A Compendium on Health of Urban Poor in South East Asia

Abstract of select Papers and Reports

Urban Health Resource Center, New Delhi
List of Publications


HEALTH AND LIVING CONDITIONS IN EIGHT INDIAN CITIES
Kamla Gupta, Fred Arnold, H. Lhungdim: August 2009

ABSTRACT
This report analyzes health and living conditions in eight large Indian cities (Chennai, Delhi, Hyderabad, Indore, Kolkata, Meerut, Mumbai, and Nagpur). The report is based on data from India's 2005-06 National Family Health Survey (NFHS-3). A special feature of NFHS-3 is that the sample was designed to allow separate estimates of population, health, and nutrition indicators to be generated for each of these eight cities, as well as for the residents of slum and non-slum areas in these cities. In addition, a wealth index was constructed for households in urban India as a whole, using NFHS-3 data on household assets and housing characteristics. For the purposes of this report, the urban poor population is defined as those persons belonging to the lowest quartile on this wealth index.

The study examines the living environment, socioeconomic characteristics of households and the population, children's living arrangements, children's work, the health and nutrition of children and adults, fertility and family planning, utilization of maternal health services, knowledge of HIV/AIDS, attitudes of adults toward schools providing family life education for children, and other important aspects of urban life for the eight cities by slum/non-slum residence and for the urban poor.

The analysis shows that more than half of the population in Mumbai lives in slums, whereas the slum population varies widely in the other seven cities. Major differences in the estimation of the size of the slum population are found depending on how slum areas are defined (according to the 2001 Census designation or observation of the area by the NFHS-3 team supervisor at the time of the fieldwork). The poor population in these cities varies within a narrower range, from 7 percent in Mumbai to 20 percent in Nagpur. The analysis finds that a substantial proportion of the poor population does not live in slums and that a substantial proportion of slum dwellers are not poor (that is, they do not fall into the bottom quartile on the NFHS-3 wealth index). In some cities, the poor are mostly concentrated in slum areas, whereas the reverse is true in other cities.

Although slum dwellers are generally worse off than non-slum dwellers, this pattern is not consistently true for all indicators in every city, and the differentials are quite small in some cases. However, there are large disparities in health and living conditions between the poor and the non-poor in these cities. Although there is an obvious need to improve living conditions and the health of slum dwellers, it is equally apparent that programs that focus solely on slum areas will not be able to address the urgent needs of the large poor population not living in slums.
2. **Home delivery and newborn care practices among urban women in western Nepal: a questionnaire survey**

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**Abstract**

**Background**

About 98% of newborn deaths occur in developing countries, where most newborns deaths occur at home. In Nepal, approximately, 90% of deliveries take place at home. Information about reasons for delivering at home and newborn care practices in urban areas of Nepal is lacking and such information will be useful for policy makers.

**Methods**

A cross-sectional survey was carried out in the immunisation clinics of Pokhara city, western Nepal during January and February, 2006. Two trained health workers administered a semi-structured questionnaire to the mothers who had delivered at home.

**Results**

A total of 240 mothers were interviewed. Planned home deliveries were 140 (58.3%) and 100 (41.7%) were unplanned. Only 6.2% of deliveries had a skilled birth attendant present and 38 (15.8%) mothers gave birth alone. Only 46 (16.2%) women had used a clean home delivery kit and only 92 (38.3%) birth attendants had washed their hands. The umbilical cord was cut after expulsion of placenta in 154 (64.2%) deliveries and cord was cut using a new/boiled blade in 217 (90.4%) deliveries. Mustard oil was applied to the umbilical cord in 53 (22.1%) deliveries. Birth place was heated throughout the delivery in 88 (64.2%) deliveries. Only 100 (45.8%) newborns were wrapped within 10 minutes and 233 (97.1%) were wrapped within 30 minutes. Majority (93.8%) of the newborns were given a bath soon after birth. Mustard oil massage of the newborns was a common practice (144, 60%). Sixteen (10.8%) mothers did not feed colostrum to their babies. Prelactal feeds were given to 37(15.2%) newborns. Initiation rates of breast-feeding were 57.9% within one hour and 85.4% within 24 hours. Main reasons cited for delivering at home were 'preference' (25.7%), 'ease and convenience' (21.4%) for planned deliveries while 'precipitate labor' (51%), 'lack of transportation' (18%) and 'lack of escort' during labor (11%) were cited for the unplanned ones.

**Conclusion**

High-risk home delivery and newborn care practices are common in urban population also. In-depth qualitative studies are needed to explore the reasons for delivering at home. Community-based interventions are required to improve the number of families engaging a skilled attendant and hygiene during delivery. The high-risk traditional newborn care practices like delayed wrapping, bathing, mustard oil massage, prelacteal feeding and discarding colostrum need to be addressed by culturally acceptable community-based health education programmes.
3. Newborn care practices in urban slums: Evidence from central India

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Abstract

One-third of India's urban population resides in slums and squatters, in extreme poverty conditions. Newborn care is sub-optimal among India's urban poor, yet scarcely documented. We assessed newborn care practices in 11 urban slums of Indore in Central India. Practices such as clean cord care, thermal care, timely initiation of breastfeeding and exclusive breastfeeding upto neonatal period were enquired from 312 mothers of infants aged 2–4 months. Correlates of these practices were identified using multiple logistic regression. 72.1% births were home births (slum-home: 56.4%, native-village home: 15.7%). Slum-based traditional birth attendants (sTBAs) conducted 77.3% slum-home births. Skilled assistance during slum-home births was low (7.4%). Clean cord care (22.2%) and thermal care (10.2%) practices were also low. Trained or skilled assistance during slum-home births was positively associated with clean cord care (OR 4.8 CI 1.7–13.6) and thermal care (OR 2.0 CI: 1.1–4.1). Timely initiation of breastfeeding was sub-optimal (50.6%) even in facility births. Exclusive breastfeeding upto neonatal period was higher for mothers counselled on exclusive breastfeeding by a health volunteer during neonatal period (OR 2.3, CI 1.4–3.8). Following emerge imperative for improving newborn care in urban slums- i) antenatal and postnatal counselling by trained health volunteers, ii) enhancing competence of sTBAs and linking them to affordable facilities and iii) sensitizing and training public health facility staff.

Keywords
Slums, urban poor, newborn care, logistic regression

4. Newborn Care Practices Regarding Thermal Protection Among Slum Dwellers in Rachna Town, Lahore, Punjab

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Abstract

The period after birth is often marked by cultural practices. Some of these hinder health and survival of newborn, like bathing the baby immediately after birth. Understanding their beliefs and practices is an important part of ensuring effective timely care. This paper describes newborn care practices in urban slum “Rachna Town”.

Keywords

Method: A quantitative baseline survey was conducted in Rachna Town among women who delivered within last year (n = 168) in depth semi structured focal group discussions well also carried out to in depth understand these Practices.

Results: Majority of women delivered at home (98%). 37.2% women gave bath to baby immediately, 77.8% within 6 hours, while 18.3% within 7 – 24 hours and 4.2% after 24 hours. Only 18.8% babies were wrapped immediately before placenta was delivered while 71.5% of them were wrapped after delivery of placenta.

Conclusion: Poor new born practices are seen in Rachna town, an urban Slum of Lahore. Interventional program should be started in these slums in the heart of Punjab.

5. Strengthening functional community provider linkages: Lessons from the Indore urban health programme
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Abstract
Weak linkages between health providers and slum communities hinder the improvement of health services for India’s urban poor. To address this issue, an urban health programme is implementing two approaches in Indore city, Madhya Pradesh, the demand_supply linkage approach and ward coordination approach. The former is based on the premise that building social capital, i.e. norms and networks within a community facilitating collective action, helps improve the demand and supply of health services for the urban poor. The latter focuses on encouraging local stakeholders to function in a coordinated manner to ensure better health service coverage in underserved slum areas.

Findings suggest that the programme has enhanced utilization of services among Indore’s slum communities and helped improve immunization coverage and other maternal and child health indicators.

Keywords: Vulnerability assessment, social capital, demand_supply linkage approach, ward coordination approach, community-based organization, cluster coordination team

6. Prospective study of determinants and costs of home births in Mumbai slums
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Abstract

Background
Around 86% of births in Mumbai, India, occur in healthcare institutions, but this aggregate figure hides substantial variation and little is known about urban home births. We aimed to
explore factors influencing the choice of home delivery, care practices and costs, and to identify characteristics of women, households and the environment which might increase the likelihood of home birth.

Methods
As part of the City Initiative for Newborn Health, we used a key informant surveillance system to identify births prospectively in 48 slum communities in six wards of Mumbai, covering a population of 280 000. Births and outcomes were documented prospectively by local women and mothers were interviewed in detail at six weeks after delivery. We examined the prevalence of home births and their associations with potential determinants using regression models.

Results
We described 1708 (16%) home deliveries among 10 754 births over two years, 2005-2007. The proportion varied from 6% to 24%, depending on area. The most commonly cited reasons for home birth were custom and lack of time to reach a healthcare facility during labour. Seventy percent of home deliveries were assisted by a traditional birth attendant (dai), and 6% by skilled health personnel. The median cost of a home delivery was US$ 21, of institutional delivery in the public sector US$ 32, and in the private sector US$ 118. In an adjusted multivariable regression model, the odds of home delivery increased with illiteracy, parity, socioeconomic poverty, poorer housing, lack of water supply, population transience, and hazardous location.

Conclusions
We estimate 32 000 annual home births to residents of Mumbai’s slums. These are unevenly distributed and cluster with other markers of vulnerability. Since cost does not appear to be a dominant disincentive to institutional delivery, efforts are needed to improve the client experience at public sector institutions. It might also be productive to concentrate on intensive outreach in vulnerable areas by community-based health workers, who could play a greater part in helping women plan their deliveries and making sure that they get help in time.

7. Newborn care practices among slum dwellers in Dhaka, Bangladesh: a quantitative and qualitative exploratory study
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Abstract

Background
Urbanization is occurring at a rapid pace, especially in low-income countries. Dhaka, Bangladesh, is estimated to grow to 50 million by 2015, with 21 million living in urban slums. Although health services are available, neonatal mortality is higher in slum areas than in urban non-slum areas. The Manoshi program works to improve maternal, newborn, and child health in urban slums in Bangladesh. This paper describes newborn care practices in urban slums in Dhaka and provides program recommendations.

**Methods**
A quantitative baseline survey was conducted in six urban slum areas to measure newborn care practices among recently delivered women (n = 1,256). Thirty-six in-depth semi-structured interviews were conducted to explore newborn care practices among currently pregnant women (n = 18) and women who had at least one delivery (n = 18).

**Results**
In the baseline survey, the majority of women gave birth at home (84%). Most women reported having knowledge about drying the baby (64%), wrapping the baby after birth (59%), and cord care (46%). In the in-depth interviews, almost all women reported using sterilized instruments to cut the cord. Babies are typically bathed soon after birth to purify them from the birth process. There was extensive care given to the umbilical cord including massage and/or applying substances, as well as a variety of practices to keep the baby warm. Exclusive breastfeeding was rare; most women reported first giving their babies sweet water, honey and/or other foods.

**Conclusion**
These reported newborn care practices are similar to those in rural areas of Bangladesh and to urban and rural areas in the South Asia region. There are several program implications. Educational messages to promote providing newborn care immediately after birth, using sterile thread, delaying bathing, and ensuring dry cord care and exclusive breastfeeding are needed. Programs in urban slum areas should also consider interventions to improve social support for women, especially first time mothers. These interventions may improve newborn survival and help achieve MDG4.

8. *Bangladesh Health Care Centers Offer Urban Poor More than Medicine*, ADB Media

**Abstract**

DHAKA, BANGLADESH (23 October 2002) - At the Dolaipar primary health care center (PHC) in Dhaka, 23-year-old Munni Begum waits to have her dressing changed. Her second baby was born at the PHC 9 days earlier by Caesarian section. Her home is 2 hours away by bus, but her brother and sister live in a slum only 1 kilometer away from the Dolaipar PHC. She moved to their house toward the end of her pregnancy so that she could have her second child at the PHC. "I suffered during my first delivery, even though that was not a Caesarian," the woman says with a shudder. "There were so many complications." She decided not to take any chances with the second delivery. "Here, I felt much safer," she says of the PHC. And for good reason. Bangladesh has high maternal and infant mortality rates: 390 mothers died per every 100,000
live births in 1996-2000, and 54 babies died per every 1,000 live births in 2000, according to
ADB’s Key Indicators 2002. "More and more women are coming to the center now for
deliveries," says Dr. Humayra Begum, manager of the PHC. Apart from safe deliveries and
antenatal and postnatal care, the PHC’s 20-bed comprehensive reproductive health care center
also provides advice on hygiene, nutrition, and health care for the mother and child. The
Bangladesh Women’s Health Coalition (BWHC) runs this PHC with financial support from ADB.
BWHC, one of 14 partner nongovernment organizations (NGOs) that runs such PHCs, takes
charge of the doctors, counselors, and other health workers. The Nordic Development Fund
and the United Nations Population Fund have provided equipment for the center. This is one of
105 PHCs that ADB supports in the country’s most populous cities of Chittagong, Dhaka, Khulna,
and Rajshahi. Between them, the PHCs serve about 5.3 million people-most of them poor. The

**Urban Primary Health Care Project**, supported by a US$40 million loan from ADB, is
implemented through partnership agreements with 14 NGOs and the Chittagong City
Corporation. The project covers 60 PHCs in the capital, Dhaka. In the PHC in Dhaka's Arambagh-
Mirpur area, Rani Begum describes her 3-year-old son's symptoms to the paramedic who
registers new cases. Little Ismail has had a nagging cough for about a year now, explains his
visibly worried mother. Ismail has also been losing weight. "I took him to a private doctor, who
treated him for asthma," says Rani. She spent 1,040 taka (US$18 at 57 taka to US$1) on the
treatment. "But there was no improvement," she says. Three months ago, as Ismail's condition
worsened, Rani gave up her job to care for him. She had worked in a garments factory since the
age of 10 to supplement the family income. Rani married at 13 and became a mother when she
was not quite 17. She is hopeful the PHC doctor will be able to treat Ismail's problem. The
treatment will also cost less than that dispensed by a private doctor. "Here, we charge a one-
time Tk10 registration fee and the doctor’s fee is only Tk20 per visit," says Dr. Afrosa Sultana,
manager of the PHC, which is run by an NGO called the Pragati Samaj Kallan Pratishtha.
Medicines are provided at half their market value. "I heard about the PHC from a health worker
at the satellite clinic," says Rani. Every PHC supported by ADB under the project has between
three and six satellite clinics. These are weekly outreach clinics run by health workers in slums
and other poor communities. They provide first aid, health education, and referral to the PHC.
The medical professionals at the PHCs and satellite clinics provide both preventive and curative
medicine. They also advise, counsel, and educate clients. "For example, if someone comes to
us with a skin infection, we provide treatment, and we also provide advice on good hygiene
practices," explains Dr. Afrosa Sultana. Similarly, when the doctors and health workers see a
mалnourished mother or child, they counsel the mother about dietary habits. PHC staff
members advise on family planning, an important issue in a country with one of the highest
population densities in the world. They also counsel women who are victims of domestic
violence. The majority of patients at the PHCs are women and children. Common problems
among children include diarrhea, usually a result of drinking contaminated water, and acute
respiratory tract infections, prevalent in urban slums because of poor ventilation and
inadequate sanitation facilities. Women most often come to the centers for deliveries, and
antenatal and postnatal care. The project helps fill a gap in the country's health sector, which
has traditionally focused on reaching the rural poor rather than the urban poor. Yet in recent
years, it is the urban poor who have had the worst health problems. The Urban Primary Health
Care Project is helping prevent and cure illnesses, and reduce preventable deaths, especially among women and children.

9. All slums are not equal: child health conditions among the urban poor.

Agarwal S, Taneja S; Indian Paediatrics

Abstract

Increasing urbanization has resulted in a faster growth of slum population. Various agencies, especially those in developing countries are finding it difficult to respond to this situation effectively. Disparities among slums exist owing to various factors. This has led to varying degrees of health burden on the slum children. Child health conditions in slums with inadequate services are worse in comparison to relatively better served slums. Identification, mapping and assessment of all slums is important for locating the hitherto missed out slums and focusing on the neediest slums. In view of the differential vulnerabilities across slums, an urban child health program should build context appropriate and community-need-responsive approaches to improve children's health in the slums.


Abstract

Health and Human rights has explicit intrinsic connections and has emerged as powerful concepts within the rights based approach especially so in the backdrop of weakening public health system, unregulated growth of the private sector and restricted access to healthcare systems leading to a near-total eclipse of availability and accessibility of universal and comprehensive healthcare. A rights-based approach to health uses International Human Rights treaties and norms to hold governments accountable for their obligations under the treaties. It recognises the fact that the right to health is a fundamental right of every human being and it implies the enjoyment of the highest attainable standard of health and that it is one of the fundamental rights of every human being and that governments have a responsibility for the health of their people which can be fulfilled only through the provision of adequate health and social measures. It gets integrated into research, advocacy strategies and tools, including monitoring; community education and mobilisation; litigation and policy formulation. Right to the highest attainable standard is encapsulated in Article 12 of the International Covenant on Economic, Social and Cultural Rights. It covers the underlying preconditions necessary for health and also the provisions of medical care. The critical component within the right to health philosophy is its realisation. This paper addresses the issue of migration and its public health implications within the human rights framework. Disaggregated information on the types of migrants in India, their magnitude and their vulnerabilities impacting their health and access to healthcare has been presented. The migrants are vulnerable at the source, throughout the migratory process and at the destination areas. The degree of vulnerability of migrants in India is different in different situations and so are the challenges that migration poses for health policy-makers. Understanding migration through a human rights framework helps explain the
health needs of migrants in the context of the current migration patterns. CEHAT’s main objective of the project, Establishing Health as a Human Right is to propel within the civil society and the public domain, the movement towards realisation of the right to healthcare as a fundamental right through research and documentation, advocacy, lobbying, campaigns, awareness and education activities.

11. Bangladesh Child Survival: Municipal Health Partnership Program (MHPP), Concern Worldwide

Abstract
“This is one of the best programs that I have ever seen in my 25 years of experience,” stated Dr. David Pyle, a senior public health specialist and lead evaluator of the Bangladesh Municipal Health Program. In the first phase of the program, Concern reached a total population of 210,000 people including 73,613 women of reproductive age and children under the age of five with interventions targeting the major direct causes of mortality: measles, malnutrition, diarrhea, pneumonia, and poor maternal and newborn care.

Four key strategies guide the overall program approach:
1) Foster learning and networking across and within municipalities
2) Strengthen partnership and technical capacity between the municipality health departments and private, government and NGO service providers
3) Build more effective management capacity of the municipal authorities
4) Improve community-led health promotion emphasizing male involvement, participation, and social support for income poor households.

12. Shack/Slum Dwellers International: One experience of the contribution of membership organizations to pro-poor urban development

Celine d’Cruz (SPARC and SDI) and Diana Mitlin (IIED and IDPM, University of Manchester)

Abstract
This paper considers the experience of the membership organizations that make up the international network of Shack or Slum Dwellers International (SDI), an international network of national urban poor Federations and their support NGOs. Each federation is made up of local community organizations that are savings schemes (in which women are a majority of participants). These Federations often have a city, regional and national identity. Since its inception in 1996, the international network has grown to be active in ten countries (Asia:

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1 This international network known as Slum or Shack Dwellers International by its grassroots members in Asia and Africa respectively reflecting the identities with which the urban poor are comfortable.
Cambodia, India, Nepal, the Philippines, Sri Lanka; Africa: Kenya, Namibia, South Africa, Uganda, Zimbabwe). SDI also supports emerging federations in Brazil, Ghana, Indonesia, Malawi, Swaziland and Zambia. Through an analysis of the experiences of the SDI members, we will identify some successful strategies with regard to the contribution of membership organizations to poverty reduction in urban areas.

Prior to commencing this discussion it is important to elaborate on the meaning of membership organizations in the context of SDI.

These groups of the urban poor who join together to achieve some common goal in residentially based collectives have a recognised identity that involve individuals in joint activities within a common governance framework. SDI specifically seeks to strengthen local groups that address the collective needs of urban poor communities in ways that are inclusive of the poorest residents. “Membership” in the savings schemes is defined by participation in local community activities. There is a deliberate effort to avoid formalisation; this advantages the more articulate, literate and higher-income residents who are more familiar with the formal world. Hence membership is defined by consistent participation in savings and in other community activities.

13. Urban Health and Care-Seeking Behavior: A Case Study of Slums in India and the Philippines

Abstract
This report examines the health needs and care-seeking behavior of poor slum residents in two Asian cities – Indore, India and greater Manila, Philippines. The centerpiece of the study is a qualitative investigation set in four slums in Indore and two slums in greater Manila, where in-depth interviews of slum residents and health care providers were carried out. To supplement the qualitative analysis with quantitative background and context, we also conducted an analysis of the urban data from two recent Demographic and Health Surveys (DHS) for India and the Philippines and assembled a comprehensive portrait of poverty and health from these sources. The topics covered in the research include general health-seeking behavior and self-efficacy, family planning, maternal health, child health, tuberculosis, domestic violence and alcohol abuse, and environmental health and hygiene. Findings from the DHS analysis show that the urban poor are particularly disadvantaged as compared to their non-poor counterparts (poverty is defined using a living standards index). For example, we find that in urban India, 30% of very poor women have an unmet need for contraception compared with 17% of non-poor women. In the urban Philippines, unmet needs for birth spacing and limiting are also more prevalent among the poor – more than 30% for the poor compared with 21% for the non-poor. Poor urban women are much more likely than the non-poor to give birth at home – in urban India 63% of the very poor give birth at home compared with 24% of the non-poor; in urban

The introductory note for this conference identified political parties, trade unions and cooperatives as membership organizations that may not be associated with furthering the interests of the poor.
Philippines, 78% of the very poor give birth at home compared with 35% of the non-poor. Child mortality rates for the very poor are more than double those of the non-poor – 122 per 1000 children for the very poor compared with 50 per 1000 children for the non-poor in urban India; 47 per 1000 children for the very poor compared with 23 per 1000 children for the non-poor in urban Philippines. Findings from the qualitative interviews shed light on the reasons for these dismal health conditions among the urban poor and help explain much about their health-seeking behavior. The dependence of the urban poor on cash is a key issue – in the highly monetized urban health system, the poor lack access to health care because they lack the means to pay for it. Health care providers understand this reality and have seen that it can result in delayed or no treatment and the inability of the poor to purchase medicines and adhere to treatment schedules. Providers also share their frustration about how to convey basic health information to poor patients. The poor have great difficulty in comprehending the nature of their illness and understanding their course of treatment. We find that outpatient care is primarily sought in the private sector in Indore and in the public sector in greater Manila. In Indore, quality of care and distance to a facility are among the reasons for seeking private care. In greater Manila, the cost of private care is the main reason given for seeking public care. Immunization and family planning services are sought in the public sector in both cities because they are provided free of money cost on scheduled and predictable days. Slum women express a strong preference for giving birth at home, in a comfortable and reassuring environment. In both cities, we were told of the impersonality of hospital settings and of the brusque and insensitive treatment women believe they will receive at the hands of the staff. Our interviews also suggest that arrangements for subsidies for urban poor are unsystematic and, depending on circumstance, might or might not succeed in providing the poor with subsidized services and medicines. The report includes a discussion of these and other findings, with many direct quotes from slum residents and providers. It concludes with several recommendations on interventions targeting the urban poor.


Abstract
This report examines the decentralization experience of three East Asian countries from the perspective of how well they have addressed the special features and requirements of the health sector. These features include the substantial role of externalities, the high degree of specialization, the critical role of quality and timeliness, and the high level of knowledge required to participate in the health care system at all levels. These characteristics have important implications for the design of health policy in general, and especially for a decentralized system of service delivery and sector management. This chapter outlines the decentralization health policies and programs of Indonesia, the Philippines, and Vietnam,
focusing on the period 1985–2003, spanning the years before and after significant decentralization began in these countries. The report also points to areas where reforms may facilitate more effective health care delivery.

15. Urban Program: Healthy Start Project, Mercy Corp

Abstract

Healthy Start Project aims to develop a model of sustainable and effective breastfeeding protection and promotion program that is replicable throughout Indonesia. This will be achieved by:
1. Improving the knowledge, skills, attitude and practices regarding early and exclusive breastfeeding among public and private health care providers; including households and communities.
2. Create/strengthen/implement policies that support and protect early and exclusive breastfeeding practices.

At the health care provider’s level, Mercy Corps facilitates breastfeeding management and counseling trainings for midwives, as well as building the capacity of government partners and the Indonesian Midwives Association to implement comprehensive and sustainable breastfeeding protection and promotion programs.

At the household and community level, Mercy Corps facilitates the creation of community-sustained mother support groups where clusters of pregnant and nursing women gather to discuss breastfeeding and mutually support one another. Mercy Corps also facilitates communication campaigns and events to build greater support for early and exclusive breastfeeding practices from various elements of the communities.


Authors: Rifkin, S. B.

Abstract

In the past decade, community participation has become increasingly recognized as an important element in improving health, particularly among poor, rural and underserved populations in developing countries. The book reviews a wide range of experiences in maternal, child health and family planning programmes in an effort to identify factors and conditions that encourage effective community participation. Addressing health planners, it concentrates on questions of management and human behaviour that need to be considered when planning
health programmes based on the concept or methods of community participation. Numerous case studies from predominantly rural areas are used to develop an analytical framework for understanding why such programmes so often fail to reach their goals. The first chapter provides a brief history of community participation in health care; the second discusses the various interpretations of community participation; the third and most extensive chapter develops the analytical framework, describing programmes on the basis of their objectives and the ways in which those objectives are pursued. Five different levels of participation are identified. It is suggested that the progress and success of a programme are governed by descriptive factors which are mainly of an environmental nature, and action factors, which refer to organization, management and resource mobilization. The final chapter draws conclusions about the questions that will need to be tackled by planners and agencies.

17. Building Public Sector - NGO Partnerships for Urban RCH Services

Author(s): Agarwal, S

Abstract
The quest for better livelihood opportunities has led to large-scale migration and the mushrooming of slums in several Indian cities. Unfortunately, a significant section of the urban poor do not have access to many of the benefits of urban development. Much of the challenge of delivering services to the marginalized groups lies in identifying them and effectively approaching them, so that limited resources are utilized well and programs address real needs1. There is a presence of the public sector as well as NGOs in urban areas. The growing requirement for health services for the urban poor, owing to rapid urban population growth, necessitates thinking about the collaborative approach of the public and Non profit sector for health services in urban areas.