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),
Dr Thor Heyerdahl (Laigueglia, Italy),
Prof. Mohamed Kassas (Cairo, Egypt),
Prof. Victor A. Kovda (Moscow, USSR),
Dr Walter J. Lusigi (Nairobi, Kenya),
Prof. Shijun Ma (Beijing, China),
Dr Shirley McGreal (Summerville, South Carolina, USA),
Prof. Norman Myers (Oxford, England, UK),
Prof. Makoto Numata (Tokyo, Japan),
Prof. Nicholas Polunin (Geneva, Switzerland),
Dr (Smt.) Mrunalinidevi A. Puar (Baroda, India),
Dr S. Dillon Ripley (Washington, DC, USA),
Prof. Richard E. Schultes (Cambridge, Massachusetts, USA),
Dr Maurice F. Strong (Ottawa, Ontario, Canada),
Dr Monkombu S. Swaminathan (New Delhi & Madras, India),
Dr John R. Vallentyne (Burlington, Ontario, Canada), and
Dr Arthur H. Westing (Oslo, Norway).

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