
REPORT OF THE INTERREGIONAL MEETING ON CITY HEALTH: THE CHALLENGE OF SOCIAL JUSTICE

KARACHI, PAKISTAN
27-30 NOVEMBER 1989

Co-sponsored by:

Aga Khan University ■ FINNIDA ■ METROPOLIS ■ UNICEF ■ UNDP ■ WHO



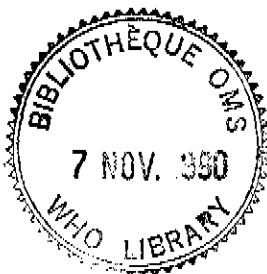
Division of Strengthening of Health Services
World Health Organization, Geneva

TAKING UP THE CHALLENGE OF SOCIAL JUSTICE:
THE "SPIRIT OF KARACHI"

The health of the most disadvantaged and poorest groups in big cities continues to deteriorate, if not absolutely, at least relative to others and to any tolerable standards. This will become a cause of greater and greater concern because of the increase in the number and size of large cities, especially in the developing countries.

Active engagement with this issue by all those responsible politically, administratively and technically, at the local, national and international levels, is indispensable in order to progress towards the Alma-Ata objective of Health for All by the Year 2000.

We must respond with energy to people's urgent need for practical, immediate help but also devise a range of measures, with vision and imagination, which will prevent further deterioration in city health. Participants at the Interregional Meeting on City Health held at Karachi in November 1989, voiced on this occasion a cry of alarm and launched an urgent appeal to all to save humanity from a catastrophe, that is all too easy to foresee unless we take immediate action to avert it.



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STRUCTURE OF THE REPORT

This publication includes the Report and recommendations of participants in the Interregional Meeting on City Health (Karachi, 27-30 November 1989) and a distillation of the Working Document and city presentations which were prepared for this Meeting. Sections 2, 3 and 4 have been prepared by the WHO Secretariat and selected extracts from city presentations have been used as examples to illustrate issues and achievements where these are identified in the text. In this context, the structure of the report is as follows:

I. Section 1 is the Report and the recommendations of the city representatives who attended the Meeting.

II. Section 2 describes the growth of urban populations, the health problems among them and the determinants of health among the urban poor.

III. Section 3 considers the policy issues and options for improving the health of the urban poor and the potential of strategic health planning. It looks at decision-making processes, the organizations and individuals involved at various levels, and ways of increasing the effectiveness of these.

IV. Section 4 is a set of concluding remarks which identify the recurrent themes which occurred throughout the conference, presentations and background papers.

SECTION 1 REPORT AND RECOMMENDATIONS OF PARTICIPANTS

1.1 INTRODUCTION

1.1.1 Representatives of 17 cities (Annex A) met to share experiences and look ahead towards further action, including cooperative action, to tackle the grave problems facing the urban poor. Cities were represented in each case by a top political leader, such as the mayor, or by a chief executive, as well as by the appropriate health specialist. This composition reflected the focus and flavour of the meeting, which concentrated not only on shared, specialist understanding, but upon political realities, constraints and opportunities for action. The meeting was organized by WHO, and sponsored by the Aga Khan University, FINNIDA, Metropolis, UNDP, UNICEF and WHO. The agenda for the four days is attached as Annex B. The programme included field visits in Karachi, both to see the situation there at first hand and to hear about pilot projects of the University's Medical School to improve the health of the urban poor.

1.1.2 The meeting opened with explanatory and supporting statements from the sponsors and from the Mayor of Karachi and the Governor of Sindh. The fact that the elected Mayor of Karachi is also a physician added piquancy to his statement about the problems posed for the city and indeed for the world by a high rate of continuing population growth. The Governor of Sindh added to his formal statement a more personal plea that delegates be willing when necessary to move by means of local initiatives and never to underestimate the intelligence, energy and common sense of poor communities.

1.2 THE SIZE AND SCALE OF CITY GROWTH AND POVERTY

1.2.1 Delegates described the situation in their own cities, including the characteristics of their population, the circumstances facing the poor, and the strengths and weaknesses of their strategies for action. Taken cumulatively, these city descriptions illustrate graphically the sheer scale of the cities, the problems posed by their continuing growth and the desperate situation faced by their poorest citizens.

1.2.2 The numbers of urban dwellers throughout the world are increasing steadily and by the end of the century they will exceed rural dwellers for the first time. This trend is even more marked in developing countries. A growth rate of around 3% was common among the cities represented, meaning a doubling of their population in a generation. In Karachi's case, the doubling will be in around a decade. In Africa and South-East Asia, the total number of urban dwellers will have more than doubled between 1980 and 2000. By the latter date, in the developing world, there will be 45 cities of more than five million inhabitants, compared with one such city in 1950. Around half of their inhabitants are likely to be living in conditions of great poverty. Because of this crisis, the total number of premature deaths in developing cities will continue to increase steadily unless the problems of the urban poor are addressed.

1.3 INEQUITY WITHIN THE CITY

1.3.1 Within almost all our cities there are stark and dramatic contrasts between the extremes of affluence and poverty. This can be seen, for example, by the juxtaposition of high-rise office and apartment blocks on the one hand, with slums and shanties, and the dramatic differences in space and style of living. But the contrasts are not simply visual. They extend to all aspects of life, including health, disease and death. The contrasts are often hidden by lack of data, but where the statistics are available and reliable, the main indices of morbidity, access to health services, and mortality portray an appalling situation for the poor in many cities, and one that can undoubtedly be improved. Among all the participants represented at the Meeting, there was a shared sense of urgency and a commitment to action.

1.4 THE HEALTH SECTOR CANNOT STAND ALONE

1.4.1 The Meeting built upon, and developed further, the emphasis placed by UNICEF and WHO upon intersectoral action. Special emphasis was placed upon:

- employment, income-generation and distribution;
- housing;
- water and sanitation;
- solid waste disposal;
- land tenure;
- environmental protection;
- population equilibrium;
- community development and empowerment.

Examples were given by cities which demonstrated by data and, in some cases, by slides and films, how some of these elements are being tackled with imagination and some success.

1.4.2 Such a list is, of course, not new, since the whole Primary Health Care approach is intersectoral. But there are several elements that are not identified in the initial Alma-Ata Declaration and there was added urgency to the discussions about solid waste disposal and environmental pollution. There was also a recognition that in many cities some reduction in population growth is an element without which the problems seem almost unmanageable at the city level.

1.5 HETEROGENEITY

1.5.1 Each city is unique, in its physical circumstances, its climate, its social characteristics, its economic position, and political context. Moreover, there are great differences within cities, not only between rich and poor, but also in the characteristics of poor neighbourhoods, and among groups living in the same neighbourhood. This heterogeneity makes it most unlikely that there can be single, standard, packaged solutions to these problems, except possibly to their most technical aspects, and at the level of very general principles. Rather, shared learning is likely to be most productive in reflecting in a different and deeper way on each other's successes and failures, and selecting and adapting particular elements from each other's experience to suit local circumstances and local preferences.

1.6 THE NEED FOR A STRATEGIC RESPONSE

1.6.1 Because effective action cannot lie with the health sector alone, any adequate strategy must contain many of the elements in paragraph 1.4.1 (and indeed others) and be owned at the city and the community levels much more broadly than by the relevant health agency on its own. It must address resource and other constraints, and set clear goals.

1.6.2 A difficulty in some cities, though by no means all, is that they have responsibility without matching authority. Mayors in such cities find their hands tied if, for example, health services are managed from the regional level, or if they have to gain central government approval for relatively small initiatives and expenditures. Other points made included the need for:

- closer interagency collaboration in support of cities by all interested organizations, including international organizations;
- finding out what national development plans and national health policies direct or suggest so that there is minimum contradiction between national and local programmes;

- better linking of efforts at the many levels from local communities to national and international organizations;
- more articulate advocacy by cities not only on behalf of their own citizens but on behalf of the rural areas with which their futures are interdependent;
- greater decentralization of authority within cities.

1.6.3 The important role which women play in addressing health issues was stressed. Examples were given of their major role in developing and implementing policies of health education, family planning and child health care. This has obvious implications for the education of women and the acceptance of their role in community participation. Equally it has implications for changes in the attitudes of men.

1.6.4 Communities must be involved in defining the range and urgency of their needs, choosing what to do, and getting it done. Nobody else can stand in their shoes. Coordination is unlikely without their assistance, and action will fail that does not have their support and build upon their own efforts to help themselves. When action involves the utilization of technology, this has to be technology that is understandable and appropriate in its local context.

1.6.5 There was a recognition of the need for appropriate information to address health issues. One must identify with some precision specific groups of the urban poor and determine their characteristics, as well as finding out what they want. This will include formal information, when it is collected comprehensively, and such informal information as community surveys. These two types of information should complement each other, and local knowledge must be used in their interpretation.

1.6.6 The urban rich have a major responsibility in meeting the health needs of the urban poor. There are both moral and pragmatic reasons for this. The title of the meeting - the challenge of social justice - recognizes the moral obligation of those with better health and larger resources to address the health needs of the urban poor. At a pragmatic level, the consequences of not addressing these issues will affect all city dwellers without respect for wealth or status, for example through the spread of disease and violence and reduction in the quality of city life. This responsibility may be fulfilled by contributing (in skills as well as in money) to city initiatives to address these issues, or by voluntary sector activities, or by a contribution of both.

1.6.7 There was a recognition of the need for balanced development. This must tackle both rural and urban problems and address very broad issues of demography and ecology. Examples were cited of the need for rural industry, and sensitive but effective planning measures to handle migration appropriately.

1.7 DECISION-MAKING PROCESSES AND STRUCTURES

1.7.1 Many of the opportunities for, or constraints on, implementation of health strategies are determined by political factors. These may be national or local, and there can be particular problems if the city government represents a different political party or parties from those in power at the national level. Political constraints can arise from opposition to, or neglect of, health policies, and from competition between groups, geographic areas, public sectors or agencies. Decision-making on type, location and management of local services will be more effective the nearer it is to the communities being served: to develop and sustain a truly decentralized system, while at the same time insisting on strategic action, requires political determination and vision of no mean order. There was a consensus that political will is often the major determinant of whether health issues of the urban poor are effectively tackled.

1.7.2 Financial factors are another obvious influence on these decisions. City health budgets are often viewed as too small in total, as well as there being arguments about how they are distributed. It was generally felt that in periods of economic difficulty

those budgets most at risk are: (a) those of health and infrastructure projects; and (b) those directed towards the poor and the powerless. Often there appears to be a great potential for increased demands and costs in health budgets, due to a combination of demographic growth, new technology and rising expectations. By contrast, some cities have great difficulty increasing their revenues because of legislative restraints or technical problems (e.g., in identifying and collecting charges). Another difficulty raised was that caused by periodic funding crises, either within the city budget or by a shortfall in external funding.

1.7.3 A wide variety of organizational factors were thought to limit effective decision-making. These included the lack of authority of city government, problems of bureaucracy, and inadequate cooperation between technocrats and politicians.

1.7.4 A recurring concern was the multiplicity of agencies involved in health issues, leading to lack of adequate coordination and problems of inefficiency and overlap. A case was made for the clarification of the roles of agencies working in the same areas. Many organizations have relatively inflexible decision-making processes which can make it difficult to decentralize decisions and to allow sufficient future flexibility (e.g., to adapt to future changes in either the scale or nature of health needs).

1.7.5 Substantial changes are needed in attitudes, orientation and skills. To achieve the scale of change required, national plans and policies should target the specific problems of the poor - both rural and urban - and shift resources accordingly. For example, hospital systems generally concentrate status and resources in high-cost specialties dealing with relatively small numbers of patients. Better linkages have to be established between the realities of people's needs, primary responses to them, and the activities of the hospitals. When these linkages exist, hospital activities can be far more effective and far more satisfying.

1.7.6 Universities in general and academic departments have a key role to play, because they train and shape the attitudes of each cadre of physicians, nurses and other health workers. They can also take a lead in primary health care projects in the poor urban neighbourhoods that are never far from their door. And their contributions are indispensable in monitoring, evaluation and research. Nongovernmental organizations also have made outstanding contributions in these fields.

1.7.7 The attitudes and skills of the principal decision-makers (and the shapers of public opinion) are a crucial factor. Politicians, senior executives, and others have on occasion left their personal mark in terms of a real and enduring improvement in the health of the urban poor. They also shape and respond to public opinion, so that improved understanding by other citizens of the aspirations of the poor, and reduction of cultural barriers and misunderstandings, can help prepare the way for action. Equally the poor are often alienated and distrustful of others, including officials. While there are no easy answers, equality of political rights with other citizens certainly helps to increase their political influence and their power to help themselves.

1.8 ACTION STRATEGY FOR URBAN HEALTH

1.8.1 A number of areas were identified for future action by participants at the Karachi Meeting and there was a clear set of recommendations agreed in the final session. These require action at different levels, for example, at city level, within cities, between agencies, at national and at international level.

1.8.2 We have collated these recommendations into the overall structure of an Action Strategy for Urban Health. The individual recommendations have their intrinsic value and we have pragmatically identified the potential of a constructive incrementalist approach. Nevertheless, the totality of these recommendations would have an effect much greater than the sum of their individual effects.

1.8.3 As indicated in the summary statement "The Spirit of Karachi", we cannot stress too highly the urgent need for the problems of urban health to be actively addressed at all levels. Hence our urgent appeal to all for an action strategy to improve the health of the increasing millions of poor urban dwellers.

1.9 THE ROLE OF CITY GOVERNMENT

1.9.1 A major concern of participants at the Karachi Meeting was that cities have responsibility without authority. While the city government appeared to be the obvious agency to take the lead in addressing the health problems of the urban poor, it was also apparent that in many instances its hands were tied by legal, organizational and financial constraints. In addition, there are many other decision-makers who may not be keen to lend their support to the city in this lead role.

1.9.2 We recommend that the role of city government needs to be strengthened and clearly defined. At a minimum, it must be the major coordinating organization for public actions for urban health within the city.

1.9.3 There is a major problem when strategies for health are separated from other city planning processes, as though health planning were a distinct entity which can be added on later. There was general concern about the side-effects of indiscriminate economic growth and development and this problem is equally true of national plans.

1.9.4 We recommend that comprehensive city development plans should be consistent with health needs and goals.

1.9.5 We further recommend that where cities have no specific plan for health they should be encouraged to develop one and that all such city plans should focus on the health of the urban poor.

1.9.6 It was accepted that city budgets and responsibilities are interdependent. While cities may play a coordinating role with limited funding it was felt that any responsibility for direct action should go hand in hand with appropriate funding.

1.9.7 It was also felt that responsibility should be more decentralized within cities so as to respond effectively to peoples' needs and engage their energy in tackling problems.

1.9.8 We recommend that cities should undertake such a decentralization process in conjunction with measures which will foster community development.

1.10 INTERACTION AT LOCAL POLICY LEVEL

1.10.1 Because of the number and complexity of organizations involved in health-related decisions, we recommend that interagency coordination committees be considered at city level. These should comprise all the relevant agencies and be chaired by the highest authority such as the Mayor.

1.10.2 We also recommend that such committees should be established within cities with backing and support from the city level.

1.10.3 As an aid to this, it was felt that municipal workshops are worth considering within cities. These should include representatives from as many sectors as possible, including people from the slums.

1.10.4 There was a recognition of the need for a balance between urban and rural development and we recommend that cities should consciously support rural developments because they are dependent on them and because they may help bring some equilibrium to urban/rural migration.

1.11 INFORMATION AND COMMUNICATION

1.11.1 There was a recognition that most cities have inadequate information on which to base a city health plan. We recommend that techniques should be selected (and, if necessary, developed) for obtaining, analysing and storing comparable relevant data about the urban poor and their needs. Only thus can plans be developed and programmes evaluated.

1.11.2 Such data should not be collected indiscriminately. For information to be meaningful, it must help to illustrate the relationships between health and broader social trends. Data collection should be planned with this objective in mind.

1.11.3 City representatives were very keen to learn from experiences in other cities, as well as their own. If this is to happen systematically then cities must be able to describe what occurred locally and there must be a mechanism for sharing information in case studies.

1.11.4 To facilitate the sharing of city experience, we recommend that consideration be given to the establishment of a clearing-house within one of the sponsoring agencies where case studies and other relevant information can be stored, catalogued and copied or loaned on request.

1.12 REORIENTATION OF MEDICAL EDUCATION AND HEALTH AGENCIES

1.12.1 One of the potential constraints on decision-making and implementation at all levels is the understanding attitudes and skills of doctors and other health workers, particularly in relation to primary health care.

1.12.2 We recommend, therefore, that the needs of the urban poor and the principles of primary health care should be integrated into the medical curriculum and into the practical experience of young physicians.

1.12.3 The same concepts, priorities and principles need to be included in educational programmes for nurses and other health workers. This is true for postgraduate, as well as basic, training and it may be that shared training exercises for health workers of different disciplines may be of added value.

1.12.4 It was widely felt at the Karachi Meeting that there is a general need to increase public, as well as professional, understanding of the determinants of health. The perception of health care by the population and by health personnel is still centred on hospitals, clinics and curative interventions both in rural areas and in cities.

1.13 FINANCE

1.13.1 A recurrent preoccupation of participants was that, no matter how much they learned about good practice and good ideas at this Meeting, they would not be able to put much of this into practice in their own cities because of difficulties in mobilizing resources. It was felt strongly that there needs to be better matching of resources, responsibilities and plans at city level.

1.13.2 We recommend that cities should seek special assistance (both technical and financial) at all levels to enable them to deal responsibly with the range of problems of the urban poor.

1.13.3 It appeared from a number of city experiences that doctors and other professionals tend to be found in much greater concentration in middle-class or better-off areas of the city.

1.13.4 We recommend that various incentives should be considered to encourage health workers to work in deprived areas.

1.13.5 Despite these financial and resource problems, there are many examples of small-scale successes with limited means. It was stressed by a number of participants that, even in the poorest communities, the capacity and willingness of the poor to help themselves should always be taken into account.

1.14 NATIONAL AND INTERNATIONAL ACTION

1.14.1 Given the size, the complexity and the commonality of problems faced by participating cities, it was apparent to all that they would need support, particularly at national and international level. A number of recommendations are made as to how this might be achieved.

1.14.2 We recommend that international cooperation should be strengthened in the field of public health, with special reference to the cities and with the support of international funding agencies.

1.14.3 We also recommend at national level that countries should first strengthen their own policies, planning systems, support systems and structures so as to be able to coordinate the needed assistance from international agencies.

1.14.4 We urgently recommend that international financial agencies should consider the negative effects of economic restructuring on the weak and vulnerable (e.g., the children of the urban poor).

1.14.5 We feel that the international network of understanding and support represented by this meeting should continue to develop, e.g., through workshops, exchange visits and a newsletter. A clearing-house for sharing case studies and other information should also be helpful. International cooperation should include the continual sharing of experience:

- among cities of the developing world;
- between developed and developing cities.

1.14.6 As a means of further developing an action strategy for urban health, we would like to see the Report of the Karachi Meeting being made available to other cities who were not participants, as well as to national and international fora which address issues that directly affect the health of the urban poor. We hope that the impassioned plea of the Spirit of Karachi will draw the attention of many organizations and individuals to the role that they can play in this strategy.

1.14.7 Participants thanked the organizers and sponsors of the Meeting for its timeliness and for the way that it had been planned and conducted. They also expressed their gratitude to all the hosts in Karachi for the warmth of their welcome.

SECTION 2 HEALTH OF THE URBAN POOR

2.1 BACKGROUND AND DEFINITIONS

2.1.1 The second half of this century has seen a major growth in urban populations in both developed and developing countries. Many of the people living in, and around, large cities exist in poverty and suffer poor health.

2.1.2 The health of city inhabitants can be viewed in a number of ways. The health of an individual can be considered either as the absence of disease or disability (which is what epidemiologists usually measure) or as complete physical, mental and social well-being. (1) Most health practitioners recognize that there is usually a correlation between all these measures of health in an individual and will take account of both elements when assessing personal health.

2.1.3 Similarly, we can demonstrate the lack of health of a population by levels of premature mortality or the prevalence of specific diseases and these measures can be used to assess the health of a given urban population or to measure health inequalities between groups within that population. However, we could also draw conclusions about the health of an urban population by a number of indicators which reflect their quality of life. This would include those relating to the quality of the environment (e.g., overcrowding, water and sewage amenities), the degree of interaction within communities (e.g., security, violence, social support networks), and the levels of social justice (e.g., income, access to health care and education). There is now a consensus among those involved in public health that there is also a correlation at population level between indicators of poor quality of life (e.g., measures of deprivation) and disease (e.g., high mortality rates).

2.2 URBAN GROWTH

2.2.1 The population of the world has not grown uniformly. Urban populations are growing about twice as fast as rural populations in developing countries. The rate of population increase in industrialized countries has declined rapidly while the least-developed countries continue to have a high population growth rate. These trends are likely to continue into the next century.

2.2.2 In the period 1990 to 2020, the total world population will increase by half (from 5.2 billion to 7.8 billion) but the urban population will double (2.2 billion to 4.5 billion) (Fig. 1). (2) Of the 2.6 billion increase in total population, 2.3 billion or 88% will be in the urban areas!

2.2.3 Between 1920 and 1985, the proportion of the world's inhabitants living in urban areas increased from 14% to 41%. The projected ratio of urban to rural population is set to increase so that the urban population will consist of 43% of the world population in 1990, 47% in 2000 and 57% in 2020. (2)

2.2.4 The difference between the proportions of urban population in developed and developing regions is shown in Fig. 2. This shows that, at present, developed regions have a high proportion of urban dwellers and this proportion is still increasing, albeit slowly. Developing countries have a lower proportion of urban dwellers but this is increasing at rates two to three times those experienced by industrialized countries in the past. (3) This means that, for many countries, the entire increase in population is taking place in cities.

2.2.5 In the year 2000, the 60 largest cities in the world will each have around 5 million, or more, people and 45 of these cities will be in the developing regions of the world. This represents a marked change in the global distribution of urban dwellers in half a century (see Fig. 3). (4)

2.2.6 Urban and peri-urban growth is due to two factors: migration and natural growth. As countries reach higher levels of urbanization, the influence of the former is less and natural increase accounts for a higher percentage of growth in urban areas, particularly among low-income groups (see Fig. 4). For the period 1960-1970, the average city growth rate in 26 cities in developing countries, was 4.3%; natural growth contributed about 2.6% and net migration and reclassification made up 1.8% of this growth. (3)

2.2.7 There are two interlinked processes in many countries. First, rapid and sustained population growth and, second, rapid urbanization. It has been argued that some developing countries have become trapped in the second stage of demographic transition without being able to achieve the social and economic gains necessary to reduce birth rates. (5)

2.2.8 In several countries, populations have begun to exceed the sustainable yield from land, forest and water systems which results in environmental degradation leading to decreased agricultural production, "natural" disasters and increased landlessness. This rural poverty and landlessness promotes rural-urban migration at the same time as the decreased agricultural yield reduces the availability and increases the cost of basic foods in urban areas. Thus, there is resultant poverty and ill-health affecting both rural and urban populations and, although this report is particularly concerned with the plight of the urban poor, it is apparent that rural development is an important strategy in supporting healthy urban development.

2.3 URBAN POVERTY AND HEALTH PROBLEMS

2.3.1 In some developing cities, the poor already make up as much as 60% of the population and the health problems of these urban poor are becoming more critical. (6) These health problems involve both diseases which are traditional to the developing country as well as diseases which have been associated with higher levels of development and industrialization.

BOMBAY (India)

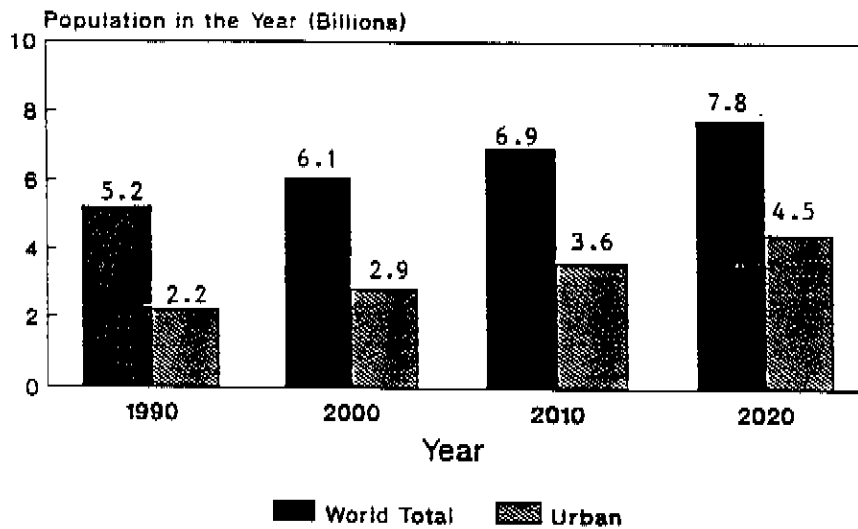
An example of the scale of urban poverty

This is a city of more than 10 million people with an annual growth rate of 3.8%. Illiteracy affects more than 30% of the population and unemployment reaches nearly 40%; in terms of health there is a city average infant mortality rate of 53.1 per 1000 and a maternal mortality rate of 0.4 per 1000. One-half of all the deaths occur under the age of 45 years and among the major causes of premature mortality and outpatient attendances are respiratory diseases (including tuberculosis), diarrhoea, dysentery, fever and accidents.

Bombay has a range of environmental problems (water, sewerage and waste disposal, pollution and working conditions) which exist throughout the city but particularly in slum areas.

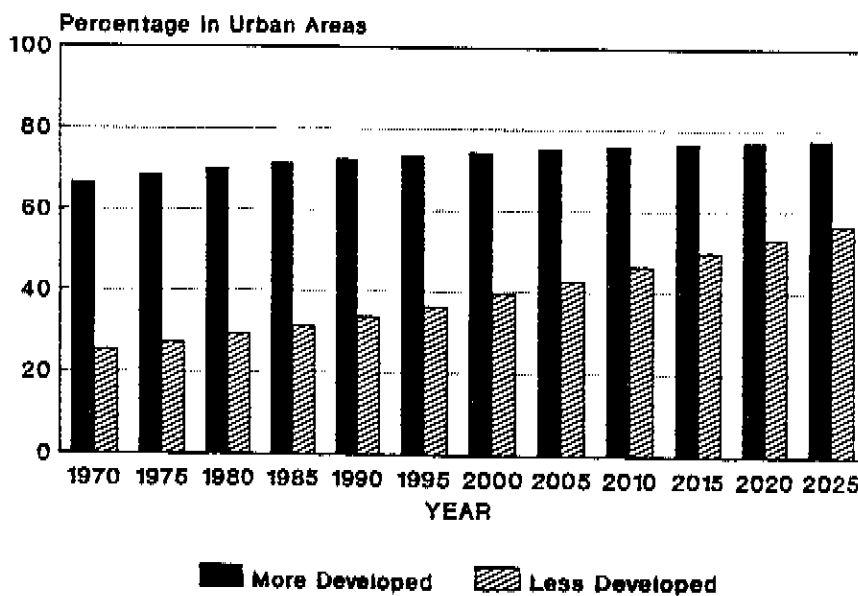
It is estimated that 45% of the population are slum dwellers and there are also a substantial number of street dwellers. These groups face particular problems in relation to overcrowding, sanitation, low income and insecure working conditions and "social hazards". It appears that this urban poverty is now self-perpetuating (rather than an overflow of rural poverty). In response to this, the city has established 66 health posts which provide some degree of integrated health services to 3.3 million people, including maternal and child health care, family welfare, immunization, health education and nutritional advice. These services have been expanded through outreach services from these 66 health posts since 1983.

FIG. 1
Urban Population Growth
From 1990 to 2020



Source: United Nations, "The Prospects of World Urbanization" Revised as of 1984-85, Population Studies, No. 101, ST/ESA/SER/101, New York, 1987.

FIG. 2
PROPORTION OF POPULATION IN URBAN AREAS
Developed/Developing Region, 1970-2025



Source: United Nations, "The Prospect of World Urbanization" Revised as of 1984-85, Population Studies No. 101, ST/ESA/SER/101, New York, 1987.

FIG. 3
Distribution of Cities with 5 million
or more population

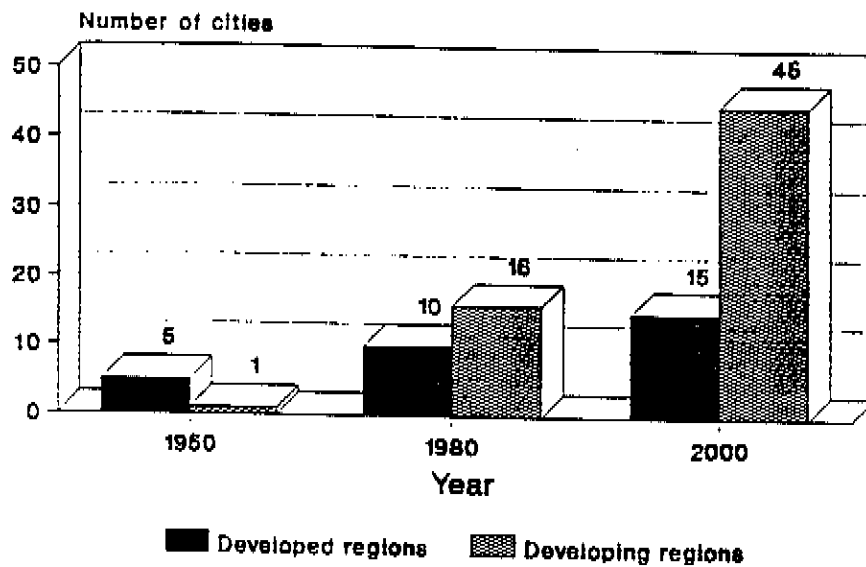
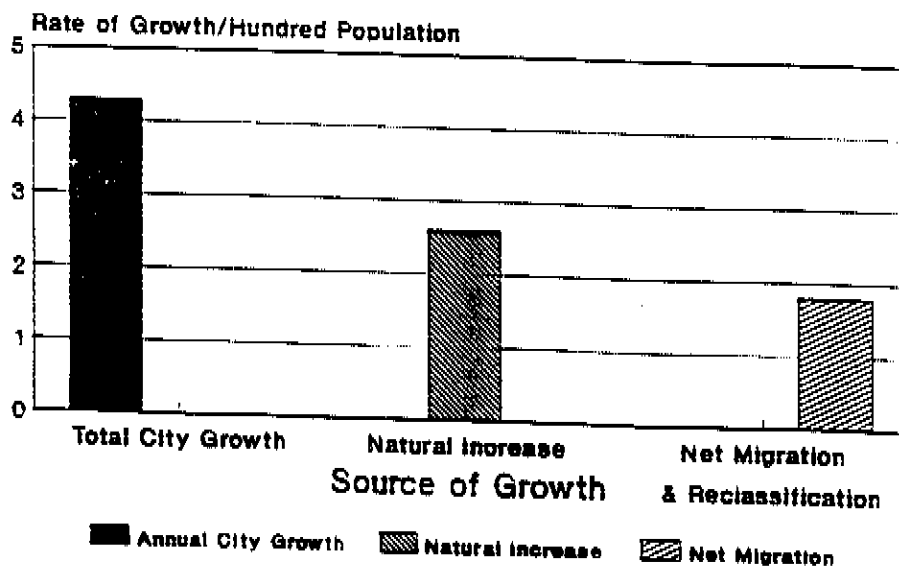


FIG. 4
Average Annual Growth Rate
Per Hundred Population, 1960-70



2.3.2 High levels of traditional health problems are indicated by high maternal, perinatal, infant and under-five mortality rates or by the prevalence of chronic infectious diseases. New health problems associated with urbanization and industrialization include cancers, hypertension, problems of drug and alcohol use, sexually-transmitted diseases (including AIDS), accidents (traffic and industrial) and violence.

2.3.3 However, the extent of these health problems is difficult to quantify. Either morbidity and mortality data are not available for the urban poor (migrants and squatters often do not have access to the hospitals and health facilities that are the sources of health data) or data are aggregated for cities or areas which masks the degree of health problems of the urban poor.

2.3.4 Table 1 shows the very large variation in under-five, infant and maternal mortality rates between countries, but there will also be large variations within these countries and, therefore, some groups, particularly the urban poor, will experience even poorer health than the worst of these figures suggest. (7)

TABLE 1. CHILD, INFANT AND MATERNAL MORTALITY

	Deaths below the age of 5 per 1000 live births	Deaths below the age of one year per 1000 live births	Maternal deaths per 100 000 live births
Very high mortality (33 countries)	211	130	450
High mortality (31 countries)	125	85	145
Medium mortality (31 countries)	108	41	90
Low mortality (34 countries)	13	10	11

Adapted from: UNICEF, The state of the world's children, 1988, New York, Oxford University Press, 1988.

2.3.5 Although there are only limited amounts of disaggregated data on urban health and social conditions, these suggest that the health of the urban poor is markedly worse than that of better-off city dwellers and not any better than that of the rural poor. (8) Levels of malnutrition and infant mortality rates have been found to be three to four times higher in the slums than elsewhere in cities, and childhood mortality four or five times higher in shantytown compared with non-shantytown dwellers.

2.3.6 Population and household densities are much higher in slum areas (e.g., 3.5 persons per room) and age structures show a great preponderance of young people (e.g., 64% under 20 years in some areas, 45% under 14 years in another).

2.3.7 Other indicators of environmental and social conditions which are occasionally available are:

Access to domestic water or standpipe

- this varies between 30% and 65% in slum and squatter settlements;

Ratio of cost of water between street vendors and piped water
- this varies between 10 times and 100 times as much;

Households with access to toilet facilities (including pit and bucket latrines)
- varies between 55% and 75% in many city slum and squatter areas.

2.4 DETERMINANTS OF THE HEALTH OF THE URBAN POOR

2.4.1 Factors which determine the health of the urban poor fall into one or more of several categories.

2.4.2 Firstly, there are those factors related to poverty which include:

- low income;
- poor living conditions (inadequate housing, overcrowding, lack of sanitation or clean water);
- low standard of education;
- inadequate nutrition (quality and quantity);
- lack of affordable transport.

CAIRO (Egypt)

Income-generation in Manshiet Nasser using garbage as the base

The past decade has seen an improvement in living conditions in Manshiet Nasser, an unplanned peripheral area of this city with a population of 60 000. These were among the poorest of the immigrants who took jobs not acceptable to others.

The residents of this area found an economic niche as scavengers and this activity became an important means of income-generation. Interestingly, improvements in housing, water, electricity, sanitation, education and health care all followed.

Despite a 10-year-old housing and environmental survey suggesting that it was not feasible to bring conditions up to acceptable standards, families began to build concrete houses of one or two floors. Piped water was then supplied by the government water authority, initially through public outlets but with increasing proportions of house connections, thus reducing the need for expensive street vendors. Electricity also reaches most houses.

Garbage is now collected by vehicle and sorted in special shelters (no longer in the home) and a new factory converts much of this to an organic fertilizer.

An important role for voluntary organizations was identified in the development of these improved living conditions. The Society of Integrated Social Welfare undertook a survey to obtain demographic data (age, sex, literacy, religion and family size) which helped in planning the work of a new health centre. They are jointly working with governmental bodies on socioeconomic, preventive and therapeutic measures to improve community health.

The Scavenger Care Society built a veterinary unit to look after the animals (essential to their livelihood) and protect against zoonotic diseases. It has also helped the health authorities in organizing training for local midwives.

Both these community organizations are helping to make health and social services more relevant and acceptable.

2.4.3 Secondly, there are man-made environmental hazards in urban areas, including:

- pollution (air, noise and water);
- solid waste accumulation;
- traffic;
- hazards at work;
- stressful conditions;
- an environment and culture which restricts healthy life-styles.

DAKAR
(Senegal)
Grappling with environmental hazards

There are a range of environmental problems affecting health and hygiene in this city. This reflects the status and shortfall of environmental health procedures, waste disposal, sanitation, water supply and housing.

As a result, a variety of innovations have been introduced to try and improve the environment:

- (1) Household waste collection. In the commune of Pikine, the narrow and muddy roads of several quarters are inaccessible to garbage trucks. Under the influence of the health committee, a system was set up using horse carts to go into the enclosed quarters and collect waste from each home. Each family contributes the modest sum of 10 FCFA.
- (2) Days of cleanliness. This was a participative approach chosen by the urban community in the commune of Dakar to clean up the capital. These operate every Sunday and involve clearing up public roads, footpaths and markets, as well as removing household garbage.
- (3) Integrated urban development. This is a project in Chodak involving three areas of action: the promotion of health, including women's health groups concerned with child health, nutrition and hygiene; environmental improvement by promoting and subsidizing the construction of individual cesspools; and family income supplementation, involving training and cooperative retailing such as market gardening, sewing, embroidery, knitting, carpentry and metal work. Otherwise 75% of family income goes on food, so households are barely subsisting.

These initiatives are all based on health-for-all principles and involve the participation of individuals and communities.

2.4.4 Thirdly, there are factors related to urban social conditions, including:

- poor social networks;
- social instability;
- insecurity of land tenure;
- alcohol and drug availability and use;
- interpersonal and family relationships;

- personal violence and criminal activities;
- lack of political responsiveness to the urban poor.

2.4.5 Finally, unequal access to health care and preventive health services are important determinants of health and these include:

- lack of health education and public information;
- inadequate provision of basic medical care;
- poor maternal and child health including:
 - immunization,
 - antenatal and obstetric care,
 - growth monitoring and nutritional rehabilitation,
 - care for diarrhoeal and respiratory infections;
- inadequate communicable disease control;
- inadequate provision of essential drugs.

2.4.6 Along with nutrition, safe water and sanitation, these health services make up the basic components of primary health care. Unfortunately, urban health services are often underplanned, underfunded, undermanaged and, among other difficulties, do not reach out to the neighbourhoods and households of the urban poor. Although there are more health services within urban than rural areas, they are often inappropriate to the needs of the urban poor, or they are not based within the areas of worst health and are not easily accessible from within these areas. This might be because of travel costs, ineligibility or inability to pay, lack of child care facilities, difficulty getting time off work, inadequate knowledge of services, unfamiliarity with other parts of the city and cultural or language problems.

ISTANBUL
(Turkey)

Poverty permeates a wealthy city

Istanbul is a city of seven million and the commercial centre of Turkey, where more than 20% of the national GNP is generated. It is a city of contradictions. For example, 9% of the population cannot read, which means there are as many illiterates in this city as the total population of two medium-sized Turkish cities combined. There are as many inhabitants living in squatter housing under substandard health conditions as the population of 12 small-sized Turkish cities combined. The comparison of Istanbul with the balance of 70 provincial centres of Turkey can be expanded further to other indicators, to find out, repeatedly, that poverty is concentrated in Istanbul, as well as wealth. The 300 000 workplaces, ranging from multinational corporations to small shops, while constituting the formal sector, simultaneously generate an informal sector, upon which survival of hundreds of thousands of people depend.

The issue at stake is whether these people forming the informal sector, and residing in squatter houses, receive appropriate services and care. It is perfectly clear that they do not.

Although public spending on health is not a negligible amount, the distribution of primary health care facilities is extremely skewed. Many health centres are supposedly serving populations between 30 to 100 000 in their catchment areas. Under these circumstances, home visits done by midwives, the most crucial services given by health centres, remain very limited. Insufficiency of vehicles and funds for fuel restrict outreach services.

Apart from these problems, serving the "needy" is challenging in terms of difficulties related to identification of the pockets where disadvantaged people live.

The general appearance of squatter house neighbourhoods in Istanbul changes rapidly, as roads are constructed, and as developers infiltrate these areas to exploit high land values.

To date, the main contributions to improving the health of the urban poor in Istanbul have been by the meticulous implementation of nationwide health programmes such as EPI, CDD and FP. More recently, a Health Master Plan, 1986-2000, has been produced for the city, along with an expanded school health programme and the provision of free water, bread, milk and transportation to those in need. The Health Master Plan, produced in coordination by the Governor of Istanbul and the universities, concentrates on a decentralization of health units, both curative and preventive, by locating new health facilities to enable easy access. Until the network of new facilities is complete, 10 health buses will be used to fill the gap, serving exclusively the disadvantaged areas.

2.5 THE SCALE AND NATURE OF THE PROBLEM

2.5.1 It was apparent from the presentations by city representatives to the Meeting that there is a tremendous heterogeneity between and, indeed, within cities. It was also apparent that in many cities the numbers involved and the speed of change are such that they make the enormity of the problems difficult to comprehend.

2.5.2 Given the many determinants of health within cities, it seems apparent that the health needs of the urban poor call for a comprehensive approach which addresses all of these factors. (6) However, while recognizing the importance of an overall goal, we realize that many cities are likely to move towards this by gradual means. A recurring question in the Meeting was how to maintain a balance between the approach of constructive incrementalism and an overall strategy for health.

2.5.3 An adequate approach, nevertheless, would require a commitment to improving the health of people living in slum and squatter settlements, a willingness among different agencies to develop common strategies to meet the health-related needs of the urban poor and a recognition that poor communities themselves have a major part to play in developing the strategies to improve health.

SECTION 3 IMPROVING CITY HEALTH

3.1 INTRODUCTION

3.1.1 The determinants of urban health have been recognized for some time and much is known about what needs to be done to improve the health of the urban poor. Safe water, reasonable housing and sanitation, adequate family income are among the fundamental requirements. So are basic nutrition, particularly for mothers and children, including the universal availability of simple oral rehydration, an immunization programme with a very high level of coverage, and basic medical services, including maternity services which are able to provide care appropriate to risk.

3.1.2 To these measures, which focus on families, can be added some that go much wider than the family, such as environmental safety, the development and maintenance of social support networks, and putting in place the foundations for an ecologically stable urban community - in other words one where people not only can survive in the short term but also can develop in ways that are viable in the longer term, and offer them some prospect of an enhanced quality of life. Because cities do not function as discrete economic and geophysical entities it is important to address a number of ecological issues if the health strategy is going to be sustainable. Fundamental to this are the interrelationships that the city has with: its rural hinterland and with neighbouring urban areas. The nature of these interrelationships is likely to be complex and will vary from city to city but issues which a health strategy might have to take on board include the following:

- (a) agriculture, food production, retailing and nutrition;
- (b) industrialization, use of raw materials, waste disposal and pollution;
- (c) transportation problems (which increase geometrically as the city expands);
- (d) education and health care;
- (e) recreation and protection;
- (f) population movements.

The essence of all these relationships is that they should aim towards sustainability. This is true of all cities, whether they are growing or not, and whether they are in developed or developing regions.

3.1.3 In short, the key problem is not our lack of scientific knowledge of what to do. How to do it is more difficult, but considerable experience with primary health care in cities has now accumulated and can be studied for answers to this complex problem.

3.2 NEED FOR A BROADLY-BASED RESPONSE

3.2.1 Increasingly there is consensus about the need for a broadly based strategic response, and a body of doctrine about its nature. For example, such a strategy should:

- (i) be based on adequate information about the urban poor: who they are, where they live, their main health needs and their organizations and capacity to help meet their needs. This is not as simple as it sounds, because the urban poor are often scattered and information about their health status and social conditions is lacking;
- (ii) reflect the community's own preferences, its commitment, its capacities and its involvement. This requires a political process which will allow community participation in all planning and strategy building and which renders policy-makers accountable to the community: the community should actually contribute to and be strengthened by the strategy;

- (iii) involve most or all of the elements identified in the preceding Section (see 2.4) and include training of community workers and volunteers in these issues;
- (iv) reorient policy, skills and resources within the health sector toward greater community participation and equity, basic medical care, preventive health, education and public information;
- (v) involve concerted commitment and coordinated action among other sectors, including housing, education, industry and urban services and infrastructure development;
- (vi) include monitoring and evaluation so that the strategy is continually adjusted based on experiences.

3.2.2 While such a strategy has frequently been described and quite widely endorsed, it remains speculative because there are few, if any, complete examples anywhere.

3.3 ROLE OF PRIMARY HEALTH CARE

3.3.1 The basic components and concepts of primary health care (PHC) are well established (see box). Because PHC is based within communities it is an appropriate entry point for a strategy aimed at improving the health of the urban poor.

BASIC COMPONENTS OF PRIMARY HEALTH CARE (9)

Health education
Food supply and proper nutrition
Safe water and basic sanitation
Maternal and child health care
Immunization
Prevention of endemic disease
Treatment of common diseases and injuries
Provision of essential drugs

BASIC CONCEPTS OF PRIMARY HEALTH CARE (10)

- | |
|---|
| <ol style="list-style-type: none">1. Universal coverage of the population, with care provided according to need.2. Services should be promotive, preventive, curative and rehabilitative.3. Services should be effective, culturally acceptable, affordable and manageable.4. Communities should be involved in the development of services so as to promote self-reliance and reduce dependence.5. Approaches to health should relate to other sectors of development. |
|---|

3.3.2 Primary health care has been described as the key to achieving Health for All (HFA) and as an integral part of the health system and of the overall social and economic development of the community. (9,10) A district health system, based on primary health care, will include self-care, family care, community health activities, first health facility and the hospital at the first referral. This is equally true for both urban and rural district health systems.

3.3.3 Prevention and care by, and for, the community itself will give visible results within a short period of time and need not require a lot of capital investment. Improving sanitation, nutrition or antenatal care, for example, will result in better health for the whole community. The energy, inventiveness, determination and will to survive of low-income urban populations are now fully acknowledged. It is becoming increasingly obvious that for any primary health care programme to succeed, local communities must be involved fully so that they are responsible for, and benefit from, an improved health delivery system. Through community participation in policy-making as well as implementation, services can be designed in explicit response to needs that people have themselves expressed and can reach further out to the poorest families. Also, communities value and better maintain services to which they have contributed.

ADDIS ABABA
(Ethiopia)

A city-wide PHC programme

Addis Ababa has developed a programme of primary health care which involves a variety of strategies, including community mobilization and training of community level health workers.

A wide variety of organizations are involved in these activities:

- urban dwellers organizations;
- women and youth associations;
- trade unions;
- nongovernmental agencies.

Primary health care committees at various levels were established.

A programme of workers training was established which involved community health agents (CHAs), traditional birth attendants (TBAs) and neighbourhood health action animators.

Eventually there are plans to appoint one CHA (and one TBA) per 1000 population but initially there will be one CHA per "kebele". There are 284 kebeles in the city and they have 5000 population on average. Training of CHAs was preceded by well-designed "trainers training" programmes to improve communication and teaching skills. An interim survey has been conducted to get an impression of the scope of involvement and efficiency of CHAs. This suggests a need for continuous support and supervision for health establishments from the city council.

The neighbourhood health action animators are volunteers selected from the youth and women's associations and are assigned to units of 30-40 families. The animators are usually members of these family units and are expected to keep account of births and deaths, register those eligible for vaccinations, and to weigh children under two years of age at monthly intervals. This approach (unique to the capital at present) has not yet been formally evaluated but much of the success of the immunization programme is credited to the volunteers.

One major problem in strengthening PHC programmes at grass-root level is the lack of effective and efficient back-up at district level. The training of doctors and other health personnel in PHC and deploying them to staff district health departments is a recent achievement.

3.3.4 Many of the resources, particularly human resources, required for primary health care services can be found within the community itself. Members of the community can be trained to become community health workers and the community can contribute its labour to construct health facilities, building materials being provided free or on credit by the government or by nongovernmental organizations. The opportunities for community cost sharing are likely to vary from place to place depending on factors such as absolute levels of poverty, capacities within the community, problems of underfunding and lack of access to services in particular areas.

BEIJING
(People's Republic of China)
Health achievements despite limited resources

Beijing demonstrates that even in a city which has expanded rapidly, it is still possible to achieve and maintain relatively good levels of health as measured by, e.g., life expectancy, maternal, childhood and perinatal mortality, immunization rates, incidence of infectious diseases.

Comparison of mortality rates for last decade

Mortality rate	1979	1988
Pregnant women	33.4/100 000	30/100 000
Infants less than 3 years	14.39%	11.99%
Newborn	9%	7.7%
Perinatal infants	15.4% (1981)	11.87%

Health care in Beijing is funded by three different means:

Government-paid medical service and labour insurance	62%
Labour insurance for employees' family covering 50%, rest paid by family	24%
Self-paid patients who later receive 50% government reimbursement	14%

Nevertheless, the present health care system faces a number of challenges:

- (1) health spending makes up 3% of the municipal budget but a strong case could be made for increasing this;
- (2) government-supported social insurance for non-insured residents would increase the comprehensiveness of health care;
- (3) health care services could be developed to improve the quality of people's health (as well as reducing mortality).

3.3.5 To be effective, primary health care is dependent on intersectoral action in a large number of areas. Some of these are identified in the box on page 23.

INTERSECTORAL ACTION FOR HEALTH

- Employment, income-generation and income distribution
- Industry
- Agriculture
- Food supply and nutrition
- Housing
- Sanitation and water supply
- Solid waste disposal
- Environmental safety and sustainability (including pollution control)
- Security of tenure
- Reasonable (but realistic) building regulations
- Transport
- Communication
- Education
- Recognition of the role of women
- Community development and empowerment
- Population equilibrium

CALIBAR
(Nigeria)

Putting together an intersectoral response

In this city, 40% of the population can be classified as poor, using a definition of less than one adequate meal per day.

Many of the problems faced by this low-income group are due to poverty, lack of sanitation, inadequate water and food, poor housing, crime and unemployment. These problems have been worsened by the structural adjustment programme which has been introduced because of financial problems.

There are apparent difficulties in: (a) developing city policies (particularly because many issues are the responsibility of regional or national government); and (b) achieving more than minimal community participation even with political statements of commitment.

The city has focused on health problems of children aged 0-2 years and pregnant women and, therefore, on the services provided by trained health workers and traditional birth attendants. There are a number of primary health care and related activities, e.g., expanded programmes of immunization, oral rehydration, housing and transportation. There are also some local initiatives to improve health and health care, e.g., primary health care management committees, local health committees, neighbourhood development organizations.

3.3.6 Slum communities, if supported by enabling policies, progress slowly but often surely. They work together to better their environment by building roads, crèches, schools and clinics and organizing garbage and sewage disposal. The provision of security of tenure and a little financial and technical assistance, as well as training from governmental or nongovernmental sources, can go a long way to enabling people to improve their situation. The basic requirements are changes in policy from those of non-recognition and non-support (or opposition) for community involvement to those of enabling or encouraging community action.

CALI
(Colombia)
Helping the micro-entrepreneur

In this city, the importance of the "Informal Sector" in urban development and, in particular, the role of the micro-entrepreneur, has been clearly demonstrated. As a means of supporting and developing this sector an educational programme has been developed by the Carvejal Foundation which adapted the basic principles of business administration to the smallest organizations, that is, to micro-businesses.

The micro-entrepreneur has a good knowledge of his craft but not of management. Although micro-entrepreneurs place credit as their most important need, the Foundation has found that credit without education can be harmful. Those micro-entrepreneurs who received management training and credit believe that the former played the more important role in the improvement of their enterprise.

By September 1989, 13 000 micro-businesses in Cali, alone, had taken at least four basic training courses. In all of Colombia, this was 70 000 and 25 000 businessmen had received loans (averaging US\$ 14 000) resulting in 30 000 direct jobs.

Examples of local initiatives include:

- (1) The self-construction of dwellings. The success of the programme carried out in Cali has depended upon the cooperation of the different participating institutions, since its functioning requires the coordination of different activities.

In addition to plots of land with public services, or what is called sites-and-services, the two most important components of self-construction are loans to increase the economic capacity of the dwellers, and the availability of construction materials in places close-by. A self-construction programme also requires support for the persons engaged in self-construction. This support consists of supplying architectural designs with several alternatives for construction, facilitating the legal approval of the municipality, providing technical assistance and coordinating the neighbours so that they help each other in an organized way.

- (2) The provision of warehouses for building materials. This is leased to manufacturers and businessmen who sell the building materials and pay a percentage of sales to the workmen.
- (3) Waste collection and recycling with funds being used to provide resources for paving of streets and payment for medical services.

3.4 THE IMPORTANCE OF DECISION-MAKING AT CITY LEVEL

3.4.1 Decision-making at city level is a principal influence on urban health:

- it is the only level where a city-wide health strategy can be developed along with the appropriate leadership for implementing the strategy. This will require a shift away from the goal of unconditional economic growth towards that of increasing the health and welfare of all citizens, especially the poorest;
- it is the main level at which services and departments have to be coordinated to achieve intersectoral action.

3.4.2 However, decision-making processes which determine city health occur at a number of different levels above or within the city and, at each of these levels, different players are involved in making (or failing to make) these decisions.

3.4.3 The different levels of decision-making processes extend from the level of international organizations to that of households. The different players vary depending on the level. Some examples of the range of participants are given in the box below.

3.4.4 Because of its central position within these levels of decision-making processes, the city is the natural level at which to develop a health strategy. However, the complexity of this decision-making machinery leads to two other conclusions:

- a city health strategy to cater for everyone including unserved and underserved groups would require a very broad base of support to have any chance of success. This, in turn, means that there must be considerable information, and opportunity for debate, provided within the city, within the community and at national level;
- there has to be a recognition of the need for coordinated decision-making and a commitment to achieve this among the various organizations involved. Otherwise, those involved in decision-making processes will be constantly frustrated by other decisions beyond their control. Therefore, there is a need for a structure and/or process to ensure both vertical and horizontal consultation and coordination in decisions affecting health within the urban community.

LOCATION OF DECISION-MAKING PROCESSES AFFECTING CITY HEALTH

International: Private companies/Governmental alliances/NGOs/Aid agencies/...
National: Ministry of Health/Other departments/Large businesses/NGOs/ Political groups/...
Municipal: Local government departments/Health boards/Local businesses/ NGOs/Community organizations/Trade unions/Professions/Academic institutions/Political groups/...
Community: Public sector staff/Voluntary organizations/Local businesses/ Community representatives/Nongovernmental organizations/ Schools/Local community organizations/Political groups/ Religious organizations/...
Families and individuals

3.4.5 Of course, given the uncertainties of obtaining city-wide coherence in strategy making, interim arrangements may need to be considered. Thus, areas of the city, such as specific zones or large neighbourhoods, might collectively adopt common principles or share in specific initiatives to promote equity in health.

3.5 BARRIERS TO ACTION

3.5.1 If there is quite a large measure of agreement about the scope and substance of an appropriate strategy, why has not more happened in practice? It would be foolish to ignore the fact that there are some real barriers to progress. Among them:

- (i) an all too obvious gap between the resources available and those needed, and the difficulties in realigning what resources there are, even when a changed pattern of expenditures seems mandatory;
- (ii) a mismatch between the heavy responsibilities that rest upon city governments and (frequently) their limited authority and limited funding;
- (iii) complexity and inconsistency among the various levels of government, so that (for example) there may be little or no support in national development plans and national health policies for local programmes to improve the health of the urban poor, or (to take a different example) the economic, environmental and social interdependency of the city and of surrounding rural areas may not be reflected in shared policy and joint action;
- (iv) lack of legal status and land tenure in many poor urban communities, combined with lack of community organizations and a political voice. Along with this powerlessness frequently goes a mistrust of authority by the poor and prejudice and discrimination against the poor from others in the city;

COLOMBO (Sri Lanka)

Community development in the Colombo Project

The Colombo project, established in 1979, was concerned with both environmental improvement and community development in the slums and shanties of the city.

At that time these were home to 50% (315 000 people) of the city population, almost entirely consisting of the urban poor (average per capita income per month of SL Rs 80.00 or less than US\$ 2.50). This group had many health problems - a high incidence of infant and child morbidity and mortality, water-related disease and nutritional deficiencies, lack of basic amenities, poor sanitation and environmental hygiene. Perhaps more fundamental, however, were the lack of land tenure, home ownership and the instability of their very existence which prevented any community-level organization to improve their situation.

There were a number of critical factors which determined the success of the Colombo project and four of these are identified below:

- (1) the project benefited opportunistically from national policy initiatives concerned with housing programmes and rights of tenure;
- (2) little would have been achieved without the political will, commitment and support, at the highest levels, to improving the status of the urban poor;

- (3) the installation of physical amenities (the visible benefit of the project) was found necessary before there was any success in achieving community participation in the project;
- (4) the community level workers (health wardens) proved to be more capable of interacting with the community and promoting identification of health needs than the traditional field worker (public health inspector, midwife or nurse).

Initially set up in 300 slum communities, the programme has gradually achieved a level of community participation and has grown in content (to meet community defined needs) and in area (to cover other slums and shantytowns).

- (v) organizational barriers to intersectoral action and a distrust of what is sometimes seen as an attempt by health agencies to pre-empt scarce resources;
- (vi) barriers, loyalties and commitments within the health sector, frequently including an inappropriate introversion by hospital medicine which often takes too little note of the contribution that it should make to the health needs of the urban poor. (Medical professionals may focus on the care and cure of inpatients to the detriment of outpatients, preventive care and community-based services);
- (vii) organizational complexity outside government as well as within it, for example nongovernmental organizations (NGOs), private companies and international agencies, with the difficulties inherent in trying to achieve effective collaboration among them all, leading to action on the ground;

LAGOS
(Nigeria)

An example of intersectoral action

The Metropolitan area of Lagos has a population of 5.25 million (1988), increasing at slightly more than 3% per annum. About 1.3 million people live in slums.

Getting things done in Lagos about health inequalities and access to health care by the poor requires the sustained commitment of the Federal and State governments, as well as the city and surrounding jurisdictions. Among the actions that are being undertaken are:

- Water supply: Establishing "mini-water works" (which are deep boreholes with compact treatment plants) in strategic locations in the densely populated areas. Access to safe water by the poor (45%) remains much less than the metropolitan average (80%).
- Housing: Construction of low- and medium-cost houses, which are sold at subsidized rates.
- Education: Provision of standard, prototype classrooms in every community.
- Transportation: A "mass transit programme", to provide commuter and student buses, to improve roads and to develop waterways and ferries.

- Nutrition: Programmes to improve nutrition, linked with provision of agricultural land for a small fee and the encouragement of increased food production.
- Environmental sanitation: The pail system of human waste disposal was abolished in 1986, with encouragement (through subsidy) for each household to build a water closet instead. Special sanitation days have been established on a monthly basis, when movement is restricted and everyone has to clean their house and surroundings, with a fine or imprisonment as the punishment for non-compliance. The adequacy of solid waste disposal is still much less (25%) for the urban poor than for the city as a whole.
- Primary health care: The Programme includes formation of local health committees, training of neighbourhood health workers, market-based distribution of contraceptives, routine teaching to mothers of ORT, and the use of national and State immunization days, with mobile and market-based EPI teams.
- Community development: There are special programmes for women (the Better Life Programme) and for mothers and children.
- Rehabilitation of destitutes: An attempt (with only limited success) to pick up and rehabilitate destitutes and beggars in the city.

Apart from governmental programmes, many local voluntary groups are active in Lagos, assisting with health programmes for the urban poor, including a strong attempt by the women lawyers to help combat drug abuse.

- (viii) sometimes the lack of any process for developing an effective overall health strategy, or even partial strategies that promise incremental gains, and the political commitment to implement them;
- (ix) a commitment to economic growth and development without consideration of the adverse effects of these policies and programmes on the health of the urban poor. The other aspect of this is the implementation of policies of structural adjustment, in times of economic crisis, without mitigating the worst effects of these on the city's poor;
- (x) a shortage of some of the relevant skills, for example, in policy analysis and formulation, health service management and in monitoring and evaluation; possibly also, in some cases, a lack of political leadership;
- (xi) impotence at the city level to resolve some problems that can only be handled at the level of regional or central government - or even internationally, such as (in some cases) the crippling impact of debt repayment.

3.5.2 To date there are more convincing examples of successful, relevant projects at the micro level than on a city-wide basis. Moving from such isolated initiatives to a total strategy has proved difficult, and it does not happen of its own accord. The problem of institutionalization of PHC projects has been recently discussed elsewhere. (6)

3.5.3 Alternatively, of course, one can start with a total strategy, but then this has to take on local life and reality before it becomes relevant to specific communities and neighbourhoods, each with their own circumstances, problems, fears and hopes.

3.5.4 Empowerment of poor communities is therefore an essential ingredient. This requires a clear resolve, patience and specific skills. It also calls for city-wide organizational structures and processes that foster and support local action.

3.6 TOOLS FOR EFFECTIVE DECISION-MAKING

3.6.1 While primary health care actions have the potential to be among the most cost-effective contributors to improvements in human welfare, this has to be documented and demonstrated. Hence, there are a number of important methods which may need to be considered for planning and decision-making.

3.6.2 Situational analysis: This is a method which can be used for summarizing and analysing the health-related problems within a city and the resources available to meet these problems. It incorporates routine and ad hoc data collection using quantitative and qualitative information from formal and informal sources. The analysis of this information, using a team approach with feedback from key contributors, including community members, should identify priority health needs and issues to be addressed at city level, the main actors to address the issues, and the resources from community, city and national levels that can be mobilized.

BANGKOK
(Thailand)

Situational analysis through the Basic Minimum Needs survey

The city has for some time had a commitment to urban primary health care (e.g., through the use of urban health volunteers) but it was realized that this commitment on its own was not enough either to provide adequate personal care or to meet the needs of communities, particularly among the urban poor.

As a result, the Basic Minimum Needs (BMN) concept was used as a developmental approach because it was "socially oriented, community based, intersectoral ... and scientifically sound". It involves eight components:

- food intake;
- housing;
- basic services, e.g., health and education;
- security;
- good culture and habits;
- income-generation;
- family planning;
- community participation and obedience of laws.

In 1987-1988, 80 communities in Bangkok conducted the BMN survey. It was found that physical problems were ranked first, followed by socioeconomic, health and behaviour problems. Major health problems included family planning, MCH and nutrition. Resurveying will be conducted yearly for monitoring and evaluation. Since a new section is responsible for community development and income-generation, with 17 new posts added in the organization of each district, the Bangkok Metropolitan Authority plans to increase coverage of community development by at least 80 communities yearly. At present, it is still in the process of learning and doing. It is felt that it is essential to have some communities as training sites and facilities for those from other communities in the near future. Community-based training programmes for health for all through the Basic Minimum Need Approach will help us as a key for shortening the time of full coverage.

3.6.3 Option appraisal: This is an aid to planning involving the review of a number of possible methods for intervention to address any of these priority issues. Which options are desirable will depend on:

- available technology;
- local circumstances, including government and community structures and capacities;
- information derived from pilot projects (locally and elsewhere);
- models of projected costs and benefits from different approaches.

3.6.4 Participatory planning: This should include national and city government officials from all related agencies, i.e., water, sanitation, social and community development, as well as health, and representatives from selected communities of the urban poor.

LUSAKA
(Zambia)

An example of participatory planning in Kamanga Township

In 1987, an Intersectoral Committee, formed by the Lusaka Urban District Council, selected Kamanga Township as an area of exceptional disadvantage, indicated by landlessness, poor water supply, lack of proper sanitation and low income. Three baseline surveys were commissioned covering social and economic aspects, health, and water supply. The Intersectoral Committee then set about organizing a workshop for opinion formers/community leaders in Kamanga Township, to discuss the survey findings and obtain the views of community leaders on priorities for action and the prospects of developing the Township with their cooperation. The workshop:

- resolved upon an order of priorities (water supply, sanitation and housing, and refuse disposal were the first three);
- committed the Kamanga community to individual and mutual self-help whereby, for example, the building of houses and latrines would be the responsibility of individual households, while water supply and a range of facilities would be matters for the community;
- pledged the Kamanga community to financial and other contributions;
- committed the local political leadership to organizing the community in various forms of participation.

The Steering Committee then formulated a plan of action to reflect community concerns, and went about "selling" the proposals to various possible funding agencies, project by project.

3.6.5 Monitoring and evaluation: Monitoring can be defined as an internal process involving, e.g., achieving target coverage, carrying out financial audit, meeting deadlines, etc. It is, thus, essentially to do with measuring process. Evaluation, on the other hand, is essentially about measuring outcomes and relating these to costs incurred. Often these will be compared against a set of target outcomes defined at the outset of the intervention (e.g., to reduce differences in levels of premature mortality between areas of a city by X%). Usually evaluation will involve external contributors as

well as those responsible for implementing the intervention. Using these definitions, monitoring tells us about the progress and feasibility of a particular option; evaluation tells us about its effectiveness and efficiency.

3.6.6 Documenting and evaluating what happened locally is essential to the process of option appraisal and decision-making and might involve the following areas:

- (a) What are the essential problems and how are these identified?
- (b) How and why were particular interventions adopted?
- (c) What was the process of consultation? At what stages did this occur and who was involved?
- (d) How was the intervention implemented? Are there documents describing the process of implementation of the project (i.e., monitoring)?
- (e) What was the outcome of the intervention (i.e., evaluation)? This should describe health improvements and the cost of the intervention. What were the outcome measures that were selected and why? Does the information allow a cost/benefit analysis?
- (f) Does the information available allow some estimate to be made of the replicability of the project? Is there other information (perhaps qualitative rather than quantitative) which will help to assess replicability?
- (g) What were the failures and shortfalls and what were the reasons and costs?

3.6.7 Clear exposition and effective communication are needed at each stage and each level for broad support (see 3.4.4), this is fundamental to any city health strategy. It should include:

- the public (including local communities);
- the politicians;
- the administrators;
- the professions.

This is not a matter of "marketing" predetermined policies, nor even simply a matter of education, rather it is a two-way process by which problems are shared and solutions explored. It will be facilitated by a team approach to decision-making.

3.6.8 The degree to which these tools are available will depend on a number of factors, for example:

- local skills available;
- pressures of time;
- financial resources;
- existing networks.

3.6.9 As a rapid, but effective, decision-making method, Rapid Appraisal (see box on p. 32) has been developed and used in a number of urban situations, and is based on the health for all principles of equity, community participation and intersectoral collaboration.

STEPS FOR RAPID APPRAISAL (11)

1. Decide what information is needed.
2. Decide how to get information:
 - documents;
 - key informant interviews;
 - observations.
3. Collect information.
4. Analyse information:
 - data and professional "common sense".
5. Review findings with key informants.
6. Define priorities.
7. Make a plan of action.
8. Monitor and evaluate.

3.6.10 There are two fundamental benefits from using the methodology of rapid appraisal. Firstly, it means that local people are involved from the outset in problem definition and priority setting. Secondly, it is a very valuable learning experience for the professionals involved. This process, however, should only be seen as a starting point and it may have to be carried out in several different areas of a city to provide an overall basis for developing a health strategy.

3.7 GAINING COMMITMENT

3.7.1 Section 3.6 concentrates on improved rationality. Important as rationality undoubtedly is, it is not sufficient. Indeed, it can be positively unhelpful to concentrate exclusively on analytical techniques without recognizing that the main blocks to action are not lack of information.

3.7.2 For example, all human organizations are, to a degree, prisoners of their own structures. Hence, to achieve intersectoral action is likely to require the establishment of groups that cross organizational boundaries, such as:

- interdepartmental committees and working parties;
- task forces dedicated to a common cause;
- neighbourhood councils that are concerned to voice opinion about a wide range of services in their locality;
- city-wide strategic teams chaired at the highest level to support PHC activity throughout the city.

THE STATE OF SÃO PAULO
(Brazil)

Moving from a centralized to a decentralized health system

The Brazilian health system used to be extremely centralized to the Federal level, and was also fragmented, with different agencies attempting to respond to the needs of people in the same geographic area. In the State of São Paulo, this position has changed through the implementation of a unified and decentralized health system (SUDS) coordinated by the State. Under the municipalization process, 560 out of 572 municipalities in the State (but excluding the Capital for the moment) have been given authority for running (among other things) their local health affairs, with control over the combined resources of health services previously run by Federal, State and Local Governments. The municipalities clear their plans and review their results with 62 regional health authorities, acting on behalf of the State. Whatever is approved in this way is passed to the central health administration of the State so that, within the State's health budget and its policy guidelines, contracts can be signed and implemented.

These arrangements allow substantial local management autonomy, without a loss of real control at the State level. Substantial additional investment in the health system has taken place under the aegis of these municipalization arrangements.

Although at an early stage, some indications of the success of this initiative are available. There has been an improvement in vaccination (DPT, poliomyelitis, measles, BCG) which has increased from a range of 75-85% (1987) to 90-98% (1989). Control programmes for cervical cancer used to reach 8% of women and this has increased to 50% (1989).

The project for the slums aims at the installation of Advanced Health Centres, Child Development Centres and collective baths, lavatories and wash tubs. The health centres will provide ambulatory care 12 hours a day with medical care, simple surgical procedures, treatment and support activities. The child centres will provide child care, hygiene, nourishment, education and health care for children 0-6 years old.

3.7.3 A second organizational block concerns the isolation and powerlessness of the urban poor (3.5.1). Their lack of status (or even of basic recognition as citizens) and distrust of authority is often combined with a lack of time to engage in any activity that does not seem essential to survival.

3.7.4 Intersectoral organizations (3.7.2) are all very well, but they can do little if they are overtly or covertly opposed within the main departments which they are supposed to represent. Too often PHC has been set up as a separate policy or management activity leaving the rest of the organization unaffected and quite possibly hostile. Thus, it may be necessary to change the rest of the organization - such as the Ministry of Health or City Health Department - before PHC is taken seriously. Similarly, there have to be substantial changes of heart and shifts in the balance of power within the health system and the medical profession to turn hostility into understanding, commitment and support. Universities, in general, and academic departments of medicine and nursing, in particular, have big roles to play, because they shape the attitudes and skills of each cadre of physicians, nurses and other health workers. They can take a lead in primary health care projects in the poor urban neighbourhoods that are never far from their doors, and their contributions are indispensable in monitoring, evaluation and research. Nongovernmental organizations have also made outstanding contributions in these fields.

KARACHI
(Pakistan)

An example of a University's contribution to PHC

Karachi is a city of some nine million, sprawling outwards over an enormous area and still growing in population at 6% a year. The main impetus to growth has come from inward immigration from rural areas, including remote areas after partition, so that Karachi's population is highly disparate, and the city does not feel rooted in its hinterland.

Although it is (by regional standards) a relatively wealthy city in a relatively wealthy country, about 40% of the population live in slum and squatter settlements.

Since 1985, the Department of Community Health Science of the Aga Khan University (AKU) has been designing and testing primary health care (PHC) modules in both rural and urban settings which have the promise of providing effective and affordable services and also serve as prototypes for PHC systems that could be replicated by municipal and provincial governments. In addition, these field sites provide training facilities for AKU's medical and nursing students in order to prepare them for dealing with the major health-related problems of Pakistan. Lastly, these field sites also provide opportunities where health services research and health manpower development activities can be conducted. Of the seven urban field sites, six are in "katchi abadis", which are among the city's poorest areas.

In implementing the PHC programme, major emphasis is being laid on community participation, community financing, promoting health and preventing disease, setting up a PHC infrastructure, establishing referral systems, providing effective treatment for common ailments, and promoting intersectoral collaboration.

3.7.5 We have already referred (3.6.7) to the need for clear exposition and effective two-way communication. Here, we emphasize that this has to be in a broad sense a political matter, though not necessarily party political. A fundamental shift of public policy, such as PHC requires, will not happen without public acceptance and political leadership. Political will is often the main determinant of whether health issues of the urban poor are effectively tackled. This means cultivating opportunities to influence key politicians, leaders, and opinion-formers, and to shape public opinion (which in turn influences those who hold or aspire to power). Equally, the poor are often alienated and distrustful of others, including officials. While there are no easy answers, equality of political rights vis-à-vis other citizens certainly helps to increase their political influence and their power to help themselves.

MANILA
(Philippines)

Manila on the Go ... An attempt to link local action to the Mayor

Manila, a metropolis of a little less than two million people with a population density of roughly 50 000 per square kilometre, is divided administratively into 899 barangays or villages, of which 234 are classified as depressed. The City of Manila is trying to tackle the problems of inequality and deprivation, both through measures to alleviate their worst aspects and through rectification in more fundamental ways. Towards these ends there is a four-year development plan for 1989 to 1992, with a health component that is multisectoral and participatory.

All of this is worthy but somewhat bureaucratic. The City Mayor has added a distinctive personal and political element with the MANILA ON THE GO programme. A trouble-shooting medico-auxiliary team, at the Mayor's personal disposal, is sent on a daily basis to a selected barangay to do whatever the barangay leaders want done.

While one can see some obvious dangers in this approach (Will political favouritism and political opportunism disturb the priorities of the City Plan? Will barangays be selected on the basis of their need or of political expedience? Will the team be in any one place for too little time to do much?), it also offers potential advantages. It forms a direct two-way link between local community leaders (at the barangay level of 2000 people on average) and the Mayor, demonstrating his commitment to helping them and briefing him continually on the state of affairs in deprived communities and on what community leaders think are the priorities.

3.7.6 Finally, it is naive not to recognize the power of money. Without some expenditure, little can be achieved. In periods of economic difficulty, programmes at greatest risk include infrastructure projects and services specifically directed towards the poor and the powerless. Health is often seen as potentially a bottomless pit in terms of public finance. This implies the need to mobilize additional resources where possible (including the resources of the poor themselves) and switch allocations within the budget towards PHC. While this may not be possible on a large scale, it can often start relatively modestly. Moreover, small, regular, incremental budget shifts, when sustained over any long period in time, add up to big changes. Such shifts can be brought about by sustained budgeting policies supported (where these exist) by long- or medium-term strategic plans.

SEOUL
(Korea)

Financing health care for all

Seoul is a booming city of some 10 million, comprising about 25% of the population of South Korea, a country of rapid industrialization and urbanization, and dramatically increasing affluence. There is, nevertheless, real poverty in Seoul, with many families living near the subsistence level on land that is threatened by commercial development.

Since 1977, there has been a medical care relief programme for the needy poor. Beneficiaries are divided into classes with varying levels of entitlement to free, or partly paid, outpatient and inpatient care. About 3.5% of the Seoul population qualify for the programme. However, medical insurance, which has long covered those who are employed by large organizations, is now being extended in stages to cover virtually the whole population. In July 1988, employment-related insurance was made compulsory, even for small firms employing five or more people. At much the same time, area-based insurance was introduced in rural areas for everyone who is not covered by an employment-related scheme.

In 1989, the same idea was extended to urban areas. In Seoul, for example, there are 22 such area insurance unions each based in a ward and governed by an elected committee of its members. Premiums are paid monthly and are related to family numbers and to means. Families with a car are obliged to pay an extra premium. Low-income families of more than four members are exempted from the basic family premium. Fifty per cent of the cost of the scheme is borne by the State.

With rising prosperity, Korea can afford to pay more for health care, including health care for the poor. It has elected to do so by extending the health insurance scheme to cover virtually everyone, rather than by expanding the safety net of the medical care programmes.

3.8 A TOTAL CITY HEALTH PLAN OR TACTICAL INCREMENTALISM?

3.8.1 Given that an effective health strategy must be intersectoral, and will call for shared commitment from local level to national, the case for a total city health plan seems obvious. Conceptually it is, and some cities have found not only that they can produce one, but that to do so is a major step forward. On the other hand, the preparation of such a plan is not an end in itself, but a means to an end. Some cities have found it easier to take a series of practical, incremental steps towards social justice than wait for a complete strategy, that remains only a dream. There is something to be said for both views and they can (at least to a degree) be reconciled.

3.8.2 A number of points need to be considered when developing a city health plan:

(a) Which agencies need to be involved?

- At which levels? e.g., city, national, community, etc.
- From which sectors? e.g., local government, health boards, nongovernmental organizations, local representative groups, businesses, trade unions, etc.

(b) What information is needed initially?

- Would rapid appraisal exercises be useful?
- Does such information provide adequate coverage of the urban poor? (This will depend on the heterogeneity, as well as the size, of the city; it is important that these exercises include representatives from vulnerable sections within the community.)

(c) Are local pilot schemes needed?

- Do local pilot schemes already exist?
- What models would be most relevant? (Some may be suggested by local information or community contacts, some may be based on successful projects developed in other cities in similar situations.)
- Have needs been locally defined, in consultation with the informants from the communities affected?

(d) What further data collection is needed?

Information from these activities will become the basis for the next steps in the planning process and problems identified may demand more detailed quantitative and qualitative information. In short, it may be necessary to know not merely what the problems are, but how many people are affected and what resources (municipal, community and nongovernmental) are available to tackle these problems. It is also important to know how these problems are distributed. For example, what are the health inequalities? What are the levels of premature mortality in different groups in the city? What are the variations in low birth weight? Disability? Household income? Access to clean water? Overcrowding? etc.

(e) Are specific efforts needed to provide universal coverage?

If many of the urban poor lack access to basic amenities and services, how can resources be used to ensure universal coverage and, therefore, be targeted to those with worst health? Can specific programmes be directed towards needs identified by these vulnerable groups? Specific programmes relating to primary

health care coverage are only likely to be successfully adopted if they address problems which have been identified by the communities themselves. If not, the programmes must wait until some of the community-defined priorities have been addressed.

(f) What areas need to be addressed in a city health strategy?

It is only after consideration of available data and experiences that a more detailed strategy can be developed to improve the health of the urban poor. This should include sections on problem analysis, strategic choices, specific action plans, implementation and evaluation. Part of the process of developing a city health strategy must include consultation and widespread communication, given the broad base of support which would be required for the implementation of such a plan. To produce a competent technical document which does not have such support, is at best a waste of valuable resources and at worst will damage the credibility of any further health strategies.

JAKARTA
(Indonesia)

A city health strategy in action

As the capital city of Indonesia and the centre of many activities, Jakarta has a strong potential to attract people to migrate to it, resulting in environmental deterioration, pressures on public facilities and perpetual socioeconomic problems. These migrants, together with those now already living in Jakarta, reside in slum areas which geographically represent 17% of Jakarta, but are occupied by about 60% of Jakarta's 8.8 million people. Owing to the lack of public facilities (including health) and the density of the population, the following major health problems have been identified:

- the health status of the urban poor is still unsatisfactory compared to Jakarta citizens in general;
- the utilization rate of health facilities by the urban poor is relatively low;
- the environmental conditions in urban slum areas in Jakarta are poor, hence the incidence of environment-related diseases is high;
- the health behaviour of the urban poor is still not adapted to healthy urban living;
- unsatisfactory socioeconomic conditions, a high unemployment rate and lack of transportation facilities are major health-related problems. For example, the incidence of psychoneurosis or psychosis among the urban poor is higher than for citizens in general, since jobless people in slum areas are subject to exceptional stress.

Ever since 1969, there has been a sustained effort, through the Kampung Improvement Programme or MHT (Mohamad Husni Thamrin), not only to transform the physical environment of the poorer areas but also to improve the general welfare of people living in them. The health component of MHT includes health services for the urban poor, and community participation.

MHT is in its third phase, launched in 1989 and culminating in 1994. There have been many positive results. The physical aspects of the Kampung have been transformed, making them more healthy and more productive. In health status, for example, IMR has dropped from 110 per 1000 live births in 1970 to 33 in 1985. Morbidity rates have also dropped. The incidence of diarrhoeal diseases as the cause of death in infants halved between 1980 and 1986, from 24% to 12%.

Nevertheless, the story is by no means complete and it would be foolish to ignore some negative impacts. For example, improved transportation has facilitated the spread of some infectious diseases. Dietary changes have increased the incidence of cardiovascular disease amongst the poor, and it has risen from number 5 to number 2 in the list of causes of death in the city. Socioeconomic change has also been accompanied by a loosening of family ties and an increase in the prevalence of psychoneurosis, psychosis, juvenile delinquency and drug abuse.

No development plan, however powerful and well conceived it may be, will solve all problems. It can, however, provide a framework for positive action, which can be reviewed and adjusted to reflect progress and tackle new challenges.

3.8.3 The lack of such a health plan, however, should not stop an incremental opportunistic approach to improving the health of the urban poor and efforts should be made to create from these initiatives a broader vision. A number of different methods of scaling up have been identified: (6)

- (a) by absorption of pilot projects into mainstream service provision, thereby gradually transforming the overall pattern of services;
- (b) by cellular multiplication of family health care activities with support from government;
- (c) by the government contracting out some aspects of family health care, e.g., training, on an agency basis, while itself incorporating the lessons into mainstream provision.

3.8.4 The point is that both the protagonists and the opponents of city-wide health plans are partly right. In the end what matters has to be action on the ground, not the elegance and comprehensiveness of the plans. On the other hand, these actions, which are likely to be fragmented and incremental, need to be based on clear principles and priorities if they are to begin to bring about change on the scale required, and make a cumulative impact on the intolerable position of the urban poor.

SECTION 4 CONCLUDING REMARKS

4.1 RESUME

4.1.1 The cry of alarm voiced by participants at the Karachi Meeting will be recognized and understood by those who have visited or worked among the world's large and expanding numbers of urban poor. Indeed, it is easy to feel overwhelmed by the size, complexity and, perhaps even, the manageability of the issues and problems.

4.1.2 Yet there are a few recurring themes which run through the report of the Karachi Meeting, the city experiences and the background material. Understanding these themes may be the key to making the incomprehensible become clearer, the overwhelming become manageable and the inevitable become avoidable. These themes fall into four broad groups:

- (a) the importance of understanding the scale of the problem;
- (b) the location of responsibilities for health in the city;
- (c) the importance of broader issues and their implications for city action;
- (d) the identification of means of addressing the health needs of the urban poor.

4.2 THE SCALE OF THE PROBLEM

4.2.1 Anyone who stops to consider the health of the urban poor will quickly be impressed by the numbers of people who fall within this group. Soon over half the world's population will live in urban areas and up to half of these may be living in poverty.

4.2.2 These changes are occurring quickly. Many of the participatory cities are already large and still growing rapidly, with much of these increasing populations being made up of poor urban dwellers. In addition to this rapid population growth, there are also rapid changes in technology and economic circumstances which directly affect these cities.

4.2.3 Another lasting impression from many presentations was the degree of health inequalities within cities. Not surprisingly this was often accompanied by a marked contrast in living circumstances between dwellers within the same city.

4.2.4 A further confirmation of the scale of the problem arises when one looks at the heterogeneity between, as well as within, cities. Similar problems occur but often in different circumstances. There are numerous variations in local geography, climate, historical influences, ethnic mix, social and cultural variables. This is just one reason why the participation of local communities is so vital in planning and implementing health initiatives.

4.3 THE LOCATION OF RESPONSIBILITIES

4.3.1 The whole rationale behind organizing the Karachi Meeting was the recognition that decision-makers at city level have a key part to play in tackling the problems of the urban poor. This is a crucial level for determining the extent and effectiveness of intersectoral collaboration which is vital to tackling health problems within the city. It is also an important focus of accountability for political and technical decisions. Nevertheless, it would be naive to assume that decision-making at city level is all that is needed to achieve an improvement in the health of its poorer inhabitants. The city is constrained from "above", as it were, by regional and national legislation and policy and from "below" by the aspirations and activities of communities, households and individuals. It is also constrained by the resources it can command.

4.3.2 It appeared, at times, in the Karachi Meeting that cities are faced with choosing between a strategic or incrementalist approach to health. Should they attempt to draft, consult and implement a city health plan (against formidable odds) or should they, given the constraints on city action, concentrate on useful, relatively modest, initiatives to improve the health of small pockets of urban dwellers? As the issues were worked through, however, these two approaches looked less like competing options and more like complementary components. A city health plan that is not based on lessons learned from local experiences (failures, as well as achievements) is not likely to be credible and its implementation will be threatened by each problem and set-back. On the other hand, there is no guarantee that a collection of piecemeal activities will make any systematic cumulative impact on the inequalities, deprivation and lack of services which shape the health of the urban poor; success in one area may simply mean that the health problems have been shifted to a new patch.

4.3.3 Often a key factor identified at city level, was that of political will. The conviction and commitment of those responsible for decision-making in the city will influence the extent to which cooperation is achieved between the different levels of decision-makers. Political will is also the major determinant as to whether the sum of many small local initiatives will make up a comprehensive health strategy to improve the health of the urban poor in that city.

4.4 CITY HEALTH IN A WIDER CONTEXT

4.4.1 One of the recurring themes raised by city representatives was the balance between urban and rural development and the impact of this on health in their city. There are at least three ways in which city and rural environments are interdependent:

- (a) urban and rural development must occur in harmony if there is to be any prospect of population equilibrium. Urban development alone will exacerbate or precipitate the increase in numbers of urban poor faster than any economic or environmental development can provide for;
- (b) the city is dependent on surrounding areas for many of its basic needs. This is most apparent in relation to food production and water supply. For cities to neglect, squander or despoil this "resource" is short-sighted in the extreme. The surrounding areas may also help meet recreational, educational and aesthetic needs;
- (c) although it is a theme much larger than could be addressed in any depth at the Karachi Meeting, participants were well aware of the importance of achieving a balance in the environmental and ecological relationships between urban and rural areas. In particular, these issues came to the fore when discussing city problems of solid waste disposal, industrialization, fuel supply, housing and land use.

4.4.2 Another very broad issue which recurred frequently was the international perspective. The relationship between developed and developing countries, for example in economic and technical fields, was perceived to have a major influence on the quality of city life and the options for city action. There was also a recognition that a number of decisions affecting health in the representative cities, were made at an international level whether by government coalitions, nongovernmental organizations or privately-owned companies or trusts.

4.5 THE MEANS TO IMPROVE CITY HEALTH

4.5.1 There are a variety of models, systems, tools and principles which appear, from practical experience in participating cities and other areas, to offer the means to improve the health of the urban poor. Those that came up most often were:

- (a) the ways in which urban primary health care could contribute to intersectoral action to improve the health of the poor in specific localities;
- (b) the importance of increasing participation by communities in decisions and activities which affect their health and well-being.

Hence, the recurring concern for sharing information with local groups and representatives, for decentralization and for community development.

4.5.2 All city representatives recognized the contribution to be made by appropriate skills in helping to meet the health needs of the urban poor (and, therefore, the importance of relevant training). There was a concern that this message should be taken on board by medical schools and clinical teachers based within cities. There was also a recognition that relevant training was equally crucial for many other health-related skills in professional and voluntary workers.

4.5.3 Allied to this theme of training is that of the need for relevant information and communication. However, the development of these systems has its own costs both in equipment and staff time. Perhaps because of this, many cities have limited information with which to assess health needs, monitor interventions and evaluate outcomes. Most participants were aware that the costs of not having adequate information and communication was also high.

4.5.4 It would be disingenuous to pretend that city representatives (politicians and technical officers) did not see an overwhelming case for more resources to be made available to improve city health. Obviously there are a variety of ways in which assistance could be given, e.g., technical assistance, training packages, and finance for pilot developments. Participants recognized that they must strengthen their own policy development and support structures as well as seeking assistance from outside sources. All cities have a considerable resource of "people power" and many have substantial pockets of wealth, some of which may be mobilized locally to help meet the urgent needs of the urban poor.

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ANNEX B

AGENDA

Monday, 27 November 1989

1. Opening
2. Presentation of city experiences - plenary

Tuesday, 28 November 1989

3. Field visit
4. Continuation of city experiences - plenary

Wednesday, 29 November 1989

5. Working groups on Topics 1, 2 and 3 and suggestion of strategies for action:
 - (a) Policy issues and options
 - (b) Decision-making process
 - (c) Development, cooperation and follow-up
6. Presentation of group reports - plenary

Thursday, 30 November 1989

7. Review of draft report
8. Adoption of the report and strategies for action
9. Closure of the meeting

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