**Sub-Themes:**   **Factors affecting access to healthcare and efforts/challenges in securing PHC**

Title of paper: **It’s not enough to tweak old models: Urban PHC calls for new paradigms and approaches**

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By 2050, urban populations will increase to 62% in Africa, a growth that UN organisations note to be one of the most important global health issues of the 21st century. In 2016-8, we gathered and analysed diverse forms of evidence and experience on inequalities in urban health, its determinants and responses to it within east and southern African (ESA) countries. This included literature review, analysis of quantitative indicators, content analysis of evidence on practices and participatory review by youth in Lusaka and Harare. The literature on urban health in ESA countries appears to lag behind the rapid, multifactorial changes taking place in urban areas, focusing on negative health outcomes rather than the assets for health, pointing to weak links between primary care services and urban public health and limited collaborative interaction across sectors. Participatory review with urban youth in two cities suggested that ‘health’ has become narrowly and medically defined in their experience and experience, poorly reflecting the psycho-social, economic and environmental determinants they see as associated with improvements in their health. In other regions globally, the concept of ‘wellbeing’ better captures this broader lens, and is being accompanied by measurement of its various dimensions as indicators of national progress. Our analysis of the cross country health data collected in the 16 ESA countries found more limited assessment of such measures, with a focus on negative health outcomes, ignoring the many socially-defined dimensions of vulnerability, variations in risk environments and assets that are important for urban health. These findings suggest that meeting the growing challenges in urban health for our region demands new paradigms, new approaches to urban PHC and new indicators to inform analysis and planning. It implies framing urban PHC within a more holistic ‘wellbeing’ paradigm, encompassing physical, material, psycho-social and ecological dimensions, with space for diverse forms of local knowledge and public voice; away from an urban PHC that is singularly preoccupied with managing negative outcomes and that sees people as health ‘problems’, to greater use of asset based approaches. This implies a more organised, continuous relationship between our urban primary care services and their populations than the currently ad hoc one of people presenting to facilities with problems, with proactive measures for family and population health, reaching into community settings, working with and as an entry point for other services that support health and a contributor to processes for meaningful resident participation in urban planning.