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HEALTH PROMOTION IN THE CITY: A Review of Current Practice and Future Prospects in the United States

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■ **Abstract** To achieve its health goals, the United States must reduce the disproportionate burden of illness and poor health borne by urban populations. In the 20th century, patterns of immigration and migration, changes in the global economy, increases in income inequality, and more federal support for suburbanization have made it increasingly difficult for cities to protect the health of all residents. In the last 25 years, epidemics of human immunodeficiency virus infections and substance abuse and increases in homelessness, lack of health insurance, rates of violence, and concentrations of certain pollutants have also damaged the health of urban residents. Several common strategies for health promotion are described, and their relevance to the unique characteristics of urban populations is assessed. To identify ways to strengthen health promotion practices in U.S. cities, lessons have been taken from five related fields of endeavor: human rights, church- and faith-based social action, community economic development, youth development, and the new social movements. By integrating lessons from these areas into their practice, public health professionals can help to revitalize the historic mission of public health, contribute to creating healthier cities, and better achieve national health objectives.

INTRODUCTION

No trend has had a more decisive impact on public health in the second millennium than the urbanization of human populations. Cities are both the cradles of infectious diseases, environmental pollution, and social problems such as addiction, violence, and sedentary lifestyles and the source of public health innovations such as clean-water systems, public sanitation, housing and workplace health and safety standards, and the community health education campaign (84, 148, 164, 165, 216). As the world's population continues to move into urban areas, creating healthy

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cities will remain a fundamental public health challenge in the centuries to come. In the more immediate future, the ability of the United States to realize the health goals set out in Healthy People 2010 (197) will depend in large part on being able to reduce the disproportionate burden of illness and poor health borne by urban populations.

Cities are important to the health of the public for several reasons. By the year 2000, the majority of the world's populations live in cities and their surrounding metropolitan areas (222), and increasingly, urban areas concentrate the poorest and most vulnerable sectors of the population (135). Thus, an ever larger proportion of the world's health problems are found in cities. Moreover, health conditions that are entrenched in cities, such as the human immunodeficiency virus (HIV) epidemic, substance abuse, and violence, can spread to rural and suburban areas, creating incentives for society as a whole to address these problems at their source (3, 200, 202, 203). Finally, cities often have the human, financial, and social capital that is needed to promote health and prevent disease, making it possible to set goals for improvement.

In 1986, the World Health Organization's Ottawa Charter for Health Promotion defined health promotion as "the process of enabling people to increase control over, and to improve their health" (219). It identified five goals for health promotion: a reorientation of health services, development of personal skills for health, creation of health-promoting public policy, development of supportive environments, and strengthening of community action for health. The Fourth International Conference on Health Promotion, held in Jakarta in 1997, reiterated and expanded the concept. The Jakarta Declaration on Health Promotion into the 21st Century declared that "...health is a basic human right and essential for social and economic development" (220), and the report noted that trends such as urbanization threatened "the health and well-being of millions of people."

PROFILE OF U.S. URBAN POPULATION

In 1990, according to the U.S. Census Bureau, 80% of the U.S. population lived in metropolitan areas, which the Bureau defines as a city with a total population of $\geq$50,000 inhabitants or an urbanized core area of $\geq$50,000 inhabitants, with another 50,000 people who are closely integrated socially and economically with the core. Between 1980 and 1992, the population living in metropolitan areas grew by almost 15%, more than three times the growth rate of the nonmetropolitan population (195). Almost half (46%) of the U.S. population lives in the 51 metropolitan areas with populations of more than one million.

Central cities are defined as the urban cores of metropolitan areas and have minimum populations of 15,000 persons. In 1996, the United States had 539 central cities. Of these, 218 had a population of >100,000 people and accounted for one quarter of the total U.S. population. The terms "city" and "urban" are used here to refer to central cities, although an increasing proportion of the larger metropolitan population now lives in suburban areas that share urban characteristics such as

poverty, dense populations, and social problems including violence and substance abuse (56, 198, 202).

URBANIZATION IN THE POST-WORLD WAR II PERIOD

To identify opportunities for health promotion, public health planners must understand the social context of urbanization in the United States. In the last 50 years, profound changes in the national and global economies have influenced every aspect of urban life. From early in this century through the end of World War II, the growth of urban industry and the collapse of rural agricultural economies in the South, the Caribbean, and elsewhere encouraged millions of people to move to U.S. cities (125).

After the war, federal housing, tax, and transportation policies encouraged millions of middle-class Americans to move from the cities to the suburbs. Thus, as poor people of color were moving into cities, middle-class whites were moving out, leaving cities with greater social needs and a smaller tax base (32). Not only middle-class residents, but jobs, left cities. Some were lost to suburbs, where land prices and taxes were lower; others were lost to lower-wage regions or nations, and still others to automation (15). These losses affected cities most adversely. As the manufacturing jobs that had drawn people into cities disappeared, the stability they had created in low-income urban communities gradually eroded. In the past, these jobs had provided a bumpy but relatively certain road out of extreme poverty for several generations of newly arrived city residents (214). Changes in the availability of entry-level manufacturing jobs, combined with the growth of low-wage service sector jobs and wage stagnation, further reduced the income available to poor urban families. By the 1990s, a significant proportion of the urban poor were working families earning minimum or sub-minimum wages (214).

This loss of employers and taxpayers inevitably led to reductions in tax revenues for cities. The combination of fewer resources, a poorer population, and increasing demands for health care, education, and social services squeezed city coffers to their limits (32). By 1980, the financial and political opposition to public funding for urban development for low-income populations became stronger, leading to further reductions in city services (121). Tax policies further contributed to the widening gap between rich and poor (194), especially in major cities (76), where new extremes of wealth and poverty coexisted, often in geographically adjoining neighborhoods (135).

Deindustrialization and migration to the suburbs led some cities to experience catastrophic population loss. In the past two decades, Detroit, for example, lost a third of its population, but doubled its poverty rate (222). Several neighborhoods in the Bronx, a borough of New York City, lost between 50% and 80% of their population and housing stock in the 1970s. Cutbacks in city services such as fire and police protection and health and social services led to increases in arson, building abandonment, and disruption of the social networks that support health (201, 203).

These trends contributed to the concentration of disadvantaged populations in urban areas. In 1959, 56% of poor people lived in rural areas and small towns, 27% in central cities, and 17% in suburbs. By 1985, however, the distribution had changed dramatically, with 43% of the poor now living in central cities and 28% in the suburbs (76). These new urban poor were disproportionately African-American and Latino. Wilson (213, 214) has argued that this concentration of poor people and their isolation from the mainstream economy and employment contributed to the social pathology of urban ghettoes.

National immigration policies—and global economic forces—have further changed the composition of urban populations. Between 1980 and 1990, the number of legal immigrants coming to the United States doubled compared with the decade of the 1950s. Most of these new immigrants came from Latin America and Asia rather than Europe, which had been the source of earlier immigrants (75). By 1990, >15% of residents of the 100 largest cities were foreign born, almost twice the rate for the population as a whole (9).

Long-term changes in governance also adversely affected cities. Beginning in the early 1980s, a growing number of federal programs were transferred to state governments, often through block grants. In many states, state legislatures have historically favored suburban and rural areas (32). As states regained the control of federal dollars that they had lost in the post-World War II period, cities often felt short-changed, losing financial support for human services even as needs grew (121). In the latter half of the 20th century, global multinational companies took on a growing political role (81). Their ability to shape government policies on trade, taxes, wages, environmental regulation, and health policy reduced the influence of the urban political machines and social movements that had won resources and concessions in the New Deal and postwar period (81, 156).

The strong U.S. economy of the 1990s has ameliorated some urban problems while leaving others unchanged. For the first time since the 1960s, the income gap between African-Americans and whites began to diminish, and many poor families were able to afford their own homes. Unemployment rates were at record lows (198). At the same time, a recent report prepared by the U.S. Department of Housing and Urban Development (198) found that between a fifth and a third of U.S. cities continue to experience serious economic problems.

In addition, a record number of Americans, especially urbanites, are without health insurance. In New York City, for example, 28% of the population lacked health insurance in 1998 (191). Finally, some experts worry that, as the time limits for welfare imposed by the 1996 legislation go into effect, some portion of low-income urban populations may find themselves without adequate employment, health care, housing, or food (52). Recent sharp declines in the number of Americans, especially those living in cities, who are enrolled in Medicaid and the Food Stamp programs have fueled these fears (154).

In the final quarter of the 20th century, the long-term trends of the post–World War II period combined with more specific events to create new threats to the health of urban populations. Sometime in the mid-1970s, HIV infection arrived in

the United States, spreading rapidly among two primarily urban populations: gay and bisexual men and injecting drug users. By the 1990s, HIV had become the leading cause of death in many urban communities, contributing to reductions in overall life span among some urban populations (29). HIV also contributed with other factors to a resurgence of tuberculosis, an infectious disease that had been on the decline for almost a century (124).

In the mid-1980s, a new form of cocaine known as crack or rock became widely available in urban communities across the United States. Although this country has experienced previous drug epidemics, crack was particularly damaging because it involved women and adolescents as well as adult men. The crack epidemic wreaked havoc on families and neighborhoods; in some areas the drug trade became the primary employer of young people (18, 41, 159, 160). For many impoverished crack addicts, selling sex was the only way to support their habit, which contributed to urban epidemics of gonorrhea, syphilis, and other sexually transmitted diseases (70).

The damage caused by crack and other illicit drugs was amplified by the ready availability of guns. Between 1985 and 1993, teen-age homicide rates—including both victims and perpetrators—more than doubled, with guns accounting for almost all of the extra deaths (16). Overall, homicide rates in the 100 largest U.S. cities were twice as high as for the nation as a whole (8). In the second half of the 1990s, rates of violence and crime declined in many U.S. cities (42).

Inadequate housing is associated with a variety of physical and mental health problems (21, 92). For the last two decades, a significant proportion of the urban poor have faced serious housing problems, ranging from overcrowding, high costs, and substandard conditions to frank homelessness (32, 129). Causes of homelessness or overcrowding include reductions in federal support for low-income housing, conversion of low-income housing into middle- and upper-income housing or to commercial uses, the rise in poverty and low-wage jobs, deinstitutionalization of the mentally ill without adequate community mental health services, and increasing rates of drug and alcohol use leading to eviction (100, 166).

For the United States as a whole, environmental quality has improved in the last 25 years, primarily as a result of increased federal regulation and increased public pressure for a clean environment (51). In certain urban communities, however, environmental problems continue to threaten health. Air pollution and other environmental conditions have been associated with increasing rates of illness and death from asthma in some U.S. cities (39, 40, 122). Despite substantial reductions in lead poisoning (131, 136, 169), lead continues to threaten the health of urban children. Other studies suggest that fine particulates and carcinogenic air toxins affect urban populations disproportionately (49, 93, 158).

In summary, recent and more long-term changes in the social and economic forces that shape U.S. cities influence the health of urban populations, creating new demands on and opportunities for health promotion and disease prevention. These same trends have also created several subpopulations that are especially vulnerable to poor health and are heavily concentrated in cities. These include

those living in urban high-poverty neighborhoods, whose numbers doubled from 4.1 million to 8 million between 1970 and 1990 (99); children living in poverty, who increased by 22% during the 1980s (32); recent immigrants, especially those coming from developing nations; the homeless and near-homeless; drug and alcohol users and their families; those without health insurance—almost one fifth of the U.S. population in the late 1990s (167); those involved in the criminal justice system (42, 83, 171); and the long-term unemployed. The morbidity and mortality of these groups have been shown to be several times higher than other less disadvantaged populations (68, 74, 92, 138). These overlapping sectors of the urban community present the greatest test to those who want to improve the health of urban populations.

CHARACTERISTICS OF CITIES THAT AFFECT HEALTH

To plan effective health promotion and disease prevention interventions for urban populations requires an understanding of both the social forces that have shaped cities and the unique characteristics that distinguish cities from other areas. Some important features of urban settings are population density, population diversity, high levels of income inequality, and the breadth and depth of social networks, community organizations, and service agencies (63, 65).

By definition, cities have an abundance of people. Cities are crowded, bustling, and energetic. Crowds can facilitate the transmission of infectious diseases (124), and urban street life can also contribute to the spread of social diseases like substance abuse and violence (7, 18). Crowding may also contribute to stress and its resulting physical and mental health problems (12). Ironically, people can also get "lost in the crowd" in the city, contributing to social isolation and to weakened social values that may contribute to mental illness, drug addiction, and violence (106).

Population density has its advantages too. It offers multiple opportunities for meeting new people and finding like-minded peers, escaping restrictions on freedom, and finding excitement and stimulation (148). It also creates opportunities for community organization. The relationships between population density and health are complex (12): A deteriorating tenement and a high-rise condominium can have the same density, but very different living conditions.

In the United States, cities are considerably more diverse than rural and suburban areas (9). Thus, urban residents are likely to interact with people with different values, ethnicities, religions, and national origins, creating opportunities for new knowledge and growth and for conflict.

In addition, in developed and developing nations, cities have experienced increasing concentrations of wealth and poverty (135, 222). Perceptions of inequity may contribute to disaffection, alienation, and social conflict (106, 135). The concentration of extreme poverty in cities has had a profound impact on the health of urban populations, leaving some groups with an overwhelming burden of ill health

(68, 74, 92, 138, 157, 224). A growing body of literature demonstrates that income inequality contributes to adverse health outcomes (105, 106, 128, 151, 223).

The combination of population density and diversity creates the conditions for multiple social networks in cities. The ready availability of social networks in cities can have a positive impact on health [e.g. mutual aid to increase the supply of food, housing, or other resources (180)], or it can increase risk (e.g. access to gangs or drug users). As well as active informal social networks, cities also have a wealth of neighborhood organizations, religious groups, and community service providers, which constitute an important foundation for health promotion.

CURRENT STRATEGIES TO PROMOTE HEALTH

In the past two decades, public health professionals have launched a variety of interventions designed to improve the health of urban populations. Public health strategies are defined as organized activities designed to achieve specified health outcomes based on an analysis of causal factors and informed by a theory of health determinants. Although the approaches listed here are not mutually exclusive—in fact many interventions integrate two or more strategies—each has distinct advantages and disadvantages. Most of these strategies are also used in nonurban areas; the focus here is on the application of these strategies in urban settings.

Access to Quality Primary Care

The primary-care setting offers important opportunities for health promotion. Improving access to quality primary health care for low-income urban residents has been a goal of federal policy since at least the 1960s. The single largest effort has been the Medicaid program, which pays for health care for eligible enrolled poor people. In urban areas, the financing provided by Medicaid helped to redistribute health care resources into under-served areas and to improve health for low-income children and their parents (167). Publicly funded neighborhood health centers, community mental health centers, family-planning clinics, shelter-based health services, and school-based health clinics reached some vulnerable urban populations not served by traditional providers (21, 72, 78, 132, 189).

National initiatives, such as those to control high blood pressure and diabetes (48, 137), increase screening for cancer (120), and immunize children and adolescents (13, 30), seek to improve the capacity of primary-care providers to promote health and prevent disease by counseling, screening, and educating their patients. These programs often target low-income urban populations.

A third type of effort recruited residents of low-income urban communities to become professional or paraprofessional providers, provided support and loan forgiveness to those who agreed to serve in these areas, or trained health providers to communicate more effectively with the diverse populations living in cities (71, 112). Improving the supply of practitioners in low-income urban areas and

the cultural match between patients and providers is believed to improve access and communication, maximizing opportunities for health promotion.

More recently, managed-care organizations (MCOs) have taken on a greater role in providing health care to urban populations (37). As more states mandate that Medicaid clients enroll in managed care, MCOs will play an increasingly important role in health promotion. In some cities, the local health department has assumed responsibility for monitoring managed care. In Los Angeles, for example, the county Department of Health Services has developed memoranda of understanding that require Medicaid-funded MCOs to support such services as family planning, prenatal care, tuberculosis control, and HIV counseling and testing (37). However, in some cases managed care providers may not be willing or able to provide traditional clinical public health services. In Milwaukee, for example, an outbreak of >1000 cases of measles was attributed primarily to the failure of a health maintenance organization to immunize its Medicaid enrollees (8).

Increasing access to quality primary care can reduce morbidity and prevent hospital admissions for many conditions, including asthma, diabetes, and hypertension. Preventable hospital admissions in most U.S. cities were significantly higher in low-income areas than high-income areas (4).

Increase Health Knowledge

Health education is defined as "any combination of learning activities designed to facilitate voluntary actions conducive to health" (79). Perhaps the most common health education strategy has been to launch educational campaigns that provide the general public with new knowledge about a health issue. Recent examples include the national media campaigns on HIV infection in the late 1980s and early 1990s, the Five-A-Day campaign designed by the U.S. Department of Agriculture to encourage more consumption of fruits and vegetables (90), and the Back-to-Sleep campaign to reduce sudden infant death syndrome by encouraging parents to have their infant sleep in a supine position (162). These undertakings have reached millions of Americans and increased knowledge about some health conditions. They have also contributed to changes in diet and sexual behavior that have led to reductions in heart disease, HIV infection, and other conditions (78).

Media campaigns may be less effective in reaching low-income populations. Moreover, urban vulnerable populations whose basic needs for shelter, nutrition, and health care are often unmet may not benefit from low-intensity knowledge campaigns that do not otherwise address their difficult living circumstances. Cities also have high proportions of individuals with limited English proficiency and/or low levels of literacy; to reach this population may require use of multiple languages or nonwritten communication (1).

Reduce Risky Behaviors

Behaviors such as cigarette smoking, physical inactivity, high-fat and low-fiber diets, risky sexual practices, drug and alcohol use, violence, and unsafe driving

are the proximate causes for the majority of morbidity and mortality in the United States (139). Research suggests that many of these behaviors and their adverse health consequences may be more prevalent in urban areas, especially in low-income urban populations. For example, smoking- and tobacco-related mortality has been shown to be higher in a low-income area in New York City than in the rest of the state or country (150), and those in lower-income groups (concentrated in cities) consume significantly fewer portions of fruits and vegetables than those in higher-income groups (115). On the other hand, residents of central metropolitan areas report less physical inactivity than rural or suburban residents, even after adjusting for poverty levels (31).

Health promotion interventions seek to reduce health-damaging behavior by providing information, skills, social support, and referrals to needed services. Most interventions address a single or a few closely related behaviors linked to a few specific adverse health outcomes. Several national demonstration projects have targeted various types of risk behavior in urban settings, including the AIDS Community Demonstration Projects in five U.S. cities—Dallas, Denver, Long Beach, New York, and Seattle (27)—and the Centers for Disease Control and Prevention (CDC) youth violence prevention projects operating in cities such as Los Angeles, Tucson, Chicago, and New York (28).

Other national risk reduction initiatives have been implemented in both urban and other settings. These include the Planned Approach to Community Health (PATCH), which seeks to enhance the capacity of communities to plan, implement, and evaluate comprehensive, community-based health promotion activities (79, 119). PATCH was developed in the mid-1980s by the CDC in partnership with state and local health departments and community groups. Hundreds of urban, rural, and suburban communities around the United States have used the PATCH model to address issues such as physical inactivity, tobacco use, breast cancer, access to health care, child abuse, and cardiovascular disease. Interventions have included the use of mass media, educational workshops, school-based health education, lay health adviser programs, policy advocacy, physical activity events, and environmental measures (17, 26, 161, 190). In general, the primary goal has been to reduce risk behavior.

Evaluations of PATCH have emphasized the process of community mobilization and the program's ability to address problems identified by the community (19, 181). These evaluations have identified factors that contribute to successful implementation. Few evaluations, however, have documented either policy changes or changes in health status resulting from PATCH activities, in part because of the difficulties in designing and carrying out such studies. An assessment of 27 PATCH sites in 13 states (181) found that 72% of all sites were in rural areas and that urban and minority populations were less likely to be targeted.

Other national risk reduction programs such as the Child and Adolescent Trial for Cardiovascular Health (CATCH) (54, 130), the Community Intervention Trial for Smoking Cessation (COMMIT) (36), and the various heart health programs (176, 215), have been carried out in both urban and nonurban settings but have

rarely presented data comparing outcomes by setting. In addition, these programs have generally not reached disadvantaged urban populations. In one exception, Shea et al (172, 173) report that it is feasible to implement community-based cardiovascular health promotion programs in low-income urban communities but that ongoing financial and organizational support is necessary if these programs are to be sustained.

In general, the results of large-scale risk reduction programs have been disappointing, perhaps in part because the interventions have been of limited intensity and few have fully involved community residents in designing and tailoring the intervention (60, 183, 215). These limitations may be particularly important in diverse, low-income urban communities (63, 65).

Increase Social Support

Stress has been demonstrated to play a role in causing or exacerbating a variety of health outcomes, including overall mortality, poor pregnancy outcomes, and heart disease (25, 35, 223). Stress is defined as the psychological or physiological response to internal or external events that upset an individual's homeostasis (126). Some evidence suggests that urban residents, especially low-income populations, may experience higher levels of stress owing to poverty, racism, disrespect from mainstream society, poor housing, a deteriorated physical environment, or other factors (105, 109, 117, 134). Both empirical and theoretical work suggests that social support may buffer the effects of stress, reducing its adverse health impact (89, 95, 184).

Interventions to increase social support in urban communities have used strategies such as peer education, lay health advisers, self-help, community organization, and case management (58, 59, 84, 111) to achieve outcomes such as improved maternal and child health (152), increased use of mammography (174), prevention of substance abuse (111), reduced drug use and HIV risk behavior (67, 107), and lower rates of hospitalizations and emergency room visits for asthma (33). Social support interventions may be especially well suited to low-income urban communities because they capitalize on these communities' principal resource: the knowledge, skills, and commitment of people who live in them (63, 65, 118).

Reduce Stigma and Marginalization

Cities have become home to a variety of populations often ostracized by mainstream society (9, 41, 50, 75, 76, 100, 101, 110, 199, 214). Discrimination leads to poor health by a variety of mechanisms: segregated and therefore inferior housing, reduced employment and educational opportunities (113, 135, 214), barriers to health care and other social services (10, 91), maladaptive behavioral responses to discrimination such as drug use or interpersonal violence (7, 18, 209, 214), higher levels of social stress (109), and overt violence (6). Reducing stigma, a strategy seldom used directly by public health professionals, may warrant further attention.

Interventions to reduce stigmatization take the form of advocacy to discourage or punish overt discrimination, empowerment to help individuals or groups to

overcome stigmatization, and public campaigns to promote tolerance and respect (96, 204, 205). Self-help groups of drug users, gay men, homeless people, and others have organized to reduce barriers to care and to change discriminatory public attitudes (45, 114, 199, 218, 223). National organizations have worked to pass state and national legislation to increase punishment for hate crimes, ban discrimination against gay and lesbian people, and reduce housing and employment bias or sexual violence and harassment (34, 114, 178, 199).

Advocate Health-Promoting Policies

Policy development is a core public health function, and in the last decade, the public health community has given greater attention to the effects of public policy on health (145, 177). National debates on health care, tobacco, illicit drug, environmental, reproductive-health, and other policies have attracted media and popular attention. Public health officials and researchers have offered a theoretical rationale for devoting more attention to creating public policies that promote health and prevent disease (140, 145, 177). National policies on taxes, transportation, housing, and criminal justice, among others, have a major impact on the social environment within cities; in addition, national and local policies on such issues as welfare, Medicaid, food stamps, and immigration disproportionately affect urban populations. Thus, developing public policies that promote health has the potential to improve the health of city dwellers.

Public health strategies for policy change include legislative or electoral advocacy, lawsuits, and media campaigns. Recent examples include campaigns to expand health insurance coverage for low-income children and families (167), force landlords to remove leaded paint from houses and apartments (103), discourage drunk driving (44, 211), and improve access to foods that prevent cancer, heart disease, and other chronic conditions (90).

A specific type of policy advocacy targets disease promoters, those who benefit from selling or promoting products that contribute to illness or death. The tobacco industry, gun manufacturers, the alcohol industry, illicit drug dealers, and producers of high-fat, low-nutrient-value foods are examples of industries that profit from their lethal products. Dense markets, the presence of corporate headquarters and political influence, and an established media presence for advertising make cities an attractive venue for disease promoters. In recent years, various advocacy groups, public health officials, and elected officials have used boycotts, lawsuits, legislation, and community-organizing campaigns to restrict the ability of these industries to market their wares. For example, >20 cities and counties have sued gun manufacturers both to win damages and to impose tighter restrictions on selling firearms (143).

Improve Urban Physical Environments

Improving the physical environment in cities was one of the earliest goals of the modern public health movement. Two dimensions of the urban physical environment influence human health. First, toxins such as lead, asbestos, various air and

water pollutants, and diesel exhausts disproportionately affect urban populations, in some cases because of higher rates of exposure and in others because of higher concentrations (49, 53, 136, 158). Second, the physical design of cities can affect public safety, social interactions, access to exercise, and more intangible esthetic factors that may influence mental health (94, 98).

Strategies to reduce pollutants include environmental regulation, advocacy for stricter enforcement of existing rules, campaigns to prevent pollution by encouraging reduction of the use of toxic substances, recycling, and encouraging nonpolluting forms of transportation. Draft statements of Healthy People 2010 (197), for example, include goals for increasing walking, bicycling, and the use of public transportation so as to reduce pollution and traffic from automobiles. Strategies to improve urban design to promote health include modification of land use zoning, creation of more parks and recreational areas, redesign of accident-prone traffic intersections, and improved lighting and design to increase safety (80, 98, 148).

Meet Basic Needs

People without shelter and food are unlikely to make health a priority. For the two fifths of central-city residents living below the federal poverty line (206), adequate housing and sufficient food to avoid hunger are not assured (149). Meeting these needs contributes directly to health by protecting individuals from the elements and nutritional diseases, and it also allows people to focus on other needs such as health care, education, and reduction of risk behavior.

Efforts to meet the basic needs of vulnerable urban populations fall into two categories: (*a*) national and state efforts to make housing and adequate nutrition entitlements and (*b*) social service strategies aimed at individuals or families, such as case management, advocacy, or harm reduction. Examples of the first include Food Stamps; the Women, Infants, and Children program, which offers food to pregnant women, mothers, and young children; the school lunch and breakfast programs; senior citizen food programs; and federal and state homeless services and housing assistance programs (55, 149). Although these are mainly national programs that serve people in all settings, their clientele are concentrated in urban areas.

Some interventions to reduce hunger and inadequate housing seek to link people with existing services and to address underlying conditions that may contribute to lack of housing or food, such as drug addiction, mental illness, or lack of job skills. In the 1990s, in response to the HIV and crack epidemics and urban homelessness, some programs offered transitional and temporary housing, food, and access to showers as a way of enticing drug users and homeless people into more comprehensive services. By meeting basic needs without a lengthy intake process or a requirement of sobriety or abstinence, these low-threshold or low-intensity services sought to reintegrate marginalized populations (66, 86).

Create Supportive Social Environments

The urban social environment has a profound influence on health (25, 63, 98). Strategies to promote urban health by modifying the social environment include

increasing social support and reintegrating marginalized populations to create more cohesive, inclusive, and health-reinforcing communities. Public health activities that can lead to improved urban social environments include campaigns to improve the quality of life by reducing graffiti, abandoned junk-filled lots, or public drunkenness; media or other efforts to reduce discrimination and promote tolerance; creation of safe public spaces for socialization, political discussion, or recreation; and intergenerational or multicultural programs to link young and older people and those of different cultures or ethnicities. Interventions to improve social cohesion may also reduce other social problems such as crime and violence (105, 106, 168).

Reduce Income Inequality

As research evidence on the adverse health impact of income inequality accumulates (14, 105, 106, 128, 151), public health professionals may need to put more emphasis on strategies to reduce income inequality, especially in urban areas, where income inequality is high and growing. Strategies to reduce income inequality include public investments in child care, education and higher education, job training, housing, health care, and other sectors that help individuals and families to move out of poverty; increasing minimum wages and the negative tax income; and developing more progressive tax policies. Few of these policies are viewed favorably by most current policy makers in the United States, making implementation on a wide scale difficult (47, 185). Defining an appropriate and feasible role for public health in reducing income inequality will present a significant challenge in the coming years.

IMPLEMENTING HEALTH PROMOTION IN URBAN COMMUNITIES

To promote health effectively in urban communities, public health professionals must both select from the strategies described previously and also engage the various stakeholders in the process of planning and carrying out activities. The literature on the implementation of urban health promotion reveals several recurring problems and suggests guidelines for more effective practice.

Several characteristics of cities can make implementation of health promotion more difficult. Population diversity can lead to ethnic, class, or generational conflict, making it difficult to bring people together to achieve common health goals. Income and power inequalities in cities can exclude two key constituencies for urban health promotion from the planning process: those who make many of the decisions that shape health and the disadvantaged and marginalized populations who suffer most from ill health (24, 63, 217). The many formal and informal organizations in urban neighborhoods often compete for resources and clients, complicating coalition building (66, 142). Low-income and minority residents may distrust public health workers (186), reducing their willingness to join health campaigns. Most city governments organize services categorically, making horizontal

integration of key sectors difficult. Finally, health promotion planners often have difficulty deciding who best represents the community (59, 108, 182). Those willing to participate are not always representative of the community, and some urban communities are so diverse that no single voice can speak for all sectors of the population (88).

To overcome these obstacles, experienced health promoters suggest several strategies (2, 20, 46, 64, 78, 79, 85, 104, 146): (*a*) Include all key stakeholders in all stages of implementation, making a special effort to give disadvantaged populations an equal voice in planning; (*b*) tailor interventions to meet the diverse needs of sectors of the urban population; (*c*) choose realistic goals for coalitions and networks, avoiding exceeding the scope of shared interests or requiring burdensome sacrifices of time, resources, or drift from mission; (*d*) build trust over time based on shared assessment of common experience, rather than expecting trust as a condition of collaboration; (*e*) create public forums in which communities, organizations, and health professionals can analyze health problems and propose solutions; (*f*) expect real solutions to complex urban health problems to require years of effort; (*g*) resist the call for quick fixes.

Several multisite programs have attempted to implement these and other principles in U.S. and other cities in the last several years. The Healthy Cities Project was launched by the World Health Organization in 1986 as "a means of legitimizing, nurturing, and supporting the process of community empowerment" (188). Using community participation as the method, Healthy Cities seeks to achieve the goal of health for all by reducing inequalities, strengthening health gains, and reducing morbidity and mortality in cities around the world (43). In the late 1990s, Healthy Cities focused on advocating healthy public policies and strengthening city planning for health (43, 61).

To achieve its goals, Healthy Cities partnerships establish a high-level group of key policy makers to review the city's health, develop a strategy for collaborating to improve health status, and take action to mobilize the community (11). In the United States, dozens of communities in urban and nonurban areas have used the Healthy Cities model or joined one of the two networks that coordinate Healthy Cities and Healthy Communities in this country (Larned and Associates, Larkspur, Calif., unpublished data).

Evaluation studies of Healthy Cities have concentrated more on process than outcome. Healthy Cities researchers have struggled to identify appropriate research roles for community residents, to define the specific content and goals of their interventions, and to select suitable measures of individual, community, and policy change (43, 144). As a result, the impact of Healthy Cities activities on the health of urban residents or the broader urban environment has yet to be ascertained. Advocates of Healthy Cities believe that the model has "proved to be a very effective and versatile vehicle for bringing Health for All to the local level" (188).

Other national efforts include Fighting Back, an effort to reduce alcohol and substance abuse in 14 cities and counties (179), a community-health promotion

program supported by the Henry J. Kaiser Family Foundation (210), a Robert Wood Johnson Foundation–funded program to improve child health in several big cities, and an Annie E Casey Foundation effort to strengthen the capacity of low-income urban communities to protect children and their families (175). To date, these and similar initiatives have focused more on the process of mobilizing communities and public agencies for health and community development than on changes in the health status of populations. An evaluation of Fighting Back did not demonstrate changes in alcohol and drug use in targeted communities compared with demographically similar communities, as measured by a random household telephone survey (102, 170).

SETTINGS FOR URBAN HEALTH PROMOTION

Expanding the scope and accessibility of health promotion activities in cities is likely to increase their impact. In most urban communities, especially poor ones, residents continually encounter disease promotion, for example, tobacco advertisements, media glorification of violence and sex, drug dealers, liquor stores, or weapons for sale. By making it easier to find health promoters—a friend or neighbor who will help a person in recovery to maintain abstinence, a place to buy low-cost healthy food, a safe place to exercise, a role model or mentor who can guide a young person—public health planners can help to create healthier cities.

To achieve this goal will require locating health promotion interventions in a wide array of settings, enlisting more neighborhood residents and institutions in implementing programs, and defining health in broader ways. Table 1 illustrates settings that can reach different sectors of urban populations. Currently, the vast majority of health promotion programs are located in a few settings: health care centers, schools, youth programs, and social service agencies. Although these settings reach broad cross-sections of the population, they fail to reach many at highest risk of various health problems, often those who are already marginalized. Health promotion programs, especially in fields such as HIV prevention and substance abuse, have demonstrated that it is possible to launch interventions that can reach vulnerable populations in varied settings. Seldom, however, have these creative and innovative programs been replicated in multiple settings and rarely have they reached more than a fraction of the population in need, a necessary condition for having a public health impact. Thus, to multiply their effect, it will be necessary to increase both the types of settings in which programs are offered and the number of programs in each type of setting.

EVALUATION OF URBAN HEALTH PROMOTION

Evaluation of urban health promotion interventions faces the usual difficulties involved in assessing the impact of complex interventions on deeply rooted problems (207). Some of these obstacles are compounded by the unique characteristics of

TABLE 1 Selected settings for urban health promotion

Setting	Possible Target Populations	Possible Health Conditions
City jails and lock ups, juvenile justice facilities	Drug users, victims and perpetrators of violence, young people in trouble	Drug and alcohol use, violence, TB, STDs, HIV infection, mental health problems
Taxi and van services, public transportation	Adult males, working people, recent immigrants	Information on health care, sexual and reproductive health, HIV
Public housing projects	Adolescents, families, older people, children	Heart disease, asthma, HIV, alcohol and drug abuse, violence, immunization, contraception
Beauty parlors and barber shops	Women, men	Sexual and reproductive health, cancer, heart disease, HIV
Sports leagues	Children and adolescents, adult men	Nutrition, fitness, sexual health, violence, drug and alcohol use, immunization
Ethnic clubs	Families, single adults, older people	Information on health care, safety, violence, drug and alcohol use
Churches	Older people, adults, adolescents	Chronic disease, HIV, environmental issues, alcohol and drug use, violence, sexual health
Afterschool programs	School age children and their parents	Physical fitness, nutrition, violence, substance abuse, asthma, mental health, immunization, access to care
Welfare-to-work programs	Low income mothers and children, single adults	Asthma and other chronic diseases, nutrition, substance abuse, mental health, access to health care, reproductive health, immunizations

urban communities and their health issues. For example, evaluation of multisite interventions requires careful attention to the context in which each site implements a common program. Observed differences in outcome may be caused by differences in setting rather than intervention effects, requiring evaluators to carefully describe the context and explore its impact on program outcomes.

The interactions between process and outcome in health promotion interventions are often complex and understudied. In urban communities, population

diversity, difficulties in enlisting the participation of distrustful or disadvantaged residents or overburdened organizations, and the effect of multiple other influences on urban life make it especially difficult to attribute changes in population health status to specified interventions. A related problem is that most urban neighborhoods have many interventions in place simultaneously, with little effort to understand their cumulative impact or their synergistic interactions.

For these reasons, ecological research, program, and evaluation models, which elucidate the complex interactions among multiple levels, may be especially appropriate for evaluating urban health promotion (77, 96, 141). Recent reviews have explored other dimensions of the evaluation of health promotion and related community interventions, including community-based and participatory research (97, 176) and theory of change evaluations (69), two approaches that may help to inform the evaluation of urban health promotion.

NEW DIRECTIONS FOR URBAN HEALTH PROMOTION

In the last ~20 years, public health professionals, in partnership with other relevant stakeholders, have created innovative programs designed to improve the health of people living in cities. A few of these have been demonstrated to contribute to reductions in illness, injury, or death, and many have engaged populations at risk of poor health. Compared with the magnitude of the social, economic, and health problems of disadvantaged urban populations, however, the impact of these interventions seems insufficient to reduce the public health burden that poor urban residents bear. With few exceptions, health promotion interventions in the United States have not targeted the most disadvantaged urban populations and have had difficulty engaging them as partners or participants in health promotion activities. Few programs address, much less reduce, the powerful social, political, and economic forces that push poor urban residents into ill health. Thus, it is unlikely that simply doing more of what we have been doing will by itself solve the health problems of U.S. cities.

A comparison of commonly used strategies for health promotion in U.S. cities with the suggested goals proposed by the Ottawa Charter (219) and the Jakarta Declaration on Health Promotion (220) suggests that even wealthy industrial countries such as the United States have a long way to go. To achieve the broad aims that these documents outline, "enabling people to increase control over, and to improve their health" (219) or recognizing health as "a basic human right ... essential for social and economic development" (220), will require significant shifts in political philosophy and allocation of resources.

By examining other arenas of theory and practice, public health workers can help to forge an expanded practice of health promotion that will contribute to healthier cities. However, absent a renewed national commitment to U.S. cities, especially their low-income populations, and without a new vision of the role of federal, state, and local government in implementing such a plan, it is unlikely that

the well-being and quality of life of urban populations will improve substantially. The challenge for public health workers is to identify the specific tasks for which they will take responsibility and other actions that can contribute to a broader dialog on the future of cities.

Several fields of experience may help to guide the development of a new agenda to improve the health of urban populations. They have the potential to address some of the shortcomings in current practice and to expand the breadth and depth of urban health promotion in the United States.

Human Rights

The human rights approach seeks to "promote and protect the societal-level prerequisites for human well-being in which each individual can achieve his or her full potential" (133). Based on the Universal Declaration of Human Rights (192) and the subsequent International Covenants on Economic, Social and Cultural Rights and Civil and Political Rights (193), the human rights perspective creates a moral and legal framework for guaranteeing all sectors of society the basic necessities for well-being. Human rights language and concepts may help to expand public health's focus from health care and individual behavior to living conditions and the environment. Monitoring of human rights abuses is a first step for action, a task that might be integrated with traditional public health surveillance. Given the growing income inequality in U.S. cities and its adverse impact on health, a human rights emphasis may help to restore public health's historic concerns with social justice (116).

Around the world, human rights have been a powerful idea that has helped to mobilize citizen and government action to remove authoritarian regimes, intervene to stop genocide and discrimination, and broaden citizen rights to participate in governance (133). In the United States, human rights organizations have acted against police brutality, abuse of prisoners, and discrimination against gay and lesbian people, African-Americans, and women and for full political participation for various disadvantaged groups. Each of these activities addresses some determinant of ill health for urban populations. Human rights concepts may help to create a rationale for government action to reduce the social determinants of urban ill health. For example, the American College of Physicians has called for a national program to reduce the unfair "urban health penalty" imposed by poor living conditions in many U.S. cities (4).

Church and Church-Based Activities

Churches have long played a key role in urban communities. They have been refuges from oppression, spaces for social mobilization, cultural centers, leadership development institutes, providers of social services and support, agents of socialization and acculturation, educational institutions, and pulpits for visionaries (57, 62, 127, 147, 225).

Many urban churches are already active in health promotion and related services. A survey of 635 black churches in the northern United States in the early 1990s (187) found that two thirds of the churches operated one or more community

outreach programs. Many of the churches had ongoing ties with a variety of secular agencies including police, schools, welfare departments, hospitals, youth organizations, and local prisons, suggesting that religious organizations may be able to serve as bridges among various systems. In Latino communities, the Catholic and Pentecostal churches often play a similar role.

Beyond their involvement in existing health activities, churches and other faith-based institutions have much to offer to health promotion planners. First, they have credibility and roots in urban low-income communities. In many devastated neighborhoods, churches are among the oldest and most established community institutions. Second, churches offer spirituality and faith. They combat the ideology of despair, materialism, and cynicism that pervades low-income urban communities. Churches offer an antidote to what Cornell West (208) has called nihilism, the "disease of the soul" that makes life feel meaningless, hopeless, and loveless for many residents of poor urban communities. Third, religious institutions have the capacity to mobilize low-income urban communities on issues ranging from teen pregnancy and drug abuse to low-income housing programs. Although urban churches are not homogeneous and some have been unwilling to address some health issues related to sexuality (34), they are an example of the enduring institutions that constitute the foundation for health promotion in urban communities.

Community Economic Development

Beginning in the 1960s, in response to the civil rights movement and insurrections in African-American urban neighborhoods around the nation, the federal government and private philanthropy launched a number of initiatives designed to improve urban neighborhoods. After the mid-1970s, declining economic growth and a more conservative political climate sharply reduced these experiments, but some remain in place. Several recent reviews summarize the accomplishments and limitations of these programs (22, 38, 73, 82, 87).

Although these programs differ in their goals, scopes, and methods, assessments of various comprehensive approaches suggest some common findings relevant to urban health. Comprehensive programs often evolve from addressing a single or a few needs to seeking to meet multiple needs and involve collaborative relationships with several organizations. These programs often serve as a bridge between local residents and government, political parties, and private industry. Organizations report multiple benefits from comprehensive approaches, including improving overall service coordination, removing barriers to access, and reaching vulnerable populations.

Comprehensive community development models demonstrate to public health planners the possibility of addressing multiple issues simultaneously; of developing structures that offer some community residents an ongoing voice in governance; of linking service delivery with political advocacy; of strengthening the community's capacity to reduce dependence on external forces; and of mobilizing social capital for community improvement.

Youth Development

Youth development emphasizes that young people have assets to be developed, in addition to problems (5, 155). Rather than focusing on specific risk behaviors, youth development interventions seek to create healthy pathways to adulthood. They also strengthen the ability of families, communities, schools, and other organizations to help young people acquire the knowledge, skills, and values that promote health (212). Youth development challenges categorical public health approaches and promises new ways to reintegrate young people into the mainstream of urban communities. By linking efforts in health, education, social services, juvenile justice, and job training, youth development achieves the horizontal integration that categorical health promotion programs may lack.

New Social Movements

From the 1970s to the early 1990s, a variety of social movements emerged in response to changing social conditions, including the women's movement, the environmental justice movement, the gay and lesbian movement, and the HIV prevention and services movement (23, 114, 153, 163). Most had their base in urban areas.

Social movements offer potential solutions to some of the specific problems that urban health promotion programs have encountered. They have successfully linked different levels of experience: the personal and the political, behavior change and institutional change, and local and national action. These movements have demonstrated concrete strategies for empowerment education, that is, taking action to change institutional forces based on an analysis of one's own experience. This vertical integration of various levels helps participants both to see the concrete results of their efforts in their own community and to feel part of a broader, potentially more powerful force, two incentives to continued involvement.

Second, the social movements provide a vehicle for tapping into deeper aspirations that can sustain participation over the long run. Social movements have the power to move people into sustained action. If human resources are the primary capital of low-income urban communities, social movements may be the force that can mobilize this capital.

A third contribution of social movements is their willingness to take on the disease promoters. The rhetoric of consensus and the dependence on established powers has often made it difficult for urban health promoters to challenge individuals or organizations that contribute to ill health, for example, promoters of alcohol and tobacco, government officials who cut services to the poor, or executives of polluting industries. Social movements are also willing to work outside established political channels. Given widespread public disenchantment about the value of voting and other traditional political behavior to achieve desired ends, groups that use other tactics may be able to mobilize constituencies that often remain outside the political process, especially the disadvantaged urban populations that experience the most serious health problems (156).

Finally, the social movements have forged new approaches to creating a culture that sustains involvement of participants over time, a serious problem facing urban health promotion programs. Means of communication used to achieve this end include women's and gay support and consciousness-raising groups; alternative institutions such as women's health centers and gay community centers; women's, gay, and black media such as community newspapers, videos, and cable shows; and open participatory forums in which individuals voice grievances, plan strategy, and celebrate successes. These and similar activities provide activists with the opportunity for ongoing face-to-face interactions that build the social networks that can provide continuing support for participation.

Urban health promotion planners can benefit from these lessons by developing programmatic links with existing social movements. Current movements that have a presence in urban communities include the environmental justice and sustainable development movements, the gay and lesbian and the intertwined AIDS movements, the still coalescing movement for immigrant rights, the newly reenergized labor movement, and the various coalitions for living wages and against the dismantling of federal welfare entitlements or abuses of workfare participants. Each of these movements has potential interests in health and may be open to joining with public health projects to improve the well being of urban communities.

By integrating the lessons of these five disparate experiences into their practice, public health workers can forge a new approach to urban health promotion that builds on previous accomplishments while addressing the limitations of current approaches. Developing a new practice for urban public health will require collaboration among practitioners, academics, and researchers in public health, urban planning, social work, social sciences, medicine, and nursing; urban policy makers and officials at the local, state, and national levels; public and private funding groups; and residents and activists living in urban communities.

For much of human history, cities have been in the forefront of public health innovation. In the last quarter of the 20th century, broader social, economic, and political forces threatened the well-being and living conditions of urban populations in the United States, especially the poor and marginalized. Developing new strategies to promote health and prevent disease among people living in cities in the new century offers the public health profession an opportunity to revitalize its historic mission as well as to achieve basic health objectives.

LITERATURE CITED

1. Ad Hoc Committee of Health Literacy for the Council on Scientific Affairs, American Medical Association. 1999. Health literacy. Rep. Counc. Sci. Aff. *JAMA* 281:552–57
2. Aguirre-Molina M, Ramirez A, Ramirez M. 1993. Health promotion and disease prevention strategies. *Public Health Rep.* 108:559–64

3. Amato PR, Zuo J. 1992. Rural poverty, urban poverty, and psychological well-being. *Soc. Q.* 33(2):229–40
4. American College of Physicians. 1997. Inner-city health care. *Ann. Intern. Med.* 127:485–90
5. American Youth Policy Forum. 1995. *Contract with America's Youth: Toward a National Youth Development Agenda.* Washington, DC: Am. Youth Policy Forum
6. Amnesty International USA. 1994. *Breaking the Silence: Human Rights Violations Based on Sexual Orientation.* New York: Amnesty International
7. Anderson E. 1990. *Streetwise: Race, Class and Change in an Urban Community.* Chicago: Univ. Chicago Press. 276 pp.
8. Andrulis D. 1997. The public sector in health care: evolution or dissolution? *Health Aff.* 16:131–40
9. Andrulis D, Ginsberg C, Shaw-Taylor Y, Martin V. 1995. *Urban Social Health: A Chartbook Profiling the Nation's One Hundred Largest Cities.* Washington, DC: Natl. Public Health Hosp. Inst. 163 pp.
10. Annas GJ. 1999. The impact of health policies on human rights: AIDS and TB control. In *Health and Human Rights: A Reader*, ed. JM Mann, S Gruskin, MA Grodin, GJ Annas, pp. 37–45. New York: Routledge
11. Ashton J. 1991. *Healthy Cities.* Bristol, PA: Open Univ. Press. 235 pp.
12. Baum A, Davis GE, Aiello JR. 1989. Crowding and neighborhood mediation of urban density. *J. Popul.* 1:266–28
13. Bernier R. 1994. Toward a more population-based approach to immunization: fostering private and public-sector collaboration. *Am. J. Health Promot.* 84:1567–68
14. Black D, Morris JN, Smith C, Townsend P, Whitehead M. 1988. *Inequalities in Health: The Black Report; The Health Divide.* London: Penguin. 399 pp.
15. Bluestone B, Harrison B.1982. *The Deindustrialization of America: Plant Closings, Community Abandonments and the Dismantling of Basic Industry.* New York: Basic Books. 323 pp.
16. Blumenstein A. 1995. Youth violence, guns and the illicit-drug industry. *J. Crim. Law* 86:10–36
17. Bogan III G, Omar A, Knobloch S, Liburd L, O'Rourke T. 1992. Organizing an urban African-American community for health promotion: lessons from Chicago. *J. Health Educ.* 23:157–59
18. Bourgois P. 1995. *In Search of Respect: Selling Crack in El Barrio.* New York: Cambridge Univ. Press. 392 pp.
19. Braddy B, Orenstein D, Brownstein JN, Cook T. 1992. PATCH: an example of community empowerment for health. *J. Health Educ.* 23:179–82
20. Braithwaite RL, Lythcott N. 1989. Community empowerment as a strategy for health promotion for black and other minority populations. *JAMA* 261(2):282–83
21. Brickner PW, Scallan BC. 1986. Homeless persons and health care. *Ann. Intern. Med.* 104:405–9
22. Brown P, Garg S. 1997. *Foundations and Comprehensive Community Initiatives: The Challenges of Partnership*, pp. 1–27. Chicago, IL: Chapin Hall Cent. Child. Univ. Chicago
23. Bullard RD, ed. 1996. *Unequal Protection: Environmental Justice and Communities of Color.* San Francisco: Sierra Club. 416 pp.
24. Butterfoss FD, Goodman RM, Wandersman A. 1993. Community coalitions for health promotion and disease prevention. *Health Educ. Res.* 8:315–30
25. Cassel J. 1976. The contribution of the social environment to host resistance. *Am. J. Epidemiol.* 104:107–23
26. Centers for Disease Control and Prevention. 1993. *Planned Approach to Community Health (PATCH): Guide for the Local Coordinator.* Atlanta: Natl. Cent. Chronic Dis. Prev. Health Promot., Div. Chronic Dis. Control Community Interven.

27. Centers for Disease Control and Prevention. 1996. Community-level prevention of human immunodeficiency virus infection among high-risk populations: the AIDS Community Demonstration Projects. *Morbid. Mortal. Wkly. Rep.* 45(RR-6):1–24
28. Centers for Disease Control and Prevention. 1996. *Steps to Successful Implementation of Youth Violence Prevention Programs*. Atlanta: US Cent. Dis. Control. 32 pp.
29. Centers for Disease Control and Prevention. 1996. Update: mortality attributable to HIV infection among persons aged 25–44 years—United States, 1994. *Morbid. Mortal. Wkly. Rep.* 45:121–25
30. Centers for Disease Control and Prevention. 1997. Status report on the childhood immunization initiative: national, state and urban area vaccination coverage levels among children aged 19–35 months—United States, 1996. *Morbid. Mortal. Wkly. Rep.* 46:657–71
31. Centers for Disease Control and Prevention. 1998. Self-reported physical inactivity by degree of urbanization—United States, 1996. *Morbid. Mortal. Wkly. Rep.* 47:1097–1100
32. Cisneros H, ed. 1993. *Interwoven Destinies: Cities and the Nation*. New York: Norton. 367 pp.
33. Clark NM, Starr-Scneidkraut NJ. 1994. Management of asthma by patients and families. *Am. J. Resp. Crit. Care Med.* 149:S54–66
34. Cohen CJ. 1999. *The Boundaries of Blackness: AIDS and the Breakdown of Black Politics*. Chicago: Univ. Chicago Press. 394 pp.
35. Cohen S, Syme SL, eds. 1984. *Social Support and Health*. Orlando, FL: Academic. 390 pp.
36. COMMIT Research Group. 1995. Community Intervention Trial for Smoking Cessation (COMMIT): cohort results from a four-year community intervention. *Am. J. Public Health.* 85:183–92
37. Committee on Public Health, Institute of Medicine. 1996. *Healthy Communities: New Partnerships for the Future of Public Health—A Report on the First Year of the Committee on Public Health*, pp. 13–29. Washington, DC: Natl. Acad. Press
38. Connell JP, Kubish AC, Schorr LB, Weiss CH, eds. 1995. *New Approaches to Evaluating Community Initiatives*. Washington, DC: Aspen Inst. 153 pp.
39. Crain EF, Weiss KB, Bijur PE, Hersh M, Westbrook L, Stein REK. 1994. An estimate of the prevalence of asthma and wheezing among inner-city children. *Pediatrics* 94:356–62
40. Cunningham J, Dockery DW, Speizer FE. 1996. Race, asthma and persistent wheeze in Philadelphia school children. *Am. J. Public Health* 86:1406–9
41. Currie E. 1993. *Reckoning: Drugs, the Cities and the American Future*. New York: Hill & Wang. 405 pp.
42. Currie E. 1998. *Crime and Punishment in America: Why the Solutions to America's Most Pressing Social Crisis Have Not Worked and What Will*. New York: Metropolitan. 230 pp.
43. Davies J, Kelly M, eds. 1993. *Healthy Cities Research and Practice*. London: Routledge. 192 pp.
44. DeJong W. 1996. MADD Massachusetts versus Senator Burke: a media advocacy case study. *Health Educ. Q.* 23:318–29
45. DesJarlais D, Friedan SR, Ward TP. 1993. Harm reduction: a public health response to the AIDS epidemic among injecting drug users. *Annu. Rev. Public Health* 14: 413–50
46. DesJarlais D, Padian N, Winkelstein W. 1994. Targeted and universal strategies for preventing HIV transmission. *N. Engl. J. Med.* 331(21):1452–53
47. de la Barra X. 1998. Poverty: the main cause of ill health in urban children. *Health Educ. Behav.* 25:46–59
48. Diabetes Prevention Program Research Group. 1996. *Diabetes Prevention*

program (DPP) Protocol. Springfield, VA: Natl. Tech. Inf. Serv.
49. Dockery DW, Ware JH, Ferris BG, Speizer FE, Cook NR. 1993. An association between air pollution and mortality in six U.S. cities. *N. Engl. J. Med.* 329:1753–57
50. Dohrenwend BP, Dohrenwend BS. 1974. Psychiatric disorders in urban settings. In *American Handbook of Psychiatry.* Vol 2: *Child and Adolescent Psychiatry, Sociocultural and Community Psychiatry*, ed. S Arite, pp. 424–47. New York: Basic Books
51. Easterbrook G. 1995. *A Moment on the Earth: The Coming of Age of Environmental Optimism.* New York: Viking. 769 pp.
52. Edelman P. 1999. Clinton's cosmetic poverty tour. *New York Times*, July 8, p. A27
53. Egan T. 1996. Urban sprawl strains western states. *N. Y. Times*, Dec. 29, pp. 1, 20
54. Elder JP, McGraw SA, Stone EJ, Reed DB, Harsha DW, et al. 1994. CATCH: process evaluation of environmental factors and programs. *Health Educ. Q.* (Suppl. 2):S107–27
55. Ellwood D. 1988. *Poor Support.* New York: Basic Books. 288 pp.
56. El Nasser H, Hansen B. 1999. Suburban cities gain on older ones in numbers. *USA Today,* June 30, p. 6A
57. Eng E, Hatch J, Callan A. 1985. Institutionalizing social support through the church and into the community. *Health Educ. Q.* 12:81–92
58. Eng E, Young R. 1992. Lay health advisers as community change agents. *J. Fam. Community Health* 15:24–40
59. Fisher E, Auslander W, Sussman L, Owens N, Jackson-Thompson J. 1992. Community organization and health promotion in minority neighborhoods. *Ethn. Dis.* 2:252–72
60. Fisher E. 1995. Editorial: the results of the COMMIT trial. *Am. J. Public Health* 85:159–60
61. Flynn BC. 1996. Healthy Cities: towards worldwide health promotion. *Annu. Rev. Public Health* 17:229–309
62. Freedman SG. 1993. *Upon this Rock: The Miracles of a Black Church.* New York: Harper Collins. 373 pp.
63. Freudenberg N. 1998. Community-based health education for urban populations: an overview. *Health Educ. Behav.* 25:11–23
64. Freudenberg N, Eng E, Flay B, Parcel G, Rogers T, Wallerstein N. 1995. Strengthening individual and community capacity to prevent disease and promote health: in search of relevant theories and principles. *Health Educ. Q.* 22:290–306
65. Freudenberg N, Manoncourt E. 1998. Urban health promotion: current practices and new directions. *Health Educ. Behav.* 25:138–45
66. Freudenberg N, Trinidad U. 1992. The role of community organizations in responding to the AIDS epidemic in two Latino communities in New York City. *Health Educ. Q.* 19(2):219–32
67. Freudenberg N, Wilets I, Greene MB, Richie BE. 1998. Linking women in jail to community services: factors associated with rearrest and retention of drug-using women following release from jail. *J. Am. Med. Women's. Assoc.* 53:89–93
68. Friedman LN, Williams MT, Singh TP, Frieden TR. 1996. Tuberculosis, AIDS and death among substance abusers on welfare in New York City. *N. Engl. J. Med.* 334:828–33
69. Fulbright-Anderson K, Kubisch AC, Connell JP, eds. 1998. *New Approaches to Evaluating Community Initiatives.* Vol. 2: *Theory, Measurement and Analysis.* Queenstown, MD: Aspen Inst.
70. Fullilove R, Fullilove M, Bowser M, Gross S. 1990. Risk of sexually transmitted disease among black adolescent crack users in Oakland and San Francisco, California. *JAMA* 263:851–55
71. Gany F, De Bocanegra HT. 1996. Overcoming barriers to improving the health of

immigrant women. *J. Am. Med. Women's. Assoc.* 51:155–60

72. Geiger J. 1984. Community health centers: health care as an instrument of social change. In *Reforming Medicine: Lessons of the Last Quarter Century*, ed. VW Sidel, R Sidel, pp. 11–32. New York: Pantheon
73. General Accounting Office. 1995. *Community Development Comprehensive Approaches Address Multiple Needs But Are Challenging to Implement. GAO/RCED/HEHS-95-69*. US Gen. Account. Off. Washington, DC
74. Geronimus AT, Bound J, Waidmann TA, Hillemeier MM, Burns PB. 1996. Excess mortality among Blacks and Whites in the United States. *N. Engl. J. Med.* 335:1552–58
75. Ginzberg E. 1993. The changing urban scene: 1960–1990 and beyond. In *Interwoven Destinies: Cities and the Nation*, ed. H Cisneros, pp. 33–47. New York: Norton
76. Goldsmith W, Blakely E. 1992. *Separate Societies: Poverty and Inequality in U.S. Cities*. Philadelphia, PA: Temple Univ. Press. 247 pp.
77. Goodman R. 1999. Principles and tools for evaluating community-based prevention and health promotion programs. In *Community-Based Prevention: Programs that Work*, ed. RC Brownson, EA Baker, LF Novick, pp. 211–27. Gaithersburg, MD: Aspen Publ.
78. Green LW. Prevention and health education in clinical, school and community settings. In *Public Health and Preventive Medicine*, ed. RB Wallace, pp. 889–904. Stamford, CT: Appleton & Lange. 14th ed.
79. Green LW, Kreuter MW. 1999. *Health Promotion Planning: An Educational and Ecological Approach*. Mountain View, CA: Mayfield. 621 pp. 3rd ed.
80. Greenberg M. 1994. Linking city planning and public health in the United States. *J. Plan. Lit.* 8:235–39
81. Greider W. 1997. *One World, Ready or Not: The Manic Logic of Global Capitalism*. New York: Simon & Schuster. 528 pp.
82. Halpern R. 1995. *Rebuilding the Inner City: A History of Neighborhood Initiatives to Address Poverty in the United States*. New York: Columbia Univ. Press. 257 pp.
83. Hammett TM, Gaiter JL, Crawford C. 1998. Reaching seriously at-risk populations: health interventions in criminal justice settings. *Health Educ. Behav.* 25:99–120
84. Hancock T, Duhl L. 1988. *Promoting Health in the Urban Context. WHO Healthy Cities Pap. 1*. Copenhagen, Denmark: FADL Publishers
85. Hancock L, Sanson-Fisher RW, Redman S, Burton R, Burton L, et al. 1997. Community action for health promotion: a review of methods and outcomes 1990–1995. *Am. J. Prev. Med.* 13(4):229–39
86. Harm Reduction Coalition. 1995. *Mission Statement*. Oakland, CA: Harm Reduct. Coalit.
87. Harrison B. 1995. *Building Bridges: Community Development Corporations and the World of Employment Training*. New York: Ford Found
88. Hawe P. 1994. Capturing the meaning of 'community' in community intervention evaluation: some contributions from community psychology. *Health Promot. Int.* 9(3):199–210
89. Heany CA, Israel BI. 1997. Social networks and social support in health education. In *Health Behavior and Health Education: Theory, Research and Practice*, ed. K Glanz, FM Lewis, BK Rimer, pp. 179–205. San Francisco: Jossey-Bass. 2nd ed.
90. Heimendinger J, Van Duyn MA, Chapelsky D, Foerster S, Stables G. 1999. The national 5-a-day better health program: a large-scale nutrition intervention. In. *Community-Based Prevention Programs that Work*, ed. RC Brownson, ES Baker, LF Novick, pp. 109–21. Gaithersburg, MD: Aspen Publ.

91. Hendriks A. 1999. Disabled persons and their right to equal treatment: allowing differentiation while ending discrimination. In *Health and Human Rights: A Reader*, ed. JM Mann, S Gruskin, MA Grodin, GJ Annas, pp. 113–29. New York: Routledge
92. Hibbs JR, Benner L, Klugman L, Spencer R, Macchia I, et al. 1994. Mortality in a cohort of homelesss adults in Philadelphia. *N. Engl. J. Med.* 331:304–9
93. Hilts P. 1996. Fine particles in air cause many deaths, study suggests. *N. Y. Times*, May 9, p. B10
94. Hinkle LE, Loring WC, eds. 1977. *The effect of the manmade environment on health and behavior. DHEW Publ. (CDC)77-8318*, US Public Health Serv., Atlanta
95. Israel BA. 1985. Social networks and social support: implications for natural helper and community level interventions. *Health Educ. Q.* 12:65–80
96. Israel BA, Checkoway B, Schulz A, Zimmerman M. 1994. Health education and community empowerment: conceptualizing and measuring perceptions of individual, organizational and community control. *Health Educ. Q.* 21:149–70
97. Israel BA, Schulz AJ, Parker EA, Becker AB. 1998. Review of community-based research: assessing partnership approaches to improving public health. *Annu. Rev. Public Health* 19:173–202
98. Jacobs J. 1961. *The Death and Life of Great American Cities*. New York: Vintage. 458 pp.
99. Jargowsky PA. 1997. *Poverty and Place: Ghettos, Barrios and the American City*, pp. 29–58. New York: Russell Sage Found.
100. Jencks C. 1994. *The Homeless*. Cambridge, MA: Harvard Univ. Press. 161 pp.
101. Jones-Correa M. 1998. *Between Two Nations: The Political Predicament of Latino Immigrants in New York City*. Ithaca, NY: Cornell Univ. Press. 272 pp.
102. Kadushin C, Reber E, Saxe L, Livert D. 1999. The substance abuse system. *Subst. Use Misuse* 34:1681–1710
103. Kass D, Freudenberg N. 1997. Coalition building to prevent childhood lead poisoning: a case study from New York City. In *Community Organizing and Community Building for Health*, ed. M Minkler, pp. 278–88. New Brunswick, NJ: Rutgers Univ. Press
104. Katz MF, Kreuter MW. 1996. Community assessment and empowerment. In *Principles of Public Health Practice*, ed. FD Scutchfield, CW Keck, pp. 147–57. New York: Delmar
105. Kawachi I, Kennedy BP, Lochner K, Protherow-Stith D. 1997. Social capital, income inequality and mortality. *Am. J. Public Health* 87:1491–99
106. Kawachi I, Kennedy BP, Wilkinson RG. 1999. Crime: social disorganization and relative deprivation. *Soc. Sci. Med.* 48: 719–31
107. Kelly J, Lawrence JS, Stevenson Y, Hauth AC, Kalichman, et al. 1992. Community AIDS/HIV risk reduction: the effects of endorsements by popular people in three cities. *Am. J. Public Health* 82:1483–89
108. Kelly KJ, Van Vlaenderen H. 1996. Dynamics of participation in a community health project. *Soc. Sci. Med.* 42:1235–46
109. Kennedy BP, Kawachi I, Lochner K, Jones C, Protherow-Stith D. 1997. (Dis)respect and black mortality. *Ethn. Dis.* 7:207–14
110. Kessler RC, McGonagle KA, Zhao S, Nelson CB, Hughes M, et al. 1994. Lifetime and 12-month prevalence of DSM-II-R psychiatric disorders in the United States. *Arch. Gen. Psychiatry* 51:8–19
111. Klepp KI, Halper A, Perry CL. 1986. The efficacy of peer leaders in drug abuse prevention. *J. Sch. Health* 56:407–11
112. Komaromy M, Grumbach K, Drake M, Vranizan K, Lurie N, et al. 1996. The role of black and Hispanic physicians in

providing care for underserved populations. *N. Engl. J. Med.* 334:1305–10
113. Kozol J. 1991. *Savage Inequalities*. New York: Crown. 272 pp.
114. Kramer L. 1989. *Reports from the Holocaust: The Making of an AIDS Activist*. New York: St. Martin's. 289 pp.
115. Krebs-Smith SM, Cook A, Subar AF, Cleveland L, Friday J. 1995. U.S. adults' fruit and vegetable intakes, 1989 to 1991: a revised baseline for the Healthy People 2000 objective. *Am. J. Public Health* 85:1623–29
116. Kreiger N, Birn A-E. 1998. A vision of social justice as the foundation of public health: commemorating 150 years of the spirit of 1848. *Am. J. Public Health* 88:1603–6
117. Kreiger N, Sidney S. 1996. Racial discrimination and blood pressure: the CARDIA study of young black and white adults. *Am. J. Public Health* 86:1370–78
118. Kretzmann JP, McKnight JL. 1993. *Building Communities from the Inside Out: A Path Towards Finding and Mobilizing Community's Assets*. Chicago: ACTA. 376 pp.
119. Kreuter M. 1992. PATCH: Its origin, basic concepts, and links to contemporary public health policy. *J. Health Educ.* 23:135–39
120. Lacey L. 1993. Cancer prevention and early detection strategies for reaching underserved urban, low-income black women: barriers and objectives. *Cancer* 72(Suppl.):1078–83
121. Ladd HF, Yinger J. 1991. *America's Ailing Cities: Fiscal Health and the Design of Urban Policy*. Baltimore, MD: Johns Hopkins Univ. Press. 348 pp. Updated ed.
122. Lang DM, Polansky M. 1994. Patterns of asthma mortality in Philadelphia from 1969 to 1991. *N. Engl. J. Med.* 331:1542–46
123. Deleted in proof
124. Lederberg JL, Shope RE, Oaks SC, eds. 1992. *Emerging Infections: Microbial Threats to Health in the United States*, pp. 34–112. Washington, DC: Natl. Acad.
125. Lehmann N. 1991. *The Promised Land: The Great Black Migration and How It Changed America*. New York: Vintage. 408 pp.
126. Lerman C, Glanz K. 1997. Stress, coping and health behavior. In *Health Behavior and Health Education Theory, Research, and Practice*, ed. K Glanz, FM Lewis, BK Rimer, pp. 113–38. San Francisco: Jossey-Bass. 2nd ed.
127. Lincoln CE, Mamiya LH. 1990. *The Black Church in the African American Experience*, pp. 115–63. Durham, NC: Duke Univ. Press
128. Link BG, Northridge ME, Phelan JC, Ganz M. 1998. Social epidemiology and the fundamental cause concept: on the structuring of effective cancer screens by socioeconomic status. *Milbank Mem. Fund Q.* 76:375–402
129. Link BG, Susser E, Stueve A, Phelan J, Moore RE, Struening E. 1994. Lifetime and five-year prevalence of homelessness in the United States. *Am. J. Public Health* 84:1907–12
130. Luepker RV, Murray DM, Jacobs DR, Mittelmark MB, Bracht N, et al. 1994. Community education for cardiovascular disease prevention: risk factor changes in the Minnesota heart health program. *Am. J. Public Health* 84:1383–93
131. Mahaffey K, Annest J, Roberts J. Murphy R. 1982. National estimates of blood lead levels: United States, 1976–1980: association with selected demographic and socioeconomic factors. *N. Engl. J. Med.* 307:573–79
132. Malgrem JA, Martin ML, Nicola RM. 1996. Health care access of poverty-level older adults in subsidized public housing. *Public Health Rep.* 11:260–63
133. Mann JM, Gostin L, Gruskin S, Brennan T, Lazzarine Z, Fineberg H. 1999. Health and human rights. In *Health and Human Rights Reader*, ed. JM Mann, S Gruskin,

MA Grodin, GJ Annas, pp. 7–20. New York: Routledge
134. Marmot MG, Fuhrer R, Ettner SL, Marks NF, Bumpass LL, Ryff CD. 1998. Contribution of psychosocial factors to socioeconomic differences in health. *Milbank Mem. Fund Q.* 76:403–48
135. Massey D. 1996. Into the age of extremes: concentrated affluence and poverty in the 21st century. *Demography* 33:395–412
136. Matte T. 1999. Reducing blood lead levels: benefits and strategies. *JAMA* 281: 2340–42
137. McClellan W, Wilber JA. 1985. A decade's experience with hypertension control programs in the United States: the empirical basis for a model of community control programs. In *Hypertension Control in the Community*, ed. JB Rosenfeld, DS Silverberg, R Viskiper. London: Libbey
138. McCord C, Freeman H. 1990. Excess mortality in Harlem. *N. Engl. J. Med.* 322:173–78
139. McGinnis JM, Foege WH. 1993. Actual causes of death in the United States. *JAMA* 270:2207–12
140. McKinlay JB. 1993. The promotion of health through planned sociopolitical change: challenges for research and policy. *Soc. Sci. Med.* 36:109–17
141. McLeroy KR, Bibeau D, Steckler A, Glanz K. 1988. An ecological perspective on health promotion programs. *Health Educ. Q.* 15:351–77
142. McLeroy KR, Kegler M, Steckler A, Burdine JM, Wisotzky. 1994. Community coalitions for health promotion: summary and further reflections. *Health. Educ. Res.* 9:1–12
143. Meier B. 1999. Cities turn to gun-tracing data for legal assault on industry. *N. Y. Times,* July 23, p. A16
144. Milewa T, de Leeuw E. 1996. Reason and protest in the new urban public health movement: an observation on the sociological analysis of political discourse in the healthy city. *B. J. Soc.* 47:657–70
145. Milio N. 1999. Priorities and strategies for promoting community-based prevention policies. In *Community-Based Prevention Programs That Work*, ed. RC Brownson, ES Baker, LF Novick, pp. 20–41. Gaithersburg, MD: Aspen
146. Minkler M, Wallerstein N. 1997. Improving health through community organization and community building. In *Health Behavior and Health Education Theory, Research and Practice*, ed. K Glanz, FM Lewis, BK Rimer, pp. 241–69. San Francisco: Jossey-Bass. 2nd ed.
147. Mukenge IR. 1983. *The Black Church in Urban America: A Case Study in Political Economy*. New York: Univ. Press Am.
148. Mumford L. 1961. *The City in History: Its Origins, Its Transformations and its Prospects*. New York: Harcourt Brace Jovanovich. 720 pp.
149. Nestle M. 1998. Hunger in the United States: policy implications. *Soc. Res.* 66:257–82
150. Northridge ME, Morabia A, Ganz ML, Bassett MT, Gemen D, et al. 1998. Contribution of smoking to excess mortality in Harlem. *Am. J. Epidemiol.* 147:250–58
151. Pappas G, Queen S, Hadden W, Fisher G. 1993. The increasing disparity in mortality between socioeconomic groups in the United States, 1960 and 1986. *N. Engl. J. Med.* 329:103–9. Erratum. 1993. *N. Engl. J. Med.* 329:1139
152. Parker EA, Shultz AJ, Israel BA, Hollis R. 1998. East side Detroit village health worker partnership: community-based lay health advisor intervention in an urban area. *Health Educ. Behav.* 25:24–45
153. Patton C. 1990. *Inventing AIDS*. New York: Routledge. 176 pp.
154. Pear R. 1999. Clinton plan to seek out those eligible for food stamps. *N. Y. Times*, July 14, p. A16
155. Pittman KJ, Cahill M. 1992. *Youth and Caring. The Role of Youth Programs in the Development of Caring*, pp. 1–15.

Washington, DC: Acad. Educ. Dev.
156. Piven FF, Cloward RA. 1997. *The Breaking of the American Social Compact*. New York: New Press. 452 pp.
157. Polednak AP. 1997. *Segregation, Poverty and Mortality in Urban African Americans*. New York: Oxford Univ. Press. 184 pp.
158. Pope CA 3rd, Thun MJ, Namboodiri MM, Dockery DW, Dvans JS, et al. 1995. Particulate air pollution as a predictor of mortality in a prospective study of U.S. adults. *Am. J. Respir. Crit. Care Med.* 151:669–74
159. Reinarmen C, Levine HG, eds. 1998. *Crack in America: Demon Drugs and Social Justice*. Berkeley: Univ. Calif. Press. 388 pp.
160. Ricardo IB. 1994. Life choices of African-American youth living in public housing: perspectives on drug trafficking. *Pediatrics* 93:1055–59
161. Rivo M, Gray K, Whitaker M, Coward R, Liburd LC, et al. 1992. Implementing PATCH in public housing communities: the District of Columbia experience. *J. Health Educ.* 23:148–52
162. Roberts J. 1995. America: a hesitant downward trend. *Br. Med. J.* 310:8
163. Rodriquez-Trias H. 1994. The women's health movement: women take power. In *Reforming Medicine: Lessons of the Last Quarter Century*, ed. VW Sidel, R Sidel, pp. 107–12. New York: Pantheon
164. Rosen G. 1975. *Preventive Medicine in the United States, 1900–1975: Trends and Interpretations*. New York: Sci. Hist. Publ. 94 pp.
165. Rosner D, ed. 1995. *Hives of Sickness: Public Health and Epidemics in New York City*. New Brunswick, NJ: Rutgers Univ. Press. 223 pp.
166. Rossi P. 1991. *Down and Out in America*. Chicago: Univ. Chicago Press. 264 pp.
167. Rowland D, Salganicoff A, Keenan PS. 1999. The key to the door: Medicaid's role in improving health care for women and children. *Annu. Rev. Public Health* 20:403–26
168. Sampson RJ, Raudenbush SW, Earls F. 1997. Neighborhoods and violent crime: a multilevel study of collective efficacy. *Science* 277:918–24
169. Sargent JD, Brown MJ, Freeman JL, Bailey A, Goodman D, Freeman DH. 1995. Childhood lead poisoning in Massachusetts communities: its association with sociodemographic and housing characteristics. *Am. J. Public Health* 85:528–34
170. Saxe L, Rebor E, Hallfors D, Kadushin C, Jones C, et al. 1997. Thinking globally, act locally: assessing the impact of community-based substance abuse prevention. *Eval. Program Plan.* 20:357–66
171. Sentencing Project. 1998. *Prison Population, Projection and Analysis*. Washington, DC: Sentencing Project. 20 pp.
172. Shea S, Basch C, Wechsler H, Lantigua R. 1996. The Washington Heights-Inwood Healthy Heart Program: a 5-year report from a disadvantaged urban setting. *Am. J. Public Health* 86:166–71
173. Shea S, Basch C, Lantigua R, Wechsler H. 1992. The Washington Heights-Inwood Healthy Heart Program: a third generation community-based cardiovascular disease prevention program in a disadvantaged urban community. *Prev. Med.* 21:203–17
174. Skinner CS, Sykes RK, Monsees BS, Andriole DA, Arfken CL, Fisher EB. 1998. Learn, share and live: breast cancer education for older, urban minority women. *Health Educ. Behav.* 25:146–59
175. Sommerfeld M. 1999. Casey goes to bat for families. *Chron. Philan.* 11(17):1, 9
176. Sorenson G, Emmons K, Hunt MK, Johnston D. 1998. Implications of the results of community intervention trials. *Annu. Rev. Public Health* 19:379–416
177. Speers MA, Schmid TL. 1995. Policy and environmental interventions for the prevention and control of cardiovascular diseases. *Health Educ. Q.* 22:476–77

178. Sparks CH, Bar On BA. 1985. *A Social Change Approach to the Prevention of Sexual Violence Against Women. Stone Cent. Dev. Serv. Stud. Ser. 83-08*, pp. 1–18. Wellesley, MA: Wellesley Coll. Stone Cent.
179. Spickard WA, Dixon GL, Sarver FW. 1994. Fighting back against America's public health enemy number one. *Bull. NY Acad. Med.* 71:111–35
180. Stack CB. 1974. *All Our Kin: Strategies for Survival in a Black Community*. New York: Harper and Row. 175 pp.
181. Steckler A, Orvill K, Eng E, Dawson L. 1989. *Patching it Together: a Formative Evaluation of CDC's Planned Approach to Community Health (PATCH) Program*, pp. 1–15. Chapel Hill, NC: Univ. North Carolina
182. Stone L. 1992. Cultural influences in community participation in health. *Soc. Sci. Med.* 35(4):409–17
183. Susser M. 1995. Editorial: the tribulations of trials—interventions in communities. *Am. J. Public Health* 85:156–58
184. Syme SL. 1998. Social and economic disparities in health: thoughts about intervention. *Milbank Mem. Fund Q.* 76:493–505
185. Terris M. 1999. The neoliberal triad of anti-health reforms: government budget cutting, deregulation, and privatization. *J. Public Health Policy* 20:149–67
186. Thomas SB, Quinn SC. 1991. The Tuskegee syphilis study, 1932–1972: implications for HIV education and AIDS risk reduction programs in the Black community. *Am. J. Public Health* 81:1498–1505
187. Thomas SB, Quinn SC, Billingley A, Caldwell C. 1994. The characteristics of northern black churches with community health outreach programs. *Am. J. Public Health* 84:575–79
188. Tsouras A. 1995. The WHO Healthy Cities Project: state of the art and future plans. *Health Promot. Int.* 10(2):133–41
189. Tyler CW, Petersen HB. 1998. Family planning programs and practices: an epidemiological viewpoint. In *Public Health and Preventive Medicine*, ed. RB Wallace, pp. 1187–205. Stamford, CT: Appleton & Lange. 14th ed.
190. Ugarte C, Duarte P, Wilson K. 1992. PATCH as a model for development of a Hispanic health needs assessment: the El Paso experience. *J. Health Educ.* 23:153–56
191. United Hospital Fund. 1999. *Taking Steps, Losing Ground: The Challenge of New Yorkers Without Health Insurance*, pp. 1–6. New York: United Hosp. Fund
192. United Nations. 1948. *Universal Declaration of Human Rights*. Approved December 1948. New York: United Nations
193. United Nations. 1966. *International Covenant on Economic, Social and Cultural Rights*. Approved December 1966. New York: United Nations
194. United States Bureau of the Census. 1989. *Money Income and Poverty Status in the United States—1989*. Washington, DC: US Bur. Census
195. United States Bureau of the Census. 1995. *Statistical Abstract of the United States: 1995*. Washington, DC: US Bur. Census
196. United States Department of Health and Human Services. 1991. *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*. Washington, DC: US Govt. Print. Off. 692 pp.
197. United States Department of Health and Human Services. 1998. *Healthy People 2010: National Health Promotion and Disease Prevention Objectives*. Washington, DC: US Dep. Health Hum. Serv. (Draft)
198. United States Department of Housing and Urban Development. 1999. *State of the Cities: 1999*. Washington, DC: US Govt. Print. Off.
199. Vaid U. 1996. *Virtual Equality: The Mainstreaming of Gay and Lesbian Liberation*. New York: Double Day. 464 pp.
200. Verheij RA. 1996. Explaining urban-rural variations in health: a review of

interactions between individual and the environment. *Soc. Sci. Med.* 42:923–35
201. Wallace D, Wallace R. 1998. *A Plague on Your Houses: How New York Was Burned Down and National Public Health Crumbled*. New York: Verso. 222 pp.
202. Wallace R, Wallace D. 1993. The coming crisis of public health in the suburbs. *Milbank Mem. Fund Q.* 71:543–64
203. Wallace R, Wallace D. 1997. Community marginalisation and the diffusion of disease and disorder in the United States. *Br. Med. J.* 314:1341–45
204. Wallack LM, Dorfman S, Jernigan D, Themba M. 1993. *Media Advocacy and Public Health: Power for Prevention*, pp. 1–25. Newbury Park, CA: Sage
205. Wallerstein N. 1992. Powerlessness, empowerment and health: implications for health promotion programs. *Am. J. Health Promot.* 6:197–205
206. Weinberg DH. 1998. *Press Briefing on 1997 Income and Poverty Estimates*. Washington, DC: US Census Bur.
207. Weiss CH. 1998. *Evaluation: Methods for Studying Programs and Policies*. Upper Saddle River, NJ: Prentice Hall. 2nd ed.
208. West C. 1993. *Race Matters*, pp. 9–20. Boston, MA: Beacon
209. Whitehead TL, Peterson J, Kaljee L. 1994. The "hustle": socioeconomic deprivation, urban drug trafficking, and low-income, African-American male gender identity. *Pediatrics* 93:1050–54
210. Wickizer T, Von Korff M, Cheadle A, Maeser J, Wagner E, et al. 1993. Activating communities for health promotion: a process evaluation method. *Am. J. Public Health* 83(4):561–67
211. Williams AF. 1992. Decline in alcohol-impaired driving and crashes and why it occurred. *Alcohol Drugs Driv.* 8:71–76
212. Williams T, Kornblum W. 1995. Public housing projects as successful environments for adolescent development. *Ann. NY Acad. Sci.* 749:153–76
213. Wilson WJ. 1987. *The Truly Disadvantaged: The Inner City, the Underclass, and Public Policy*. Chicago, IL: Univ. Chicago. 254 pp.
214. Wilson WJ. 1996. *When Work Disappears: The World of the New Urban Poor*. New York: Knopf. 322 pp.
215. Winkelby MA. 1994. Editorial: the future of community-based cardiovascular disease intervention studies. *Am. J. Public Health* 84:1369–72
216. Winslow C-EA. 1984. The evolution and significance of the modern public health campaign. *J. Public Health Policy*. 65 pp.
217. Woelk GB. 1992. Cultural and structural influences in the creation of and participation in community health programs. *Soc. Sci. Med.* 35:419–24
218. Wohlfeiler D. 1997. Community organizing and community building among gay and bisexual men: the STOP AIDS Project. In *Community Organizing and Community Building for Health*, ed. M Minkler, pp. 230–43. New Brunswick, NJ: Rutgers Univ. Press
219. World Health Organization. 1986. Ottawa Charter for health promotion. *Health Promot. Int.* I:iii–iv
220. World Health Organization. 1997. *The Jakarta Declaration on Health Promotion in the Twenty-First Century*. Geneva: WHO. 12 pp.
221. Deleted in proof.
222. World Resources Institute. 1996. *World Resources 1996–97: The Urban Environment*, pp. 31–56. New York: Oxford Univ. Press
223. Yeich S. 1994. *The Politics of Ending Homelessness*. Lanham, MD: Univ. Press. 101 pp.
224. Yen I, Syme SL. 1999. The social environment and health. *Annu. Rev. Public Health* 20:287–308
225. Zald MN, McCarthy JD, eds. 1987. *Social Movements in an Organizational Society: Collected Essays*. New Brunswick, NJ: Transaction. 435 pp.