

CHAPTER 4

Urban Health: Learning From Systems That Work

“if we don’t act now,” warned the former health minister for Mexico, Julio Frenk, addressing the issue of global health, “the divide between rich and poor, North and South, will continue to grow, with serious consequences for economic development.”

Frenk’s simple but compelling logic struck a theme often repeated in the Summit sessions on Urban Health. Later, Gordon McGranahan, who heads the Human Settlements Group at the London-based International Institute for Environment and Development, would put an even finer point on this logic: “Maximizing health would be far better for the poor than maximizing economic output,” he said.

Layers of bureaucracy, sometimes openly corrupt, have clogged financial pipelines and sometimes just gobbled up millions of donor dollars intended for economic development in poor nations, McGranahan told those assembled. Not much of this funding actually results in better lives for the poor. Too often resources never arrive at the local level, where they are desperately needed. A focus on health, McGranahan argued, would be a more effective and powerful alternative for improving the quality of life and economic outlook—for the urban poor. The bottom line is that healthy people are more productive.

healthy people
are more
productive

These Summit participants came from a wide variety of institutes and agencies organized around global urban health issues, including academia, journalism, philanthropy, and major NGOs such as the World Health Organization (WHO), USAID, and UN-HABITAT.

Health improvement, in its broadest sense, quickly emerged as the connective tissue linking all of the challenges facing the Global South for this century. Health is intricately interwoven with such basic urban challenges as clean water and adequate sanitation. It touches more complex concerns, too, from how urban areas are designed and planned, to managing a globalized economy, to surviving the effects of climate change.

clean water

sanitation

effects of
climate change

Informal settlements, too often just slums where people live in squalor, may be the epicenter of the world's most critical health problems. Poor sanitation, frequent flooding, open sewers, dumping, people living atop garbage dumps, rapidly spreading diseases, proximity to air pollutants—all these factors lead to poor health outcomes for at least 1 billion people, a profound health and moral issue. The conditions challenge entire metropolises—and the entire world. That's because within hours, a slum bug can spread to cities worldwide, making pandemic preparedness, as one participant put it, "the speedboat for slum research."

flooding

air pollutants

pandemic
preparedness

The overarching theme of this week-long Summit session was the need to shift the health conversation from the vulnerabilities of the Global South to its potential for resilience, to talk less about its problems and instead figure out how to encourage, nurture, and spread examples of positive interventions. Another crosscutting theme was the call to rely more on social capital, networks, and community-driven approaches to replace top-heavy, donor-driven, bureaucracy-laden projects.

potential for
resilience

triple health
burden

The week's deliberations were formally launched with a forceful presentation by Frenk, who is now a senior fellow with the Bill & Melinda Gates Foundation. In Frenk's estimation, today's poor carry a triple health burden. Many have yet to emerge from persisting health problems such as reproductive diseases, or malaria and dengue. Exacerbated by inadequate living conditions, these maladies persist because health systems fail. And with climate warming welcoming mosquitoes to new locales, more urban communities, such as Nairobi, are likely targets of vector-borne disease.

globesity

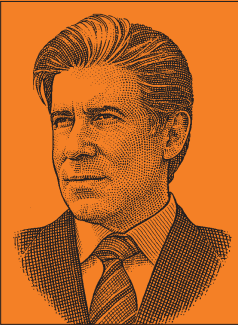
Added to these are communicable disease patterns, from erstwhile diseases such as tuberculosis to the still-growing threat of HIV/AIDS. And on top of those burdens, globalization's effects show up in rising rates of mental illness and hazards resulting from climate change. Side by side, malnutrition and obesity—called “globesity” by Frenk—also now plague the urban poor across the developing world.

Yet Frenk also brought a message of optimism and hope. During his ministerial service, Mexico adopted a broad new health initiative, supported by a 93 percent legislative majority. The program's three pillars include incentives to improve personal health, the beginnings of universal access to health care, and innovation such as reliance on social capital and networks rather than just more health centers.

Setting a research-driven framework for the week's discussions was Trudy Harpham, author and researcher with wide experience in the developing world. She began by outlining

Growing out of Poverty: Revolutionizing Health Care

Julio Frenk



Former Minister of Health for Mexico, currently a senior fellow with the Bill & Melinda Gates Foundation, Seattle, Washington, and President of the Carso Health Institute, Mexico; plenary speaker

without healthy populations, countries will not grow out of poverty. Some 70 percent of urban dwellers in Africa and 43 percent in Latin America are poor. Living conditions in the cities of these regions can be fertile ground for infectious diseases, malnutrition, injury, and mental illness, often making urban poverty far more oppressive than rural poverty. Mal-development is also common in these urban settings. In contrast to advanced societies, where new problems tend to replace old ones, in mal-developed societies, old and new problems coexist in a complex present fraught with contradictions. Throughout cities in the developing world, traditional public health problems are compounded by new maladies related to globalization, climate change, and detrimental lifestyles.

To persuade finance ministers to support building or revamping health systems, you have to show them that improving the health of citizens can help achieve economic objectives. For example, healthy children perform better academically and healthy people of all ages are more productive. In Mexico we have put a new program into law that embraces successful reforms while making health care universally available as a social right. This program took a three-pronged approach:

1. We launched a new generation of health-promotion and disease-prevention strategies, such as high tobacco taxes to discourage smoking among young people, improved traffic flows to reduce motor vehicle accidents, and strengthened crime prevention policies and other efforts to discourage family and gender violence.
2. We are moving toward universal health insurance. Mexico's segmented health system was tied to employment, overlooking 50 percent of the population. The insurance plan for the self-employed is on target to help cover all of the more than 100 million residents by 2010.
3. We have been innovative in care and delivery. In the past, primary care meant primitive care for poor people. The new concept involves fewer health centers and more networks: sets of agile services

recognizing that disease and health concerns are not discrete episodes but conditions that must be addressed throughout life. Utilizing technological advances including information technology, these redesigned services provide coordinated continuity of care for mobile populations.

With the United States and Mexico straddling the busiest border in the world, illegal immigration into the United States does factor into these mobile populations. Keep in mind, however, that the majority of border crossings for health-care reasons are from the United States into Mexico—Americans seeking cheaper drugs and treatments. In this age of globalization, the mobility of populations within and from all countries must be considered in the planning process for improved health systems.

the principal determinants of the health of the urban poor. Harpham reminded the group that the underlying causes of poor health are complex, spanning multiple sectors and multiple levels, extending well beyond just poor access to medical treatment.

determinants of health

Harpham recalled the Alma Ata Declaration on Primary Care, the visionary agenda that emerged from the International Conference on Primary Care in 1978. Its emphasis on primary care has since been adopted by all members of the WHO. The original Alma Ata vision targeted multiple sector responses. In practice, however, what emerged was selective primary health care. Anything resembling a multi-sector approach was left waiting in the wings.

Multi-sector approaches, Harpham continued, must start with “joined-up” government. Getting government departments with their separate missions, however, to communicate and coordinate invariably becomes a major challenge. A prime example is the Healthy Cities project, popularized in the United States in the 1990s. It asserted that hospitals, clinics, and doctors alone cannot serve human health adequately; that jobs, the environment, social conditions, and treatment of children are just as—if not more—critical to peoples’ long-term health; and that all segments of a community need to be engaged in a comprehensive place-based health strategy. Healthy Cities sought to increase local government capacity to improve living

conditions and to form partnerships with other communities and community-based organizations. It also stressed creating a network of cities within and across nations to exchange important information and technology.

However, an evaluation of the Healthy Cities program conducted by Harpham and her colleagues in 2001 found limited, though respectable, impact. The initiative did raise awareness in many places; in some cities the program mounted some significant project to improve the environment. But limited political commitment undermined even small successes.

In Europe, Healthy Cities also performed reasonably well in some instances, though it still failed to yield lasting urban health plans. But in the Global South the initiative never took hold at all. The explanation, in retrospect, seems obvious: Most of the participating municipalities had not requested these projects. Instigated by donors, Healthy Cities lacked the legitimacy and energy of a local initiative driven by community demand. Eliya Zulu, deputy director of the African Population and Health Research Center, put it best: "It is critical that the people in the community are actively involved and demand it," he said. "And without government commitment as well, there's not much that can be achieved."

On a positive note, an important change has begun in health research, Harpham reported. Health studies used to focus mostly on the biological, demographic, and behavioral characteristics of individuals. What is now clear is the powerful impact of other factors, most prominently the relationships

formed by people in a defined place—what is now commonly called “social capital.”

No list of determinants of urban health is complete without an exploration of four critical factors that exert a powerful impact on the health of the community:

Poverty. People commonly equate slums with poverty, but poor neighborhoods are not uniformly poor. Some studies even suggest that a tenth of people living in slums have enough income to have more choices about where they live. Conversely the poor can also be found embedded in more moderate-income communities. There are also many people who remain in one place geographically but move in and out of poverty. Since statistical averaging can easily distort reality, strategies to reach all the poor must resist temptations to see communities as homogeneous.

Household income, or livelihood, emerges as the most trusted measure of financial standing. It includes all members and sources and takes into account the relative vulnerabilities of various financial sources. As poverty is shown to be anything but one-dimensional, the argument for multilevel and intersectoral responses grows stronger.

Although urban poverty may not be uniformly well understood, the health consequences of poverty seem quite clear and are among the greatest challenges facing the world today. Poor people are likelier to get sick, less likely to have access to care, and unlikely to receive adequate treatment. The driving lesson in urban health is the velocity of the growth of the urban poor, with Latin America, Africa, and Asia as the major theaters. Some

current and projected number of slum dwellers, by region

region	East Asia	Latin America and the Caribbean	North Africa	Oceania	Sub-Saharan Africa	South Central Asia	Southeast Asia	Western Asia	total
Urban population, 2001 (millions)	533	399	76	2	231	452	203	125	2,021
Number of slum dwellers, 2001 (millions)	193.8	127.6	21.4	0.5	166.2	262.4	56.8	41.3	869.9
Percent of slum dwellers from urban population, 2001	36.4	32	28.1	25	72	58	28	33.1	43
Projected urban population, 2020 (millions)	845.7	543.2	137.2	3.8	452.3	748.8	337.6	194.9	3,263.4
Percent of slum dwellers, 2020 (assuming nothing is done)	36.4	32.0	28.1	25.0	72.0	58.0	28.0	33.1	43.0
Projected number of slum dwellers, 2020 (millions)	307.5	173.7	38.5	0.9	325.4	434.7	94.4	64.4	1,439.6
Increase in number of slum dwellers, 2001–20 (millions)	113.7	46.1	17.2	0.4	159.2	172.3	37.7	23.1	569.7
Percent of slum dwellers targeted for upgrading, 2001–20	20.0	8.1	3.0	0.1	27.9	30.2	6.6	4.1	100
Number of slum dwellers targeted for upgrading, 2001–20 (millions)	20.0	8.1	3.0	0.1	27.9	30.2	6.6	4.1	100
Low-income urban dwellers requiring alternatives, 2005–2020 (millions)	113.7	46.1	17.2	0.5	159.2	172.3	37.7	23.1	569.7

Note: Numbers in table may not sum to totals due to rounding

Credit: Adapted from data in UN-HABITAT 2003a, p. 14

60 percent of today's poor live in Asia, and 60 percent of the projected growth in poverty will occur there if current trends persist.

Social Capital. The impact that social dynamics have on community health is gaining wider attention among health researchers. The consequences of social dysfunction are already well understood. For example, when gangs disrupt the safety of communities and street violence is common, residents' health, particularly their mental health, is compromised. But now there is also growing interest in the positive connections between social capital and health. The notion is that health can be improved by strengthening the social networks, interpersonal relationships, and mediating institutions—places of worship, block clubs, etc.—that link people to one another.

link between
social capital
and health

Unfortunately, there are few studies confirming the link between social capital and health in the cities of developing nations. One frequently cited study comes from Cali, Colombia. During the height of that city's drug-related violence, the usual law enforcement and medical interventions were having little effect. Local officials decided to work to strengthen the relationships linking young men to each other and to key community institutions. This social model had a dramatic effect and homicide rates plummeted.

Physical Environment. The Global South now faces multiple perils of population explosion and climate change on top of an unforgiving plague of poor access to drinking water, basic sanitation, and shelter.

Poor Health Takes Many Forms

in sub-saharan africa the dominant threats to health continue to be the living conditions that people in the developed world blithely assume are omnipresent: piped potable water, access to toilets that are safe and sanitary, housing that affords enough space for families and keeps out harsh elements.

In Asia, health problems among the poor are made even worse by high rates of smoking and drug use, respiratory and heart disease being the all-too common consequences. HIV/AIDS remains a major cause of death across the Global South; it is the number one cause in Africa. In India, groups of poor people commonly make their living sorting through trash for its salvage value. Worse, up to 80 percent of the nearly 400,000 known tons of electronics recycled in just the United States ends up in India, China, or Nigeria, where workers use hammers and bare hands to extract metal and glass, exposing themselves to a potentially lethal brew of toxic chemicals.

Poor sanitation alone accounts for a high proportion of the death rates from malaria and diarrhea every year all over the Global South. Many of these deaths are of children. And in addition to both inadequate sanitation and shelter, many people also face the daily specter of violence. Densely packed living conditions set the stage for brutal behavior that causes injuries and death. The likelihood of violence increases further as the raw contrasts between those making a good living and those just scraping by widens—even within the slums themselves. Often cited are the favelas of Latin America—also known as *barriadas*, *vecinidades*, or *pueblas juvenes*—where, even when there is decent and stable housing, violence persists as a serious problem. Much of the brutality is rooted in illegal drug trade and the organized gangs that fight for control of these markets. Under these circumstances it is hardly mysterious that fear and anxiety become dominant emotions; mental health suffers, even among those with access to services and steady incomes. Depression and anxiety dominate the list of health challenges.

Where people have no regular access to potable water, it is most often the women who take on the burden of taking a container to some source and bearing it back, sometimes several times a day. The physical burden is one thing, but stories abound of women subjected to theft, even rape, on these journeys of necessity. In many places, women must also endure a silent form of personal violation, such as when public facilities provide toilets for men only. How can people focus on general improvements in community health when fear of attack and personal affronts are daily experiences?

Failure to access even the basic conditions of a livable environment—water, sanitation, and adequate shelter—accounts for much of the disease that occurs in the Global South. Some 2.5 billion people lack basic sanitation, and an estimated 1.8 million people die annually from the effects of poor sanitation. Many are children under the age of five. Water and sanitation deficiencies explain nearly all instances of childhood diarrhea. Households that rely on wood and dung to fuel indoor stoves produce air pollution that can lead to asthma, tuberculosis, or any number of infectious diseases. Children and the elderly are especially vulnerable. Dangers now considered rare in the developed world (lead paint poisoning, mold, pest infestations, for instance) add to the peril in the Global South.

Industrial Pollution. Although dramatically reduced in the Global North over the past century, dangerous emissions associated with industrial production continue to take a heavy toll, in illness and early death, in cities of the Global South, Russia, and the Ukraine. A 2007 ranking by the Blacksmith Institute of the world's most polluted cities indicated that virtually all the residents were afflicted by industrially generated chemicals pumped by factories into the atmosphere or water supplies. In Vapid, India, one of the cities listed, mercury in groundwater was found to be 96 times higher than WHO standards.

Health Services. Many heads nodded when one Summit panelist suggested that the medical industry had “hijacked”

the health care agenda, even in developing countries. The implication: preventive measures and environment make a greater difference. Even so, the availability of medical treatment matters. Key issues are reasonable access to care, the quality of care, and affordability, Harpham said. In the Global South, the poor often wander from place to place seeking appropriate care.

settlements
that are not
recognized

A core problem persists: A significant proportion of the urban poor in Global South cities live in settlements that are not recognized, not mapped, not even acknowledged. “They’re not supposed to be here,” said Anthony Kolb, urban health adviser for USAID, so government officials conclude they don’t “have to provide any services.”

A study from Delhi, India, cited by Harpham underscores the medical services problems that poor people face. It compared services available to residents in seven rich and poor Delhi neighborhoods. Not surprisingly the providers considered to be the most competent were concentrated in the better neighborhoods. More striking, though, was the ease with which poor people became trapped in no-win propositions. Private providers were found less competent but put forth higher effort to meet the needs of the poor. Public providers, by contrast, were better qualified but scored low on effort. “The poor received low-quality care from the private sector because doctors do not know much and low-quality care from the public sector because doctors do not do much,” said plenary speaker Frenk.

learning from what works

The time is ripe to make a fundamental shift in focus on health for people of the poor neighborhoods of the Global South. “Instead of talking about the problem,” said Harpham, “we need now to focus on what to do. Let us not pretend we need more knowledge.” In the past ten years, she added, “Much has been learned about ‘determinants’ of health and outcomes. If more research is needed, it should be about the interventions, with less focus on vulnerability and more about resilience.”

Harpham’s implication: what is still uncertain is which interventions pay off. But the clearly promising arenas are social capital and networks. Some participants, however, were not so certain that enough is known to pin down which programs are worth financing. “We all understand the problem, but we still do not have enough information about what works to know what to finance,” said Mark Rosenberg, executive director of the Task Force for Child Survival and Development.

Several participants suggested compiling an urban health index that would catalog improvements (and reversals) in the conditions that influence health. Establishing a baseline would enable researchers to track progress, show the positive impact of interventions, and build a case for investment in better population health. Others suggested that an urban health index might even prove to be a relaunching pad for the Healthy Cities movement. “We need a standard platform because we seem to be data-rich,” said Ariel Pablos-Mendez, associate professor of medicine and public health at Columbia

University who had recently joined the Rockefeller Foundation staff, but the data “are not coming together in a form to be shared with decision makers.”

When the data comes together, a likely finding will be that no region succeeds unless the income levels for all its less-well-off citizens rise. A continued press for economic growth, though insufficient by itself and not even likely without also improving health status, would be one of the key strategies, participants agreed—but only if the economic gains are spread throughout the population. “Urban risks go down as income goes up,” said Elliott Sclar, director of the Center for Sustainable Urban Development at Columbia University. “There’s a consistent correlation between rises in GDP and social indicators.”

Interventions do not have to be immediate or comprehensive successes to be significant. Even if successful health interventions are spotty, limited in scope, and not well-documented, participants agreed that potentially promising initiatives should be cross-fertilized. UN-HABITAT has undertaken an ongoing effort to catalog promising projects, although a scan of its list suggests most included are narrowly focused projects, not multi-sector, multilevel efforts. An exception: an initiative in Surat, said in 1995 to be one of India’s filthiest cities. Ravaged by epidemic disease in the wake of historic floods, the city was plagued by tons of debris, including the rotting carcasses of animals. A massive cleanup helped restore this coastal city, known for its textiles and as a major center for

cutting and polishing diamonds. By 1997 Surat could boast that it was India's second cleanest city. Strong public participation processes and early-warning public-health systems anchored the turnaround. When another flood came in 2006 Surat's officials and people drew on their experience and cleaned up from the storm before disease could take hold in the population.

In a Summit background paper, David Vlahov of the New York Academy of Medicine and his colleagues described the experience of the Tirol district in Belo-Horizonte, Brazil's third largest metropolitan area. In 2005 the city launched a program of family health centers. Tirol was able to secure services of a doctor, a physician's assistant, a nurse and three outreach workers from the community. The team was assigned to track the health needs of households in a population tract of some 4,000 people. Team members did not wait for people to call. They went to each house, collecting data on every factor, including daily nutrition, drug use, and infectious diseases. Although the initiative is too new to measure its effects, early results are encouraging.

In Calcutta, India, an organization known as Praysam enlisted children of the urban poor to help survey household conditions and promote changes that could improve community health. The initiative began in the mid-1990s in the city's Rishi Aurobindo Colony. The approach has been so powerful that the area is now considered a model slum. Its alleys are clean, and malaria and diarrhea, once dominant conditions, are now rare. The children say (translated from Bengali),

“We bathe daily and try to be neat, or else we will fall sick and our fun will be beat.” This health model, mobilizing for better health through neighborhood children, is now spreading to other urban areas of India. Praysam’s founder and philosopher-in-chief, Amian Ganguly, participated in the Summit.

Evidence that small-scale interventions can often help improve health conditions emerged from a discussion group led by University of Zimbabwe epidemiology professor Godfrey Woelke. Some of the examples were putting speed bumps on dangerous residential roads in Harare, Zimbabwe; introducing midday meals in a community in India; and making condoms mandatory for West Bengalis who work the sex trade. Small steps build a climate for collaboration while making community health a little better, the group said.

Smoking remains a major source of health problems in the Global South, especially Asia. In Thailand an aggressive push is under way to reduce tobacco use. Measures include big tax increases, bans on advertising, and prohibitions on smoking in public places. Funds for health promotion in Thailand have gone from \$1 million to \$44 million, reported Susan Mercado, with WHO in Kobe, Japan.

Another recent and potentially promising example comes from the sprawling slum of Kibera, in Nairobi, where volunteers now feed garbage into a giant concrete oven. The process not only removes the solid waste that is otherwise scattered, but it also provides a source of heat for bathing and cooking. Volunteers gather rubbish, even going door to door. If the experiment proves successful, the Christian Science Monitor reported

reduce
tobacco use

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in 2007, the initiative could be replicated with support from NGOs and the United Nations Environment Program, which provided initial capital.

Public health is also improving in Bogotá, Colombia, thanks to the efforts of recent mayors to promote respect for life and civility (fighting the city and country's notorious violence), tame traffic to create safer streets for the broad masses of the population, add new green spaces available to all citizens, start a model bus system on exclusive rights-of-way, and provide improved access to food and health care for poor residents.

safer streets

engaging the community: the crucial first step

Community participation, the panelists noted time and again, is the starting point for every successful initiative to improve the health of the urban poor. Genuine involvement of those most affected is essential to build legitimacy. Veterans of the process counsel that engaging residents requires patience; there are walls of suspicion to overcome and relationships of trust take time to build.

One discussion group reported how the University of São Paulo, in an effort to insulate itself from the violence of the surrounding community, started building walls around its facilities. Later, after direct engagement in the community, the university began employing community members. Over time, relationships developed. People in the community could see roles for themselves within the university and university staff had a fresh sense of the wider community assets.

The bottom line is that improved urban health must start with a heavy dose of inclusion: reaching out, listening, mobilizing the most vulnerable population groups. Where exclusion is evident—ignoring areas where poor people have concentrated, for example, or simply not listening to the voices of the poor when plans and decisions are made—reversing course is the best remedy. WHO's Mercado put it plainly: "Participation is the key element in making this more integrative approach work." The best-known large-scale example of taking engagement seriously is Shack/Slum Dwellers International (SDI). At its origin, community members themselves recognized the need to engage and mobilize the community. SDI has become an association of large national federations making common cause around the urban poor—sharing experiences of organizing and problem-solving.

implementation: getting more on board

Community engagement, while indispensable, is just half the battle. Once the community is mobilized and partnerships forged with local governments, it is important that public officials and other institutional authorities understand that urban health needs to be addressed as a multi-sector challenge. Often a catalyst is required, participants said, to persuade officialdom to cross the usual dividing turf lines. Sometimes an event provides the catalyst. Sometimes it is a persistent individual, a champion for the cause. Public officials, once they come together, find that there is much they can do collaboratively that none of them could manage alone. And they learn to see the community leaders

as partners. In the Miraflores area of Lima, Peru, for example, an active mayor linked professionals across multiple sectors to improve conditions for the elderly. The mayor believed this would raise the level of living for the whole city.

Another approach is active effort to engage the media to help address community health concerns. That strategy has been used to tackle reproductive-health issues in Indonesia, Bangladesh, and the Philippines. One measurable result: an increase in the use of contraceptive devices.

engage the
media

Forging regional networks of like-minded colleagues can also help advance urban health. A prime example is the Asian Infectious Disease Project, involving local officials in New Delhi, Hanoi, Jakarta, Singapore, Taipei, Tokyo, and Yangon.

Although many of the world's major challenges now exist in cities, national governments have much to say about whether there is any progress. In its State of the World Cities 2006 report, the United Nations highlighted Brazil, Egypt, Mexico, South Africa, Thailand, and Tunisia as having made significant progress in upgrading slums and improving services for the urban poor. Other countries, such as Burkina Faso and Tanzania, had demonstrated a strong political commitment—the necessary starting point.

State of the
World Cities

The U.N. report realistically acknowledges, however, that political commitments must be institutionalized beyond a single administration. The drive for improved health needs to be cemented as a long-term, strategic plank in not just a

city's but a country's design for a better future. What would it cost? The United Nations suggests about \$1,800 a person served. It also suggests that \$1,090 of that could be borne by government, the rest from donor and private capital.

Where national governments do not have a record of commitment to improving health of populations at the local level, financial flows of capital and aid should be specifically framed to ensure that funding reaches the communities where the poorest citizens live.

an agenda for action

At the end of a week of hard-hitting discussion and deliberations, the Summit health group reached a strong consensus from multiple discussion groups:

Move from a focus on vulnerabilities to an agenda of resilience. Much has already been learned about the determinants of health. While still measuring the vulnerable conditions of the poor, a next priority should be balancing that effort with at least equal emphasis on solutions and good demonstrations of progress, however small and localized.

Originate every effort within the affected communities. Failure to start with demand from the grassroots crippled the Healthy Cities movement in much of the developing world and limited its impact elsewhere. Authentic (and early) engagement of residents of targeted communities nearly always pays big dividends.

Develop partnerships across levels and sectors.

Often, there is great desire to move quickly to get projects under way. But lifting the health of whole communities requires a network of leadership and support that takes time to cultivate. And health departments may not end up leading the charge. Do not ask the WHO to be a community organizer; the agency will not be good at that, said USAID's Kolb. But groups such as the WHO can take a valuable role in setting standards. The aim is to build a culture where narrowly trained professionals can look past their dividing points and imagine and plan for outcomes only a collective force can produce.

Make maps to show the reality. Starting with the community and its residents, collect data, map it, graph it, make tables, and create the most compelling visual and verbal case possible. Make the case clearly for both political leaders and heads of donor organizations. Some cities, participants suggested, could be designated as health observatories, targeted for more systematic mapping, spatial analysis, and tracking of social determinants. Such a project could involve international, national, and local partners, advisory boards, business professionals, and academics to help translate the findings and channel the knowledge. Information gathering is valuable, but the process must emphasize action, added Waleska Caiaffa, associate professor at Brazil's Federal University of Minas Gerais.

Create an urban health index for the cities of the Global South. Rather than listing an index of ills, create a health index cataloging improvements in the conditions that influence health. Establishing a baseline would enable researchers to track progress, show the positive impact of interventions, and

build a case for investment in better public health. A widely implemented urban health index would lead to comparisons within cities and across cities. An index would also create a platform on which interventions could be tracked, evaluated, and compared, all vital steps toward replicating and scaling up what works best.

Resurrect, re-brand, and relaunch the Healthy Cities program. The idea behind Healthy Cities was sound; the fault was in its execution. “In too many places,” said Marilyn Rice, a regional adviser with the Pan American World Health Organization, “the Healthy Cities program was just a project.” It never changed the culture to a multi-sector health orientation. Still, as WHO’s Mercado told the group, there have been benefits from the Healthy Cities program, as cities have “learned from each other,” particularly from what did not work. Clearly, in too many cities, the silos of separatism survived every effort to create multi-sector partnerships. But, noted Rosenberg of the Task Force for Child Survival and Development, “the transport people are asking the same question as the health people. So maybe if we got these groups together, it’s possible we could find important areas of agreement.” Mercado cited several examples of progress traceable to Healthy Cities program work: the health plan created by citizens for themselves in Dar es Salaam, Tanzania; the breakthrough for citizens in Port Alegre, Brazil, to have a say in how public money is spent through the policy known now as “participatory budgeting”; the process that enabled an entire community to coalesce around spaces for walking and cycling in Victoria, Australia.

Design a system of health services that fits the highest priority needs of the urban poor. Improving actual

health and medical services is not simply a matter of transporting Western models or the best of the North to the growing cities of the South. Living conditions that facilitate healthier lives is primary. And, of course, what all people of the world share is the desire to have decent access to medical services. We are learning, said Frenk, how easily this becomes segregated. “Unfortunately one of the big distortions for primary health care was to think that it was health care for the poor. It really became not primary health care but primitive health care, and we know very well that services for the poor end up being poor services,” he told the Summit assembly.

In sum, health panel participants urged that policy makers and donor organizations recognize the central and catalytic role that health improvement plays in the struggle to assist the urban poor. Better health starts with better living conditions and is a precondition for any financial betterment.

The panel, while respecting the expert knowledge that health professionals and consultants bring, was clear about transforming the typical top-down, donor-driven, bureaucratically organized, standard-delivered, large-scale health system to one that originates with bottom-up, community-driven organizing and priority setting. Experience in the field shows that when local communities get organized, they set priorities that reflect their needs. The result is programs that reflect a variety of approaches, not one standard solution.

To persuade the world to care and invest in strangers who live in places most people have never been to will require a real leap forward in communication, participants agreed.

“We need more stories, not just studies,” said Brenda Wilson, National Public Radio foreign correspondent, expressing the hope that people will support a health agenda for the urban poor. To do this it is essential to “talk straight,” avoiding the usual language of studies and academic conferences.

As to the health professionals, the message is to escape those silos, look at the problem broadly, and cultivate partners in community organizations and NGOs. The Center for Sustainable Urban Development’s Sclar found the right tone for a conclusion as he simultaneously set the stage for the Summit’s following week: “We need planners and lawyers and public health people, but now we really need people who understand this broader agenda,” he said. “We need a new class of urban professionals who know how to move across lines.”