

Urban Health Literature Review

July 2004

Topic A. Urban living and burden of disease

Topic B. Perspectives on urban population health

Topic A. Urban living and burden of disease

Source: Am J Public Health. 2003 Sep;93(9):1420-30.

Title: **Health, morality, and housing: the "tenement problem" in Chicago.**

Author: Garb M

Affiliation: Department of History, Campus Box 1062, University of Washington, 1 Brookings Drive, St. Louis, MO

Abstract: In this article, I trace the history of Chicago's Health Department, exploring when and how housing conditions came to be considered a serious social problem requiring municipal regulation. Although journalists and labor leaders were among the first Chicagoans to link tenement housing to the spread of contagious disease, Health Department officials quickly began regulating the city's housing stock under their own authority. I argue that in attempting to eliminate the dangers of contagious disease, a long-standing public health threat, health officials drew new attention to the dangers of multifamily dwellings and set a precedent for government regulation of living conditions in tenement dwellings.

Source: Ann Behav Med. 2003 Spring;25(2):80-91

Title: **Environmental correlates of walking and cycling: findings from the transportation, urban design, and planning literatures.**

Author: Saelens BE, Sallis JF, Frank LD

Affiliation: University of Cincinnati College of Medicine and Cincinnati Children's Hospital Medical Center, Cincinnati

Abstract: Research in transportation, urban design, and planning has examined associations between physical environment variables and individuals' walking and cycling for transport. Constructs, methods, and findings from these fields can be applied by physical activity and health researchers to improve understanding of environmental influences on physical activity. In this review, neighborhood environment characteristics proposed to be relevant to walking/cycling for transport are defined, including population density, connectivity, and land use mix. Neighborhood comparison and correlational studies with nonmotorized transport outcomes are considered, with evidence suggesting that residents from communities with higher density, greater connectivity, and more land use mix report higher rates of walking/cycling for utilitarian purposes than low-density, poorly connected, and single land use neighborhoods. Environmental variables appear to add to variance accounted for beyond sociodemographic predictors of walking/cycling for transport. Implications of the transportation literature for physical activity and related research are outlined. Future research directions are detailed for physical activity research to further examine the impact of neighborhood and other physical environment factors on physical activity and the potential interactive effects of psychosocial and environmental variables. The transportation, urban design, and planning literatures provide a valuable starting point for multidisciplinary research on environmental contributions to physical activity levels in the population.

Source: J Community Health 1995 October: 20(5):423-31

Title: **A comparison of health status between rural and urban adults**

Author: Mainous AG 3rd, Kohrs FP

Affiliation: Department of Family Practice, University of Kentucky College of Medicine, Lexington

Abstract: The objective of the study was to examine and compare health status between rural and urban adults. The data are from a 1993 statewide probability-based telephone survey of adult Kentuckians (n = 662). Metropolitan Statistical Area (MSA) residents (n = 264) and nonMSA residents (n = 398) were compared using the Medical Outcomes Study, Short Form Health Survey (SF-20). Self-perceived urban (n = 406) and rural (n = 256) residents were also compared. Additional analyses were stratified by the age categories of 18-44, 45-64, and > or = 65 years of age. Few differences in health status existed between rural and urban adults. However, rural elders (> or = 65 years) had significantly poorer health status than urban elders. After controlling for demographic variables in multiple regressions, rural elders had significantly poorer functioning (all p < .05) than urban elders as measured by the SF-20 subscales of a) physical functioning, b) role functioning, c) social functioning, d) general mental health, and e) general health perceptions. No differences between rural and urban residents were noted for the pain subscale. Although the health status of rural and urban adults is generally similar, the rural elderly have significantly worse health status than their urban counterparts.

Source: J Health Soc Behav. 2002 Dec;43(4):383-99.

Title: Neighborhood structural disadvantage, collective efficacy, and self-rated physical health in an urban setting.

Author: Browning CR, Cagney KA.

Affiliation: Department of Sociology, Ohio State University, Columbus, OH

Abstract: Our analyses examine the role neighborhood structural characteristics--including concentrated disadvantage, residential instability, and immigrant concentration--as well as collective efficacy in promoting physical health among neighborhood residents. Using data from the 1990 census, the 1994 Project on Human Development in Chicago Neighborhoods Community Survey, and the 1991-2000 Metropolitan Chicago Information Center-Metro Survey, we model the effects of individual and neighborhood level factors on self-rated physical health employing hierarchical ordered logit models. First, we find that neighborhood socioeconomic disadvantage is not significantly related to self-rated physical health when individual level demographic and health background are controlled. Second, individuals residing in neighborhoods with higher levels of collective efficacy report better overall health. Finally, socioeconomic disadvantage and collective efficacy condition the positive effects of individual level education on physical health.

Source: J Epidemiol Community Health. 1999 June; 53(6): 325-34

Title: Poverty, time and place: variation in excess mortality across selected US populations, 1980-1990.

Author: Geronimus AT, Bound J, Walmann TA

Affiliation: Department of Health Behavior and Health education, University of Michigan School of Public Health, USA

Abstract: **STUDY OBJECTIVE:** To describe variation in levels and causes of excess mortality and temporal mortality change among young and middle aged adults in a regionally diverse set of poor local populations in the USA. **DESIGN:** Using standard demographic techniques, death certificate and census data were analysed to make sex specific population level estimates of 1980 and 1990 death rates for residents of selected areas of concentrated poverty. For comparison, data for whites and blacks nationwide were analysed. **SETTING:** African American communities in Harlem, Central City Detroit, Chicago's south side, the Louisiana Delta, the Black Belt region of Alabama, and Eastern North Carolina. Non-Hispanic white communities in

Cleveland, Detroit, Appalachian Kentucky, South Central Louisiana, Northeastern Alabama, and Western North Carolina. PARTICIPANTS: All black residents or all white residents of each specific community and in the nation, 1979-1981 and 1989-1991. MAIN RESULTS: Substantial variability exists in levels, trends, and causes of excess mortality in poor populations across localities. African American residents of urban/northern communities suffer extremely high and growing rates of excess mortality. Rural residents exhibit an important mortality advantage that widens over the decade. Homicide deaths contribute little to the rise in excess mortality, nor do AIDS deaths contribute outside of specific localities. Deaths attributable to circulatory disease are the leading cause of excess mortality in most locations. CONCLUSIONS: Important differences exist among persistently impoverished populations in the degree to which their poverty translates into excess mortality. Social epidemiological inquiry and health promotion initiatives should be attentive to local conditions. The severely disadvantageous mortality profiles experienced by urban African Americans relative to the rural poor and to national averages call for understanding.

Source: Soc Sci Med. 2000 Oct;51(8):1143-61.

Title: **Residential segregation and the epidemiology of infectious diseases.**

Author: Acevedo-Garcia D.

Affiliation: Department of Health and Social Behavior, Harvard School of Public Health, Boston, MA

Abstract: Several empirical studies have documented the effects of residential segregation on health inequalities between the US African-American and white populations. However, the majority of such studies have not explained the pathways that link residential segregation and specific health outcomes. This paper presents a conceptual framework of the role that residential segregation may play in the epidemiology of tuberculosis (TB) and other infectious diseases. This is an important issue given the concentration of TB cases among US racial/ethnic minorities and the increasing gap in the incidence of infectious diseases between minorities and the white majority. Segregation may have an indirect effect on the transmission of TB because of its negative impact on the quality of neighborhood environment in segregated communities. Segregation concentrates poverty, overcrowded and dilapidated housing and social disintegration in minority areas, and results in limited access to health care. Furthermore, two dimensions of residential segregation (isolation and concentration) may have direct effects on TB transmission. The isolation of minorities confines TB to segregated areas and prevents transmission to the rest of the population. High-density levels in minority areas increase the probability of transmission within the segregated group. In order to operationalize the above pathways, health researchers may rely on the segregation literature, which has conceptualized various dimensions of residential segregation and proposed ways to measure them. The indirect pathways that link segregation and TB can be captured through exposure indices, which quantify the concentration of risk factors for TB for various racial and ethnic groups. The direct pathways can be captured through the isolation index (which is a proxy for the degree of interaction between the segregated group and the rest of the population) and two proposed measures of density (which are proxies for the likelihood of transmission within the segregated group and from the segregated group to the rest of the population).

Source: Am J Prev Med. 2001 Oct;21(3):182-8.

Title: **Are rural residents less likely to obtain recommended preventive healthcare services?**

Author: Casey MM, Thiede Call K, Klingner JM

Affiliations: Rural Health Research Center, University of Minnesota, Minneapolis, Minnesota

Abstract: BACKGROUND: This study examined rural-urban differences in utilization of preventive healthcare services and assessed the impact of rural residence, demographic factors, health

insurance status, and health system characteristics on the likelihood of obtaining each service. METHODS: National data from the 1997 Behavioral Risk Factor Surveillance System (BRFSS) and the 1999 Area Resource File were used to evaluate the adequacy of preventive services obtained by rural and urban women and men, using three sets of nationally accepted preventive services guidelines from the American Cancer Society, U.S. Preventive Services Task Force, and Healthy People 2010. Logistic regression models were developed to control for the effect of demographic factors, health insurance status, and health system characteristics. RESULTS: Rural residents are less likely than urban residents to obtain certain preventive health services and are further behind urban residents in meeting Healthy People 2010 objectives. CONCLUSIONS: Efforts to increase rural preventive services utilization need to build on federal, state, and community-based initiatives and to recognize the special challenges that rural areas present.

Source: Am J Public Health. 2000 Feb;90(2):230-6.

Title: **"Broken windows" and the risk of gonorrhea.**

Author: Cohen D, Spear S, Scribner R, Kissinger P, Mason K, Wildgen J.

Affiliation: Louisiana State University Medical Center, New Orleans

Abstracts: OBJECTIVES: We examined the relationships between neighborhood conditions and gonorrhea. METHODS: We assessed 55 block groups by rating housing and street conditions. We mapped all cases of gonorrhea between 1994 and 1996 and calculated aggregated case rates by block group. We obtained public school inspection reports and assigned findings to the block groups served by the neighborhood schools. A "broken windows" index measured housing quality, abandoned cars, graffiti, trash, and public school deterioration. Using data from the 1990 census and 1995 updates, we determined the association between "broken windows," demographic characteristics, and gonorrhea rates. RESULTS: The broken windows index explained more of the variance in gonorrhea rates than did a poverty index measuring income, unemployment, and low education. In high-poverty neighborhoods, block groups with high broken windows scores had significantly higher gonorrhea rates than block groups with low broken windows scores (46.6 per 1000 vs 25.8 per 1000; $P < .001$). CONCLUSIONS: The robust association of deteriorated physical conditions of local neighborhoods with gonorrhea rates, independent of poverty, merits an intervention trial to test whether the environment has a causal role in influencing high-risk sexual behaviors.

Source: Sex Transm Dis. 2004 Feb;31(2):117-22.

Title: **Perceived social cohesion and prevalence of sexually transmitted diseases.**

Author: Ellen JM, Jennings JM, Meyers T, Chung SE, Taylor R.

Abstract: Division of General Pediatrics and Adolescent Medicine, Department of Pediatrics, School of Medicine, Johns Hopkins University, Baltimore, Maryland

Abstract: BACKGROUND: Although physical attributes have been shown to be associated with sexually transmitted disease (STD) rates, there is little information about the association between social attributes and STD rates. GOAL: The objective of this study was to determine the association between gonorrhea prevalence and perceptions of social cohesion in impoverished, urban neighborhoods. STUDY DESIGN: We conducted a street-based survey of 18- to 24-year-olds residing in selected census block groups in Baltimore City, Maryland. Census block groups eligible for selection were defined as impoverished (greater than 20% in poverty) and unstable (lowest 25th percentile for stability). From the eligible census block groups, 5 from high gonorrhea rate (greater than the 75th percentile) census block groups and 5 from the lower gonorrhea rate (lowest 25th percentile to equal or greater than the 75th percentile) census block groups were randomly selected. Participants within the 10 selected census block groups were recruited using a street-intercept method. Participants were asked about perceived social cohesion and control.

RESULTS: Results showed that for young adults 18 to 24 years of age residing in high gonorrhea census block groups, the mean social cohesion index scores were 1.7 points lower than mean social cohesion index scores of the participants residing in the low gonorrhea census block groups ($P < 0.01$). CONCLUSION: Future research needs to be conducted to determine the temporal association between gonorrhea prevalence and local social cohesion dynamics.

Source: Am J Public Health. 2003 Sep;93(9):1439-41.

Title: **The intersection of urban planning, art, and public health: the Sunnyside Piazza.**

Author: Semenza JC.

Affiliation: School of Community Health, Portland State University, Portland, OR

Abstract: Deteriorating physical features of urban environments can negatively influence public health. Dilapidated environments and urban blight tend to promote alienation and can be associated with social disorder, vandalism, crime, drug abuse, traffic violations, and littering, which in turn affects health and well-being. In the late 1990s, the Sunnyside neighborhood in Portland, Ore, was plagued by many of these problems. In an attempt to invigorate neighborhood stewardship, the community organized and created a public gathering place; together, they painted a gigantic sunflower in the middle of an intersection and installed several interactive art features. As a result of these collective actions of "place-making," social capital has increased, thus revitalizing the community, and expanded social networks among residents have stimulated a sense of well-being.

Source: Soc Sci Med. 2004 Mar;58(6):1137-46.

Title: **Effects of urbanization, economic development, and migration of workers on suicide mortality in Japan.**

Author: Otsu A, Araki S, Sakai R, Yokoyama K, Scott Voorhees A.

Affiliation: Department of Public Health and Occupational Medicine, Graduate School of Medicine and School of Medicine, The University of Tokyo, Bunkyo-ku, Tokyo, Japan.

Abstract: The relationships between male or female age-adjusted suicide mortality and social life factors for all 47 Japanese prefectures in 1980, 1985 and 1990 were investigated by stepwise multiple regression analysis after classification of 20 social life indicators by factor analysis. During this period, Japan experienced the second economic crisis (the so-called secondary oil crisis) in 1980-1983 and economic prosperity (bubble economy) in 1986-1990. In all the three years, male suicide mortality was significantly related inversely to the urbanization and economic development factor, the result of which was consistent with the data in our previous study for the years 1970 and 1975. Similarly, the male mortality was positively related to the factor of migration of workers in the three years. No factor significantly related to female mortality for all the three years was found. It is suggested that (1) urbanization was a major determinant which prevented male suicide mortality during the past 20 years (1970-1990) in Japan; (2) migration of workers became an important factor for male suicide mortality during these 10 years; and (3) female suicide mortality was less vulnerable to social life factors for these 20 years than the male mortality.

Source: The Lancet, Vol. 363 June 19, 2004 pg 2012-2013

Title: **Is urbanicity an environmental risk-factor for psychiatric disorders?**

Authors: Peen J, Dekker J

Affiliations: Research department, mentrum mental health organization Amsterdam, and Department of Clinical Psychology, Vrije Universiteit, 1070 AV Amsterdam, Netherlands

Abstract: The link between urbanicity and the development of psychiatric disorders is well established. Recently, Kristina Sundquist and colleagues showed once again, with a strong study design, that there is a link between degree of urbanization and first admission for psychosis. For men, the risk of first admission for psychosis was 68% higher in the most densely populated areas of Sweden than in the least densely populated areas (on a scale with five categories of urbanization). For women, the risk was 77% higher. These results were all independent of age, marital status, education, and immigrant status. The results for psychosis contrast with the weak correlations found for depression (12% higher for men and 20% higher for women). Possible explanations given by the investigators for the increased risk in cities compared with rural areas are differences in social support, stressful life events, and familial liability.

Source: Br J Psychiatry. 2004 Apr;184:293-8.

Title: Urbanization and incidence of psychosis and depression: follow-up study of 4.4 million women and men in Sweden.

Author: Sundquist K, Frank G, Sundquist J

Affiliation: Family Medicine, Karolinska Institutet, Stockholm, Sweden.

Abstract: BACKGROUND: Previous studies of differences in mental health between urban and rural populations are inconsistent. AIMS: To examine whether a high level of urbanization is associated with increased incidence rates of psychosis and depression, after adjustment for age, marital status, education and immigrant status. METHOD: Follow-up study of the total Swedish population aged 25-64 years with respect to first hospital admission for psychosis or depression. Level of urbanization was defined by population density and divided into quintiles. RESULTS: With increasing levels of urbanization the incidence rates of psychosis and depression rose. In the full models, those living in the most densely populated areas (quintile 5) had 68-77% more risk of developing psychosis and 12-20% more risk of developing depression than the reference group (quintile 1). CONCLUSIONS: A high level of urbanization is associated with increased risk of psychosis and depression for both women and men.

Source: J Environ Psych. 2003;23, 109-123

Title: Tracking restoration in natural and urban field settings.

Author: Hartig T, Evans GW, Jamner LD, Davis DS, and Gärling T.

Affiliation: Institute for Housing and Urban Research, Uppsala University, Sweden

Abstract: We compared psychophysiological stress recovery and directed attention restoration in natural and urban field settings using repeated measures of ambulatory blood pressure, emotion, and attention collected from 112 randomly assigned young adults. To vary restoration needs, we had half of the subjects begin the environmental treatment directly after driving to the field site. The other half completed attentionally demanding tasks just before the treatment. After the drive or the tasks, sitting in a room with tree views promoted more rapid decline in diastolic blood pressure than sitting in a viewless room. Subsequently walking in a nature reserve initially fostered blood pressure change that indicated greater stress reduction than afforded by walking in the urban surroundings. Performance on an attentional test improved slightly from the pretest to the midpoint of the walk in the nature reserve, while it declined in the urban setting. This opened a performance gap that persisted after the walk. Positive affect increased and anger decreased in the nature reserve by the end of the walk; the opposite pattern emerged in the urban environment. The task manipulation affected emotional self-reports. We discuss implications of the results for theories about restorative environments and environmental health promotion measures.

Source: Schizophr Bull. 1990;16(4):591-604.

Title: **Geographical distribution of insanity in America: evidence for an urban factor.**

Author: Torrey EF, Bowler A.

Affiliation: Twin Study Unit, NIMH Neurosciences Center, St. Elizabeths Hospital, Washington, DC.

Abstract: The geographic distribution of insanity and schizophrenia in the United States is examined for 9 separate years between 1880 and 1963. A concentration of these conditions in Northeastern and Pacific Coast States was remarkably consistent over the 83 years. States with a high prevalence rate had approximately three times more insanity and schizophrenia than those with a low prevalence rate. There is a direct regional correlation of insanity/schizophrenia with urbanization, which is consistent with previous studies. There is also a direct regional correlation of schizophrenia with socioeconomic status, which contradicts previous studies carried out in large cities in which the schizophrenic rates were inversely correlated with socioeconomic status. The apparent discrepancy can be explained by postulating that the direct regional correlations are due to correlations of urbanization and socioeconomic status (cities have higher mean incomes than rural areas) whereas, within a particular city, schizophrenia is more prevalent among lower socioeconomic groups because of drift and other factors. Social, stress and crowding, genetic, and biological factors are discussed as possible explanations for the urban factor associated with insanity/schizophrenia

Source: N Engl J Med. 1993 Dec 9;329(24):1753-9.

Title: **An association between air pollution and mortality in six U.S. cities.**

Author: Dockery DW, Pope CA 3rd, Xu X, Spengler JD, Ware JH, Fay ME, Ferris BG Jr, Speizer FE.

Affiliation: Environmental Epidemiology Program, Harvard School of Public Health, Boston, MA

Abstract: BACKGROUND. Recent studies have reported associations between particulate air pollution and daily mortality rates. Population-based, cross-sectional studies of metropolitan areas in the United States have also found associations between particulate air pollution and annual mortality rates, but these studies have been criticized, in part because they did not directly control for cigarette smoking and other health risks. METHODS. In this prospective cohort study, we estimated the effects of air pollution on mortality, while controlling for individual risk factors. Survival analysis, including Cox proportional-hazards regression modeling, was conducted with data from a 14-to-16-year mortality follow-up of 8111 adults in six U.S. cities. RESULTS. Mortality rates were most strongly associated with cigarette smoking. After adjusting for smoking and other risk factors, we observed statistically significant and robust associations between air pollution and mortality. The adjusted mortality-rate ratio for the most polluted of the cities as compared with the least polluted was 1.26 (95 percent confidence interval, 1.08 to 1.47). Air pollution was positively associated with death from lung cancer and cardiopulmonary disease but not with death from other causes considered together. Mortality was most strongly associated with air pollution with fine particulates, including sulfates. CONCLUSIONS. Although the effects of other, unmeasured risk factors cannot be excluded with certainty, these results suggest that fine-particulate air pollution, or a more complex pollution mixture associated with fine particulate matter, contributes to excess mortality in certain U.S. cities.

Report

Source: http://www.cmf.org/programs/newyork/karpati_disparities.pdf

Title: **Health Disparities in New York City**

Author: New York City Department of Health and Mental Hygiene

Abstract: Although there have been great advances in the health of New Yorkers and the U.S. population over the past century, not all groups have benefitted equally. Differences in people's health may be caused by many factors, but when differences reflect social inequalities, they are referred to as health disparities and are of particular concern to the public health community and society as a whole.

Topic B. Perspectives on urban population health

Source: Am J Public Health. 2003 Sep;93(9):1451-6.

Title: **Healthy places: exploring the evidence.**

Author: Frumkin H

Affiliation: Department of Environmental and Occupational Health, Rollins School of Public Health, Emory University, Atlanta, GA

Abstract: "Sense of place" is a widely discussed concept in fields as diverse as geography, environmental psychology, and art, but it has little traction in the field of public health. The health impact of place includes physical, psychological, social, spiritual, and aesthetic outcomes. In this article, the author introduces sense of place as a public health construct. While many recommendations for "good places" are available, few are based on empirical evidence, and thus they are incompatible with current public health practice. Evidence-based recommendations for healthy place making could have important public health implications. Four aspects of the built environment, at different spatial scales-nature contact, buildings, public spaces, and urban form-are identified as offering promising opportunities for public health research, and potential research agendas for each are discussed.

Source: Am J Prev Med. 2002 Aug;23(2 Suppl):64-73.

Title: **How the built environment affects physical activity: views from urban planning.**

Author: Handy SL, Boarnet MG, Ewing R, Killingsworth RE.

Affiliation: School of Architecture, University of Texas at Austin

Abstract: The link between the built environment and human behavior has long been of interest to the field of urban planning, but direct assessments of the links between the built environment and physical activity as it influences personal health are still rare in the field. Yet the concepts, theories, and methods used by urban planners provide a foundation for an emerging body of research on the relationship between the built environment and physical activity. Recent research efforts in urban planning have focused on the idea that land use and design policies can be used to increase transit use as well as walking and bicycling. The development of appropriate measures for the built environment and for travel behavior is an essential element of this research. The link between the built environment and travel behavior is then made using theoretical frameworks borrowed from economics, and in particular, the concept of travel as a derived demand. The available evidence lends itself to the argument that a combination of urban design, land use patterns, and transportation systems that promotes walking and bicycling will help create active, healthier, and more livable communities. To provide more conclusive evidence, however, researchers must address the following issues: An alternative to the derived-demand framework must be developed for walking, measures of the built environment must be refined, and more-complete data on walking must be developed. In addition, detailed data on the built environment must be spatially matched to detailed data on travel behavior.

Source: AAOHN J. 2004 Jun;52(6):242-6.

Title: **Urban sprawl and you: how sprawl adversely affects worker health.**

Author: Pohanka M, Fitzgerald S.

Affiliation: U.S. Navy Nurse Corps, National Naval Medical Center, Bethesda, MD

Abstract: Urban sprawl, once thought of as just an environmental issue, is currently gaining momentum as an emerging public health issue worthy of research and political attention. Characteristics seen in sprawling communities include increasing traffic volumes; inadequate public transportation; pedestrian unfriendly streets; and the division of businesses, shops, and homes. These characteristics can affect health in many ways. Greater air pollution contributes to higher asthma and other lung disorder rates. An increased dependence on the automobile encourages a more sedentary lifestyle and can potentially contribute to obesity. The increased danger and stress of long commutes can lead to more accidents, anxiety, and social isolation. Occupational health nurses can become involved by promoting physical activity in the workplace, creating programs for injury prevention and stress management, becoming involved in political smart growth measures, and educating and encouraging colleagues to become active in addressing this issue.

Source: Health Promot Int. 2001 Jun;16(2):111-25.

Title: **Healthy city projects in developing countries: the first evaluation.**

Author: Harpham T, Burton S, Blue I.

Affiliation: Faculty of Built Environment, South Bank University, London, UK.

Abstract: The 'healthy city' concept has only recently been adopted in developing countries. From 1995 to 1999, the World Health Organization (WHO), Geneva, supported healthy city projects (HCPs) in Cox's Bazar (Bangladesh), Dar es Salaam (Tanzania), Fayoum (Egypt), Managua (Nicaragua) and Quetta (Pakistan). The authors evaluated four of these projects, representing the first major evaluation of HCPs in developing countries. Methods used were stakeholder analysis, workshops, document analysis and interviews with 102 managers/implementers and 103 intended beneficiaries. Municipal health plan development (one of the main components of the healthy city strategy) in these cities was limited, which is a similar finding to evaluations of HCPs in Europe. The main activities selected by the projects were awareness raising and environmental improvements, particularly solid waste disposal. Two of the cities effectively used the 'settings' approach of the healthy city concept, whereby places such as markets and schools are targeted. The evaluation found that stakeholder involvement varied in relation to: (i) the level of knowledge of the project; (ii) the project office location; (iii) the project management structure; and (iv) type of activities (ranging from low stakeholder involvement in capital-intensive infrastructure projects, to high in some settings-type activities). There was evidence to suggest that understanding of environment-health links was increased across stakeholders. There was limited political commitment to the healthy city projects, perhaps due to the fact that most of the municipalities had not requested the projects. Consequently, the projects had little influence on written/expressed municipal policies. Some of the projects mobilized considerable resources, and most projects achieved effective intersectoral collaboration. WHO support enabled the project coordinators to network at national and international levels, and the capacity of these individuals (although not necessarily their institutions) was increased by the project. The average annual running cost of the projects was approximately 132,000 US dollars per city, which is close to the costs of the only other HCP for which a cost analysis has been undertaken, Bangkok (115,000 US dollars per year) Recommendations for these and other HCPs are provided.

Source: Scand J Public Health. 2002;Suppl 59:34-40.

Title: **Inequalities in urban areas: innovative approaches to complex issues.**

Author: Lawrence RJ.

Affiliations: Centre for Human Ecology and Environmental Sciences, University of Geneva, Switzerland.

Abstract: Urbanization, a characteristic of the twentieth century, is a profound transformation of human settlement processes and their outcomes, which has not been well understood in terms of both positive and negative impacts. This paper argues that the interrelations between urban planning, health, social, and environmental policies have been poorly articulated until now. Although sectoral approaches have often applied remedial and corrective measures to overcome unsatisfactory conditions in urban areas, today we know that infectious diseases stemming from insanitary conditions are not the leading cause of morbidity and mortality in Europe. Nonetheless diverse forms of ill health remain associated with place of work and residence. Therefore, in order to deal with the complexity and diversity of urban areas there is an urgent need to move from conventional, sectoral approaches based on biomedical models of health to coordinated action stemming from an ecological interpretation of health including its social determinants. This kind of approach is presented in order to promote health and social development at the local level.

Source: Environ Urban. 1993 Oct;5(2):87-111.

Title: **The impact on health of urban environments.**

Author: Satterthwaite D.

Abstract: PIP: In developing countries, environmental hazards in urban areas mainly affect low-income people--especially women, children, and migrants--the people who are least able to avoid the hazards and/or least able to deal with the illness or injury they cause. Poor people are priced out of safe, well-located, well-serviced housing and land sites. Hazards include biological pathogens; chemical pollutants; scarce, over-priced, or poor quality natural resources; physical hazards; natural resource degradation; and national/global environmental degradation. These preventable health burdens cause disease, accidents, and premature death. Biological pathogens have the most serious impact on human health. Crowded conditions, poor sanitation, inadequate water supplies, poor facilities for preparing and storing food, and inadequate hygiene contribute to biological pathogen-induced ill health. Common chemical pollutants in urban areas are lead, indoor air pollutants from fuel combustion, toxic/hazardous wastes, and ambient air pollution. A shortage of fresh water is often why some urban households do not have a safe and adequate water supply. Limited land in cities prevents the urban poor from growing their own crops or maintaining livestock. Common physical hazards in cities are traffic accidents; burns, scalds, and accidental fires and poisonings; falls; and floods. Overcrowding, poor building material, and settlements on dangerous sites (e.g., flood plains, steep hillsides, and dumps) are example of physical hazards. Noise, overcrowding, inappropriate design, and stresses contribute to the growing psychosocial health problems of many urban dwellers in developing countries, especially of adolescents and young adults. Poorer urban residents who begin or are included in initiatives to improve their neighborhoods are more likely to develop integrated responses to nonenvironmental and environmental problems and to make sure that environmental action programs meet local needs and realities.

Source: Environment & Behavior , Vol 36(1), Jan 2004. pp. 41-69.

Title: **Neighborhood Evaluation Within a Multiplace Perspective on Urban Activities.**

Author: Bonaiuto, Marino , U Rome La Sapienza, Italy Affiliation: Bonnes, Mirilia , U Rome La Sapienza, Italy

Abstract: Within place theory, the research investigated relationships between activities carried out in a place and evaluative aspects of the same place. In the study, 152 inhabitants, ages 18 to 55, all living in the same neighborhood of Rome (Italy) were sampled by sex. An individual questionnaire included three scales to measure frequency of activities (23 items for neighborhood, 32 items for city center, and 11 items for suburbs) and a 47-item scale to measure degree of satisfaction/dissatisfaction toward various aspects of neighborhood. Multivariate data analyses

identified four groups of inhabitants (neighborhood confined, marginal escape users, multiplace hyperactive, and quality users), each characterized by a specific pattern of multiplace urban activity. Each group was characterized by sociodemographic and/or residential variables. Finally, each group was also characterized by a specific pattern of neighborhood evaluations, with respect to three main aspects (building/population density and uninhabitability, social-spatial insecurity, and functional inadequacy/unavailability).

Source: Chest. 2004 May;125(5):1719-25.

Title: **Obstructive lung disease among the urban homeless.**

Author: Snyder LD, Eisner MD.

Affiliation: Department of Medicine, University of California, San Francisco

Abstract: STUDY OBJECTIVES: Homelessness is a growing problem in the United States that may significantly impair physical health. The homeless have a high prevalence of cigarette smoking, poor nutrition, and adverse environmental exposures, which could contribute to obstructive lung disease (OLD). Despite this risk, the prevalence of OLD among the homeless remains unknown. We aimed to systematically assess the prevalence of OLD among the urban homeless. DESIGN, SETTING, AND PARTICIPANTS: We conducted a cross-sectional study of the prevalence of OLD among homeless individuals in San Francisco. By random sampling, we recruited 68 adults living in one homeless shelter to participate in a structured interview survey and spirometry assessment. We used a multifaceted approach to assess OLD, including respiratory symptoms, self-reported physician diagnosis of asthma, chronic bronchitis, emphysema, or COPD, and spirometry (defined as FEV1 < 80% predicted and FEV1/FVC ratio < 0.70). RESULTS: Sixty-eight adults completed the survey, and 67 adults completed the spirometry. Homeless adults were likely to be homeless < 1 year and homeless for the first time. There was a high prevalence of cigarette smoking (75% ever smokers, 68% current smokers). The prevalence of symptoms suggestive of OLD was high, including cough (29%), wheezing (40%), chronic bronchitis symptoms (21%), and dyspnea on exertion (29%). A substantial proportion of homeless subjects indicated a prior diagnosis of asthma (24%), chronic bronchitis (19%), and COPD (4%). Based on spirometry, the prevalence of OLD was 15% (95% confidence interval, 8 to 26%), which was more than double the expected prevalence in the general US population. CONCLUSIONS: As OLD is a leading cause of death in the United States, it is important to identify it early for treatment. Homeless individuals have a higher-than-expected prevalence of OLD. Public health interventions should target the homeless population for prevention and treatment of OLD.