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# Improving Urban Health A Programme for Action

Division of Strengthening of Health Services  
World Health Organization, Geneva, 1988



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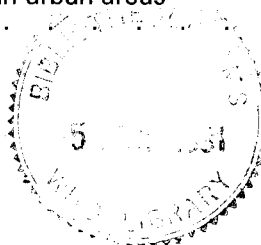
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# GLOBAL PROGRAMME STATEMENT FOR IMPROVING URBAN HEALTH SERVICES

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## ***The Background***

The policy of Primary Health Care (PHC) accepted by the Member States of the World Health Organization at Alma-Ata in 1978 was conceived to address the problems of those to whom health care was unaffordable, inaccessible and, in its present form, unacceptable. As the majority of these people lived at that time in rural areas, the focus of effort began there. However, it was shortly recognized that similar problems existed among those who lived in the slums and squatter areas of the burgeoning cities of both developed and developing countries. As a result, a short time after signing the Alma-Ata Declaration, the originators of this policy, the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) convened a series of meetings to define and explore the health needs of the urban poor.

These meetings brought together a variety of people including health officials, a range of municipal authorities and nongovernmental organizations (NGOs) to review problems and propose possible solutions for the rapidly growing population of low-income people who lived mainly in the cities of developing countries. Not only did these gatherings provide fertile ground for exchange of ideas and experiences, they also stimulated others to undertake activities to address the health problems of the urban poor. The meetings began to build a network of those involved in urban primary health care to provide exchange of information, as well as to build support for an increasingly demanding area of health improvement which, by its nature, must involve governments and the people they serve.

WHO, with other United Nations agencies, national governments and NGOs, recognizes the health plight of the urban poor as a continuing and critical concern. As a result, it has produced this document to review the situation, to provide the rationale for concerted efforts, to define strategies and to highlight areas of action for the future. In conclusion, this document outlines the direction of WHO support for urban primary health care.

## ***The Situation***

To justify concern for the health of urban populations, it is only necessary to review recent United Nations statistics. In 1920, only 14 per cent of the world's population lived in cities. In 1985, 41 per cent were urban dwellers. By the year 2010, more than 50 per cent are projected to be urban inhabitants. In the more developed countries of the world, over half of the population has been living in urban areas since the middle of this century. In the less developed countries, this level of urbanization is expected to occur in the last decade of this century and the first decade of the next century.

Statistics on urbanization point to some important trends. Firstly, urbanization no longer affects only a minority of people. A majority are now touched by its influence. Secondly, urbanization is not only a problem for the industrialized world but also is, and will continue to be, a major demographic feature

TABLE 1. URBAN POPULATION, TOTAL INCREASE IN POPULATION, AND PERCENTAGE INCREASE, 1975-2000

<i>Major areas of less-developed regions</i>	<i>Total urban population in millions</i>		<i>Total population increase 1975-2000</i>	<i>% increase 1975-2000</i>
	<i>1975</i>	<i>2000</i>		
Less-developed regions	838.4	2122.1	1283.7	253
Northern Africa	38.2	109.8	71.6	287
Sub-Saharan Africa	66.0	251.9	185.9	382
Latin America	198.1	428.1	230.0	216
China	218.0	491.9	273.9	226
Other East Asia	30.6	64.6	34.0	211
Eastern South Asia	68.8	179.8	111.0	261
Middle South Asia	175.9	477.9	302.0	272
Western South Asia	21.2	64.0	42.8	302
Melanesia-Micronesia-Polynesia	1.1	4.5	3.4	409

Source: United Nations Population Division's projections based on 1980 estimates (computer print-out).

of the developing world. Thirdly, urbanization is no longer confined only to capital cities. It has also spread to other cities. Fourthly, urbanization is not a temporary problem. Only one-quarter of the increase in population growth on the average is due to migration; the remainder is due to natural increase. Finally, and probably the most important point, urbanization has meant and will continue to mean for the immediate period, that in many countries, especially in the developing world, 50 per cent of urban residents live below the poverty line. The problems of urbanization, thus, often become problems of the poor and of their impact and influence on the cities of the future.

The health situation which arises from this rapid urbanization truly reflects the problems of poverty. A highly concentrated, low-income population without a proper public health structure suffers the contagious diseases of rural areas as well as those generated by the urban environment. In addition, although urban areas traditionally have had a concentration of health services and resources, these are not accessible or available to the majority of urban residents.

More specifically, many health problems revolve around the lack of housing and environmental sanitation. In the slum and squatter areas of the developing world, housing is make-shift and congested. With these high concentrations of population in small areas, environmental sanitation, like housing, is grossly inadequate. While in rural areas, the need for a water supply is greater than that of sanitation, in urban areas, because of the extremely crowded conditions and close proximity of all urban dwellers, both are equally important. Water, both in quality and quantity is necessary for disease prevention. However, not only is clean water unavailable in the areas inhabited by the urban poor but sewage facilities and proper waste disposal are virtually non-existent.

The urban environment in which low-income people live and work has direct consequences on their health status. Diseases among the urban poor can be divided into three major categories. Firstly, there are those diseases which are most directly related to poverty which appear as a result of low

income, poor living conditions, little education, inadequate diets, overcrowding and under protection: these are gastroenteritis, tuberculosis, infectious diseases and diseases related to malnutrition. Secondly, there are diseases which are the result of man-made conditions in urban areas such as those related to air and noise pollution, traffic, stress and eating habits that lead to cardiovascular, neoplastic and mental diseases. Thirdly, there are diseases which are related to social instability and insecurity of land tenure and income such as alcoholism, drug abuse, venereal disease, and crimes of violence.

TABLE 2. PROPORTION OF SQUATTERS AND SLUM DWELLERS IN SELECTED CITIES (By region in descending order)

<i>Region and city</i>	<i>Year</i>	<i>City population (in thousands)</i>	<i>Slum dwellers, squatters (in thousands)</i>	<i>Percentage of slums and squatters to city population</i>
<b>AFRICA</b>				
Addis Ababa	1981	1200	948	79
Casablanca	1971	1506	1054	70
Kinshasa	1969	1288	733	60
Nairobi	1970	535	177	33
Dakar	1969	500	150	30
<b>LATIN AMERICA</b>				
Bogotá	1969	2294	1376	60
Buenos Aires	1970	2972	1486	50
Mexico City	1966	3287	1500	46
Caracas	1974	2369	1000	42
Lima	1970	2877	1148	40
Rio de Janeiro	1970	4855	1456	30
Santiago	1964	2184	546	25
<b>SOUTH ASIA</b>				
Calcutta	1971	8000	5328	67
Bombay	1971	6000	2475	41
Delhi	1970	3877	1400	36
Dacca	1973	1700	300	35
Karachi	1971	3428	800	23
<b>EAST ASIA</b>				
Manila	1972	4400	1540	35
Pusan	1969	1675	527	31
Seoul	1969	4600	1320	29
Jakarta	1972	4576	1190	26
Bangkok/Thonburi	1970	3041	600	20
Hong Kong	1969	3617	600	17

**Source:** *World housing survey 1974: an overview of the state of housing, building and planning within human settlements*, Department of Economic and Social Affairs, United Nations, New York, ST/ESA/30, 2976, Table 48, pp. 159-164; *The improvement of slums and uncontrolled settlements: Report of the Interregional Seminar on the Improvement of Slums and Uncontrolled Settlements*, Medellín, Colombia, 15 February - 1 March 1970, Department of Economic and Social Affairs, United Nations, New York, ST/TAO/SER.C/124, 1971, pp. 21-23; *Report of the municipality of Addis Ababa to the City Council*, July 1981, p. 7; *Housing Asia's millions*, Ottawa, IDRC, 1979, Table 8, p. 53.

Attempts to improve these conditions for large numbers of people have been limited by a number of factors. The existing municipal infrastructures are not adequate to provide services for the rapidly expanding urban populations and, in many cities, are inhibited by the lack of communication and co-ordination among municipal authorities including the health sector. Under these conditions, planning for urban development becomes short-term and crisis-oriented. Too often, programmes and resources are duplicated limiting their impact on a wider number of people.

Another factor is that in many urban areas, the low-income groups, because they are mobile and are from different areas of the country, do not have strong community organizations. As a result, they find it difficult to mobilize commitment and resources for improvement. The failure of organized efforts has had other consequences. Low-income groups have little influence on municipal policies, limited access to resources and no legal redress for their problems.

### ***Highlights of activities undertaken***

In recognition of this situation, WHO, other international agencies and many NGOs have begun to undertake activities to improve the health situation in urban areas. WHO and UNICEF have held a number of meetings bringing together health and other municipal authorities as well as NGO groups to define the major urban health issues for the urban poor, to exchange innovative solutions to health problems and to begin a network of concerned people and organizations.

WHO has also undertaken two other sets of activities. One focuses on developing guidelines for research/action in order that urban authorities and other groups can survey and plan health programmes for the urban poor. The other revolves around efforts for promoting the recognition of and advocating solutions to health aspects of environmental improvements, especially for mothers and children, including housing, sanitation, pest control and pollution control.

At WHO regional offices, concern about urban health problems has grown. In the African Region, following concern expressed at an Interregional Consultation on Strengthening Ministries of Health for PHC, a workshop was held in Addis Ababa in Autumn 1986 in which the problems of the urban poor in Ethiopia, Kenya, Tanzania and Zambia were discussed. In the Eastern Mediterranean Region, countries have agreed to look into the health needs of the rapidly growing peri-urban populations. The European Region has launched a Healthy Cities Project to promote well-being and positive health, intersectoral and community participation as part of the "new public health" movement for the large urban populations of this part of the world. The Pan American Health Organization is undertaking studies to explore the impact of socio-economic factors on the health of low-income urban groups and also to investigate how the experiences of rural primary health care might be applicable to urban primary health care. In the South-East Asia Region, studies on service coverage for urban dwellers and on reforms in urban health service

delivery are under way in order to identify urban problems and seek solutions through resource coordination and allocation by the various municipal departments and agencies. The Western Pacific Region hosted a WHO/UNICEF interregional meeting in 1986 where representatives from all over the world exchanged ideas about health improvements for the urban poor.

WHO's work has been complemented and supported by other international agencies. For example, UNICEF, in continuing collaboration with WHO, has jointly hosted a number of meetings. In addition, it has supported an urban basic service programme in various cities in the developing world which focuses on providing an integrated approach to activities for the urban poor. The United Nations HABITAT programme named 1987 as the International Year of Shelter for the Homeless calling attention to the plight of these underprivileged millions and to innovative solutions to their problems. The World Bank has for some time given loans for urban developments including site and service schemes, urban health centres and improved water and sanitation. Numerous NGOs have also contributed to the experiences and improvements in health for low-income urban dwellers. Activities range from community water and sanitation schemes and community health worker programmes to wider community development activities focusing on income-generation, literacy classes and pre-schools for the children of working parents.

### ***Rationale for Action***

The health situation of urban inhabitants calls for immediate and concerted action to deal with existing problems and to prevent further deterioration. Experience demands that this action will have to address the problems in terms of redistribution and availability of resource and the involvement of communities themselves in decisions about resources choices. To ensure health improvements for all those living in urban areas, policies which seek equity, maximize the use of existing resources and ensure community involvement must be pursued.

To achieve equity, firstly, it is necessary to give priority to the needs of the poor and underserved urban populations. The services provided by city administrations, although nearly always having much more financial and human resources than rural areas, are unequally distributed and often are not available to the poor and unserved. If health is to be improved for all urban dwellers, scarce resources must be allocated to those who lack access to both services and opportunities to improve their health and to the creation of an environment which can sustain improvements.

Secondly, it is necessary to focus attention on low-income people in countries which lack the means to provide a health and social service infrastructure to protect the poor. In these countries, which include most of the developing world and therefore the majority of nations, the urban poor lack assurance of any type of welfare support. Often this access to resources for improvement is blocked by the lack of legal status for recent migrants and their offspring. As a result, inhabitants of slum and squatter areas have neither rights to welfare services nor to municipal schemes for housing and environmental improvements.

Finally, equity demands action for the plight of those especially vulnerable groups within the low-income populations. These are: children who, in addition to being the most vulnerable in poor urban environments, suffer from lack of parental care, as adults are the income earners; girls and women who often head single parent households and work in conditions which injure both physical and mental health; youths who have no jobs and low self-esteem and wander the streets in search of drugs, drink and/or other stimulation which can lead to violence; the elderly who physically can no longer work, but who still require care; the under- and unemployed who work irregularly and often in squalid and dangerous conditions; and the mentally and physically handicapped.

To seek to maximize the use of scarce resources, action must focus on providing services and their delivery appropriate to the needs of the majority of the people. To do this, ways must be sought to stress specific preventive measures, to the integration of health services with other welfare services particularly for the low-income groups and to mobilize community support, and especially a commitment of resources. At a time when resources are becoming more limited, there is a need for flexibility and innovation to develop health care which can meet the needs and demands of a rapidly growing poor urban population.

## ***Objectives***

The objectives of WHO's Global Programme for Urban Primary Health Care rest on the principles of primary health care and emerge from the rationale for action. They are:

1. to promote primary health care which emphasizes equity and community involvement in urban areas;
2. to promote improvement in the health status of the urban population especially for unserved and underserved people;
3. to provide technical support to government and municipal health authorities to achieve the above objectives.

## ***The Strategy***

While primary health care applies the same principles to improve health for people in both rural and urban areas, the urban situation, as has been described, has some major differences. Among them are the rapid increase in population, the concentration but limited accessibility of health facilities and services and the diversify of urban communities. Primary health care strategies and principles are needed to ensure better health. Again, based on experience, three appear to be most important.

The first strategy is to develop and strengthen collaboration within the various parts of the health sector and among the various other sectors, municipal authorities, agencies and nongovernmental organizations which are involved

in improving urban health care. In many situations, those people providing health services rarely communicate with each other. Services are often in competition, are duplicated and concentrate on those with better incomes. As a result, services become more costly and less effective. A similar situation exists among the different authorities and agencies involved in health improvements. While there are many such groups concerned with health and welfare, particularly of the urban poor, all too often the fight among them for resources and power negate their professed objectives. Again, the result is increasingly high-cost health care, beneficiary dissatisfaction and the inability to cope effectively with the needs and demands of the population.

To overcome these difficulties, PHC advocates collaboration and coordination of all groups concerned with health improvement. In some cities, this coordination has been undertaken by the municipal council which, for health programmes, has been reorganized to include all authorities, agencies and nongovernmental groups involved in improving health. In other cities, a coordinating agency has been established for this purpose. Such approaches are helping to solve problems of resource scarcity and maldistribution and to develop a multisectoral approach to problems which have multiple causes.

The second strategy is to reorient health services and health staff to meet a wide range of urban health problems. Traditionally, urban areas have received the majority of a country's health budget supporting institution-based, curative services which has led to the growth of large hospitals with massive numbers of clinically-oriented staff. It has also led to the reduction of resources, facilities and personnel available to meet the health needs of the majority of urban dwellers.

PHC calls for change in this type and delivery of health care by emphasizing preventive, community-based, decentralized and appropriate health services provided by staff trained to initiate and support this change. Staff need to recognize that health services alone will not improve the plight of the urban poor. They must learn to work with a range of authorities, agencies and people who are concerned about health improvements and develop flexible responses to problems which manifest as disease but which have root causes in the socioeconomic conditions of the individual.

The third strategy is involving community people in solutions to their own health problems. In the past, solutions to health problems have too often been given to people without their consultation and/or consent. Thus, people often received advice which was inappropriate and unacceptable leaving them little motivation to act upon it.

The PHC approach takes as its major principle the involvement of the people for whom health care is to serve. This involvement, of which involvement in decision-making is the key, ranges from participating in promoting ways to develop healthy living habits and life-styles to contributions to health care in the form of money, materials and manpower. Although more difficult in urban than rural areas, there are instances where communities in slum and squatter areas have organized to form health and development committees to attack a range of health problems from sewage to income-generation. Community health workers have been trained to provide first-line health care which is affordable, accessible and acceptable. Community involvement is helping to ensure that health resources match health needs.

## ***Areas for Action***

A review of urban problems and innovative solutions indicate that there are a number of areas for action where the primary health care approach is improving the situation especially for the urban poor. These examples provide support, ideas and inspiration for others. Among these areas are:

### **PLANNING AND DECISION-MAKING**

#### **The problem:**

Traditional management of health care systems has centred on the management of disease. Primary health care has the following eight components: education concerning the prevailing health problems and methods of preventing and controlling them; promotion of food supply and proper nutrition; adequate supply of safe water and basic sanitation; maternal and child health, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; the appropriate treatment of common diseases and injuries; and provision of essential drugs; which clearly demands reorientation of health care delivery. Firstly, it requires information beyond disease incidence and prevalence rates, beyond morbidity and mortality rates. Information must be obtained about the socio-economic conditions of large and poor communities and about traditions, beliefs and attitudes. Once the information has been obtained it is imperative to know how to use it for planning, monitoring and evaluating urban health programmes. Too often data is collected and stored at vast expense and to no one's profit.

While statistics are available to show the rapid growth rates of urban areas, in terms of health patterns, these statistics give only aggregate numbers. There are few which provide information showing the difference in health care and health status among different income groups. Often data obtained from hospitals and health centres only reflect the problems of those who are able to come for care. They do not show the health problems of those who find the services inaccessible due to location or to being unaffordable in terms of time and/or money; nor do they record any of the conditions which give rise to the health problems for which treatment is sought.

Another critical planning problem is that of financing health care. Although urban centres have the most advanced facilities and the best trained staff, the cost of developing and maintaining such establishments has meant lack of minimum coverage for the poor and most vulnerable groups. While per capita expenditure is sometimes three times as high in urban than in rural areas, low-income groups do not reap any benefits. A major reason is that expenditure supports large curative facilities in central locations which are too expensive in terms of time and money for the poor. In a period of shrinking resources and increasing demands, alternative methods need to be found which do not rely on hospital, curative health care. Many health care institutions, such as social security, are still heavily involved in curative services with limited attention being paid to the preventive and promotive aspects of health.

### ***The issues:***

New management systems for urban primary health care will need to find ways of identifying and collecting relevant information and methods by which it can be put to use by both planners and beneficiaries. This means that a wide range of information including data about social and economic as well as health status needs to be available. One important step is to identify the indicators which will show gains or losses toward meeting programme objectives and reflect whether service coverage is available for the most vulnerable groups. Another is involving the target beneficiaries in collection and interpretation of information in order that the plans will reflect both their assessments and commitment to the future.

Financial management systems cannot rely only on state support or meeting costs with fees for services. Programmes which stress prevention, develop community contribution and support, and integrate with other welfare programmes suggest some alternatives. Also management of financing through social security programmes, pre-paid health care and health insurance might help overcome some barriers.

### **The experience:**

Several cities have begun to develop monitoring systems based on a number of indicators of social development. In Bangkok, 33 indicators are identified which cover attitudes and other subjective measurements as well as objective measures such as morbidity and mortality. The communities take the responsibility of collecting this information by using questionnaires and analysing them to see where the basic needs standards are not being met. When problems are identified, the community prepares a development plan proposal to tackle priority problems and submits it to the district authorities. The problems which are beyond the ability of the community to solve are referred to the district or the Bangkok Municipal Authority or the National Government. In addition, the municipal authorities have set targets to ensure improved health which stress preventive actions. The information to monitor these targets is included in these community surveys.

The social security system which operates in 16 countries of Latin America has been gaining credibility as a means of financial planning for service coverage, particularly for those in urban areas. Originally accused of creating a dual system of care for the rich and the poor, as more people come into employment and thus reap the benefits of workers' insurance for themselves and family, this accusation is less valid. In Brazil, for example, in the 1960s, service coverage extended to only about 23 per cent of the economically active population. In 1984, over 85 per cent had coverage. The benefits of social security are equitably fixed and are able to shift resources from the more affluent to the poor. The most critical problem today seems to be to reduce the cost of inflation in order to continue the expanding benefits of the system.

## COORDINATING HEALTH ACTIVITIES

### **The problem:**

Within the health sector in many urban areas there is little coordination. In some cases, provision of health services is the responsibility of the national Ministry of Health and the provision of environmental services is usually under the municipal authorities. Communication between the two is often minimal. In other cases, vertical organization of health activities impedes coordination and, as a result, has objectives which often overlap, or compete with other programmes.

Coordination among sectors including health, education, environmental sanitation, labour, etc., has often proved as difficult as coordination within the health sector. The linkages between health improvements and improvements in the existing socioeconomic environments have been clearly demonstrated. Health improvements depend as much on a wide range of community development activities as on health service coverage. Coordinated action is hampered by competition for resources and prestige and by a single sector, top down approach to health problems, especially among the urban poor. In many municipalities the sector defines the problems in terms of the available solutions. The community is not asked to define its needs and is not requested to consider intersectoral support for the problems they define.

### **The issues:**

As already stated primary health care calls for restructuring of service delivery. To provide better coordination and communication, these structures need to include improved exchanges between central and local staff; the strengthening of the city information system to monitor progress and test the value of health interventions; the involvement of beneficiaries in planning the programmes; and a new role for health personnel.

Multisectoral cooperation also must be actively pursued. To be effective, it must operate at a variety of levels including ministerial, departmental, national, provincial, municipal and local and might usefully involve institutes of management, public health and urban affairs. Collaboration among these different groups should be based on needs identified at the local level by community leaders with joint action being developed with agencies relevant to specific situations, aimed at solving specific community problems. NGO contributions should be emphasized. Finally, linkages among various sectors need to be strengthened between the municipal and local levels through central authorities and community organizations. It can also take place at the municipal level through coordinating bodies to tackle specific problems.

**The experience:**

The Sang Kancil programme in Kuala Lumpur, Malaysia began as an effort of the University medical school and National Family Planning Board with funds from overseas donors to provide health services to the urban poor. Starting with a community-defined need for crèches for working mothers, the service providers quickly realized that health services alone would not improve health status and requested aid from the Government to provide water, sanitation and other public services. Lacking the resources, the Government, with the help of UNICEF, mobilized a number of official agencies and Ministries to participate in a joint effort of slum improvement. They joined the already created community organization teams to tackle the wide range of health problems. The result was the creation of a programme which shifted from a single agency to a multi-agency delivery of services through the creation of programme teams; moved from an institutional operation to a community operation through the support of community action groups; shifted the focus on beneficiaries in general to a specific focus on the urban poor as the target group went from indirect approaches to activities directly involving the urban poor family as a key unit in development; and changed from single-agency resource utilization to inter-agency resource sharing. One result of this combined effort was a government decision to create a Social Development Division, the only unit with a multilevel structure. Another was the re-zoning of urban dwellings to ensure more resources for the low-income groups. A third was the creation and strengthening of local community organizations.

## TRAINING AND REORIENTATION

**The problem:**

Health care systems, particularly in urban areas, have been hospital-based and curative-oriented. People who staff these institutions, the majority of the health systems personnel, have been clinically trained in specialized skills and have developed a belief that health is beyond the power of the individual, that it is only in the sphere of those with advanced training. Their education focuses on how to treat individuals using the special knowledge they have acquired. This philosophy contradicts that of primary health care which sees communities and individuals as being responsible for their own health, and individuals as partners with medical professionals in seeking improvements.

**The issues:**

There is a need for the traditional institution-based health care delivery system to be reoriented toward a community-based health care system. This suggests that within the hospital framework some of the following actions could be taken. A series of activities should be developed which integrate

hospitals into primary health care at all levels, not just the tertiary referral level. Hospitals can be involved in programme development, coordination, and evaluation of implementing the main elements of primary health care and can become training bases for staff reorientation toward community care. They can also provide management and administrative support.

Curative, clinically-oriented staff should undergo training in order to carry out tasks and develop the attitudes necessary for primary health care. Such action will call for retraining of existing staff to perform new duties and develop the necessary management skills. For example, public health nurses may become key people in the promotion of community health by learning community development skills and working among the low-income groups. Recognition and active support by medical professionals must be given to the community health workers and community volunteers, who provide the first line of medical care and undertake important preventive work in the slums and squatter areas of the city.

### **The experience:**

In the early 1980s, the Aga Khan Health Services built and began to operate a 700-bed, newly-constructed hospital in Karachi, Pakistan. The commitment of the management committee and hospital supporters was to ensure that the hospital developed, implemented and maintained a primary health care programme. A major part of this commitment is the training of health professionals within the attached medical school. The teaching programmes focus on field-oriented, community-based primary health care with priorities to mothers and children, coupled with the control of endemic diseases. This approach gives students practical experience in the slums of Karachi as well as the very poor rural areas of the Sind and the Northern frontier areas. Structurally the services provided for training new professionals in Karachi are divided into three tiers. These are: the community health worker (CHW) at the household and community level; the lady health visitors working out of health posts to supervise the CHWs; and the doctor-nurse teams working out of health centres to support the other two levels. The referral system links the community with the base hospital which is also committed to supporting primary health care. The training and orientation that both staff and students share is beginning to define a positive role for hospitals in primary health care which involves supporting community health needs, setting role models for new medical staff and seeking the collaboration of other sectors to improve the health care of the very poor, especially in the urban slums of Karachi.

## **MOTIVATING PUBLIC ACTIONS**

### **The problem:**

Improvements in health status among both individuals and communities are not only affected by access to health services but also by what people

choose to do to and for themselves. One set of choices depends on individual health behaviour. Life-style, diet, and smoking are critical to good health.

Another set of choices focus on community rather than personal actions. For the people in low-income areas, these choices are more relevant because other choices are limited by the socioeconomic and environmental factors over which they do not have much influence. Unfortunately, low-income urban populations are often characterized by lack of community organization and community concern. Often uprooted from strong family and rural ties, urban migrants move to areas where they know no one and where traditional support systems are non-existent. In addition, health concerns, much like these concerns in rural areas, are low priorities. Where people live in concentrated areas with insecurity of land and income, in poor and rubbish-infested environments, their wide ranging problems demand a wide range of actions.

### **The issues:**

Among the better-off urban dwellers, a major issue is that of supporting individuals to make changes in their life-styles to improve their health conditions. WHO's "Healthy Cities" programme focuses on health promotion and creating awareness to stimulate positive change. By mobilizing government support for these health campaigns, the programme hopes not only to inform people about the consequences of various alternative health behaviour but also to persuade them to make good health choices.

Among low-income people in cities in developing countries, where community action is likely to have a greater impact than individual action for health improvements, the issue is often that of the development of community organizations. Where these are present, low-income people have been able to improve their waste disposal, secure land tenure, engage teachers for learning income-generating skills and provide community health workers for first-line health care. Where community organizations are lacking, health staff will need to support their creation by helping community organizers or possibly by becoming community organizers. While building organizations is not easy, experience suggests that in the long term, they are the only alternative to supporting and maintaining health improvements among the urban poor.

### **The experience:**

In Colombo, Sri Lanka, Health Wardens, who are semiprofessional community health workers, have been nominated by the city's Public Health Department. They help establish residents' organizations, which was the community's first priority, and then work to promote health, nutrition and sanitation. The 100 Health Wardens have organized nearly 300 communities and initiated voluntary sanitation campaigns, skills training, religious events, sports/cultural programmes for children, etc. Residents have actively participated in these various programmes but have not served as formal Health Wardens. The Wardens are mainly relatively young school-leavers selected by the Public Health Department. They receive two months training in health education, nutrition, sanitation and community development.

## RESEARCH AND DEVELOPMENT ACTIVITIES

### **The problem:**

At present, in all the above areas of action, there are reports and publications of a wide and varied number of programmes which have sought innovative solutions to the problems of urban health especially among the low-income groups. However, there have been few writings which systematically and critically analyse these experiences. As a result there are many descriptions of pilot programmes but little in the literature which identifies ways to expand these small programmes or of duplicating them in other areas or countries.

In addition, little work has been done to analyse the lessons and to provide a methodology and guidelines for use by other planners. The lack of good comparative studies based on operational research limits the systematic transfer of ideas and approaches which could speed the development of urban health care programmes.

### **The issues:**

One major issue is how to gain reliable data for planning and evaluating programmes. In the past, few municipalities have had resources to do an extensive baseline study. Where it has been tried the results have been less than satisfactory due to problems of both data gathering and interpretation.

Another issue is the problem of how to systematically collect and analyse information useful for evaluation and for a plan of action for urban programmes. Such an exercise calls for a multisectoral effort with expertise from educationalists, sanitarians, and social scientists, with medical professionals and, to be responsive to the needs of poor communities, calls for ways of involving people needing improved health care. Studies need to be developed which are both retrospective and prospective and designed to identify crucial lessons from urban experiences. In addition, methodologies need to be developed to allow planners/decision-makers to make rapid appraisals of urban health situations.

### **The experience:**

After a meeting sponsored by WHO in Africa in 1986, two countries, Tanzania and Zambia, decided to undertake projects on urban primary health care. In Tanzania, the municipal officer joined with other municipal authorities and health staff to begin to identify a programme for action. Recognizing the limits of time and money and the lack of available statistics, they decided to use a modified Delphi technique survey to assess health problems. A simple questionnaire was designed and key informants from both the community and officialdom were asked questions by professionals from the health sector. A workshop was planned to present results to municipal officers and to develop a programme based on the community's views of its own health problems.

In Zambia, the municipal medical officer, again working with other city officials and university researchers, after consulting people in one of the poorer townships, designed a programme for slum upgrading by improving housing, sanitation and health services. With the help of a wide range of professionals, a simple baseline survey was designed which included inputs from the community and became the basis for the monitoring and evaluation of the project. Having selected specific interventions for health improvements, a workshop was planned to present preliminary data assessing the impact of their work.

### ***Action by WHO***

WHO is committed to strengthen and support the actions that have been described. The Organization will provide assistance for development and support of the areas of action described above.

To do this, WHO, upon request from governments and health and municipal officials will continue to *give technical cooperation* to help develop urban primary health care programmes. This cooperation would include collection and interpretation of health information for decision-making. It would include coordinating health activities within the health sector as well as with other key sectors for improving health. It would include training health personnel to reorient the health system toward primary health care. It would include exploring methods and activities to motivate people to participate in their own health care and to make good health choices. It would include developing and adapting methodologies and guidelines for assessing urban primary health care programmes.

In addition, WHO will continue to *build and support networks* of health and municipal authorities, government agencies and nongovernmental organizations which are involved in developing urban primary health care programmes. Activities might include sharing information among various different municipalities, convening meetings to discuss particular critical issues, sharing experiences among urban groups, and continuing jointly with other international organizations to seek ways of mobilizing joint support of those cities involved in developing programmes for the urban poor.

Finally, WHO will continue to *promote health concerns* in the context of primary health care as a means of improving the health of urban people. By providing information about the health aspects of various activities designed to improve the plight of the urban poor and highlighting their significance in dealing with urban problems, the Organization will contribute to finding long-term and lasting solutions to problems which are nearing crisis in many cities of the world.

## ***A Call for Extrabudgetary Support***

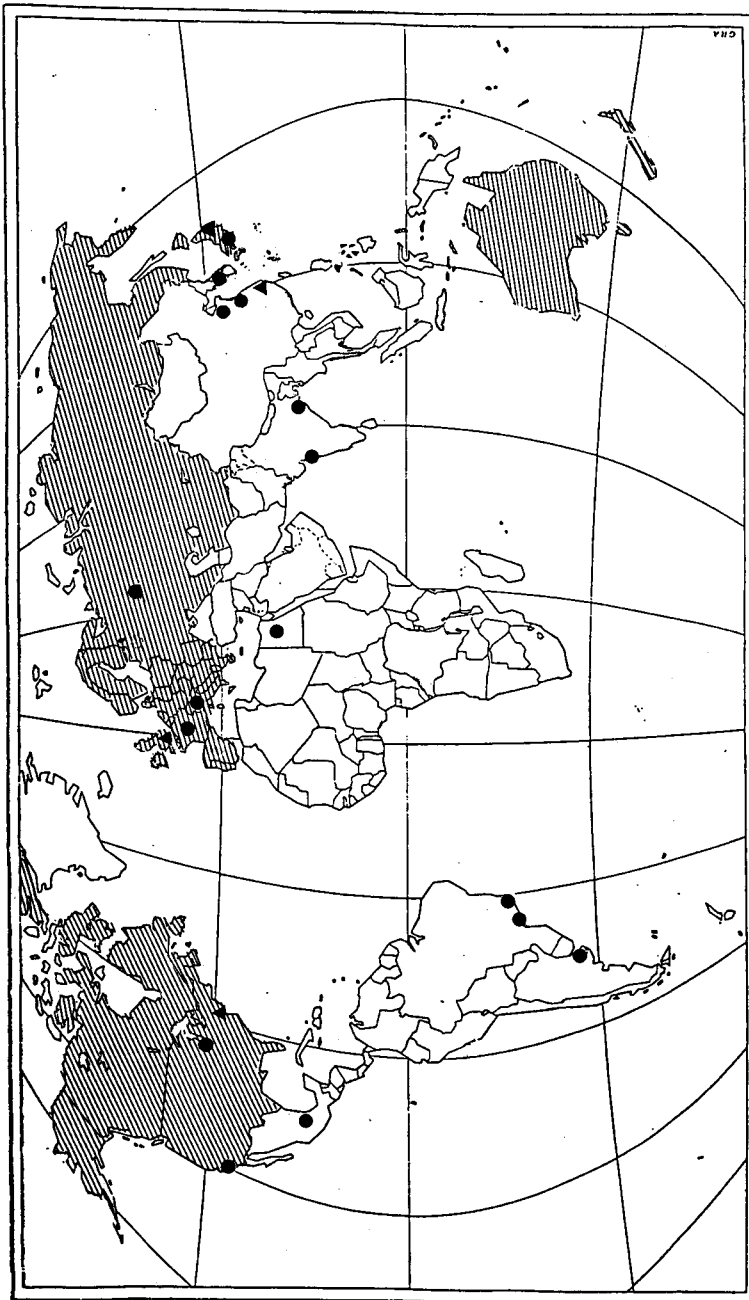
WHO will need extrabudgetary funds to develop these cooperative links with city health authorities and municipalities. Support will be needed for the following activities:

1. developing and adapting *methodologies* for data collection, specific to urban situations, particularly the underserved, with the involvement of the beneficiaries themselves;
2. developing guidelines for the use of this health information in the *planning* and *evaluation* of programmes;
3. developing, based on the analysis of this information, programmes for *reorienting* the health care system based on equity, and *training* staff to be responsive to community rather than institutional demands;
4. supporting the organization for *research and development* activities on the major issues of health development in urban settings;
5. maintaining the incipient *network* of groups working among low-income urban people to build mutual exchanges and support;
6. developing the *promotion* of primary health care as an alternative approach to meeting the health needs of the rapidly growing urban populations.

## ***Conclusion***

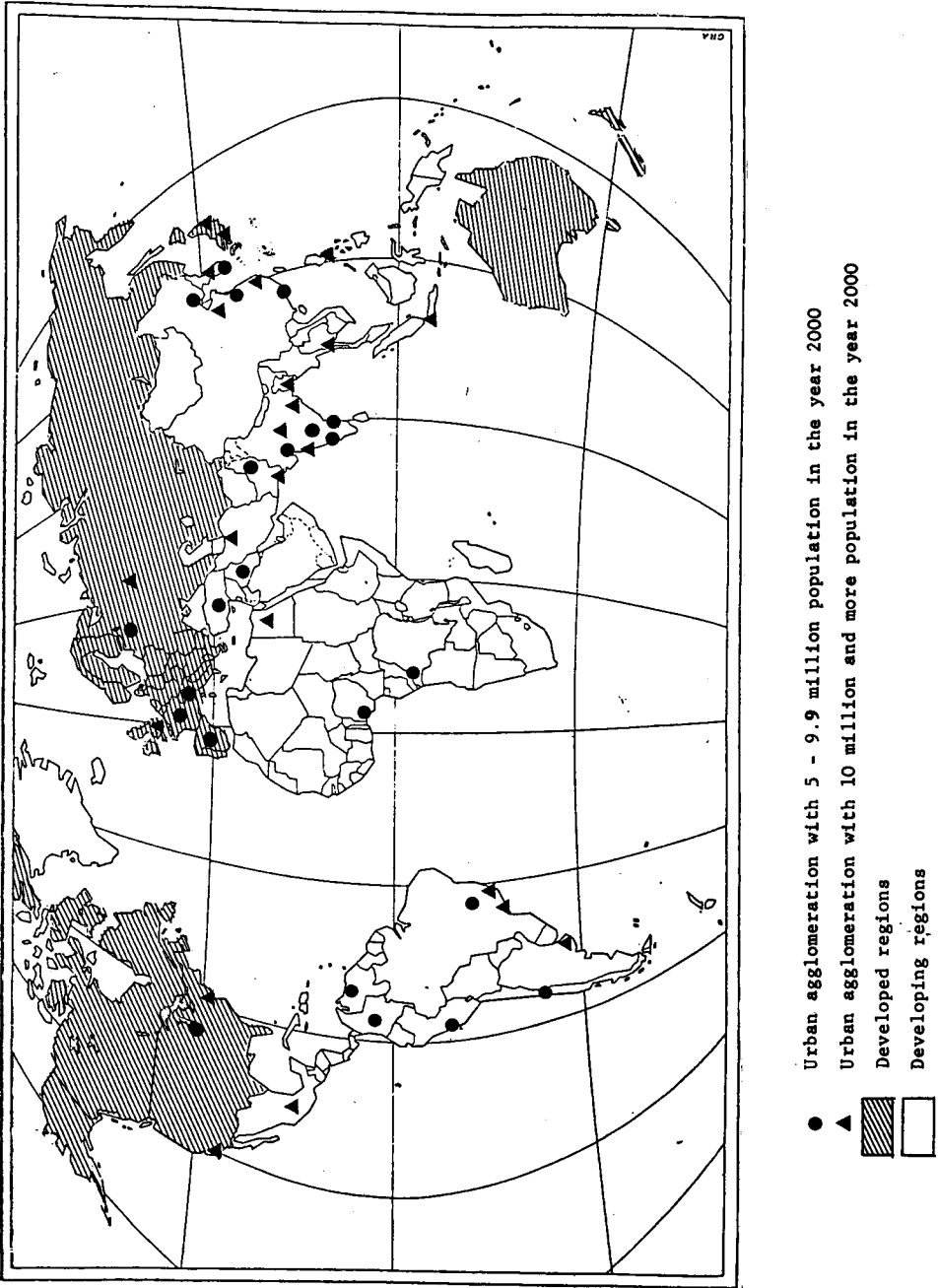
In conclusion, the Global Programme on Urban Primary Health Care seeks to address the health needs of the rapidly expanding populations living in large urban conglomerations. To do so, the programme emphasizes the necessity of seeking ways for the equitable distribution of existing resources, for involving communities in decisions and actions to improve their own health, for multisectoral approaches to solutions for urban health problems, and for reorienting the existing health services and health staff to implement and promote these principles of primary health care. The future of health improvements demands decisive and systematic action and support. The Global Programme is designed to contribute by promoting and supporting primary health care to address urban problems in the context of urban health development.

# Appendix I



- Urban agglomeration with 5 - 9.9 million population in the year 1970
- ▲ Urban agglomeration with 10 million and more population in the year 1970
- ▨ Developed regions
- Developing regions

# Appendix I



# Appendix II

PROPORTION OF POPULATION LIVING IN URBAN AREAS BY THE YEAR 2000

