of partnership, scope of work and the terms of joining the project. Dr. Lapitan asked the BHUP coordinators to make a note of the points and send a letter to the HULC partners.
    f. What are the policy components of the "research and action project"?
    g. The selection method and competence of SHINE to do the training on this issue.
4) TM suggested that we along with Dr. Anuradha of Samata Project, IIM, Dr. Nadakumar of Ramiah Meedical College and others draft a letter stating the scope of project, nature of partnership, etc. after the meeting concluded. We met a small group after the meeting, and gave them points on what should be included in the letter. The BHUP team were given a copy of the suggested points, which included details of project, budget, expected outcomes, responsibilities, inputs required (human resources, time, materials) and so on.
5) After the meeting, we met with Dr. Lapitan, introduced ourselves and discussed with him about the project. We also met Dr. TM and thanked him for the open dialogue. He told us that he was very happy that we had raised the issues. He also said that he was expecting that we would raise questions on why only USD 1500 was kept for each HULC. Many BMP doctors while leaving the hall came and thanked us for raising these issues and said "somebody needs to raise these issues, as they are always ignored".

P.T.O

Notes of BHUP Training on January 22, 2007 at 9.30 a.m.
Urban Health Training Centre

1) The first module training sessions were scheduled to be held from 23-25th Jan. It was later rescheduled to 22-23rd, and 25th Jan. SJC called up one of the local co-ordinators, Kameshwari on the previous evening (21st) to confirm whether the meeting was still happening on the same dates, she said that there had been some change and that we had to speak to Dr. Thandava Murthy, the senior local coordinator to discuss it. She refused to give further information. Dr. Thandava Murthy did not answer his phone in spite of both NT and SJC calling repeatedly. SJC later spoke to Dr. Vijayalakshmi, the Chief Health Officer of BMP who also did not give any information. He later called up Ms. Vijayalaksmi Bose, the WHO consultant for the project, who said that BHUP had sent our letter to WHO for clearance, since we had raised many questions.
2) SJC and NT went to Urban Health Training Centre on January 22, 2007. They met Dr. Thandava Murthy who said that we could not participate in the programme as our name was not cleared by WHO, and that our communication to them had been forwarded to WHO, since we had raised many questions.
3) NT spoke to Dr. Lapitan and told him that our names were not among the list of participants, and that we were being kept out for raising questions. NT asked him whether they were informed of it, and if so, whether as a WKC representative, he would approve of groups being kept out for raising queries in a research project. He just said that SHINE had sent the list of participants and that they were not involved in it.
4) Later SJC and NT met Ms. Vijayalaksmi Bose, who said that we had been very confrontational in our approach. She said that she knew Dr. Thelma who was not confrontational at all, and she did not know whether the rest of CHC was "rabid". (She later said that she withdrew her comment about CHC being rabid, but she stood by the fact that we were confrontational). She said that she had observed us at other meetings and found that we raised these issues too frequently, in a manner which would make BMP wary of us. (Note: The only meetings where she was present were the BHUP launch meeting on December 4, 2006 and January 6, 2007, in which SJC participated. But he did not even speak once at the first meeting as there was no opportunity for dialogue. In the other meeting, all the participants raised several queries about the project, including SJC. The only other meeting she was present was during the introductory meeting on 7th Dec in which TN and SJC participated. So, there is no basis for her observation).
5) We told her that we had only raised questions about the methodology and implementation of the project, as it was a research project. And there was no other opportunity where we could be confrontational. She said that she could not comment on this issue, since she was not there, nor had we sent a copy of the letter to her.
6) We raised the point that the least "professionalism" that could have been shown was to have informed us that we were not to attend the training, after giving us a letter inviting us for the same. She said that she was sorry regarding that.
7) The participants at the meeting including a doctor of BMP, Mr. Sundaram of SJJ and Dr. Anuradha said that they were very upset with us being kept out. Sundaram and Anuradha said that they would raise it in the meeting.

(Prepared by Naveen and Chander, 22 Jan, 2007)

DRAFT
IIMB LETTERHEAD

January 9, 2007

Dr. P.S. Thandava Murthy
Local Co-ordinator
Bangalore Health Urbanization Project (BHUP)
Pobbathy Health Centre
Sajan Rao Circle, V.V. Puram
Bangalore – 560 004

Dear Dr. Murthy,

Thank you for your letter dated XXX and for the invitation to join the Healthy Urbanization Learning Circle (HULC).

We are happy to be involved in discussions regarding the HULC and the Bangalore Healthy Urbanization Project. However, please note that we cannot formally accept the invitation to join the HULC until a scope of work and an agreement is finalized for the same.

Dr. Anuradha, Clinical Director and Ms. Kalyani Subbiah, Project Director of my research program (The Samata Health Study) will participate in the HULC Managers Meet being scheduled on the 16th of January, 2007. I will be attending the Welcome Reception along with both of my colleagues on the 18th January evening.

We look forward to a very fruitful association with BHUP and are eager to finalize the agreement and scope of work for the same at the earliest.

Sincerely,

Suneeta Krishnan, Ph.D
Visiting Faculty, Center for Public Policy
Indian Institute of Management, Bangalore

and

Adjunct Assistant Professor
Dept. of Obstetrics, Gynecology and Reproductive Sciences
University of California, San Francisco

Notes of conversation with Shanmuga Sundaram, SJJ and Dr. Sunita Krishnan, IIM – regarding the BHUP training programme organized by SHINE

First day of training – 22 Jan '07 (As reported by Shanmuga Sundaram)

1) Training did not contain anything related to the technical aspects of the action research project. The whole day session was conducted by Mr. Sheshadri alone, who just read out the various concepts from the project module.
2) Ms. Kameshwari, local co-ordinator of BHUP, who is a part of the core team is also from SHINE.

Second day of training – 23 Jan '07 (As reported by Dr. Sunita Krishnan)

1) This morning, as Ms. Kalyani from Samata project, IIM entered the training hall, Ms. Kameshwari called her aside and asked her to introduce herself as a 'suchimitra' and not as a NGO representative. Ms. Kalyani refused to do so, and went in to attend the session.
2) The topic today was about communication, and Mr. Sheshadri was talking "rubbish".
3) He was often reciting slokas in between and was promoting CDs of slokas and other religious materials during the training. The WHO observers were silent all through the sessions.
4) Ms. Kalyani, who represented IIM walked out of the training as she was not comfortable and she could not get anything useful from the training.
5) IIM team is deciding to pull out of the project.
6) Being a WHO project, the activities going on in the name of "social determinants" need to be taken up at the WHO level.

(As reported by Shanmuga Sundaram)

1) All examples of Mr. Sheshadri about poverty are from Ramayana, Mahabharata and from Germany.
2) His explanation of poverty was comparison of a rich man from Germany (with whom he stayed years ago) with the life style of president of India, and that even among the rich, we are poor.
3) The whole day session was again conducted by Mr. Sheshadri alone.

SJC's telephonic conversation with Ms. Vijayalakshmi Bose (VB) and Dr. Thandava Murthy (TM)

1) SJC spoke to VB first and asked for a written communication stating the reasons for not including CHC's name in the participants list, even after sending us a letter 'thanking us for accepting to join the project'.
2) VB responded that she was informed that we had raised many queries, but she had not seen a copy of our letter, and requested us to forward the copy of our letter to her, so that she could respond.
3) SJC then spoke to TM, asking for the written communication, when he said that he would send it. But he had sent the letter to WHO for approval, and he would get back to us, once he got a response from them.

Bangalore Healthy Urbanization Project

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AGENDA

2:00pm to 2:10pm	-	Welcome remarks by CHO,BMP.
2:10pm to 3:15pm	-	Detail discussion on the BHUP Project by Dr.P.S.Thandava Murthy

Notes of BHUP Meeting on January 16th, 2007 at 3.00 p.m., Dassappa Maternity Home

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(Prepared by Naveen and Chander, 22 Jan, 2007)

privatization. The international community and public health experts have universally recognized the important role of the state in infectious disease control through public health systems, popular education and people's participation. In the current neo-liberal context this role needs to be re-inforced.

48. Newer problems of HIV/AIDS, SARS AND Avian flu have been addressed by the UNESCAP over the past few years in its resolutions. The recent 3x5 initiative of the WHO, which aims to increase access to treatment is welcome as a timely response to the severity and magnitude of the disease and to the treatment access campaign. Dialogue between UNESCAP and WHO will help to enhance coverage and capacity building in Asia as early as possible. Newer treatment protocols, simplified procedures, etc will be adopted, monitored and constantly updated as new knowledge becomes available, after reviewing its social applicability. Most importantly countries could use the existing provisions in the WTO clauses to ensure adequate supply of good quality, generic drugs at affordable prices. Lessons could be learnt from Thailand, Cambodia, India and other countries. Health education efforts regarding these diseases should not generate fear but spread positive messages. Methods of positive living for persons already infected could been encouraged. Use of adjunct therapies such as herbal remedies, massage and other forms of healing that recognized not to cause harm will be encouraged. Life skills education and women's health empowerment that has already been initiated in most countries will be expanded through widespread capacity building.

49. The region is faced with a double burden of diseases with non-communicable diseases (NCD) and traffic accidents taking a heavy toll. The Pacific island countries, Japan, China, Australia and New Zealand have already initiated health promotion campaigns through the government, voluntary sector, private sector and professional associations to bring about lifestyle changes such as adequate exercise, healthy diets, stress management, compulsory use of helmets and seat belts, rules about drinking and driving etc. With an ageing population these measures are necessary to reduce the burden of cardiovascular diseases, hypertension, stroke, diabetes and other NCDs. Abuild up of capacity in the public and private sector for management of these disorders is necessary. Ratification of the Framework Convention for Tobacco Control (FCTC) and implementation of bans on advertising and sponsorship of tobacco products, smoking in public places and stringent curbs on smuggling, would help control the epidemic of tobacco related diseases, including cancers in the Region. Other measures for prevention, control and care of cancer also need to be instituted.

50. The health internet work project of the WHO has piloted the use of the internet and information and communication technology (ICT) for providing easy access to research information on important public health problems to health providers and citizens. ICT offers great potential and needs to be widely used. Internet based public health training programmes are being designed. The use of hand

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Dear Sir S. J. chander
Community Health cell

With sense of gratitude, we thank you and your Organization for accepting to be an active team member of Healthy Urbanization Learning Circle. As you are aware that H.U.L.C forms the live wire of the research committee of the Bangalore Healthy Urbanization Project.

As deliberated in our meetings, you will be working with other team members of the H.U.L.C's. The training will be conducted by SHINE in the presence of observers from WKC Japan, WHO SEARO India. The details are as follows:

1. HULC Managers meetings 16-1-2007 Morning
2. Welcome Reception on: 18-1-2007
3. Module 1. 23, 24, 25 Jan 2007
4. Module 2. 31,1.2 Feb 2007

Your participation is very essential in the above events to bring out the desired changes in the findings of research work, which you will be conducting.

Look forward for your continued Co- Ordination to make BHU project a reality.

A line of confirmation will give lot of motivation to take up new challenges

WE WORK TOGETHER TO MAKE BANGALORE-HEALTHY PLACE TO LIVE.

Your's faithfully

Dr. P.S. Thandava Murthy
Local co-ordinator.

Ref: ~~13-12~~ CHC/13.2/2006/510 December 29, 2006

Dr. M. Vijayalaksmi
The Chief Health Officer
Bengaluru Mahanagara Palike
Bengaluru

Dear Dr. Vijayalakshmi,

Greetings from Community Health Cell!

My colleagues have been attending the Bangalore Health Urbanization Project (BHUP) meetings. We are very happy that social determinants and equity focus are getting its due importance in health policy processes of the city. As you are aware, CHC is associated with a similar process with the WHO. Dr. Thelma Narayan who is CHC's Consultant on Public Health has been a member of the Measurement and Evidence Knowledge Network of WHO's Commission of Social Determinants of Health (CSDH). CHC has been working on community health, health policy and urban health issues, especially those concerning the urban poor, since many years. As we reach our twenty-fifth year, we are consolidating our experiences and materials into training modules in health. Over the past three and a half years itself, we have trained over 40 doctors and social workers on these issues, through an intensive six months - one year community health fellowship scheme.

At the BHUP meetings, NGOs were called to take on responsibility for different Health Urbanization Learning Circles (HULCs). Dr. Thelma had said that Shantinagar was the closest one to our centre. As a government official you would very well know that such serious matters as these cannot be done only on telephonic conversation. Hence, we request you to send us a written invitation to join the project with details about the project, nature of the partnership, expectations from us, the time commitment needed, the expected outcomes and the financial resources available. This would be presented at the meetings of our team and Society members (since CHC is a registered Society) where a final decision would be taken.

We already have gathered enough materials on this project from various sources including WHO and the website. Using this knowledge, our experience and networking, we believe that we could contribute positively to this project. We hope our professional involvement would be adequately compensated. Since we work on tight programme and budget lines, substantial field work would require services of some field staff, which needs to be paid for.

One of CHC's main thrust is on improving the public health system, and as such, we believe strongly in working with the state. We would be very happy to work with you on this project. Looking forward to hearing from you.

Sincerely,

E. Premdas
Coordinator

Print Take on Letterhead
2/1/07

Sent by Courier on 2nd Jan 07

Naveen

From: "Community Health Cell" <chc@sochara.org>
To: <pstmurthy@gmail.com>; <chinthaladevi@gmail.com>
Cc: <premdas@sochara.org>; <naveen@sochara.org>; <chander@sochara.org>
Sent: 12 January 2007 15:37
Subject: Reg. BHUP project

Dr. P.S. Thandava Murthy
Local Co-ordinator
Bangalore Health Urbanization Project (BHUP)
Pobbathy Health Centre
Sajan Rao Circle, V.V. Puram
Bangalore – 560 004

Greetings from Community Health Cell!

Thank you for inviting us to the HULC Mangers meeting on 16th January 2007 and the welcome reception on 18th January 2007. This is to inform you that Mr. S. J. Chander and Mr. Naveen Thomas will attend the Manager's meeting, while Dr. Thelma Narayan will attend the welcome reception.

We would like to bring to your notice that we have still not received an invitation letter outlining the nature of partnership, scope of work and the terms of joining the project. We would like to reiterate that we cannot formal join the HULC until we receive the formal invitation for the same.

Looking forward to hearing from you.

Sincerely,

E. Premdas
Coordinator

.....

E. Premdas
Community Health Cell (CHC)
No. 359 (Old No. 367), Srinivasa Nilaya
Jakkasandra, 1st Main
1st Block, Koramangala
Bangalore - 560 034. India
Tel: +91-(0) 80-25531518
Telefax: +91-(0) 80-25525372
Email: premdas@sochara.org
Website: www.sochara.org

Dr Vijayalakshmi Bose

Dear Dr Thandava Murthy and MS Vijayalakshmi Bose

Greetings for the New Year. We were rather surprised at the recent developments when two of our team members who were invited formally by you to participate in a series of meeting on the Bangalore Healthy Urbanisation Project (a partnership project of BMP, WKC Japan, WHO India and SEARO) for 16th and 18th Jan, then 23-25th Jan and 31 Jan, 1-2 Feb were asked to stay away from the training just because it an interactive, participatory ~~work~~ is a spirit of true partnership they raised some issues and questions for clarifications and dialogue. Even if their ~~exuberance~~ enthusiasm were youthfully we see this as highly irregular, unprofessional and not in keeping with our

and www.phmovement.org and www.phmovement.org

democratic traditions and the spirit of partnership
Our centre for over 24 years has worked for a civil society and peoples voice in Policy making and health (see www.sochara.org
system development. Starting from Networking and training of ngo partners to build capacity for this system development role we have over the years worked closely with the Karnataka State Government - in its Health Task Force; then helped evolve the Integrated State health policy; the integrated Health, Nutrition and Population project and worked as advisors to various other committees and expert groups of the MP and other states and National Rural Health Mission.
As host of the Global and Planning commission/AI every level we have facilitated civil society/ngo voices and participation and built their capacity to be assertive and not silent
As host of the Peoples Health Movement

to be interactive and true partners as representatives closer to the people.

cc. Dr. Cheeran

efforts at NGO participation
While we do agree that there
can be mistakes on both sides
which can be sorted out by
dialogue - we believe the process
followed so far has been an
unfortunately negative development
and needs to be discussed
urgently.
We enclose some papers as
background materials
We also wish to point out that
CHC did not offer to join the
project but there were requests
at different levels from WHO country office
downwards asking us to do so
The turn of events is
particularly surprising in this
~~situation~~ context.
With best wishes and looking
forward to further dialogue

Ram Nair. Rochna Nair E. Prendergast

Global Secretariat in Bangalore we provoked the WHO to set up the WHO Commission on Social Determinants of Health and are working closely with the WHO-CSDH secretariat and various Knowledge Commission Dr Theon. Narayan is on the Measurement and Evidence Knowledge Network. The co-chairmanship is the heart of our network. We are facilitating civil society and ngo engagement in India, Africa, Latin America and with all these hubs continue to do so.

We are, therefore, surprised that in our home state, with the long history of engagement and accepted credibility, our CHC team members can be literally thrown out of a professional dialogue meeting just for asking questions and to be called rebellion as well.

This makes a total farce of the

1/25/2007

Draft letter - BHUP

Urgent

RN : read, edit and send back

TN : read, edit and send back to EP.

25/1/07.

Jan 25, 2007

Dear Dr. Vijayalakshmi, Dr. Thandava Murthy and Ms. Vijayalakshmi Bose,

Greetings for the New Year. We are rather surprised at the recent developments when two of our team members who were invited formally by you to participate in a series of meetings on the Bangalore Healthy Urbanisation Project (a partnership project of BMP, WKC Japan, WHO India and SEARO) on December 4th, 7th, 21st 2006, January 6th, 16th, 18th 2007, and then later on January 23-25th and January 31st – February 2nd 2007 were asked to stay away from the training just because in an interactive, participatory way and in a true spirit of partnership they raised some issues and questions for clarifications and dialogue. Even if they were earnestly enthusiastic, we see this as highly irregular and unprofessional – not keeping with our democratic traditions and the spirit of partnership.

Our centre, for over 24 years has worked for a civil society and people's voice in policy making and health systems development (see www.sochara.org, www.phm-india.org and www.phmovement.org). Starting from networking and training of NGO partners to build capacity for this system development role, we have over the years worked very closely with the Karnataka State Government in its Health task Force, then helped evolve the Integrated State Health Policy, the Integrated Health, Nutrition and Population Project and worked as advisors to various other committees and expert groups of the MP and Orissa states and the National Rural Health Mission and Planning Commission. At every level we have facilitated civil society, NGO voices and participation and built their capacities to be assertive and not subservient – to be interactive and true partners as representatives closer to the people. As host of the People's Health Movement Global Secretariat in Bangalore we provoked the WHO to set up the WHO Commission on Social Determinants of Health (CSDH) and are working closely with the WHO-CSDH secretariat and various knowledge commissions. Dr. Thelma Narayan is on the Measurement and Evidence Knowledge Network. The Kobe centre in Japan is the hub of another network. We are facilitating civil society and NGO engagement in India, Africa, and Latin America with all these hubs.

We are therefore surprised that in our own home state, with the long history of engagement and accepted credibility, our CHC team members were asked to stay away form a professional training, for reasons that have not been communicated to us as yet. This makes a farce of the efforts at NGO participation. While there could be mistakes on both sides, which can be sorted out by dialogue – we believe that the process followed so far has been an unfortunately negative development, and needs to be discussed urgently.

We enclose some papers as background material. We also wish to point out that CHC did not offer to join the project, but there were requests at different levels from WHO country office downwards asking us to do so. The turn of events is particularly surprising in this context.

With best wishes and looking forward to further dialogue.

Sincerely,

Dr. Ravi Narayan
Community Health Advisor

Dr. Thelma Narayan
Consultant – Public Health

Mr. E. Premdas
Co-ordinator

* Copy to: Dr. Cherian Varghese, National Professional Officer, WHO

* Encl : BHUP letter to CHC dt 6 Jan 07
CHC's communication dt 29 Dec 06 and 12 Jan 07

D:\Naveen\Communication.doc

RN 25/1/07

EP → RN → TN

25/1/07

In response to this, the **WHO Commission on Social Determinants of Health (CSDH)** was launched by the late Dr Lee Jong-wook, WHO Director-General in February 2005 to tackle the "**causes behind the causes of ill health**". In the same year, the WHO Kobe Centre was selected as the hub of the Knowledge Network on Urban Settings of the CSDH, one of nine Knowledge Networks that would support the work of the Commission.

BHUP
Right project with a wrong people

Bangalore Healthy Urbanization Project (BHUP)

Action research project carried out by BHUP supported by WKC, Japan.

BMP is not involved in this BMP has provided place only.

Document the information through the action research. The information will be given to BMP for developing a policy framework. BMP is the second municipal council that has a policy in a draft form. The information will be given to knowledge network on urban setting. The Knowledge Network on Urban Settings (KNUS) is focused on synthesizing global knowledge **on social determinants of health and urbanization**.

The overall goal of the project
is to promote health equity in urban settings, particularly among exposed populations through actions in areas that relates to the project objectives:

1. **Developing strategies:** Building an evidence base, generating policy ideas, evaluating current experiences and interventions, developing public health methodologies for health equity assessment and evaluation and deriving new knowledge on social determinants and health inequity.
2. **Demonstrating the applicability of strategies**: Demonstrating how "generic" municipal strategies can be applied and combined with tactical and context-specific interventions to promote health equity.
3. **Capacity building**: Building capacity at the level of the individual, the organization and the system by creating a learning environment for stakeholders, leadership training applied projects and international exchange of experience.
4. **Policy advocacy**: Developing and applying principles of advocacy, communication and social mobilization to influence health governance at all levels and enhance understanding of how a social determinants approach can integrated in national health systems.

Developing strategies (Project Objective 1)
The ultimate purpose of the Urban Health Assessment Framework (UHF) is to provide reliable and comprehensive information for decision and policy makers, local governments and authorities, researchers, local communities, and public and private sectors. Functioning as a strategic framework, the UHF aims to effectively and

appropriately identify and address strength, weakness, challenges and opportunities to improve the urban health conditions in cities.

Demonstrating the applicability of strategies (Project Objective 2)

Action research – "Action research consists of ... research methodologies which pursue action and research outcomes at the same time ... It also has some characteristic differences from most other qualitative methods. Action research tends to be:

- cyclic -- similar steps tend to recur, in a similar sequence;
- participative -- the clients and informants are involved as partners, or at least active participants, in the research process;
- qualitative -- it deals more often with language than with numbers; and
- reflective -- critical reflection upon the process and outcomes are important parts of each cycle."[6]

Capacity building (Project Objective 3)

The capacity building component of the Healthy Urbanization Project provides a structure for implementation of activities at the healthy urbanization field research sites. In addition to training, activities may include action research projects, technical assistance, monitoring group learning, technology transfer, field visits and international exchange. The proposed capacity building component is composed of three modules on healthy urbanization. Participants are expected to carry out projects that will address social determinants of health using health promotion approaches and tools introduced during the didactic portion of the course. The programme is flexible, dynamic and can be adapted to local contexts by including appropriate training and capacity-building materials, methods and approaches that are most suited to local needs. It aims to enhance practical skills among teams across five categories (intra-personal qualities, interpersonal qualities, cognitive skills, communication skills and task-specific skills). Opportunities for cross-regional sharing and learning are also provided.

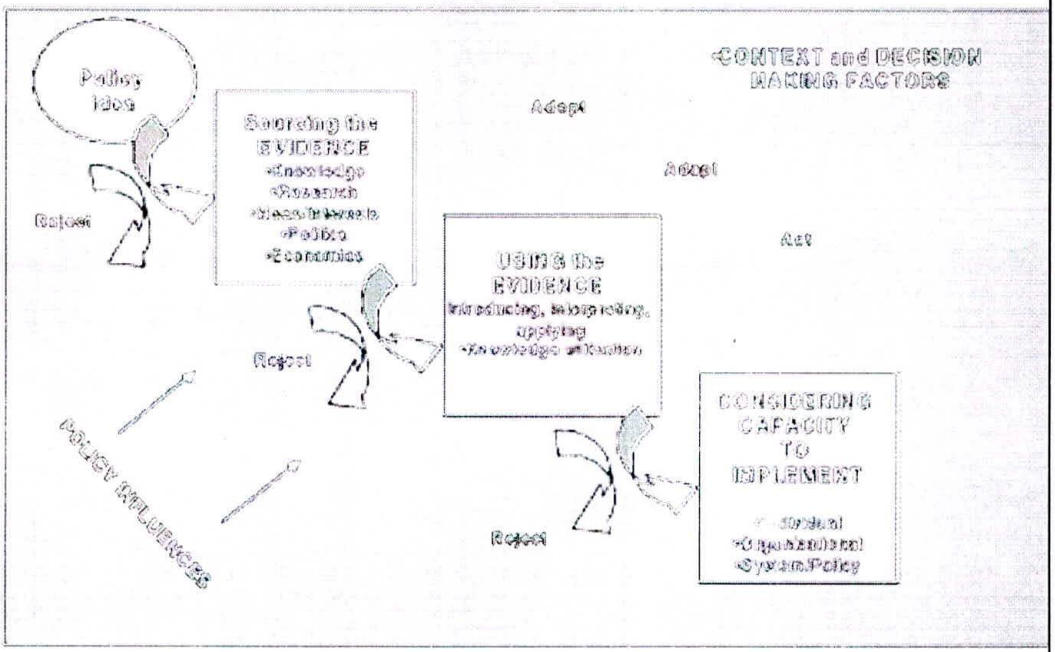
Capacity building modules

Capacity building in the ***Healthy Urbanization Project*** will be undertaken through the organization of "***Healthy Urbanization Learning Circles***".

Healthy Urbanization Learning Circles are networks of multi-sectoral and interdisciplinary teams that will undertake action research projects at the city level through a guided process that will introduce public health methodologies for action to improve governance, optimize the impact of social determinants and promote health equity in the urban settings.

Healthy Urbanization Learning Circles will use the "Evidence-Informed Policy and Practice Pathways (see figure 6) as a model for influencing policy and practice throughout municipal decision-making processes. Policy ideas provide the starting point for the sourcing of evidence. Sources of evidence are multiple and varied. Using the evidence includes interpreting and applying knowledge in specific contexts. Capacity to implement is considered from the perspective of the individual, the organization and the system.

Figure 6: Evidence-Informed Policy and Practice Pathway



DOI: 10.1371/journal.pmed.0030166.g001

[3] Bowen, Zwi AB (2005). Pathways to "Evidence-Informed" Policy and Practice: A Framework for Actions. PLOS Med 2(7): e166

Healthy Urbanization Learning Circles will undertake capacity building activities over a 9–12-month period that is organized around four modules[9]:

- Module 1: Overview of Healthy Urbanization: Situation Analysis
- Module 2: Healthy Urbanization Challenges: Strategy Development and Project Proposal Writing
- Module 3: Healthy Urbanization Opportunities: Social Mobilization for Intersectoral Actions.
- Module 4: Mainstreaming Healthy Urbanization: Sustaining Action through Advocacy

Healthy Urbanization Learning Circles will be guided by the following principles:

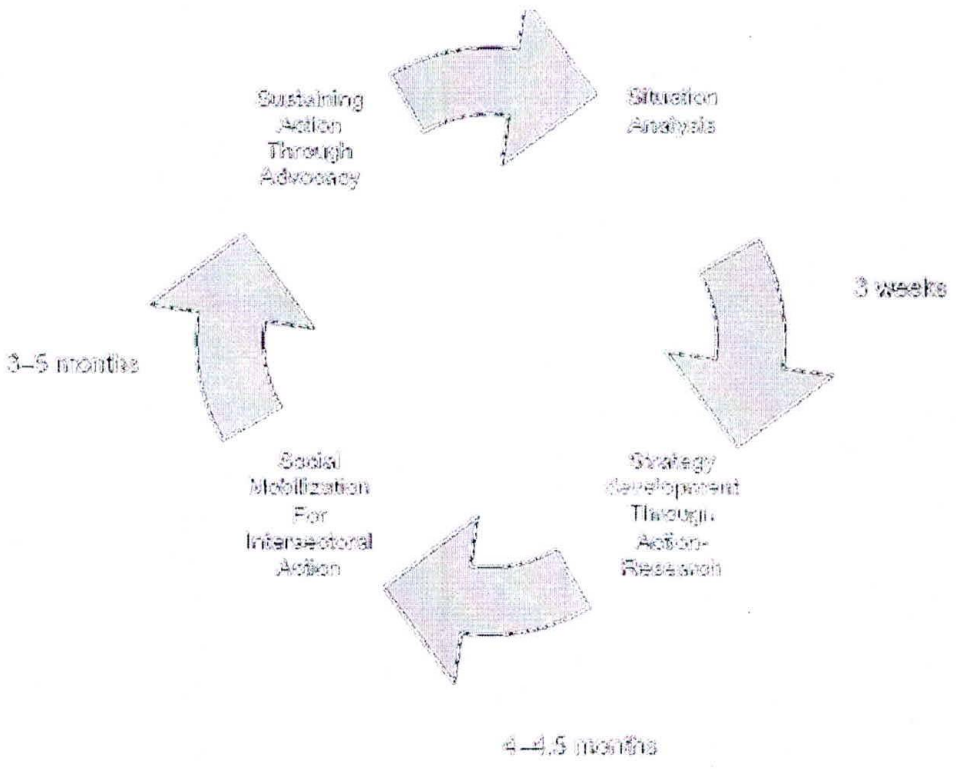
- Emphasizing applied skills, not just theoretical knowledge;
- Training in a highly interactive manner, drawing on personal experience to reinforce team learning;
- Encouraging strategic thinking in the promotion of healthy urbanization;
- Emphasizing the use of good governance principles in decision-making;
- Using action research projects to reinforce classroom learning, multiply training benefits and generate results;
- Providing opportunities for mentoring and technical support through national and international networking; and
- Soliciting feedback as a means of improving the learning process.

General criteria for participants in the ***Healthy Urbanization Learning Circles*** are provided as preliminary guidance, but local groups are strongly encouraged to develop appropriate criteria to meet the needs of the sites. It is proposed that participants are:

• Recognized as having a commitment to the improvement of health in the city;
• Known to value social justice and equity;
• Respected as influential members of the community;
• Engaged in work that promotes positive social values;
• Highly motivated and will exercise leadership in their sphere of influence;
• Representatives of different gender and sectors who are stakeholders in social determinants of health.

Policy advocacy (Project Objective 4)
Activities will be undertaken to ensure that new knowledge and good practices are linked and integrated with national health systems development and wider social and political processes. The project will create opportunities to advocate for healthy public policy and more responsive health systems, particularly in relation to:
Effective management of inter-sectoral collaboration to ensure maximum impact and the judicious use of limited resources for health;
Decision-making that harmonizes competing interests to achieve the higher goal of health equity as a social good.

2006–2007 Timeframe Situation Analysis Strategy developmentThrough Action-Research Sustaining Action Through Advocacy Social Mobilization For Intersectoral Action
3–5 months 3 weeks 4–4.5 months



Areas of concern

The structure that BMP has developed for this project

Central nodal team of 15 members chaired by the commissioner of BMP (Dr. Thandavamoorthi says BMP has nothing to do with this project this is BHUP.
Other members of the team members are form BMTC, NIMHANS, BWSSB, Social welfare department, ex mayor, ICH, SHINE, WHO SEARO, WKC representative, Vijalakshmi Bose.

Implementation team

BMP deputy commissioner
CHO, BMP, Dr. Thandavemoorthy and Kameshwari, ex Mayor, ICH, rep from 7 HULC circles.

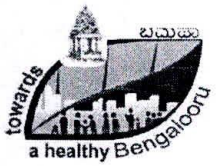
Field team
Health officers of BMP both public health and clinical
Superintendents of all 6-referral hospital
Prolead team members
Dr. Srinivas and Hariharan

Filed partners

NIMHANS -1
Freedom foundation-1
Community Health Cell-1
MS Ramiha Medical College-1
St. Johns Medical College-1
BMP -2

- right project and very people
- methodology
- Comparision

Bangalore Healthy Urbanization Project
an urban health research site



A partnership project of BMP, WKC Japan and WHO India and SEARO

Report of the preparatory phase and proposed programme implementation plan

Ms.Vijayluxmi Bose MS
Consultant (BHUP)
Dr. Cherian Varghese MD, M Phil., Ph.D.
Cluster focal point (NMH), WHO India
7th December 2006

HEALTHY URBANIZATION LEARNING CIRCLES

BMP-managed HULC

Composition:

- Medical Officer – selected because he/she has knowledge of community and major health and non-health initiatives.
- Is a BMP employee and has influence over the area around health centre.
- Can provide leadership to the HULC.

BMP - HULC

- Local NGO representative who is familiar with the area and the exposed populations.
- Post-Graduate student (preferably from Social Work or the social sciences) who is able and willing to do action research. (Maybe as part of thesis work).

BMP-HULC

- Suchimithras – (stakeholders). Selected because they are familiar with BMP and work voluntarily in the community.
- They have influence within the community.

Other HULCS

- BMP will manage 2 HULCS.
- Others will be managed by – NIMHANS, M.S.Ramaiah Medical College.
- Community Health Centre, VOICES.
- St.John's Hospital or Freedom Foundation

HULC Mandate

- Following intensive training (5 days between 22nd & 31st January).
- HULCS will develop an action research proposal according to the seven themes selected by BMP.
- The research will be based on social determinants of health and needs of exposed populations.

Action research

- Proposals will be sent by BHUP office to WHO & WKC for review.
- HULCS will be given a small grant to carry out action research.
- These will NOT be interventions but recommendations for policy formulation and ideas for better governance.

Practice to policy

- Action research will find evidence to support practice and identify policy development pathways
- Research will inform existing draft health policy.
- HULCS will report to Central Nodal Team & Implementation team via the BHUP.

Practice to policy

- This reporting will be done through a series of short reports which will be presented to the two committees for inclusion in the policy.
- The Central Nodal team will meet quarterly.
- The Implementation Team will meet monthly.

HULC - OUTCOMES

- Identification of key social determinants within the 7 areas identified by BMP-BHUP.
- Use action research methodologies to identify what can be changed.
- Areas where policy decisions are needed.
- Report and document these for inclusion in the policy framework.

BHUP Responsibilities

- Coordinate HULC training with SHine.
- Monitor progress of action research.
- Hold monthly review meetings with HULCs.
- Convene meetings of the Central Nodal Team and implementation team.
- Facilitate reporting by HULCS

HULC Responsibility

- All 4 HULC team members will have to undergo 9 days training (3+3+3) over a 9-month period, starting end-January 2007.
- They will collaboratively develop an action research proposal.
- Conduct research and report periodically to Central Nodal Team & Implementation Team.

KNUS

- Create local knowledge networks (where appropriate).
- Generate documentation that will feed into the Local Steering Committee.
- And via the Local Steering Committee to WKC and KNUS.

Bangalore Healthy Urbanization Project

an urban health research site

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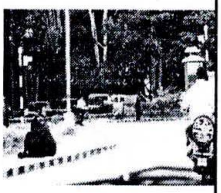
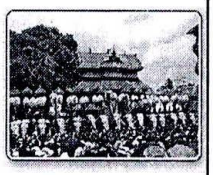
Healthy Urbanization

- Healthy urbanization is a coordinated series of health promoting, policy-related activities informed by evidence and research.



BHUP- Major partners

- The Bangalore Healthy urbanization project is a partnership with the WHO Kobe Centre, (WKC) Japan, the World Health Organization (India Country office (WCO) and South East Asia Regional Office -SEARO) and the Bangalore Mahanagara Palike (BMP – the Municipal Corporation of Bangalore).



Field Research Sites-Global

- Globally, the project is known as 'optimizing the impact of social determinants of health on exposed populations in urban settings for 2006-2007' .
- 6 healthy urbanization field research sites selected in San Joaquin (Chile), **Bangalore (India)**, Kobe/Hyogo (Japan), Suzhou (China), Ariana, (Tunisia) and Nakuru, (Kenya).

The beginning..

- Bangalore had initiated programmes towards wellness and established healthy life style centres in collaboration with WCO, CAMHADD and other partners.
- The economic growth and the cosmopolitan nature provides a good setting
- Representatives from BMP and others were part of the ProLead training and have been active towards health promotion.

Bangalore Healthy Urbanization Project

1st Joint Mission

& Scoping paper

Joint WKC-WHO Mission

- WKC and WHO (SEARO and India) held consultation in New Delhi and took a mission to Bangalore. Discussions were held with various stakeholders.
- BMP agreed for the project and WHO India (WCO) developed a draft plan.
- WCO identified NIMHANS as the agency for preparing the scoping paper in consultation with partners.
- NIMHANS (Dr. G Gururaj) reviewed the existing data and information, programmes in Bangalore and held extensive consultations to develop the scoping paper.

Challenges-scoping paper

- The challenges and areas identified were
  - Capacity and Coordination among agencies
  - Intersectoral collaboration between health and other agencies
  - Information systems
  - Socio-economic disparities
  - Access to care, especially for Non Communicable Diseases
  - Enhance capacity of health systems for NCD prevention and management
  - Mental health and substance abuse
  - Health system capacity
  - Injury prevention and trauma care
  - Evidence based policies and programmes
  - Capacity building for individuals and institutions
  - Strengthen health promotion policy and practice
  - Governance issues
  - Targeted interventions

Bangalore Healthy Urbanization Project

Scope of the Project

Bangalore Mahanagar Palika

- **Bangalore Mahanagar Palike is the principal nodal agency that delivers services to the city.**
- **BHUP works with BMP and partners to bring about healthy urbanization through action research.**

BHUP

- **Will address strategic health issues based on the scoping paper and wider consultations**
- **Undertake capacity building**
  - **Through action research.**
- **Focus on governance related interventions.**
  - **that optimizes impacts of social determinants**

BHUP-Social determinants of health

1. **Access to care**
2. **Poverty (lack of income).**
3. **Inadequate food and shelter.**
4. **Improper sanitation, waste disposal and civic amenities.**
5. **Insecure employment and other stresses.**
6. **Use of harmful substances - tobacco and alcohol.**
7. **Environment pollution.**
8. **Poor education status.**
9. **Unsafe workplaces.**
10. **Violence and injuries**

The seven selected themes

- **BHUP will address the following social determinants with a view to influence them through policy and programmes**
  1. **Water and sanitation**
  2. **Access to care**
  3. **Violence against women and elderly**
  4. **Lifestyle related diseases**
  5. **Education**
  6. **Transportation**
  7. **Low and uncertain incomes**

The Process of BHUP

- **7 HULCS identified**
- **Their capacity will be developed**
- **They will undertake action research and each one will work on a selected theme under the flowing ToR**
  - **Policy advocacy**
  - **Capacity building**
  - **Developing strategies**
  - **Demonstration of applicability of strategies**

Bangalore Healthy Urbanization Project

Systems & Linkages

Information Systems

- **Tools for measuring social and health determinants over a period of time (baseline and over time) in well defined, representative populations.**
- **Develop a framework for health information system with inputs from public and private hospitals.**

BHUP Collaboration

- **Departments concerned with urban improvement e.g Slum Department, Water & Sanitation, Roads & Public Works, Social Welfare, Electricity Board.**
- **Transport, Labour, Judiciary, Women & Children**
- **Medical Colleges, academic institutions, Community Based Organizations, Civil Society, Corporate sector.**

Bangalore Healthy Urbanization Project

Goals & Objectives

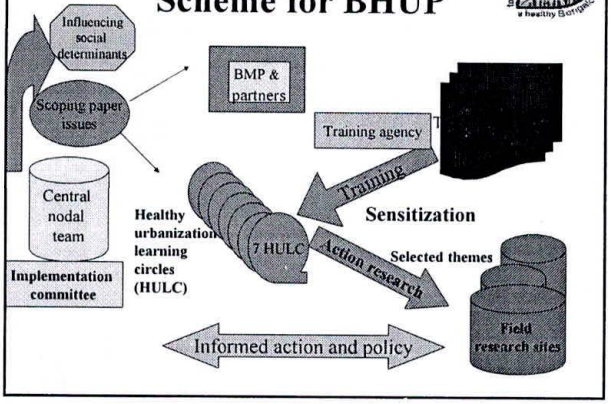
BHUP- Goals

- **BHUP will engage BMP on a journey towards a healthy Bengalooru**
  - **The slected themes wil be studied through action research by trained HULCs**
  - **The outcome of the action research in terms of capacity building, policy advocacy, strategy development and its application will be used by BMP and other governance structures to improve the thematic areas studied.**

Bangalore Healthy Urbanization Project

Implementation

Scheme for BHUP



Operations for BHUP at BMP

- BMP has set up implementation-practice-policy pathways.
- Two committees
  - **CENTRAL NODAL TEAM**
    - High-level committee chaired by Commissioner, BMP (members-20).
  - **IMPLEMENTATION TEAM**:
    - Mid-level professionals (members-25)

HULCS

- **Are networks of multi-sectoral and interdisciplinary teams that will undertake action research projects.**
- **BHUP will have 7 HULCS.**
  - Selected on the basis of:
    - ✓track record of commitment to the improvement of health in the city;
    - ✓ value social justice and equity;
    - ✓These criteria apply to all members of HULCS.

HULCs in Bangalore

- **HULCS will be trained**
- **Will undertake action research based on their capacities and areas of expertise**
- **HULC members will implement the interventions in the thematic areas.**
- **Each HULC will work on all the thematic areas.**
- **Outcome of this work will pass through implementation and nodal committees**

HULCS

- Members of HULCS will be drawn from BMP, research institutions, providers and civil society organizations.
- Will use evidence to influence policy and practice throughout municipal decision-making processes.
  1. BMP
  2. BMP
  3. NIMHANS
  4. MS Ramaiah Medical College
  5. VOICES
  6. CRS/St Johns
  7. CHC

Site selection for action research

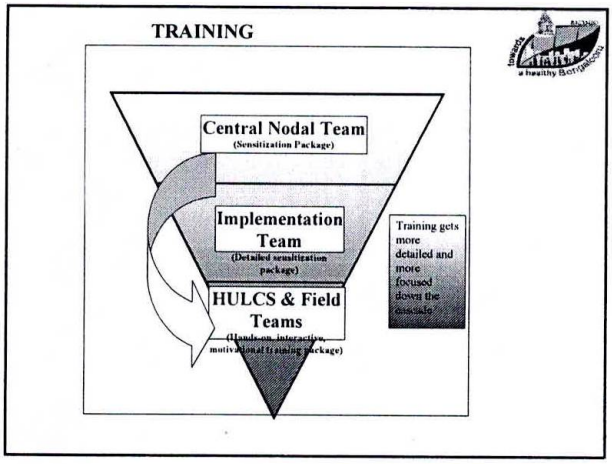
- BHUP action research will be through 7 health centre areas (Pobbathy, Shanthinagar, Vidhyapeetha, Moodapalya, Mathikere, Robertson Road and Vasanthnagar)
- And in 14 low resource settings.

Partners

- All related departments (police, PWD, Department of Women and Child, social welfare).
- Media.
- Corporate sector.
- All stakeholders.

Capacity Building

Key project component



Sensitization

- **Central Nodal Team** (High-level committee chaired by Commissioner, BMP).
- Half –day sensitization on social determinants of health, policy, governance and advocacy issues.

Sensitization (Contd.)

Implementation Team

- Half-day sensitization and training on social determinants of health, action research, implementation & monitoring issues.

HULC Training

- **HULC members' training needs, training strategies, materials, pedagogy etc to be worked out according to *Guidelines for action* and local/site needs.**
- **Addressing social determinants of health.**
- **Identifying evidence-informed policy and practice pathways.**

Training

- **Training Design will be adapted from the WKC modules according to site needs.**
- **Designated training agency selected by WKC upon WHO recommendation will be responsible.**
- **Training for HULCS will be in English & Kannada (local language).**

Training

WKC Training

- **28 Trainees**

- **7** young, active, motivated and committed individuals from Implementation Team.
- **21** trainees -
- 7 from HULCS.
- 7 Health Centre doctors.
- 7 Board of visitors of 7 centre hospitals.
- 7 from community.

Capacity Building

- **Total number to be sensitized =115.**
- **Total to be trained under WKC adapted modules =28.**

Training modules

- **The currently available training modules (WKC) have been reviewed and they are not suitable for the trainees and the BHUP needs**
- **The selected training agency will have to work with all partners and consultants to realign the training modules to the BHUP processes and outcomes**

BHUP: Current status…

And the way forward

Work Completed

- **Consultants at Delhi and Bangalore**
- **Training modules reviewed**
- **Scoping paper done and recommendations reviewed**
- **HULC formation planned**
- **PIP developed**
- **Agencies identified**
- **Office at Pobbathy Maternity Centre.**
  - **Office refurbished.**
  - **Computers installed .**

Next Steps

- **Training agency selection – December 2006.**
- **WKC Training – December 2006**
- **BHUP Project Launch – December 4th 2006.**
  - **State Health Minister, dignitaries, BMP officials, providers, professionals & civil society organizations to be represented.**

HULC Composition

- Interdisciplinary group composed of professionals and civil society organizations/members primarily from social sector.
- Other members of HULC to include health centre doctor, stakeholder, members of civil society, academics, professionals, providers and practitioners.

- Each HULC will select a theme/area according to their expertise.
- The action research projects will be developed according to the needs of the exposed populations in the selected sites and the social determinants of health priorities identified by the HULC.

HULC Operations

- Each HULC will have a nodal organization.
- This nodal organization will be responsible for drafting the action research proposal with inputs from other HULC members, coordinating meetings, making presentations to the Central Nodal Team & the Implementation Team.

HULC Operations (Contd.)

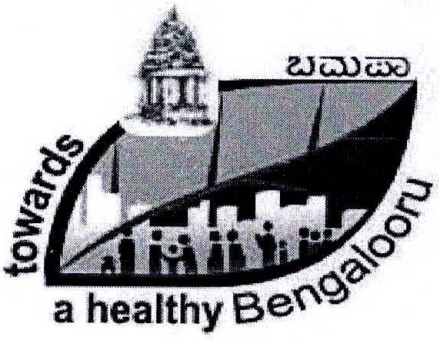
- Each HULC will appoint a nodal officer who will monitor the functioning of the HULC.
- Within the HULC, each participant will have a say and bring to the action research proposal their individual experience and expertise.

HULC functions

- Following the training, HULCS will develop action research plans for 7 months.
- Upon approval by WHO & WKC, these research proposals will be given a small grant to enable them to do the action research.
- HULCS will draw upon the resources of BMP whenever necessary. E.g. answers to queries on housing, water, sanitation etc.

HULC partner organizations

1. BMP
2. NIMHANS
3. VOICES
4. St. John's or Ramaiah Medical College.
5. CHC
- Bangalore College of Social Sciences/Social Work.



DRAFT

Bangalore Healthy Urbanization Project (BHUP)

An urban health research site

A partnership project of BMP, with WKC Japan and WHO (SEARO and India)

BHUP Operational Guidelines

Bangalore Healthy Urbanization Project (BHUP)

An urban health research site

A partnership project of BMP, with WKC Japan and WHO (SEARO and India)

Bangalore Healthy Urbanization is an action research project that promotes health equity in urban settings with a primary focus on basic determinants of health. The project advocates a balance of economic, physical, political, cultural and social development to achieve over all healthy urbanization

Background:

Being the 6th largest metropolis in India, Bangalore is a living witness to the changing face of Indian cities. The city is an ever-increasing hub of industrial and technological growth, changing rapidly specially during the last two decades. Urbanization, industrialization, migration, changing lifestyles – culture – values of people, and economic growth are the hallmarks of the city's growth and development.

Exposed populations

With urbanization and industrialization, slums are becoming a common feature in all cities of India. They primarily constitute the underprivileged and or the disadvantaged groups in the urban areas. Referred to as the "exposed population" they are at a greater risk of experiencing unfavourable social conditions over a longer period. Search for employment, opportunities for education, changes in production and marketing practices, direct and indirect effects of development with the ultimate quest being a search for better life among its citizens are some of the reasons behind this growth. The major characteristics of slum population include – large family structures, low levels of literacy, poverty, skilled and unskilled categories of work force along with poor health status.

Bangalore Healthy Urbanization Project of Bangalore

Under BHUP, 7 Health Centers with 14 Slums have been identified. The identified Health Centres are 1. Pobbathi Maternity Home

2. Vasanthnagar Dispensary
3. Mathikere Health Centre
4. Modalpalya Health Centre

...2

5. Shanthinagar Maternity Home
6. Robertson Road Health Centre
7. Vidyapeeta Health Centre

A sample survey was undertaken (n=3,50000) in the 14 slums with a view to compile a situation analysis of various issues that need to be addressed under the healthy urbanization project. The specific objectives of this survey were to identify:

a. Key determinants of health and its associations with health outcomes.
b. Current health status of exposed populations.
c. Response of the health system and their partners through various policies and programmes.
d. Developing a framework for developing and implementing future activities.

(a) Social Determinants

(Key determinants of health and its associations with health outcomes.)

Social determinants are broadly defined as those conditions present in the living and working environments of individuals and families and are considered as causes behind the causes of poor health outcomes as they are linked to both social and environmental consequences of human actions; in turn driven by structural determinants. These broadly reflect the outcomes of wider economic/political structures and systems as well as individual life styles.

A review of available data indicate that the major social determinants in the urban poor society of the city of Bangalore include:

- Low standards of living as reflected by poverty and low-income levels.
- Poor access to good education.
- Employment related issues like under employment, unemployment, low skilled jobs, less opportunities for growth and consequently low and uncertain incomes.
- Overcrowding in all slum populations due to large families and small availability of space with meager facilities to expand in the near future. The average family size is more than 6 living in less than 400 sq. ft.
- Inadequate water and sanitation facilities as more than half the population do not have access to potable water and toilets.

...3

- Marginalized status of women with regard to education, employment, rights, access to health care and other amenities.

- Issues with regard to survival and safety, especially of women and children due to gender disparities, increasing alcohol usage and exploitation by local people. Violence against women and children is extremely high in slum populations.

- Problems in transportation as people have to travel long distances in the absence of personalized modes of transport.

- Changing life styles, value systems and culture due to changing patterns of living, influence of visual and print media, and increasing life style related risk factors like tobacco, alcohol and changing food habits.

- Demographic transition, which has resulted in the growth of elderly population from nearly 6% in 1991 to the current levels of 8% by 2005. The elderly face complex problems with regard to several social and cultural determinants of health.

- A wide range of belief systems and practices of individuals and families, which directly influence the basic understanding of health and illness.

- Socio-political context and the local governance, which have played a major role in defining the living standards, accessibility and affordability to services and thereby health inequalities.

Among the factors listed above, major factors of importance are -

- Poverty, education, employment and income, water and sanitation, safety and survival, growing elderly population and issues with local governance.

(b) Health status of the exposed population in Bangalore slums

- Conditions like nutritional deficiencies, some infectious diseases (gastroenteritis, hepatitis, respiratory infections, etc.) have been on the decline, while Malaria and Tuberculosis are still major public health problems.

- Risk factors like tobacco usage (20-30% among adult men), alcohol consumption (20-30% among men in 15+age groups), increasing preference to unhealthy food along with decreased consumption of fruits and vegetables are on the increase. Physiological risk factors like hypertension, increased glucose and lipid levels, and suicidal ideations are the most emerging conditions.

...4

- HIV/AIDS is on the increase, especially among the lower income societies as per available data. While no specific data exists on the total burden of HIV/AIDS and high-risk sexual behaviors in exposed population, anecdotal evidence indicates that this is on the increase.

(c) Health Systems & Promotion Policy

In the city of Bangalore, Bangalore Mahanagar Palike (BMP) is a nodal agency responsible for delivering services to the poor, while people are free to choose services from other local care providers. The review of available data indicates that:

- The city has nearly 10 tertiary care centres, 8 Medical College Hospitals, 500 small to large private hospitals and nearly 5000 family practitioners providing healthcare.
- BMP under its own purview 68 urban family welfare centres, 23 maternity hospitals, 6 referral hospitals and 20 dispensaries and offers a wide range of preventive, promotive and curative services.
- The existing system has adequately geared up to meet the challenges of communicable diseases in terms of resources, skills and mechanisms, while the same is totally deficient for non-communicable diseases and injuries.
- While most of the slum duelers use government hospital for treatment 30% of them take facilities from private hospitals.

Health promotion policy has been developed by Bangalore Mahanagara Palike based on the National Health Policy 2002 and the state policy to suit the specific needs of the BMP;

(d) Key Challenges for Bangalore Healthy Urbanization Project (BHUP)

1. The city of Bangalore has grown disproportionately in the last two decades. BMP estimates that there are around 800 slums 464 officially registered. *The city planners and administrators need to seriously consider and provide essential services for adequate health and socio economic development of these exposed communities.*
2. A review of health status of these communities reveals that communicable and infectious diseases are declining marginally, while non-communicable diseases and injuries are increasing. *The infrastructure to deal with communicable diseases is fairly established while the capacity and facilities to deal with the emerging problems is highly inadequate.*

3. Among the emerging problems, issues linked to social determinants of health are a priority. Employment, income, education, gender issues, safety and survival concerns, local administration and governance and others operate in complex ways resulting in changing health patterns and often get linked to value systems, lifestyles and cultural dimensions of people's life.

The way forward

Based on review of available data, interactions with stakeholders and opinion of communities, it is imperative that programmes based on reducing health inequalities and social determinants and health promotion needs to be put in place for the healthy urbanization project. This requires:

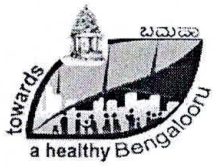
Establishment of a central Nodal Committee

- Commissioner / Spl. Commissioner - Chairperson;
- Deputy Commissioner (Health) - Vice Chairman
- Chief Health Officer - Member
- Project Co-ordinator - Dr. Venkatesh MOH(Shivajinagar) to be approved
- Representatives of Bangalore Metropolitan Transport Corporation (BMTC)
- Slum Clearance Board, Social Welfare Board
- Education Officer – BMP
- Public Relations Officer – BMP
- Prolead Team representatives
- Institute of Child Health (Dr. Shivananda who has been traned by W.H.O.)
- NIMHANS & designated W.H.O. as training Agency for BHUP

- **Implementation team**
  Health Officer, (Public Health & Clinical)
  Superintendents of Referral Hospitals
  Prolead team members.
  Medical Officer's of 7 identified Health Centres.
  Medical Officer's Health of 7 Health Centres (Public Health)

Through *"Bangalore Healthy Urbanization Project"*, the BMP seeks to confront the issue of health inequity initially through 7 Health centres that will undertake action research projects in 14 slums where public health methodologies for action will be introduced.

Bangalore Healthy Urbanization Project
an urban health research site



A partnership project of
BMP, WKC Japan and WHO
India and SEARO

Proposed programme implementation plan

HEALTHY URBANIZATION LEARNING CIRCLES

BMP-managed HULC

Composition:

- Medical Officer – selected because he/she has knowledge of community and major health and non-health initiatives.
- Is a BMP employee and has influence over the area around health centre.
- Can provide leadership to the HULC.

BMP - HULC

- Local NGO representative who is familiar with the area and the exposed populations.
- Post-Graduate student (preferably from Social Work or the social sciences) who is able and willing to do action research. (Maybe as part of thesis work).

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- Suchimithras – (stakeholders). Selected because they are familiar with BMP and work voluntarily in the community.
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- BMP will manage 2 HULCS.
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HULC Mandate

- Following intensive training (5 days between 22nd & 31st January).
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- The research will be based on social determinants of health and needs of exposed populations.

Action research

- Proposals will be sent by BHUP office to WHO & WKC for review.
- HULCS will be given a small grant to carry out action research.
- These will NOT be interventions but recommendations for policy formulation and ideas for better governance.

Practice to policy

- Action research will find evidence to support practice and identify policy development pathways
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Practice to policy

- This reporting will be done through a series of short reports which will be presented to the two committees for inclusion in the policy.
- The Central Nodal team will meet quarterly.
- The Implementation Team will meet monthly.

HULC - OUTCOMES

- Identification of key social determinants within the 7 areas identified by BMP-BHUP.
- Use action research methodologies to identify what can be changed.
- Areas where policy decisions are needed.
- Report and document these for inclusion in the policy framework.

BHUP Responsibilities

- Coordinate HULC training with SHine.
- Monitor progress of action research.
- Hold monthly review meetings with HULCs.
- Convene meetings of the Central Nodal Team and implementation team.
- Facilitate reporting by HULCS

HULC Responsibility

- All 4 HULC team members will have to undergo 9 days training (3+3+3) over a 9-month period, starting end-January 2007.
- They will collaboratively develop an action research proposal.
- Conduct research and report periodically to Central Nodal Team & Implementation Team.

KNUS

- Create local knowledge networks (where appropriate).
- Generate documentation that will feed into the Local Steering Committee.
- And via the Local Steering Committee to WKC and KNUS.

HEALTH CARE UNDER THE BANGALORE MAHANAGARA PALIKE (BMP)

The aim of the Urban Family Welfare Centres (UFWC) and Maternity Homes (MH) is to provide family welfare services and MCH (maternal and child health) services to people living inside the Bangalore city corporation limits.

SERVICES OFFERED UNDER FAMILY WELFARE CENTERS (UFWCs)

- Family planning methods both temporary and permanent
- Immunization for children and pregnant women
- Antenatal and post natal care
- General health check up camps
- Laproscopy camp
- Sexually Transmitted Diseases clinic
- Medical Termination of pregnancies
- Satisfied customer meeting

SERVICES OFFERED UNDER MATERNITY HOMES

Outpatient

- Treatment of minor ailment, and immunization for women and children. Antenatal care for women.

Inpatient

- Deliveries
- Tubectomies
- Cesarean and Hysterectomies

STAFF PATTERN UNDER UFWCs

- One medical officer
- One lady health visitor for 5000 population
- Three Auxiliary Nurse Midwife (ANM) for 15000 population

Both the LHV's and ANMs should make home visit for identifying pregnant women and to motivate them to attend ANC clinic follow up of women who have delivered for post natal care. Identify children for immunization and motivate them to immunize. Identify people for family planning.

STAFFING PATTERN UNDER MATERNITY HOMES

- One doctor (gynaecologist)
- One paediatrician for two maternity homes
- Three staff nurses
- Three ayahs

- three *pourakarmikas*
- Three peons.

There are six referral centers in the following places, one center for four to five maternity homes

1. Siddhiah road
2. Ulsoor
3. Srirampura
4. Hosehalli
5. Goripalya
6. Banashakari

Following staff would be available in each of these referral centers

- Superintendent
- One surgeon
- Two to three gynaecologists
- One anaesthetist
- One paediatrician
- Five to six staff nurses
- Class four workers.

INDIA POPULATION PROJECT (IPP)

India population project eight is run with rupees 40 crore is borrowed as loan form the World Bank. The project period is spread for five years. The project covers population of .851 million urban poor living under the Bangalore Mahanagara Palike (BMP) limits.

Aims and objectives of the project

- To deliver family welfare services and Maternal and child health services to the urban poor.
- To improve the maternal and child health services
- To reduce the fertility rate among the urban poor.

Facilities under the project

- Create one health center for every 50000 population.
- Create 64health centers to promote Nutrition, Family welfare, antenatal and post natal care, medical checkup of school going children, immunization of mother and child, treatment of minor ailments and specialized services.
- Strengthening the existing 37 Urban Family Welfare centers.
- Establish 60 new health centers.
- Conversion of 24 Maternity Homes as referral centers.
- Appointment of 970 link workers.
- Formation of SHE clubs
- Designing and supply of health education material and procurement of audio visual aids for community education.
- Female education
- Income generation activities for women through SHE club.
- Environmental sanitation.

Second Karnataka State Health Assembly
Parallel Session on Urban Health

Background paper prepared by: S.J.Chander, Community Health Cell, Bangalore

Introduction

In the era of globalization only the glamorous part of the cities have attracted the attention of media. More the glamour the cities become for the rich and the elite more the misery it adds to the poor who constitute a significant portion in every city. Cities have always been the economic powerhouses and the political never centers but unfortunately neither the political power nor the economic abundance has done much to the urban poor ever to meet the bare minimum basic needs.

Who are these urban poor? They are generally characterized by poverty, lack of substandard housing, overcrowding, social exclusion (especially from informal sector of employment) and insecurity. (UN Habitat 2003). UNESCO description of the term" fourth world" seems to fit urban poor living in slums. They are described as a sub proletariat whose housing, sanitation, clothing, and food are inadequate; whose cause is not championed by politicians and unions, who have limited information, education and voice; and who, because of indifference or intolerance and the way they are affected by the law and administrative practice, are systematically prevented from exercising the rights that the other people take for granted. *(UNESCO 'fourth world and human rights, Paris 1980)*

From the economic point of view they are considered as burden and from health point of view, a danger (Fernand Laurant, J Introduction, Human rights in urban areas, Paris UNESCO 1983.)

Future trend and urban poverty

The experts are of the opinion that the urban areas of developing world will experience an exponential population growth in the future as a result by 2035 developing counties will be a home for more than half of the worlds poor. Already over 495 million urban poor people are living in developing countries on less than 1 $ a day. [1]

India's urban population is one of the largest in the world constituting over 320 million people. The urban population has increased 8 times in the last 50 years, grown form 44 million to 320 million. Highest growth was recorded from 1951 to 1991. The number of towns increased from around 2,843 in 1951 to approximately 5,100 in 2001. The number of cities with over one million populations has nearly doubled since 1980, from 12 to 23, with the urban population rising from 26.8% to over 35%. Urban India has 25.7% of the national population.

In India, while the urban average growth is stabilized at 3% over the past decade urban poverty continues to grow with the alarming slum growth rate of 5-6%. The official figure for urban poverty was recorded as 32%. It is predicted that while it will take 10 years for the urban

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[1] *Improving health outcomes among urban poor- the challenges and opportunities Lessons from India Family Welfare Urban Slums Project G. N.V. Ramana Sr. Public Health Specialist, Elizabeth Lule Advisor, Population and Reproductive Health*

population to double; it would take only 5 years for the urban poor population to double. [2] Between 39-43% of India's slum population is distributed in the metropolitan cities of Calcutta, Mumbai, Delhi and Chennai. About 1.5 million people are living in about 800 slums in Bangalore. (India CLEN Neonatal Health Research Initiative, 2004.)
The rapid growth of cities creates a major concern on infrastructures and basic amenities to make life comfortable both the rich and poor. The urban dwellers continue face more problems such as inadequate housing, water, sanitation, employment opportunities and various pollutions affecting the environment. They also become vulnerable to industrial accidents such as Bhopal Union Carbide industry. The death rate due to accidents is twenty times more than the US. The growth further puts pressures on the existing services such as, transportation, health care, education.[1]

Health of the urban poor

The widening gap between the rich and the poor accelerated by the process of globalization has been document worldwide. The rural poor turn to cities for survival. Those who turn to the urban areas to escape rural poverty and unemployment do not find much solace when the land up in the urban areas. They subject themselves to double peril; firstly they become more venerable to health problems caused undesirable living condition secondly they become target for the politically influenced liquor barons who aggressively sell their products among urban poor.

The key factors affecting health of the urban poor are poverty and undesirable living conditions. Poverty is defined as lack of specific consumption or not enough to eat; lack of command over commodities exercised by a population and capability to function in a society.[4] Unemployment, irregular employment opportunities or unpredictable employment availability is key factor responsible for the inflicting poverty status. As result the basic minimum necessities for maintaining health is under stake leading to poor dietary intake, poor housing and illiteracy. The second major problem affecting the health of the urban poor is their poor living condition. One wonders why there is an undesirable environmental practice among the poor. The truth is not that all the urban poor do not desire better living conditions, there is lack of awareness on health and disease and their rights. They do not know who is responsible for providing better living conditions for them. They elected representatives are accessible once in five years, before they are elected. As result of poor living condition they fall prey to communicable diseases and infectious diseases. Lack of regular employment opportunities and recreational facilities have led the men to fall prey to social problems such as alcoholism and tobacco consumption. As consequences of these problems the adolescent girls and women become more vulnerable sexual abuse, violence and stress. The major portion of the income that the man earns goes in for alcohol, depriving the families the money for nutritious food and educational needs.

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[2] *All Slums are Not Equal: Child Health Conditions Among the Urban Poor Indian Pediatrics 2005; 42:233-244*,Siddharth Agarwal & Shivani Taneja

1

http://www.photius.com/countries/india/society/india_society_the_growth_of_cities.html Data as of September 1995

[4] *Understanding the poor cities in India and formulating appropriate anti poverty actions, discussion paper for south Asia urban city and management course, Goa, India.2000.*

While there is inadequate response to improve the key determinants such as employment, water and sanitation and housing that can promote the health of the urban poor, the services for managing the life crisis affecting their mental, physical and social health is pitiable. India Family Welfare Urban Slums Project in its report admits that urban water supply and sanitation sector in the country is suffering from inadequate levels of service, an increasing demand-supply gap, poor sanitary conditions and deteriorating financial and technical performance. A recent study conducted by the Jansahoyg a urban resource centere in Bangalore revealed that 10 out of the 14 samples collected form water source for the urban poor were unfit for consumption. Regarding housing, It is estimated that there are about 2,60,000 houses in the slums of Bangalore city of which only 10% of the have RCC which is built by government, NGO/CBO and the communities themselves[5].

Health care services for the urban poor

The term Primary Health care is being loosely used.

India started responding to this challenge as early as 1982 by developing policy framework for urban primary health care. A new initiative known as Urban Revamping Scheme was started in 1984 with strong focus on improving linkages of primary health and family planning services with other urban basic services such as clean drinking water and sanitation. This was followed by several other initiatives including the Bank supported urban primary care project in. Bombay and Chennai during 1988 and 1995 and the current project which closed in 2002.

The Government of India's US$ 81 million Family Welfare Urban Slums project supported by the World Bank helped to develop new partnerships between local communities, municipalities and non-government sector to improve reproductive and child health outcomes among 11.3 urban poor populations of India. Implemented during 1994-2002 under the stewardship of Ministry of Health & Family Welfare, the project aimed to (a) reduce fertility by improving access and demand for family planning services; and (b) improve maternal and child health by decreasing maternal and infant mortality rates among slum residents of Bangalore, Delhi, Hyderabad and Kolkata.

The project scope was subsequently extended to 94 smaller towns in the states of Andhra Pradesh, Karnataka and West Bengal. (**Improving health outcomes among urban poor- The challenges and opportunities**
Lessons from India Family Welfare Urban Slums Project
G. N.V. Ramana Sr. Public Health Specialist
Elizabeth Lule Advisor, Population and Reproductive Health)

In Karnataka there are about 87 Urban Family Welfare Centres, 124 Urban Health Centres and 24 district-level and 149 taluk-level hospitals. There are 51 other hospitals, including super-specialty hospitals, which treat often the non-communicable diseases such as heart diseases, and cancer. The Karnataka government has been regularly borrowing crores or rupees through the Karnataka Health System Development Project (KSHDP) during the past seven years during the past seven years 624 crores have been borrowed to upgrade the infrastructure for 204 taluk and district hospitals. While six of the hospital won the ISO 9002 certification still there are urban health centers without doctors, and medicines. It is reported that some hospitals have been privatized. The role for private sector needs to be regularly scrutinized. The government has established 44 primary trauma care centeres in various places.

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[5] *PROOF Network, Bangalore*

There are around 22,000 practicing doctors in the State. With regard to the availability of doctors, doctor available with the private sectors are three times more than the public sector. While 4197 doctors are working with the public health care institutions, about 15,000 are with the private sector this includes qualified practitioners from others systems of medicine. Regarding bed strength the government institutions have 43,479, about 2000 health care institutions with the private sector have al most the same number of beds.[67]
With regards to accessing these services user fee has been introduced in many government run health care institutions. Studies carried out elsewhere shows that user fees are barrier for many poor people to access the services. The experience of JAA-K revealed the same while implementing the right to health care campaign. Urban areas are witnessing arrival of more poor people from the rural areas. Obtaining the BPL card is found to be a difficult process for these people, more over the way the BPL cards were issues also raises concern among the poor, as it was distributed randomly rather rationally according to the poverty status. While 50 000 rupees is available for accessing specialized care from the chief ministers relief fun, the procedure for availing and information is pivotal. The government has been sectioning about one lakh to every district hospital a year as an additional budget for purchasing drugs that are not available with the government. Information on the way this amount is used needs to be disclosed to the people. . It is reported that the government has handed over the super specialty hospital in Raicher built under the OPEC grant for the poor has been handed over to Apollo Hospitals due to shortage of specialist and funds. The government pays 3-4 cores every year for the maintenance. Information on services offered, utilization pattern, number of poor people use these services needs to be disclosed.

Volume 21 - Issue 18, Aug. 28 - Sep. 10, 2004, Frontline
http://indiaclen.org/Annex%20F_FINAL.pdf

Conclusion

Increasing infrastructure development for providing curative care will not provide a long-term solution for the problem of the urban poor. Firstly factors inflicting poverty needs to be addressed on priority basis. Secondly there is a need for immediate attention from the government to address the land issue by notifying the slums. This will help a few government bodies would come forward to provide the basic amenities thereby paving the way for promoting preventive and promotive health care. Thirdly the problem of alcohol has to be addressed as highest priority. Certainly there is a need for collaborative efforts by Government, voluntary organization and people for improving and strengthening the existing services and to identify areas needing intervention.

The present health care facilities available for urban poor which is family welfare and family planning focused should move towards a comprehensive primary health care, enabling people to take care of their own health not merely providing some services. It is hoped that this dialogue would help focus the discussion achieving this.

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[6] *Volume 21 - Issue 18, Aug. 28 - Sep. 10, 2004, Frontline*

Bangalore plans preventive health for urban poor

Vijaya K – Bangalore Issue Dtd. 16th to 28th February 2003

The Bangalore Mahanagara Palike (Bangalore City Corporation) in association with the Commonwealth Association for Mental Handicap and Development Disabilities (CAMHADD) and Sri Jayadeva Institute of Cardiology has embarked upon a project to provide healthcare for urban poor. A pilot project will be initially conducted for a year in Yeshwantpur, downtown Bangalore.

"A tri-sector dialogue for a healthy community was held to identify key areas for intervention in order to develop a city plan for preventive health with special focus on the urban poor, which constitute 30 per cent of about 65.23 lakh population in the Bangalore city," informed Dr Jayachandra Rao, Chief Health Officer, BCC.

With the involvement of two private hospitals R V Dental College and M S Ramaiah Medical College the project will initially cover 6 wards i.e. around 3 lakhs population. The pilot project is expected to flag off next month will be extended to other parts of the city later making use of the existing infrastructure.

The decision for the pilot project was taken after holding a series of workshops with stakeholders, workshops with key health professionals like health administrators, medical officers, health inspectors, lady health visitors and also auxiliary nurse midwives" said Dr Jayachandra while speaking to Express Healthcare Management.

The BCC runs 68 urban family welfare centres or health centres, 6 referral hospitals and 24 maternity homes. "This is one of our efforts to get ourselves attached to major health institutions both government and private to provide better healthcare to urban poor. BCC just completed a five year India Population Project VIII which was initiated in the year 1994 with the financial aid of World Bank to the tune of about Rs 390 million. The project with support from NGOs aimed at urban slums of Bangalore metropolitan area focussed on mother and child care.

It had also undertaken the task of constructing new health centres, renovation of existing maternity homes and health centres. Accidents and trauma care, cardiovascular diseases, coronary artery disease, hypertension, rheumatic heart diseases, HIV/Aids and primary health care are some of the issues that BCC has been working on in addition to providing public health services like biomedical waste management, control of communicable diseases, overall management of mother and child healthcare, control of rabies, malaria and dengue.

http://www.expresshealthcaremgmt.com/20030228/hospi1.shtml

HEALTH CARE IN KARNATAKA

Frontline, Volume 21 - Issue 18, Aug. 28 - Sep. 10, 2004

The State's Health and Family Welfare Services has 8,143 sub-centres (that is, one for 5,000 people), 581 Primary Health Units (PHUs), 1,679 Primary Health Centres (PHCs), 19 mobile units, 7,304 maternity annexes, 17 urban PHCs and 110 Community Health Centres. While the doctor-population ratio is 1:10,260, the bed to population ratio is 1:1,220. In a novel scheme to improve services, the government has allowed 14 PHCs to be managed by medical colleges and trusts. At these PHCs, 75 per cent of the staff salary is paid by the government and 25 per cent by the private entrepreneur.

There are 87 Urban Family Welfare Centres, 124 Urban Health Centres and 24 district-level and 149 taluk-level hospitals. There are 51 other hospitals, including super-speciality hospitals, which treat illnesses like cancer, heart ailments and tuberculosis. As part of the World Bank-funded Karnataka Health Systems Project, the State government has over the past seven years strengthened and upgraded at a cost of Rs.624 crores the infrastructure in 204 of its taluk and district hospitals. As a consequence, six government hospitals have won ISO-9002 certification. Under the project, user charges are levied in taluk and district hospitals, non-clinical services in some hospitals have been privatised and 44 primary trauma care centres established to provide emergency services to accident victims.

http://www.hinduonnet.com/fline/fl2118/stories/20040910002909100.htm

To RN, EP Attended a part of the meeting on the BUHP on 7/12/06 at Bobathi Maternity Home, Sajjan Rao Circle, V V Puram B'lore at 3pm with SJC. Ms Susan Loo from WKC, Ms Vijayalakshmi Bose from India country office, Dr Vijayalakshmi CMO-BMP, Mr Seshadri from SHINE & others were present.

Bangalore Healthy Urbanization Project (BHUP)
an urban health research site

towards a healthy Bengaluru

A partnership project of BMP, WKC Japan and WHO India and SEARO

Proposed programme implementation plan

- There is a pilot project with WKC-WHO-BMP called BHUP launched on 4th Dec 06. This is for nine months, Seven healthy urbanization learning circles are planned in B'lore.

It involves 9 days of training, action research through 3-4 member teams with local community to identify social determinants of health on which action can be taken. These need to be put up as policy recommendations

HEALTHY URBANIZATION LEARNING CIRCLES

- BMP has developed a draft health policy which needs to be critiqued
- The whole process is equity oriented.
- BMP would like CHC to take responsibility for 1 HULC - possibly Shantinagar which is closer to us.
- There is a small minicule budget
- The pilot is part of a ten year endeavour.

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Composition:

- Medical Officer – selected because he/she has knowledge of community and major health and non-health initiatives.
- Is a BMP employee and has influence over the area around health centre.
- Can provide leadership to the HULC.

- SJC could participate in the program if CHC decides to take it up. The first training is for 5 days in Jan 07 (21-31st)

TN
7/12/06.

This initiative is linked to the WHO CSDH Knowledge Network on Urban Settings (KNUS)

BMP - HULC

- Local NGO representative who is familiar with the area and the exposed populations.
- Post-Graduate student (preferably from Social Work or the social sciences) who is able and willing to do action research. (Maybe as part of thesis work).

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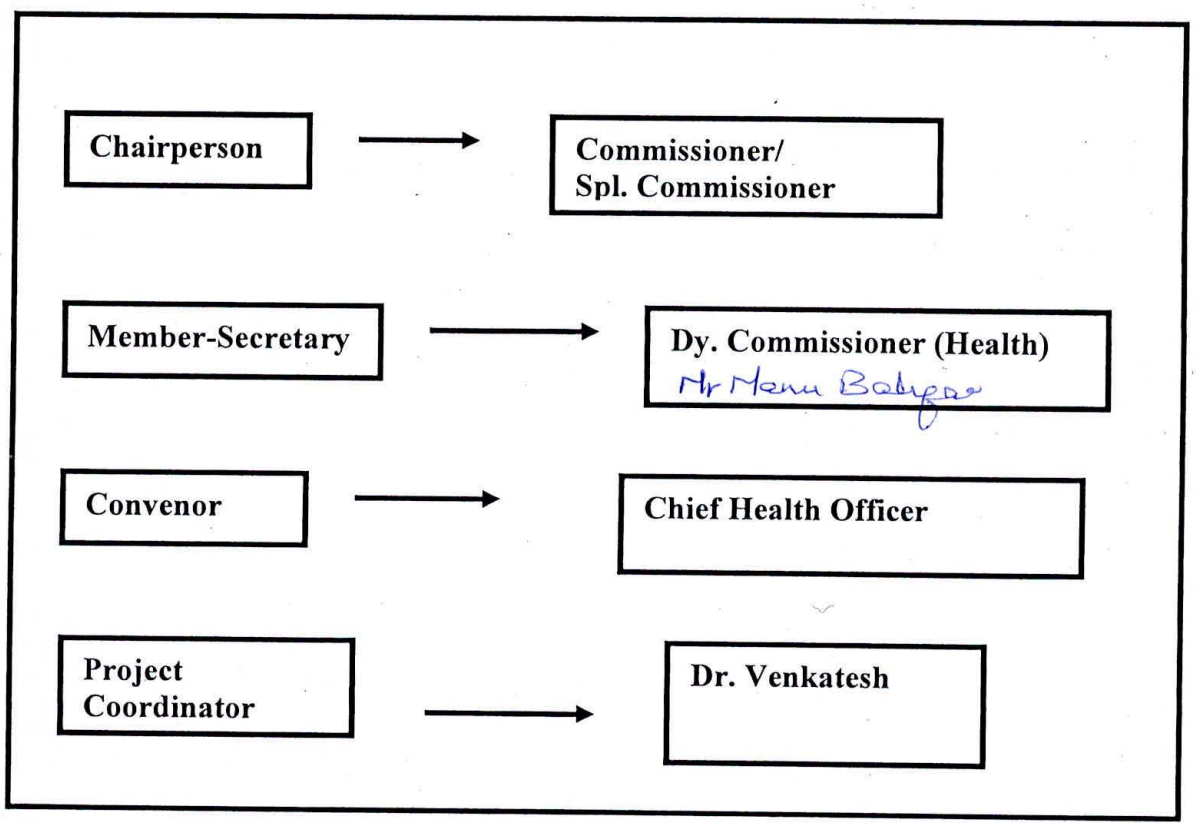
- And via the Local Steering Committee to WKC and KNUS.

BMP operational aspects for BHUP

1. BMP has constituted a CENTRAL NODAL TEAM with personnel at the highest level in various sectors

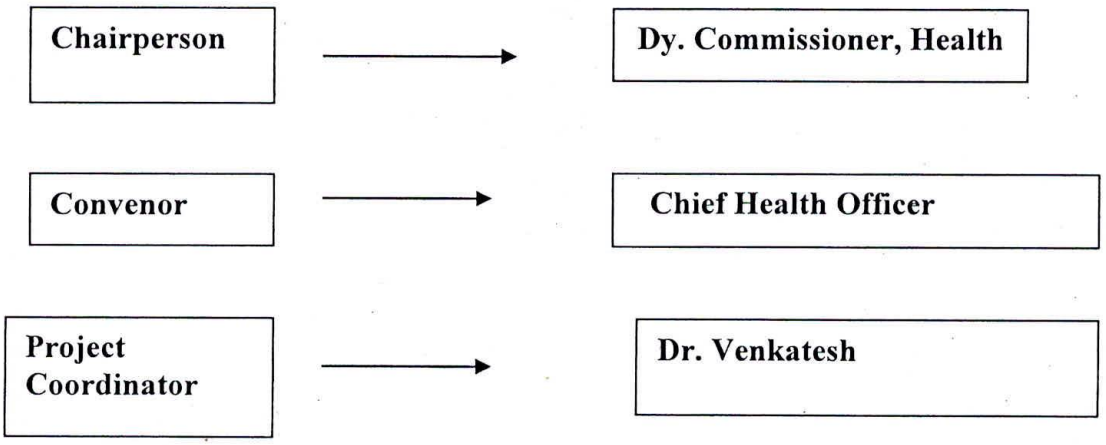
CENTRAL NODAL TEAM



Members:

1. Dr. Gururaj, Professor of Epidemiology, NIMHANS
2. Chief Engineer, Bangalore Metropolitan Transport Corporation (BMTC)
3. Chief Engineer, Bangalore Water & Sanitation Board (BWSSB)
4. Chief Engineer, Slum Clearance Board.
5. Dy. Social Welfare Officer, Social Welfare Board
6. Dy. Commissioner, Social Welfare, BMP
7. Education Officer, BMP
8. Public Relations Officer, BMP
9. Mr. P.R. Ramesh, ProLead Team
10. Dr. Shivananda, Director, Institute of Child Health
11. Mr. Sheshadri, Director, SHine.
12. Dr. Davison Munodawafa, WHO/SEARO
13. Dr. Cherian Varghese, WHO-WR
14. WKC-representative Ms Susan Loo
15. Ms. Vijayluxmi Bose

2. IMPLEMNETATION TEAM FOR BHUP



Core team members

1. Dr. Vijayalakshmi, CHO, BMP
2. Dr. P.S.Thandavamurthy
3. Ms. Kameshwari
4. Ms. Vijayluxmi Bose
5. Mr. P.R.Ramesh
6. Dr. Shivananda, ICH
7. Representatives from HULCS (7)

Field team members:

1. Health Officers, Public Health (E,W,S)
2. Health Officers, Clinical (W, S, E)
3. Superintendents of Referral Hospitals – 6
4. ProLead Team members – Dr. Sriniwas, Dr. Harikiran

Training needs and suggested formats for training

NOTES FROM A VISIT TO SHANTINAGAR MATERNITY HOME (SMH) AND NEARBY SLUMS BY S. J. CHANDER AND NAVEEN – 19 DEC 2006

- Visited Shantinagar Maternity Home (SMH). Met the Medical Officer, Dr. Sandhya. Explained about purpose of visit, and gave brief introduction to CHC and its activities.
- Dr. Sandhya is a medical graduate from Bangalore Medical College (BMC), originally from Kolar. She was earlier working on contract basis and now has been regularized. She has a private practice (one hour per day, Rs.50 consultation) in Hebbal where she stays. She started the practice 16 years ago. Her husband is also in Government service. She was trained by Dr. C.M. Francis on health administration during the IPP-VIII trainings.
- In SMH, she is in charge of Preventive Cardiology programme for *pourakarmikas* of Bengaluru Mahanagara Palike (BMP), which was started in association with Commonwealth Association for Mental Handicap and Developmental Disabilities (CAMHADD), United Kingdom. Now, she is also in charge of the Bengaluru Healthy Urbanisation Project (BHUP) in SMH. On 20th Dec, another programme on school health is being started in the centre, where dental and ENT check-up will be done for children from BMP schools.
- She said that they have already completed collecting information from nearby slums in preparation for the BHUP. The slums were chosen for BHUP on the basis of this information
- The slums they covered were Vinayakanagar, Sathyavelunagar, Jalakanteshwara Pura (J.K. Pura) and a settlement of migrant workers from Gulbarga (about 150 households). The first three are in a cluster.
- Later, over coffee, discussed about corruption in the maternity home, the corruption faced by doctors from clerical staff (second division clerks) in BMP, the unwillingness/ inability of the higher-ups to take notice, the attitude of MH staff when hauled up for corruption, etc. Also discussed about supply of drugs, attitude of patient's to drugs and treatment, their perceptions about drugs given from the health centres, etc.
- She said that organisations/ groups working in the slum include Shanta Jeeva Jyothi, REDS and MICO. A senior citizens' home is also run in the area, with support and collaboration of BMP.
- Visited the J.K. Pura slum, where Shanta Jeeva Jyothi (SJJ) is located (in a BMP building). Met Rajesh, who gave information about the area. SJJ works on leprosy and disability issues. A photo of Dr. Benjamin treating people afflicted with leprosy was put up on their walls.
- Information given by Rajesh, SJJ: The whole of Vinayakanagar has over 3000 houses, of which small pockets are slum-like. J.K.Pura has 348 houses (BMP has numbered the houses and 348 numbers have been allotted). Satyavelunagar is a slum which is located on a private land and is under dispute. It has about 180 households. BMP does not provide any facilities there.
- These areas are flanked by the cemetery on one side and Bengaluru Metropolitan Transport Corporation (B.M.T.C.), Shantinagar offices and yards on the other.
- J.K.Pura is an over-crowded mixed dwelling area with some *pucca* houses (some newly built multi-floored buildings) and mostly small houses, with no ventilation, narrow roads and poor sanitation.
- Satyavelunagar is a very congested area with sewer flowing and stray animals and children all around. Sanitation facilities is almost non-existent. Some shelters (looking like toilets) are not being used. They are in constant fear of eviction. Women's Voice and Kolageri Nivasigala Samyukta Sanghatane (KKNS) work there. We spoke to an old lady, who told us, *"Two people came some time back and told us that they had evicted people from the Poornima Theatre slum and demolished the houses. So, evicting the Sathyavelunagar people would be no big deal.* ***But as long as KKNS is there, nobody can touch us****"*. Ruth Manorama is slated to visit the slum and have a meeting next month. Posters of Women's Voice with Ruth's photo were pasted all around the area.

General Observations

- SMH and the slums are in a radius of about 7-8 kms from CHC. The medical officer in-charge Dr. Sandhya, seemed very co-operative and interested in working together.
- Though adjacent to each other, the slums are spread across a large area. Also the nature of people and communities varies from street to street and cluster to cluster.
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- Community mobilisation for an action research would require constant full-time work in the area, building rapport, identifying groups, understanding the group dynamics in the area and anchoring the mobilisation efforts around a tangible service/ work.
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- Report by Naveen Thomas

Some thoughts for BHUP meeting on 21st Dec 2006 (discussion with SJC)

- Need to clarify about partner's (our) role
- Budget (under what heads)
- Research plan, design and methodology
- Role of the learning circle and mode of functioning
- BMP draft health policy?
- What after pilot project?
- Time-line or calendar of events
- Involving other organizations
- Involve groups experienced in addressing housing, land rights, water/sanitation, etc.
- Training? Research/ Working with urban poor/ etc.

BHUP file

Notes on meeting on the Bangalore Healthy Urbanisation Project (BHUP) held at Pobbathy Health Centre, V.V.Puram, Bangalore

- The meeting was called for by the Local Co-ordinators Dr. P.S.Thandava Murthy (PST) and Ms. Kameshwari.
- The agenda was welcome remarks by CHO, BMP (who did not turn up until the end of the meeting) and detailed discussion on the BHUP by PST (who retd. From BMP last year after 30 years of service).
- The meeting slated to start at 2.00 p.m., started at 3.00.
- PST said that the aim of the project was to study the impact of urbanization in Bangalore.
- It was NOT a curative health project, NOT a BMP project, but a 1 year (of which 3 months has already passed) WHO/ WKC research-oriented project on the social determinants of health.
- Process so far:
  - Scoping paper done by Dr. Gururaj, NIMHANS. (got a set photocopied for us)
  - Baseline data for 14 slums done (some places, still ongoing) by BMP. (will get data when we require)
  - Health Promotion Policy of BMP (have asked Dr. Vijayalaksmi, CHO, BMP who promised to email it to me).
  - Training modules sent by WKC (Its being adapted by SHINE to meet our standards. We can get a copy.)
- The next two trainings by SHINE (I and II Module) will be basically about the survey – what to do, how to do, etc. The dates for the trainings are Jan 17 -19, 2007 and Jan 29 – 30, 2007.
- The aim of the survey is to identify what social determinants exist in that particular selected slum and to see if any policy exists to address it. If it does, then to bring it before the implementation committee; if not, to suggest policy measures to address it.
- The partners would meet every month and submit a report of the work and grogress, which would be compiled and reported to WHO/ WKC by the Local Co-ordinators.
- The Implementation Committee which is composed of heads of various departments (like water and sanitation, health, traffic, etc.) will meet once a month, and take up implementation of policies (if it exists) to address the identified social determinants.
- The Central Nodal Committee, which comprises of decision makers and others, will meet quarterly to oversee issues of implementation and to take up issues where new policies need to be formulated.
- There is no funding directly available for organisations, but only for conducting programmes, meetings, etc.

Discussed with NT/TN SP/ SJC on 22/12/06 11.30 – 12.30

NT: to write a note to BMP
- Prepare a note for others - partners

BHUP file? discuss with NT

Points raised by NT at the meeting

- **NT:** If it is not a BMP project (this is factually wrong, because the brochure clearly says "**a partnership project of BMP**, with WKC Japan, WHO (SEARO and India)), then what is BMP's role?
  PST: after a lot of denial, he finally said that BMP was the 'nodal agency'.
- **NT:** What is binding on other departments to implement what the BHUP suggests?
  PST: They have signed an MoU with …… (need to clarify and get copies) that they would implement the suggestions.
- **NT:** Clarify partners (NGO) role. Are we doing research (leg work) for a project/ research being done by WHO/WKC, since BMP has washed its hands off, saying that it is not responsible for the project?

PST: The partners are not just doing the leg work. They are also representing the case to the implementation committee and central nodal committee. As junior officers, the BMP staff or the project staff cannot question the senior officers, but the partner NGOs can do that. And in the Implementation Committee and the Central Nodal Committee, the case would not be presented by the Local co-ordinators but by the various Health Urbanisation Learning Circles (HULCs) at the community level.

- **NT:** What is the volume of data to be collected? Does it have to be collected door-to-door in the selected slums. Is there any money to pay surveyors? (also raised by Shanmuga Sundaram of Shanta Jeeva Jyothi (SJJ)).
  PST: The questionnaire could be quite long, since it covers the social determinants. All households in the selected slums will have to be interviewed. But partners can choose the slums to be taken up. There is no money to pay as honorariums or salaries.
- **NT:** Can we involve other organisations who work in the area?
  PST: The HULC is supposed to consist of 4 members. The doctor of the health centre, NGO, PG student and suchimitra or local volunteer or anybody which the team leader (TL) finds suitable. In areas where NGOs take the lead, the NGO would be the TL. The TL could choose to substitute the place of PG student and suchimitra or local volunteer with anybody else they choose to, including other organisations. So, in regard to working with SJJ in Shantinagar, we could choose to have SJJ as one of the 4 members in addition to Dr. Sandhya, the health centre doctor and CHC.
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- **NT:** Any research has ethical dimensions. So, if we collect information from a community, what would be our responsibility/ accountability to them, if the project ends after one-year? Similarly, social determinants by its very nature takes longer than one year to change. So, what would be our role at the end of one year.
  PST: Though the project is only for one year. WHO/ WKC has said that they would continue the process for the next five year at least.
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- BHUP office: 41692754
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- Report prepared by Naveen Thomas

Participants
1. Dr Ramesh Kanbargi, Centre for Social Dev.
2. Freedom Found'n, Sharmila
3. Mahila Samaj - Sriranjpwan.
4. VOICES -
5. NIMHANS, Kamini did not come
NO NGO has confirmed partic. so far -
want partics confirm by Monday.

Budget 110,500 USD for B'Love.

SHINE 30,000 USD.

Sloping 3,000 USD.

Projector + mp3 - 10,500 USD

Salaries 54,000 USD

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Good note - see comments overleaf.
VR
25/12/06.

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- BMP draft health policy?
- What after pilot project?
- Time-line or calendar of events
- Involving other organizations
- Involve groups experienced in addressing housing, land rights, water/sanitation, etc.
- Training? Research/ Working with urban poor/ etc.

• The visit & the written note are essential for the CHC team to decide whether an involvement with the BHUP is necessary & feasible. This is part of an evidence based approach to decision making in CHC.
• Since CHC has one member (SJC) committed to working on health in the urban & outter (NT) who has expressed an interest in urban health since several months → think it is necessary for the two to be grounded in a process & to make a firm commitment to achieve results. BHUP is a good opportunity to be actively involved in a community based process focussing on equity & the social determinants of health.
• NT & SJC should both attend the meetings & evolve a strategy
• The 9 month pilot is a prelude to a 10 year process which will be city wide. You can ask & ensure that "unauthorised" slum & Greater Bangalore be included over a period of time. So will appropriate that it is necessary for BHUP to grow in a phased manner
P1. check the BMP website for the draft BMP health policy / ring Dr. Vijayalakshmi & ensure that CHC gets a copy on 21st. circulate photocopies to JAJU group & invited CHC.
Be proactive in developing a time line & involving others but just have meetings with NGOs & others working in the area.
get the budget for CHC taking the responsibility for 1 area (Shantinagar) for the 9 month period. Sat 2/12

Bangalore Healthy Urbanization Project

an urban health research site

A partnership project of

BMP, WKC Japan, WHO India and SEARO

Meeting of Medical Officers of Health

Dear Sir,

You are cordially invited for the detailed discussion of Bangalore Healthy Urbanization Project on 21.12.2006.

Time : 2.00pm.
Date : Thursday, 21st December 2006.
Venue : Pobbathi Maternity Home, 1st floor, Sajjan Rao Circle.

Year's sincerely,

For C. Kaushi

Dr.P.S.Thandavamurthy,
Local Coordinators.

To,
Mr.S.J.Chander
Community Health Cell
#359, Srinivasa Nilaya
Jakkasandra
Ist Main, Ist Block
Koramangala
Bangalore-34
Mo-9448034152
Ph-25531518

- straight minerva circle
- Left (KIMS)
- behind kims hospital (opp gayana samaja)

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20/12/06

Meeting - advance notice, agenda.

Partnership - sharing information, working together, (draft BMP health policy)
respect for each other. (consulting others before fixing meeting dates).

Complementary role - supplement each other's knowledge and experience. and influence.

Ex: BMP officials say 'keep surroundings clean' - people say its your job.

- 'Reasons of rapid urbanisation' - incomplete list
  - land prices ↑, people selling land in
  - peripheral areas
  - People seeking medical care.

Action research -

Notes of BHUP Meeting on January 16th, 2007 at 3.00 p.m., Dassappa Maternity Home

1) Agenda: Further clarification about the project with Jostacio Merno Lapitan of the Urbanisation and Emergency Preparedness Programme, WHO Centre for Health Development (WHO Kobe Centre).
2) 2) The meeting started one hour late at 4.00 p.m. as Dr. Lapitan (a Filipino, working with WKC) had just arrived. Dr. Thandava Murthy (TM) introduced the project, by again saying that it was not a BMP project and repeated the same details as in the earlier meetings. After the introduction, the floor was thrown open for questions.
3) We raised the following issues:
    a. If it is not a BMP project, why is there so much BMP involvement? Also the brochure says that it is a "partnership project of BMP with WKC, Japan WHO (SEARO & India). TM accepted that it was a BMP project.
    b. Methodology used for selection of seven areas for the project. TM replied that the BMP Commissioner chose one area from different directions.
    c. The logic behind composition of HULC members (NGO, BMP Dr., Suchimitra and PG student). Dr. Lapitan said that it was based on previous projects' experience in developing countries.
    d. The ethicality of burdening link workers and other community workers (who themselves are from "low-resource settings") to do additional work without compensation. (Earlier a BMP doctor had confided in us that link workers had not been paid their honorariums from last August). Dr. Lapitan said that BMP informed them that voluntary agencies were already working in the area and would provide voluntary service for the project. But regarding payment to field workers, he said that it could be reconsidered. USD 1500 was kept aside for each HULC and some of that money could be used for it.
    e. HULC members have been requesting for communication stating the nature of partnership, scope of work and the terms of joining the project. Dr. Lapitan asked the BHUP coordinators to make a note of the points and send a letter to the HULC partners.
    f. What are the policy components of the "research and action project"?
    g. The selection method and competence of SHINE to do the training on this issue.
4) TM suggested that we along with Dr. Anuradha of Samata Project, IIM, Dr. Nadakumar of Ramiah Meedical College and others draft a letter stating the scope of project, nature of partnership, etc. after the meeting concluded. We met a small group after the meeting, and gave them points on what should be included in the letter. The BHUP team were given a copy of the suggested points, which included details of project, budget, expected outcomes, responsibilities, inputs required (human resources, time, materials) and so on.
5) After the meeting, we met with Dr. Lapitan, introduced ourselves and discussed with him about the project. We also met Dr. TM and thanked him for the open dialogue. He told us that he was very happy that we had raised the issues. He also said that he was expecting that we would raise questions on why only USD 1500 was kept for each HULC. Many BMP doctors while leaving the hall came and thanked us for raising these issues and said "somebody needs to raise these issues, as they are always ignored".

SJC+NT From what you have written, I think you both have done the right thing. We often have to pay a price for our commitments. However lets always be open to further dialogue if the occasion arises. In the meantime keep the other urban groups informed. It is important that you have kept this documented. Show it to EP+RN for discussion. Is a JABU meeting being planned?

Sn 22/1/07.

Notes of BHUP Training on January 22, 2007 at 9.30 a.m.
Urban Health Training Centre

1) The first module training sessions were scheduled to be held from 23-25th Jan. It was later rescheduled to 22-23rd, and 25th Jan. SJC called up one of the local co-ordinators, Kameshwari on the previous evening (21st) to confirm whether the meeting was still happening on the same dates, she said that there had been some change and that we had to speak to Dr. Thandava Murthy, the senior local coordinator to discuss it. She refused to give further information. Dr. Thandava Murthy did not answer his phone in spite of both NT and SJC calling repeatedly. SJC later spoke to Dr. Vijayalakshmi, the Chief Health Officer of BMP who also did not give any information. He later called up Ms. Vijayalaksmi Bose, the WHO consultant for the project, who said that BHUP had sent our letter to WHO for clearance, since we had raised many questions.
2) SJC and NT went to Urban Health Training Centre on January 22, 2007. They met Dr. Thandava Murthy who said that we could not participate in the programme as our name was not cleared by WHO, and that our communication to them had been forwarded to WHO, since we had raised many questions.
3) NT spoke to Dr. Lapitan and told him that our names were not among the list of participants, and that we were being kept out for raising questions. NT asked him whether they were informed of it, and if so, whether as a WKC representative, he would approve of groups being kept out for raising queries in a research project. He just said that SHINE had sent the list of participants and that they were not involved in it.
4) Later SJC and NT met Ms. Vijayalaksmi Bose, who said that we had been very confrontational in our approach. She said that she knew Dr. Thelma who was not confrontational at all, and she did not know whether the rest of CHC was "rabid". (She later said that she withdrew her comment about CHC being rabid, but she stood by the fact that we were confrontational). She said that she had observed us at other meetings and found that we raised these issues too frequently, in a manner which would make BMP wary of us. (Note: The only meetings where she was present were the BHUP launch meeting on December 4, 2006 and January 6, 2007, in which SJC participated. But he did not even speak once at the first meeting as there was no opportunity for dialogue. In the other meeting, all the participants raised several queries about the project, including SJC. The only other meeting she was present was during the introductory meeting on 7th Dec in which TN and SJC participated. So, there is no basis for her observation).
5) We told her that we had only raised questions about the methodology and implementation of the project, as it was a research project. And there was no other opportunity where we could be confrontational. She said that she could not comment on this issue, since she was not there, nor had we sent a copy of the letter to her.
6) We raised the point that the least "professionalism" that could have been shown was to have informed us that we were not to attend the training, after giving us a letter inviting us for the same. She said that she was sorry regarding that.
7) The participants at the meeting including a doctor of BMP, Mr. Sundaram of SJJ and Dr. Anuradha said that they were very upset with us being kept out. Sundaram and Anuradha said that they would raise it in the meeting.

(Prepared by Naveen and Chander, 22 Jan, 2007)

to NT/ EP/ TN/ for information
F. 13/1/06

The third meeting of the Bngalore Healthy urbanization was held on January 6th Saturday, at Pobathi health center from 12 to 2.30 pm. The following partners were present for the meeting.

Dr. Nandakumar	M S Ramiah Medical College
Dr. Anuradha	Samatha IIM Bangalore
Dr. Sunitha Krishna	Samatha IIM Bangalore
Ms. Radhamani	MICO Bosch
Mr. Rajeev	Shantha Jeevajyothi
Mr. Ganesan	
Ms. Amudha	SPAD
Mr. S.J.Chander	**Community Health Cell**
Ms. Vijayalakshi Bise	WHO India Country office
Dr. Thandavamurthy	coordinator BHUP
Ms. Kameshwari	coordinator BHUP
Dr. Venkatesh	Nodal officer BMP

Though I informed Ms. Kameshwari to send the agenda of the meeting, she did not. When all the partners met at Pobathi Health Center on 5th Ms. Vijayalakshmi Bose said the agenda of the meeting was to get to know more about the partner organization and the person representing each of the partner organization.

Ms. Vijayalkshi bose said this is her first project with the Indian agency; she has health promotion, communication and advocacy background.

Ms. Radahmani is a professional social worker of MICO BOSCH. Dr. Nadakumar is an assistant professor from the Community Medicine Department of M S Ramiah medical College. He has been working with the pulse polio programme of BMP.

Dr. Anuradha is a Gynecologist earlier worked with Samaraksha has joined Samatha of IIM since last one year. Dr.Suneeta is also from Samath IIM. They focus on gender and health with specific focus on reproductive and child health.

Ms. Vijayalkshi bose said the BHUP project aims at carrying out an action research for producing evidences on social determinants of health. The evidence would be used for policy formulation by Banaglroe Mahanagara Palike (BMP). Regarding producing evidence, she said she doesn't need any complaints but evidences. She said BMP has identified 10 social determinants and it would be useful if each HULC takes two social determinants to work on as time will be constrain and the project will be over in a year.

Role of NGOs

NGO representatives are one of the four partners of the HULC. When asked about the role of NGOs she said, NGOs will just guide the research team. She said MSW student would play the role of field investigators. About the research design and methodologies the BHUP team were not sure. They said each HULC could independently carry out based on their interest and skills. She said after the module I training which will happen

17/1/07 SJC- These notes are useful. Please document all meetings/ interactions + keep hardcopies in a file for analysis, reference, planning + review purposes JN

from 23-25 January 2007 the HULC partners will put a proposal to WHO for a small seed money. SHINE will the conducting the training and will impart skills related to leadership, interpersonal communication and motivation.

Regarding MOU, Dr. Thandavamurthy has circulated a letter to all the partners thanking them for agreeing to work with BHUP. The letter also communicated the dates of managers meeting which will take place on 17th January, 2007 and the welcome reception on 18th January,2007 in which the director in charge of the healthy urbanization project of WHO will participate.

Partners comment

Representative of Ms. Ramiah Mediccal College, Sammath, IIM and CHC met after the meeting and discussed. A common consensus was that since no formal letter to collaborate with BHUP was sent, not to agree to collaborate unless a letter is sent. A reply would be sent to the letter circulated by Dr. Thandavamurthy that we would agree to participate in the meetings mentioned. All the three agencies found out The BHUP team neither has clarity not has skill to carry out the action research, therefore we should not allow BHUP to just use us but to work out with BHUP the MOU if we offer our skills in designing the action research.

(Prepared by S.J. Chander.)

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research for healthy cities

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Editorial

"Yet another newsletter?" you might ask. Yes. Yet another one. But a useful newsletter.

The WHO Healthy Cities Project has become a global movement. According to our most recent counts, over 400 cities worldwide are involved in innovation of the public health realm into a 'new public health'. All of these cities have one or more links to academic institutions, or undertake research endeavours themselves.

At a series of Healthy Cities conferences it has become clear that traditional research methods are not fully applicable to new public health questions any more.

The academic resources for research for healthy cities are little efficient; in a scholarly world that has been dominated by high specialization and professionalism it turns out that academics who'd want to transcend the boundaries of their discipline are limited in choice of fora and platforms to exchange interdisciplinary experiences.

This newsletter is therefore timely. It gives new local public health researchers an opportunity to exchange ideas and experiences without having to go through the treadmill of academic journal assessment and referee procedures. Especially young researchers, at the outset of a possibly promising interdisciplinary career, often find these procedures tiring and frustrating, even to the extent that they eventually retreat to the comforts of mono-disciplinary work.

You receive this Newsletter because over the past couple of years you participated in a Healthy Cities meeting. Therefore, you know what the problems are which the movement is facing. Thus, we don't have to argue that this publication is suited to your needs. We invite you to make this Research for Healthy Cities Newsletter a success; you are free to submit material for each of the sections in this publication:

* Research notes - short descriptions of recent projects, methodology and outcomes. You may want to invite colleagues from around the world to comment or request your publications (this Newsletter is mailed to 500 researchers from at least 20 different disciplines in over 50 countries);
* Research plans - short descriptions of intended projects, research policies, methodological problems, or requests for information on specific topics;
* Meetings;
* Miscellaneous.

Another point - subscription to this Newsletter is free of charge. The first volume (4 issues in 1991) is already financed, and more monies are becoming available for following years. However, ninety percent of the people on our present mailing list are from the Western/North-European hemisphere. We would appreciate it very much if you would be able to fill out the 'Subscriptions free!' box on the last page with names and addresses of colleagues possibly interested in this

publication - especially from other regions. You may even want to xerox the last page, and distribute it to colleagues at meetings or through mail.

Evelyne de Leeuw MA MPH PhD
Editor-in-chief

Publications

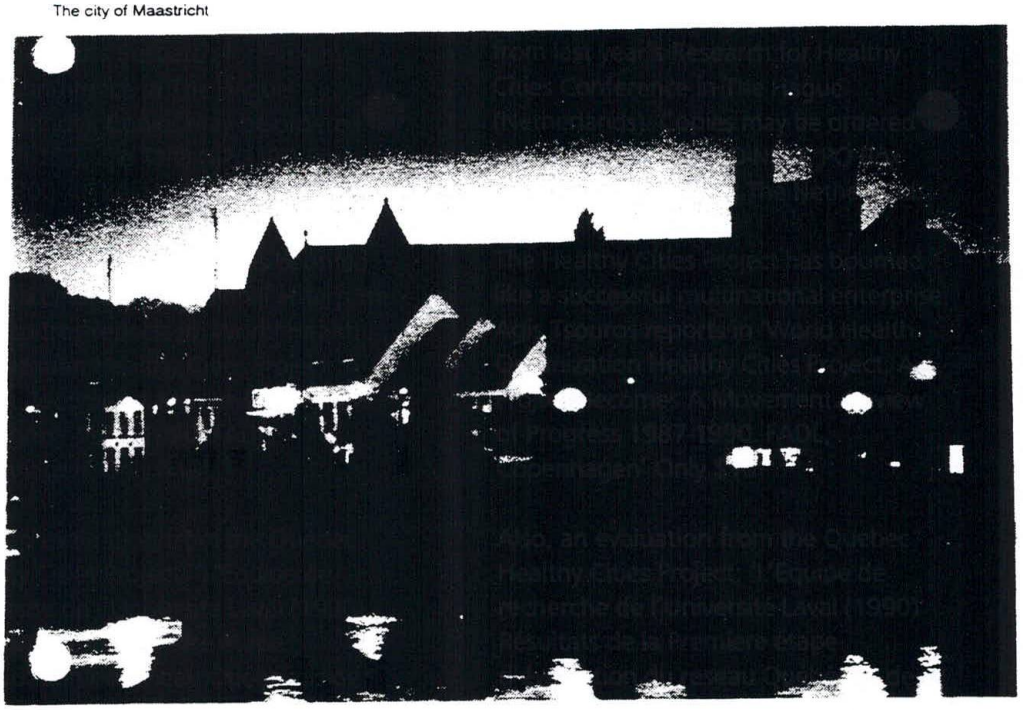
'Streetwise' is a magazine of urban studies providing a forum for radical thinking on urban issues, policy development and education. Subscription for National Association for Urban Studies members £10, institutions £20, individuals £14.50. International subscribers add £4 for postage. Apply at: Streetwise, Lewis Cohen, Urban Studies Centre at Brighton Polytechnic, 68 Grand Parade, Brighton BN2 2JY, England.

'Research for Healthy Cities' is the 140-page book containing keynote speeches from last year's Research for Healthy Cities Conference in The Hague (Netherlands). Copies may be ordered through TSG, c/o TNO-NIPG, PO Box 124, 2300 AC Leiden, The Netherlands.

The Healthy Cities Project has boomed like a successful multinational enterprise. Agis Tsouros reports in 'World Health Organization Healthy Cities Project: A Project Becomes A Movement. Review of Progress 1987-1990. FADL, Copenhagen' Only $10!

Also, an evaluation from the Quebec Healthy Cities Project: 'L'Equipe de recherche de l'Université Laval (1990) Résultats de la Premiere étape d'évaluation du reseau Québécois de "Villes et Villages en Santé" Contact Michel O'Neill, Ecole des Sciences infirmières, Cité Universitaire, Quabec, QC, Canada.

The city of Maastricht



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Return to:
Evelyne de Leeuw
Department of Health Ethics & Philosophy
University of Limburg

PO Box 616
6200 MD Maastricht
The Netherlands

Research notes

Healthy Cities now also in Flemish Belgium

Apart from some isolated efforts, the Flemish part of Belgium has never been successful in jumping on the racing Healthy City train. This might change now. The province of Limburg investigated the capacities of municipalities, aldermen and local civil servants to work in the frame of the new public health. Their findings were that new monies were badly needed; funding is now under way to appoint public health policy makers in each city and municipality.
Information: Provinciebestuur, Dienst Public Relations. Dr. Willemsstraat 23, 3500 Hasselt, Belgium (fax (11) 22.71.92)

Indicators for Healthy Cities: Canadian developments

The federal ministry of Health and Welfare in Canada is pursuing its 'Knowledge development program in health promotion'. One of its priorities for the 1989-90 period is to stimulate exchanges across Canada to foster the development of indicators to evaluate the healthy cities ventures. Indicators development in health promotion was singled out as one of the top priorities for research at the end of a three years long consultation process involving over a thousand academic and non-academic researchers across the country, as well as users of research results. In december 1989, it was decided after a national seminar on indicators where Prof. Horst Noack of Berne University in Switzerland was a distinguished lecturer, that the very complex issue of indicators construction should be approached on a specific topic if any concrete result were to be expected in a one year time span. It was thus agreed that indicators for Healthy Cities was to be the focus, due to the pressing needs of the fast growing netweroks of Healthy communities in English Canada and Villes et villages en Sante in Quebec. For general information on the Knowledge development strategy in Health Promotion, contact Dr. Michael Nelson, Health and Welfare Canada, health Promotion Directorate, Jeanne Mance Building (room 420), Tunney's Pasture, Ottawa, Ontario, Canada K1A 1B 4; tel. (613)-957-7797.

The strategy to advance and disseminate knowledge on Healthy Cities indicators is to hold a series of six seminars in various parts of the country as to build bridges between various academic disciplines as

well as bridges between academics and decision makers at the municipal or other levels. The first of these seminars has been held in the Prairie Region (Manitoba and Sasketchewan provinces) on February 19, 1990 and wass a unique occasion both to discuss Healthy Communities indicators and to further develop the network of health promotion researchers in this part of the country. Details on this workshop as well as the proceedings ar available from Dr. Joan Feahter, Health Status Research Unit, Department of Community Health and Epidemiology, University of Sasketchewan, Saskatoon, Canada S7N 0W0, tel: (306)-966-7939.

Two other workshops have been formally scheduled. The first will be held in Vancouver on October 19 for the Western part of the country (Territory of Yukon as well as province of British Columbia) and the second in Montreal, on November 1, for Quebec. The contact persons are: Sharon Manson-Willms, Center for Human Settlements, University of British Columbia; 2206 East Mall, Vancouver, B.C., Canada, tel. (604)-228-6081; fax: (604)-228-6164 and Michel O'Neill, Ecole des Sciences infoirmieres, Unviersite Laval, Quebec, Qc, Canada, G1K 7P4, tel: (418)-656-3356, fax: (418)-656-3174.

The three other workshops will held be shortly. These regional workshops will culminate in a special meeting during a national conference on research methods in health promotion to be held in Toronto from November 30 to December 2, 1990, where the progress made in the different regions will be put together. people interested by this conference can write to: 'Health promotion research methods: expanding the repertoire', Continuing Education, Faculty of Medicine, University of Toronto, Toronto, Ontario, Canada, M5S 1A8, tel: (416)-978-2781.

Academic infrastructures for Health Promotion research are developing in Canada

At least three universities have begun to formalize such structures. In Ontario, the University of Toronto has created a Center for Health promotion whose director is Dr. Irving Rootman, formerly from the Health Promotion Directorate of Health and Welfare Canada. He can be reached at: Center for Health Promotion, University of Toronto, Mc Murrich Building, 12 Queen's Park Crescent, Toronto, Ontario, M5S 1A8, tel: (416)-978-1809.

The University of British Columbia has started an Institute for Health Promotion, Faculty of Graduate Studies, Mather Building, 5804 Fairview Avenue, Vancouver, B.C., Canada, V6T 1W5, tel: (604)-228-2258, fax: (604)-228-4994.

Laval University, in Quebec City is also starting a 'Groupe de recherche et d'intervention en promotion de la santé', under the joint leadership of Dr. Gaston Godin and Dr. Michel O'Neill. They can both be reached at: Ecole des Sciences infirmières, Université Laval, Quebec, Qc, Canada, G1K 7P4, tel: (418)-656-3356, fax: (418)-656-3174.

The research program of these organizations has yet to be finalized but, given the importance of both Healthy Communities and Villes et Villages en Santé, it is very likely that research endeavors related to Healthy Cities will be undertaken by one or the other of these centers or by many of them as a joint venture.

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Cité Universitaire,
Quebec, Canada G1K 7P4

HEALTH FOR ALL 2000

THE WHO HEALTHY CITIES PROJECT

WHO / EURO
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2100 - Copenhagen,
Denmark

University of Edinburgh

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The Netherlands

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research for healthy cities

2

Editorial

We're getting off the ground with Research for Healthy Cities! In the months that elapsed since the first issue of this Newsletter, we

* increased the number of subsriptions from 250 to nearly 600;
* witnessed the creation of numerous Health Promotion Research groups;
* received over 120 publications related to the Healthy Cities movement; and
* started preparations for a meeting aimed at Healthy Cities researchers in the summer of 1992, either in Quebec (Canada) or Maastricht (Netherlands).

Please fill out the form on the next pages to indicate your interests and availability for such a meeting.

Lots of news, you'll understand. In this issue a short description of a Healthy Cities Network analysis, several reports from meetings, new publications, and miscellaneous news.

Evelyne de Leeuw MA MPH PhD
Editor-in-chief

Guest editorial

Evaluating Healthy Cities: the most urgent research task.

Michel O'Neill, Ph.D.(1)

There are several research areas that could be developed in relation to the Healthy Cities movement. What I would like to argue however is that the most urgent task to which academic and non-academic researchers should devote their time is the evaluation of the ongoing tidal wave of municipalities running to join the healthy cities movement all over the world. I am aware that pushing for the evaluation of something new and innovative can be the best way to hinder it or, for interests made uneasy by it -especially if powerful- to get rid of the thing. I am also much aware that under the heading 'evaluation' a whole sore of totally different research endeavors can be undertaken as well as totally different types of questions to be asked. I nevertheless think it is the research priority for at least two reasons.

The first one is very pragmatic. Once the original commitment made by cities has elapsed for some time, and when the hard reality of implementing the stimulating but hazy concepts of healthy cities has been around for a while, questions are automatically raised about what this initiative is producing, and if it is worth continuing it. These questions can be asked by city politicians or civil servants for electoral or financial reasons, by the people running the project to have a sense of direction and accomplishment, by academics interested at theorizing on a fascinating innovation, etc. However, if there is to be a long term commitment to the project wherever, there is no way to avoid a kind of assessment of what Healthy Cities produce. The second reason is that it is one of the research areas where interaction between users and producers of knowledge, as suggested in the ideological rhetoric of health promotion, is unescapable. As I have been able to witness over the last year, in several workshops devoted to information or indicators to assess Healthy Cities on both sides of the Atlantic, who evaluates what, for which purpose, with which kinds of information and in which delays has tremendous consequences and poses more than one delemna that are in my opinion essential to confront for the very survival of the movement.

It forces academics from a wide array of fields and disciplines, who usually think of themselves as the knowledgeable researchers, to interact with the politicians, the bureaucrats and the community groups as well as to negotiate -or to be told ...- what evaluation should be done. It shows that in many a place, the development of healthy cities networks is very uneven and that evaluation concerns are very diversified indeed. Moreover, it raises all kinds of difficult issues about the link between evaluation and control. Should localities performing 'poorly' (however this is defined) be excluded of the network? Should relabelled old things be considered legitimate healthy cities endeavors or should just new things started after the healthy cities ideology like equity, intersectoriality or participation, move out? For how long? Who decides?

Despite these dilemmas, I would thus argue that having rigorous and relevant evaluative looks at the development of Healthy Cities, be it within a city, within a national network or even internationally, is very necessary. Otherwise, the movement might quickly become very vulnerable and dissolve at the same pace it has grown!

(1) Professeur titulaire, Groupe de récherche et d'intervention en promotion de la santé et École des Sciences infirmières, Université Laval, Quebec, Qc, Canada

Publications

From different corners of the world we received reports with Healthy Cities Evaluations:

Baum, Fran et al. (1990) Healthy Cities Noarlunga Evaluation. Southern Community Health Research Unit, c/o Flinders Medical Centre, Bedford Park, South Australia 5042. ISBN 0 7243 0477 7
Also available from this address: a needs assessment manual.
Cardinal, Lise & Michel O'Neill (1990) Résultats de la premiere étape d'évaluation du réseau Québécois de 'Villes et Villages en Santé'. Université Laval, Québec, Canada

Blackstaff Community Health Project (1991) The Blackstaff Community Health Profile. Olympia community Centre, 14 Boucher Road, Belfast BT12 6HR, Northern-Ireland

Other publications received include:
Bracht, Neil, editor (1990) Health Promotion at the Community Level. Sage, Newbury Park, USA

Evers, Silvia (1990) Health for All indicators in health interview surveys. WHO/EURO, Copenhagen

Scott-Samuel, Alex (1990) Total participation, total health. Reinventing the Peckham Health Centre for the 1990s. Scottish Academic Press, 139 Leith Walk, Edinburgh EH6 8NS, Scotland. ISBN 0 7073 0630 2

Leeuw, Evelyne de, editor (1991) Gezonde Steden. Lokale gezondheidsbevordering in theorie, politiek en praktijk. Van Gorcum, Assen, Netherlands. ISBN 90 232 2632 1. 320-page Dutch handbook. Shouldn't pose a lot of reading problems to Germans and Scandinavians, but Spanish and English translations are nevertheless underway.

Cappon, Daniel; 'Indicators for a healthy city'. Environmental Management and Health, an International Journal, 1(1)9-18, 1990.

Fortin, Jean-Paul; O'Neill, Michel; Groleau, Gisele; Lemieux, Vincent; Cardinao, L; Racine, Pierre; Les conditions de réussite du mouvement quebeçois de 'Villes et villages en santé'; Quebec, Université Laval, septembre 1991, 148 pages.

Milio, Nancy; 'Healthy Cities: the New Public Health and Supportive Research', Health Promotion International, 5(4):291-299, 1990.

O'Neill, Michel; Cardinal, Lise; Fortin, Jean-Paul; Groleau, Gisele; 'La naissance reseau quebeçois de villes et villages en santé', Récherches Sociographiques, 31(3):405-418, 1990.

The new bible is out! Out of the most up to date research literature, ten years after the PRECEDE model, Green and collaborators have devised the PROCEED model to plan and conduct health promotion interventions, adding policy and environmental interventions to the more behaviorally focused model of 1980. The authors also make a strong plea that communities are the central locus where health promotion should be carried out. Green, L.W. and Krewter, M.W.; Health Promotion Planning, an Educational and Environmental Approach; Mayfield; Mountain View; California; 1991; 506 pages.

Report

Network analysis as a method.

Marleen Goumans

Summary
Because of several reasons individuals, groups and organizations keep up relationships with their environments, and, by means of this, build networks. Every network is unique in its form and functioning, but there are some common characteristics to be distinghuished. In a study of networks, an analysis of the different relationships (such as kind of relationship, intensity or amount) will provide useful information about structure and functioning of the network. There are many methods used, but in fact there are four main approaches: a descriptive, a socio-metric, a graph-theoretical and a blockmodeling method. To analyse structure and functioning of national Healthy Cities networks a method was used which contained some elements of those four approaches. Because they all did not exactly fit in with the subject of Healthy Cities, and adaptation was needed. The outcome of the inquiry confirmed the importance of a well defined network analysis when a mutually connected group of actors (individuals, groups or organizations) are under study.

Introduction
Network analysis can be regarded as a research instrument to interpret behaviour in a wide variety of social situations. And, moreover, it enables one to create a better understanding of the network (for example functioning, structure, development, outcome). It is mostly used in the field of sociology, politicology, antropology and socio-psychology.
In this article the authors' experience on this subject, based on a inquiry on national Healthy Cities networks, will be drawn upon to illustrate the possibilities of network analysis in the field of 'new-public-health networks'.
This article is not a summary of the findings and conclusions of the inquiry.

Social networks
Almost every organization is surrounded by an environment which influences her and which has to be taken into account when planning, organizing or implementing activities. This means that an organization, but also groups or individuals, keep up different kinds of relationships (very formal, such as a 'interlocking directorate' on top-level, or informal by means of a telephone call or a drink) with organizations, groups and individuals in their environments because of political, social, economical or other considerations. Common goals and interests or (strategic) importance of the other party for realizing the stated goal: the most important reasons for a form of collaboration.
According to the literature a social network can be defined as:

> *"A group of actors (individuals, groups or corporations), which are mutually connected by means of many social relationships (for example kinship relations, financial trans-actions, organizational information channels)."*
> *(Felling and Hüttner, p. 248)*

Although every network is unique in its form and functioning, there are several common characteristics, such as (without being exhaustive): equity, not bureaucratic, know the right people, informal circuit, common character, complexity, cost a lot of energy, patience, effort and cooperation, flexibility, sharing of knowledge. Those characteristics have a so called 'glue-function'. That means, the way organizations stay together, reasons why relationships continue and the network structure will last.

Network analysis
In a network a participant (individual, group, organization) is linked to other participants by means of exchanging resources. One organization can be participating in several networks, and has the possibility of linking networks with each other. This does not mean that all those relationships are of the same character. In one network it may be a very loose information-exchange concept, while the same organization has a highly formalized relationship in the other network. Often a visual picture of a situation increases the understanding and insight in the matter. This is the reason why in network analysis and network research the visualisation of the network structure is a part of the study which receives much attention. Such a network structure is called a 'topology'

(Goumans 1991a, p. 25 - 31). In a simple network which consists of two participants (in this case cities and/or organizations), it is obvious that they are connected and communicate with each other. However it will be more difficult when the number of participants gets larger to detect who is communicating with whom (remember the mathematic lessons on calculation of probabilities...).
The purpose of network analysis is, according to Stokman (1982, p. 168):

> *"To define content and patterns of social relationships (collaboration) between participants of a network; and in the meanwhile examine the consequenses of these patterns on the behaviour of the social entities and the influence of this behaviour on the patterns."*

The focus can be on a variety of elements (such a specific organization, environment of the network, motivation to participate, quality of the relation, power, organizational charcteristics), and there are different methods used. The problems a researcher has to face when he or she starts with an analysis consist among others of how to define the borders of the research field (what should be included, what not, and why); the absence of an uniform theory about network analysis; the methods used are different for many studies (because the research fields are different); and difficulties how to define the relations which will be taken into account.

Approaches

Although the methods used are fragmentated there are in fact four main approaches. A descriptive method, in this method the network will be analysed by describing and examine various elements which are connected to the network (such as bases for relationships, specific situational factors, resource flows, characteristics of the environment). A socio-metric method, this method is also descriptive but uses also matrices and sociometrical indices (such as status score, group cohesion). A sociometrical matrix expresses for example who interacts with whom, and a sociogram illustrates the relationships established between the different groups or organizations. A graph theoretical method, within this method relationships between social entities are represented by points which are connected by means of lines (points and lines are very easy for mathematical purposes). In a graph the direction of the information flow is not visible, in a directed graph (digraph) however this is mead visible by means of arrows. By means of a digraph many network characteristics can be illustrated. For example distances (in the graph) between participants; detection of centres; who acts as a inter-mediating station. And the block-modeling method, this method tries to create an algabraic structure out of social relationships. Here the focus is not on individuals but on groups of persons. Advanced computer programmes have been developed to 'block' the data and provide calculations (abstracting some aspects of the structure), and provide therefore the information that is needed to analyse and describe the structure content and influence of the relations.

Analysis of national Healthy Cities networks

The objective of the inquiry was to analyse organization and structure of national Healthy Cities networks. Because national networks are an example of social networks (participants interchange different resources (such as information, money, people, facilities)), the idea was to use one of the techniques as outlined above.
Two research objectives were formulated:

1. How are the different national Healthy Cities networks organized and how well do they function?
2. Analyse the relationships between actors (participants) in a national network in view of the creation of a M.I.P..

A Management Information Plan (M.I.P.) is in this case:

> *A plan which structures and provides insight into the information flows between participants of a national network, and between national networks and the WHO/Euro/ HCPO.*

In every organization (in this case network) one can discover a multitude of information flows. The larger the organization, the larger, and most of the time more complex, are the resource flows which go along. Therefore it is important to structure, coordinate and organize those resource flows, thus to take care of information management. Information management and policy is made more concrete by means of a information plan.
Data were gathered by means of documentation materials in the field of the Healthy Cities project and the national networks, consultation of team members and a questionnaire which was sent out to fourteen national networks in Europe. The latter has been the most important source of information for answering the research questions, and as such as the most important source for structural analysis of the national Healthy Cities networks.

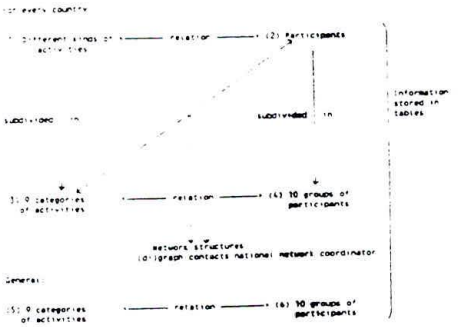

Figure 1. FRAMEWORK FOR STRUCTURING DATA

The data were structured as shown in figure 1. The different kinds of activities (1) as used in the questionnaire, can be subdivided into nine categories (3). The participants of a national network (2) can be subdivided into ten groups of participants (4). Attention was paid to:
relation (1) - (2) on country level
relation (3) - (2) on country level
relation (3) - (4) to compare countries with each other
relation (5) - (6) to create a general picture of a network

To make comparisons between the different national networks possible and useful, there has to be worked with some general parameters. In this particular inquiry this means dividing the different activities in 'categories of activities' and the different participants of every single country in 'groups of participants'. Important was that all the participants as appeared in this study, were represented in one of the general groups. And moreover the categories and groups had not to be too general and still had to yield useful information.The comparisons as made in this inquiry are stored in tables. For comparison (3) - (2) (see figure 1) it was also possible to provide information about frequencies of involvement in certain activities and the resources which were used by the participants (see table 1). However for comparisons (3) - (4) and (5) - (6) it was not possible to provide detailed information about frequencies and resources. This because the range of frequencies was ver wide (0 to 365) and the amount of respondents low (8).

Groups of Participants	Activities								
	1	2	3	4	5	6	7	8	9
1 secretary	6	5	1	3	2	4	4	2	-
2 HC project city	9	5	5	6	6	6	5	3	1
3 HC-Cities	8	5	5	6	5	5	6	1	1
4 HC-Committees	6	4	2	5	4	4	4	-	-
5 HC-Coordinator	7	6	3	7	8	7	6	1	1
6 Government (national)	8	4	4	6	4	4	4	1	1
7 Government (local)	2	4	4	5	5	5	5	-	1
8 Research institutes	4	4	3	5	4	5	7	4	1
9 Interest groups	2	3	2	2	2	2	3	-	-
10 Other	2	4	3	4	1	1	3	-	-

Table 1. PARTICIPANTS AND ACTIVITIES

In table 1, the activities are presented horizontally by means of numbers (1 to 9), and the participants are presented vertically by means of letters and abbreviations or the

name of the particular group of participants. The tables concerning 'participants in relation with activities' (table 1) and 'resources and frequencies' (table 2) are almost similar.

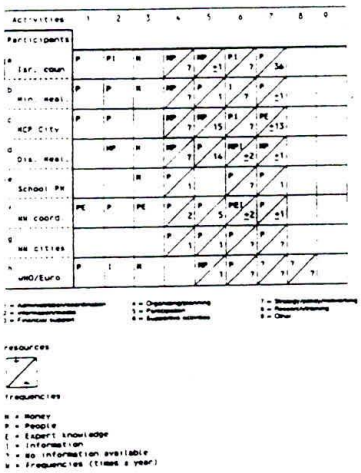

Table 2. RESOURCES AND FREQUENCIES (EXAMPLE: ISRAEL NATIONAL NETWORK

The first one provides information about who is involved in what (marked with X), and the latter provides information about the resources used (marked with letters) and the frequency (times per year) with which a participant is involved in an activity (marked with numbers). The latter provides insight into the intensity of the involvement. For example, two participants can be involved in the same activity, but one can do this once a year and the other can do this very regularly. To make comparisons between national networks possible and legitimate, there were also tables used were the participants of a country were divided into groups. It was also possible to study the role of a specific participant in the several national networks. In this case the several countries (in stead of activities) were presented vertically. By means of using those grids, several comparisons were, and could be, made. Thus, the approach used for analysing the relational structure of national Healthy Cities networks, was not exactly one of the four methods. It was rather a combination of those methods with ideas of the researcher. For every country a general dexcription was given about development of the network until so far (descriptive method). After this the most important participants of a network, as detected by the researcher and checked by the respondent, were introduced (descriptive). The activities of a network and the involvement of the different participants were processed into tables (socio-metrical method). Some extra attention was given to the role of the WHO/Euro Healthy Cities project office and national network coordinator in every network, a digraph was used to show the relational structure of the national network coordinator (descriptive and graph theoretical method). Followed by a description of the importance of different activities and organizations for the national network (descriptive). And finally the relation between activities and participants were presented again, but now in a way which makes it possible to compare the different networks with each other (block modeling method [when realizing that is spoken about 'groups of participants' in relation with 'categories of activities']).

Discussion

Networks are interesting but difficult to study since they do not have natural boundaries. When a network as a whole is impracticably large, the usual procedure is to dreate a 'subgraph' and treat is as a representative sample of the whole network. Therefore when collecting information about (the existence of) relationships between participants of the network, one has to be aware that one is working with only a part of the total network. It is in this case very important to use clear definitions of terms used, relationships which are taken into account and meaning of those relationships in this research.

The inquiry on national Healthy Cities networks is on a national level, but imagine a road-network, there are high-ways and roads but there also streets and small landroads which are not taken into account. Regarding the research objectives, the first objective has been reached partly. It was possible to write eight reports anout the structure, functioning and organization of national networks, and those findings are useful in the way that they provide insight into a network structure; provide insight into the relation between the participants and the activities which are organized or take place; provide insight into the role of the WHO. However, it was not possible to speak about structures of national networks in a sense of 'who is communicating with whom (except for the communication (relation) between a network coordinator and other participants); it was only possible to speak about structures in a sense of 'what is going on; who is doing what'.

The second objective has also been reached partly. As mentioned before, it was not possible to analyse the relations between the different participants. However, the results are useful for the development of a Management Information Plan (M.I.P.). The basis of a M.I.P. consists among others of a description of the participants, their activities and the resource flows. The findings proved information about the participants of a network; their functions and roles in the network; their relationships with the national network coordinator; their activities in and for the network; and the resources they provide for the network.

This shows also that techniques which are developed in other fields (and/or for other purposes) can be used, but have to be adapted to the specific situation and environment in which it will be used. And the outcome has to be interpreted in the light of these adaptions.

For more information about "What about Healthy Networks?" an analysis of structure and organization of national Healthy Cities networks in Europe, please contact Marleen Goumans (+31 40 384099)

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The Netherlands

References:

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8. Mitchell, J.C. (1969). Social netwo. n urban situations. Manchester.

News

New director in Vancouver

The Institute for Health Promotion Research, of the University of British Columbia in Vancouver, Canada, has recently appointed its first director, the well known Dr. Lawrence W. Green. British Columbia has a very lively network of Healthy Communities, and it is most likely that some of the research endeavors of the Institute will be linked to it in the near future.
Institute for Health Promotion Research, Faculty of Graduate Studies, Mather Building, 5804 Fairview Ave., Vancouver, B.C., Canada V6T 1W5; tel. (604) 228 2258; fax (604) 228 4994.

New money for health promotion

In August 1991, two federal granting agencies of the Canadian government, the National Health Research and Development Program (NHRDP) of Health and Welfare Canada as well as the Social Sciences and Humanities Research Council (SSHRC), have announced a 2.5 million dollars (CAN) joint venture to fund up to five national centers in health promotion. This infrastructure money is to be given in the amount of 100,000 dollars a year for five years to each center, chosen by a peer review process, in order to stimulate the development of top quality academic research directly linked to the needs of agencies and grass-roots organizations involved in health promotion practice. Details on this most welcome innovative program, that could inspire other central or regional governments, can be obtained from:
Social Sciences and Humanities Research Council of Canada, c/o Julie Dompierre, Strategic Grants Division, 255 Albert Street, Box 1610, Ottawa, Ontar, Canada, K1P 6G4; tel. (613) 992 4227.

WHO Healthy Cities Collaborating Center in US

The Institute of Action Research for Community Health, based in the School of Nursing of Indiana University in Indianapolis, USA, has been designated a WHO collaborating Center on Healthy Cities matters as of the beginning of 1991; the activities of this new center include research and dissemination of healthy cities information.
Institute of Ation Research for Community health, School of Nursing, Indiana University, NU 237, 111 Middle Drive, Indianapolis, IN 46202, USA; tel. (317) 274 3319.

Indicators workshop

As part of the Health Promotion Knowledge Development initiative of the Canadian Health Promotion Directorate of Health and Welfare Canada, a series of five regional (Winnipeg, Vancouver, Montreal, Calgary, Toronto) and two national (Toronto) workshops was held in 1990-1991, the scheme in six cases out of seven being related to information or indicators to assess Healthy Communities. The proceedings of several of these workshops are either already or soon to be available as well as more general analyses about what was learnt in such a series of workshops. For information, contact
Sylvain Paradis, Health Promotion Directorate, Health and Welfare Canada, Jeanne Mance Building room 420, Tunneys' Pasture, Ottawa, Ontario, K1A 1B4, tel. (613) 954 8026.

Research for Health for All: the Healthy City and its evaluation.

Mike Kelly

Early in April, 1991 a conference entitled 'Research for Health for All: the Healthy City and its Evaluation' was held in Glasgow. The meeting was organized by the Healthy Cities Project Glasgow, the Department of Public Health, University of Glasgow, Greater Glasgow Health Board, the Scottish Health Education Group, the Strathclyde Regional Council and the British Sociological Association.

The purpose of the meeting was to bring together three constituencies. The first was as academic researchers with an interest in applied aspects of health and social and scientific research related to the Health for All targets and the concept of the Healthy City. The second was policy makers, planners and initiators at national and local level. The third were member of ordinary local communities.
Some 137 people were present from these three groups.

The theme of the conference was communication between the three constituencies as they relate to and use socia scientific and medical research. Some years ago, the British Sociological Association had recognised that much sociological and other social scientific research has a direct bearing on the Health for All targets, and on its translation into the Healthy Cities programme. However many sociologists and others working in the field seem unable to share their results with others and sometime show little understanding of, or interest in, the mechanisms whereby such research may be disseminated to a broader community (Kelly 1988). Ordinary members of communities on whom research is done hav little control over the way findings are generated, commented upon and used eith by academic or by policy makers and planners. It was this concern which led to th establishment of the meeting.

The aim of the conference, therefore, was t bring the three constituencies together within a structured framework in order to encourage discussion and exchange of idea The mechanism used was to invite a numbe

INFORMATION FORM RESEARCH FOR HEALTHY CITIES SEMIN SUMMER 1992 QUEBEC/MAASTRICHT

Seminar population:
A maximum number of 35 participants from as diverse fields as possible

Seminar purpose:
To develop an international Healthy Cities Research agenda

Name: _____

Address: _____

Phone: _____ Fax: _____

E-mail: _____

Return to:
Evelyne de Leeuw, Research for Healthy Cities Newsletter, Dept. GEW, University of Limburg,
PO Box 616, 6200 MD Maastricht, The Netherlands. Fax: +31 43 254838

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of distinguished authors prepare papers in advance of the conference, which were to act as a focus for discussion. The invited authors were: Sonja Hunt; Lee Adams; Jan Smithies; Agis Tsouros; Trevor Hancock and Margaret Whitehead.
The lessons which we learned from the conference were as follows:

From an organizational point of view, the idea of pre-prepared papers acting as a focus for structured discussion works quite well. However the workshops really required better focus with specific aims and objectives to achieve. The recommendations from the meeting would probably have had a less diffuse quality had we thought to structure the process in this way.
At a more general level it is clearly possible to bring together the three constituencies, although each is discrete and the assumptions of each are different. Communication between the three constituencies can be problematic and quarrelsome but that does not detract from either the importance of attempting to open up links nor from the benefits that may be derived from so doing. We believe that the meeting in Glasgow was an important first step in this facilitation process and the hope is that other groups, locally, nationally and internationally will pick up the idea and develop it further.
The proceedings of the conference along with recommendations for further action and in conjunction with other invited authors from North America (Michel O'Neill) and Australasia (Fran Baum) will be published during 1992, by Routledge and Kegan Paul in London.

Reference:
Kelly, M.; Workshop and Information Exchange on Health for All, Social Research Association News No. 6, July/August, 1988, pp 10-11.

The Rotterdam Local Health Information System

In Rotterdam a local health information system has been set up by the Municipal Health Service, referring to target 35 of the Healthy Cities Project. The information system aims to (1) monitor the health situation and related factors in Rotterdam at neighbourhoud level and (2) contribute to the development of a local health policy for reducing the differences in health.
Information is collected on health (e.g. mortality, morbidity), lifestyle (e.g. smoking, alcoholconsumption, drugabuse), social environment (e.g. educational level, unemployment, marital status), physical environment (e.g. housing, traffic, noise) and the health care system. The system is a collection of quantitative data linked with qualitative information. Quantitative data are collected from various institutions and municipal services, and from the population itself by means of health surveys.
The resources for qualitative information include opinions and ideas of key informants living or working in specific neighbourhoods, and articles on health and health related factors published in local newspapers.
The data are collected at neighbourhood level and are updated annually. All data are stored in a central database and can be accessed in various ways with the help of a range of software. First results show a number of differences between neighbourhoods. On the basic of this information, recommendations can be made to improve the health in a systematic way.
Information: J.A.M. van Oers, Municipal Health Service for Rotterdam area, Schiedamsedijk 95, 3011 EN Rotterdam, the Netherlands.

Austrian course

The Interuniversitäres Forschungsinstitut für Fernstudien (inter-university institute for advanced research) is going to organize, in collaboration with WHO, courses with duration of several weeks spread over different periods. The courses will focus on increasing strategic capabilities of local health promotors.
The first period is between 11-15 November in Vienna. Total costs: öS 8400.
Information:
IFF, Siebensterngasse 42/10, A-1070 Vienna, Austria. Telefax (0222) 93433118

Research Clearing-house in Maastricht

The School of Health Sciences at the University of Limburg has established a clearinghouse for healthy cities research. Research reports will be collected and made available upon request. The institution thus needs: - research reports
- requests

Contact:
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Dept. GEW
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PO Box 616
6200 MD Maastricht
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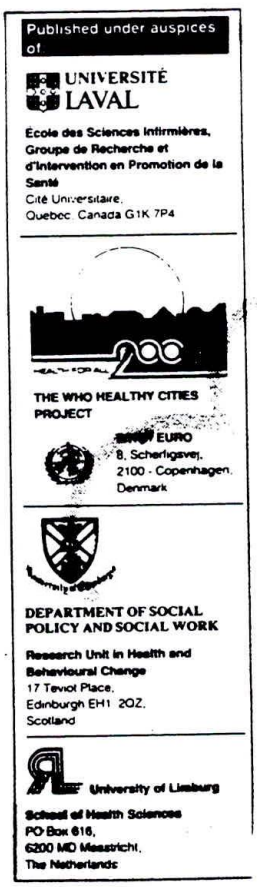
phone (43) 888767 or 888780
fax (43) 254838



Job description:
Involved in research:
- ☐ > 50% of time
- ☐ < 50% of time

Relevant publications
(empirical research only):

_____
_____
_____
_____
(or enclose list)

Research area (max. 2):
- ☐ Lifestyles
- ☐ Community health
- ☐ Environmental health
- ☐ Participation
- ☐ Management
- ☐ Policy
- ☐ Social epidemiology
- ☐ Clinical epidemiology
- ☐ Other:

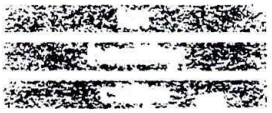
_____
_____

Focus of research:
- ☐ Cities
- ☐ Neighborhoods
- ☐ Communities
- ☐ Settings (e.g. schools, workplace)
- ☐ Vulnerable groups (e.g. children, elderly)
- ☐ Determinants (e.g. AIDS, food & nutrition)
- ☐ Other:

_____

- ☐ Yes, I am interested in attending the seminar
- ☐ No, I'm not, but keep me informed
- ☐ No, I'm not interested

1992 / April



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Editorial

Healthy cities begin to be flourishing all around the world. The World Health Assembly's attention to urban health last year has clearly stimulated numerous cities around the world to adopt health promotion principles in urban planning. This means good news as well as bad news. The good news is undoubtedly that health increasingly is put on political agendas. The bad news is that as yet research endeavours still seem to be carried out in an isolated way.
The Clearing House for Research for Healthy Cities in Maastricht (Netherlands) is currently establishing an annotated bibliography. Inventory of present data shows that over a period of only four years (1988-1992) the number of publications increased from about 10 to 100 annually. However, most of the publications are little empirical and restrict themselves to rethoric. The total number of published empirical inquiries (be they qualitative or quantitative, outcome evaluations or process analyses, clinical or social epidemiological) is around twenty.

Reason for anxiety?
Probably not, for two reasons. On the one hand, we know that a lot of research is currently being carried out, and hope to see reports in the near future. On the other hand, a tradition in healthy cities research has yet to be established. However, there is a lot of confusion and uncertainty, among researchers as well as healthy cities officers, about where to go from here.

Healthy Cities Research Agenda
In order to establish consensus in the academic community about a 1990s research agenda for healthy cities, the University of Limburg is hosting a 'Research for Healthy Cities Expert Seminar' from 15 through 19 November 1992 (previously announced for Summer 1992). In cooperation with Université Laval (Québec) and the University of Glasgow/Glasgow Healthy Cities Project a select group of researchers will be invited to participate in problem-based and community-driven debates. The stage for the discussion will be set through a 'Position Paper'.
Invitees may expect information on the meeting soonest. Of course, the proceedings will be available to all our readers, together with the bibliography mentioned above

Evelyne de Leeuw
Editor-in-chief

Guest Editorial

Is the project making a difference?
My conviction that it does is always at a peak when I visit cities and see and feel the extent of the impact of the project, on people, decision-makers and structures that are concerned with health. It is important at this stage to ask ourselves wether we are sustaining a myth or missing the wood for the trees, eager to evaluate and look for significant city health gains, but missing the point of what this is all about? Are we just a sophisticated campaign that timely managed to catch the imagination and the attention of hundreds of cities or is it that its full scale effect can only be seen with a birds eye view? I don't want to repeat the calls for a new paradigm of research and I don't want to bring up the issue of appropriate indicators for healthy cities again. We have heard all this ad nauseam.

My point is that the project as it has grown and developed out there, is much more than the sum of its stated methods and activities. The project is a source of inspiration and meaning which each city is weaving into its fabric in a different way -to give cities and organizations a new reason for existing. How do we evaluate this.

It was a fascinating exercise at our recent business meeting in Mechelen to hear what's in it for every city. Anxious to live up to traditional epidemiological expectations we become defensive and shy about its full potential. This potential has reached new meanings in cities with special needs. Take St. Petersburg or Zagreb for example. For Mr. Sonchal this project is clearly a major vehicle to reform health care and international resource mobilisation to address the health implications of major social problems in this city. For the thousands of refugees in Zagreb, the help from one project city alone (Horsens) was worth seven million dollars.
The WHO project phase 1987-1992 is now ending and a new action orientated phase will start in 1993 to 1997 with old and new cities. Furthermore national networks in Europe are now in the process of creating an association together with WHO. This means a better structured EURONET and a stronger political base for public health advocacy at European level. No doubt now more than ever we need to mobilise resources, imagination and incentives for research that can throw light and appreciation of the multiple facets and effects of this project. Social scientist need to be more involved. We need more research that is directed towards evaluating innovation and changes in social and political processes. But in reality although we may sense, breath or intuitively appreciate the impact of the project it will always be difficult to put a finger on the project's overall impact. I think that the project is not only a means for change but it has created a unique medium conducive for innovation and international cooperation.

Agis Tsouros, MD, PhD
Healthy Cities Project Coordinator
WHO/EURO

Sheffield Information and Research Forum

Only a few Healthy Cities initiatives have ready access to research capacities (universities, institutes, etc.). Nonetheless, most of those cities and communities recognize the need for research. The *Healthy Sheffield 2000 Initiative* has found a clever way of dealing with this problem. They established an *Information and Research Forum*. The terms of reference of this IRF were defined as follows: "The IRF will promote the coordination of public health information and research in Sheffield in support of the Healthy Sheffield Initiative. It aims to facilitate collaboration between statutory and voluntary service providers, academic researchers and community initiatives in the field of public health. It will liaise with the Sheffield Information 2000 Project."
IRf has published its first annual review recently and takes the local 'Our City Our Health' document as a starting point for further activities.

Information and requests:
Liz Gaere
Health Promotion Research Officer
Sheffield Health Authority
West Royd, 119 Manchester Road
Sheffield S10 5DN
fax +44 742 660498

German Healthy Cities evaluated

The European Centre for Social Welfare Policy and Research (Vienna) and Werkstatt für Gesundheit (Hamburg) are currently evaluating German Healthy Cities with emphasis on the potentials and limits of an interaction between an international organization like WHO and local groups and actors. The project is financed by the German Ministry of Health.

Information:
Adalbert Evers
European Centre for Social Welfare Policy and Research
Berggasse 17
1090 Vienna
Austria
fax +43 1 31 45 05 19

Canadian provinces on right track (again)

Canada remains to be an active core of the healthy cities movement. During a series of conferences and community meetings last fall 'Villes et Villages en Santé' and 'Healthy Communities' were further strengthened. Québec has always had a lively network, which is now being evaluated extensively by Michel O'Neill c.s. (Université Laval, Groupe de Recherche et d'Intervention en Promotion de la Santé, École des Sciences Infirmières, Cité universitaire, Quebec, Canada G1K 7P4, fax 09-1-418-656-7747).
Provinces of Manitoba and Saskatchewan have started numerous community vision workshops; Joan Feather (Dept. of Community Health and Epidemiology, University of Saskatoon, Saskatoon S7N 0W0, Canada, phone 09-1-306-966-7932, fax 09-1-306-966-7920) edited proceedings of a related conference.
The British Columbia Public Health Association organized a conference on the issue of 'Healthy Public Policy - Everybody's Business' centering around Healthy Communities (Jane Hoffmeyer, #300-30 East 6th Ave., Vancouver BC V5T 4P4).

WHO Collaborating Center in Healthy Cities at Indiana University

The World Health Organization (WHO) has designated the Indiana University School of Nursing Institute of Action Research for Community Health as a WHO Collaborating Center in Healthy Cities. This is the first WHO Collaborating Center designation for Indiana University (IU), and it is a recognition of IU's long standing commitment to international knowledge development, dissemination, and utilization. This status also is a result of the work of Healthy Cities Indiana, a collaborative program between IU, Indiana Public Health Association, six Healthy Cities in Indiana, and the W.K. Kellogg Foundation. The Center brings new opportunities for interdisciplinary collaboration in research, training and information exchange and carries an initial designation for four years.
As a WHO Collaborating Center the Institute is identifying research needs, and is conducting and collaborating in research relevant to the Healthy Cities movement. One of the first research efforts involves developing a global Healthy Cities information system. This system will be accessible to community leaders and researchers interested in Healthy Cities. The Center also will issue reports about the worldwide Healthy Cities movement; provide research and training opportunities for visiting scholars and WHO visiting scientists and research trainees; organize and host national and international conferences and congresses on issues relevant to the Healthy Cities movement; and, promote information exchange about Healthy Cities programs, research, and resources.
The official inauguration of the Center was held October 31 - November 1, 1991 at he University Place Hotel and Conference Center on the Indiana University - Purdue University, Indianapolis campus. The theme of the conference was "public Policies for healthy Cities: Involving the Policy Makers." Keynote speakers included Dr. Angela McBride, Interim Dean of the School of Nursing; Dr. Greg Goldstein, WHO, Geneva; Dr. Agis Tsouros, WHO - European Region, Copenhagen; Dr. Robert Knouss, Pan American Health Organization; Dr. Trevor Hancock, Public Health Consultant, Canada; Dr. Sheila Smythe, New York Medical College, New York; and Mr. Richard Louv, Columnist San Diego Times, California. Most of the participants came from North America to welcome the new WHO Center to Indiana University.
Further information about the WHO Collaborating Center In Healthy Cities may be obtained through:

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Analysis of the implementation of three "Healthy City" initiatives in the Montreal area

In September 1991, a research team began tot evaluate some "Healthy City" initiatives in the Montreal area. Concerned at the outset with looking for indicators, the team chose a method which was perhaps less ambitious than analysing the results, but which is nevertheless just as promising: the study of the implementation of the projects.

Three initiatives are under study: Pointe-Claire, a small Montreal suburb whose population can generally be described as being of a high level socio-economically, and two of Montreal's working class communities, Mercier-Est and Saint-Michel. The evaluation will make it possible to focus on the context in which these initiatives take place and to identify elements likely to affect their success.

The three initiatives are being analysed individually and comparatively according to a series of variables. the analysis is first looking at the initiatives' external environment (laws, by-laws...) and internal environment (characteristics of the local community). It will then study the way in which the three predominant elements in the Healthy City concept are put into practice (sharing of common objectives, citizen participation, intersectorial action) by those involved, to keep the project moving in the right direction. Lastly, it will focus its attention on the concertation structure and activities generated by the initiatives.

The Evaluation method used is based on the same approach used by the Healthy Cities movement, i.e. the participation of the principals involved. Data collection, which occurs throughout the study via interviews, field observation and the perusal of written documents, includes periods of analysis closely involving those responsible for the initiatives, by means of a steering committee.
The committee, consisting of representatives of the initiatives under study and researchers, meets on a monthly basis. The former are asked to comment on the data collected by the latter. The results of these analyses are then conveyed to the three communities by means of a means of a monthly liaison bulletin.

In the spring of 1992, mid-way through the evaluation process, a committee of health promotion experts will submit its opinion on the congruence of the principal elements in the Health Cities concept and the orientations of the three initiatives under study, based on summaries of cases in each location.

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(Cet article a été traduit par Helena Scheffer, Hopital Général du Lakeshore)

Intersectoral collaboration: Theory and Practice

Central to the Healthy Cities project is the notion of intersectoral collaboration to achieve the development and implementation of Healthy public policy and health promotion at the city level. It is both about fostering interdependence between agencies in order to launch new programmes which require the resources of more than one agency and its about reorientation of existing public policy to include and acknowledge the health dimension. What intersectoral collaboration means is getting organisations and people within those organisations and people within those organisations to work together. Understanding interorganisations to work together. Understanding interorganisational behaviour is therefore crucial to any evaluation of the likely effectiveness of intersectoral activity. Interorganisational theory and the growing empirical literature on collaborative activity in a variety of contexts from the relationship between health and personal social services to inner city policy and environmental planning, can provide a framework for analysis. Such a frame work was used to analyse the early experience of the Healthy City project in Liverpool[1] and is currently being developed to provide a model framework for training and education on intersectoral collaboration[2]. The original study contains a review of interorganisational theory and of empirical studies done in three areas, WHO intersectoral projects in developing countries, joint car planning in the UK and inner city policy in the UK. This provided the framework of analysis of the process taking place at the time in Liverpool using qualitative methods including interviews with key personnel and participant observation. The research was used to help and identify prospects for interagency working offering insights for those working in the Project of possible sources of conflict and change.
Both the theoretical and empirical literature demonstrates that interorganisational interaction is a complex, multilevel and fluid process which can only develop over time and only when it is perceived by organisations and individuals as advantageous to the pursuit of internal and common goals. The slow developmental process takes place via many short bursts of exchanges around individual problems and through small scale transactions with little risk involved. Over time trust develops but large scale commitments rarely occur early.
Research further indicates that interorganisational relations operate in a cyclical manner, early ad hoc activities leading over time to more formalised relations which create inner tensions followed by a phase of reduced interaction. Indeed the whole process is one of constant flux between interdependence and conflict. Benson[3] suggests however there are a number of strategies that can be adopted to manage the process and bring about change in organisational relationship. The study referred to here covered the first phase of development with intersectoral activity consisting of small projects with only verbal commitment from the large agencies to the Project as a whole and generally a low level of awareness amongst members of the contributing organisations of the Project.

In many ways the Healthy Cities Project is the renegotiation and recognition by agencies of their respective responsibilities for the domain of public health. It is also about reorienting the flow of resources within and between organisations. Thus, a number of key elements were identified by the study as relevant to effective intersectoral collaboration. The study examined the environmental context of the Project, the degree of organisational connectedness, domain consensus and territorial tension the distribution of power in terms of access to and control over strategic resources, the flow of resources in existing interorganisational relations, and the degree of actual and perceived centrality of key organisations. the role of informal structures were also examined, in the particular networking, interpersonal relationships and the degree of belief in a common philosophy and ideology amongst potential key actors. This informal level holds crucial ingredients in determining the likelihood of successful collaboration. A recurrent theme highlighted in research studies is the role of key personnel with specific personal and social skills called networking skills.
Like all those cities chosen by WHO, participation in the original project for Liverpool meant the adoption of a specific planning framework which reflected the assumptions of a rational planning model. Research on intersectoral collaboration demonstrates, however, that in practice interagency cooperation rarely takes place in a programmed manner and often varies in its degree of intensity over time. Both empirical and theoretical studies indicate that the existence of a formal framework does not guarantee collaboration and indeed effective and real collaboration is rare. While formal structures may provide a symbolic signal to the individuals working within the organisations concerned of the general commitment to intersectoral working, those formal structures merely pay lip service to the process or even may hinder it. The interplay of inward looking organisational goals and objectives and structures, professional jealousy and a lack of understanding of the possible linkages between agencies which all research studies reveal were all manifest in the experience of Liverpool.

The task that the Healthy Cities project in

Liverpool had and has been given was an impossible task and totally unrealistic. It was expected that within five years, the goals of the major agencies would be reorientated, agencies that were unclear of what their goals were anyway and who were under constant threat of change in a different direction from external forces. It required an internal restructuring of those agencies and the development of skills amongst managers for the management of change in a city where change is slow. At the same time the Project was expected to maintain a high level of visibility and enhance community involvement from a base in an agency that historically was perceived as having low credibility and a poor record of intersectoral working. It is not surprising therefore that activity has largely been at an informal level. Yet given past research, this is the level at which successful collaboration is possible if the right skills amongst managers and key personnel are encouraged[4]. It is networking that lies at the heart of collaboration. Such networks provide the cement that any structure set up requires and the channels through which information and resources can flow reducing the level of uncertainty and fostering trust. Wether The Liverpool project develops will depend in effective networking. The process of intersectoral networking can bring about the cultural change necessary through the diffusion of beliefs and attitudes that will change the behaviour and assumptive worlds of key decision-makers that influence public policy and health promotion action. Cultural change takes along time to emerge and often involves conflict not consensus.

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HEALTH FOR ALL 2000

THE WHO HEALTHY CITIES PROJECT

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Denmark

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research for healthy cities

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Editorial

The fourth issue of this Newsletter has taken some time to produce. The Clearing House has been extremely busy in organizing an expert meeting on Healthy Cities Research in November, 1992. This meeting has been extremely successful. Thirty academic and practice researchers have been meeting in Maastricht where they discussed various issues pertaining to a research agenda for healthy cities. The proceedings book of the meeting is available from our centre (see Publications). Issues 4 and 5 of the Newsletter will be devoted largely to the presentations given at the seminar. They were generally innovative, interdisciplinary and challenging orthodox research practices. You are invited to contact authors in order to strengthen our international network. Also, please send us any material you want to have published as news in this circular. Longer manuscripts may also be published in our Research for Healthy Cities Monograph Series. You are invited to submit such contributions.

Evelyne de Leeuw
editor

Guest editorial

Understanding through information exchange.

Our world has become a global health village, generating an urgent need for mutual learning and understanding. We live at a time of increasing health interdependence both within and between nation states. Health has no political allegiances, but we have to recognise that it does align itself with economies. The wealth gap between countries and between socio-economic classes within countries is widening. This economic schism is mirrored with an ever widening health "gap". There are tragic inequalities in health worldwide which need to be addressed urgently.

One way of drawing attention to this international injustice is to sponsor applied research into the causes and solutions of ill health and health inequalities and to make that research evident and familiar. In the developed world we are very good at collecting data by employing a variety of instruments but less successful at publicising the research findings and the implications of the data analyses. Thankfully there is now growing support and evidence that this is changing.

Cardiovascular intervention studies, such as North Kerelia, Standford and Hearbeat Wales have been diligent in publishing the results of the interventions. Indeed Heartbeat Wales has not only published over 100 of its own technical and briefing reports it has also ensured a wide coverage for its findings in many academic and professional journals.

Similarly the Health Cities project has generated a wealth of interest. Over the last couple of years it has spawned a number of publications including this one dedicated to informing readers and practitioners on the latest developments in the programme. Even if the research parameters, let alone the research results have yet to be agreed, the production of a newsletter can only benefit academics and practitioners eager to develop their work in city health. Our experience in publishing "Positive Health" for over eight years now, has demonstrated the need for the dissemination of informed opinion and information through an international newsletter. The critical point is that the newsletter should be accessible and "user friendly". Academic journals and periodicals can afford to be less concerned with these issues since they reach, in general, a different more dedicated readership. "Health Promotion International" does try to bridge this difference by combining all the traits of academic publishing with an applied and practical approach to health promotion by supporting the development of action as outlined in the Ottawa Charter. Indeed HPI has encouraged submissions from Health City researchers and practitioners and over the last five years has a good record in publishing papers in this area.

Communication has been the growth industry of the twentieth century, and I suspect will continue to be beyond the year 2000. We need to feed of this growth by developing our own communication media. Whilst we might need to exercise some caution in promoting the proliferation of broadsheets, newsletters and bulletins we must recognise that they do provide an excellent forum for information exchange especially when they supplement other communication means such as symposia and conferences. Research for Healthy Cities is a classic example of this relationship and consequently will, I am sure, grow from strength to strength.

Gordon Macdonald.
Associate Editor, Health Promotion International.
Editor-in-Chief, Positive Health.

research for healthy cities

Publications

The Research for Healthy Cities Clearing House is publishing a Monograph Series. The first three volumes are now available:

Polman, L., M. Goumans & E. de Leeuw (1992) Healthy Cities Research Bibliography. RHC Monograph Series No. 1. Maastricht (250 pages)
ISBN 90-74590-01-2

Leeuw, E. de, M. O'Neill, M. Goumans & F. de Bruijn (1992) Healthy Cities Research Agenda. Proceedings of an expert panel. RHC Monograph Series No. 2. Maastricht (70 pages)
ISBN 90-74590-02-0

Goumans, M. (1992) What about healthy networks? An analysis of structure and organization of national healthy cities networks in Europe. RHC Monograph Series No. 3. Maastricht (100 pages)
ISBN 90 74590-03-9

Orders:
These publications may be ordered through your regular bookseller (quote our address) or directly from:
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University of Limburg
PO Box 616
6200 MD Maastricht
The Netherlands
fax +31 43 67 09 32

The price for each volume is DFL 25.
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Maastricht, 15-18 November 1992

Abstracts from the Research for Healthy Cities Expert Panel

The Development, implementation and evaluation of local health projects

Since 1988 the Department of Health Education of the University of Limburg is involved in the development, implementation and evaluation of local health projects. The most important project, the "Healthy Bergeyk" project, started in 1990. Bergeyk is a Dutch municipality with 10.000 inhabitants. The development of the Bergeyk project was based on community organization principles (intersectoral co-operation, participation, social network approach, structural changes, etc.), as well as health education behavioral change models. The major goal of the project was a reduction in cancer-related and coronary heart disease-related risk behavior prevalence. During the experimental phase of this project, a project group with representatives from eleven different sectors organised several health activities for their community, such as stop smoking courses, nutrition education meetings, self-help materials on smoking and nutrition, an information centre, mass.media messages, a sandwich "Healthy Bergeyk" which was sold in local cafetaria's, etc. The project group was supported by a parttime local co-ordinator and used a workbook that was developed by the university. In this workbook about 30 possible health activities were described. To assess the results of the project, Bergeyk was copared to a control community. Telephone interviews were conducted at three times with about 600 inhabitants from both the experimental and the control community. The pretest was in February 1990 (T1), project implementation took place from March 1990 to February 1991, while two follow-ups were conducted in February 1991 (T2) and September 1991 (T3). Process-evaluation was assessed during the whole implementation period. At T2 more than 80% of the respondents in the experimental group wwas familiar with the project. Additionally, almost 40% said that they had talked with someone else about the project. Of those familiar with the project, more than 80% thought it to be important to have a project like "Healthy Bergeyk" in their community. Almost 80% thought the project should be continued. As far as behavioral effects were concerned, the results suggested that the project successfully reduced fat intake in the experimental community, compared to the control community. No significant effects were found on smoking behavior, alcohol consumption or exposure to artificial sunlight. On the whole, the projectgroup members were satisfied with their participation in the projectgroup and the function of the group. Especially the intersectoral co-operation was judged positively. The time presure on the project as a results of the fact that there was a research connected to the project, was a negativ side of the project. Also, the projectgroup had the opinion that the University had been to steering at some occasions. After the research was finished, the project has been taken over and continued by the projectgroup, though the university is still in de advisory committee o the Health Bereyk project.Currently, the Department is conducting the process-evaluation of the local fat reduction program "Let op Vet" (Watch fat) in Alkmaar. This project is an experi- -t initialized by the Dutch Steering C -mitte on Good Nutrition. In the next few years, this committee aims to start several local nutrition projects as a continuation of the National "Let op Vet" Campaign. In Alkma an analysis will be made of local policy development and intersectoral co-operatic Besides the projects described, the Department of Health Education conducts several worksite projects and projects on smoking prevention in schools. Also, the Department advises the Regional Health Center, that is starting neighbourhood health projects in Maastricht. Finally, the Department aims to start a research on th possibilities and willingness of national organisations to support local nutrition projects.

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Maastricht, 15-18 November 1992 **Abstracts from the Research for Healthy Cities Expert Panel**

Planning healthy Communities

Video "Best Laid Plans"
(VHS format) 20 minutes
(produced by S A C H R U)

This video is a wry look at a health department's attempt at needs assessment the goes wrong. It raises questions about the use of research by bureaucracies, ways in which communities can be involved in research and the most appropriate methodologies for community health needs assessment The video was made to accompany a manual on how to do community health needs assessment he video would be a good discussion starter about these issues which are central to Healthy Cities research agendas

Research for Healthy cities: experiences from down-under

Healthy cities was adopted as a national pilot project in Australia in 1987. Four "cities" were involved in the three year pilot Noarlunga (South Australia), Illawarra (new South Wales), Canberra (Australian Capital Territory) and Nganampa Health Council (central Australia). The national project co-ordinated research and evaluation endeavours for the three year period. This resulted in detailed evaluations of the evelopment of a Healthy Cities evaluation framework. These and subsequent developments will be described in the paper

Healthy Cities research in Australia has been of two types: evaluation of Healthy Cities initiatives and the development of ways of measuring the health and assessing needs of cities and other communities. Both of these categories of research have raised substantive methodological concerns about issues such as competing and complementary research paradigms, the value of research to planning and the values and interest underlying research. The paper will review these issues drawing on Australian experiences, and consider ways in which research can be made more participative and contribute to encouraging policy agendas to shift towards health promotion goals.

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The Healthy Cities Movement in the Valencian Network

The Valencian Community occupies the strip of Mediterranean coast between Catalonia and Murcia and has a population of almost 4 million inhabitants In 1987 the idea of Healthy cities in our Region began to develop. The University of Alicante and the Valencian Institute for Studies in Public Health (IVESP) took on the committment of giving research and training support to the H.C. Project in the Region, some months later the regional Network was established. From 1987 until February 1992, 59 cities (which house 62% of the total population) made up the Valencian Healthy Cities Network. The interest of the cities to join the Network altered over the years, but it was related to municipal elections
Among the tacit committments of the Network one can highlight

1 Approval by a council majority of the willingness to join the network and obligation to carry out a Health Diagnosis.
2 Setting up of a Health Plan that corrects the existing deficiencies and inequalities in health.
3 The above should be carries out an intersectorial approach including community participation.

1 EVALUATION

After 4 years working in the Network we decided to start a process of evaluation or assessment of the project. We interviewed those responsible for the project in each city (mayor, health councillor and technical coordinator), asking them about two kinds of variables:

1 Outcome variables: those related to the committments taken (health Diagnosis and Planification)
2 Other variables that could explain the success or failure of the idea, such as political parties supporting it, the person to start the project, budget, size, participation in the network activities, external support, etc.

And ... what happened?

2 EVALUATION RESULTS

1 We have had some 'good side effects' of the evaluation, implying that the interviews have had a 'motivation' effect on the politicians and an improvement in the relationship between them and us
2 We can now say that:
Most of the municipalities have had good outcomes measures (in terms of Health Diagnosis and Plan Fulfillment).

But less than half of them have developed intersectoral and have practiced participative ways of working. Looking at the healthier factors, we show geographical and cultural proximity, technical support and attendance of the annual meetings as favourable factors for the development of the project. And we detect the important role that the network plays in giving information, encouraging motivation, facilitating cooperation, coordination and better use of resources.

What are we going to do with these results?

1 We gave some feed-back to the participants in the Regional Healthy Cities annual meeting last April.
2 We will have workshops with them to discuss the difficulties they have and to plan future activities.
3 We want to establish evaluation as a process and to repeat the interviews with a visit to them every year

Conclusions

Concerning the evaluation methodology

1 It's very difficult to evaluate this kind of projects or movement. We need a dynamic, partipative, flexible, motivating and in some way 'political evaluation. It's necessary to involve and respect the politicians and their needs, and at the same time to assess what's happening and to simulate the process.
2 It is necessary to separate:
A Political evaluation, from
B Public Policies analysis

Concerning the results in our network:

1 Quantity doesn't mean quality, in other words:
* We have many cities in the network but not all of them are really working in the 'H.C. Movement '. Some of them are interested just in the beautiful flap of H.C. but not in the health of the citizens.
* On the other hand, the bigger the city, the worse the results. All three cities with more than 100.000 inhabitants have important problems in developing the H.C. ideas.

2 The movement, at least in our reality, depends too much on personal involment, and individual leadership. Which means that the possibilities of continuity are very

weak. In fact we have some cities that have experienced good development until the politician or the political components changed. Then, the movement came to a standstill.

Challenges

1 To develop methods to assess healthy public policies

2 To move from politics to policies
Obtaining
Continuity. To overcome politician and personal changes
Mechanisms of social accountability
Favourable social climate

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Sharing evidence of good practice in the Healthy Cities movement.

Introduction

A movement such as Healthy Cities is vulnerable to the charge that it is stronger on rhetoric than achievements unless it can demonstrate examples of practice which are innovative, distinctive, applicable elsewhere and compatible with the goals and values of the movement as a whole. Yet identifying "models of good practice" can be a problematic research task. We may ask: who is defining good practice; at what stage can initiatives be identified as successful; and how are local experimences to be made useful and disseminated to others, particularly given the great diversity of settings for Healthy City projects? The research I shall be presenting was an attempt to negotiate a method for describing local Healthy Cities practice as a preliminary to developing frameworks which could be used for evaluation.

Aims

1 To pilot a research approach to enable project participants to identify and describe project and programme development work which they considered worth disseminating and to elicit their criteria for success.

2 To describe and analyse a range of local Healthy Cities activity within the context of contemporary health promotion goals and values in order to address questions including: to what extent is Healthy Cities practice distinctive, what practical lessons have been learned in the project about initiating and sustaining change at city level, what do participants consider to be the processes which contribute to success/failure and what are their assessments of the policy context in which the projects operates in their city?

3 To produce a critical view of the information aprocess entailed in the research in order to identify obstacles to be better description and dissemination of reports of Healthy Cities practice

Methods

The main data collection instrument was an extensive written questionnaire which was negotiated with WHO and sent out by them to all cities participating in the Healthy Cities project in 1991. The questionnaire was semi-structured with a large number of open questions. Project respondents were asked to select up to three Healthy City activities in their city which they considered to be their greatest achievements. Questions covered aims, processes and resources, outcomes and self-perceived reasons for success. Supplementary informal material in the form of reports etc. was also solicited.

Results

To date information has been obtained on 36 activities in 14 cities and is being analysed by qualitative methods. Preliminary analyses suggest that intersectoral collaboration is identified by many participants as an important process in obtaining resourses for a project. Outcomes identified by participants as useful include increased or denser activity within networks associated with project activities. The analysis will be completed by October 1992 and in the presentation I hope to suggest how subjective material of this type could be incorporated into pluralist evaluation strategies for Healthy City projects.

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Constructing Involvement in Healthy Cities

The goals of the research project Constructing Involvement in Healthy Cities are manyfold. One is the design of a typology on the topic of participation. Another is the classification and description of characteristic Dutch Healthy City projects with the help of criteria and a questionnaire derived from the typology. A comparison is made with US and Canadian projects studied on location. The third goal is a field experiment in the North part of Amsterdam. Here in a collaboration between the Amsterdam local authorities, the health and welfare services, the immigrant comm ties and the Utrecht University a project called Immigrants and Health is established. The method used is an integrated and non individual modification of the Delphi method. While developing a health project with and for immigrants an underlying purpose is finding a way out from the dichotomies of top-down versus bottom up, objective versus perceived health and research versus action. Meanwhile, in a fourth project, a more solid theoretical base for Healthy Cities in social sciences is attempted to build. Used are among other theories from the tradition of Urban Studies.

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Thoughts on Research

- The need for a multi-disciplinary systems oriented study of health and cities.
- The problem of synthesis of ideas from diverse orientations. How can we pull together ideas from medicine, to politics, sociology economics, etcetera.
- How can we study values that are important to a Healthy City program? Wh is the relationship of Healthy City to other values in the community? The importance culture, religious practices and local custo
- An awareness of the base line data needed, that is obtainable from existing studies and reports.
- What are the new kinds of data needed

The importance of studying process
Too often we look at input and output, and ignore the way business gets done
This would include research on issues of "social entrepreneurship", or how to get business done, creativity developing concepts and ideas, planning, programs, and management. Some preliminiry material on the topic is in my book.
The Social Entrepreneurship of Change, Pace University Press, New York, 1990
Tools for research, which include anthropological research and other qualitative techniques, library research including "browsing" through information from diverse fields, quantitative inquiry, and more
One area that interests me is the processes of getting to know a city, using some other techniques outlined in "Guide to Assessing Healthy Cities", which Hancock and I wrote

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Analysis of the implementation of three "Healthy City" initiatives in the Montreal area

In September 1991, a research team began to evaluate some "Healthy City" initiatives in the Montreal area. At first concerned about the research of indicators, the team chose a method which was perhaps less ambitious than analysing the results, but which is nevertheless just as promissing: the study of the implementation of the projects.

Three Case studies
Three initiatives ware under study: Pointe-Claire, a small Montreal suburb whose population can generally be described as being of a high socio-economic status and two of Montreal's working class communities, Mercier-Est and Saint-Michel. The three initiatives are being analysed individually and comparatively according to a series of variables. The analysis is first looking at the initiatives' external environment (laws, by-laws...) and those of the internal environment (characteristics of the local community). It will then study the way in which the three predominant elements in the Healthy City concept are put into practice by those involved, to keep the project moving in the right direction sharing of common objectives, citizen participation and intersectorial action. Finally, the analysis will focus on the concertation structure and activities generated by the initiatives

Interactive method
The evaluation method used is based on the same approach used by the Healthy Cities movement, i.e. on the participation of the parties involved. Data collection occurs throughout the study via interviews, field observation, perusal of written documents. It is interspersed of periods of analysis closely involving those responsible for the initiatives, by means of a steering committee
The committee, consisting of representatives of the studied initiatives and researchers, meets on a monthly basis
The representatives are asked to comment on the data collected by the researchers
The outcome of these monthly meetings are then conveyed to the three communities by means of a monthly liaison bulletin

Significant results
The analysis showed the attractiveness of the "Healthy City" project. Such attractiveness lies upon its flexible and efficient functionning methods to mobilize citizens and organisations from different backgrounds around common and diverse projects

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Information Technologies as Tools for Healthier Cities. Policies for the 1990's in Latin America

This research program, started by CEUR and Fundacion RED in 1992, intends to study the use of information and communication technologies (ICT) in the field of public and private health services' management, using Buenos Aires and Rio de Janeiro as case studies. The main goal is to propose policies for healthier cities, in the areas of epidemies prevention (AIDS, cholera, etc.) and the rationalisation of human, economic and technological ressources
The research is developping the following steps
a) Identification of current experiences on the use of ICT in the management of public and private health services, b) Evaluation of the impacts of ICT use regarding benefits for users, health 'providers', the health system and urban life quality; impacts on connected areas, such as training and research, prevention and public information campaigns, etc.; c) Evaluation of the impact of ICT application considering the level of efficiency achieved, the degree of operativity, the coverage of the services and the interaction with urban areas such as water and sanitation, environment, conservation, services for lower income groups, etc.; d) Comparison between the cases of Buenos Aires and Rio, f) Proposals of policies for ICT application for healthier cities

The program also partipates in a network including teams from Venezuela (CENDES), U.S.A. (university of Hawaii) and Mexico (Cologie de Mexico)

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The Rotterdam Health information system

In Rotterdam a local health information system had been developed which supports the local strategies for Health for All.
The WHO "healthy Cities project" makes such a system highly desirable.
The paper pays attention to the goals and design of the system and presents some results.

The central aims of information systems are:
1. to record the health situation and related factors in the city of Rotterdam at district and neighbourhood level;
2. to contribute to the development of a local health policy for reducing the noted differences in the health situation of the population.

The information system contains data relevant to health, not only information on health itself but also on "determents of health"

Information is collected from various sources that can be roughly categorized as follows

statistical information, such as mortality and morbidity rates, figures covering health related areas like housing, employment and leisure time activities and so on, and so forth,
data collected from the population itself among others by questionnaires (health surveys) data related to health , lifestyles and determants of health,
documentary information (gathered from the local newspapers and limitedcirculation leaflets),
ideas and views of key members of the community as expressed in personal interviews, group discussions or in questionnaires

The system is a collection of quantitave data (numerical material from various statistics and health surveys) linked with qualitative data (with emphasis on content, underlying information derived from documentation, key informants, etcetera) The data are collected and presented at district and neighbourhood level
The paper will discuss some results and the meaning of the system for health policy

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A Comparison of Pre-defined Categorical Health Projects and Open-ended Community-defined "Healthy City" Projects: A Tale of Two Cities

One of the guiding principles of the "Healthy Cities" process has been that the community ideally begins with a clean slate which to define its own priorities for its community development effort. Much of the research base, however, on which health autorities have been convinced to throw their weight behind healthy community projects has been generated in categorical health programs, such as heart disease prevention projects, and these have usually been university-based rather than community-based. This paper will compare some of the differences in the implementation experiences between community-based projects pursuing the pre-defined categorical health model, particularly in cardiovascular disease prevention, and healthy community projects sponsored by the same Ministry of Health in British Columbia, but starting from a carte blanche with respect to the definition of health or health-related problems. Our methodology will be to compare the actual experience of two groups of projects in the same province of Canada, matching comparable communities and examining at least the early stages of their development. Neither group of projects will have reached a point of having concrete outcomes that can be compared at the time of the conference, but we should be able to compare the barriers and challenges they encountered in the planning and mobilization process, how they overcame these problems, and how the respective program plans meet various technical criteria of planning such as clear objectives, timetables, allocation of resources, and assignment of responsibility. The community projects will be compared also on how they meet criteria of health promotion as promulgated by various provincial, national and international organizations such as the Health and Welfare Canada (Achieving Health for All), the B.C. Ministry of Health, the American Public Health Association, and the World Health Organisation. Finally, we will include a discussion of how different "models" or assumptions drive the implementation process.

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Rapid development of WHO Healthy Cities Project outside of Europe

The WHO Healthy Cities Project is best known for its work in cities throughout Europe, as well as the US, Canada, Australia, New Zealand and Japan. What is less well known is the rapid development of Healthy Cities projects in an increasing number of developing countries.
The objective of the Healthy Cities project is to strengthen the capability and capacity of municipal governments, and to provide opportunities for individuals, families and community groups, to deal with their health and environmental problems. "Healthy Cities" achieves this by providing a framework which combines several key elements:

Increased awareness of health and environment issues in urban development efforts by all municipal and national authorities,
A network of cities which provides information exchange and technology transfer,
A linkage of technical programmes for health and the environment with political mobilization and community participation
New partnerships are developed between municipal government agencies (health, water, sanitation, housing, social welfare, etc.), universities, NGOs, private companies and community organizations and groups, to make the urban environment supportive of health rather than damaging to it.

Major developments in Healthy Cities in the last six months include:

*** In the Eastern Mediterranean region:**
Many countries are planning national networks of Healthy Cities. There was a remarkable meeting in Teheran in December 1991, attended by 19 out of 23 major cities in Iran, the provincial capitals, with 19 mayors in attendance and many key political figures. A Healthy Cities office has been set up in Teheran, and projects have been started to upgrade a number of low-income housing areas in the city.

In Pakistan, in February 1992, there was a meeting in Lahore to set up a national network of Healthy Cities which attracted many mayors and national officials, and it is planned to commence the project in 12 major cities including all provincial capitals and the national capital.

A number of other countries in the region are setting up, or have plans to set up, similar networks including Saudi Arabia, Egypt, Yemen, Tunisia and Morocco. Many of the above cities intend to participate in the 7th International WHO Healthy Cities Symposium, Copenhagen, 9-12 June 1992, with a particular interest in developing

twinning arrangements with European cities.

*** In the African region:**
A major meeting in Ghana of the Accra Healthy Cities Project took place in March 1992, with a focus on a review of health problems in Accra, and on developing broad strategy directions, which covered the following areas: environmental sanitation, food hygiene, development of urban health services, school health, public education and communication, community involvement in health and sanitation, and land-use planning. A subsequent workshop in Sogakope undertook to develop specific action plans. There was an excellent attendance by senior politicians and good media coverage. The Ghanaian city of Kumasi was also represented at this meeting. A series of further activities were identified with a particular focus on the role of sub-district health management teams.

An African French-speaking network of Healthy Cities is progressing well, and with Canadian Government support, a preliminary meeting of this network is planned to take place in Dakar, Senegal, 2-5 June 1992. It includes Cameroon, Chad, Congo, Zaire and Senegal. Ghana and Nigeria may also attend the meeting.

The Third Global French-speaking Healthy Cities Congres is scheduled to take place in Montreal and Sherbrooke (Canada, Province of Quebec) from 27 September to 2 October 1992, and cities located in all WHO regions are expected to attend.

*** In the South-East Asian Region:**
A network is being developed in 6 cities in various countries (Bangkok, Kanpur, Hyderabad, Dkaha, Surabaya, Colombo), and funding for initial activities is in the process of being secured. Healthy Cities will be the focus of a WHO inter-country meeting on urban health in New Delhi planned for August this year.

*** In the Americas:**
Apart from Canada and the US, Healthy Cities initiatives are in progress in Brazil (Rio de Janeiro), Bolivia and Colombia (collaboration with Canada/Quebec).
The WHO Collaborating Centre in Indiana is actively working to promote an international network of cities in this region, and is also developing a global database on healthy cities.
There is an international meeting on Healthy Cities planned by Western Pacific Consortium for Public Health to take place in San Francisco in December 1993, which is expected to attract many cities from South and Central America that wish to participate in Healthy Cities. The meeting will be bilingual, in English and Spanish.

*** In the Western Pacific region:**
There have been discussions on a city networking project involving participants from China, Malaysia, Philippines, Republic of Korea, Singapore, Japan, Australia and New Zealand. Only the latter 3 countries have an established Healthy Cities project, but all are discussing and planning a project.

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What about healthy networks? An analysis of national healthy cities networks in Europe.

The World Health Organization (WHO/Euro Healthy Cities Project has received much attention since the first project cities were selected in 1987. In fact many more cities than can participate showed (and still show) their interest. This initiatives have been taken to establish activities similar th the Healthy Cities Project, not only in Europe but all over the world, 'national networks of Healthy Cities' have developed. The national networks in Europe call themselves 'EURONET', a European network of national Healthy Cities networks. EURONET is not a formal association; how this initiative will develop in the near future is under discussion.
A national network is an example of a social network, but because of its complexity and different levels of 'networking', is difficult to analyse. However analysis, and evaluation, is needed to review the functioning and impact of the healthy cities idea. To study and analyse the networks in Europe, which are as a whole rather large, a selection has been made to reduce the number of participants)n = 14) number of resources (n = 4) and (categories of) activities (n = 9) which were examined. The analysis provided information about the development of the network; among other things it looked at: why they started, who took the initiative, what changes occurred during the period of development, who were the participants at a national level, what activities were undertaken, and the relationship between activities and participant. As expected, the findings did not provide a uniform picture of 'what a national Healthy Cities network should look like' nor did the give the recipe of 'how to become a Healthy Cities network'. However, the strength of national networks is that the have the potential to continue the Healthy Cities project aims and objectives, even if the WHO project ever ceases.

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Report on a Proposal to EC "Evaluation of the World Health Organization's Healthy Cities Project and of its Spin-off-Effects in Six European States"

The BIOMED programme offered an opportunity for collaborative research programmes within the EC. Together with five other partners (Greece, Italy, Austria, Spain, Great Britain) we developed a proposal and sent it to the EC. This proposal has been postponed to winter 92/93.
In its summary we stated:

"The Healthy Cities Project is innovative in that it introduces, on a local level, new patterns of decision-making and administrative planning as well as new aims, structures and instruments of health policy. The WHO directs a complex and much-in-depth action programme at local institutions without spending substantial financial funding. In this respect, too, the WHO Project, in international discussion, is treated as a model. This model may also be interesting, in accordance with the

conclusions of Maastricht, for future EC action programmes which will improve the health systems in the Member States.

Evaluation of the WHO Project, however, is only beginning in some countries or regions. The evaluation will critically review the extent to which innovations have effectively been realized. It will examine the ways of making operational the conceptual goals and will scrutinize the problems of communication between all parties concerned (WHO/Cities, cities/cities within the national subnetworks, municipal administrations/citizines initiatives/local ɔerts).

It will further provide knowledge about how a supra-national body can, and needs to, guide the local process of action in the respective countries. For such results to become comparable and productive for future European action programmes, it appears useful to organize a coordinated and comprehensive evaluation study under the BIOMED 1 Programme.

The proposed Concerted Action will therefore consist in (1.) establishing common criteria, methods and tools for the national evaluation studies to be carried out by the participating research teams, (2.) jointly comparing and analysing the national results with a view to compiling a comprehensive evaluation report. Such Action needs a ɔoordinating body, certain meetings of ɛembers of the researchteams, communication facilities and scientific support in order to achieve a "European added value" under the BIOMED 1 Programme. Six research teams from consulting institutions (small enterprises) or universities will join in the Concerted Action, such teams representing six European countries with a focus on Southern Europe. It is hoped to work for two years."

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Theoretical Problems and practical applications: developing an appropriate science for Healthy Cities

This paper describes briefly a series of small scale research projects carried out in Glasgow between 1987 and 1991. Each of these projects used the community development perspective on health and attempted to put into practice some of the Health for All principles particularly participation and intersectoral collaboration. The three projects are concerned with the effects of unemployment on health, provision of child care support in multi-deprived communities and the development of a community health profile. Each of these projects has been linked to the University Department of Public Health and to the Healthy Cities project in Glasgow. The strengths of these projects are identified including their focus on participation, empowerment and change. Some of the tensions and difficulties in these projects are also described. In particular, the lack of a clear theoretical and methodological framework, the need to statisfy very disparate constituencies, highly positivistic expectations of communities as well as local politicians, the role of local politicians themselves in the research process, the role of city hall bureaucrats in the research, and the relationship to mainstream medical public health.

A sociological account of the tensions and difficulties is provided in terms of the difference between modern and post-modern theories of social formation. It is further argued that the disjunction between the pathogenic disease model and the salutogenic positive health model and a failure to integrate different analytic and conceptual levels (individual, organisational, social and environmental) helps to explain the difficulties of applying Health for All principles within a conventional scientific discourse.

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HEALTH FOR ALL 2000

THE WHO HEALTHY CITIES PROJECT

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1994 / Januari

research for healthy cities

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Editorial

Healthy City Conferences booming industry?

Following the explosive growth of the healthy cities movement academics now witness a booming conference industry around the theme. If you'd really want, you could be in Hilton Hotels and on Jumbo-Jets year round. The last quarter of 1993 witnessed two healthy city confe-rences which both claimed to be 'global'. Between 25 and 30 October 1993, the 1993 Cultural Capital of Europe, Antwerp, was host to a twin-conference 'City 93; urban environment, social issues and health in cities' - 'EPH 93; environment and public health in modern society'. Although many, many interesting presentations were proposed, the infrastructure and logistics of the conference did not facilitate the type of exchange healthy cities initiatives require. Too many lengthy plenary lectures and too little workshops in weird environments (imagine conducting four parallel work-sessions with around 300 people seated aside long tables in one and the same hall...). Colleagues who did not attend the Antwerp meeting may consider themselves fortunate: they didn't waste any money. Those who stayed at home between 7 and 12 December missed out on a great International Healthy Cities and Communities Conference in San Francisco. Although dominated by US participants, the conference bore a truly global healthy city attitude. The conference was organized through healthy cities principles: public participation and self-organizing systems brought about a meeting with nearly 100 worksessions and some impressive plenary presentations. A 'Commons' area facilitated communication and exchange of experience, and site visits in the Bay Area brought to light some of the appalling environmental and social conditions in the US as well as the incredibly creative solutions implemented. It is still unclear whether there will be proceedings of the conference (one would expect the organizers require several massive volumes). However, the work-session devoted to research, run by the Maastricht WHO Collaborating Centre, added about 50 researchers to the list of subscribers of this Newsletter. In upcoming issues several of the projects presented at the conference will be described and/or reviewed.
Stay tuned!

Evelyne de Leeuw
editor

Guest editorial

Cityhealth research network aims to put the cooperation back into research.

Co-operation is a precondition for effective healthy cities research. No one discipline, research centre or nationality could expect to encompass all the necessary perspectives. Moreover, partnership between researchers and practitioners is essential in healthy cities research. The need for co-operative approaches to healthy cities research derives from the priorities in urban health practice which the healthy cities movement have brought to light. There is a need, not only to create, but also to transfer knowledge about how to undertake programmes to improve and sustain the health and environment of cities. This in turn calls for a new set of research skills. We need to be able to evaluate the effectiveness of approaches to urban health, taking into account differences in local settings and using criteria which are meaning-ful, not only to technical experts but also to politicians and local residents. This requires that we can work together to improve communication, to integrate different kinds of expertise and to disseminate knowledge of good practice. In practice grant-awarding systems and research jobs often favour competition, specialisation and topic-based approaches. But funding from the European Union has provided a way for some urban health researchers to tackle these problems. The EU Human Capital and Mobility programme aims to improve human resources by enabling researchers to move within Europe to develop their skills. Under this programme the Commission has awarded a grant for a research network on the theme, CITYHEALTH. Over the next eighteen months, seven research centres in different European countries will be jointly developing and comparing approaches to the evaluation of urban health policies and practices. The grant for the network will be used to employ at each centre a researcher from another European country and for a small number of joint meetings. Within the network research programme, each research centre has selected a complementary research theme and has also identified a project which can be used to train the researcher and to give him or her the opportunity to contact local practitioners in the field. The network themes include environmental health, policy development, organisational development and impact evaluation. The advertisement for the network research posts appears in this issue of the newsletter. Please help us to publicise it widely. With this recruitment the network is taking the first step to model a process of research co-operation which is based on sharing skills between countries and disciplines.

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Québec network publishes directory

The network office of the Réseau Québecois de Villes et Villages en Santé has just published a wonderful directory with listings of participating cities and villages, some of their core indicators (demographic information, contact addresses, responsible coordinator and politician), and past, current, future and possible projects in the cities. Apart from a quite mobilizing book (it just shows how broad and powerful the Quebecois Healthy Cities movement is) the material presented in the document might also be of interest to researchers formulating healthy city research questions. The scope of current activities turns out to be very wide, and researchers may use the descriptions provide to lay foundations for community and action relevant (and therefore 'fundable'?) inquiries. The availability of the material on diskette would facilitate the use of the material for research purposes.

Contact:
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1050, Chemin Sainte-Foy
Québec
Québec G1S 4L8, Canada
fax +1 418 682 7925

Research Monographs still avalaible

Iman, L., M. Goumans & E. de Leeuw (1992) Healthy Cities Research Bibliography. RHC Monograph Series No. 1. Maastricht (250 pages)
ISBN 90-74590-01-2

Leeuw, E. de, M. O'Neill, M. Goumans & F. de Bruijn (1992) Healthy Cities Research Agenda. Proceedings of an expert panel. RHC Monograph Series No. 2. Maastricht (70 pages)
ISBN 90-74590-02-0

Goumans, M. (1992) What about healthy networks? An analysis of structure and organization of national healthy cities networks in Europe. RHC Monograph Series No. 3. Maastricht (100 pages)
ISBN 90-74590-03-9

Stirk, M. (1993) An exploratory inquiry into the meaning and implementation of health promotion within the health promotion and health education departments in England and Wales. RHC Monograph Series No. 4. Maastricht (88 pages)
ISBN 90-74590-04-7

Orders:
These publications may be ordered through your regular bookseller (quote our address) or directly from:
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6200 MD Maastricht, The Netherlands
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Abstracts from the Research for Healthy Cities Expert Panel

Health and Housing Survey 1992, Belfast

The Healthy Cities Project is a World Health Organisation initiative to create a European network of Healthy Cities whose residents and administrators will corporately ensure that health in the widest sense, is explicitly considered in policies, plans and programmes which directly or indirectly affect the health of the city residents.
The project seeks to stress three key elements of health promotion within the urban context;

1. The promotion of healthy lifestyle of city dwellers.
2. The promotion of health as a fundamental consideration within public policy, plans and programmes.
3. The creation of a healthier urban environment.

The condition and nature of dwellings have a major influence on the lives of residents and is widely believed to have a direct bearing on the quality of day to day living and health. The empirical evaluation of the direct relationship between housing conditions and the health of occupants has posed significant difficulties because of the multifactoral non-housing variables, the inadequate indices for measuring health and hygenic quality of housing and the lack of specific epidemiological studies.
The Housing Executive in this role as a statutory agency for housing in Belfast has developed a specific research project in conjunction with the Eastern Health and Social Services Board.
The overall aim of the research is to examine the extent to which self reported health of individuals varies between different urban environments.
The scope and direction of the research is governed by five specified objectives:

1. To broadly identify the types of urban environments which may have an impact on the health of residents.
2. To select case study areas within Belfast urban areas which represent these environments.
3. To measure the health status of the residents using the Nottingham Health Profile (NHP) as the core measurement technique.
4. To explore the casual relationships between the health status of the residents, housing environment and other socio economic factors.
5. To explore these relationships over time by longitudinal analysis.

The project involves measuring the self-reported health status of tenants in high rise estates, redevelopment areas, sectarian interface locations, high density locations and on an estate recognised as "good quality". The total number of dwellings in the project is approximately 700.
The questionnaire to be used is based on the Nottingham Health Profile which is a technique to measure comparative health scores of different housing environments and includes measures of stress, physical pain, mobility problems and social isolation. Information will also be gathered on the housing and environmental conditions and the social and demographic profile of the residents. The project is being jointly funded by the Housing Executive and the Eastern Health and Social Services Board. Fieldwork will be carried out during June 1992 and preliminary results will be available in October/November 1992.

Abstracts from the Research for Healthy Cities Expert Panel

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Participatory Action research: the development of a paradigm for evaluation of Healthy Cities

Participatory Action research is a qualitative holistic inductive research methodology which involves the subjects of the research in the research process from the initial design stage through data gathering and analysis to the final conclusion. It is about learning and empowerment and its strength lies in the abillity to study major changes through the creation of an environment in which the participants give and get valid information, make free and informal choices and generate their commitment to the results of their enquiry. While any evaluation method chosen should be the one best suited to the questions asked. Participatory action research is a research methodology that carries out research according to the principles of Health for All.
The paper discusses the methodology, its strengths and weaknesses illustrated with examples of three on-going Research for Healthy Cities projects in Liverpool.

Networking and intersectoral Collaboration: theory and practice.
The purpose of this paper is to examine network forms of organisation and assess their significance for the study of intersectoral collaboration and community participation both at the heart of the Healthy Cities project.
The emergence or reemergence of network forms of organisation has been highlighted by a number of authors covering a wide range of areas. It is now recognised as replacing older forms of organisational interaction amongst commercial, industrial and public sector organisations (Powel, 1990). Research has established, for example, that networking lies at the heart of Japanese industry's ability to sustain a system of continuous innovation (Mody, 1990.) Networks provide the channels through which information and resources can flow reducing the level of uncertainty and fostering trust and the allocation of resources and encouraging the development and dessemination of ideas, experiences and skills. Networks can take different forms and have different functions but there are certain underlying element that are common to all networks, the existence of which it is hypothesised help to account for the degree of succes or otherwise in achieving change for health for all. Understanding the development of networking and networking skills are fundamental tools for those working for health for all.

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Environment and urbanization

The October 1993 issue of the journal Environment and Urbanization is devoted to health and well-being in (mostly third world) cities. The journal contains articles on such diverse topics as intra-urban differentials in Accra, violence prevention in US cities, respiratory diseases in Jakarta, the healthy cities movement, and disaster management in Lusaka. As always, there is a very extensive book corner. Subscription rates for two issues (of about 200 pages) per year are £8 (third world) or £17 (elsewhere).
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fax +44 71 388 2826

Urban Management Programme

The UMP, a joint effort by Habitat and World Bank is publishing reports and well as working papers. The UMP publications series shows by now 12 titles (interesting ones like A Review of Environmental Health Impacts in Developing Country Cities (no. 6) or Elements of Urban Management (no. 11) and ones on first sight less interesting to healthy cities like no.1, Property Tax Reform). The first issue in the Working Paper Series is Environmental Innovation and Management in Curitiba, Brazil.
Maybe unknowingly, the paper is a prime example of an excellent healthy city project.
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Urban Policy and Economic Development

Perhaps the best way for healthy cities developers to read the World Development Report 'Investing in health' is in combination with a somewhat older World Bank publication: Urban Policy and Economic Development; an agenda for the nineties (1991, ISBN 0-8213-1816-0).
World Bank, 1818 H Street, NW, Washington DC 20433, USA
fax +1 202 477 6391

Development of Evaluation Framework in Canada

Apparently the best way to start the evaluation of healthy cities and communities effort is through a research network. Apart from the network funded by the European Union described in our guest editorial, the Canadians have also formed a network that covers almost all provinces of the country. The network will perform an 'evaluability assessment' in order to clarify constituent theoretical frames as well as stakeholder concerns, needs and expectations.
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Electronic communication developing further

The WHO Collaborating Centre in Healthy Cities of Indiana University has set up a Global Healthy Cities Information System on internet. It will contain programme and tool descriptions. Information:
WHO CC in Healthy Cities
IARCH
1111 Middle Drive NU 236
Indianapolis IN 46202
USA
fax +1 317 274 2285
EMail CITYNET@INDYVAX.IUPUI.EDU

The WHO Collaborating Centre for Research on Healthy Cities is also expanding its electronic services. The research bibliography (500 entries including lengthy abstracts) will go on-line by 1 February 1994. It will be an interactive search system; those logging on will also be given the opportunity to download into the system their own publications, abstracts and references. Of course, one-to-one communications remain possible too.
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University of Limburg

research for healthy cities

ISPM

Liverpool John Moores University

Helmut Hildebrandt Gesundheits Consult

SOGESS

IVESP

City health

EC Research Network for the Evaluation of Urban Health Policy and Practice

Short term research post abroad

Seven recently trained researchers are required immediately to take part in research on sustainable healthy cities in Europe. As part of a collaborative, international network, you will help to develop common evaluation approaches in a multidisciplinary environment. Posts are available in:

- *Germany (4 months) at Helmut Hildebrandt Gesundheits Consult, Hamburg;*
- *Greece (9 months) at the Institute for Social and Preventive Medicine (ISPM), Athens;*
- *Italy (6 months) at Sistemi Organizzazione e Gestione Servizi Sociali e Sanitari (SOGESS), Milan;*
- *Netherlands (12 months) at Research for Healthy Cities Taskforce, University of Limburg, Maastricht;*
- *Spain (12 months) at the Institut Valencia d'Estudis en Salut Publica (IVESP), Valencia;*
- *UK (12 months) at the Institute for Health, Liverpool John Moores University, Liverpool;*
- *UK (18 months) at the Research Unit in Health and Behavioural Change (RUHBC), University of Edinburgh (Co-ordinating Centre).*

You will work at a centre in a European country of which you are not a national or long-term resident. You have a good command of English, are qualified in a health, social or human science, and have research experience and good communication skills. Proficiency in the language of the country you apply to work in is desirable.

Requirements and conditions are specific to each centre. For an information pack and application form, send a postcard giving your name and address to "CityHealth" to any of the addresses below:

RUHBC, 24 Buccleuch Place, Edinburgh, EH8 9LN, UK.

ISPM, 32 Skoufa Street, 106 73 Athens, Greece.

SOGESS, Via de Amicis 53, 20123 Milano, Italy.

Evelyne de Leeuw, Research for Healthy Cities, University of Limburg, PO Box 616, 6200 MD Maastricht, The Netherlands.

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HEALTH FOR ALL 2000

THE WHO HEALTHY CITIES PROJECT

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n e t w e r k

g e z o n d e s t e d e n

THE HEALTHY CITIES PROJECT OF THE WORLD HEALTH ORGANIZATION

The Netherlands Healthy Cities Network
1992

The Healthy Cities Project of the World Health Organization

Background

In September 1986, eleven cities were selected to be the first participants in the Healthy Cities project of the World Health Organization, Regional Office for Europe. The project was introduced to demonstrate that new approaches to public health, grounded in the Health for All principles would work at the local level.

We thought that, if the project would be successful, it would provide the foundation for a new locally based public health movement and enhance the health and well being of people living in European cities.

Five years later, 35 European cities are participating in the Healthy Cities project. National and subnational Healthy Cities networks have been set up in 18 countries and they involve of about 400 cities. Regional networks are functioning in Australia, Canada and the United States and individual cities are working with the project model in several other countries.

What is a Healthy City?

In the first Healthy Cities papers, Hancock and Duhl (1988) define a Healthy City:

> "as one that is continually creating and improving those physical and social environments and expanding those community resources which enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential".

A Healthy City is defined by a process and not just an outcome. A Healthy City is not one that has achieved a particular health status level, but is a city that is conscious of health as an urban issue and that is striving to improve it. Any city can be a healthy city if it is committed to health and has a structure and process to work for its improvement.

The Healthy Cities is rooted in a concept of what a city is and a vision of what a healthy city can become. A city is viewed as a complex organism that is living, breathing, growing and constantly changing. The project strives to realize the vision of a healthy city through a process of political commitment, visibility for health, institutional change and innovative action for health and the environment.

The ultimate goal of Healthy Cities is to:

> "improve health and wellbeing by applying the principles and strategies of Health for All and Health Promotion at the city level".

There are no simple solutions or recipes for this Healthy City process. Strategies at the local level must be compatible with the cultural, social and organizational traditions of a city.

However, any Healthy City should strive to provide:
- A clean, safe physical environment of high quality (including housing quality);
- An ecosystem that is stable now and sustainable in the long term;
- A strong, mutually supportive and non-exploitive community;
- A high degree of participation and control by the public over the decisions affecting their lives, health and well-being;
- The meeting of basic needs (for food, water, shelter, income, safety and work) for all the city's people;
- Access to a wide variety of experiences and resources, with the chance for a wide variety of contact, interactions and communication;
- A diverse, vital and innovative city economy;
- The encouragement of conectedness with the past, with the cultural and biological heritage of citydwellers and with other groups and individuals;
- A form that is compatible with and enhances the preceding characteristics;
- An optimum level of appropriate public health and sick care services accessible to all; and
- High health status (high levels of positive health and low levels of disease).

Framework for action for Healthy Cities

As was previously mentioned, the principles of Health for All and strategic development in health promotion provide the framework for action in local Healthy Cities projects.

Local action means political support. This implies getting political commitment from city councils to reorient policies towards equity, health promotion and disease prevention, in other words: new approaches for public health.

Political commitment is the first step in working towards a healthy city. Cities that have entered the WHO Healthy Cities network over the past six years have been requested to make such commitments. These cities have been asked to formulate intersectoral health promotion plans with a strong environmental component and to secure the resources for implementing them. These should amongst others include an intersectoral political committee, mechanisms for public participation and a project office with full time staff. Long term strategic planning, environmental analysis and accountability mechanisms are used in these cities as tools to influence policy formulation and implementation.

Healthy cities initiatives imply an abitious health agenda:

- Local action to reduce inequalities in health status;
- Priority for health promotion and disease prevention;
- Cooperative action for health among departments of city government and other public and private organizations;
- Greater participation by community groups in decisionmaking and action to improve health and the city environment;
- Health care reform to place greater emphasis on primary health care and on disease prevention and reform of environmental services;
- Adoption of healthy public policy throughout city government and in other sectors;
- Cooperation among cities in developing new approaches to public health.

The project becomes a movement

The diversity of the 35 cities in the WHO project network show that there are different ways to create this policital commitment to improve the health of the city residents. Project cities are located in 18 countries with different political systems, economies and social conditions. They vary in size from Horsens in Denmark with a population of 55.000 to St. Petersburg, the Russian Federation, with more than 4 million residents. Some enjoy a high standard of living and health, while others suffer widespread unemployment, poverty, lack of resources and the health problems commonly associated with severe deprivation. There are wide differences in ilifestyles, environmental conditions and access to primary health care within cities. The city administrations have varying degrees of jurisdiction over matters that affect health and different organizational structures through which to address health problems. But regardless of these differences, they all strive to become a healthy city.

Within the WHO project network multi-city action plans have been set up recently to bring groups of cities together to address key issues, such as nutrition, tobacco use, women's health issues, traffic control and AIDS. Under these plans groups of cities compare experience as a basis for agreeing on better methods to follow the future. Each action plan is linked to the relevant programme within WHO/EURO.

Dissemination of Healthy Cities strategies has been greatly accelerated by the growth of national and subnational Healthy Cities networks, now existing in 18 countries. Both national networks and the number of cities participating in the movement have grown much more rapidly than expected. The scope and intensity of network activities varies. The activities currently include advocating for Healthy Cities, through dissemination of information by means of translated background documents, newsletters, information packages, and organizing business meetings, workshops and training courses.

The future

WHO/EURO has renewed its commitment to Healthy Cities by deciding to continue the project for another five years. In this second phase the project will retain its commitment to the principles of health for all and to health promotion strategies. This will mean continued concern for equity, sustainable development, creation of settings for healthy living and health care reform.
Major initiatives in this second phase of the project should reflect the achievements of the first period of five years and the challenges of the future. While work accomplished in phase one will continue, in the second phase new approaches and priorities will be needed. Committed effort will be required at the international, national and local level.

In so far as the WHO project is concerned, the methods developed over the past five years will continue to be applicable in the future. Some adjustments in approach will be made to reflect new priorities, the current state of development and the support networks that now exist.

WHO will work with its national and local partners to create a network of Healthy Cities reaching accross the European Region. It will be their challenge to protect and improve public health in a period of unprecedented political, enonomic and social transition.

The National Healthy Cities Network in the Netherlands

History

The participants from the Netherlands at the second Healthy Cities Conference in Düsseldorf in 1987 were so inspired by what they heard, that they agreed with the formation of a National Network of Healthy Cities in our country.

Three months after the Düsseldorf Conference a follow-up meeting took place in Eindhoven for all those interested in the Healthy Cities project. During this meeting it became clear that there was enough enthousiasm in various Dutch cities for establishing a National Healthy Cities Network. At this meeting a so-called "Core Group" was formed. This Core Group consists of people who were and still are willing to invest time, knowledge and energy in the Healthy Cities movement. The main task of this Core Group is to function as an initiator and promoter of ideas for the Network.

The year 1988 turned out to be an important year for the Healthy Cities movement in the Netherlands. In January, the city of Eindhoven was designated by WHO as one of their project cities. Also in january 1988 the Core Group of the National Network published its first policy document for the Network. This document included a proposition for the structure of the Network, the Strategies for the network activities and the need for a project office to support these network activities. In September 1988, the Ministry of Welfare, Health and Cultural affairs decided to subsidize this Support Centre and staff for two years, as it was felt that a National Healthy Cities Network is an important stimulus for the development of the new public health at local level in the Netherlands.

The Support Centre for the National Network started in January 1989 in Eindhoven with three part time staff members: a network coordinator, a project officer and a secretary.

In 1990, when the initial period of two years ended, the Core Group felt that we had to continue the Network and its Support Centre. Due to the enthusiasm for Healthy Cities and the Network, the workload of the staff members at the Support Centre increased and we felt that we needed two full time officers for carrying out all the necessary work. The Ministry of Health reacted positively to this request of the Core Group and they decided to continue to support the Healthy Cities Network for four more years with an increased budget for network activities and for two full time staff members with secretarial support. It was also decided that the Support Centre would stay in Eindhoven until the end of 1992 and than move to Rotterdam. The City of Rotterdam was appointed by WHO as second project city for the Netherlands in July 1991.

Organization of the Network

The Healthy Cities Network is an open platform where all those who are interested or involved in Healthy Cities in the Netherlands and in Flanders (Belgium) can meet to exchange ideas and practical information. The Network has no other participation criteria than a clear commitment to the Health for All and Health Promotion principles. This commitment can range from a personal to an organizational and a political commitment. In order to involve as many people and organizations as possible, no membership fees are asked. The aim was to create a large, open, interactive communication network for Healthy Cities in the Netherlands.

Within such an open interactive system, the Network concentrates its activities on two main target groups:

- The first and main target group consists of those persons and organizations that are active in the health system, for instance: workers at public health services, health policy makers at national and local level as well as at the administrative and executive level, health promotion officers, epidemiologists, politicians, academics and students at universities and other research institutes and many persons working in other governmental and non-governmental organizations.
- The second target group is formed by the potential partners with whom intersectoral action for health can be developed, such as community development and environmental organizations, city planners and architects.

Next to these target groups, we also distinguish two different kind of involvement with the Network. First, there is for instance the personal and/or organizational involvement from professionals working at the previous mentioned organizations and institutes. This group consists of approximately 500 persons. The second group is formed by municipalities that are implementing the Healthy Cities philosophy as a result of their local health policy as established by their City Councils. In approximately fifteen Dutch municipalities, including the large cities as Amsterdam, Rotterdam, The Hague and Utrecht, but also in smaller cities like Almelo, Lelystad, Almere, Eindhoven, Tilburg, Groningen and Maastricht, activities within the "spirit of Healthy Cities" have been started.

Network activities

The main task of the Network and its participants, of the Core Group and of the Support Centre is to enable, mediate and advocate for Healthy Cities in the Netherlands.

The Core Group of the Network has as main task to function as an initiator and promotor of ideas for the Network and to contribute to the development of new strategies for new public health at the local level in the Netherlands.

Dissemination of information on Healthy Cities initiatives in the Netherlands and in other countries is a major activity for the Support Centre.
A newsletter "Nieuwsbrief Gezonde Steden" with national as well as international information has been published on a regular basis since 1989. This newsletter is distributed free of charge to anyone who applies for a subscription.

This year we started with publishing of the so-called "Dutch Health Cities papers", a series of booklets on relevant Healthy Cities topics. The first booklet was on the Healthy Cities project in general and described its concepts and principles and the way the project grew into a movement at national as well as international level. The second booklet was issued last week and gives a general description of the development of healthy public policy and health policies at the local level and contains a large variety of Dutch models of good practice. We have planned to issue three more books this year: on research for Healthy Cities, on intersectoral action and on environmental activities.
Information packages containing various articles on different Healthy Cities topics are also available.

The Support Centre has a well documented library on Healthy Cities which contains national as well as international (i.e. english) information on relevant subjects. This documentation centre is open for everybody and all books and reports are lend out free of charge.

The Support Centre organizes one or two plenary Network Meetings each year. The subject of these meetings are actual health topics in the Netherlands or important Network issues.

Each year a National Network Symposium, based on the annual theme of the international Healthy Cities project is organized in order to give feedback from the annual Healthy Cities symposium.

Many smaller technical workshops are organized during the year. These meetings are always organized in close collaboration with other organizations.

This year we also started with "Healthy City visits". For a start, the two WHO project cities Eindhoven and Rotterdam are organizing a one day meeting where they explain and show on location what is being done in their city within the framework of the Healthy Cities project.

In collaboration with the Dutch Health Education Centre and the University of Maastricht we developed a training course as an introduction to Healthy Cities.

We give consultations on location in cities or at the Support Centre. We also give lectures in cities, at polytechnics, universities and other organizations on request.

We also attend many national conferences and symposia on Healthy Cities related topics in order to promote the Healthy Cities ideas in these areas.

Achievements

Since the start of the Network, we have seen that the concepts and principles of Healthy Cities have been picked up by many municipalities in the Netherlands. In the beginning we started with a small group of enthousiastic people, but in the course of the past five years the Healthy Cities principles were adopted as guidelines for many local health policies. Healthy Cities was explicitely mentioned not only in the policy documents of Eindhoven and Rotterdam, but also in those of Almelo, Almere, Dronten, The Hague, Groningen, Lelystad, Tilburg, Utrecht and Groningen.

In many other cities, "Healthy Cities" activities are carried out. Although these activities -often initiated by the public health services or by community development workers- are not always labeled as "Healthy Cities", they have similair aims, such as a bottom up and multidisciplinary approach. The Dutch Institute for Care and Welfare played an important role in this development. This Institute started the "Healthy Communities" project, in which they developed a video programme, a handbook of models of good practice and a training course with regard to the practial aspects of health promotion at the local level.

Summarized, we can say that the Healty Cities movement in the Netherlands is well on its way.

The future

There will be a National Healthy Cities Network with a Support Centre in Rotterdam at least until 1 January 1995. For the next two years the Network activities will be subsidized by the Dutch Ministry of Health.
The Support Centre shall continue its activities with regard to the dissemination of information by means of the newsletter, reports from workshops and other meetings and the series of Healthy Cities booklets. We also will continue to organize training and other workshops and provide consultation.

We do expect, however, some changes. For instance, the structure of our Network will problably be transformed. We still are convinced that the threshold for becoming interested in Healthy Cities and for joining the Network should be as low as possible. But, we have also witnessed that after some years the very open platform structure also means a rather low commitment to the Network and its activities. The Core Group of the Network started a discussion to find a solution for this problem. We expect to have another Network structure in the course of 1993.

Regardless of the formal structure of the Network, our principal aim is and will be in the future: to enable, mediate and advocate for Healthy Cities and new public health at the local level.

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The Netherlands Healthy Cities Network

The Netherlands enjoys a high standard of health care: health services are accesible to all, both financially and otherwise. The national government as well as the local authorities are responsible for taking statutory measures and creating the right conditions for the prevention of disease and accidents and the improvement of treatment and care. It is worth noting that average life expectancy in the Netherlands has risen from arount 50 in 1900 to 73 for men and 79 for women. This is due in large part to advances in medical science, while improved hygiene, better housing and a safer working environment have also contributed.

The National Healthy Cities Network was establised in 1987 as a result of the Düsseldorf Healthy Cities Conference. In 1989 a Support Centre in Eindhoven, WHO project city, with two part time professionals was subsidized by the Ministry of Welfare, Health and Cultural Affairs for a period of two years. In 1991 it was decided to continue this financial support for another period of four years for two full time professionals. As from January 1st 1993, the Support Centre for the Network will be located in Rotterdam, the second WHO project city in the Netherlands.

The aim of the Network and its Support Centre is to enable, mediate and advocate for Healthy Cities in the Netherlands, through organizing training, symposia, workshops and other meetings, by distributing a Healthy Cities Newsletter, by publishing the so-called Dutch "Healthy Cities" papers and by giving lectures and consultation.

The Network is an open platform where all those interested in Healthy Cities can meet to exchange ideas and practical information. The Network has no other participation criteria than a clear commitment to the Health for All principles. No membership fees are asked. The Network can be described as an communication network.

After five years, the ideas and principles of Healthy Cities have been picked up by many cities and other organizations in the Netherlands. In approximately fifteen local health policy documents Healthy Cities are mentioned as guiding principle and many public health services and community development workers consider Healthy Cities as a challenge for their activities.

Healthy Cities are well on their way in the Netherlands.

the activities of the Dutch national network

by Janine Cosijn, National Network Coordinator

In the previous number of this newsletter two fellow countrymen expressed their - somewhat critical- views on Healthy Cities initiatives in the Netherlands. As this was the first time that Dutch activities were described in this newsletter, I felt it was necessary to give more background information on the Dutch National Healthy Cities Network.

The first initiatives to create a Healthy Cities Network in the Netherlands were taken almost immediately after the second Healthy Cities conference in Düsseldorf in 1987. The Dutch participants at this conference were so inspired by what they heard, that at a follow up meeting of this conference, they agreed that there was enough enthousiasm in various Dutch cities for creating a national network.

A steering group, the so-called "Core Group" was established to function as an initiator and promotor of ideas for the Network and to define the terms of reference for the network. The group consists of people who were and still are willing to invest time, knowledge and energy in the Healthy Cities movement in the Netherlands.

This Core Group published a first policy document for the Network in 1988. This document included a proposition for the working structure of the network, the strategy for its activities and the need for a project office to support these activities. In september 1988, the national Ministry of Welfare, Health and Cultural Affairs decided to subsidize a support centre and staff for an initial period for two years, as it was felt that a national Healthy Cities network is an important stimulus for the development of the new public health at the local level in the Netherlands. The Support Centre started in Eindhoven (WHO project city) in 1989 with part time staff members. When the first period ended, the Core Group felt that the Network and the Support Centre had to be continued with full time staff members this time. The Ministry of Health reacted positively to the request of the Core Group and they decided to continue the support for the Dutch network for four more years with an increased budget for network activities and for two full time staff members with secretarial support. It was also decided that the Support Centre would stay in Eindhoven until the end of 1992 and than move to Rotterdam, the second WHO project city in the Netherlands.

Due to the financial support of the Dutch government, the Netherlands Healthy Cities network is at this moment the only national network in Europe that is able to employ two full time professionals.

When the network started five years ago, the Core Group very clearly chose for the "structure follows stratey" approach. This approach is concerned with creating possiblities for innovation. Whenever you start with something new and unexpected, there is alway little room for it. Only few people are willing to experiment with new things and these people are always watched closely and critically by more conservative colleagues. A first positive reaction to introducing something new is creating tolerance until succes becomes visible. Then you reach the second phase, where you are given the benefit of the doubt. Innovative trendsetters go beyond this phase and they dare to speak out loud what they believe in and stand for. Gradually, the group that promotes innovation grows and the new trend manifestates itself. After a certain period of time, a period which can vary according to the groups involved, the new thing becomes an everyday phenomenon and becomes then institutionalized.
The strategy of the Core Group was first to concentrate on the innovators and to involve as many people in the network as possible, before creating any official structure such as a legal organisation. The main objective of this network was to advocate for the Healthy Cities principles and the main tasks of the support centre were to fulfill the advocacy function and to disseminate information in various ways. The network is therefore also described as an open communication platform, with no other participation criteria than a clear commitment to the health for all and health promotion principles as stated by WHO. A network, which can be joined by everyone interested in Healthy Cities, where no membership fees are asked.

In 1990 two major developments in the Netherlands influenced the Healthy Cities movement.
The first was that in June 1990 the Dutch legislation put the responsibility for health protection and health promotion in the hands of the local authorities. The Collective Prevention Act instructed the Dutch municipalities to develop a local health policy. This implies that health is, or at least is supposed to be, on the political agenda of the city. The problem, however, is how to make the policy makers aware of the Healthy Cities approach in preparing and implementing a local health policy. This is one of the main tasks of the Network.
The second important development for Healthy Cities in the Netherlands is the so-called Social Innovation movement, which aims to improve social relationships at the local level. Social Innovation is initiated by the national government, which also finances social innovation-projects. Many of the key principles of this Social Innovation movement are similar those of Healthy Cities, such as: strengthen community participation, bottom-up, intersectoral and multidisciplinary approaches at the local level. In Rotterdam, the Healthy Cities project and its activities is one of the many projects initiated within the overall municipal Social Innovation programme. And in Eindhoven, Healthy Cities and Social Innovation initatiatives are also linked together. When I have to explain in the Netherlands in one sentence what the Healthy Cities project is about, I often use the expression that "the Healthy Cities project deals with the health aspects within Social Innovation". Social Innovation started with four main topics: housing, education, employment and social security. Healthy Cities adds the health dimension to these issues. This development implies that there are many initiatives developed in the Netherlands which could be labelled Healthy City, but which have been initiated within a Social Innovation programme. But is this labelling

or desire to claim the ownership of the ideas so important? I don't think so, as long as we are all aiming at creating together a better world to live in. And there is an important task for the Healthy Cities network: to increase the awareness for the health dimension in those Social Innovation programmes which are mainly focussed on the four initial topics.

As the Healthy Cities project is initially about finding ways to implement the new public health, it was obvious that the first group of people interested in this project would be found in those institutions dealing with public health matters in the Netherlands. This are the Municipal Public Health Departments. These Public Health Services have a long tradition in social medecine. With the introduction of the Collective Prevention Act, they now also have a responsibility to support the local authorities in developing a health policy. Some Dutch cities have discovered that the Healthy Cities project can be used as a framework for this. In approximately fifteen Dutch municipalities, including the large cities as Amsterdam, Rotterdam, the Hague and Utrecht, but also in smaller cities like Almelo, Lelystad, Almere, Eindhoven, Tilburg, Groningen and Maastricht, activities within the "spirit of Healthy Cities" have been started.

The main task of the Network and its participants is to enable, mediate and advocate for Healthy Cities. Dissemination of information on Healthy Cities is one of the major activities of the Support Centre. A newsletter " Nieuwsbrief Gezonde Steden" is distributed free of charge on a regular basis since 1989. This year we started to publish the so-called "Dutch Healthy Cities papers", a series of booklets on relevant Healthy Cities topics. Plenary meetings are organized twice a year, one always giving feedback on the annual international Healthy Cities symposium and many other network meetings and training workshops are organised to exchange information and experciences.

As mentioned before, the Network is set up as an open communication platform. Within this platform, three target groups can be distinguised. Representatives from these target groups are the participants in the Dutch Network. The first target group consists of those persons that are reponsible for the development and implementation of local health policies: the politicians and the policy makers. The second group consist of those professionals involved in public health, such as workers at the municipal public health services, other governmental and non-governmental institutions and scientific and other research institutions. The third target group is formed by the potential partners with whom intersectoral action for health can be developed such as community development and environmental organizations.

The future for the national Healthy Cities network in the Netherlands looks good. The national Ministry of Health will finance the Support Centre and its activities until 1995. That implies that the work of enabling, mediating and advocating for Healthy Cities and new public health at the local level will be continued for at least two more years. But it is up to the cities themselves to develop and implement healthy policies to improve their citizens health and well-being.

Healthy Cities - Cities fit to live in
Vol no 4 Issue no 3

"Healthy Cities are well on their way in the Netherlands"

A summary of the Dutch national network

by Janine Cosijn, National Network Coordinator

In a previous edition of this newsletter two fellow countrymen expressed their - somewhat critical - views on Healthy initiatives in the Netherlands. As this was the first time that Dutch activities where described in this newsletter, I felt it was necessary to give more background information on the Dutch National Healthy Cities Network.

The first initiatives to create a Healthy Cities Network in the Netherlands were taken almost immediately after the second Healthy Cities conference in Dusseldorf in 1987. The Dutch participants at that conference were so inspired by what they heard, that at a follow up meeting, they agreed that there was enough enthusiasm in various Dutch cities for creating a national network.

A steering group, the so-called "Core Group" was established to function as an initiator and promoter of ideas for the Network and to define the terms of reference. The group consists of people who were and still are willing to invest time, knowledge and energy in the Healthy Cities movement in the Netherlands.

Policy

This Core Group published a first policy document for the Network in 1988. This document included a proposition for the working structure of the network, the strategy for its activities and the need for a project office to support these activities. In September 1988, the national Ministry of Welfare, Health and Cultural Affairs decided to subsidise a support centre and staff for an initial period for two years, as it was felt that a national Healthy Cities network would be an important stimulus for the development of the new public health at the local level in the Netherlands. The Support Centre started in Eindhoven (a WHO project city) in 1989 with part time staff members. The Core Group felt that the Network and the Support Centre should be continued with full time staff. The Ministry of Health continued supporting the Dutch network for four more years with an increased budget for network activities and for two full time staff members with secretarial support.

Due to the financial support of the Dutch government, the Netherlands Healthy Cities network is the only national network in Europe able to employ two full time professionals.

When the network started five years ago, the Core Group very clearly chose the "structure follows strategy" approach concerned with creating possibilities for innovation. Whenever you start with something new and unexpected, there is always little room for it; few people are willing to experiment with new things and these people are always watched closely and critically by more conservative colleagues. A first positive action when introducing something new is to create tolerance until success becomes visible. Then you reach the second phase, where you are given the benefit of the doubt. Innovative trendsetters go beyond this phase and have the courage to speak out loud about what they believe in and stand for. Gradually, the group that promotes innovation grows and the new trend manifests itself. After a certain period of time, a period which can vary according to the groups involved, the new idea becomes an everyday phenomenon and then becomes institutionalized.

Strategy

The strategy of the Core Group was first to concentrate on the innovators and to involve as many people in the network as possible, before creating any official structure such as a legal organisation. The main tasks of the support centre were to fulfil the advocacy function and to disseminate information in various ways. The network can be seen as an open communication platform, with no other participation criteria than a clear commitment to the health for all and health promotion principles as stated by WHO. Within this platform, three target groups can be distinguished. Representatives from these target groups are the participants in the Dutch Network

Target Groups

The first target group consists of those persons who are responsible for the development and implementation of local health policies: the politicians and the policy makers. The second group consists of those professionals involved in public health, such as workers at the municipal public health services, other governmental and non-governmental institutions and scientific and other research institutions. The third target group is formed by the potential partners with whom intersectoral action for health can be developed such as community development and environmental organisations. The network can be joined by everyone interested in Healthy Cities, and no membership

Amsterdam, one of about 15 municipalities in the Netherlands which have found that healthy cities provides a useful framework for new public health policy such as the Collective Prevention Act.

Netherlands

Continued from Page 7

fees are asked.

In 1990 two major developments in the Netherlands influenced the Healthy Cities movement. In June 1990 the Dutch legislation put responsibility for health protection and health promotion in the hands of local authorities. The Collective Prevention Act instructed the Dutch municipalities to develop a local health policy. This implies that health is, or at least is supposed to be, on the political agenda of the city. The problem, however, is how to make the policy makers aware of the Healthy Cities approach in preparing and implementing a local health policy. This is one of the main asks of the Network.

The second is the so-called Social Innovation movement, which aims to improve social relationships at the local level. Social Innovation is initiated by the national government, which also finances the projects. Many of the key principles of this Social Innovation movement are similar those of Healthy Cities, such as: strengthen community participation, bottom-up and intersectoral and multidisciplinary approaches at the local level.

There are many initiatives developed in the Netherlands which could be included under the Healthy Cities label, but which have been initiated within a Social Innovation programme. But is this labelling or desire to claim the ownership of the ideas so important? I don't think so, as long as we are all aiming at creating together a better world to live in. And there is an important task for the Healthy Cities network: to increase the awareness for the health dimension in those Social Innovation programmes which are mainly focussed on the four initial topics.

Resposibility

As the Healthy Cities project is initially about finding ways to implement the new public health , it was obvious that the first group of people interested in this project would be found in those institutions dealing with public health matters in the Netherlands. These are the Municipal Public Health Departments, whose services have a long tradition in social medicine. With the introduction of the Collective Prevention Act, they now also have a responsibility to support the local authorities in developing a health policy. Some Dutch Cities have discovered that the Healthy Cities project can be used as a framework for this. In approximately fifteen Dutch municipalities, activities within the "spirit of Healthy Cities" have been started.

The main task of the Network and its participants is to enable, mediate and advocate for Healthy Cities. Dissemination of information on Healthy Cities is one of the major activities of the Support Centre. A newsletter is distributed. We publish the so-called "Dutch Healthy Cities papers , a series of booklets on relevant Healthy Cities topics. Network meetings and training workshops are organised.

The future for the national Healthy Cities network in the Netherlands looks good. The national Ministry of Health will finance the Support Centre and its activities until 1995. That implies that the work of enabling, mediating and advocating for Healthy Cities and new public health at the local level will be continued for at least two more years. But it is up to the Cities themselves to develop and implement healthy policies to improve their citizens' health and well-being. In Rotterdam, the Healthy Cities project and its activities is one of the many projects initiated with[in] the overall municipal Social Innovation programme. And in Eindhoven, Healthy Cities and Social Innovation initiatives are also linked together. When I have to explain in the Netherlands in one sentence what the Healthy Cities project is about, I often use the expression that "the Healthy Cities project deals with the health aspects within Social Innovations". Social Innovation started with four main topics: housing, education, employment and social security. Healthy Cities adds the health dimension to these issues.

The structure of the Netherlands Healthy Cities Network

presentation for the workshop on National Healthy Cities Networks
1992 Copenhagen Healthy Cities Conference

Janine Cosijn, coordinator

When compared to other National Healthy Cities Networks in Europe, the Healthy Cities Network in the Netherlands has a very open structure. The Network is meant to be a platform where all those who are interested or involved in Healthy Cities can meet to exchange information and ideas. The Network has, therefore no other participation criteria than a clear commitment to the Health for All and Health Promotion principles. Our Network can be decribed as a communication network in stead of an association of cities.

That was the way the Network started in 1987. It was decided at that time to concentrate first on developing of a strategy for Healthy Cities in the Netherlands, before setting up a firm structure. We chose for a "structure follows strategy" approach. We decided to involve as many people and organizations in the Network as possible in order to create an open interactive network. In the beginning, those people who had become immediately enthousiastic for the ideas of Healthy Cities were the main target group for the Network. Through this group of 'innovators for Healthy Cities' in the Netherlands we tried to spread the message and to involve more persons and organizations. Therefore no membershipcriteria were established, no fees were asked. We also distributed the newsletter free of charge, everybody could attend the meetings and workshops.

This strategy worked. Many people and organizations became interested and involved in Healthy Cities initiatives. Healthy Cities is mentioned as guiding principles for many local health policy documents.

Although the content of Healthy Cities and dissemination of information are and will remain the most important issue for the Network and its activities, it is also felt that after five years, another structure than the open platform would be more appropriate. This in order to increase the political and other commitment to Healthy Cities. We feel that cities, especially City Councils and other institutions do want to belong to a more structured organization that the open platform. A kind of membership will probably also increase the commitment.

At present we are discussing possible options for a new structure. This is not an easy discussion, because there is a danger that for example the question whether or not we should become a legal association could very easily become more important than the concepts and principles for Healthy Cities. However, as long as we are aware of this danger, we can fight it. We expect that in the course of 1993 we will have solved this problem.

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DEBATE

To educate or promote health?

That is the question

Jeff French

CURRENTLY a small minority of health authorities have decided or been advised to change the name of their health education departments to that of health promotion department, and to rename their health education officers 'health promotion officers/advisers' It has also been mooted that the Health Education Council and other health education organisations should consider a change of title. Before any such decision is taken, I feel it would be as well to address some fundamental questions regarding health promotion. Why have some people decided that this change of title is necessary? What are the implications of this decision? And what significance does it hold?

Why change?

In answer to the first question a number of explanations are possible. The phrase 'health promotion' may be perceived as a more accurate description of the role carried out by health education officers. Health promotion may be viewed by some as a more 'scientific' activity than health education, and more readily amenable to quantitative evaluation. Some may favour health promotion because it sounds like an up-market high-profile approach to health education, and obviously this type of approach is both much easier to understand and also more readily seen to be done than many current approaches to health education. All these reasons have their base in a dissatisfaction with existing approaches to health education. But is this sufficient grounds for its rejection? I think not; very few district health authorities have actually established fully staffed and funded health education units. In fact, such units can be counted on one hand. Is it not, then, a little premature to abandon a concept and a way of working which has never been funded to a position where it can begin to work effectively?

In addition, some workers in health education and community medicine view health promotion as an attractive enough field to fight over, leading to a power struggle between HEOs and community physicians. This, of course, is a very negative view, and statements like "we are really changing our name to lay a claim to this way of working" will only serve to divide the very people who through co-operation could and should be prime movers for health promotion.

Implications

What implications does the adoption of the phrase 'health promotion' into a title of a worker or organisation entail? Current definitions of health promotion are many and wide-ranging. Activities seen to fall within the remit of health promotion include behavioural change, personal education, self-empowerment, mass media information and education, administrative and legislative change, community development, preventive medicine, curative medicine, positive health services, and so on. If we accept such definitions, then to adopt the title of health promotion officer/adviser, or health promotion organisation, is to imply that a worker or organisation has some special ability or expertise which enables them to marshal all the above activities. This position is clearly ludicrous, for it would surely require a superman/woman to fulfil such a role, even if it was desirable, which it is not. Surprisingly, some even go so far as to propose the development and employment of such super-people[1].

It is evident that health promotion, by its very nature, cannot become the preserve of any one group of workers, and that any attempt to professionalise health promoton in this way would lead to the fulfillment of one of the World Health Organisation's fears, namely "there is a danger that health promotion will be appropriated by one professional group and made a field of specialisation to the exclusion of other professionals and lay people. To increase control over their own health, the public require a greater share in all resources by professionals and government"[2].

Health promotion demands widespread participation. Consequently it is necessary to involve administrators, opinion leaders, community networks, politicians, voluntary organisations, individuals and others. It is only in this way that true health promotion will result. One group of workers cannot encompass the range of skills or exert the necessary influence to bring about health promotion. However, those concerned with health education can and do educate this wide spectrum of influence about the need and process of health promotion. This is the role of health education, to stimulate and facilitate health promotion, not to dominate it. Those of us who are lucky to live in a broadly democratic society and cherish the concept of democracy, should oppose any professional group which seeks to annex health promotion, because

health promotion is the responsibility of all and should be fashioned by the will of the majority and not by a small number of individuals. Education has a vital role to play, in the words of Henry Peter: "Education makes a people easy to lead, but difficult to drive, easy to govern, but impossible to enslave".[3]

We would be well advised, then, as Williams[4] states, to be sceptical about those who claim to be expert in health promotion and seek to sell us a product that is not theirs to sell.

A change of title from health education to health promotion would appear to indicate a change of function, which would be immediately obvious if job descriptions or terms of reference of individuals or organisations are compared. Why, then, if one does make those comparisons, are only minor differences to be seen? Why have health promotion officers not been granted real powers to affect the health of local people, for instance the right to veto any health authority or local government decision that they judge might unfavourably affect the health of local populations, or the right to insist on the introduction of no smoking areas? The answer, of course, is simple: health promotion officers/advisers are viewed not as real agents of change, but as marketing agents and media relations workers, paid to create a transient splash of publicity or act as secretary to a policy-making group. The only real power a health promotion officer/adviser possesses is that of persuasion and education; that is why in reality he or she is still a health education officer, albeit using a limited range of high-profile methods. These methods themselves are cause for concern. It is almost as if health promotion were being used as a time machine to transport us back twenty years to the mass media approaches of health education which have long since shown to be of limited value if used in isolation.

Whither health promotion?

Am I, therefore, advocating the rejection of health promotion? Most certainly not. I fully endorse the WHO definition of health promotion[2], and view health promotion as the means through which the health of our population can be improved. I also commend the establishment at district and regional level of multi disciplinary health promotion teams. Health promotion is the responsibility of all those who are concerned to bring about the improvement of health. Health education is an aspect of health promotion and its role is to maximise the involvement in health promotion, as well as providing people with information, skills and experiences through which they can exercise a greater degree of control of their own health. I fundamentally reject the notion that health promotion is or could be an area over which one professional group could or should dominate. Health promotion should be seen as a banner under which a wide variety of people can gather to work for the enhancement of people's health. It is both illogical and counterproductive for any one group to appropriate health promotion, and I therefore commend the HEC and the vast majority of organisations and health education units with the sense to refrain from incorporating the phrase 'health promotion' into their titles, which by the very act of doing so negates the purpose.

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MENTAL HEALTH

Education in human relatio with mental handicap

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HUMAN relationships teaching within health education is explored in the context of providing services for people with mental handicap. The paper considers [illegible] workers into schools to develop this area. Human relationships education is important in enabling mentally handicapped people to survive independently within the community.

al outline

rincipality of Monaco is a small town. Climate and health conditions are ood, and there are sufficient well-trained doctors to serve the population. ı problems in Monaco are thus less acute than in other countries, but education is nevertheless not neglected.

ıoolchildren (about 5,000 children and adolescents) have a medical and check-up at least once a year; on this occasion, doctors and dentists give patients' any advice they think necessary.

time to time sessions are also held during which short films are shown on, ample, the harmful effects of alcohol, smoking and drugs.

lonaco Red Cross also runs regular courses on mother and child health, f the elderly, and care of the sick.

ffice of Occupational Medicine is in charge of preventive occupational ine, and its main function is to supervise the environmental hygiene in ss firms and factories, and the safety of the workers; in this regard, lists advise employers and staff representatives on accident prevention and ational diseases.

THE NETHERLANDS

J. HAGENDOORN

Statistic data

Capital :	Amsterdam
Surface area :	41,160 km²
Population :	14,600,000
Density :	355
Annual rate of increase :	0.4
Infant mortality rate :	8.0 per 1,000 live births
Life expectancy at birth :	76
Urban population :	89%
Number of unemployed :	694,100 (11.6%)

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Health education trends and objectives

Health education has a long tradition in The Netherlands. In the middle of the 19th century information was available on ante and post natal care, use of alcohol, hygiene, etc.
The term health education was introduced by a government committee in 1961. Health education encompasses all activities undertaken to influence consciously and systematically the relationship between health and behaviour and is seen as part of health promotion. Health promotion also includes activities in the related fields of education, legislation, health care, taxation, welfare work, etc.
Up till 1975 there was much discussion about the organisation of health education and policy related issues.
In 1976 a committee for National Planning in Health Education was established, which gave a strong impetus to the further development of health education.
Many of the committee's recommendations were put into practice, e.g.

- implementation of health education activities in every stratum of the Dutch health care system;
- support for these activities by special health educators in the main health care institutes;
- regional bureaus to support the health education activities of the several institutes;
- introduction of health education in schools;
- a national institute to support the development of health education and improve its quality;
- a national board for health education to advise the government and health education practitioners.

Meanwhile, a special department for health education was incorporated within the Ministry of Health.
Strongly supported by government policy, the broad trend in health education in Holland shows rapid development in schools and in general health care.
The main aim is the formation of a coherent and continuous system of education and care in which health education is an integral and undeniable part.
In addition, increased attention has to be given to the educational aspects of the activities of voluntary organisations and specific institutions working in areas such as nutrition, road and home safety, dental health, cardiovascular diseases, smoking, cancer, alcohol and drugs, birth control and sex education.

Health education within health policies

At government level:

- During the last three years, health education has been given considerable emphasis in Dutch legislation.
- Although government health policy is constrained by limited resources, health

They are even formulated as cornerstones of policy for future years. There is a change from health care policy to health policy.

- In the same way high priority is given to the development of systematic patient education.
- Health education was introduced as a compulsory subject in primary schools in the Netherlands in 1985.
- A law was passed which made information and health education compulsory in the work place.
- The National Health Council (an advisory council for the Minister of Health) has a special standing committee on health education.

At organisational level:

- Many important health care organisations formally accepted the long-term policy to introduce health education.
- The most important organisations in public health, primary health and mental health expressed their willingness to develop health education within their sectors. Funds have been and still are made available to provide the money needed for this development.
- Some initiatives started about twenty years ago, others are just beginning, and much (still) has to be done, but primary conditions for the implementation process have been created.

Organisation and planning of health education in the health system

The general principle of the organisation of health education in the Dutch health care system is: every health worker (e.g. doctor, nurse, social worker) has not only a curative, but also a preventive role, part of which is health education. But experience shows, curative work has a tendency to dominate and expand at the expense of preventive work.
Special attention has to be given to develop and consolidate the preventive elements; therefore special health educators must be appointed to do this job. They are employed in several strata of the Dutch health care system, and their main role is to be supportive, but sometimes they are also involved in concrete health education activity. Occasionally they are supported by their national health care organisations, and mostly by the Dutch Health Education Centre.
It is possible to specialise in health education at several universities. However, only at the University of Limburg there is a specialised curriculum of health education. Most Dutch health educators have had an academic training.
The introduction of patient educators in hospitals and clinics has just started. There is experimentation with several models, sometimes in cooperation with patient organisations.
Health education is carried out not only in the health care system. Every region has many organisations which are involved in health education activities: e.g. sex education, anti-smoking, non-drinking, healthy food etc.

To support and to coordinate these activities the government has created 20 regional bureaus for health education. Research is being done to evaluate the functioning of these bureaus.
The development of health education in the Netherlands is based on the assumption that, although activities are mostly carried out by non-specialists, health education is nevertheless a specialised activity for which appropriate skills are needed, particularly in the field of communication. These activities have to be supported by information, training, research, special methods and careful registration.

Health system, general lines:	Paid by:
1 Public health care (mainly preventive)	municipality
2 Primary health care	
- ante and post natal care (mainly preventive)	national insurance law
- home care of the elderly (mainly curative)	
- general practitioners (mainly curative)	health insurance funds
3 Ambulatory mental health care (curative/preventive)	national insurance law
4 Intramural somatic care hospitals/clinics (mainly curative)	health insurance funds private insurance companies
5 Intramural mental care hospitals/clinics (mainly curative)	national insurance law

For these reasons, the Dutch Health Education Centre was founded in 1981. This national institute aims specifically to stimulate the development of health education in the Netherlands and to improve the quality of related activities. The institute carries out pioneer projects to stimulate developments in patient education, school health education and AIDS information in secondary schools. Projects on efficiency and occupational health education are being developed. During the five years of its existence this institute has acquired a central place in the development of health education in the Netherlands.
At the moment about 300 full-time health educators are working in the Dutch health care system. Approximately 1000 health education projects are carried out.

Health education in the school system

Health education in primary schools (including kindergarten) has been an incidental activity until 1985. The new law on primary schools in 1985 made health education a compulsory subject. Every teacher has to give attention to health education subjects. Over the next few years much thought has to be given to the systematic introduction of health education in primary schools. A general curriculum and a manual for teachers has been developed. A three year implementation project was started at the Dutch Health Education Centre which aims to collect literature on health education and make it available to primary

schools; to coordinate the work of organisations involved in integrating health education into the primary school curriculum; to develop instruments that promote adequate support at national and regional levels; and to give advice and support to teachers and health care workers.
The general trend is to incorporate health education in the curriculum. There is no special role for doctors, nurses, dentists, volunteers, etc. in giving special aspects of health education.
In secondary schools, depending on the type of school, health education sometimes is integrated in the curriculum and sometimes it is a special course. In some schools special teachers are appointed for health education.
Much has to be done to reach an adequate level of health education in secondary schools.

Mass media and health education

The mass media – TV, radio, newspapers, journals and magazines – are used for general campaigns. The government itself carries out promotions in a limited way, however the majority is done by the specialised national institutes, e.g. campaigns in road safety, anti-smoking, moderation in drinking, good nutrition, etc. Educational television also plays an important role in this field. The mass media, in addition, provide an important general information service to the public on various health education topics.
The Dutch Health Education Centre does not carry out campaigns itself, it has primarily an advisory role.

Health education training

In general, developments in training stem from the need for health educators in the several sectors of health care or for teachers in education.
With the expanding demand for academically trained health educators, several universities focus attention on health education. Specialisation in health education is possible at one university.
Some teacher training programmes in Holland pay attention to health education, sometimes even as a special subject.
There is still much discussion about whether health education should be a special subject or integrated in other subjects in secondary schools.

Research

A considerable amount of research is done on health education topics by universities and specialised research institutes.
Each year, the Dutch Health Education Centre publishes overviews on ongoing research and recently completed and published research. Most researchers in the field of health education are members of a special research working group in the

Centre. At the moment is has approximately 140 members. The Centre has an advisory role to both the government and private organisations in the development of health education research/programmes at national level.

Dutch Union for Health Education

The Dutch Union for Health Education was established in 1979 to support the development of health education in the Netherlands, and now has about 500 members. It publishes a journal, organises an academic lecture every year, has a 'theme of the year' around which special activities are organised and has special working groups.

Recent developments

The introduction of a new law on labour conditions, which includes a range of measures concerning health education, necessitates giving special attention to the introduction of health education in the workplace.
An introductory programme will be devised by the Dutch Health Education Centre in cooperation with several (business) organisations.
Another area of development is health education for the elderly. Henceforth, special attention has to be given to enable special approaches in this field.

Conclusions

Present conclusions for the development of health education in the Netherlands:

- gradually health education has been accepted as an integral part of (health) care, but there is still a long way to go;
- health education will only be carried out systematically if there is continuous support from certain specialists in the field;
- a national and regional policy is under construction to support and promote the development of health education;
- a structure for scientific support was established to encourage the introduction and improve the quality of health education activities;
- health education is not only a part of the health care and educational systems but is also an important subject in the industrial sector. Basically health education has its roots in a broader system of health promotion by means of laws, regulations, etc. which are vital for the health and well-being of the people;
- in general in The Netherlands favourable conditions exist for the development of health education in the future.

NORWAY

E. HEIBERG ENDRESEN

Statistic data

Capital	Oslo
Surface area	324,219 km²
Population	4,200,000
Density	13
Annual rate of increase	0.2
Infant mortality rate	8.3 per 1,000 live births
Life expectancy at birth	76
Urban population	70%
Number of unemployed	31,700 (1.5%)

Address

The World Health Organisation's Definition of Health Promotion: Three Problems

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Introduction

This paper highlights three problems with the definition of Health Promotion which has been advanced by the World Health Organisation (WHO). These are: a tendency to oppose medical and social explanations of illness, a focus on the future rather than on the present and a failure to take account of known processes of behavioural change. The WHO definition is not necessarily the best, or the only definition of Health Promotion. However it is influential through its association with major programmes such as Health For All 2000 and the Healthy Cities Project. Therefore in view of its potential impact on current planning, the internal contradictions of the definition merit attention.

The 1986 WHO Charter for Health Promotion (The Ottawa Charter)[1] defines Health Promotion as 'the process of enabling people to increase control over and improve their health'. This process requires for its implementation a number of major political, social and economic pre-requisites. These are identified by WHO as peace, shelter, adequate education, basic nutrition, sufficient income, a stable material environment, sustainable resources, social justice and equity. It is argued that a social system without this basis is a very difficult one in which to promote health. The Charter specifies five basic activities of Health Promotion as a consequence of the definition:

1. building healthy public policy,
2. creating supportive environments,
3. strengthening community action,
4. developing personal skills, and
5. reorienting health services to their users.

This approach to Health Promotion is based on a social model of illness and health. Therefore it largely avoids explanations of disease which are centred on individuals, in favour of interventions aimed at the social and environmental forces which have negative effects on people's lives. The programme set by the Ottawa Charter is universal, for it seeks to effect changes in social systems from the local to the global level. It places major political and social issues within the orbit of medicine but sees medicine as only part of the process of Health Promotion[2].

The three problems

While the WHO definition and its practical implications are extremely interesting, a number of matters should not go unchallenged. The first concerns the alleged difference between medical and social models of health and illness upon which it is based.

Medical and social models of illness

The WHO definition, emphasising political, economic and social factors, is derived from the view that much modern medicine fails to meet the needs of individuals and populations. High technology and high cost medicine are said to be of limited value in dealing with, or preventing, the major health problems which afflict both developing and developed societies. This is true, so the argument goes, in relation to diseases associated with poverty and malnutrition in the Third World and to premature mortality and degenerative diseases in advanced societies. High technology medicine is said to encourage dependency on the medical profession, and to discharge individuals and groups from taking responsibility from their own health. The suggested solution is to change the emphasis in service provision from a concentration upon sick individuals, towards appropriate forms of primary care and measures to address the social conditions and the political and economic factors which determine patterns of health and illness. Communities should become more active as empowered and liberated participants in matters relating to their own health.

The danger of this approach lies not in its intent. Rather, an enthusiasm for non-medical explanations of disease may lead to a false and unhelpful dichotomy between the so-called medical and social models of health and illness. A convincing case can be made that the medical and social models are in fact not very different in so far as both hold that bad precursors lead to bad outcomes. The fact that, in the medical model, precursors are largely of microscopic dimensions and in the social model they are defects in social structure, and that the outcome is called disease in the medical model and social disintegration or deviance in the social model, should not detract from their similarities.

The concordance of the social and medical models is an idea particularly associated with the work of Antonovsky[3,4]. He argued that both the behavioural and medical sciences tend to concentrate upon disorder and abnormality. The difference between them is one of method, not of their inherent approach. Both seek to explain the origins of breakdown, whether of bodily systems or of social systems. This is acknowledged as a highly appropriate activity for these sciences. In addition Antonovsky suggests that medical and behavioural science should *also* focus on survival of systems. In the context of Health Promotion this means that they should be applied to study of the origins of health as well as the origins of disease.

The critical question in such an approach for Health Promotion is why certain individuals, groups, households, communities, social classes and societies are better able than others to withstand the onslaughts of economic exploitation, poor social conditions, noxious environmental hazards, self-injurious conduct, virulent micro-organisms and accidents. The debate between social and medical models becomes irrelevant, if the contributions both can make to the study of survival as well as of system breakdown are emphasised.

Target setting

The second problem which resides in the WHO's definition of Health Promotion is its strong orientation towards *action* for change-for-the-better. The setting of goals which, if achieved, will bring much needed improvement to the health of populations or groups is the logical policy to follow from this orientation. For example, in the Healthy Cities Project much effort has been expended in devising appropriate indicators to measure future states of change. While an orientation towards the future and attempts at scientific evaluation using indicators are understandable and laudable, there is a danger that targets for future achievement may distract attention from present Health Promotion needs in existing communities. For example, epidemiological arithmetic may be employed to assign targets for the health of total populations at some remote time in the future. By targeting a 15% reduction in a specific disease in a particular community by the year 2000 a future improved state of affairs is identified. But people are living in that community now. They may find survival uncertain and difficult at the moment. They will probably continue to do so in the year 2000 or 2010 and beyond. Community health profiles often show that ordinary people are, unsurprisingly, very concerned with problems of living in the here and now and with problems of surviving today, tomorrow or next week. They tend to be much less concerned with problems of dying or not dying by the year 2000, except in the most general sense.

A compelling argument can be made that the practice of Health Promotion should assist or facilitate healthy living now, rather than set targets in the anticipation, or hope, of a better future. (This is not to say that traditional preventive medicine should not aim to reduce premature mortality by the year 2000 or any other date, but Health Promotion and preventive medicine should not be considered synonymous).

It can be argued that the cornerstone of such an approach to Health Promotion should be an understanding and development of coping processes and skills. For example, the observation that a high rate of coronary heart disease is related to smoking may lead to attempts to stop people smoking. An education or other type of preventive programme may be developed. However, if the programme ignores the fact that (addiction and pleasure aside) some people routinely cope, or think they cope, with the stresses of their lives by using tobacco, and does not offer alternative coping skills or does not address the origins of the stress, its chances of success are likely to be limited to those who can find ways of dealing with stress other than by smoking. The very up-beat WHO approach to the future and the targets, the very creditable desire to change this for the long term good, may be the undoing of a programme if it ignores people's present problems.

Behavioural and social change

The third problem with the WHO definition is its scant attention to the sciences of behavioural and social change. The disciplines of Sociology, Psychology and Social Psychology are directly concerned with the kinds of changes which the Ottawa Charter seeks to encourage. Sociology was founded on investigations of how societies as a whole or their component parts have developed and changed. The discipline consequently has many models of social change. Psychology takes as one of its core elements the development and change of the individual. Social psychology focuses on group dynamics and change. If to these three are added the disciplines of Political Science, Education,

Anthropology, Marketing, and Organisational Behaviour which all study change in particular facets of human activity, the availability of models to understand change is enormous.

WHO statements make little reference to the available literature on behavioural and social change[5]. This is unfortunate because if the agenda for Health Promotion is change in a broad sense, or if particular changes are required at local level to improve the life chances of individual communities, some reference to the models which may help in that process would be appropriate[6]. Of course not everyone involved in Health Promotion can be a polymath with respect to the breadth of the Behavioural and Social Sciences. However, if and when a Health Promotion intervention is planned at any level—community, local, regional, national or even global—attention should be given to the model of social and behavioural change that will operate[7]. Thought needs to be given to how an intervention will work. A clinician always knows what he or she expects from particular actions. Processes may not be fully understood, but a framework (the real medical model rather than the straw man frequently attacked by the social model of health) exists to make sense of actions and to interpret results.

Social and Behavioural Scientific models have exactly the same role. The processes they seek to describe may not be completely understood, but they do provide a useful means of making sense of what is going on. This simple idea sometimes seems to be lost from view in WHO statements in which Health Promotion is presented as a combination of good intentions and ideological conviction rather than as a matter of science.

Conclusion

Health Promotion is a new, exciting and potentially very important development. But there are difficulties with WHO's definition. If the definition is to form the basis for practice, the three concerns of this paper need to be addressed. Health Promotion should not be portrayed as an exclusive alternative to medicine. It must work with medicine towards understanding the origins of health in addition to the causes of disease. A focus on the future should not detract from current needs. Finally, any intervention should be adequately informed by appropriate models of change drawn from the social and behavioural sciences.

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'I have noted five patterns of natural history of disease, that apply to most common diseases:

'Once and forever'. Once present, the condition will persist until death, eg cystic fibrosis and other congenital disorders and acquired conditions, such as an amputated part.

'Disorders that children outgrow'. Many children have conditions which they outgrow naturally and without treatment, eg the catarrhal child syndrome, non-retractable foreskin, strawberry naevi, knock knees and umbilical hernia.

'Disorders of ageing'. As we live longer, our bodies age and degenerate, and we become prone, for example, to cancers, osteoarthritis, coronary artery disease, high blood pressure, chronic bronchitis, cataracts, deafness, strokes, and diabetes.

'Come and then go'. Some conditions commence in early or mid-adult life, there follows a period of clinical activity for 5, 10 or even 20 years, and then symptoms tend to diminish and disappear.

Such a course occurs in migraine, acute back syndrome, asthma, hay fever, duodenal ulcer, anxiety-depression, urinary tract infections in women, tennis elbow, and other soft tissue rheumatism.

'Young and old'. To complete the picture, there are a few diagnoses most prevalent in the young and the elderly, eg acute wheezy chests, herniae, hydrocele, and constipation.'

Health Problem Dimensions of Third World Urban Poor

With emphasis on Metropolis Bangalore, India

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Contents

1 Introduction

1.1 Urbanisation Trends in the Developing Countries

The largest and most extensive migration in human history is taking place during our contemporary times. This is the migration of the rural people to urban settings. The predominant part of this migration is taking place in the developing world.

The urban population of the world estimated at about 2 billion for 1985, is projected to reach 3.2 billion by 2000 AD and 5.5 billion by 2025, increases of 56% between 85 and 2000 and 72% between 2000 and 2025. From 1985 to 1990, the population of the less developed regions grew by 4.5% annually (see figure in Appendix). The level of urbanisation in developing regions is expected to increase from 37% in 85, to 45% by the end of the century and to 61% by 2025 (World Health Statistics Quarterly, 1991).

A significant proportion of the urban population reside in large agglomerations, which grow at such a fast pace that the services and infrastructure provided cannot keep pace. In 1985 there were 99 such agglomerations with population of over 2 million and 50 of them were in developing countries. It is expected that by the year 2000, there will be 28 `mega cities', of which 22 will be in less developed countries. Mega cities are defined by U. N as cities with more than 8 million inhabitants (World Health Statistics Quarterly, 1991).

The major contribution to the growth of cities is from natural increase (about two thirds), however migration is equally important as the natural increase among migrant population being high, as they are in the young age group 15-29. The third reason is because of reclassification of settlements.

1.2 Urbanisation Trends in India.

In 1901, less than one out of ten persons (26 million) lived in urban areas in about 1900 settlements. In 1971 the ratio changed to one in five (110 million) in about 3000 urban settlements. In 1981 it accelerated to one in four (160 million) in about 3300 settlements and by 2001 it is expected to be one in three (350 million) in about 4000 urban areas (Ribeiro E. F. N 1990).

Much variation is seen in the levels and rates of urbanisation among the twenty five states and seven union territories that constitutes the country. The highest being Maharashtra with 35% urbanisation and the lowest being Arunachal Pradesh with 6% urbanisation. Grouping urban areas into three categories namely cities (100,000 population and above), medium towns (between 20,000 and 100,000 population) and small towns (below 20,000 population), the highest population growth is noticed among cities in the period 1901-1981 (26% to 60%). The other two categories have remained the same or decreased. It is estimated that by the year 2001, about a third of the urban population (112 million), will be living in 36 Metropolitan areas i.e.

population of one million or above the fastest growth being expected in the metropolitan areas or large cities (Rebeiro E. F. N., 1990).

1.3 Features of Urbanisation process in Third World Countries

There are certain features that stand out in the urbanisation process that Third World countries are experiencing, some of which aspects were different in the process that the Western nations underwent earlier.

-The rate of urbanisation and the increase in urban population is very high.

-The urbanisation is happening in the midst considerably limited resources.

-The quality of life, in terms of conveniences, infrastructure, pollution and health levels is much lower for the metropolises in the Developing World.

-The urban growth is taking place in an unplanned manner and the governmental efforts at providing infrastructure and other supports, inadequate as they are, is occurring in a reactive manner.

-A large proportion of the urban population 30-50%, are totally excluded from access to facilities and services and glossed over in the planning process.

-There is an increasing number of urban poor or the "informal sector" of labour, who employed casually in low paid, tedious jobs, with no security and some of whom are self employed in petty street vending.

-There is increasing pollution of the urban air, land and water, as result of the economic activities in the urban areas and because of the accumulation of wastes from commercial and domestic activities.

1.4 Urban Poverty in India.

By official estimate (perhaps underestimated) 27. 7% of the urban population falls below the poverty line, which in the year 1987-88 was estimated at 57 million people. Estimates of poverty are based on the average calorie intake of the household and does not take into account poverty caused by environmental degradation and poor life supports. Expenditure groups in which average daily calorie intake for the household members is below 2140 calories in urban areas, is counted as belonging to below poverty line (Shah, 1990).

The manifestations of poverty are now quite obvious in the Indian cities and according to the National Commission on Urbanisation include:

-proliferation of slums and bustees

-fast growth of the informal sector

-increasing casualisation and underemployment of labour

-pressure on civil services

-high rate of educational and health contingencies coupled with under utilisation of social services

-undergrowth of physical and mental capacities and degradation of human resources
-growing sense of hopelessness, rising crime rate and group violence.

1.5 The Health of the Urban Poor

When one focuses on the health aspects of the urban poor in the developing world again certain features are noticeable at a macro level. There appears to be stages through which the population passes through in the health continuum, which is referred to by some authors as the `epidemiological transition' to explain the adjustments that the migrating population makes with the new environment. In its essence the explanation is that there is an initial phase of increased illnesses from epidemics, infections and nutritional problems, followed by a phase of decreased epidemics and communicable diseases, but still present significantly. This phase can be prolonged with the coexistence simultaneously of the diseases of `modernity'. This is followed by the picture as seen in western societies when there is an increased occurrence of manmade diseases or diseases of modernity.

When one moves from the macro picture to a micro level analysis one is constrained by the paucity of health data related to the urban poor. The data that is collected is invariably of the entire urban population and disaggragated data of the urban poor is rarely available. Isolated studies available show that health status of the urban poor in the developing countries is significantly worse than their better off neighbours and also worse as compared to the rural counterparts. There appears to be a very large need of health related problems for the urban poor.

This area related to the health needs of the urban poor has received insufficient attention, until the last one and a half decades, during which period there has been a burgeoning of interest.

The patterns of morbidity and mortality observed show relationship to the environment and behaviours associated with the situation of origin, and of the situation in which the poor are now secluded and also from the complex web of poverty associated factors. The picture is one of:

-high prevalence of communicable diseases and malnutrition
-cardiovascular, mental diseases and neoplasm and accidents of various sorts
-alcohol, drug abuse, crime, child abuse and sexually transmitted diseases

Available studies suggest that infant mortality rates and disease incidences are several times higher in the poorer neighbourhoods as compared to the averages in the whole city (World Health Statistics Quarterly, 1991).

1.6 Health Care Provision

The health care response to these problems have primarily been of the hospital oriented curative type without specifically targeting the urban poor or their varied problems. The services remain under-utilised also because of their geographical and financial inaccessibility. This situation raises a question whether the `health need assessment of the urban poor' is adequate?

1.7 Study Question

Given the background as stated above it is important that a comprehensive understanding is developed of the health related needs of the urban poor and what are the possible solutions and responses.

What are the priority factors (variables) associated with the health status of the poor, in the urban ghettos (slums) of the metropolitan city of Bangalore, in a developing country India, and at what levels are they operating?

What can be done?

2 Methods and Limitations

2.1 What is a Case-Study?

Yin (1984) defines case-study as An empirical enquiry that investigates a contemporary phenomenon, within its real life context when the boundaries between the phenomenon and the context are not clearly evident and in which multiple sources of evidence are used. The case-study is an important scientific method, to answer the questions of `why' and `how', with regard to a phenomenon that is currently happening. Case-study also retains the holistic and meaningful characteristics of real life events. As case-study is not based on a sample population it cannot be generalised to a population, however case-study can be used to generalise and expand theory, or theoretical propositions.

2.2 How this Study was done

The study presented in this article is really a case study carried out during the period 1986-90, of seven slums in the metropolis of Bangalore in India. The population living in these seven slums was about 2000 families or roughly 13,000 persons. Several types of evidences are incorporated in this study. They are:

1) Observations of the health problems, physical conditions of living and life style aspects of the people, carried out, while doing health work for four years in this community. Fortnightly every slum was visited in rotation, an average of three hours was spent in the slum community during every visit. The activities during visit included curative care and health education of those individual patients referred by the health volunteers, making visits to the homes of those families with specific problems and participating in women's meetings which consisted of women's organisational activities and education on health problems. Activities related to supervision and guiding of health volunteers were also carried out during these visits.

The perspective from which health problems were addressed consisted of a multidimensional view of disease causation and an integrated approach to health promotion.

2) Observations of the outcome of interventions made specifically in the area of nutritional supplementation and growth monitoring, health education, organised community actions through trained health workers, for improving environmental sanitation. Emphasis was on community participation in these activities, during the stages of problem identification, action planning, implementation and review of actions. The community representatives were equally active during the efforts directed at the city administration towards improving infrastructure and services.

The monthly reflection meetings of the health volunteers were a source of insight into how the community perceived their health problems, their relationship dynamics, and responses of the

administration to their initiatives. These observations however were not made with the vigour required for an experimental study.

3) Information gathered from key informants, the health volunteers, who were representatives of the communities. There was a good rapport established with the key informants over the years of involvement with their problems, which facilitated spontaneous sharing of their perspectives, belief systems and emotional outlooks, which individuals are usually reluctant to share. The key informant interviews took place with representatives from five slums in formal situations and several others during informal situations.

4) Information from innumerable group discussions, most of which were in the context of the health education classes held. Four specific focus group interviews were done for the purpose of writing this report in four different slums.

5) Information gathered from secondary sources:

The following government officials were contacted-At the state level a joint director of health and a statistical officer concerned with the health information, were interviewed from the State Health Department and functionaries of the Slum Clearance Board were also similarly interviewed.

-At the city level the deputy commissioner of the City Corporation and the person in-charge of public health, the head of Family Welfare services were interviewed and a days visit was done with the Mobile Health Team during their visit to the slums. Also two project officers concerned with two programmes relevant for the slum people namely The Integrated Child Development Scheme (I.C.D.S.), and Women and Child Welfare programme were interviewed. The Bangalore Development Authority (B.D.A.) which also has jurisdiction over several slums, it was not possible to contact. The officials were asked about their services for the slum areas and the handicaps and possible solutions perceived by them.

In order to get access to the government officials often it was necessary to get the recommendation of a senior beaurocrat, and the officials generally had a defensive posture and were reluctant to pass on relevant documents.

-Five N.G.O.'s working in Bangalore slums were interviewed two of whom were working with street children. Similarly a journalist with development orientation who had been writing on issues of urban poor and the public health professor of the local Medical College with students doing studies in the slums were also interviewed on their perspectives on the problems and solutions.

6) A list of locally available reports and articles pertaining to Bangalore slums were also made use of.

7) As a method of further validating the perspectives the first draft of the study was circulated among colleagues in the Community Health Cell Bangalore, a health research resource group on whose behalf this study was undertaken and among two N.G.O. colleagues and their feedback was incorporated. on the urban slums.

As can be deduced, the enquiry did not initially start with a study question, but from an open approach to understand the problems one was confronted with in the course of working with the poor people in the slums. The study question was stated only at the end of the four year's work, when the need was experienced to record the experiences as a descriptive and explanatory report. At this point already certain patterns and relationships were evident. To supplement the evidence, four `focus group interviews' were held, as well as five lengthy key informant interviews. The focus group and key informant interviews were held in an open-ended fashion, though a check list of points related to the factors and relationships that had surfaced, served as a guide. Secondary data, oral and written were gathered, especially relating to the infrastructure and services available in the slum areas.

At the time of presenting this report not many studies were available on this subject. This has been rewritten after further literature survey was entered into, to compare with findings from other situations and with perspectives that were not present in this study. Hence in this report the literature survey is placed after the `Findings from the study'.

2.3 Limitations of the Study

1) As stated earlier the collection of evidence, did not start with a study question, but it came to be stated at a later stage, when information was being collected for reporting.

2) As a relationship was developed with the community studied over the years of involvement, observer bias resulting from this factor has not been screened for.

3) The information collected, in the majority of cases came from the women, as they were the primary participant of the health programme. In that context men's perspective are not adequately represented.

4) The study population was primarily those associated with the programmes of one non governmental agency. Any variability arising out of this factor has not been looked into.

5) The study period was 1986-90. Subsequently a multisectoral intervention aimed at the slums in the whole metropolis has been initiated by the government which would have changed the particulars related to infrastructure and services and affected the health situation. However in the context of the regional, national and especially Third World phenomenon of Urbanisation, the evidence and conclusions still have validity.

6) No quantitative survey was undertaken specially for the case study. However information from the existing surveys of the N.G.O. mentioned has been utilised.

3 The Findings of the Study

3.1 Common Health Problems in Bangalore Slums

The diseases most commonly noticed in the slum clinic were the following:

Children
- malnutrition
- diarrhoea's and dysentery and parasitic gut infection
- acute respiratory illnesses and viral fevers
- skin-, eye-, ear- and throat infections
- vaccine preventable diseases
- accidents and injuries

Women
- malnutrition
- pregnancy and delivery related symptoms and complications
- menstrual irregularities and vaginal discharge
- musculoskeletal pains
- sexually transmitted diseases
- psychosomatic complaints
- hypertension (occasionally)

Men (less frequent consultation)
- acute and chronic respiratory illnesses
- injuries and accidents
- skin and gastro-intestinal infections
- sexually transmitted diseases

This pattern of commonly occurring illnesses were also found in the records of the Mobile Health Team of the Corporation of Bangalore city which had responsibility for covering certain slum areas.

On routine analysis the diseases could be related to the following risk factors, namely:

poverty, unhygienic local environment, poor personal hygiene, unsafe habits and poor health knowledge, emotional stress and poor health seeking behaviours.

3.2 Multi Level Aetiology

The study indicated on further analysis that several types of factors were involved in causing the health problems. These factors could be grouped under the different levels that they were operating at and hence need to be addressed, if changes were to be made.

LEVEL	FACTORS
1 Individual	1 Awareness a- poor awareness of health promoting factors b- poor awareness of the environmental and societal factors causing ill health 2 Sense of powerlessness and fatality resulting in low motivation for change
2 Neighbourhood / community	a- low level of belongingness and commitment to that community b- low level of social support network c- poor community organisation and constructive leadership d- negative social behaviours
3.1 Micro environmental 3.2 Institutional	1a- quality of housing 1b- quality of sanitation 1c- quality of water supply 2a- quality of the provision of basic amenities and infrastructure 2b- quality of services provided
4 Macro environmental	a- social b- political c- economic d- cultural

3.3 Individual Level Factors

3.3.1 Poor Awareness of Health Promoting Factors

1) Personal hygiene for well being-there is some understanding regarding the negative outcomes of not being regular in habits such as bathing, oral and facial hygiene, washing of hands especially before cooking and wearing of clean clothes, though reinforcing the concepts would be useful. The major hurdle is the availability of facilities as will be indicated later.
Low personal hygiene resulted in widespread occurrence of skin infections - parasitic and bacterial, poor dental health, eye infections, and gut infections and parasitic infestations.

2) Balanced nutrition for health-the diet had a preponderance of carbohydrates and insufficient other nutrients. Carbohydrate foods are also the cheapest items that can be bought. Food items with poor nutritive value because of being old or overripe were also consumed as they were available in small measures from the local vendors inside the slum.
Certain food fads or beliefs existing among the population affected the quality of nutrients: An example is the cereal polished rice which was costlier was preferred over the more nutrient and cheaper but coarser cereal ragi due to the status value attached to the former.
Certain cooking practices contributed negatively to nutrition: Traditional items like chutneys and preserves which have good nutritional value were gradually forgotten by the new generation of migrant women.
These reasons, combined with the poverty of the people resulted in high occurrence of malnutrition among the slum dwellers, most noticeable and measurable in the small children. The records of the voluntary agency working with them showed that 50%-55% of the children below 5 years of age were at risk due to moderate or severe malnutrition, resulting in high morbidity and mortality.

3) Preventive measures and care during illnesses-there was a low level of awareness regarding the long term benefits of vaccine protection for certain illnesses whereas the short term inconveniences from it were given more importance.
-There was a loss of knowledge regarding traditional nursing care and home remedies (grand mother's remedies) and hence illnesses were managed poorly. Additionally people had a strong belief in the magical benefits of modern medicines and injections, which often contributed to iatrogenic illnesses.
-There was little awareness regarding psychosomatic origin of symptoms which were attributed to external uncontrollable causes such as the climate or the water used.

4) Healthy child rearing practices-there was poor knowledge regarding the negative outcomes of bottle feeding of infants, use of improper weaning foods and normal milestones of child growth.

5) Healthy reproductive and sexual practices-the women did not have much understanding on the physiological aspects of the reproductory system and also on the methods of contraception. Hence they experience a lack of control over their bodies.
Though symptoms related to the genital tract are not uncommon certain negative cultural beliefs delay seeking of expert care.
Similarly childbearing and lactation is associated with many cultural beliefs related to diet and medicines, some of which seem to have negative consequences.
Hence a healthy balance of helpful traditional practices and beliefs and useful modern scientific practices and understandings which is required for health was lacking among the urban poor.

3.3.2 Poor Awareness of the Environmental and Social Factors

Although factors operating at different levels are contributing to the ill health of the people, this awareness is lacking among the urban poor. However the urban poor have internalised certain negative beliefs about themselves and their situation which hamper their problem solving energies. They have a negative self image, believe they are wrongdoers, that they do not have a right to belong to the urban community and the reasons for their situation are internal to themselves such as `their fate'. This negative image undermines the motivation for change and for taking health seeking initiatives.

3.4 Neighbourhood and Community Level

3.4.1 Low Level of Belongingness and Commitment

Slum dwellers have lost their roots in the original community of origin (villages) but have not developed belongingness and relationships in the new environment. Lack of tenurial entitlement contributes to this situation, which is also caused by the absence of shared cultural backgrounds (as people from different language and ethnic groups are thrown together), temporariness of stay in one place, and the estrangement they feel in the urban situation. Hence it becomes difficult to develop a community spirit which is necessary for the psychological growth of the individual and development of supportive community norms.

3.4.2 Low Level of Social Support Networks

Neighbours have the same high levels of needs and very little resources to offer real support whether material, informational or emotional.

This results in widespread occurrence of psychosomatic symptoms and low coping abilities. Excessive alcohol consumption among men and a significant number of women was noticed in Bangalore slums (the discussion groups came up with a percentage of 90% for men and 10% for women).

The support structure of the family was also affected in many cases resulting in single parent households (mostly women as the single parent) or in the phenomenon of street children.

3.4.3 Poor Community Organisation and Constructive Leadership

No representative form of organisation or leadership existed in the community (except what was developing as a result of the intervention of the voluntary agency). The legitimacy for the traditional leadership, was that either they had physical power or financial or status power and their interest in the leadership position was purely for monetary benefit. Hence the community could not effectively mobilise themselves, to name their problems and work out solutions that improved the quality of their lives.

Another related problem was that people possessed very little documents which were needed to identify them to become eligible for welfare programmes. Hence they were dependent on these so called leaders who were `middle man' link to the authorities.

3.4.4 Negative Social Behaviours

Some anti-social elements took refuge in the slums, as there were no functioning civic authority to discipline them, and they had the blessings of local politicians.

In certain locations, criminal activities were pursued by them such as drug trafficking, prostitution and violence. This added to the insecurity experienced by the slum dwellers especially the women. Stress related Health Problems are quite rampant in the slums.

3.5 Quality of Infrastructure

3.5.1 Quality of Housing

In the majority of slums no intervention on housing had been carried out by any agency. In such locations housing were of very poor standards. They were overcrowded-in small one room dwellings where 5-7 people lived. There was little ventilation as rows of such huts were separated by only a small space of 2-3 feet. They were made of mud and waste materials. The occupants were exposed to risks from air pollution because of poor ventilation, smoke from kerosene stoves used for cooking as well as fumes from industrial activities that were carried out in the neighbourhood.

Respiratory illnesses were a common problem among slum dwellers.

3.5.2 Quality of Sanitation

The immediate narrow surroundings were used by the slum dwellers for washing and bathing and for defaecation by the children. The small drains flowing between these rows of huts got periodically blocked by the domestic wastes and overflowed. In the rainy season the overflows not only covered the pavements, but also entered the huts.

The rubbish dumps were located in the slums and they were cleared infrequently as the responsible authorities were ill equipped for this task and the slum dwellers could not exert pressure on them. Hence their contents frequently overflowed spreading infective material around.

Public toilets were very few in the slums and private toilets did not exist. Since their maintenance was also poor they were another source of infective material.

The occupants were at risk from water borne infections, rheumatic complaints related to dampness and accidents from house collapse. Diarrhoeal diseases were a common problem among slum dwellers.

3.5.3 Quality of Water

The water sources were limitted in the slums. There were 1 water tap for 20-50 families and the duration of water supply was limitted to 2 to 3 hours per day during normal periods. Hence safe water was a precious commodity in Bangalore slums which was procured after much effort.

Hence using this water for personal hygiene was less of a priority for the slum dwellers resulting in high occurrence of skin infections and parasitic infestations. Endangered drinking water contributed to high incidence of water borne diseases.

3.6 Services Provided

3.6.1 Multiplicity of Agencies

During the study period the slums studied came under the authority of three separate government bodies: The Slum Clearance Board, The Bangalore Development Authority and The Corporation of Bangalore City. Each of them were only partially responsible for the infrastructural and service needs of the people living under their jurisdiction. By default the remaining needs became the responsibility of the other governmental departments such as the health department or the Bangalore city Water Board. However these departments did not recognise it as their responsibility and did not have specific programmes to serve them. The three government bodies mentioned had insufficient funds allocated for the required infrastructural and service provision. In addition the programmes were not tailored for the particular requirement of the slum dwellers for example the Slum Clearance Board built several

low cost buildings which were not suitable for the people. They found the construction low quality, inconvenient and above all the monthly payment instalments too high.
Only a small proportion of the programmes planned do actually reach the community. The government departments function in beaurocratic ways, giving rise to innumerable delays and corruption is a pervading problem. The institutions are not accountable downwards to the community and the slum dwellers neither have knowledge of the programmes or have the coercive power to exert influence.

3.6.2 Quality of Social Services Provided

The slum communities require intensive input of certain social services given their backwardness. The important services required are Health, Education, Community development including support for income generation. The programmes that exist are poor quality and suffer from various problems. There is insufficient allocation of funds, beneficiary identification is poor, need assessment is very superficial and the programmes implemented are generally ineffective. As has been mentioned earlier since the slum dwellers possess very little identification documents they become ineligible for programmes. Since programmes are generally planned and implemented vertically, meaning they are planned by a central agency, without consideration of the local conditions and actors, they fail to get the beneficiary's participation. Such programmes also lack monitoring and evaluation affecting their quality. As an example the children from the slums find it difficult to get into the government schools for not having `birth certificates and other documents. Those who attend schools have generally poor performance and high dropout rates. Whereas a more appropriate programme would be of the non-formal type with emphasis on skill training.
Similarly the health services provided by the City Corporation consisted of mobile curative teams which made weekly visits to the slums to provide curative services. However the need of the community was primary health care, available on a continuous basis and secondary care with smoothly functioning referral structure.

The non governmental sector consisting of for profit and not for profit organisations also render certain services in the slums. They however possess much less resources and their scale of operation is small. Many General Practitioners (GPs) have established their practices around the slums and are available on a continuous basis for curative service such as first aid and symptomatic treatment of illnesses. However they take no responsibility for preventive care or appropriate referrals. Certain voluntary agencies offer services of non formal education, preventive care, sanitation or housing. Their services are often piece-meal and little co-ordination exists between the agencies involved in adjoining areas.
Given the above situation, the outcome is that the quality of services available to the slum dwellers are poor. An inference that comes up strongly is that there is a lacuna in the nation's planning process for the urban poor.

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3.7 Macro Environmental Factors

The slum dwellers experienced their community as being marginalised or cut off from the rest of the society. Their concerns which had roots in the outside society, apart from the factors already mentioned, were the following:

1) Poverty-Roughly more than two thirds of the women participating in the group discussions stated they had to work to support their families. A large number worked as daily labourers especially in the construction sector getting employment three or four times a week. Another large number worked as domestic help and needed to work in two to three households long hours to gain subsistence income. Both the groups were grossly low paid. About one in ten were self employed foot path vendors, whose income was slightly better than the previous two categories.

The working conditions and remuneration were grossly inadequate for them but they were forced to continue as they badly needed the additional income. At the time of the study the women involved in domestic help were struggling to establish as an association to make demands of the state for minimum working conditions with the encouragement of an agency.

2) Land tenure-The legal ownership of the house-site held the key to tapping into the infrastructural and service provisions of the State. However various almost insurmountable problems and inaccessibility to decision making powers were experienced by the poor which put them at the mercy of the `slum lord-politician-beaurocracy axis.

3) Harassment-The police raided the slum areas periodically and beat up the inhabitants indiscriminately in pursuit of alleged miscreants. Continually the poor experienced being denigrated or insulted by the police.

The beaurocracy showed a lack of responsiveness to their grievances and had to be routinely bribed to obtain documents required to access welfare programmes. The government procedures appeared completely alien and beyond their capacity to make it work. The hostile and unsympathetic attitudes of the government hospital functionaries did not engender trust.

The local slum ruffians with their connections to criminal groups outside created a sense of physical insecurity.

4) Helplessness-The slum dwellers and their associations felt completely helpless in influencing the macro environment to better the quality of their life. On the other hand the external situation frequently created life threatening crisis situations which oppressed them and produced a sense of hopelessness.

4 Literature Survey on 'Health of the Urban Poor'

4.1 An Explanation

The literature survey was done through a CD ROM search of Medline express and PsycLit up to 1996 using the key words: urban health, urban renewal, child welfare, primary health care, health promotion, urban poor, developing countries, empowerment, epidemiology etc. The data base of the Library of the Royal Tropical Institute was also searched using similar keywords but specifically for India. This procured additional materials specific for India. Most of the identified materials could be procured through the Inter Library Loan scheme. It was found that out of this a priority list of materials contained most of the relevant data and the rest contained peripheral information.

The chapter on Findings of the Study are presented prior to the chapter on Literature Survey on Health of the Urban Poor. This unusual order is followed as the study took place in that chronological sequence as mentioned in the chapter on Methods and Limitations. The literature survey enlarged the perspective and brought some quantitative measures to support the findings of the study. The particular aspects that got emphasised include the emerging perspective on urban poor in the Indian Government and how this perspective relates to the ground reality in terms of policies, planning, and infrastructure and services; the physical environmental needs of the slums and positive experiences in meeting them from different countries which are reflected in the solutions suggested. It also affirmed the creative energies of the urban poor, one experienced at the micro level.

In its essence the literature survey done was consistent with the findings of the micro level study except for minor variations. Literature shows increased cardiovascular diseases and cancer, which were not observed at the micro level. This could have been because the scale of observations at micro level were too small to detect the increase of these problems or secondary level investigative facilities may be required. Substance abuse especially alcoholism, which appeared to be major health and social problem have lesser priority in the literature. This may relate to the type of literature accessed as Indian Urban Health literature was sparse. For the same reason the more recent developmental programmes and seemingly pro-poor policies could not be adequately assessed for their scope.

The Literature survey outcome presented below will need to be related to within this limitation.

4.2 Focus on Urban Health

4.2.1 Evolution of Interest

Trudy Harpham and Carolyn Stephens (1992, p. 111-120) traces the interest in urban health to the late Seventies. The Alma Ata Declaration of Primary Health Care popularised the

multidimensional multisectoral causation of health/ill health. This was seen mainly in the context of rural health where most of the people of the Third World lived, and Urban areas were thought to be already well served by the curative institutions present there. The seminal paper published by W.H.O. and U.N.I.C.E.F. and authored by Alessandro Rossi- Espagnet, drew attention to the health problems of the urban poor by stressing two arguments-one the rapid urbanisation process that is going on in the Third World countries and two the rapid growth of the numbers of urban poor and the inequalities in need that was becoming a reality. This spurred interest in urban health problems and urban health care. In the succeeding decades considerable research and writings have resulted in this area.

4.2.2 Disaggragated Data on Urban Poor

D.R. Phillips (1993, p. 93-107) analysing the Third World trends in urbanisation and health states that there is considerable disparity between the health of the urban poor and their richer counterparts though the lack of disaggragated collection of statistics may not show it. His paper introduces the idea of `Epidemiological transition' that the urbanising Third World societies go through-that there are progressive stages with corresponding epidemiological picture. While life expectancy might be higher in many urbanised countries, the morbidity has not changed, the inhabitants are suffering from different forms of ill health chronic and degenerative rather than infective. In the more underdeveloped of the Third World countries there may be a double burden of diseases both the infective type and the chronic and degenerative type. These conclusions appear to be drawn from macro level data and the connections between ill health and intermediate variables operating at micro levels are not brought out.

T. Harpham and C. Stephens (1991) lists several studies that shed light on intra urban health differentials in Third World countries and states that the main picture that emerges is the link between poverty and mortality, without reference to intermediate variables. Difficulties also arise due to the differing categorisation of causes of death used in different countries.

4.3 Aetiology of Ill health

4.3.1 Multiple Aetiology of Disease

Cairncross, Hardoy, and Satterthwaite (1990) argue that the links between housing in the broader context (which includes the physical structure, the environment around it, the location and the infrastructure and services provided) and health for the urban poor has been ignored for various reasons. Engineers and architects have concentrated on the physical aspects of housing related to norms and legal requirements and ignored the health outcomes as these were not clearly defined, though vaguely perceived. Traditionally research related to health outcomes were carried out by health professionals, who focused on Epidemiology and Biological factors. Policy recommendations arising out of such research stressed, health care solutions. With the

popular acceptance of multisectoral causation of health the links between these aspects began to be explored. The recent trend towards `Selective Primary Health Care' according to the authors is the same old medical orientation, which excludes aspects such as water, sanitation and housing.

4.3.2 A Classification of Multiple Aetiology

They present a systematic classification of the factors causing health problems of the urban poor, which is reproduced in summary form below.

BACKGROUND FACTORS	UNDERLYING FACTORS	INTERMEDIARY FACTORS
1 The strength and prosperity of the national economy. 2 National society political structure, laws and the ways and means by which they are enforced. 3 Distribution of income and capital assets within the society. These set the context for any individual's possibility of obtaining adequate income and the possibilities for government to provide infrastructure and services.	1 Physical / Environmental -including characteristics of the house (e.g.. amount of space, physical materials) and the workplace (including quality of indoor environment and the degree of protection from injury by machines, toxic chemicals etc.) characteristics of the house site (e.g.. risk of flooding, landslide or other natural disaster) and location especially in relation to health services. 2 Infrastructure and service provision- quality and quantity of water, provision for sanitation and drainage, garbage disposal, health care, emergency services, public transport, etc. 3 Socio-economic characteristics of the person concerned-diet, income and kind of work, time available to cook nutritious food, take care of children, to improve housing and other health promoting activities. Also legal status and location within society which influences whether help can be got in a crisis. 4 Age and gender -in relation to certain specific health problems.	1 Knowledge of health enhancing behaviour at the individual/household level. 2 Knowledge of health enhancing behaviour at community level and level of community organisation. 3 Use made of health care system and other public services and facilities.

4.4 Macro Level Factors

4.4.1 Poor Economy

When the macro level `background factors' in the above scheme are looked at, common for most Third World countries is the poor strength of their economies and the bleakness of the future of these economies. The world market is unfairly acting for them, the real value of the primary commodities produced by them continue to diminish and cost of manufactured items and technologies continue to rise. This trend does not promise any improvement as far as the resources allocated by the governments or trained personnel available or technologies for urban infrastructure and services development for the poor. Economic prosperity also partly determines the income of the poor, though the distribution of wealth plays an important role.

Nurul Amin (1992, p. 119-130) argues from a market economy perspective that, the Third World nations have uncritically adopted Western norms, standards and legal statutes pertaining to urbanisation and the urban poor or the `Informal Sector', that is impractical. The urbanisation process in these countries are happening in the midst of great paucity of resources unlike the situation that existed in the West.

In the Housing sector most of the housing structures of the poor are below the standard and hence illegal. In the Economic sector access to credit and services provided by the state is blocked from the urban poor, due to the requirements of documents on permanent registration or the need for collaterals etc. Proactive policies and programmes to support the self employed economic initiative of the poor are conspicuously absent, and what is present is harassment of various sorts. Amin argues that in the resource starved Third World countries where the governments are unable to provide the required infrastructural, institutional and service facilities, the broad macro level or the `market' needs to be broadened to include the urban poor.

4.4.2 Macro Level: Situation in India

Kirtee Shah (1990) states that in India the urban economy is characterised by the inability of the formal wage sector to expand fast enough to absorb the increasing labour force resulting in the expansion of the non wage and informal sector. The share of actual consumption of the lowest thirty percent of the urban population has remained at the same level over the years.

The urban growth in India has taken place in an unbalanced fashion, with the metropolises growing the fastest. The macro economic policies (Ravindran, 1990) further reinforced this concentration. Major cities receive a disproportionately larger share of the total national expenditure on education, subsidies for water power, transport etc.

Frank Jan Borst (1989) chronicles the evolution of policies relating to the urban poor in India. Before the Seventies the approach to the housing needs of the poor was the `Slum Clearance' and relocating them in multistoried tenements. Some of the ideological attitude underlying was

that slums are eyesores and source of infection and ill health to the rest of the urban populace, slum dwellers do not have a class consciousness and are incapable of producing solutions and hence it must be done for them. However the Slum Clearance Policy was not successful in the context of the grossly insufficient allocation of resources for this purpose, and the mismatch of the constructed tenements to the social habits and preferences of the beneficiaries and their economic conditions.

Failure of this policy and the rapidly increasing numbers of the urban poor, and the influences of John F.C. Turner's ideas of `self help housing' the new policy of `Slum Improvement' came into being. The programmes have the goal of providing the basic infrastructure and services for maintenance and a minimal level of land tenure ship. This approach has met with mixed results, as it has resulted in problems such as the poor being pushed out of sites they have helped to develop as the price of land started skyrocketing.

The theoretical underpinnings of this policy have been questioned by Neo-Marxist thinkers and academics. They claim that this is a means for strengthening the capitalist system by the cheap cost of reproduction of the labour, incorporation of the `petty commodity production '(the informal housing) into the capitalist market. Whereas the problems of the urban poor stem from the operation of the capitalist economic system.

In the late Eighties a more comprehensive policy is emerging based on the recommendations of the National Commission on Urbanisation (1988).

4.5 Meso Level Factors

4.5.1 Housing and Health

Several case studies done in the recent decade bring out this link clearly. The health of the inhabitants are affected as the slums are located in environmentally poor locations. Frank Jan Borst (1989) states that about sixty five percent of the slums in the major metropolises of India are located in government property, but inhospitable due to being prone to flooding, or degraded from environmental reasons. The main reason for this fact being that there is less chance of eviction and hence the greater de facto tenure ship it provides. There is some degree of variation in this proportion of slums on government or private property based on the history and the availability of land in the major metropolises.

A Case Study

In a detailed study of three slums in the city of Allahabad in the state of Uttar Pradesh, H.N. Mishra (1990) and team could identify the following. Over two-thirds of the cities households live in one roomed flats or shacks. In one of the slums studied (Cheetpur) the household income for the majority of families was below $200 a year (about Rs. 6000). Forty percent of the households live in one room, with another forty four percent living in two

rooms. Half of all households have less than two square meters area per person. The main source of water was a well which was frequently contaminated and one public stand pipe for the 500 odd people. There was no drainage, no public or private latrines resulting in open air defaecation. Problems of hygiene were confounded by the fact that animals were kept by the households within the rooms. There were two electric poles from which illegal connections had been taken. The school provisions were inadequate.

The health situation was deplorable. Anaemia was quite common, sixty percent of the population had the skin infection scabies, fifty percent had worm infestation by stool test. Dietary survey revealed, that most of the population had a dietary intake of less than 1500 calories-less than the minimum required. Among the 143 children's death recorded in the period 1970-84, all were due to infections and accidents. Of these 143 deaths 73 died as infants before reaching one year of age, all from infective causes.

They conclude that though it is difficult to attribute precise reasons for the health conditions, the inadequate provision of water which was exposed to contamination, lack of provision of hygienic disposal of waste and the very low incomes and hence poor food intake were the important factors as well as the lack of emergency and life saving services.

Goldstein (1990) associates three factors of housing as causally resulting in health problems: the site of the settlement, the physical environment, and the social environment. They are interrelated and there importance varies from settlement to settlement.

Dangerous land site and the overburdening of the capacity of the site by dense settlement of crammed houses increase the risk of drowning, falls, burns, cuts, bites and accidental poisoning.

The environment in and around housing offers a range of habitat that is exploited by arthropod pests and vectors of diseases (Schofield, et al., 1990). The pests include flies, mosquitoes, cockroaches, bedbugs, ticks and mites which cause several infectious and parasitic diseases. Designers and builders pay attention to only those aspects of construction that have a bearing on the structural integrity of the houses. Good design and appropriate materials can reduce the risk of pest infestations.

A third aspect of vulnerability exist, which can not be attributed to poor housing or environmental conditions directly, but to the social environment, namely: social deviance, criminal behaviour and mental illness.

Several problems are noticeable in the housing sector which point to governmental inaction and inappropriate responses (Schofield, et al., 1990; Knudsen & Slooff, 1992).

- Lack of assurance of security of tenure which is important for individual and community participation in building and maintenance of the immediate environments.
- Poor access to institutional credits and training for house construction
- Lack of promotion of low cost indigenous housing and low cost house improvements which can limit vector borne diseases.

4.5.2 Safe Water and Health

Sandy Cairncross (1990) states that in 1985 midway through the decade of stress on water and sanitation in the Eighties, more than 300 million people in the Third World did not have access to safe water, and another sizeable number was underserved. They depended on contaminated surface water for their needs. The importance of quality of safe water is well understood, but in this context the quantity is even more important. The author points out that a review of over 70 research studies done by Esrey & Habicht in 1986 on the relationship of water and health concluded that quantity of water was equally important. Insufficient quantity of safe water is linked to the endemicity of diarrhoeal diseases which takes a high toll through infant and child deaths, whereas contamination of protected water which is more sporadic results in epidemics of Cholera, Typhoid etc. Insufficient quantity is also associated with various skin and eye infections. The following table referred to by Sinnatamby (1990) expresses the importance of availability of water clearly:

Typical effects of improved water supply and sanitation on diarrhoeal morbidity.

Condition	Median reduction in diarrhoeal morbidity (percent)
Improved water quality	16
Improved water availability	25
Improved water quality and availability	37
Improved excreta disposal	22

(Source: Esrey et al, 1985)

Consumption of water is related significantly to the nearness of water source, and rises from below 20 litres per capita daily to a more appropriate level of around 60 litres per capita per day as the source is brought to within 100 metres of residence. As a rule in Third World countries the authorities are not able to meet the consumers demand for water and hence have to resort to intermittent supply of water. Those who are least served are the poorest, who must then buy it from waterless, as this is an indispensable commodity. She quoted studies to show (Briscoe, 1985) that twenty to thirty percent of the urban poor buy water at an enormous price of about one-fifth of their daily earnings. This cost goes up higher as the sources become scarcer.

4.5.3 Facilities for Sanitation, Drainage and Health

It is essential for human health to remove safely and regularly the waste materials, both solid and liquid produced in the household, as well as drain the surface water that collects in human habitations. The health related outcomes come from, contamination of food, water sources and the immediate living environment by pathogens ,causing various infections and illnesses. They

commonly cause gut infections, skin infections, various vector borne infections such as malaria, filaria and schistosomiasis.

Gehan Sinnatamby (1990) opines that more than two billion people-about sixty percent of the Third World population have no access to sanitation. As most of the urban poor live in informal or illegal settlements, less than sixteen percent have any access to sanitation, which could be much worse in particular slums.

In the Dharawi slum area in Bombay (Borst, 1989) there was approximately one toilet for over 300 people and one public tap for every 320 people. Even in improved slum areas the amenities could be quite deficient according to the same author. As the tenements of the urban poor are located in inhospitable terrain and are also illegal, they have greater need for sanitation and drainage but little chance of obtaining it.

Trudy Harpham and Carolyn Stephens (1991) listing studies linking health outcomes and causative factors among the urban poor, (though there is a paucity of such studies) shows that there were direct causal relationship found between, availability of safe water, sanitation facilities and quality of dwellings and the infant and child mortality, in the different countries of the Third World where the studies came from. There was a significantly high correlation in some studies, between mother's education and infant mortality.

4.5.4 Urban Health Services

The Urban Health Services did not come up for critical scrutiny for long time as the assumption was that as a large share of the health care resources are already concentrated in the urban areas, the services are adequate. As mentioned earlier attention began to get focused on the deficiencies in the existing system internationally from the 80's, when W.H.O. stressed this area (Harpham & Stephens, 1992).

According to World Health Statistics Quarterly (1991, p. 234) it is now widely accepted that P.H.C.-approach offers the best possibility of solutions given the complexity and multidimensional aspects of the health problems of the urban poor.

The problems in tinkering with the existing sectoral health programmes to make them into effective primary health care programmes, are multifold. Among the constraints faced in the urban poor areas are:

- the heterogeneity of communities, widespread individualism and a low sense of collective responsibility.
- the difficulty of reaching the poorest groups, i.e. the homeless, jobless and the street children to name a few.
- the difficulty of obtaining voluntary work from people who are struggling for survival and are crucially dependent on cash incomes.
- the multiplicity of agencies resisting co-ordination, opposition from the medical establishment, politicians and public to the changes in the way resources are allocated.

- the problems faced by the city administration by the scale and tempo of urbanisation (World Health Statistics Quarterly, 1991).

As a result the distribution, availability and utilisation of health facilities and services are not related to the population distribution and the needs. Paradoxically health units located in the periphery, closer to the poor communities are under-utilised and bypassed as the facilities are poor and understaffed. Whereas the centrally located facilities are overcrowded and improperly utilised. There are large groups of the poor who are underserved and have accessibility problems (World Health Statistical Quarterly, 1991).

In India two different approaches are developing simultaneously to address the deficiencies in urban health care (Harpham & Stephens, 1992). In the slum improvement / slum development approach, the health services are integrated with other services and supports under one umbrella. In the second type the unisectoral approach the effort has been to strengthen the primary health care services, with the important policy recommendations given by the `Krishnan Committee', in the early 80's. The recommendations specified the structure and staffing pattern of the revamped services which were to be located in the slum itself. However the scheme was not implemented by most Municipalities, partly because other components for an effective delivery system were not addressed and partly because sufficient funds were not allocated by the central government.
In Greater Bombay Municipality which did implement the scheme, the effectiveness was found to be unsatisfactory as outreach work was not done by the health post staff who were diverted for other work. The poor people continued to use the hospitals for minor ailments and thus continued to over use the facilities (Harpham & Stephens, 1992).

4.5.5 Urban Pollution

The major problem of pollution in urban areas is that of air pollution. The major contributors and their relative importance varies from city to city. In cities with high concentration of industries, they are the major contributors through the chemicals released into the air. The burning of high sulphur fuels such as coal or oils by industries and the domestic burning of wood or coal also contributes. The exhaust gases from poorly maintained motor vehicle engines, the high levels of lead in the petrol together with the congested streets, contribute significantly to urban pollution (World Health Statistics Quarterly, 1991).
High levels of air pollution have been linked to high incidence of Bronchitis, Asthma and Pneumonia.
The industries contribute to the pollution of local water sources by the discharge of untreated effluents into open sewers. Water sources are also polluted by poorly managed waste dumps (Our Common Future, 1987).

In most instances there is little or no incentive for industry to cut down on polluting emissions or effluents, as there is inadequate monitoring and penalising mechanisms for pollution control (World Health Statistics Quarterly, 1991).

4.6 Local Level Factors

4.6.1 Supportive Community Dynamics

Research suggests that `social support' may directly enhance health regardless of stress level and protect people from negative consequences of stressful situations. Communities where members provide one another with various forms of support such as emotional support, instrumental support (tangible aid and services), informational support and appraisal support (feedback, affirmation, social comparison) would be at less risk of negative effects of stress than in communities where mutual support does not exist (Israel, 1994).

Several constraints to the development of supportive dynamics among the urban poor communities have been suggested by authors. Hall has proposed a model that includes several aspects related to the community and some outside of the community (Borst, 1989):

- The environment, natural and built- community feeling and solidarity develop easier, when there is distinct physical and psychological boundaries.
- Heterogeneous population- when there is heterogeneity due to class and cultural and linguistic differences residents are less likely to invest time in community activities.
- Resident's perception- traditional links with community of origin are considered to be more important than the links with present neighbourhood.
- Social and economic interactions- functional areas (geographic) may be present with social and economic interactions which can facilitate community networks.
- Local leadership:

  Non existent or competing local leadership can be a constraint. Community development may be contrary to the interests of the slum leaders as it will disturb the existing dependency relationship.

  Conflicting goals of existing Voluntary Associations may come in the way of community coming together.
- Suitable premises- availability of central focus points strengthen the community feeling by giving the population a physical means to interact.
- Established local politicians and beaurocrats outside of the community- community building is not in the interest of local politicians and government officials all too often, who benefit from the existing dependency relationship and the axis with the slum leader and hence will oppose in diverse ways.

- The Macro environment- the attitude of the larger environment such as the State, Agencies with interest in the slum or of the population in the better of neighbourhoods have an influence on the community dynamics.
  The negative role played by slum leaders and the consequences of the axis with politicians and beaurocrats have been quoted as a particular impediment to community building (Borst, 1989; Asthana, 1994).

4.6.2 The Family and Urban Poverty

The family structure breaks down in the face of the risks, pressures and deprivations of urban poverty (Lepore et al., 1991). The consequences are gravest for women and children and are being recorded to be a major problem. The following excerpt is illustrative (World Health Statistics Quarterly, 1991, p. 205-206).

A significant proportion of urban households are headed by women without family or social support. Many have to seek employment to support the family and are confined to low income occupations with long working hours resulting in the younger children being deprived of care and protection. They also run a persistent risk of pregnancy in their search for male support, are often malnourished, exposed to mental stress, sexual harassment and abuse.

Children-the urban environment is particularly hostile to children due to lack of parental supervision or abandonment, early childhood labour and other consequences of urban poverty. The number of street children have grown and the circumstances in which they live seriously jeopardise their health, safety and moral welfare. Estimated to number about 80 million the abandoned children suffer inevitably the consequences of lack of sanitation, clean water, occupational accidents, sexually transmitted diseases, drug abuse, crime and a deep sense of insecurity and emotional conflict. Sexual exploitation is another serious problem, with thousands of young girls and boys as young as twelve years having been sold into prostitution, child pornography and drug trafficking (World Health Statistics Quarterly, 1991).

4.7 Theories of Social Change and Health of the Poor

`Public Health has contributed to interest in the term Empowerment, with the recognition of powerlessness as a broad risk factor for disease, and, consequently, empowerment as a health enhancing strategy... Community empowerment is defined as a social action process in which individuals and groups act to gain mastery over their lives in the context of changing their social and political environment' (Wallerstein & Bernstein, 1994, p.142).

Referring to the Brazilian educator Paulo Freire, the authors say that he advocates a participatory education process in which people are not objects or recipients of political and educational projects, but actors in history, able to name their problems and their solutions to transform themselves in the process of changing oppressive circumstances. According to Freire

Community Empowerment starts when people listen to each other, engage in participatory / liberatory dialogue, identify their commonalities and construct new strategies for change.
Labonte (1994) clarifies empowering professional and institutional health promotion practices. He offers an empowerment model for concerned professionals and institutions, consisting of five levels: personal care, group development, community organisation, coalition advocacy and political action. Capacity needs to be built at all the five levels. He cautions on the difference between the understanding of empowerment for the professionals and that for the community, both of which are separate. Professionals and professional institutions can aid up to a point, by helping to make the oppressive structures more amenable and sensitive to the organised demands of the disadvantaged communities.
In the context of the multiplying problems of powerlessness of the urban poor to influence their environment, the critical ideas from theory point to -community empowerment and linkage to policy and political solutions that decrease health and socio-economic inequities.

5 Implications and Requirements

5.1. International Experience

International experiences in Third World countries in reversing the rural urban migration trends have been equivocal. Most developing countries governments have been concerned about the consequences of the rapid growth of their cities. Concern has been expressed for the overloaded public services, inadequate social infrastructure, environmental degradation and the large resources needed to deal with the problem (U.N. document, 1991).

There are several implications to the multidimensional causation of the Third World urban problems in which the low health status of the urban poor is one outcome. The health problems cannot be seen in isolation and solutions have to be found at multiple levels. Health professionals cannot rigidly draw the line on what constitutes their responsibility, as it is necessary to have a broad perspective of the framework in which better solutions can be found. Actors at different levels of influence in the nation, need to be involved and develop effective co-ordination with each other.

Several researchers and lobbyists (Hardoy & Satterthwaite, 1990; Shah, 1990; Amin, 1992) suggests that though there are reasons to be pessimistic about the future of Third World cities and towns, there are positive trends that need to be supported.

Looking at the Indian situation certain actions need urgent attention, which are listed below.

5.2 Macro Level

5.2.1 Balanced Urbanisation

Concerted efforts need to be made by those responsible in the government such as the Ministry of Urban Development and the Planning Commission to decelerate the trend towards rapid unplanned urbanisation and rapid growth of metropolitan and large cities. A comprehensive policy that corrects regional and city imbalances need to be implemented.

Though the fifth five year plan documents onwards spoke of need for balanced urbanisation process, concrete actions did not result. The assumptions appeared to be that by tackling rural poverty would take care of urban poverty. However there is now a recognition that both need to be addressed with sufficient emphasis and vigour.

The National Commission on Urbanisation's policy guidelines (Rebeiro, 1990) have set a comprehensive policy perspective, on the urbanisation process in the country and have specific recommendations. The Commission recommends that future strategy for urbanisation in India must ensure adequate investment in selected growth centres and regions, so that they develop self sustaining economic growth and offer avenues for employment to the surplus population of not only surrounding villages, but also nearby towns which are stagnating. Commission has assessed that at least Rs. 30 billion would be required to achieve this in the 8th plan period.

Approximately 329 cities or generators of economic momentum (GEMS) have been identified by the commission based on physical location, availability of water and energy and transportation. Similarly 49 Spatial priority urbanisation regions (SPURS) have been identified covering the whole country, and cutting across state boundaries.

Political leaders at the national level and policy makers and implementors in the urban development ministry, need to act with vision and determination recognising that the drift have been allowed to go along for too long.

5.2.2 Attitudinal Change towards Urban Poor

There needs to be an attitudinal change towards the urban poor from the different segments of the society.

There needs to be a recognition by the decision makers, policy makers and political forces that wield power in the Egalitarian society, that the two faces of urban life -one of vast luxury and the other of extreme misery, need to be changed. Economic reasons dictate that the nation should get the full benefit from the productive potential of this segment of the population. Political alignments beginning to take shape at the national level suggests that the poor are starting to articulate their needs increasingly.

The economic contributions of the urban poor need to be recognised for its full extent and value, and supported concretely. It needs to be recognised that it is the lowly paid efforts of the urban poor -the unskilled construction workers, city cleaners, contract labourers in industry and commercial establishments or self employed foot path vendors or the multitude of self employed petty manufacturers in the slums, that contribute to the wealth of the towns and cities and determine the direction of their growth. They need to be enabled to share in the benefits and the quality of life that are available in urban life.

It needs to be recognised that slums are the result of the unaided effort of the poor (not supported by the government or the private sector), to find creative solutions to the urban housing crisis. Hence their energies, initiatives and entrepreneurship need to be supported by the government. At the same time it need to be ensured that conditions for the health of the poor and the rest of the urban population is safeguarded. This calls for enabling statutes, policies and legal provisions that provides access for the poor to -resources, technology, information, skills and protection, both in the housing sector and for productive economic activity. Explaining further such measures include, protection from exploitation in the informal labour market, access to credit, loans, skill training and provision of facilities for informal entrepreneurship. Proportion of newly developed urban areas need to be assigned for economically weaker sections, so that they are protected from the skyrocketing urban land market. Standards for house construction and facilities need to be made relevant and appropriate to the needs of the poor. Such actions are in contrast to the present situation which is one of denial of access through ill conceived norms, statutes and standards. Official perception of the urban poor see them as wrongdoers and lead to harassment, not to speak of

the violent governmental actions, such as slum demolitions without providing suitable alternatives.

5.2.3 Programmes for the Urban Poor

The national government needs to invest sufficient resources, for development of housing, infrastructure and services.

The resources allocated need to be sufficiently large taking into account that 30%-50% urbanites in many of the cities are the poor. In raising the resources creative use of legislations like `The Urban Land Ceiling Act', and allotting of unutilised land already in government's possession under different departments needs to be done.

The planning of these investments should be done carefully, so as to address real priorities, rather than being frittered away in elite projects as has often happened in the past. Providing of tenurial rights and the essential infrastructure for a healthy environment are important issues in this context.

The National Commission on Urbanisation has presented to the government in 1988 (Shah, 1990) "a 13 point programme package titled the `New Deal for the Urban Poor', aimed at improving the income and consumption levels of the urban poor. The programmes aim at extending the access of the poor to basic environmental and social services, ensuring better utilisation and suggestions for changes in the legal, institutional and administrative set-up for effective delivery. The programme package is estimated to cost Rs. 10,75 billions, over a five year period. The programme is expected to bring income and employment benefits to 4.4 million families and 6.3 million families are expected to receive multiple service benefits."

5.3 The Meso Level

5.3.1 Programmes and Services

The Urban Development Ministry need to encourage low cost and appropriate technologies in provision of infrastructure.

The programmes developed need to be directed at low cost solutions for the housing and infrastructural needs of the poor, eliciting their participation in the need assessment, planning, implementation and monitoring of the implementation. In such a context there is greater possibility of solutions that are appropriate and sustainable. Solutions are culturally appropriate which takes into account, the cultural and lifestyle preferences of the people. They are sustainable which builds upon local technology and available materials, upgrading the technology where necessary. This would also give an impetus to related local cottage industries and increasing employment potential.

Several studies in the past two decades have brought out the feasibility of using local technology and locally available materials for house construction, with appropriate measures to

take care of the disease producing agents that are prevalent with tropical conditions. Much innovative work has also been done in the area of low cost sanitation, latrines, sewerage systems and solid waste removal technologies, which are culturally appropriate and have community building dimensions. Importantly such low cost programmes have also demonstrated cost recovery. The community can be trained and enabled to maintain these services-which is a much better situation than depending solely on inefficient, beaurocratic government machinery.

The programmes need to be comprehensive, which includes not only the housing and infrastructural aspects, but also services and community organisation and participation.

5.3.2 Devolution of Authority

The state level Urban Development Ministry Departments needs to devolve effective authority to Urban Local Bodies and Community Institutions.

The Urban Local Bodies over the decades have become stunted and weak due to lack of decentralisation at the state level (Mohan, 1990). They lack in resources, trained personnel and prestige. The funds have tended to be devolved on an ad hoc basis, while the centralised agencies took over more and more of the functions, several of such bodies lack representative leadership. However these institutions have the responsibility for the creation and maintenance of infrastructure and services. These Bodies need to be strengthened through elected leadership, devolution of powers and finances, as well as need to raise additional finances creatively. They also need to revamp the archaic and unsuitable norms and standards that prevent poor people access to their resources and services.

They need to work in close collaboration with local community institutions, who can represent each individual's need. At the moment by and large local community organisations are non-existent or are non representative.

5.3.3 Health Care Services

The Ministry of Health needs to ensure that the organisation and implementation of Health Services for the Urban Poor is based on the principles of Primary Health Care.

There is need for a system of collecting health data that is specific for the urban poor and which is disaggragated from the general urban health data, so that health care need identification and monitoring of the programmes can be effective.

The health service needs to give emphasis to preventive and promotive health aspects as well as to a credible curative service. A large proportion of the health problems of the urban poor require preventive and promotive interventions.

An effective system would incorporate community participation through `health volunteers/health committees' and appropriately trained primary health care staff, supported by sufficient resources of `rational drugs' and appropriate medical technology.

The referral system for responding to complicated problems needs to work. Health care institutions particularly in the Voluntary Sector have much to contribute to the city's referral network. The whole system need to be accountable to the poor communities.

5.3.4 Educational Services

The educational services of the Ministry of Education needs to be flexible and need oriented.
They need to take into account the employed status of the children, employment oriented practical skills and lack of interest of the poor in purely academic education.

5.3.5 Reorienting Officials

The ministry of Urban Development and the various institutes for urban studies along with their State counterparts need to bring about a reorientation of the officials concerned with urban programmes.
There is need for reorienting the concerned officials at the municipal regional and national levels, to become sensitive to local realities and problems, peoples cultural preferences, their initiative and creativity and the feasibility of indigenous appropriate technologies. Their academic training in approaches and technologies applicable for conditions elsewhere, are not suited often for solving the escalating problems of the urban poor.
Different method of functioning is called for, which is multisectoral and integrated, where the various programmes are co-ordinated under one Body.

5.4 Empowerment Process and Partnership with Non Governmental Organisations (N.G.O.'s)

The Ministry of Urban Development along with the other concerned bodies and State Departments need to recognise that the ultimate goal of development is empowerment.
Active community participation and devolution of powers regarding decisions on resources to the community, are two essential ingredients for the success and sustainability of programmes. Governmental programmes historically have not had much success in engendering positive community dynamics, developing constructive leadership or community participation. Theories of Community Organisation and Empowerment, make it clear that it is a process that has to be enabled and nurtured, based on democratic principles. Even the weakest segments in the society need to be enabled to express their needs, and to take actions themselves, within their boundaries to change the dehumanising conditions. N.G.O.'s working for non-profit motives, at the micro level, have demonstrated their effectiveness in being facilitators and agents of change. They have also developed with the community's participation, creative and appropriate technologies, management practices and participative monitoring and evaluation procedures. Hence for effective development and running of the programmes, a tripartite partnership consisting of peoples organisations, credible local N.G.O.'s and government agencies is

favoured. The goal being eventually the peoples organisations will take over the responsibility for the development of the community and the resources and supports will be provided by the government.

The Structural Adjustment Policy of the international financial institutions advocate `Privatisation'. In developing infrastructure and services for the poor privatisation may not be appropriate uniformly, but would be useful in selective situations (Cairncross et al., 1991). `Privatisation of natural monopolies such as piped water, sewers and drains, presents governments with special problems, since there are no competitive pressures to help keep down price and encourage improved quality. Allowing private enterprises to provide certain services which are provided inadequately or not at all by local government is worth considering, especially if the services are not natural monopolies.'

However involvement of N.G.O.'s in this context can be quite appropriate as they have the capacity to provide quality service at low cost.

5.5 Urban Basic Services for the Poor (U.B.S.P.)- a Model

Ministry of Urban Development needs to vigorously implement U.B.S.P. and credible N.G.O.'s need to actively participate in critiquing and implementing this programme.

A positive event in India is that as an outcome of the recommendations of the National Commission on Urbanisation (1988) and some successful urban experiments, a comprehensive and multisectoral nation-wide programme is evolving with the participation also of U.N.I.C.E.F. The Urban Community Development Projects (U.C.D.'s) with bilateral support also have a comprehensive approach. They are a small step in addressing the urgent needs of the poor through a programme. Political support for larger commitment of resources and development of enlightened leadership at the different levels including the local level are essential for the success of the programme.

5.6 Individual / Neighbourhood level

At the individual/neighbourhood (small community level), several needs have to be addressed. This is best done by the organisations of the poor themselves with facilitatory help from the Government programmes and concerned N.G.O.'s.

Awareness of the individuals and neighbourhoods of the multidimensional causation of disease and how they operate in their situation need to be enhanced.

Knowledge and skills relating to preventive/promotive aspects of health, within the individual's control such as: personal hygiene, immunisations, balanced diet, injurious habits, appropriate care of the children and the ill and reproductive health, to name the important areas need to be enhanced.

Knowledge and skills relating to developing and sustaining community initiatives for improving environment and accessing resources (governmental and others) and developing autonomy needs to be fostered.

An important issue to be addressed is the status of women, through development of women's organisations, raising the economic power of women and enhancing their access to resources.

6 Summary

There is a very large problem among the Third World urban poor, regarding health and quality of life. Research is deficient in this area. The magnitude of the problems were not anticipated until less than two decades ago.

At the macro level, the international economic order and the particular economic situation of a country have a direct bearing on the process of urbanisation in a Third World country. This factor compounds the migration pressures generated by the economic activity in urban centres. India, like most other Third World countries, has not been successful by and large in planning for or allocating adequate resources to take care of magnitude of needs of the growing urban populations. Proactive measures to produce a balanced growth of urbanisation have been missing. One surprising result is the virtual lacuna, of policies and programmes specifically meant for addressing the needs of urban poor.

At the meso level in India, the functioning of the various institutions, infrastructure and programmes in relation to urban poor, are not suited to produce the best results. Whereas a participatory, intersectoral and well co-ordinated approach with flexibility to incorporate innovative experience is required, the present efforts often end up with little meaningful results for the poor.

At the micro level of local communities, various forms of division are inherent as result of the process by which urban communities came into being. The dynamics resulting from the self interest of local politicians, beaurocracy and other vested interests, further deepen this division. The multiple levels of aetiological factors cause a complex situation of poverty and deprivation and health contingencies, which were studied by qualitative methods in several slums in the metropolis of Bangalore. These findings are presented.

Literature survey of Indian and Third World country experiences show a more or less common pattern of aetiologic factors and outcome results-deprivations of different kind.

The recommendations focus on macro level actors, the state and the beaurocracy, intermediate actors namely institutions and non governmental organisations, and at the micro level the urban poor themselves. The urban poor have demonstrated considerable innovativeness and tenacious energy. Determined efforts from all sectors are needed in the face of this calamity that is already upon us.

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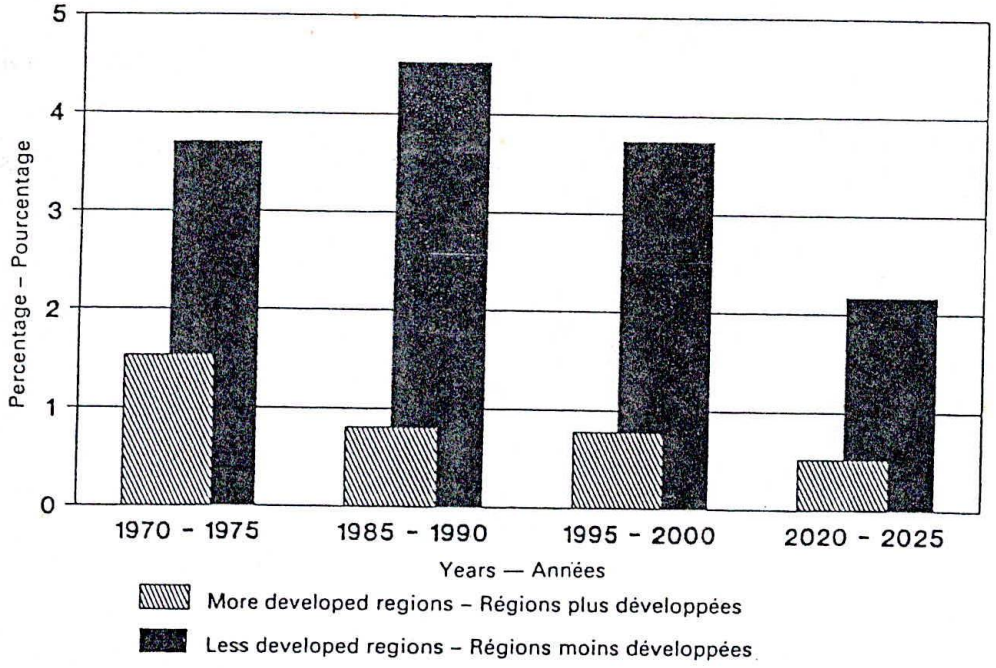
Appendix

AVERAGE ANNUAL URBAN GROWTH RATE, LESS DEVELOPED REGIONS AND MORE DEVELOPED REGIONS, 1970-1975 TO 2020-2025

TAUX ANNUEL MOYEN DE LA CROISSANCE URBAINE DANS LES RÉGIONS MOINS DÉVELOPPÉES ET DANS LES RÉGIONS PLUS DÉVELOPPÉES, DE 1970-1975 À 2020-2025



DEV - 3B.

Urbanisation and Health

Input for meeting with Dr. Ravi Narayan, Society for Community Health Awareness, Research and Action (Sochara), Bangalore, PHM India

09. September 2008

medico international

Urbanisation – Trends

- The majority of people in the world (3.3 bn., UNFPA) are living today in urban areas
- Since 1950 the urban world population has more than quadrupled.
- It will increase further to 5 bn. people until 2030, most of the growth taking place in smaller cities.
- Whereas Africa and Asia are the least urbanized continents in relative terms their urban population will grow by nearly 1.5 bn. people between 2005 and 2030.
- This growth is not paralleled by an increase in employment opportunities in the formal sector, especially not in sub-Saharan Africa; a development being described as urbanisation of poverty:
- One third of the urban population in the world lives in slums or informal settlements that dont meet basic infrastructure necessities

(Urbanisation of Poverty)

Urbanisation – International Events and Actors

- 1976, 1996 United Nations Conference on Human Settlement, Habitat 1 & 2
- 1978: United Nations Centre for Human Settlements (UNCHS)
- 1987: World Commission on Environment and Development (WCED), report 'Our Common Future', also known as the Brundtland Report
- 2002: UNCHS transformed to United Nations Human Settlements Programme (UN-Habitat) under the UN Economic and Social Council (ECOSOC)
- 2002: World Urban Forum (WUF), a biennial gathering open to all partners of the Habitat Agenda including local authorities, non-profit and for-profit organizations
- 2004 United Cities and Local Governments (UCLG), local authority network
- 2005: WHO Commission on Social Determinants of Health - Knowledge Network on Urban Settings (KNUS)
- 2005 African Ministerial Conference on Housing and Urban Development (AMCHUD)
- 2007 UNFPA report 'State of the World Population 2007' emphasize the people's right to live in the city as well as the opportunities of urban growth

Selforganizing Initiatives

- Shack / Slum Dwellers International (SDI), a grassroots network founded in 1996 representing the interests of the urban poor www.sdinet.org
- Brasilien: *Movimento Sem-Teto do Centro*, (MSTC)
- Südafrika

Multidimensional View of Urban Poverty

- inadequate and often unstable income,
- poor quality, hazardous, overcrowded, and often insecure housing,
- inadequate provision of basic services (safe water, sanitation)
- inadequate, unstable or risky asset base,
- inadequate public infrastructure (e.g. transportation)
- inadequate protection of rights through the operation of law and
- voicelessness and powerlessness within non-responsive political systems and bureaucratic structures

UN-Habitat, State of the World's Cities Report 2006/7: The Millennium Goals and Urban Sustainability. Malta: Earthscan, p. 25).

Urbanisation and Health

- Disaggregated data on common health problems show striking intra-city inequalities between the wealthy and the urban poor, who are carrying a double burden of disease (chronic, noncommunicable diseases and high prevalence of infectious diseases).

Health Risks of Urban Poor

- Shelter deprivation
- Malnutrition
- Environmental pollution
- Traffic
- Violence
- Climate Change
- HIV/AIDS
- Katastrophic Health Expenses

Shelter Deprivation

- Poor quality housing: no insolation, no safe heating: Acute respiratory infections
- Poor Water, Sanitation: waterborne diseases, diarrhoea
- Overcrowding: Spread of infectious diseases, measles, tuberculosis (In Nairobi, for instance, 60% of the inhabitants live in 130 informal settlements covering 5% of the urban area.)
- Hazardous Locations: prone to natural (e.g. flooding, land slides) and technological (e.g. industrial toxic pollution, Bhopal) disaster

Water and Sanitation

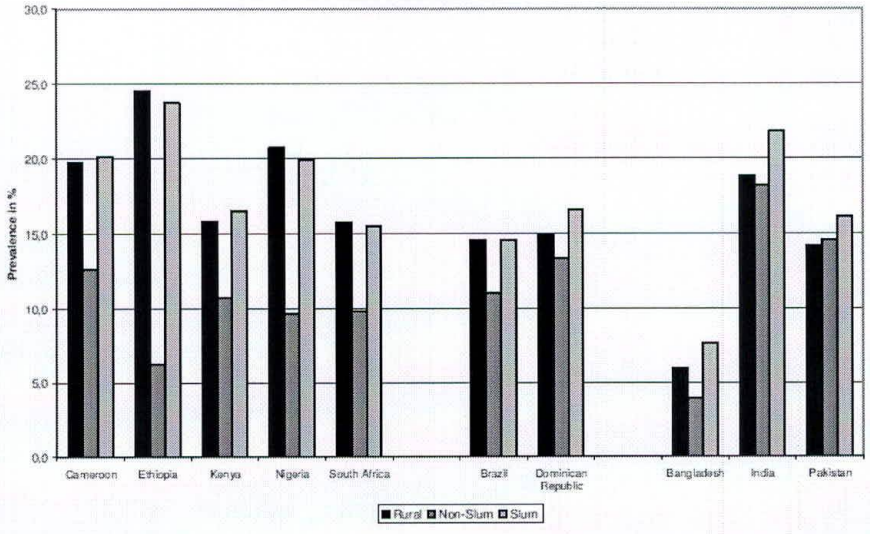


Fig. 3: Diarrhoea prevalence among children under five years in selected countries according to settlement type. Source: Own figure, based on UN-Habitat 2006 according to Demographic and Health Surveys 1995-2003.

Malnutrition

- High food prices in cities
- No space to grow own food
- Unsafe and unhealthy Street food (microbiological contamination → gastrointestinal infections; dense fatty, suggar/salt rich → overweight/ diabetes/cardiovascular diseases

Income and Nutrition

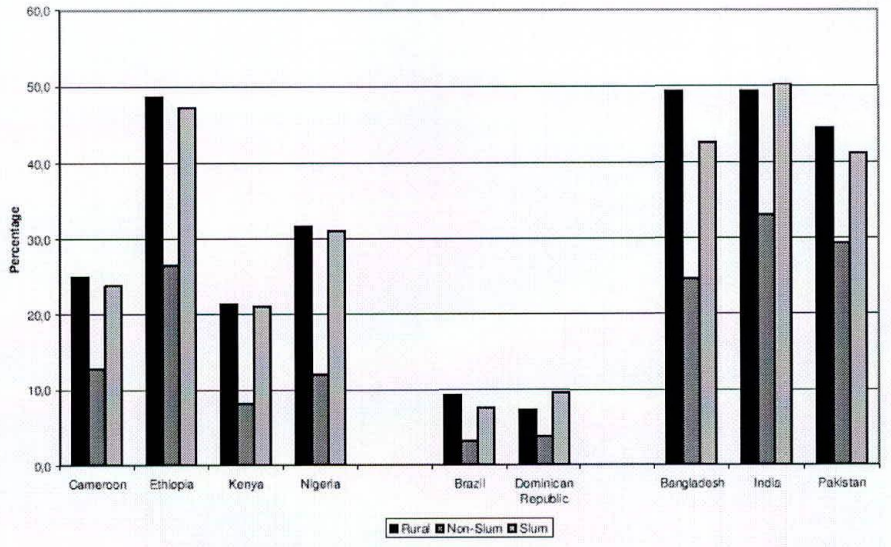


Fig. 4: Percentage of malnourished children under five years in selected countries according to settlement type. Source: Own figure, based on UN-Habitat 2006.

Environmental pollution

- Indoor air pollution: open heating/cooking without proper ventilation → respiratory infections
- Outdoor air pollution: traffic, industrial
- Industrial contamination of water / soil

Traffic

- 1,2 mio. deaths and 50 mio. Injuries
- Poorly planned, overcrowded public transport services
- Insufficient safety controls
- Means of mobility of poor are least protected (walking, bicycles, rikshas, motorbikes, buses)
- In some cities of the developing world accidents are already the leading cause of death in the younger age groups
- Continues to increase because of increasing motorisation

Violence

- Especially visible in younger age groups.
- In Sao Paulo and Rio de Janeiro mortality rates for the age group 15-24 showed a continuous decline between 1930 and 1980 before they started to increase again due to urban violence.
- A comparison of the wealthiest and poorest neighbourhoods revealed that mortality rates were up to **eleven times higher** in the poorest neighborhoods.
- A high prevalence of violence in a neighborhood also affects the mental and psycho-social well-being of its residents because of fear, critical life events, and a lack of control over resources and social support.

Climate Change

- Poor neighborhoods are most vulnerable to climate disaster (floods, hurricans, cyclones) because being located on steep hill sides (e.g. Vargas, Venezuela), in poorly drained areas or in low elevation coastal zones (LECZ), (e.g. Bangladesh)
- Flooding of latrines lead to contaminated water sources and promote the spread of water-borne diseases.
- Worldwide LECZ cover only 2% of the land area but 13% of the world urban population an almost 500 million people, respectively, live there

HIV / AIDS

- Urban poor (expecially young women) have higher prevalences and are more vulnerable to STDs
- Work migration / traffic routes and corridors
- high unemployment rates and low salaries promote transactional sexual activity among the urban poor
- Also higher rates of sexual violence

Rural-Urban HIV/AIDS Prevalence

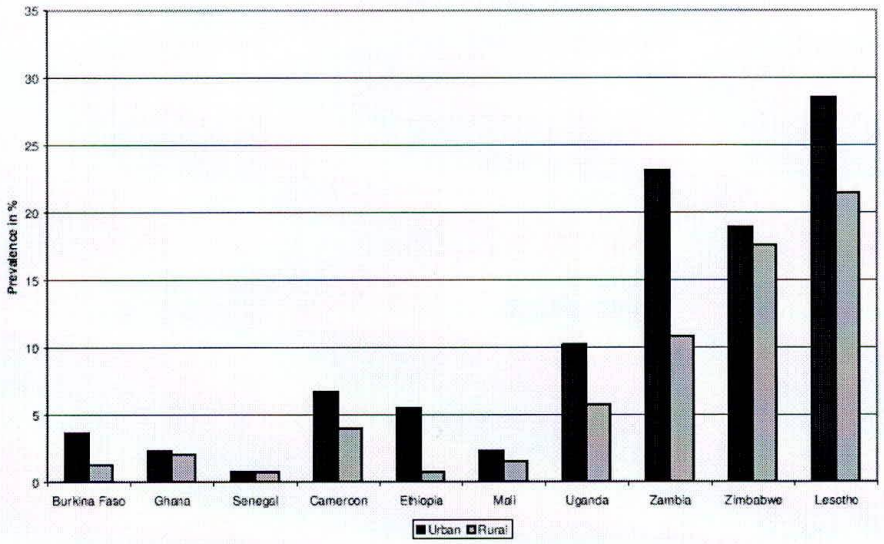


Fig. 5: HIV prevalence among 15-49-aged adults in selected countries. Source: Own figure, based on Demographic and Health Surveys 2001-2006.

Access to Health Care

- Less problems with availability of health services but with affordability
- Out of pocket payments in private and public health services are further aggravating poverty
- 100 Mio. People annually become poor because of catastrophic health costs

Intersectoral challenges for health promotion

- Improving the general and specific determinants of health
- Making Health services accessible and affordable for all, particulary the poor
-

General Challenges

- develop national urban strategies
- strengthen local authorities, which need to have the capacities to manage local problems (need political power, decision-making capacity and access to revenues based on the wealth generated in cities)
- promote self-reliance and citizen involvement: support of the informal sector, facilitation of loans to small entrepreneurs, building cooperatives and neighbourhood associations, provision of tenure to illegal dwellers and easement of building and housing regulations.
- provide better serviced, better-located, legal alternatives to illegal plots' as well as advice and technical assistance on how to improve building, health and hygiene
- tap more resources (conflation and provision of underused private or public estate, the support of urban agriculture and the recycling of solid waste)

World Commission on Eenvironment and Development (1987). Our Common Future (Brundland Report). Oxford: Oxford University Press.

Strenghening local authorities and citizen involvement

- Democratisation and decentralisation to the lowest appropriate level in order to achieve a balance of power, enabling the poor to put across their interests, also against higher social strata.
- Based on the acknowledgement that every person has a right to live in the city.
- Local governance: inclusive, participative decision-making processes and the devolution of political, administrative and financial power away from central governments to subnational and local authorities.
- Underlying aim: Reorient governance to the needs of the urban population and make it transparent, accountable and responsive.
- The role of the central government is it to facilitate a conducive environment, i.e. through fiscal transfers, municipal elections and spatial planning

UN-Habitat, State of the World's Cities Report 2006/7: The Millennium Goals and Urban Sustainability. Malta: Earthscan

Challenge of Financing of Urban Development

- The UN Millennium Project calculated that a slum upgrading package for 100 million current slum dwellers plus new construction on vacant land for 700 million potential new slum dwellers would cost on average $1,800 per person and $1,440 bn. in total (UN-Habitat, 2006).
- UN-Habitat favours a mixed financing by donors, governments, local authorities relying on the national capital market and an extended revenue base as well as beneficiaries making use of savings and housing microfinance.

Health specific Challenges

- optimise the social determinants of health and thus to reduce existing health inequities within cities:
- Social determinants on environmental hazards and threats (i.e. unsafe water, exposure to extremes of temperature and noise)
- Economic barriers (i.e. poverty, education, cost of medical care)
- Values, Behaviour and Lifestyle (i.e. health literacy, stigma)
- Social and political exclusion (i.e. community decision-making processes, access to welfare or social support services

WHO Kobe Centre (2005). A Billion Voices: Listening and Responding to the Health Needs of Slum Dwellers and Informal Settlers in New Urban Settings http://www.who.int/social_determinants/resources/urban_settings.pdf

Strategies for improving urban Health challenges

- Improving governance, good governance being characterized by 'participation, rule of law, transparency, responsiveness, consensus orientation, equity, effectiveness and efficiency, accountability and strategic vision'
- Responsibility and power should be shifted to local authorities and their partners at the local level.
- In order to be successful local level interventions have to be ecological and population-based, integrative as well as system-based.
- Strategic actions should focus on slum-upgrading, improving access to quality health care, targeted health promotion, integration of health, welfare and education services and sustainable urban development.

WHO, Kobe Centre, 2005

Why wasn't there good governance in the past?

- *Existing power relations and the fact that there are also those interest groups who already have a beneficial connection to the state. Accordingly,concede that 'those with greater resources of experience, money or skill can game the local system as they can a national government'. Therefore establishing good governance is not an easy process but it may act as a strong ethic and political vision to follow.*

Sven Voigtländer, Jürgen Breckenkamp, Oliver Razum (2008) Urbanisation in developing countries: Trends, health consequences and challenges, Bielefeld, 2008 (unpublished)

DEV - 3B

Monitoring the Expenditure and Outcomes to Improve Health Services for Urban Poor Women in Bangalore

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Background

- Two-year project (August 2009 – July 2011) on maternal heath services of BBMP maternity homes in Bangalore
- Thematic areas of study include
  - Antenatal care
  - Delivery
  - Postnatal care
  - Immunization
  - Family welfare services
- Tools used in the study
  - Citizen Report Card (CRC)
  - Community Score Card (CSC)

Citizen Report Card (CRC)

- A Citizen Report card is a simple but powerful tool which is built from surveys with actual users of public services.
- Feedback from Users on experiences with public services is collected, analyzed and disseminated, in a systematic and transparent manner.
- The findings, which are backed by hard facts and figures, can be used equally by institutions from both sides - the civil society, can demand and lobby for improvement, while the service provider can use the findings to initiate or strengthen reform measures.
- The CRC approach evolved by the Public Affairs Centre (PAC) has been considered an international best practice to improve public services.

Aspects covered in a CRC

- ACCESS and USAGE
- Quality and RELIABILITY of the service
- COPING STRATEGIES
- RESPONSIVENESS of the staff
- CORRUPTION & Hidden Costs
- SATISFACTION with the services
- SUGGESTIONS FOR IMPROVEMENT of service delivery

ज ज-8: शौचालय की सुविधा के प्रकार की उपलब्धता के अनुसार परिवार
HH-8: HOUSEHOLDS BY AVAILABILITY OF TYPE OF LATRINE FACILITY

योग ग्रामीण नगरीय	परिवारों की कुल संख्या/ Total number of households	परिवारों की संख्या जिनके पास परिसर में शौचालय की सुविधा है/ Number of households having latrine facility within the premises	परिसर में शौचालय की सुविधा के प्रकार/Type of latrine facility within the premises								परिवारों की संख्या जिनके पास परिसर में शौचालय सुविधा नहीं है/ Number of households not having latrine facility within the premises	परिसर में शौचालय की सुविधा नहीं/ No latrine within premises		Total Rural Urban
			फ्लश/पोर फ्लश शौचालय किससे जुड़ा है/ Flush/pour flush latrine connected to			गड्ढा शौचालय/ Pit latrine		मल-मूत्र खुली नाली में बहाया जाता है/ Night soil disposed into open drain	सर्विस शौचालय/ Service Latrine			वैकल्पिक स्रोत/ Alternative source		
			पाइप सीवर प्रणाली/ Piped sewer system	सेप्टिक टैंक/ Septic tank	अन्य प्रणाली/ Other system	स्लैब के सहित/ हवादार उन्नत गड्ढा/ With slab/ ventilated improved pit	स्लैब रहित/ खुला गड्ढा/ Without slab/open pit		मल-मूत्र व्यक्ति द्वारा हटाया जाता है/ Night soil removed by human	मल-मूत्र हटाने के लिये जानवरों का उपयोग/ Night soil serviced by animal		सार्वजनिक शौचालय/ Public latrine	खुले में/ open	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	1
जिला - चामाराजानगर 578/District - Chamarajanagar 578														
योग	244,198	57,295	10,150	9,061	2,830	31,653	1,012	1,974	16	599	186,903	4,937	181,966	Total
ग्रामीण	203,748	31,279	2,593	6,034	1,407	20,036	577	187	0	445	172,469	3,386	169,083	Rural
नगरीय	40,450	26,016	7,557	3,027	1,423	11,617	435	1,787	16	154	14,434	1,551	12,883	Urban
जिला - गुलबर्गा 579/District - Gulbarga 579														
योग	465,245	118,792	60,489	43,657	5,457	2,031	1,489	3,687	32	1,950	346,453	25,426	321,027	Total
ग्रामीण	311,531	13,911	2,382	7,846	1,812	911	165	347	0	448	297,620	16,423	281,197	Rural
नगरीय	153,714	104,881	58,107	35,811	3,645	1,120	1,324	3,340	32	1,502	48,833	9,003	39,830	Urban
जिला - यादगिर 580/District - Yadgir 580														
योग	200,424	22,523	3,795	14,857	1,424	865	290	1,061	0	231	177,901	14,395	163,506	Total
ग्रामीण	161,665	6,938	1,187	4,212	690	510	134	109	0	96	154,727	10,239	144,488	Rural
नगरीय	38,759	15,585	2,608	10,645	734	355	156	952	0	135	23,174	4,156	19,018	Urban
जिला - कोलार 581/District - Kolar 581														
योग	330,990	141,675	39,187	38,394	6,781	50,894	1,653	3,268	543	955	189,315	14,285	175,030	Total
ग्रामीण	226,245	57,664	6,218	14,834	4,231	30,799	688	380	56	458	168,581	4,156	164,425	Rural
नगरीय	104,745	84,011	32,969	23,560	2,550	20,095	965	2,888	487	497	20,734	10,129	10,605	Urban
जिला - चिक्कबल्लापुरा 582/District - Chikkaballapura 582														
योग	282,311	102,957	25,436	26,217	4,368	42,697	1,871	1,322	249	797	179,354	7,052	172,302	Total
ग्रामीण	220,309	50,677	4,667	12,574	2,789	28,410	1,137	314	38	748	169,632	5,957	163,675	Rural
नगरीय	62,002	52,280	20,769	13,643	1,579	14,287	734	1,008	211	49	9,722	1,095	8,627	Urban
जिला - बेंगलुरू ग्रामीण 583/District - Bangalore Rural 583														
योग	224,745	179,589	15,857	47,463	4,035	104,596	1,766	5,022	528	322	45,156	2,979	42,177	Total
ग्रामीण	162,398	122,643	7,058	25,836	3,020	84,850	1,334	120	302	123	39,755	1,528	38,227	Rural
नगरीय	62,347	56,946	8,799	21,627	1,015	19,746	432	4,902	226	199	5,401	1,451	3,950	Urban

( ) Postnatal care
( ) Home visits (Field visits by health workers)
( ) Specialist care (which type?):

( ) X-ray and scanning facilities (specify):

v. List all government schemes implemented in the Health Centre

5. Functioning and problems

i. Availability of doctor(s) on working days (days and timings)

ii. Does the doctor(s) work in another hospital?

iii. Average no of patient visits on normal day of functioning

iv. Does the Health centre display the user fee board? (If yes, please provide list of fees)

v. If possible, ask one of the staff what equipment they are lacking and list here

vi. Is there a committee formed in the Health Centre, e.g. Board of Visitors, Arogya Raksha Samiti?

ज ज-8: शौचालय की सुविधा के प्रकार की उपलब्धता के अनुसार परिवार
HH-8: HOUSEHOLDS BY AVAILABILITY OF TYPE OF LATRINE FACILITY

योग ग्रामीण नगरीय	परिवारों की कुल संख्या/ Total number of households	परिवारों की संख्या जिनके पास परिसर में शौचालय की सुविधा है/ Number of households having latrine facility within the premises	परिसर में शौचालय की सुविधा के प्रकार/Type of latrine facility within the premises								परिवारों की संख्या जिनके पास परिसर में शौचालय सुविधा नहीं है/ Number of households not having latrine facility within the premises	परिसर में शौचालय की सुविधा नहीं/ No latrine within premises		Total Rural Urban
			फ्लश/पोर फ्लश शौचालय किससे जुड़ा है/ Flush/pour flush latrine connected to			गड्ढा शौचालय/ Pit latrine		मल-मूत्र खुली नाली में बहाया जाता है/ Night soil disposed into open drain	सर्विस शौचालय/ Service Latrine			वैकल्पिक स्रोत/ Alternative source		
			पाइप सीवर प्रणाली/ Piped sewer system	सेप्टिक टैंक/ Septic tank	अन्य प्रणाली/ Other system	स्लैब के सहित/ हवादार उन्नत गड्ढा/ With slab/ ventilated improved pit	स्लैब रहित/ खुला गड्ढा/ Without slab/open pit		मल-मूत्र व्यक्ति द्वारा हटाया जाता है/ Night soil removed by human	मल-मूत्र हटाने के लिये जानवरों का उपयोग/ Night soil serviced by animal		सार्वजनिक शौचालय/ Public latrine	खुले में/ open	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	1
जिला - बेंगलुरू 572/District - Bangalore 572														
योग	2,377,056	2,254,599	1,715,904	169,046	21,745	325,175	5,581	8,096	3,776	5,276	122,457	37,061	85,396	Total
ग्रामीण	207,628	155,366	27,377	31,954	3,432	90,228	1,181	410	317	467	52,262	3,799	48,463	Rural
नगरीय	2,169,428	2,099,233	1,688,527	137,092	18,313	234,947	4,400	7,686	3,459	4,809	70,195	33,262	36,933	Urban
जिला - मंड्या 573/District - Mandya 573														
योग	426,578	159,818	43,943	17,601	4,053	90,783	1,167	1,460	167	644	266,760	5,637	261,123	Total
ग्रामीण	354,049	97,526	6,742	12,228	2,424	74,264	966	265	96	541	256,523	3,814	252,709	Rural
नगरीय	72,529	62,292	37,201	5,373	1,629	16,519	201	1,195	71	103	10,237	1,823	8,414	Urban
जिला - हासन 574/District - Hassan 574														
योग	429,292	171,212	50,705	20,140	4,148	94,051	1,005	613	108	442	258,080	8,327	249,753	Total
ग्रामीण	339,911	90,891	4,066	11,822	3,060	70,209	914	397	0	423	249,020	7,050	241,970	Rural
नगरीय	89,381	80,321	46,639	8,318	1,088	23,842	91	216	108	19	9,060	1,277	7,783	Urban
जिला - दक्षिण कन्नड 575/District - Dakshina Kannada 575														
योग	425,291	394,069	52,741	248,191	2,859	89,557	353	87	12	269	31,222	1,888	29,334	Total
ग्रामीण	220,806	194,578	7,124	116,948	1,850	68,101	264	50	12	229	26,228	869	25,359	Rural
नगरीय	204,485	199,491	45,617	131,243	1,009	21,456	89	37	0	40	4,994	1,019	3,975	Urban
जिला - कोडगु 576/District - Kodagu 576														
योग	138,303	112,626	9,580	80,464	2,549	18,482	1,322	94	46	89	25,677	1,411	24,266	Total
ग्रामीण	118,509	93,421	7,807	64,544	2,389	17,205	1,277	65	46	88	25,088	1,187	23,901	Rural
नगरीय	19,794	19,205	1,773	15,920	160	1,277	45	29	0	1	589	224	365	Urban
जिला - मैसूरू 577/District - Mysore 577														
योग	688,422	378,503	240,414	18,470	5,658	107,667	2,456	2,717	19	1,102	309,919	9,177	300,742	Total
ग्रामीण	401,655	108,475	9,591	12,431	4,086	79,149	1,631	698	19	870	293,180	5,539	287,641	Rural
नगरीय	286,767	270,028	230,823	6,039	1,572	28,518	825	2,019	0	232	16,739	3,638	13,101	Urban

vii. Any problems experienced with hospital, such as corruption, availability of doctors, availability of medicines, availability of tests, attitude of staff, access to schemes, etc.

viii. Case studies (attach)

ज ज-8: शौचालय की सुविधा के प्रकार की उपलब्धता के अनुसार परिवार
HH-8: HOUSEHOLDS BY AVAILABILITY OF TYPE OF LATRINE FACILITY

योग ग्रामीण नगरीय	परिवारों की कुल संख्या/ Total number of households	परिवारों की संख्या जिनके पास परिसर में शौचालय की सुविधा है/ Number of households having latrine facility within the premises	परिसर में शौचालय की सुविधा के प्रकार/Type of latrine facility within the premises								परिवारों की संख्या जिनके पास परिसर में शौचालय सुविधा नहीं है/ Number of households not having latrine facility within the premises	परिसर में शौचालय की सुविधा नहीं/ No latrine within premises		Total Rural Urban
			फ्लश/पोर फ्लश शौचालय किससे जुड़ा है/ Flush/pour flush latrine connected to			गड्ढा शौचालय/ Pit latrine		मल-मूत्र खुली नाली में बहाया जाता है/ Night soil disposed into open drain	सर्विस शौचालय/ Service Latrine			वैकल्पिक स्रोत/ Alternative source		
			पाइप सीवर प्रणाली/ Piped sewer system	सेप्टिक टैंक/ Septic tank	अन्य प्रणाली/ Other system	स्लैब के सहित/ हवादार उन्नत गड्ढा/ With slab/ ventilated improved pit	स्लैब रहित/ खुला गड्ढा/ Without slab/open pit		मल-मूत्र व्यक्ति द्वारा हटाया जाता है/ Night soil removed by human	मल-मूत्र हटाने के लिये जानवरों का उपयोग/ Night soil serviced by animal		सार्वजनिक शौचालय/ Public latrine	खुले में/ open	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	1
जिला - चित्रदुर्गा 566/District - Chitradurga 566														
योग	354,143	107,142	23,137	12,094	2,850	62,615	951	3,822	123	1,550	247,001	8,573	238,428	Total
ग्रामीण	282,019	53,839	4,436	7,947	2,260	36,834	572	747	25	1,018	228,180	6,570	221,610	Rural
नगरीय	72,124	53,303	18,701	4,147	590	25,781	379	3,075	98	532	18,821	2,003	16,818	Urban
जिला - दावणगेरे 567/District - Davanagere 567														
योग	404,840	188,046	84,558	17,049	3,885	76,409	748	3,557	101	1,739	216,794	11,669	205,125	Total
ग्रामीण	272,929	81,363	5,545	7,578	2,686	64,109	523	376	69	477	191,566	5,226	186,340	Rural
नगरीय	131,911	106,683	79,013	9,471	1,199	12,300	225	3,181	32	1,262	25,228	6,443	18,785	Urban
जिला - शिमोगा 568/District - Shimoga 568														
योग	402,139	286,129	51,269	48,446	5,148	175,434	3,609	1,605	129	489	116,010	8,178	107,832	Total
ग्रामीण	257,060	158,828	5,726	16,163	2,876	129,943	3,055	514	129	422	98,232	2,657	95,575	Rural
नगरीय	145,079	127,301	45,543	32,283	2,272	45,491	554	1,091	0	67	17,778	5,521	12,257	Urban
जिला - उडुपी 569/District - Udupi 569														
योग	246,313	214,808	8,371	174,881	1,675	29,540	94	99	0	148	31,505	1,300	30,205	Total
ग्रामीण	174,548	145,909	2,556	120,301	1,098	21,683	74	76	0	121	28,639	739	27,900	Rural
नगरीय	71,765	68,899	5,815	54,580	577	7,857	20	23	0	27	2,866	561	2,305	Urban
जिला - चिक्कमगलूरू 570/District - Chikmagalur 570														
योग	272,173	167,369	16,684	26,890	2,676	119,393	720	458	119	429	104,804	2,870	101,934	Total
ग्रामीण	215,334	116,556	4,053	17,601	2,283	91,508	610	124	119	258	98,778	2,256	96,522	Rural
नगरीय	56,839	50,813	12,631	9,289	393	27,885	110	334	0	171	6,026	614	5,412	Urban
जिला - तुमकूरू 571/District - Tumkur 571														
योग	636,394	206,821	45,563	38,787	7,078	108,261	1,630	3,805	325	1,372	429,573	9,165	420,408	Total
ग्रामीण	495,885	90,868	4,975	16,519	4,407	62,436	973	682	145	731	405,017	6,187	398,830	Rural
नगरीय	140,509	115,953	40,588	22,268	2,671	45,825	657	3,123	180	641	24,556	2,978	21,578	Urban

6. ನೀವು ಕಾರ್ಯನಿರ್ವಹಿಸುತ್ತಿರುವ ಜಾಗದಲ್ಲಿ ಆರೋಗ್ಯ ಸಂಬಂಧಿತ ತೊಂದರೆಗಳು

ಗಂಡಸರಿಗೆ	ಮಹಿಳೆಯರಿಗೆ	ಮಕ್ಕಳಿಗೆ (ಗಂಡು/ಹೆಣ್ಣು)	ಟಿಕೆ–ಟಿಪ್ಪಣಿ

7. ನಿಮ್ಮ ಕಾರ್ಯಕ್ಷೇತ್ರದಲ್ಲಿ ಸರಕಾರಿ ಆರೋಗ್ಯ ಕೇಂದ್ರವಿದೆಯೇ?

- ಸರಕಾರಿ ಆರೋಗ್ಯ ಕೇಂದ್ರ ಇಲ್ಲದೆ ಇದ್ದರೇ ನಿಮ್ಮ ಸಂಸ್ಥೆಯು ಕಾರ್ಯನಿರ್ವಹಿಸುತ್ತಿರುವ ಕಾರ್ಯಕ್ಷೇತ್ರದ ವಿವರ

ज ज-8: शौचालय की सुविधा के प्रकार की उपलब्धता के अनुसार परिवार
HH-8: HOUSEHOLDS BY AVAILABILITY OF TYPE OF LATRINE FACILITY

योग ग्रामीण नगरीय	परिवारों की कुल संख्या/ Total number of households	परिवारों की संख्या जिनके पास परिसर में शौचालय की सुविधा है/ Number of households having latrine facility within the premises	परिसर में शौचालय की सुविधा के प्रकार/Type of latrine facility within the premises								परिवारों की संख्या जिनके पास परिसर में शौचालय सुविधा नहीं है/ Number of households not having latrine facility within the premises	परिसर में शौचालय की सुविधा नहीं/ No latrine within premises		Total Rural Urban
			फ्लश/पोर फ्लश शौचालय किससे जुड़ा है/ Flush/pour flush latrine connected to			गड्ढा शौचालय/ Pit latrine		मल-मूत्र खुली नाली में बहाया जाता है/ Night soil disposed into open drain	सर्विस शौचालय/ Service Latrine			वैकल्पिक स्रोत/ Alternative source		
			पाइप सीवर प्रणाली/ Piped sewer system	सेप्टिक टैंक/ Septic tank	अन्य प्रणाली/ Other system	स्लैब के सहित/ हवादार उन्नत गड्ढा/ With slab/ ventilated improved pit	स्लैब रहित/ खुला गड्ढा/ Without slab/open pit		मल-मूत्र व्यक्ति द्वारा हटाया जाता है/ Night soil removed by human	मल-मूत्र हटाने के लिये जानवरों का उपयोग/ Night soil serviced by animal		सार्वजनिक शौचालय/ Public latrine	खुले में/ open	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	1
जिला - कोप्पल 560/District - Koppal 560														
योग	259,396	47,931	5,491	31,944	2,017	7,715	269	215	0	280	211,465	35,878	175,587	Total
ग्रामीण	213,217	25,565	2,814	14,105	1,658	6,465	167	117	0	239	187,652	25,448	162,204	Rural
नगरीय	46,179	22,366	2,677	17,839	359	1,250	102	98	0	41	23,813	10,430	13,383	Urban
जिला - गदग 561/District - Gadag 561														
योग	215,602	45,668	10,544	26,948	2,903	3,221	1,101	477	0	474	169,934	21,389	148,545	Total
ग्रामीण	137,799	12,732	2,687	6,107	1,551	1,727	242	137	0	281	125,067	7,801	117,266	Rural
नगरीय	77,803	32,936	7,857	20,841	1,352	1,494	859	340	0	193	44,867	13,588	31,279	Urban
जिला - धारवाड़ 562/District - Dharwad 562														
योग	372,054	212,091	137,804	55,403	4,680	10,653	2,033	734	173	611	159,963	13,024	146,939	Total
ग्रामीण	157,960	36,449	2,306	22,477	2,175	7,517	1,565	185	98	126	121,511	2,408	119,103	Rural
नगरीय	214,094	175,642	135,498	32,926	2,505	3,136	468	549	75	485	38,452	10,616	27,836	Urban
जिला - उत्तर कन्नड 563/District - Uttara Kannada 563														
योग	319,912	189,843	15,494	130,523	7,570	34,174	1,361	345	0	376	130,069	7,346	122,723	Total
ग्रामीण	226,803	114,752	5,748	73,188	5,317	28,935	1,128	149	0	287	112,051	2,561	109,490	Rural
नगरीय	93,109	75,091	9,746	57,335	2,253	5,239	233	196	0	89	18,018	4,785	13,233	Urban
जिला - हावेरी 564/District - Haveri 564														
योग	325,456	121,420	14,623	60,653	4,546	35,458	4,403	796	229	712	204,036	8,814	195,222	Total
ग्रामीण	254,181	71,774	3,960	31,317	3,490	30,113	1,981	299	218	396	182,407	4,430	177,977	Rural
नगरीय	71,275	49,646	10,663	29,336	1,056	5,345	2,422	497	11	316	21,629	4,384	17,245	Urban
जिला - बल्लारी 565/District - Bellary 565														
योग	481,704	156,110	84,313	25,567	4,135	37,368	904	2,227	11	1,585	325,594	53,650	271,944	Total
ग्रामीण	291,383	35,296	4,020	7,118	1,955	20,852	477	311	11	552	256,087	29,564	226,523	Rural
नगरीय	190,321	120,814	80,293	18,449	2,180	16,516	427	1,916	0	1,033	69,507	24,086	45,421	Urban

ज ज-8: शौचालय की सुविधा के प्रकार की उपलब्धता के अनुसार परिवार
HH-8: HOUSEHOLDS BY AVAILABILITY OF TYPE OF LATRINE FACILITY

योग ग्रामीण नगरीय	परिवारों की कुल संख्या/ Total number of households	परिवारों की संख्या जिनके पास परिसर में शौचालय की सुविधा है/ Number of households having latrine facility within the premises	परिसर में शौचालय की सुविधा के प्रकार/Type of latrine facility within the premises								परिवारों की संख्या जिनके पास परिसर में शौचालय सुविधा नहीं है/ Number of households not having latrine facility within the premises	परिसर में शौचालय की सुविधा नहीं/ No latrine within premises		Total Rural Urban
			फ्लश/पोर फ्लश शौचालय किससे जुड़ा है/ Flush/pour flush latrine connected to			गड्ढा शौचालय/ Pit latrine		मल-मूत्र खुली नाली में बहाया जाता है/ Night soil disposed into open drain	सर्विस शौचालय/ Service Latrine			वैकल्पिक स्रोत/ Alternative source		
			पाइप सीवर प्रणाली/ Piped sewer system	सेप्टिक टैंक/ Septic tank	अन्य प्रणाली/ Other system	स्लैब के सहित/ हवादार उन्नत गड्ढा/ With slab/ ventilated improved pit	स्लैब रहित/ खुला गड्ढा/ Without slab/open pit		मल-मूत्र व्यक्ति द्वारा हटाया जाता है/ Night soil removed by human	मल-मूत्र हटाने के लिये जानवरों का उपयोग/ Night soil serviced by animal		सार्वजनिक शौचालय/ Public latrine	खुले में/ open	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	1
राज्य - कर्नाटक 29/STATE - KARNATAKA 29														
योग	13,179,911	6,749,396	2,394,610	1,711,701	155,429	1,745,410	43,709	61,802	7,740	28,995	6,430,515	504,217	5,926,298	Total
ग्रामीण	7,864,196	2,234,534	160,870	805,618	90,803	1,127,230	25,245	9,328	2,052	13,388	5,629,662	272,968	5,356,694	Rural
नगरीय	5,315,715	4,514,862	2,833,740	906,083	64,626	618,180	18,464	52,474	5,688	15,607	800,853	231,249	569,604	Urban
जिला - बेलगांव 555/District - Belgaum 555														
योग	963,825	316,225	94,512	186,213	17,946	10,257	2,355	2,521	343	2,278	647,600	74,989	572,611	Total
ग्रामीण	708,069	131,009	11,322	93,036	14,149	8,242	1,510	958	204	1,588	577,060	42,997	534,063	Rural
नगरीय	255,756	185,216	82,990	93,177	3,797	2,015	845	1,563	139	690	70,540	31,992	38,548	Urban
जिला - बागलकोट 556/District - Bagalkot 556														
योग	355,337	166,813	25,744	32,981	3,376	3,021	228	398	167	898	288,564	35,618	252,946	Total
ग्रामीण	239,746	17,187	2,059	10,188	2,209	1,935	175	145	116	360	221,559	16,411	205,148	Rural
नगरीय	115,591	49,626	23,685	22,793	1,167	1,086	53	253	51	538	67,005	19,207	47,798	Urban
जिला - बिजापुर 557/District - Bijapur 557														
योग	495,076	73,300	42,428	22,692	4,381	2,069	271	349	109	1,001	331,776	34,408	297,368	Total
ग्रामीण	307,984	15,516	1,600	8,911	2,738	1,562	105	144	0	456	292,468	25,000	267,468	Rural
नगरीय	97,092	57,784	40,828	13,781	1,643	507	166	205	109	545	39,308	9,408	29,900	Urban
जिला - बीदर 558/District - Bidar 558														
योग	313,521	72,805	14,850	39,836	7,176	4,229	1,260	4,286	21	1,145	240,716	9,605	231,111	Total
ग्रामीण	237,380	20,983	2,952	10,723	3,877	2,083	567	352	0	429	216,397	7,033	209,364	Rural
नगरीय	76,141	51,822	11,898	29,115	3,299	2,146	693	3,934	21	716	24,319	2,572	21,747	Urban
जिला - रायचूर 559/District - Raichur 559														
योग	359,337	74,323	25,407	33,573	4,709	6,285	790	2,519	95	948	285,011	30,573	254,438	Total
ग्रामीण	264,274	26,397	3,485	13,363	3,235	5,134	449	262	32	437	237,877	17,951	219,926	Rural
नगरीय	95,063	47,929	21,922	20,210	1,474	1,151	341	2,257	63	511	47,134	12,622	34,512	Urban

DEV-3B

Plan for Delivery of Family Welfare Services in Slums (Bangalore City) - Based on The Need Assessment of Slum Dwellers (IPP-VIII)

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Bangalore is the fastest growing city of India with a total population of 41,08.013 (1991census). This unprecedented, unplanned growth has resulted in the growth of many slums and lack of basic civic amenities. Bangalore has organised urban health services provided by the net work of hospitals, health centres, maternity homes and dispensaries but these facilities are not available to lower section of the urban community for various reasons. Out-reach services of these institutions do not exist or are inadequate to meet the Primary Health Care needs of the slum dweller.

In the present proposal efforts are made to identify problems and to strengthen the delivery of family welfare/primary health care services to the urban poor. This is consistent with the objective of the national health policy which aims at taking the services nearer to the door steps of the people and ensuring full participation of the community in health development process. It is proposed to reorganise and strengthen the existing facilities as per the requirement. Strengthening of out reach services and involvement of community in taking care of its health needs are the main points of the present proposal.

Various strategies for improving the delivery of family welfare/primary health care services to urban poor could include the following :-

a) Development of effective out-reach services
b) Strengthening of infrastructural facilities
c) Involvement of Private Medical Practititioners and NGOs and
d) Intensive IEC (Information, Education & Communication) compaign.

A health centre will serve a population of 50,000. Family welfare and Primary health care services will be provided through link workers, domiciliary visits of ANM/LHV. To

back up the services, one out of every four health centres will be upgraded to have in-patient facilities with 25 beds. For this purpose, some of the exisiting maternity homes will be selected. The services will include :

1. Care of pregnant women including treatment of specific nutritional disorders.
2. Safe deliveries.
3. Post-natal care including care of new born.
4. Nutritional care upto the age of five.
5. Immunization against vaccine preventable diseases.
6. Advice, supplies and facilities for Family Welfare.
7. Health and nutrition education especially the need for breast feeding and weaning practices, immunisation, nutritious diet during pregnancy and lactation, etc.
8. Treatment of minor ailments of women and children.
9. Knowledge of vaccine preventable diseases and diarrhoeal diseases.
10. Detection of suspected cases of TB and Leprosy and their referral and follow-up.

SETTING UP OF NEW HEALTH CENTRES AND UP GRADED HEALTH CENTRES

It has been estimated on the basis of projected population i.e. 48.78 lakh by 1995, that 97 health centres and 24 upgraded health centres will be required. The break-up of health centres and upgraded health centres is as follows :

Status	Health Centre	Upgraded Health Centre
Required	97	24
Existing	37	30 Maternity Homes
Addl. requirement	60	24

- Strengthening in terms of staff, equipment, drugs and contingencies
- Strengthening in terms of staff, equipment, ambulance, drugs, staff quarters (only for 6 centres) and contingencies.

Strengthening of existing centres and setting up of new centre will be taken in phased manner as follows :-

Year	I	II	III	IV	V	Total
New centres (60)	20	15	10	8	7	60
Strengthening of 37 HCs	5	5	10	12	5	37
Strengthening of 24UHCs	6	5	5	5	3	24

Strengthening of exisiting HCs and UPHCs and setting up of new centres will be taken up from the periphery of the city.

ORGANIZATION CHART

COMMISSIONER/ADMINISTRATOR

HEALTH OFFICER

Additional Health Officer (FW & MCH)

Non-Government Organisations : Private Medical Practitioners

Administration and Monitoring Unit	Training Unit	I E C Unit
- Deputy Health Officer (FW & MCH) -Statistician - U D C	- Apex training team	- Extn. Education Officer - Extn. Educator - Driver cum projectionist

Upgraded Health Centre

Sr. Medical Officer	1
Gynecologist cum Resd. LMO	1
Paediatrician	1
Anaesthetist (Part time)	1
Staff Nurse	4
Clerk	2
Pharmacist cum store keeper	3
Lab. Technician	1
O.T. attendant	1
Statistical assistant	1
Peon	1
Sweeperess	3
Chowkidar	1
Driver	1

TASKS

- Out patient services
- Specialised MCH Care
- Conduction of Normal and high risk deliveries
- MTP
- Sterilization
- Inpatient care of Gynae/Obs. cases
- Laboratory services
- Referrals
- Supervision of Health centres

Health Centre (HC) HC HC HC

Lady Medical Officer	1
LHV/PHN	2
ANM/Health worker (Female)	7
Health worker (Male)	1
Computer cum clerk	1
Peon	1
Sweeper cum chowkidar	1
Dias (link worker)	10

TASKS

- Treatment of common ailments of mother and children including diarrhoes (mild dehydration)
- Ante Natal, Natal and Post Natal care
- Immunization
- Vit. A for prevention of blindness
- ORS for diarrhoea
- Supplementary Nutrition
- Family Planning
  - IUD insertion, Condom and Oral pill distribution
- Urine (Albumin & sugar) and Blood Esamination
- Referral for Sterilization, High risk & completed cases to upgraded Health centre and other Hospitals
- Surveillance of vaccine preventable diseases & Diarrhoea.

It is suggested to introduce various records and reports at various levels, right from the field staff, HC, and UPHC, to monitoring unit. So the information can flow both ways i.e. from field staff to the decision maker and vice versa.

Training is an important component of the proposal. Its major objects is to instal an out-reach/extension bias in the health functionaries. Training will be carried out a different levels for different categories of Health workers.

TRAINING PLANT

Catergories	Venue of Training	Trainers	Duration	Training Needs	Training Methodology
1. Apex training team	National Institute of Health and Family Welfare Services, NEW DELHI.	Faculty from NIHAFWS	3 working days	a) Emerging Urban Health needs and problems of slums. b) Project Strategy for delivery of Family Welfare Services. c) Communication Technology d) Planning and organisation of training programmes and management techniques.	Lectures/discussions and group discussions
2. Sr. Medical Officers, specialists, Gynaecologist Paedatrician	H.F.W.I.C.	Faculty from H.F.W.I.C.	2 working days	a) Motivational technology with special reference to Family Welfare. b) Inter personal communications.	Lecturer/discussions Demonstration and Field training
3. Extension Educator	H.F.W.I.C.	Faculty from H.F.W.I.C.	4 days	a) Planning, organisation and evaluation of training communication techniques in health and family welfare, production and testing of training & communication materials. b) Extension techniques, planning, organisation and testing of training/ communication centres.	Lecture/discussions group discussions and field training.
4. LMOs, PHNs, LHVs	H.F.W.I.C.	Faculty/ H.Officers SMOs, Extension education officer	5 Days	a) Problems of Urban Primary Health Care, new b) Use of communication strategy in training c) Awareness creation, motivational technology. d) Management techniques e) Clinical update f) Monitoring and Supervision	Lecture/workshop, group discussions and field experience.
5. Health worker	Health centre	SMO/MO Extension Educator	5 Days	a) Update in prevention and promotive health care b) Antenatal checkups, deliveries Postnatal check-ups. c) Identification of high risk	Lecture/workshop field experience and practical training/ demonstration

Catergories	Venue of Training	Trainers	Duration	Training Needs	Training Methodology
				mothers. d) Care of new born & infants e) Motivational techniques person to person communication f) Maintenance of various records and reports.	
6. Link workers (Dai)	Health Centre	PHN-LHV, ANM Extension Educators	30 Days	a) Contacting community for awareness creating. b) Motivating women particularly pregnant women. c) Update on delivery method, aseptic delivery, care of pregnant women, postnatal care, care of infants and care of minor ailments in the community.	Lectures/group discussion Demonstration. Roleplay Field observation and real situation.
7. Private practitioners, NGOs and Karnataka Slum Clearance Board(KSCB) workers.	Health Office	Health Officer consisted by extension educators	1 Day orientation /seminar.	a) Orientation to innovation approach/extension approach.	Lecture, individual presentations and discussions
8. Angawadi worker	Health centre	LHV/PHN Extension Educator	1 Day orientation	a) Contacting community for awareness creating. b) Motivating women particularly pregnant women for ANC and T.T. Immunization.	Lecture/Role play.

A survey conducted in slums of Bangalore revealed that 85% of population is availing the services of Private Medical Practitioners (PMPs). It is because of fact that they are in large number and have high level of local acceptance and respect, particularly in slum areas. So, the success of implementation of the programme of strengthening of family welfare services in urban areas will also depend largely on the involvement of PMPs and NGOs providing these services.

During the interviews with PMPs, all PMPs expressed their willingness to participate in the Government Health programme. So, it is proposed in the plan to identify the PMPs and NGOs and involve them in the following activities :-

PLAN FOR INVOLVEMENT

Area	Institution	Task	Supplies (free)	Records	Report To
Immunization (free)	Nursing Homes Polyclinics clinics/ dispensaries	Immunization of eligible children attending institution	Vaccines Cold chain equipment	List of Immunised children doese wise Mothers TT	UFWC/ area ANM
Family Planning	Nursing homes Poly clinic clinic/ Dispensaries	F P services including MTP(only) Nursing homes)	IUCDs Oral Pills Condoms	Appro-priate register of services done	Area UFWC/ ANM
MCH-ANC. Natal PNC	Nursing homes Poly Clinic Clinic. Dispensaries	Motivation for regis-tration & referral to appropriate institution	Iron and Folic acid and TT	Appropriate register of work done	Area UFWC ANM
ORT	Nursing homes Poly clinics clinics/ dispensaries	Assessment of degree of dehydra tion and treatment	ORS Pkts	Appropriate register of work done	Area UFWC/ ANM
Health Education	do	Motivation & advice on Preven-tive Measures	Leaflets Posters etc.	.....	.....

To strengthen the communication support of training activities and inter-personnel communication for attitudinal changes it is proposed to establish one IEC unit. This unit will beresponsible for planning and organisation of Health education activities in the city and coordinate with ANM/LHV and male worker in the conduction of health education activities..