A44/Technical Discussions/8

14 May 1991

WORLD HEALTH ORGANIZATION

ORGANISATION MONDIALE DE LA SANTE

FORTY-FOURTH WORLD HEALTH ASSEMBLY

# REPORT OF TECHNICAL DISCUSSIONS

# STRATEGIES FOR HEALTH FOR ALL IN THE FACE OF RAPID URBANIZATION

CONTENTS



## INTRODUCTION

The recent emergence of a sense of pressing urgency about the urban condition, about urban health and the situation of the urban poor can be quite easily justified by reference to world demographic trends. By the year 2000 a majority of the world's population will live in large towns or cities and for most urban dwellers the urban setting will play a major part in determining their health. Moreover it is becoming increasingly clear that the way in which we choose to organize and run our cities will be critical to the future ecology of the planet itself.

Urban growth is driven by the search for employment, changes in production and marketing practices, the direct and indirect effects of development policies and the perception that cities offer a better life than do the increasingly depressed rural areas in many parts of the world. Analysis of the demographic trends shows the following:

- that urban populations have greatly increased in the last 40 years;
- that the greatest increases have been in the developing countries;
- that urban populations will increase even more rapidly in the next 35 years with explosive growth of cities in developing countries;

and that

- although the number of rural dwellers will increase, their share of total population will not; people living in cities will become a global majority and the developing countries will approach the urbanization levels of the industrialized countries.

During the period 1990 to 2020 the total world population will increase by one-half from 5.2 billion to 7.8 billion but the urban population will double. Of the 2.6 billion increase, 2.3 billion will be in city areas. For many countries the entire increase in

population is taking place in urban areas. One effect of this growth is that some third-world cities are expected to reach extremely large sizes by the end of the century: Mexico City, 31 million; Sao Paolo, 26 million: Rio de Janeiro, Bombay, Calcutta and Jakarta, each over 16 million; Seoul, Cairo and Manila, 12 million.

Cities in developing countries are growing because of natural increase (excess of births over deaths), in-migration and the reclassification of illegal squatters on the urban fringes. In the earlier stages of city development migration tends to be the dominant influence on urban growth. In later stages natural increase usually becomes the main reason for growth being sustained.

In many countries urban populations now exceed the sustainable yield from surrounding land, forest and water systems with resulting environmental degradation, decreased agricultural production, "natural disasters" and increased landlessness. As a result there is poverty and ill-health affecting both rural and urban populations combined with severe ecological pressures on the environment. Health impacts are felt through the "traditional" diseases of under-development, the chronic diseases associated with development and the incidence of psychosocial problems. Health impacts of development will be an important focus of discussion at the United Nations Conference on Environment and Development in 1992 in Brazil.

It is becoming clear that neither a rural nor an urban focus in itself is sufficient but that it is necessary to consider the interactions between the two and that rural development is an essential part of urban development.

Nor are the problems of the urban poor confined to the developing countries. In industrialized parts of the world, cities are to be found at many different stages of development. In some parts new cities are still being established and old ones continue to grow and to be remodelled. In other parts, once great cities are in a process of rapid economic decline and are experiencing pollution, a deteriorating physical infrastructure and decay of the city core, together with the loss of younger and more skilled people to more economically vibrant areas. The populations left behind in such shrinking urban areas tend to be older and sicker with more social stress and diminished networks of social support. These effects are compounded by the limited access to health and social services which usually accompanies low income.

The health consequences of urban poverty in cities of developed countries include a high incidence of heart disease and stroke, cancer, drug and alcohol abuse, accidents, violence, AIDS and sexually transmitted diseases. In cities in the developing world a high incidence of these conditions exists alongside traditional health problems, such as high maternal, perinatal, infant and child death rates. In this sense the urban areas of the developing countries are getting the worst of both worlds.

The selection of urban health as the focus of the 44th Technical Discussions of the World Health Assembly was a highly significant event and marked the explicit recognition of the importance now given to this issue. Six background documents were produced for the discussions, as follows:

1. Health and the cities: a global overview

2. Cities and the population issue

3. Development of urban environmental health services

4. The organization of urban health systems

5. City networks for health

6. Urban policies and health status.

The technical discussions themselves included a plenary session with opening remarks by the Director-General of the World Health Organization, Dr Hiroshi Nakajima, and a statement by the Chairman of the discussions, Sir Donald Acheson, on the key issues in urban health. Three keynote addresses followed:

1. Dr Rodrigo Guerrero on the subject of urban health systems;

2. Mrs Annette Sabouraud on urban health and city networks;

3. Dr Emil Salim on population growth and urban development.

Each address was followed by a period of discussion and comment from delegates and participants.

Following the plenary session the technical discussions took the form of four workshops:

1. Development of urban environmental health services

2. Organization of urban health systems (two groups)

3. City networks for health

4. Urban policies and health status.

Dr Nakajima reminded the audience of the recent emphasis on rural health care and of the need to see the interrelationship between rural and urban conditions. He pointed out that urbanization in itself was not a bad thing providing as it did a major force for development. Urbanization only became a problem when the rate of growth of the population living in the cities exceeded the capacity of the infrastructure to absorb and support it.

Earlier, in his statement to the Executive Board and the World Health Assembly, Dr Nakajima had referred to the need for a new paradigm for health which took account of the demographic transition, of changing patterns of ill-health and of the potential offered by technological advances. Such a paradigm must consist of a world view in which health was seen as an investment in the future of mankind and central to development and to the quality of life. For this to happen, health should become a major political issue at the cabinet level of government. If health was to be seen as a human right, it could not be left entirely to market forces because the most disadvantaged would become even worse off. For the new paradigm to succeed it would need to make better use of science and technology in the cause of humanity and would need to integrate the collection and dissemination of health information with health promotion, disease prevention and control.

Sir Donald Acheson drew attention to the importance of the new environmental aspects of urban health and the interrelationship of the many different urban problems with health impacts. In encouraging participants to take a positive view and to identify opportunities for making a contribution to improving urban conditions and health, Sir Donald identified six personal imperatives:

1. to decentralize and put the emphasis for action at the municipal level;

2. to mobilize everyone who can help in city networks;

3. to invest in safe drinking-water and waste disposal;

4. to help the poor to enhance their incomes and improve their houses;

5. to provide families with a range of sustainable health services in or near their homes with an emphasis on family planning as the centre-piece;

6. to ask the poor to identify their own needs and priorities and to expect surprises.

Sir Donald encouraged participants to show humility in approaching the poor and to work for the partnership and commitment which could release the trapped vitality of deprived communities. By taking this route, problems which seemed hopeless or insoluble at the national or even the city level became approachable at the neighbourhood level.

It was, he said, not only necessary to work at the international strategic level to ensure coherent policy and action between governmental and nongovernmental agencies and others, but also to work at the integrated level of the city and country to achieve results.

Dr Guerrero drew on his experience as the head of an academic department of public health in Cali, Colombia, of the university providing leadership in innovation through partnership with the urban poor. He pointed out that the most expensive services are those which do not yet exist - that the poor pay more to obtain what may be readily available for the better off and that universities had an obligation to rediscover the leadership tradition of public health pioneers such as Chadwick and Duncan, of being advocates for the poor and facilitating community-based initiatives.

In discussion, the situation faced by illegal new citizens was addressed and the problem of providing services for people who have no statutory civic rights. These new residents were at multiple risk but at the same time contributed to the economy and development of the city in ways which were not always immediately apparent. It was felt that official attitudes could be more supportive of illegal citizens in acquiring rights to health.

One problem which was identified was that of developing countries which had inherited concepts from the preceding colonial powers which may not be appropriate in the light of the local culture, developmental stage, or health needs. Often there had been only minor adjustments to such inherited concepts and there was always a danger of new inappropriate concepts being exported to them.

Urban health systems and initiatives needed to be designed to meet local health needs rather than administrative convenience.

Mrs Sabouraud described the experience of promoting the European Regional Healthy Cities Project as a town councillor. This approach was described as being the challenge of translating health for all into action at the local population level. It was possible over a period of time to influence the development of city health policies by an intersectoral approach. Examples from the French city of Rennes included work in the fields of education, adolescence, literacy, safety in the home and in the outside environment, environmental issues themselves and disability.

Mrs Sabouraud spoke of the value of city networks in France and beyond for exchanging experiences of such approaches.

In discussion, reference was made to existing examples of health-for-all initiatives at the local level which involved an intersectoral approach and partnership between public, private and community organizations. One particular example was from Orangi in Karachi where the rate of urbanization is so great that the health system is complicated and fragmented. The Orangi settlement is a large squatter area in the city, lacking basic amenities such as sanitation. Community action has mobilized the community's financial resources, with voluntary technical support from the College of Engineering in Karachi, to develop a sewerage system on a self-help basis. After success in this area, the Orangi project has moved into the field of women's health, kitchen gardens and income generation schemes.

Karachi has also developed "filter clinics" as a type of extended primary health care centre which integrate medical and social care.

Dr Salim discussed the interrelationship of population growth and sustainable physical and social development. There was a limit to population growth in urban areas which could be sustained without overloading the environmental and social eco-systems. Social sustainability is possible if development gives emphasis to important aspects of life such as equity, social justice, the enlargement of people's choices in life, the increase in self-betterment and self-reliance and the eradication of poverty and not solely to economic dimensions. It was necessary to integrate an understanding of health into urban development strategies, in particular in relation to such questions as the health impact of transportation systems. The challenge needed to be met by partnership between government, nongovernmental agencies, the private and voluntary sectors. It was necessary to break down the compartments which exist between them.

In discussion the issue was raised as to whether developed and developing cities actually differed or whether they were at different stages in an evolution which would subsequently prove to be similar. The vast scale of contemporary urbanization was one clear difference.

It was felt that time is critical and that there is only perhaps half a generation to achieve real change in the way cities are run. If we spend time setting up new organizational forms this could be time lost. We need to build on existing structures such as local government, hospitals and their outreach capability, community organizations, private firms, the universities and technical institutions to provide technical support and facilitation.

One suggestion was that a powerful way to empower women would be for them to be automatically the head of the household and thereby to have social control over the resources for health.

The compartmentalized functioning of international agencies at present was a cause for concern. There was a need for collaboration and integration and for health impacts to be taken into account in economic development programmes and strategies.

## HIGHLIGHTS OF WORKING GROUP DISCUSSIONS

### THE DEVELOPMENT OF URBAN ENVIRONMENTAL HEALTH SERVICES

There are now effectively two agendas for environmental health in urban areas - the old agenda of tackling the basic sanitary problems of large numbers of people living in inadequate housing and often lacking the basic provision of water and sanitation; and the new agenda of the ecological problems which are rapidly storing up threats to human habitats around the world. The sanitary and the ecological are in effect linked by the life-styles of urban dwellers.

There are four principles which should be applied in the ecological appraisal of any city.

1. Minimim intrusion into the natural state. This requires that new development and restructuring should reflect the topographic, hydrographic, vegetal and climatic environment in which it occurs. A close reference to the natural site will benefit drainage, ventilation, insulation, the indoor climate, the microclimate, and open and green spaces. It is a responsibility of the international community and of national governments to try and ensure that people do not need to live in hazardous locations.

2. Maximum variety. This should be aimed for in the physical, social and economic structure of the city. Land uses and activities should be mixed where this does not

create hazards, rather than separated and fragmented. A range of economic activities will make cities and communities less vulnerable to change and reduce social polarization and inequality.

3. As closed a system as possible. Application of the principle of closed systems in urban and environmental management would mean that waste is recycled within the urban area wherever possible, and that water, energy and resources are renewable. The management of green space would maintain nature and recreational opportunities within cities.

4. An optimal balance between population and resources. Urban and population change must relate to the fragile natural systems and environments that support them. Balance is required at the city and neighbourhood levels to provide a high quality and supportive physical environment, as well as economic and cultural opportunities.

If they are to tackle these two agendas - the sanitary and the ecological, public health departments in most of the world's cities require strengthening. Their traditional environmental health function centres on the control of infectious and communicable diseases and is represented by the inspection of public eating places, examination and licensing of food handlers, and advisory or enforcement activities in some aspects of housing hygiene - functions that are often perceived by the public, especially in developing countries, as a "police" role, fraught with possible penalties. If involved at all in pollution control, their main function is limited to providing information on criteria and standards.

Public health departments may suffer from low status compared with other city departments; within the health department environmental health units are often accorded lower status than other programmes. The units are usually understaffed in numbers and in the array of relevant skills, with sanitarians composing the bulk of their personnel; in the largest cities one or more sanitary or public health engineers may constitute the entire staff.

A more effective public health presence in urban environmental health is paramount. The health aspects of shelter, employment, transportation, water and food supply and toxic waste are highly sensitive in cities and environmental health services are becoming even more necessary as city populations expand.

It is particularly important that in developing cities the city health departments should become more actively involved in (a) health promotion, and (b) the monitoring and control of the whole range of environmental hazards. The challenge is to meet both agendas and to integrate fully into primary health care at the neighbourhood level.

The working group on the development of urban environmental services considered these issues in some detail. The group felt that there was a need for the overall agenda to be clarified with more precise definition of the various concepts now included in environmental health. As with many aspects of urban health there is currently a lack of adequate data and information both about the health impact of development on the urban environment, and of the resources available to respond to the problems which occur. It was necessary to introduce modern management methods and techniques into environmental health departments. It was felt that ministries of health should provide agencies involved in environmental planning and services with information support, including:

- providing health information to persons concerned with the management of environmental health activities;

- linking environmental data with health status, to assist various agencies (housing, water, sanitation, etc.) to support and promote health;

- focusing on occupational health as a specific, often neglected, aspect of environmental health;

- carrying out population surveys to find out the public's satisfaction with environmental health services.

The group felt that there was a need for politicians to be more aware of environmental issues and of the interrelationship between development, health and the environment. There was a need for political commitment to enhance environmental health activities and to make sure that health and environmental health were integrated into urban development plans. The need to reorientate ministries of health to their new role of supporting integrated local actions on the environment would require a variety of activities including training health personnel and providing them with the necessary concepts, attitudes and skills.

Although environmental health departments needed to reorientate the way in which they worked, they still needed to focus clearly on some of the ever present public health threats. These included the vector-borne diseases such as malaria, filiariasis and schistosomiasis, and some other vectors which seem to thrive in urban areas. The issue of food safety was brought up by the group. It was mentioned that in low-income urban areas of developing countries most food does not go through the formal market but is usually sold by street vendors. The usual methods used to ensure food safety through legislation and inspection to ensure enforcement are not very effective in such areas.

In all these questions there is a need for effective leadership and for partnership between public, private and voluntary sectors. Health personnel need to accept the new style of working which is required, and to provide leadership through facilitation of community initiatives. Physicians, engineers, nurses and other health workers should seek partnerships at the neighbourhood level to work for improved environmental health conditions. For this to happen there needs to be decentralization of environmental health responsibilities with the delegation of commensurate authority.

The strengthening of the role of women in community action for environmental health was emphasized. Several studies have shown the effectiveness of women who are active in environmental health work. Unfortunately, the balance between their contributions and their benefits is in many cases far from equitable. There is a large gender gap in the training and resources available to men and women.

The group felt that ministries of health should support the strengthening of the environmental health input into urban planning by making arrangements to second environmental health planners to work with urban planning authorities.

Overall the problem of adequacy of resources was a recurring theme. The new IMF restructuring policies are liable to prevent health and environmental health from increasing the level of their resources. However, it was recognized that the effective use of what resources were available through better management was a priority.

Ultimately it is in the self-interest of the better-off to ensure that the environmental infrastructure is adequate to meet the needs of the urban poor. It has been demonstrated repeatedly in history that the diseases such as cholera which thrive in conditions of urban squalor although mostly affecting the poor, also tend to extend to the better-off sections of the community.

There is an urgent need for the sharing of models of good practice which work in poor communities in developing cities. Mechanisms for networking between similar cities and within cities might be one way to achieve this. Such models should emphasize the value of public participation and the adoption of a human capital approach in the assessment of urban development. That is to say that investing in the health of people is seen to be investing in the future capital of the country. It is only by pressing this approach that investment in the infrastructure for health and the environment will be accorded appropriate weighting.

On a specific note the group felt that there should be wider dissemination of WHO literature in the field of environmental health.

Recommendations for WHO

The working group recommends that WHO should:

1. Update and disseminate widely the available literature on environmental health issues and produce a glossary of technical words.

2. Provide technical support to urban environmental health development and in particular to help with initiatives on waste-water disposal for groups of individuals and small enterprises.

3. Develop suitable environmental health criteria for the assessment of the environmental health impact of urban development projects and programmes.

4. Support appropriate workshops, seminars, and courses to train health workers in the management of services for environmental health.

5. Develop a new facility to act as a catalyst in support of community and voluntary group initiatives in environmental health.

## THE ORGANIZATION OF URBAN HEALTH SYSTEMS

In taking the eight activities of primary health care identified in the Alma-Ata Declaration as the most down-to-earth starting point the background document stressed the importance of reorientating the health system in order to ensure equity of access to good quality primary health care within available resources. It also stressed the importance of appropriate mechanisms for public participation and accountability in order to ensure that services are provided which most appropriately meet the health needs of the whole population.

The background document raised 10 questions which should be asked of any community's health status and health system as the baseline against which policy should be formulated:

(1) is there an analysis of the main health problems and conditions in each part of the main urban areas and at each age in life?

(2) is this information widely available in cities so that people are able to discuss what needs to be done to improve health?

(3) is information accessible about what health services are available and how people can get access when it is needed?

(4) is action being taken to create safer, healthier and ecologically sound physical and social environments which support healthier life-styles in urban areas?

(5) are all the areas of everyday life - public, private, and voluntary - involved in planning and working for improved urban health?

(6) is there an effective way of getting everybody to work together at the neighbourhood level?

(7) are there mechanisms for identifying and supporting community leaders who speak out for better health and make sure that those factors that affect health are understood by all the public? Are the city hospitals providing public health leadership?

(8) do your cities have specific plans to collect and distribute needed information about health, to develop stronger intersectoral cooperation, and to provide adequate resources for health?

(9) is it necessary to establish new organizational infrastructures to facilitate an integrated approach to urban health, or can existing structures be adapted and made to work?

(10) is there a clear understanding and a consensus about the relative contributions of central and local government to improving and protecting urban health?

The document recognized that despite setbacks there exist many opportunities for innovative and effective action and for learning from each other. The workshop provided an opportunity for such an exchange.

The working group agreed that in view of the rapid process of urbanization there was a need for urgent reappraisal of urban health systems and that it was important that experiences should be shared by appropriate mechanisms for communication and networking.

It was felt that in some ways networks within cities were as important as those between cities as they provided a mechanism for mutual support, exchange of experience and capacity-building, particularly between community-led initiatives. Community development approaches to the development of primary health care and the integration of such approaches into the formal, nongovernmental and private sector services were felt to be at the heart of what was now needed. These should focus on neighbourhood areas (district health systems) with defined populations which provide integrated primary health care from the family to the health centre and first referral level.

One problem which was particularly identified was the way in which random infrastructure development often led to rapid informal urbanization with new slum areas containing large numbers of people who are not recognized as citizens and for whom even basic services are therefore problematic. The need for a more pro-active approach to new urban development in the provision of basic sanitation and infrastructure was stressed as was the need for a population and territorial approach to primary health care provision. At the moment local urban plans and policies often conflict with the implementation of health for all in a fundamental way.

If change is to be made there is a need for decentralization of health care to the local government level and for the adoption of policies which integrate health with urban and economic development. The impact on health is often not taken into account in economic development strategies or by nongovernmental organizations or international agencies in the programmes which they fund.

Above all there is now a need to move from overall statement and restatement of the problems of urbanization to a more analytical understanding of intra-city variation and at-risk groups so that interventions can be more appropriately targeted. There is a parallel need to move from only reporting successes to the honest reporting of true stories which enable lessons to be learned by others. The group considered the issue of the organization of urban health systems in some detail under five headings:

(1) Awareness and information

(2) Reorientation of services

(3) Leadership, organization and management

(4) Urban capacity-building

(5) The role of the World Health Organization and other international organizations in urban health development in developing countries.

1. Awareness and information

Adequate political commitment and action are not possible without awareness, which in turn depends on reliable information. In health terms, this must start from a definition of needs, particularly the needs of the most deprived. However, it is precisely this group for whom accurate information is most difficult to come by. For example, even to know who lives in the poorest neighbourhoods of the city can be difficult to determine, because of homelessness and, in many instances, lack of secure legal status and the unstructured nature of the settlements. When areas are unrecognized legally and when people are suspicious of authority, official information will be very hard to obtain. Moreover, the situation can be quite fluid. Some of the most vulnerable citizens move from place to place, and the most vulnerable of today are not necessarily the most vulnerable of tomorrow. With population growth rates of 3% or more, implying a doubling in size of the city in perhaps 20 years, nothing remains static for long. Even where, as in some developed cities, the total numbers of urban dwellers remain static, the dynamics of the population structure and the nature of neighbourhoods sometimes change dramatically over short periods of time.

Information about needs should be both objective, in terms of quantified indicators such as literacy, mortality, morbidity, and sanitation, and also subjective, in terms of people's opinions about their own difficulties, and about what would really help them. As Sir Donald Acheson put it "The State must show humility to these people, by asking them what they want, and being ready for surprises".

Information about disease, health and the quality of life can be a major driving force for change. It is a way through which the health professions can exercise leadership in public policy today as in the past. But we must also recognize that while broad studies of need are all very well, a sharper focus is required, concentrating on initiatives that seem feasible, where there is a commitment to action. For example, in relation to water supply, a study of diarrhoeal diseases and the simple survey of the availability of clean water supply points are likely to be more useful than a much more broadly-based survey. Survey results must not simply be filed for future reference, partly because that is a waste of effort, but even more because this must reinforce the suspicion and cynicism of those subjected to them, as well as the discouragement of the personnel who carry them out. Not infrequently results are published in scientific journals without the study population having prior access to conclusions reached.

A major drawback at the moment is that whilst a great deal is known about the macro-urban problem, there is little in the way of reliable local and small area neighbourhood data available. The little that is available is often not used effectively to inform the dialogue which should occur between politicians, managers, professionals and the public about the most appropriate services and their location. There is a need for appropriate local (shoe leather or barefoot) epidemiology and the aggregation of information to different levels for different purposes. For example, drawing attention to large differences in infant mortality between adjacent urban areas is an effective tool in raising community awareness and mobilizing resources. There is a particular need to try and anticipate changing health needs and to predict trends for the future, particularly those relating to age and gender balance. Good basic health information should be seen as a resource for health and not an unnecessary cost.

On the basis of a more reliable data baseline, neighbourhoods, cities and countries should share their experiences to enable them to decide what is the most appropriate urban health system to serve their needs. There is a need for a shared agenda to be developed between the public and health workers, which is based on real information and raising of awareness of the public through the use of the mass media, of educational institutions and cultural and social centres.

Examples of population and territorially based primary health care data exist from a number of countries. It seems to be particularly possible to obtain such data when there is good integration of community health workers into both the health care and the social

care systems and where health posts or clinics maintain comprehensive records on a defined population that they serve. Where systematic information gathering does not exist, novel approaches to describing health status may be possible. Such approaches include the comparison of sickness absence of schoolchildren, the use of sentinel families to monitor population coverage of primary health care and the audit of care of patients brought in dead to the hospital.

2. Reorientation of services

Although health services and health expenditures tend to be heavily concentrated in the cities, there is a mismatch between the health services available and those that would have most effect within realistic resource constraints. For example:

- referral hospitals are heavily used for first contact care which is an inappropriate use of expensive specialized facilities and skills;

- services tend to be weakest in the least well-structured areas and for the most vulnerable groups;

- the emphasis for the last several decades on therapeutic advance has tended to leave first contact and chronic care development far behind.

To reorientate the health system requires a revolution. This is a formidable challenge, and yet there is no alternative. Because of the gravity of the urban crisis and because of resource constraints, it would be wholly impractical to try to build a totally new primary health care system. Leaving existing services as they are is not an option.

Increasingly the demographic pressure combined with resource limitations and the overloading of the hospital sector has led to experiments with new forms of extended primary health care provision. There are now quite a number of examples of these extended or reference health centres from a range of countries. Typically such a centre integrates health promotion, preventive medicine, primary health care and maternal and child health services with the provision of outpatient and day surgery care with specialist treatment being provided by visiting hospital specialists.

Changing patterns of morbidity with increasing numbers of patients suffering from chronic conditions, together with new low-cost technologies, have made this kind of development compatible with high quality care. The involvement of hospital doctors in primary health care centres lends credibility to the centres' activities and further relieves the pressure on hospital inpatient and outpatient departments. Not infrequently such centres have evolved from what was originally a maternal and child health or family planning clinic.

There is evidence from a number of places of reference health centres which enjoy a high level of community involvement and of enhanced community resourcing. There are also examples of public and private sector collaboration at the primary care level.

Catchment areas need to be defined (including catchment areas in the least structured neighbourhoods) so that needs can be studied, services planned and people encouraged to use facilities rationally.

It is vital not only to protect the hospital from inappropriate use, but to involve it in outreach. It has the main concentration of health care resources in the city, and also strongly influences education, the advance of knowledge and the shaping of public opinion. Reorientating the hospital is therefore an essential task, in which WHO can play an important part. It has an element of self-preservation from the point of view of the hospital and for those working in it, who have to demonstrate their relevance in a situation where traditional modes of hospital activity are no longer satisfying demand in terms of the quantity of health care expected from them by clients, and when the quality of specialized care is thereby jeopardized.

The Declaration of Alma-Ata defines eight activities as the basic elements of primary health care, including health education, safe water and basic sanitation, and food supply and proper nutrition, besides a range of preventive and therapeutic health care activities. Such a definition makes it obvious that the approach has to be multisectoral. A range of other services in the city are crucial to health improvement, and this was repeatedly emphasized by the participants.

Some participants felt that specific services should have priority. Among those mentioned were: maternal and child health, family planning, water supply and waste disposal, the control of vectors and rodents and transportation.

One problem facing health services in many developing countries is a loss of trained staff abroad. This loss represents a net capital subsidy which is often from poorer to richer countries. However, it seems that financial reasons may not be the only driving force leading to such emigration and that not infrequently migration occurs because trained and skilled staff are not allowed to play their full part in a team which is dominated by doctors and where skill mix is not managed in a flexible way. The group discussed ways in which the boundaries between health workers can be changed to ensure the optimal use of skills to the benefit of the public.

Women health workers need to be able to play their full part in planning as well as doing health work. Unfortunately in many countries this is still resisted by men.

3. Leadership, organization and management

The revolution required in the health system and in other city services clearly will not take place by itself. Leadership, organization and management are not optional extras. However, leadership and management skills in urban health systems are in short supply in many countries, both developed and developing. The group heard examples of how poor management led to inefficiency and placed the poor at risk. In one instance a university obstetric unit refused to accept women who booked late for antenatal care and turned women away when their beds were full. As a result they filled their beds with low-risk births whilst high-risk women had nowhere to go. Another instance was of high-risk outpatient referrals being given a standard appointment in three months time, the same as lower-risk referrals.

The question arose as to who should manage and who should lead, and whether this should always be a physician. This may actually be an artificial question because the provision of leadership in deprived and underserved urban areas requires a special type of leadership (at once visionary, hard-headed and facilitative), which is earned on merit rather than endowed by appointment. However, it is clear that in respect of the reorientation of the urban health system towards primary health care and reference health centre type developments, this cannot happen without the active involvement and support of physicians. There is, therefore, a need for changes in medical education and training so that doctors are equipped to work in partnership with other professional groups and with community organizations and to ensure that both horizontal integration of medical with social care and vertical integration of primary, secondary and tertiary care can become a reality.

Universities, medical schools and other academic institutions have a particular opportunity to demonstrate their relevance in engaging with their local communities in pioneering effective urban health systems.

There was considerable emphasis on the decentralization of authority, both to the city level by central government, and to communities within cities. That, of course, is more easily said than done, and calls for political leadership, impartiality and perseverance of a high order. Leaders in the health field have to see themselves as facilitators of action by others, and this calls for new perceptions and new skills.

The group discussed the appropriateness of cost-sharing. There is controversy as to whether or not free services can lead to abuse. The evidence of selective use of private services - not always by the most affluent in society - suggests that there may be some scope for user-fees supplementing the financing of health care delivery. Whilst charges in some form may reduce inappropriate demand and add to the funds available, even when the charges are trivial they may deter the poor from seeking medical help when they need it. When charges are made it is important that they be imposed carefully and that their effects be closely monitored.

Some cities have demonstrated that imaginative and unusual initiatives can have major impacts on health, particularly for the disadvantaged. Among the examples mentioned were:

- training in basic business methods for people starting small businesses or operating in the informal sector;

- help with food distribution to reduce food prices which tend to be highest in some of the poorest neighbourhoods;

- provision of low-cost building materials and help with securing sites for those wanting to build their own homes;

- support in the organization of refuse collection and processing in unstructured communities.

Urban and rural areas are interdependent. An effective urban strategy must seek to maintain the prosperity of the surrounding rural areas and the attractiveness of living there, and increase the strength of the rural health care system; the urban health care system has a direct interest in promoting these objectives. It is necessary to find out how much care is furnished (at the health care delivery level) to out-of-town residents, since the concept of confining especially the mobile and vulnerable to facilities in their home locality was considered in many cases to be impractical.

4. Urban capacity-building

The magnitude of the tasks facing city government is frightening. In particular, it seemed that there is no correlation between the gravity of the problems and the capacity for tackling them. Some of the city administrations with the worst combination of issues to be tackled are the most fragile.

Therefore, developing support for cities can make a crucial contribution. Among the examples cited were:

- development of individuals in leadership positions or likely to move into these positions in the future;

- support by central governments; and

- support by universities, foundations and nongovernmental organizations;

- city networks and twinning arrangements;

- the activities of international organizations;

- the promotion of decentralized community-based health development systems which are sustainable;

- the performance of city health departments and the promotion and coordination of health action at city level;

- links between health services and other essential aspects of primary health care;

- organizational innovation of urban health services and of referral to secondary care;

- the financing of urban health development;

- finding a balance between local and central accountability;

- the recognition and mobilization of the urban poor and other vulnerable groups as a political, social and economic asset in urban development.

Real and effective urban capacity building requires an emphasis to be placed on community capacity assessment as well as on needs assessment. This poses a challenge to the existing way in which many health workers regard the public as passive consumers of care rather than as co-producers and maintainers of health. It also has implications for the development of methodologies for community capacity assessment.

Another aspect to the question of the orientation and motivation of health workers is the impact of a materialistic rather than a vocational motivation. It seems likely that a rampant free market philosophy can undermine vocational motivation and this undermining can be reinforced by organizational forms which do not give credit and reward to front-line workers. Equally, however, the private and informal sectors are resources in most cities that it is stupid to ignore. Rather, one needs to recognize their actual and potential contributions and their motivation, and fit them into a development strategy.

## 5. The role of WHO and other international organizations

It is essential that WHO continue to call attention to the potential tragedy in the cities, to the need to reorient the health system (including the hospitals) and the case for multisectoral action. WHO has a particular role to play in making the connection between the urban and ecological crisis and the problem of world poverty.

The building and maintenance of networks is another area of WHO activity which is essential to sustainable health systems development. Partly this is a matter of knowing what is going on in which cities, and making that information readily available. Equally, WHO can play a role in encouraging research and development and documenting good examples. Specifically WHO might assist urban development in third world cities through the development and promotion of methodologies, research, documentation, institution-building, training, the provision of opportunities for the exchange of ideas and true stories of both mistakes and achievements. WHO could also take a lead role in fund-raising and in galvanizing the collaboration of other international agencies and making them aware of the health impact of other policy initiatives.

The group believed that WHO itself should provide leadership through self-examination and by ensuring that it is setting a good example in the way in which it conducts its affairs. In particular the adoption of a more pro-active advocacy role on behalf of the urban poor and a decision to hold the annual assembly in third world cities were suggested as ways in which the World Health Organization might enhance its credibility and provide valuable leadership.

National governments and international organizations still tend to think of health as having lower priority than economic development and being about the treatment of disease. We need to change this perception, leading people to recognize that health is about the quality of life. Health is essential for a healthy economy and is, therefore, a prerequisite of economic development. Further, there is little point in economic development unless it leads to a gain in the quality of life. Consequently, health should be in the centre of the picture, not on the margin, with major implications for development policies and priorities. This is not simply a matter of competing with other public services, but also of defining "win win" strategies. There is a major potential

contribution by WHO in developing a conceptual framework for targeting the quality of life, particularly for those who are most at risk, and for getting these concepts understood by the international community.

Specifically, the group recommended that WHO should:

1. Act as a clearinghouse for information useful to countries and cities for the advancement of their urban health development processes with special emphasis on needy populations.

2. Interact with all relevant international organizations concerned with urban development and the urban poor particularly the World Bank, UNFPA, UNICEF, UNDP, UNCHS and FAO.

3. Identify institutions and nongovernmental organizations involved in urban development and the problems of the urban poor, obtain their profiles and establish collaboration on specific research, training and developmental activities related to the organization and delivery of urban health services.

4. Establish a roster of people competent and involved in the organization and functioning of urban services and the problems of the urban poor: this may be a prelude to the creation of a panel of experts in these areas.

5. Carry out an investigation and prepare a report on the structure and functioning of municipal health departments in the cities of the developing world.

6. Initiate activities leading to the definition of an intercity collaborative effort for the preparation of urban health profiles and for the review and selection of relevant methods.

7. Act as a forum for a discussion on urban-capability building in all its different aspects, involving cities of the developing world and leading to the formulation of a programme of work in this area for cities and WHO.

8. Initiate contacts and activities leading, in the course of 1992, to a review of the state-of-the-art in community-based urban neighbourhood health development programmes and to recommendations on desirable future orientations.

9. Work at the international and national levels to shift the discussion about health in the context of overall economic and social planning from disease to the quality of life, thereby moving it from the margin of thinking to the central place that it justifies and requires.

## CITY NETWORKS FOR HEALTH

Many national governments have now committed themselves to working towards health for all as an explicit social goal. In the terms of the WHO strategy of Health for All by the Year 2000, this requires a commitment to public participation and to intersectoral action aimed at improving health, particularly that of the poorest sections of the community. In a rapidly urbanizing world there also needs to be a clear commitment by towns and cities and their elected administrations to this approach. The city is often the lowest administrative level which can marshall the resources and has the political mandate and authority to develop and implement multisectoral approaches to health; yet because it is a place with which its citizens identify there are good prospects for participation harnessed to neighbourhood or civic pride.

The rapid urbanization that has characterized industrial countries over the past 150 years has become a global phenomenon. Not only is this urbanization a challenge for WHO, it is a major challenge for all United Nations and other international agencies and for

national governments. Given the rapid urbanization of the world's population, the health of urban populations becomes a major issue in ongoing efforts to achieve health for all. On the one hand, the urban setting creates some major challenges in achieving health for all; on the other hand, as a focus of a society's resources, energy and skills the city has a significant potential and provides unique opportunities to promote health.

Promoting urban health

Since 1986, WHO Regional Office for Europe has developed a project called "Healthy Cities" which seeks to bring together political and community leaders, local citizens, community organizations, professional associations and national and international agencies in a collaborative, intersectoral and community-based effort to achieve health for all at the local level. Networks and coalitions have been established within cities, between cities nationally and internationally and between cities and national and international agencies.

By putting health on the social and political agenda of local governments and by creating new structures and processes for achieving health for all, the Healthy City project has made it easier for municipal governments to: (a) develop healthy public policies; (b) encourage urban environmental health services to address not only pollution control but the wider issues of sustainable development; and (c) encourage the reorientation of urban health services. Because of its commitment to community and local government accountability, the Project also seeks to enable people to increase control over and improve their health.

The apparent success of this strategy, which is summarized in the Project's Review of Progress 1987-1990, can be judged by the fact that what was originally envisaged as a project of limited appeal involving perhaps six cities has mushroomed to involve 30 Project Cities in Europe, 17 National Networks of cities, cities in other parts of the world, and international agencies.

This project has until recently been confined to the developed countries, where it originated. Recently, however, a number of cities in developing countries have become interested in the project, and the ministers of health of the non-aligned countries and other developing countries have recommended "extending the concept of the Healthy Cities Project of Europe to become a worldwide programme". It is in this context that the working group on city networks for health has concluded that the concept of the healthy city has merit globally in the context of achieving health for all. However, the work group also concluded that the concept needs to be adapted to the particular context of developing countries.

The determinants of urban health

The WHO Healthy Cities Project takes as its starting point the broad concept of health as defined in the WHO Charter, the strategy of "Health for All by the Year 2000" and the Ottawa Charter for Health Promotion. It recognizes that people's health is determined by a broad range of factors extending beyond the health care system alone. The health of the world's people in cities and towns now and in the future will depend among other things upon:

- the meeting of people's basic health needs, in particular food, shelter and clean water;

- their level of economic development and the equitability with which that economic development is distributed;

- the environmental sustainability of that economic development;

- the quality of their built and natural physical environments, and their psychosocial environment;

- the level and quality of human services such as education, health and social services;

- the cohesiveness and support of their community's social networks;

- the tapping of the energy and creativity of the people;

- the personal skills, self-esteem, life-style and mental wellbeing of families and individuals. Health education has a particular part to play here.

Participants at the working session described from their own experience how such a broad range of factors as these are involved in achieving healthier cities. Their experience also indicated that decisions which affect these factors are taken by national, regional and local governments, by international organizations, by business and industry, by local agencies and organizations, community groups and individuals. Clearly, all of these players must be involved in the process of improving health.

But while intersectoral action has been recognized from the beginning as a key strategy for achieving health for all (and was the topic of the WHA Technical Discussions in 1986) putting the concept into practice has proved to be the most challenging and difficult aspect of the implementation of the HFA strategy at all levels.

Important strategies for promoting urban health

Participants identified important strategies that, in their experience contributed to the promotion of urban health in the context of health for all. These included local intersectoral action, decentralization, network building and community involvement.

Local intersectoral action

What makes the healthy city approach somewhat distinct is its focus on the involvement of municipal governments. Since municipal governments make many decisions that have health impacts, it is crucial that those decisions be made with an awareness of those health impacts. However, it is also important that local government not "own" the project, but be seen to be sharing the leadership of the project with communities and with other sectors beyond government. The integration of public, community and private sectors and their related networks is thus a key part of the healthy cities approach.

Examples cited by participants indicated that a political multisectoral committee, together with a technical multisectoral committee, are important elements in successful healthy city projects.

Decentralization

Experience has shown that a second important development is the decentralization of intersectoral action and decision-making within urban areas. Several participants reported that their healthy city project was functioning not only at the city level but at the neighbourhood level. This ensures that local neighbourhoods and communities are actively involved in the process of achieving health for all locally and are able to exert greater control over the conditions that affect their health.

Larger cities in the project, because of their size, have found it almost essential to decentralize their efforts and to focus on local neighbourhoods, in effect recognizing that healthy cities are based not only upon healthy public policies but also upon the active involvement of the people. This decentralization also recognizes that services have often been planned and implemented without consulting and involving the community and taking into account local people's needs and wishes.

This decentralization to local districts and neighbourhoods requires the active support of municipal governments, provision of information and advice, the decentralization of resources and the provision of practical support.

Networks and community involvement

The Healthy City Project has paid considerable attention to process at all levels, from the neighbourhood level up to the international level. A key concept is that of the network, linking different sectors within a community locally and linking cities and interest groups nationally and internationally; these networks might in the future evolve into coalitions working for health.

As its name implies, the most important networks for achieving health for all in the Healthy City Project are those within the cities themselves.

The initiative for a healthy cities project has come from different quarters in different places. In some cities it has been from a politician, a university department or the city medical officer, in others from a voluntary organization, a local government officer or a private sector group. In all cases the priority has been to establish a broader based group which represents a range of the agencies with an interest in the wider aspects of health.

The involvement of individuals, as community members, in the Healthy City Project is essential. Involvement of the existing community networks, and the mobilization of those networks in the interests of achieving health for all, is something that can only be done effectively at the local level.

The experience of the WHO Project Cities is that considerable energy can be released when key city sectors work with local neighbourhood groups and networks to address local concerns, as defined by the community. One particularly effective approach has been to work with children, through the school system, in identifying their perception of a healthy city.

Problems to be addressed

Participants also agreed that there are a number of important problems that have to be addressed if the healthy city concept is to be adapted to the situation in developing countries. Perhaps one of the most important problems is what one participant referred to as the "liberation from inherited concepts". By this was meant western and European concepts of the city, of community, and of health, among others.

One point that was made a number of times is that while developed nations are highly urbanized, many developing nations are not. They may only have one or two urban areas that can be described as cities, although they may have many other urban and rapidly urbanizing communities. In this context, the concept of the healthy community may prove more useful, since it can refer to almost any size of urban area or to neighbourhoods and communities within urban areas. The notion of "healthy villages" or "healthy neighbourhoods" is also consistent with the concept of healthy cities. Whatever the size of the community, the key point that distinguishes healthy city projects is that they involve putting health on the social and political agenda of municipal governments and linking those municipal governments to the health concerns of their citizens.

Other problems that were identified in the group included:

- the need to create links between government and community;

- the need to ensure that local government programmes are coordinated with programmes of national ministries delivered at the local level;

- the need to ensure that intersectoral committees include not only government and community, but the private sector;

- the need to avoid control of the project by any one profession or group

- the possibility that politicians might prefer not to delegate to the community;

- the possibility that centralized support by an agency or government for healthy city projects may lead to a wish to control cities and city networks, thus stifling local action. The keynote to the project is facilitation.

Another constantly recurring theme is that in rapidly urbanizing areas that have large numbers of immigrants, people may well not identify with the city at all, but with their rural roots. This led to the suggestion that in such cities, healthy city networks cannot be limited to the city itself but must reach back out into the rural communities from whence their immigrants come. On the other hand, while recent immigrants may not identify strongly with the city, they may identify with their local neighbourhood, making the strategy of neighbourhood renewal particularly relevant.

Another problem with people living in such marginal conditions is that the energy and resources they have to do other than to meet their basic needs may be slight, and they may lack the skills to address community problems. Under such circumstances, a reliance upon voluntarism to address community problems has limitations which must be acknowledged.

Finally, it was pointed out quite forcefully that people have to be free and that the community must be emancipated, if it is seriously to address its problems. Community and personal empowerment is central to the process of building healthy communities, and governments have to respect the rights and freedoms of individuals if health is to be achieved.

Benefits

While participants identified a number of problems, they also clearly identified a number of benefits from the healthy city approach.

One important benefit is that the project can place health high on the agenda of local government. Changing the agenda in this way does not necessarily require additional funds but may have significant long-term benefits for health. Many cities have clearly found the idea of the Healthy Cities Project to be helpful and have followed it spontaneously. It seems that to be identified with a move towards improved urban health can be a source of civic pride and can increase the strength of the voice for health.

The concept is sufficiently flexible that it can be applied to a wide range of communities, and is compatible with, and complementary to, similar projects such as healthy schools, healthy hospitals and healthy villages.

However, healthy cities is not just a concept; when expressed as a project, it calls for explicit public commitment by municipal governments, the establishing of feasible health goals for cities, towns and communities, and explicit commitment to full public involvement in problem identification, priority setting, planning and implementation. It also requires explicit public reporting on health status and an accountability for success or failure in achieving health goals.

At its best, it can represent the total integration of health into the life of a community and the mobilization of all components of the community's energies and resources in pursuit of health for all.

Recommendations

Recommendations for the further development and application of the healthy cities and communities concept as an important strategy for achieving health for all fall into three broad categories - city level, national level and international level.

City level

1. Municipal governments and local health authorities could consider the establishment of a healthy city type project in the context of their own situation. In doing so, they could draw upon the experience of other cities and towns that have implemented such projects.

2. Local governments involved in healthy city projects could recognize the central role and importance of community and personal participation and empowerment and the energy and creativity that emancipated communities can contribute to making cities more healthy.

3. Participating cities could utilize their participation in twinning arrangements and in national and international associations of municipalities to learn from each other and to share their experience.

4. Municipal governments could seek support from national governments and organizations and international organizations and agencies in developing healthy city projects and could ensure that such projects are well integrated with other city-orientated projects such as UNEP's sustainable cities project.

National

Participants emphasized that while national governments and international agencies could initiate and be supportive of healthy city projects, this should be done by the local communities and the municipal government.

1. Member States could encourage the creation of healthy city projects and networks as a means of achieving health for all at the local level.

2. National governments could establish inter-departmental work groups in support of healthy cities, where appropriate.

3. National healthy-city networks could be established in partnership with non-health sector and nongovernmental organizations; national associations of municipalities could play a key role here.

4. National networks need to be adequately funded on an ongoing basis (perhaps through the establishment of a national healthy city office) to allow the effective implementation of such tasks as the collection and dissemination of information and experience, skills development and network building. Consideration should be given to funding national and international resource centres.

5. National governments might consider funding pilot and model projects.

6. National governments could support research into the process and outcome of healthy city strategies.

7. National governments could strengthen the capacity, resources and mandates of local governments and respect their autonomy while enabling them to improve the health of their citizens.

National nongovernmental organization

1. National NGOs, particularly in the health, urban, environment and social justice sectors, could consider how they can individually or collaboratively support healthy city projects and national healthy city networks.

International agencies and organizations

The working group recommended that WHO should:

1. develop the healthy cities approach as a valuable way of applying the concepts and principles of health for all at the local level and as an important opportunity to raise the visibility and credibility of WHO among local governments and at the community level;

2. work closely with other United Nations agencies to ensure that international projects directed at and involving cities collaborate closely both internationally and locally;

3. work closely with international NGOs in developing and applying the healthy city concept;

4. support healthy city type networks in all its Regions, based upon the experience gained to date but adapted to the regional context;

5. encourage and support research and analysis in support of healthy city projects.

International organizations should support links between cities in developed and developing countries and should fund exchanges that will enable community members, urban professionals and politicians to benefit from the experience of other cities involved in healthy city projects.

## URBAN POLICIES AND HEALTH STATUS

That the city might be an appropriate level of focus for public health development is not a new proposition. In nineteenth century Europe and North America, it was the cities which, when confronted by the epidemic diseases that ravaged undernourished populations living in squalid housing and environmental conditions, responded to the challenge, building a movement which was based on municipal public health departments.

Many of the factors that have a major impact on health are subject to rules, regulations and laws which depend on urban policies. Housing, water supply, air and water pollution, food supply, control of vectors of transmissible diseases, and the development of local transport systems are typical examples of services to which sound urban policies must be adopted and observed. Taken together with health care services, with attitudes derived from the cultural heritage and with the levels of employment and income, they determine the health status of urban populations.

It should therefore be self-evident that professionals who are directly responsible for the health of the people ought to be more concerned with the mechanisms of elaboration and adoption of urban policies.

In the long run, at the heart of urban policies will always be the popular understanding of what appear to be the important issues. It may be possible for external or central directives to influence policy in the short term but in the longer term what will emerge are policies based on the core values of the local culture. More often than is commonly admitted there is insufficient awareness of the role that should be played by health-related policy in the complexities of life in urban populations.

Where there is a local interest in health-related policy or where this can be brought about through raising awareness, it usually leads to a flowering of different models of effective practice which depend again on the local culture.

Health education and health promotion have an important part to play in setting the agenda and raising awareness so that local models of good practice can be developed. One of the advantages of urban areas is the high level of development of forms of mass

communication which can be used to obtain direct access to the population and initiate the kind of debate which is usually needed.

Changing expectations about health can only achieve results if they produce greater public participation in the political process and in the fight for health. The mobilization of resources to improve health status will always be associated with this willingness to become involved.

In parallel with public participation, the achievement of health-for-all requires a strengthening of local government. However, it is often the case that local government needs reforming and that the voice of the public, as the consumer of public services needs a louder voice. This points towards the need for political parties, confidential votes and a choice of candidates.

Poor distribution of insufficient resources is one of the characteristics of underdevelopment, and in urban areas it is possible to find shortages in one place and duplication of services in another. Surprisingly enough underutilization of services may coexist with shortage of resources. The key to these kinds of problems may lie with population-based and resourced local health districts.

During the past decade, in particular, the lack of financial resources as a result of the international debt crisis has put great strain on health systems in the developing world. It is becoming clear that the cause of this lies predominantly with the world financial order rather than with the deficiency of individual countries.

Despite the difficulties there have been some impressive achievements by health workers struggling against adversity. For example, as a result of increased vaccination coverage and the more effective implementation of oral rehydration, infant mortality rates have improved in many areas despite reductions in public health funds.

The rapid urbanization which is currently occurring has many negative impacts on health. However, one of the benefits in the longer term is the stimulus which urbanization gives to planned parenthood with the benefits that brings to families.

We now know that in the past many of the improvements in health have come about as a result of action outside the medical sector. This understanding has led to an unfortunate tendency to present the sociopolitical and the medical and behavioural perspectives of health development as being in some way in opposition. In reality this is not the case and particularly with the technological advances which are now available, it is important to see how Dr Nakajima's new paradigm of health - one which produces a synthesis of health policy and health promotion with preventive and curative medical and social care - can be made a reality. We need to obtain the right balance.

The terms of reference of the Working Group on Urban Policy and Health Status were to formulate a series of recommendations as to how to increase the health sector's capacity and power to influence urban policy so as to promote health status. The focus was on the policies which require a coordinated effort from a number of government departments or local government agencies, as opposed to those policies which are devised by health authorities alone and which relate exclusively to health sector objectives. These multisectoral policies can be seen to involve the "foreign ministry" function of the health department - that is to say the need to influence policies in other departments and in other agencies in order to achieve health gains for the population.

There were certain recurring themes from the workshop discussions:

(1) When the concepts of health-for-all were first developed there was an assumption that the problems of health in rural areas were more urgent than those affecting urban populations. It is now increasingly realized that the rate of growth of urban populations and the conditions under which this growth is occurring make it essential for urgent action to be taken to address the health problems of urban populations.

(2) Initially, it was felt that health-for-all involved concepts which were of particular relevance to less developed countries. It is now clear that urban populations in the industrialized countries can also benefit from the application of these principles.

(3) The effective pursuit of health-for-all requires sound leadership within communities and the collaboration on equal terms of professionals and the public.

(4) It is essential that agencies should collaborate to tackle the urban health problems which confront the world.

(5) There needs to be strong and competent local government.

(6) A health district and neighbourhood health area approach is a powerful tool for ensuring population coverage and an equitable distribution of resources in ways which are compatible with people's needs and expectations.

(7) There is a need for the development of new health indicators as part of a set of social indicators that can be used to access resources and tackle the fundamental causes of urban ill-health.

(8) The change in the type of intervention which has now become commonplace indicates that there has been real progress in moving away from views of health and disease which focus on single causes towards those which acknowledge the multifactoral nature of health and disease. It is now necessary for health institutions to build on these developments in the way in which they operate to promote multidisciplinary and intersectoral working.

Major issues

A number of major issues of relevance to policy to improve urban health status were identified.

1. Population

The interaction of population growth and environmental degradation was repeatedly raised. Policies were needed to raise the status of women and to facilitate family planning as part of a holistic approach to health development.

Reducing the growth of urban populations requires effective family planning policies and programmes. Controlling fertility in urban areas is linked with several factors such as increased income, better employment, literacy and education (especially of women), better nutrition, access to health services, better availability of contraceptives, and more effective collaboration between the health system and the local people. Family planning is usually more effective when it is integrated into maternal and child health and primary health care.

Population concerns although varying in magnitude have great similarities between developed and developing countries. The population situation everywhere is a dynamic one and has special implications for health, for example, the rapid aging of the population in developed countries and in contrast the situation where, for instance, in Zambia 51% of the population is 15 years of age or younger.

2. The need for political commitment

Improvement in the health conditions of the urban poor will only come about if there is real political commitment to change. This commitment implies the willingness to respond to the will of the people and effect the many changes required in moving from narrow sectoral determination of policy to policy based on multisectoral interests.

3. Decentralization

It is essential to achieve greater local determination and decentralization of power, responsibility and resources. This must be done with care to ensure that skilled personnel are available at the local level. This has implications for human resource development and the development of management skills at all levels.

The improvement of city health cannot be effectively implemented from the national or even from the regional level. Local government needs to participate in policy development by identifying the health issues, promoting community involvement and creating the physical infrastructure which is necessary. The success of the decentralization process will be predicated on the skills and competence of the local public health departments. Their needs for training and staff development may need to be met by national or regional resources.

If the leadership capacity of municipal health personnel is not supported and developed the credibility of health services and their effectiveness will be questioned by the public.

4. Public participation

Speakers emphasized the futility of deciding urban policy without the effective involvement of the people themselves. It was pointed out that deprived population groups in urban areas were most likely to have the weakest forms of community organization and that their interests were least likely to be effectively represented.

The health sector needs to recognize that its experience and skills in the facilitation of public participation is limited and special efforts are required to reorientate and retrain health workers for this important work.

Special attention and effort is needed with regard to women as the "custodians of family health". Their vulnerability in respect of the impact on the family of urban migration is of particular concern.

The paradox of the high technology of some modern universities and hospitals in both developed and developing countries is often a stark contrast with the surrounding urban slums. The potential of these institutions to develop and sustain innovative community health services should be encouraged.

5. Leadership

Effective leadership is needed within the health sector at all levels, but there are obstacles to its achievement. Individuals with appropriate experience and skills are often difficult to retain, especially at municipal level. Supplementary financial support may be required from the national level to induce competent people to stay.

Leadership in the health sector is accustomed to addressing specific health questions particularly those which draw on professional and technical skills.

However, the issues raised in the context of urbanization go beyond these traditional health questions and it is necessary for health workers to act as catalysts for change working in partnership with a range of other types of worker and with the public. For this to occur and be successful there is a need for changed attitudes and increased skills.

6. The need for a systematic approach

While the need for a systematic approach was emphasized the lack of adequate local data is no justification for delaying action. However, most health data originate at the local level and are used in aggregated form at higher administrative levels. There is a need to develop local capability in collecting, managing and using health data in a systematic way for planning and evaluating services.

7. Primary health care

Primary health care within district health systems offers the possibility of mobilizing and focusing all the different sectors which influence health in a particular neighbourhood. At its best this can be a very powerful approach. Furthermore, this approach has the potential to direct resources towards the local health promotion priorities.

The need for exchange of information of experiences at the local, national and international level was emphasized. Such experience and information exchange is needed to learn from failures and successes in both rich and poor countries. Networks such as CITYNET, Metropolis, IULA and the WHO Healthy Cities Project, are examples of how this can be done.

8. Intersectoral collaboration

Urban development cannot be viewed entirely from either economic objectives or indicators. The social and health aspects of the activities of many sectors are increasingly being recognized. It is necessary for information to be brought together from the different sectors to create a holistic view of health and development and it is necessary to support intersectoral action to ensure the development policies are compatible with supporting and improving health.

9. Health promotion

Health promotion and health education remain the responsibility of the health sector of urban society. The capacity to disseminate this information can be enhanced through other sectors. In Pakistan, a health promotion programme now targets health and social messages to schoolchildren as part of their curriculum. The ultimate effect will go beyond the child into the home and family.

The whole range of communication resources should be drawn on in providing the public with information about health. Contrary to the prejudices of many health workers, the media can be a powerful ally in achieving change for health.

10. Financial resources

Health should be seen as an investment in the future. However, frequently financial resources are allocated to more visible policy areas than health with the consequence that there is little money available for health initiatives. There is a need to adapt taxation systems so that a larger proportion of total revenue is under the control of local authorities with a responsibility to support health development.

The international debt crisis has had a most adverse effect on local government in many urban areas. The resolution of the urban health situation is ultimately dependent on the resolution of this crisis.

The group believed that health promotion and prevention should receive priority in funding and that special economic incentives should be made available to promote investment in disadvanged urban areas.

11. The role of multi- and bi-lateral international agencies and NGOs

For international agencies, including WHO, the growing urban crisis confirms the value of many of their technical cooperation activities, but also demands significant changes. The agencies have successfully identified the global extent of this crisis, and how it relates to degradation of the global commons and the overriding issues of sustainable development. Much of the information that these agencies provide and the technology that they disseminate is directly relevant to solving urban problems. Some agencies have successfully fostered the increased interchange of pertinent knowledge and experience among countries and cities. Some external support agencies are changing

allocation policies toward assigning a greater share of available funds to meet social development needs, a tendency that should be strengthened.

Apart from the better funding of sound urban development, two types of changes are now required: first, the widening of technical cooperation to provide better support to national and local efforts; second, better internal and interagency coordination of technical cooperation and external support.

WHO is also in a position comparable to its national and local counterparts, if it is to implement its role as a major international agency devoted to human wellbeing. Its established technical capabilities and its clear policies on health for all and primary health care are strong assets in meeting the challenges of urbanization. As with national and local health authorities, however, it needs to establish focal mechanisms concerning the health problems of urbanization, to strengthen and improve its cooperation with countries, and to expand its health promoting influence among international agencies and organizations.

Harnessing the potential of nongovernmental, religious, private and voluntary organizations is a major challenge. Meshing the efforts and resources of these different groups into a common effort can also improve the use of scarce resources in meeting a massive set of needs.

Encouragement and support should be given to the voluntary networks that are developing among cities themselves, including the WHO-sponsored "Healthy Cities" project, associations such as Metropolis and CITYNET, and individual twinning schemes between cities in different countries and regions.

Several participants mentioned special needs for support by the international community such as for the countries of Eastern Europe and for the exchange of experiences among countries in determining urban policies.

Summary

From the groups' discussions it was clear that there has been a significant change in the concepts which are being used to understand urban health and that there is now much more comprehension of the multifactoral nature of ill-health and less tendency to look for single causes. There is an increasing realization that all health institutions, including hospitals, should adopt a holistic and integrated approach which includes health promotion as well as treatment and remedial interventions.

WHO continues to play a central role in the development of these concepts and is contributing in a decisive way to updating them in line with the dynamic changes which are prevalent in urban populations throughout the world.

- - -