Cities in Distress: WHO Sounds the Alarm

The mayors and chief health officers of 17 cities with millions of desperately poor slum-dwellers declared recently that 'the urban rich have a major responsibility, moral and practical, for meeting the health needs of the urban poor'. The consequences of their shirking this responsibility will affect all city-dwellers without respect for wealth or status through the spread of disease and violence and a deterioration in the quality of city life.'

This warning appears in the final report of a four-days' (27–30 November) interregional meeting in Karachi, Pakistan, on 'City Health: The Challenge of Social Justice'. Organized by the World Health Organization, the meeting was sponsored by the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the Aga Khan University of Karachi, the Finnish International Development Agency (FINNIDA), and the World Association of the Major Metropolises (Metropolis).

The mayors and health officials suggested that those better off could fulfil their responsibility by contributing their professional skills as well as money to city initiatives to help the urban poor.

Importance of Women

The meeting which brought together 60 urban experts from all over the world, also 'stressed the important role which women play' in urban health affairs. Emphasizing their 'major role in implementing health education, family planning, and child care policies', city officials said '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'.

The mayors and health officials making these points came *inter alia* from São Paulo and Cali in South America; Cairo, Casablanca, Dakar, Lagos, Addis Ababa, and Lusaka, in Africa; and Beijing, Seoul, Bangkok, Jakarta, Bombay, Colombo, Istanbul, Manila, and Karachi, in Asia.

They were in a good position to point to 'the sheer size and scale of urban population growth and urban poverty, the problems posed by their continuing growth, and the desperate situation faced by their poorest citizens.'

Alarming Statistics But Some Hope

The statistics are staggering: in the three 'developing' continents of Asia, Africa, and South America, in 1950 there was one city with a population of more than 5 million people. By the year 2000, if present trends continue, there may well be 45 such cities (Fig. 1). Around 50% of their population are likely to be living in slums and shanty towns. Among the cities represented, an annual population growth of 3% is common. This means that their populations are projected to double in a generation, with Karachi's current population of about 8 millions doubling in a decade.

Notwithstanding the formidable dimensions of the health and environmental problems of the urban poor and their appalling plight, the mayors and health officials of the 17 metropolises agreed that the situation was by no means hopeless, and that something substantial could and must be done.

In Bombay, for example, where more than 10 million people are crowded together in 440 square kilometres—almost 19,000 human beings per square km—considerable progress has been made, Dr V.P. Desai, the city's Executive Health Officer, told the meeting:

> 'About 40% of Bombay inhabitants live in slums, near high-rise office buildings and apartment houses. Most of them now have access to safe water, and two-thirds have adequate sewerage. Our family-planning programme is showing encouraging results and we have not had a major epidemic in the last five or six years.'

Casablanca, too, had a 'success story' to tell. In 1985, about 40% of the population of that Moroccan city lived in 'bidonvilles' (slums and shanty-towns). Thanks to a policy

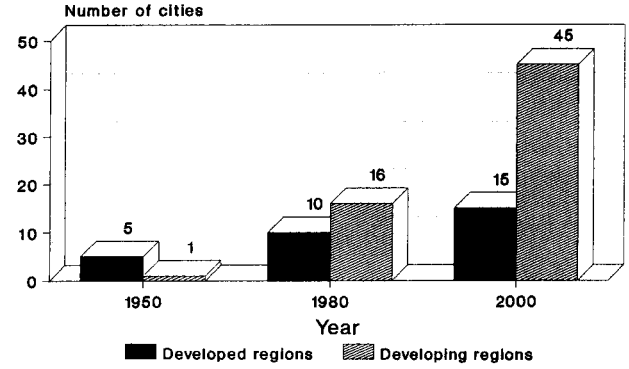

FIG. 1. *Distribution of Cities or Towns with Human Populations of 5 millions or More.*

of land tenure—giving slum dwellers the land they were living on—and of massive housing construction (50,000 units a year), today only 5% of Casablancans live in 'bidonvilles', reported Professor El Mokhtar Tazi, a leading urban official.

Mahmoud El Kholy, the Secretary-General of the Cairo Governorate, had an encouraging story to tell about the 60,000 inhabitants of what was once one of the poorest slums in the outskirts of Cairo, Manshiet Nasser:

> 'These slum-dwellers accepted jobs that no one [else] would take. They were scavengers who collected garbage which they carried in carts drawn by animals and emptied in their shelters. These shelters were made mostly out of mud, tin sheets, wood, or any available material. They shared these shelters with their animals. They lacked electricity and sanitary latrines, and got water from the nearest source, no matter how polluted it [might be].
>
> 'Poverty was the main factor. The prices of materials, sorted from the garbage (glass, paper, plastics, etc.), shot up. Families began to build concrete houses of one or two storeys. Piped water was supplied by the government water authority—some to houses, but most to public outlets nearby. Sanitary sewage-disposal now covers more than 50% of the houses. Electricity reaches most of them. Garbage is now collected by motor cars and, after being sorted in special shelters separated from the houses, is carried to a nearby, newly-built factory and fermented. The final product is an organic fertilizer. It can be done!'

Indeed It Can be Done

São Paulo, Brazil, has a population of 13 millions, of whom 2 millions live in slums, or 'favellas', in shelters made largely of cardboard and paper. Forty per cent are illiterate. If current population-growth continues, there will be some 20 to 22 millions inhabitants in this Brazilian city 10 years from now. Yet the favellas are located near wealthy neighbourhoods.

Dr Fernando Proenca de Gouvea, Under-Secretary of Health of São Paulo State, said that, two years earlier, decision-making for health matters in these slums was 'brought down to the municipal level, much closer to the people. We built health centres where people could come at any time of the day or night. There was always a doctor available. We installed nurseries for children and built toilet and washing facilities outside, near the shelters. It was not easy to reach the inhabitants of the favellas, to win their confidence, to change mentalities. It goes very slowly but it can be done. We are proving it.'

Cali has begun to tackle successfully the key problem of employment among its urban poor, according to Dr Rodrigo Guerrero, Executive Director of the Carvajal Foundation in the Colombian city:

'We recognized the importance of the informal sector or micro-business sector for the country's and the city's economy. Somewhere between 45% and 70% of employment throughout Latin America is accounted for by micro-enterprises [which] can generate jobs with low investments. Our experience in Colombia shows that an investment of about $1000 [US] creates a job. A medium-sized business would require an investment of $25,000. In Cali alone, 13,000 [generators of] micro-businessmen have taken [one of] four basic training courses. In Colombia as a whole, 70,000 have done this. We are making headway'.

The Deputy Director of Public Health of Beijing, China, Professor Shouzheng Gao, said that 'vaccination coverage for children in the city has reached 98%. All vaccines are provided without charge. Between 1984 and 1988, the incidence of tuberculosis declined from almost 67 to 30 per 1000, and TB mortality dropped from 7.8 to 4.7 per 1,000', adding that 'women and children make up two-thirds of the total population of Beijing'.

Observations and Concrete Recommendations

After listening to reports from mayors and doctors of all the 17 cities involved, the meeting made a number of concrete recommendations and pertinent observations:

(1) Never underestimate the intelligence, energy, and common-sense, of poor communities;

(2) Health problems among the urban poor cannot be solved in isolation; they should be linked to such matters as income-generation, land ownership, population balance, community participation, housing, water and sanitation, and solid-waste disposal;

(3) Solid-waste disposal and environmental pollution are problems of special urgency;

(4) A halt to population growth is absolutely essential in many cities if problems are not to become unmanageable;

(5) Each city is unique and has its own problems and peculiarities, so it is most unlikely that there can be any single, standard, packaged solution;

(6) Rural poverty has to be tackled because if it isn't, the exodus from the countryside to urban slums will make already inhuman conditions there worse, and overwhelm local authorities;

(7) The existence or absence of political willpower is often the major determinant of whether the health of the urban poor is effectively tackled;

(8) Medical care that concentrates on high-cost specialities for relatively small numbers of patients is inappropriate in dealing with the urban poor, and new approaches linked to Primary Health Care are desirable;

(9) Medical school curricula and activities should be reoriented to meet the needs of the urban poor, and young doctors and nurses [should be] encouraged to work with and in deprived urban neighbourhoods;

(10) Incentives, such as improved salaries and housing, should be found for health workers;

(11) The exchange of experiences and solutions among cities with large deprived populations living in abysmal conditions is to be encouraged.

One of the most enlightening activities of the four-days' meeting was a visit to the 'katchi abadis' (Urdu for squatter settlements) of Karachi where the Aga Khan University Medical School is carrying out pilot projects in Primary Health Care with strong community participation in seven slum areas.

Prospects Encouraging?

Although many of the participants had had intimate experience with slum areas and shanty towns in their own countries and elsewhere, they were nonetheless shocked and stunned by what they saw. But they praised city authorities for their courage in not trying to conceal a grim situation.

'In trying to introduce our professional ideas on health improvement among the urban poor and deprived around the world', said John Bryant, Professor of Community Medicine at Aga Khan University, 'we must be very cautious, very humble, and very patient. We must be willing to listen to their sense of what is important and what should be done, and to their judgement of how it should be done. In short, let the community become partners in, and not simply objectives of, health development.'

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Environmental Awareness Benefits

It gives me great pleasure to announce that, with the issue commencing the present volume of our quarterly journal—Vol. 12. No. 1 (January–March) 1989—we are fortunate to have with us a distinguished panel of mostly internationally-known leaders in the environmental movement to constitute our Editorial Panel as *Consulting Editors*. We have hopes of adding further eminent authorities in the near future, to fill gaps and serve the cause of environmental conservation for human welfare with ever more vigour.

We wish to express our grateful thanks and appreciation to our colleagues who have excelled in the main fields of environmental endeavour. They are (in alphabetical order of surnames):

Prof. Lynton K. Caldwell (Bloomington, Indiana, USA),
Prof. Raymond F. Dasmann (Santa Cruz, USA),
Prof. Paul R. Ehrlich (Stanford, California, USA),
Richard Fitter (Oxford, England, UK),
Dr. F. Raymond Fosberg (Washington, DC, USA),
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