Community-Based Health Education for Urban Populations: An Overview

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The history of public health has been intimately linked with the history of cities. Cities are both the birthplaces of the great epidemics of infectious diseases, environmental pollution, and social problems such as addiction and violence and the source of public health innovation such as clean water systems, public sanitation, and the community health education campaign.[1-4]

In the broader society, cities have also had this dual identity. On one hand, they are the centers of human civilization, the places that draw people from the countryside to find work, culture, and excitement.[5] On the other hand, the neon lights and anonymity of "sin city" are believed to lure people into lives of dissipation and ill health. Urban crime, poverty, and pollution exemplify the dangers of the city.

The urban physical and social environments have a profound impact on health and disease. Moreover, an increasing proportion of the world's population now lives in cities.[6] Yet, in the past decades, public health researchers have shown remarkably little interest in the urban environment as an object of study. Social epidemiologists have generally focused on other variables such as class, race, ethnicity, gender, or poverty status to explain differences in patterns of health and disease. Health education researchers have primarily posited social psychological theories that offer generic explanations of individual or group health behavior rather than an understanding of the interactions between a particular social and physical environment and behavior. As a result, public health professionals working with urban populations have a limited body of epidemiological and intervention research to guide their practice.

The evidence that does exist suggests that urban populations, especially low-income residents of cities, bear a disproportionate burden of ill health. Rates of such diverse conditions as HIV infection, asthma, lead poisoning, violence, and substance abuse are higher in urban than nonurban areas.[7-13] Rural and suburban populations also face serious health problems. But the combination of increasing urbanization and increasing concentration of poverty in urban areas—trends occurring both in the developed and developing world—means that a growing proportion of the world's health problems is now found in cities.[6,7] Furthermore, the close links between cities and their surrounding suburban and rural areas[14] allow health problems that go unchecked to move from urban to nonurban areas. Many U.S. suburbs are now experiencing rising rates of violence, substance abuse, and HIV infection—problems previously thought to be limited to urban areas.[15] A better understanding of the factors that shape the health status of urban populations may help to inform policies and programs that improve the health of suburban and rural populations as well. Indeed, it is unlikely that the United States will be able to achieve many of the

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Health Education & Behavior, Vol. 25 (1): 11-23 (February 1998)

health goals set out in Healthy People 2000[16] unless it finds new ways to promote health and prevent disease among urban low-income populations.

This special issue of *Health Education & Behavior* is the first of two issues on community-based health education for urban populations. The overall aim of these volumes is to address some of these gaps in the literature by presenting articles on urban health education practice and policy. The goals of this two-volume set are to familiarize readers with urban health education research and practice, to highlight policy issues that require attention, and to contribute to the creation of an urban health agenda for the next century.

Several recent developments suggest a renewed interest in urban health that provides new opportunities for health education and other public health practitioners and researchers.

- In the past 3 years, the Centers for Disease Control and Prevention (CDC) has initiated new programs to address urban health issues. For example, the CDC has funded urban research centers in Detroit, New York City, and Seattle designed to examine urban problems—such as violence, asthma, teen pregnancy, sexually transmitted diseases (STDs), HIV, and substance abuse—and to evaluate "what works" to improve the quality of life in urban areas.[17]
- In June 1996, the United Nations sponsored the Habitat II Conference on Human Settlements in Istanbul, Turkey. Representatives from governments and nongovernmental organizations from more than 100 nations gathered to chart new directions for urban programs and policy in both the Northern and Southern Hemispheres. New strategies for creating healthy cities in the 21st century are discussed in the report, *A Dialogue on Health in Human Settlements*,[18] which was prepared for the conference.
- Several national foundations—including the Robert Wood Johnson Foundation, the Annie E. Casey Foundation, the Ford Foundation, the W. K. Kellogg Foundation, and the Pew Charitable Trust—have established urban initiatives focusing on improving health or social service delivery in inner cities.
- In 1997, the American College of Physicians called for a presidential commission to develop a plan for a new "urban partnership initiative" to reduce the "urban health penalty" that deteriorating socioeconomic and environmental conditions impose on low-income urban dwellers.[19]

These developments suggest that this is an opportune time for new thinking on urban health promotion. The intent of these two special issues of *Health Education & Behavior* on community-based health education for urban populations is to stimulate innovative research, practice, and policy to improve the health of urban residents.

The articles in this issue highlight some of the current practices and policies in urban health education. Parker et al.[20] describe a lay health worker program created in the "urban villages" of Detroit. While the focus of these special issues is on the United States, any discussion of urban health must include a global perspective. de la Barra[21] examines the conditions of street children, particularly in the Southern Hemisphere. She analyzes the causes of increasing poverty among urban children and suggests policies and programs that can promote the health of this vulnerable population. Skinner and her colleagues[23] report on a program in St. Louis, Missouri, in which older African American women provide their peers with education and support aimed at promoting breast cancer screen-

ing. Wilson et al.[24] describe a countywide asthma intervention in Fresno, California, an area that includes multiethnic urban and rural populations. Finally, Hammett et al.[25] discuss health interventions in jails, prisons, and other criminal justice settings and suggest strategies for reaching an urban population at very high risk for various health problems. The following brief overview of the social characteristics of urban life constitutes a backdrop for the studies reported here.

WHAT IS A CITY?

The U.S. Census Bureau defines a metropolitan area as a city with a total population of at least 50,000 inhabitants or an urbanized core area of at least 50,000 inhabitants with another 50,000 people who are closely integrated socially and economically with the core.[26] In 1990, according to the U.S. Census Bureau, 80% of the U.S. population lived in metropolitan areas. 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.[26]

Based on the 1990 census, the Census Bureau defined 324 metropolitan areas in the United States. Three-fifths of the urban population and almost half (46%) of the total population of the United States lived in the 51 metropolitan areas with populations of one million or more. Using a narrower definition, about 65 million people, or one-quarter of the total population (and one-third of the metropolitan population), lived within the borders of the 200 cities with at least 100,000 inhabitants in 1992, sometimes referred to as central cities.[26] It is estimated that about 50% of the total population lived in suburban areas (including those that are part of a metropolitan region), and only 25% lived in rural areas.

In the past 20 years, the distinction between central cities and their surrounding metropolitan areas has become less clear. New urban and quasi-urban forms have emerged—for example, "minority," often segregated suburbs in Atlanta, Detroit, and Los Angeles;[27] "poverty" suburbs outside New York City, Philadelphia, and Detroit;[14] and "edge cities"[28] outside Boston, Chicago, and New York. More work is needed to understand the similarities and differences between central cities and their surrounding metropolitan areas and the role of regional policies and programs in promoting health.

Cities also have higher proportions of people with economic and social problems than the United States as a whole. On average, people living in the 100 largest cities are poorer, have higher unemployment rates, are more likely to live in female-headed households, and are foreign born and experience higher violent crime rates than the U.S. population as a whole.[7] Racial and ethnic minorities are also concentrated in cities. In 1990, 44% of the nation's almost 30 million African Americans lived in the 100 largest cities, more than triple their representation in the total population.[7,26] Of the 22 million Hispanics in the nation, 40% lived in these cities, more than four times the proportion in the total population.

In the developing world, cities have grown even more rapidly and pose even more daunting health and social challenges.[6,29] By the year 2000, more than half the world's population—3.3 billion people—will be living in urban areas.[6] In 1995, only 4 of the world's 25 largest cities (New York, Los Angeles, Paris, and Moscow) were in Europe or North America; the remaining 21 were in Central or South America, Asia, or Africa.[6] In 1988, the World Bank estimated that one-quarter of the developing world's poorest people lived in urban areas; by the year 2000, half of the developing world's poorest will reside in urban areas.[6]

CHARACTERISTICS OF URBAN AREAS

To understand how to promote health and prevent disease in cities, one must identify the unique characteristics that distinguish urban from nonurban areas and describe the impact of these factors on well-being. For health educators, the most important characteristics are population density, population diversity, the breadth and depth of social networks and community organizations, and the physical environment.

Population Density

By definition, cities have an abundance of people. Many of the distinctive features of urban life spring from this obvious fact. Cities are crowded, bustling, and energetic. Crowds can facilitate the transmission of infectious diseases,[30] and urban street life can also contribute to the spread of social diseases such as substance abuse and violence.[31,32] Crowding may also contribute to stress and its resulting physical and mental health problems.[33] Ironically, people can also get "lost in the crowd" in the city, contributing to social isolation and to weakened social values that in other settings may discourage addiction, violence, or risky sexual behavior.

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.[5] It also creates opportunities for community organization. Dense populations enable a division of labor that allows urban residents to specialize in highly skilled crafts or services.[5] The relationship between population density and health is complex.[33]

Population Diversity

Not only are cities highly populated, but they also have many different kinds of people. In the United States, cities are considerably more diverse than rural and suburban areas.[34] Thus, urban residents are likely to interact with people with different values, ethnicities, religions, and national origins, creating opportunities both for new knowledge and growth and for conflict. In addition, in both developed and developing nations, cities have experienced increasing concentrations of wealth and poverty.[6,35] The largest cities in the United States are home to both the poorest and the richest. Perceptions of inequity may contribute to disaffection, alienation, and social conflict.[35] The concentration of extreme poverty in cities has had a profound impact on the health status of urban populations, leaving some groups with an overwhelming burden of ill health.[36-39] Both infectious diseases and social pathology can move from these disadvantaged groups to other more privileged sectors of the urban population, creating an opportunistic incentive for society as a whole to take action.

Urban Social Networks and Community Organizations

The combination of population density and diversity creates the conditions for multiple social networks in cities. Whether individuals want to maintain sobriety or find drugs, worship with Christians or Moslems, or join the local ethnic club or the chamber

of commerce, they will be able to find others who share their goals and will support them. 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) or increase risk (e.g., access to gangs or drug users). Urban health educators need to know how to identify existing social networks, assess their contributions to health and disease, and work with them in promoting well-being.

The links between different social networks within a city present public health officials with difficult choices. While the highest risk urban populations (e.g., the homeless, active drug users, street children) generally constitute a relatively small proportion of the population, these particularly vulnerable groups usually interact with others at lower risk, raising the potential for the transmission of infectious diseases and social conditions such as addiction and violence. Public health officials can respond in at least two ways: by seeking to isolate vulnerable groups or by working to integrate them into the mainstream. The perceived benefits of the former strategy are that it contains ill health within a small population and is usually less expensive. The risks are that it will fail to contain disease, especially given population mobility and the interlocking networks within cities. Interrupting the social and economic factors that marginalize vulnerable groups (e.g., reducing homelessness, unemployment, or addiction) may cost more in the short run but offers benefits beyond the categorical condition in question (e.g., tuberculosis, violence, or sexually transmitted diseases). By seeing vulnerable populations as "canaries in the mine," rather than as a social burden, it may be possible to develop policies that benefit the population as a whole.[40] Integrating disenfranchised groups also seems to be a more ethical position, one that promotes social equity as well as health.

In addition to active informal social networks, cities have a wealth of neighborhood organizations, religious groups, and community service providers. These organizations meet perceived needs and form an important foundation for health promotion. Some are linked to regional and national groups, creating opportunities for integrating health work at various levels. The multiplicity of organizations within a defined geographic area also provides opportunities to organize coalitions and partnerships that can cut across issues, neighborhoods, or subpopulations.[41] At the same time, the potential for organizational battles for control, resources, and populations may be increased.[41]

The availability of interconnected social networks, community organizations, and coalitions constitutes fertile ground for the growth of social movements.[42,43] Thus, it is probably not accidental that many of the movements that have had a significant impact on health in the past two decades originated in urban areas. Both the women's movement and the gay and lesbian movement, for example, are primarily urban in character, and the civil rights and environmental justice movements also had urban (as well as rural) roots.[44-47] By linking with social movements, health educators may be able to increase their impact on the health of urban populations.

The Urban Physical Environment

Cities also have a distinctive physical environment. In most cities, the human-built environment overshadows the natural environment, affecting physical and mental health in largely unknown ways.[48] Several studies document a higher level of pollutants in cities, contributing to higher rates of asthma, other lung diseases, and possibly heart disease.[9,49-51] Lead poisoning, a major health problem for children,[10] is primarily an urban problem. Some research suggests that the design of cities can affect both perceptions of safety and

actual levels of violence.[52,53] On the other hand, the physical diversity of the urban environment can support and reinforce human diversity, making urban areas stimulating, enriching, and exciting.[54]

HETEROGENEITY OF CITIES

One of the difficulties facing urban researchers is the heterogeneity of cities. Not only is Seattle a very different city from Detroit, for example, but within a single city, neighborhoods can vary dramatically in ethnicity, income, and environmental conditions.[35] Citywide vital statistics often mask the wide disparities between various population groups. Thus, generalizations about "the urban condition" are subject to challenge.

To better understand the impact of cities on health, researchers need to make four different types of comparison. First, they need to compare cities to each other. Why, for example, did El Paso, Texas, have a 1993 gonorrhea rate of 45 cases per 100,000 while in St. Louis, Missouri, the rate was 1,457 per 100,000?[7]

Second, researchers need to examine differences and similarities between urban and nonurban (rural and suburban) areas. What are the specific characteristics of urban areas that contribute to higher rates of asthma or homicide? Such an understanding may lead to the development of interventions that can reduce these disparities.

Third, researchers need to compare neighborhoods and populations within a city. Why does East Harlem have rates of infant mortality, asthma hospitalizations, and homicide that are two to four times higher than those on the adjacent Upper East Side of Manhattan?[55] Levels of poverty are an obvious explanation. Only by charting the specific ways that poverty influences various health outcomes, however, can local urban and public health planners create a priority list for minimizing cities' most harmful effects, even as broader national efforts at equity are pursued.

Finally, researchers need to make historical comparisons within individual cities and in cities across the United States (or elsewhere). What factors accounted for the rapid spread of HIV infection in some U.S. cities but not others in the late 1970s and early 1980s? How will the new welfare policies affect the health of residents of Newark? Will the federal empowerment zones lead to changes in the health of people living in these areas? How has the loss of manufacturing jobs affected the well-being of Baltimore neighborhoods?

Only when we have a body of studies that makes one or more of these four types of comparisons and that integrates findings across health conditions, cities, and populations can we begin to understand the dynamic process by which cities affect health and disease. Moreover, we need studies that use both quantitative and qualitative methodologies, that cut across academic disciplines, and that take a broad look at health and the quality of life as well as specific diseases. Such a body of literature will assist in the development of policies and programs that will promote health among urban populations.

COMMON THEMES IN URBAN HEALTH EDUCATION IN THIS ISSUE

Despite the diversity of settings, health and social conditions, and populations described in the articles in this issue, a few key interrelated themes appear repeatedly. These themes illustrate some of the common characteristics of urban areas, and the articles examine the ways that health educators have addressed these circumstances.

The Importance of Social and Economic Factors

Cities are shaped by powerful social and economic forces. As Parker et al.[20] explain, the social relations in Detroit's neighborhoods are the products of the civil rights movement, the 1967 riots, and the clash between auto unions and the auto industry, among others. This particular history has informed the consciousness of current neighborhood leaders, including those who participate in the East Side Village Health Worker Partnership project. It also both inspires those carrying out health mobilizations and offers cautionary lessons on unsuccessful strategies.

In another context, de la Barra[21] describes the current policies of international agencies, such as the World Bank and the International Monetary Fund, that encourage an expansion of the free market, the privatization of municipal services, and a reduced role for government. These policies, she concludes, have in fact worsened the status of the urban poor and contributed to an increase in the number of children who are marginally housed or live on the street.

The opportunities for health promotion and disease prevention within the criminal justice system described by Hammett et al.[25] result from national and local drug and crime control policies that target urban young adults, especially African Americans and Latinos. As a result, it is now easier for urban minority males to enter jail than higher education. This has profound implications for their future employment, social status, and health.

One of the most difficult challenges facing health educators is to understand and address the links between these broad social and economic forces and health behavior. A model proposed by the sociologist William Julius Wilson[36] suggests that the lack of social structures and employment opportunities that result from the loss of manufacturing jobs in inner cities creates the conditions for behaviors that lead to drug and alcohol addiction, teen pregnancy, and violence. Loss of entry-level manufacturing jobs in urban inner cities, for example, leads to high levels of unemployment and long-term joblessness. These contribute to social disorganization: weakened social networks, reduced collective supervision of children and adolescents, and declining participation in informal and formal community organizations.[36]

These factors reduce the capacity of families and communities to respond effectively to risk behavior related to drugs, sex, and violence. In the face of limited opportunities in the legitimate economy, the drug trade becomes an accessible route to economic survival, leading to further increases in risk behavior. Finally, the behavioral patterns that are perceived necessary to succeed in this environment (e.g., willingness to use violence, early parenthood as a symbol of adulthood) both increase risk and further distance people from more privileged society.[31,56]

This analysis suggests that interventions aimed at changing individual behavior and community environments must be integrated within broader policy changes to improve the economic health of low-income urban areas. Several authors in this issue share this insight, although more work is needed on practical strategies for achieving such linkages.

The Role of Social Capital

Several authors in this issue describe the value of human resources within urban low-income communities and their potential contributions to health promotion. These resources have recently been called "social capital." Robert Putnam,[57,58] a Harvard political scientist, describes social capital as the "features of social life—networks, norms

and trust—that enable participants to act together more effectively to pursue shared objectives" (p. 34).[58] He defines "civic engagement" as "people's connections with the life of their communities." Coleman,[59] a sociologist, emphasizes the contributions of families and relatives to improved outcomes for children and youth. Voluntary associations—such as neighborhood and block groups, parent-teacher associations, and youth programs—also help to improve urban neighborhoods and reduce social isolation.

In Detroit,[20] St. Louis,[23] and Pittsburg, California,[22] for example, the authors report that community residents themselves played a key role in planning and implementing the interventions. Participants' previous experiences and their links to existing social networks constituted the foundation of the health education initiatives. Even the poorest urban neighborhood has a dense and rich configuration of human relationships that can provide support, motivation, and direct assistance to reduce risky health behavior and community problems and to improve health conditions. In many urban communities, exchanges of social capital have been a traditional survival strategy.[60]

Kretzmann and McKnight[61] emphasize the importance of conducting an inventory of these community resources as the starting point of planning an intervention, a strategy they contrast with the usual needs assessment that documents only weaknesses. By acknowledging the importance of the social capital that urban community residents bring to the health promotion planning table, professionals can reduce the inequities that are often built into community and professional partnerships.

The Value of Work on Multiple Levels

Urban communities are complex environments. As previously described, broad external social forces such as suburbanization, job loss, immigration, and tax policy influence patterns of health and disease. Within cities, a vast array of public agencies and private interests influence public health. Control of lead poisoning, for example, requires action by public health departments, housing departments, landlords, health providers, schools, child care centers, and parents.[62] Convening these stakeholders to act together to achieve health goals can be a formidable task, as El-Askari et al.[22] note.

Several of the authors in this issue describe the strategies they have developed to address the complexity of urban life. Parker et al.[20] describe how village health workers educate community residents and their families, organize for community action, and advocate for policy change. Hammett et al.[25] discuss the importance of educating inmates, correctional staff, managers, and policy makers. Skinner et al.[23] worked with neighborhood health centers, health professionals, residents of housing projects, and others to promote breast cancer screening. The Fresno Asthma Project[24] worked with families, schools, community organizations, health care facilities, and health professionals. Each article describes interventions that took place on at least two levels (e.g., individual and organization) and sometimes four or more levels (e.g., individual, family, community, agency).

Hammett et al.[25] examine the role of an entire system in promoting health and preventing disease. The criminal justice system reaches significant sectors of urban populations that are sometimes deemed "hard to reach." Wilson et al.[24] chose an entire county as the unit of intervention, offering economies of scale not available to neighborhood-based programs. The advantages of intervening at the system level, rather than within a single or a few components of the system, include the ability to reach significant sectors of the population, the greater potential for institutionalization, and the

ability to link the various systems that affect the health of urban populations. On the other hand, finding the political will to change systems is not always easy and may require skills that health educators lack.[63]

The Tension Between Categorical and Comprehensive Approaches

Each of the authors in this issue confronts the tension between developing an intervention that focuses on a specific health problem and taking on the broader constellation of urban social problems that affect health. Given the common risk factors inherent in the urban environment—poverty, joblessness, inadequate housing and education, drug addiction, lack of access to health care—a strong case can be made for comprehensive approaches to urban health promotion. On the other hand, most funding streams continue to target single diseases.

The articles describe different solutions to this tension. The urban village health workers in Detroit[20] used a comprehensive community and leadership development model to engage community residents in defining problems of concern, then developed specific interventions to address specific health problems. de la Barra[21] calls for changes in international social policy but also the development of specific interventions to reduce particular risks for urban street children. The breast cancer program in St. Louis[23] uses a categorical approach but builds on the skills and experiences of women who have addressed other community health problems. Hammett et al.[25] and Wilson et al.[24] describe categorical interventions that target entire systems (i.e., the criminal justice system and a county health care system).

The Significance of Tailoring and Targeting

Urban communities may require health educators to make difficult choices about targeting and tailoring their programs. Targeting refers to the selection of a specific population for an intervention; tailoring refers to modifications within a program to ensure that it meets the needs of particular subpopulations. On one hand, population density makes it efficient to devise citywide programs that reach a broad cross-section of the population. On the other hand, the diversity of urban populations makes it necessary to, in the lingo of advertisers, "segment the population into specific markets."[64]

In a discussion of this issue related to HIV prevention, Des Jarlais and his colleagues[65] suggested that some services needed to be universally available (e.g., basic AIDS education and access to HIV testing and counseling), while others should be targeted at those at highest risk (e.g., intensive community education, case management). Deciding what proportion of resources to devote to these different levels is a political and public health decision.

Again, the authors in this issue describe different approaches. Skinner et al.[23] targeted a specific population—older African American women—for promoting breast cancer screening and tailored their program to that population alone. Parker et al.[20] modified an approach most often used in rural areas for use in a big city. Wilson and her colleagues[24] worked with ethnic organizations in Fresno to tailor the asthma education to the various Latino and Asian American populations living in the county.

A recent review of reports in the peer-reviewed literature of interventions designed to prevent heart disease, HIV infection, substance abuse, and violence in U.S. cities[66] found

that, while many interventions targeted multiple urban populations, few described specific efforts to tailor the program to meet the special needs of the subgroups. Perhaps the lesson for health educators is to specify from the start the specific populations to be targeted and the process that will be used to tailor the intervention to these populations.

CONCLUSION

In the final analysis, many of the challenges that urban health educators confront are, in principle, no different from those that face health educators working in other settings. In practice, however, the density, diversity, and complexity of the urban environment pose specific demands that must be addressed if health promotion and disease prevention are to reduce the unique burden of ill health that city dwellers experience.

Daniel Sharp, the president of the American Assembly, has observed that "cities are critical to America's economic, political, and social future. It is in our cities that the interactions must occur that will determine if the nation functions as an integrated, civil society, or if class rigidities and racial and social disorder will characterize our future" (p. 9).[67]

As the 20th century draws to a close, health educators have a historic opportunity to contribute to improving the well-being of urban communities. It is hoped that the articles in this and the subsequent special issue will assist health educators to define a new agenda for urban health promotion. This agenda must be grounded in the realities of urban life and incorporate the lessons learned over the past few decades. Its aims are no less than to make healthy cities a reality for the 21st century.

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