



Healthy city: the diagnosis of the urban territory through the social determinants of health: Maracanaú case

Cidade saudável: o diagnóstico do território urbano por meio dos determinantes sociais de saúde: o caso Maracanaú

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ABSTRACT

To understand the urban territory through the analysis of Social Determinants of Health (SDOH) as a prerequisite for structuring a Healthy City Project. This research was characterized as a documentary survey through the Laws, Master Plan and Management Reports of the City of Maracanaú and in the Government Health Information Notebooks. The analysis took place through the reading and identification of what was about the SDOH, using Content Analysis. The results brought two categories of analysis that structured a diagnosis of the area, mapping the weaknesses found with regard to the SDOH analyzed, such as: population growth, mortality rate, urban violence, among others. It is believed that the diagnosis of the area carried out through the SDOH made it possible to identify the intervention points that can be used for the preparation of a Healthy City Project.

Keywords: Healthy City. Social Determinant of Health. Urban territory.

RESUMO

Compreender o território urbano por meio da análise dos Determinantes Sociais de Saúde (DSSs) como pressupostos para a estruturação de uma Agenda de Cidade Saudável. Esta pesquisa se caracterizou como um levantamento documental por meio das leis, plano diretor e relatórios de gestão da cidade de Maracanaú e nos cadernos de informação em saúde do governo. A análise se deu pela leitura e identificação do que versava sobre os DSSs, utilizando-se a análise de conteúdo. Os resultados trouxeram duas categorias de análise que estruturaram um diagnóstico do território, mapeando as fragilidades encontradas no que diz respeito aos DSSs analisados como crescimento demográfico, taxa de mortalidade, violência urbana, dentre outros. Acredita-se que o diagnóstico do território realizado por meio dos DSSs possibilitou identificar os pontos interventivos que possam ser utilizados para a preparação de uma agenda de cidade saudável.

Palavras-chave: Cidade Saudável. Determinante Social de Saúde. Território urbano.

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INTRODUCTION

In the last decades, Brazilian cities have become the scene of great cultural and productive centers, boosting human and social development, at the same time that the demographic, environmental, social and economic problems emerged accentuated by the way of organization and global production. In this dichotomous scenario, inequities and inequalities are targets of concern in all areas of public management, noting that only a good urban planning may be able to build “new” models of development and interventions, enabling better health conditions, expanding well-being that must be a key factor of public policies.

In this perspective, since 1970, The World Health Organization (WHO) started promoting international conferences aiming to stimulate practices of health promotion habits, substantiating public policies¹. As a result, the program health cities² was created, considering that the cost of unhealthy cities is paid by social and health services, insurance companies and society as a whole. On the other hand, healthy cities can make significant savings with services and boost local productivity³. The main core of the program must be to maximize human development for all city dwellers; have health and human development as key factors for urban decision making, giving special attention to the reduction of health inequalities⁴. Thus, healthy city is considered as an international strategy, proposed the WHO to boost long-term health and sustainable development, articulating actions that stimulate the population well-being of a certain territory².

Therefore, the Social Determinants of Health - SDOH - were used in this study as a prerequisite for understanding the urban territory and structuring a healthy city project, considering that the long-term consequences, of how urban territories are planned and projected, might modify up to 80% of health of any community due to its influence on the SDOH^{4,5}.

The SDOH, according the definition of the National Commission on Social Determinants of Health (CNDSS), are social, economic, cultural, ethical/racial, psychological and behavioral factors that influence on

the occurrence of health problems and their risk factors for the population⁵. WHO claims that the SDOH are the social conditions in which people live and work², understood as the uneven distribution in three factors: 1- material such as housing, food, work, sanitation among others; 2 – psychosocial and behavioral factors; and 3 – biological factors^{5-6,7}. For this, Dahlgren and Whitehead (1991) model was used a reference base^{6,7}. Dahlgren; Whitehead model organizes the understanding of the SDOH in three layers: the first is the nuclear one – referring to individuals with their biological traits that influence their health. Lifestyle is in the second one, which is also capable of influencing health conditions due to decision making. In the third one social and community networks are found, highlighting the level of support and empowerment of a community. Finally, (4th layer) conditions of life and work are found, with the view of factors of territory diagnosis, which is exactly the focus of investigation⁵⁻⁶.

Given this reasoning, we hypothesized that the study of the SDOH can enable the diagnosis of the city territory, leading to a better understanding of territoriality and appropriation that characterizes the first step for the implementation of healthy city project. In order to deeply understand the concepts of territoriality and appropriation, we used the environmental psychology, as it is the psychology field that is committed to studies of person/environment interaction^{8,9}. The environmental psychology makes it clear that territoriality is a pattern of behavior of a person or group which can be intentional or not, regarding the appropriation and possession of a place¹⁰⁻¹¹, packed with the multiplicity of factors, be them personal, socio-cultural or contextual, allowing the understanding of social interactions and appropriation of the physical surroundings^{8,9}. It is from the ownership that the formation of territoriality starts the process of creating a space to live and express your own sociality¹⁰. Through control of access, physical and subjective borders, performed by the community, health promotion practices are built.

Given the above, we selected factors of person/environment interaction x the SDOH, as indicators for

the construction of a healthy city project: geographic characterization; economic conditions; population growth; child mortality indicators and the arboviruses. Thus, this study aimed to understand the urban territory through the analysis of the SDOH as a prerequisite for structuring a healthy city project.

METHODOLOGY

DELIMITATION OF STUDY AND ETHICAL ISSUES

Cross-sectional documentary research carried out through secondary data analysis of the research named “Os Caminhos de uma Cidade Saudável: uma Experiência em Maracanaú”. This research is in accordance with the ethical principles in the resolution nº 466/12 of the National Health Council, approved by the Research Ethics Committee of Universidade de Fortaleza (UNIOR) under nº 3.152.503.

EMPIRICAL FIELD

The chosen city was Maracanaú, located in the metropolitan area of Fortaleza-CE, known for having the largest industrial pole of Ceará in its territory, ensuring its economic importance in this state. Its urbanization process occurred with the implementation of the industrial pole together with the construction of several housing estates at the beginning of the 80s. These two factors (industrial pole and housing estates) made the city an attraction due to the opportunity of employment and home ownership. According to data obtained in the Municipal Basic Profile– PBM – its population currently reaches 223.188 inhabitants, losing to Fortaleza, the state capital, which has 2.627.482 and Caucaia, metropolitan area of Fortaleza, with 362.223 inhabitants.

DATA COLLECTION

Data collection followed this chronological order: law nº555/1997, law nº1.945/2012, Organic Law of the Municipality (2016), Municipal Human Deve-

lopment Index (MHDI), basic profile of Maracanaú (2016 and 2017), Long-term plan of 2014-2017, Municipal Management Report (2017 and 2018) of health secretaries, social assistance and health information notebook of the government of Ceará (2017).

Access to the laws and long-term plan were carried out through the website (www.maracanau.ce.gov.br/) of the municipality. MHDI and basic profile of the city were accessed through the Instituto de Pesquisa e Estratégia Econômica do Ceará (IPECE) on the website <https://www.ipece.ce.gov.br/>. Reports of municipal management of secretaries were obtained in PDF format after requesting them through an official letter sent to each secretary. Finally, the health information notebook (2017) was available at the website <https://www.saude.ce.gov.br/> of the government of the state of Ceará.

DATA ANALYSIS

After obtaining the documents, a very careful reading to identify aspects concerning the SDOH was performed. The following SDOH were chosen for the territory diagnosis: geographic characteristics, economic conditions and population growth, as they enable the understanding of the territory characteristics; well-being conditions and public supply conditions of health, education, leisure, housing, among others, which were aligned with Dahlgren; Whitehead⁷ model. Yet, we selected indicators of cause-specific mortality, child mortality and arboviruses, which were available in the report of health secretary management (2017) and health information notebook (2017), enabling the description of the population health status; epidemiological investigation and sanitation interventions evaluation; aspects which are deeply related with territoriality, involving socio-cultural and economic factors.

We used Excel to tabulate data in variables organization (demographic growth; cause-specific mortality, child mortality and arboviruses), and for the other documents, Bardim¹² content analysis was used, obtaining two categories: 1- geographic, economic and demographic characteristics and; 2- health indicators.

RESULTS AND DISCUSSION

To implement a healthy city project, it is necessary to perform a participative management together with popular empowerment, thus planning health promotion strategies¹³⁻¹⁴. Some steps are key for the organization of this project, such as: report of the city health status; actions through the creation of alliances and partnerships; development of community abilities, community participation, healthy public policy³⁻⁴⁻¹⁴.

Based on this information the territory diagnosis becomes the first step towards the understanding of a city health status. To comprehend it, it is necessary to understand the person/environment interaction using the Environmental Psychology (EP) as a theoretical support.

[...] it studies the person in his/her physical and social context, aiming to extricate the logic of the person/environment interaction, emphasizing the perceptions, attitudes, evaluations and environmental representations of a part, and the other, the behaviors and actions that come together^{8:582}.

Within this perspective of person/environment interaction that “actions of health promotion in the territory” are structured. The knowledge of public management of the real demands of urban territories occur with the territory diagnosis that can be defined through territoriality⁵. However, in the practice of territoriality performed by public management, the territorial division established according to administrative criteria is evident, not characterizing the territory, it does not enable the understanding of potentialities and fragilities of the community and does not make the collective territorial empowerment possible.

CATEGORY 01 – GEOGRAPHIC, ECONOMIC AND DEMOGRAPHIC CHARACTERIZATION OF THE URBAN TERRITORY

The city of Maracanaú has a territorial extension of 105 km², 22km away from the capital city, it

belongs the metropolitan area of Fortaleza (RMF) which consists of the following municipalities: Aquiraz, Caucaia, Chorozinho, Eusébio, Fortaleza, Guaiuba, Horizonte, Itaitinga, Maranguape, Maracanaú, Pacajus, Pacatuba and São Gonçalo do Amarante. In 2018, there were some changes in the territorial boundaries after the signature of Termo de Ajuste de Divisas do Projeto Atlas de Divisas Georreferenciadas dos Municípios Cearenses (Term of Adjustment of the Atlas Project of Georeferenced boundaries of Ceará Municipalities) and law number 16.821 on January 09, 2019. The municipalities are still under adaptation with the division of streets and responsibilities with public equipment.

According to the Municipal Basic Profile, economically, the city has the second highest revenue in the state of Ceará, a classification that was given due to the important Industrial Park which ensures around 50% of all Ceará’s economic production. This fact took it to the seventh national position of the best cities for business in Brazil (Report of Municipal Health Management, 2017).

Due to the demand of the Industrial Park the city had, in the last 20 years, increased rates of population growth and acceleration of the urbanization process, increasing from 99,31% in 2010 to 99% in 2018. This growth rate, in a short period of time, brought about structure problems to the city such as disordered land occupation with increased areas of invasion; areas not supplied with basic services, health equipment centralization, violence, among others (Report of Municipal Health Management, 2017). Common aspects not generated by the speed of urbanization, but by the unplanned way land occupation occurred, result in situations that are unsustainable for the Public Power and collectivity¹⁵. The rapid and unplanned process of urbanization through which cities have been undergoing worldwide has been pointed out as one of the most important vectors in the production of inequities in health, associated with the increase of poverty and lack of adequate services for the emerging needs of a population that are more vulnerable and exposed to bad conditions of physical and social environment¹⁵⁻¹⁶.

This information corroborate the understanding that the urban territory is delimited by laws and agreements of public management without any community consultation or intervention. A vertical policy which did not consider the aspects of person/environment interaction was realized. This practice is antagonistic to the premise of Healthy City Project, which has the development and participation of communities in decision-making processes as one of its strategies²⁻³. With the community participation it is possible for the community to be recognized by the organization of their territory and their practices of appropriation of places and use of goods and services⁴⁻¹¹.

A good example of fragilities generated in the territory by the vertical policies is the disordered population growth associated with the unequal income distribution, which can be exemplified observing the quantitative data of families (Table 01) living in poverty in the city. Poverty is characterized by an income that is insufficient to reach goods and essential services which enable people's survival¹⁷. The increase in poverty is directly proportional to the growth of inequality that occurs with the increasing inadequate income distribution, together with the precariousness of social public policies¹⁷. The rapid population growth caused by the urbanization process is inversely proportional to the urban planning, denying the access to goods and services to part of the population that automatically becomes poorer⁶⁻¹⁸⁻¹⁹.

Table 1. Quantitative of families X poverty

Number Of Families	Family Income	Poverty
10.735	75,00 Reais	Extreme poverty
8.867	145,00 Reais	Poverty

Source: Developed by the author

In Maracanaú data allow to observe that the sum of the families quantitative obtains a total of 19.602 who are within the profile of Bolsa Família program. However, according to registration, there are 18.796 families who benefit from it, verifying that 806 do not receive it (Report of Municipal Management of Health

and Assistance Secretaries, 2017/2018). It is interesting to note this discrepancy, as the city stands in the second place regarding revenue in the state of Ceará, the seventh national place of business cities, a good classification of HDI in 2016, however with a high rate of social inequality expressed in income distribution. Such reality is not a privilege of this region, but a Brazilian tendency, because,

[...] despite the investment made in the last decade to promote employment and income improvement (BRAZILIAN INSTITUTE OF GEOGRAPHY AND STATISTICS, 2010), the country still registers a great social inequality expressed in the way land is occupied, in the access to natural resources and income distribution. Such disparities reflect between regions, states and even in the same city¹⁸⁻¹⁹.

The socio-economic disparities of the territory¹⁹ state that the speed of urbanization is not the trigger for the territory problems itself, but the processes of unsustainable occupation and exploration, unattended by horizontal public policies that consider irregular constructions, the speculative ventures of big real estate companies, the shortages of goods and services for the less favored strata. “[...] the distribution and movement of people are, in a way, dictated by a social macrostructure of power that determines“ the right place for the right person”¹⁹⁻²²⁹.

Another point of analysis of the geographic, economic and demographic characterization of the urban territory was the provision of services and support for the elderly population. In 2017, the municipality reached a total of 15,960 elderly people, of whom 9,013 were female and 6,947 male. According to management reports, there are offers of specific services for the elderly at the Elderly Living Center, in Basic Health Units (UBSs), and physical activities performed by the Fire Department.

The reports showed health promotion actions focused on the elderly population through a group of physical activities performed by firefighters in partnership with the Healthy Secretary, socialization groups

held at the Health Center for the Elderly and groups of elderly people held at the Social Assistance Reference Center (CRAS), however it was observed that data are limited to quantifying these “health”, “assistance” actions, but practices promoting the elderly autonomy in their territories are not approached. The lack of these reports and the abundance of statistical data in the reports point out that the planning of actions for the territory is not dialogical once again. No document reported how this elderly person uses public roads and means of transport, what activities are offered in their neighborhoods, the relationship with their homes and neighborhoods, key factors of the appropriation of the territory that enables active aging, in order to build a healthy city.

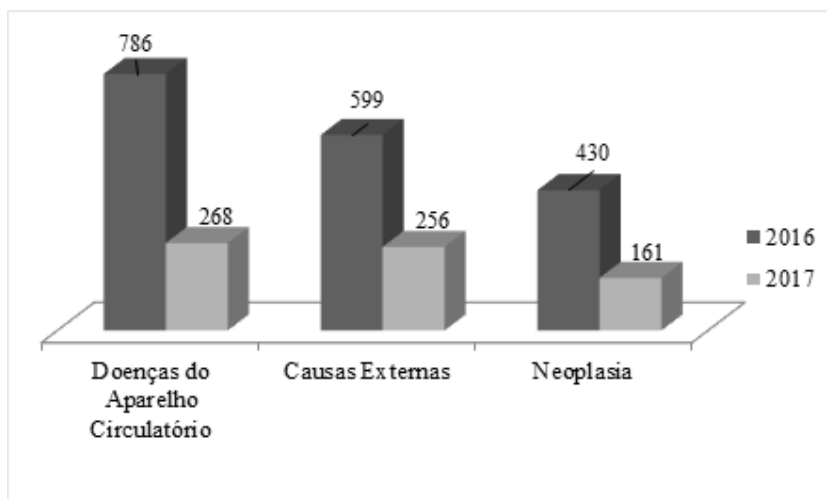
The WHO considers active aging as a life process shaped by several factors that, in isolation or in group, enable health, participation and safety of the elderly²⁰. It is understood that the act of creating strategies in the city which promote health to the elderly enables well-being, empowerment and territorializa-

tion of all the community, because a city that articulates health to the elderly has reach for all audiences¹⁻²¹.

CATEGORY 02- HEALTH INDICATORS

The analyzed SDOH in this category were cause-specific mortality, child mortality and arboviruses. The Cause-specific Mortality Indicator is calculated by the number of deaths for a specific cause, expressed by 100 thousand inhabitants, occurred in a certain territory and period of time. This indicator estimates the risk of a person dying from a particular cause, being used by public policies to classify the causes of death and their frequencies and to support planning, management and evaluation processes of health policies in order to reduce the number of deaths by specific groups²².

The indicator “cause-specific mortality” in the city of Maracanaú follows the world trend, as shown in Figure 1:



Legend: Doenças do aparelho circulatório: Circulatory system diseases - Causas externas: External causes - Neoplasia: Neoplasm

Figure 1. Cause Mortality in Maracanaú (2016 – 2017)

Source: Developed by the author

Cardiovascular disease is considered as multifactorial, originated in biological, social, economic, psychological, demographic and environmental factors. Habits that not enable a healthy lifestyle, low adherence to treatments and barriers in accessing

health systems are the most important causes of the disease²³.

The first cause of death in Maracanaú is cardiovascular diseases that were justified by the following rates: in 2018, the quantity of hypertensive peo-

ple - 30.459 -, followed by diabetic people – 12.333 – and obese people – 510, data which suggest a population with risk pathologies that can trigger cardiovascular diseases (Report of Municipal Health Management, 2017/2018).

This incidence can be altered through the modifiable risk factors of the disease - smoking, sedentarism, food, among others – which are directly influenced by the person/environment interaction. However, there were not continuous actions in the territory, aimed at health promotion for hypertensive and diabetic people. This fact also makes us believe that there is a difficulty for the community to own public spaces.

The ability of the human being to own spaces must enable the adherence of healthier habits that can be effective to lower this indicator. Habits of physical activities in parks and squares are attitudes of collective territorial empowerment viable to provide well-being and better health status for the community²⁴. Thus, it may be interesting to note that the greater appropriation of people in a city, the better the ability to take up lifestyle changes, because appropriation only happens when territorial conditions allow people to identify themselves with the community as a whole⁸.

The second cause-specific mortality rate is noticed in the municipality as “external cause”. Deaths due to homicide, traffic accidents and suicide are included in this indicator. In the analyzed territory the external cause with the highest incidence was homicide with 145,7 murders for each 100 thousand inhabitants in 2017, making Maracanaú the most violent city in the country. Data of death distribution according to neighborhoods/communities were not found in the analyzed documents, making it difficult to evaluate whether urban violence is differently attributed to specific territories. No action aimed at urban violence prevention was described in any health and assistance equipment.

Urban violence might be explained by the urbanization process which has generated a rapid population growth, without adequate planning, causing the proportionality of employment, housing, access

to goods and services demands not to occur, harming people’s well-being and health status²⁵. The urban violence analysis could not be carried out only according to the incidence of people who were achieved, because this phenomenon complexity in contemporaneity is also associated with the facets of organized crime, interfering in the territory and installing a parallel power to the State. Then, urban violence does not relate with the social conditions of populations and precarities of access to public policies²⁶.

It is understood that death for murder is the last consequence of urban violence. The phenomenon of ‘deindividualization’ can explain these rates increase, since there are not inhibition of criminal actions due to the anonymity. In addition to the lack of attention to others and mutual indifference, generating a strong feeling of fear and helplessness in the community⁸, these facts empty the city, with much more use of cars, high walls and little appropriation of public spaces.

The second analyzed indicator was “child mortality” which is concepted as the number of deaths of infants younger than one year old, by a thousand live births in a certain geographic space and year²⁷. The rates of the analyzed territory are shown in Figure 2:

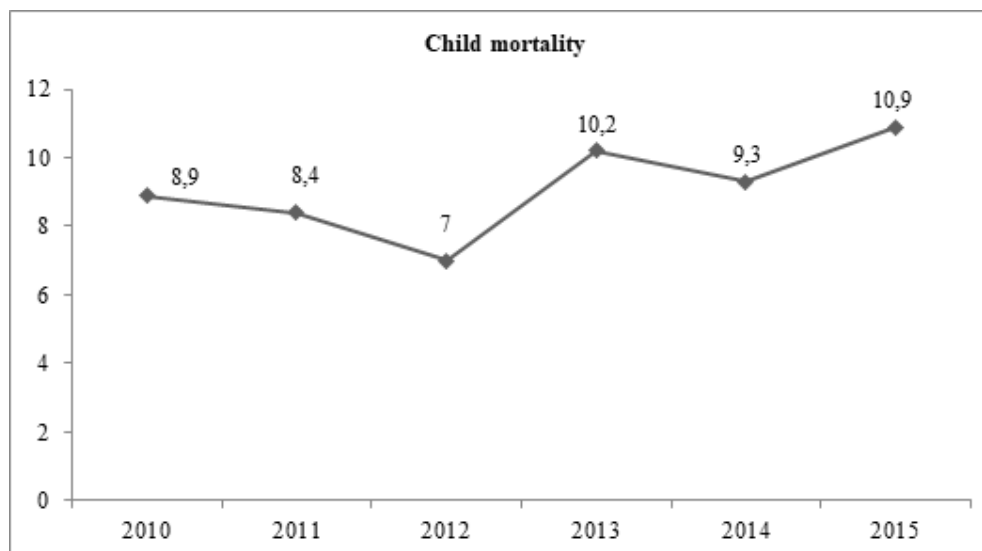


Figure 2. Child mortality in Maracanaú (2000 – 2017)

Source: Developed by the author

Observing the timeline in Figure 2, it is evident that there was an increase in the Child Mortality Rate from 2016 to 2017. Infant deaths must be a constant concern for municipal management, as they are more prone to social determinants than the ones at adulthood.

Maracanaú, in 2017, had a child mortality rate of 10,7 representing 90 deaths. Among this rate, 62 deaths were preventable, being classified as occurrences due to a failure to assist a pregnant woman or newborn. This fact is not exposed in any reports of municipal management, but some divergencies of information were found in the tabulation of data of the Health Secretary of the Municipality with the Health Secretary of the State. The causes of preventable deaths were not reported as well.

In the municipal reports actions described for this audience were found; through the Primary Care prenatal consultations, groups of pregnant women, postpartum and newborn follow-up and childcare are carried out. In tertiary care, we have the Women's Hospital, which performs an average of 300 deliveries per month, with a cesarean section rate below 40%. Infant deaths by neighborhood are not clear in the reports, which makes it impossible to analyze the data distributed in the geographical space and to identify priority areas for health interventions²⁷. Once again,

documentary analysis proves that the construction of Maracanaú epidemiological data is underutilized by the management, which reveals only the concern with filling in systems, but that it effectively does not understand the demands of the community and the real processes of territorialization of the city.

Another epidemiological data evaluated was the number of confirmed cases of arboviruses. Infectious diseases are considered zoonotic, that is, they are kept in nature in a cycle that involves a vector and a wild animal

The disorderly growth of cities, together with rivers pollution and formation of ditches, provides artificial oviposition sites for the proliferation and dissemination of mosquitoes, especially *Ae.aegypti*. Climate change also plays a positive role in the proliferation of mosquito vectors. The higher frequency of rainfall that has been observed in some places results in the accumulation of water in more containers, increasing the supply of breeding sites, natural or artificial, for the female mosquitoes to lay their eggs. In contrast, the drought period in certain regions obliges people to store water in vats or in other artificial containers, which serve as breeding sites for the proliferation and increase of the vector population^{28,5}.

Urbanization with modifications in the environment caused by anthropic actions, turn the infectious diseases synanthropic – causative vector and man. In the last ten years, Brazil has been increasing the inci-

dence of arboviruses – transmitted by vector mosquitoes – in the analyzed territory dengue fever, zika and chikungunya will be demonstrated (Figure 3)²⁷⁻²⁸.

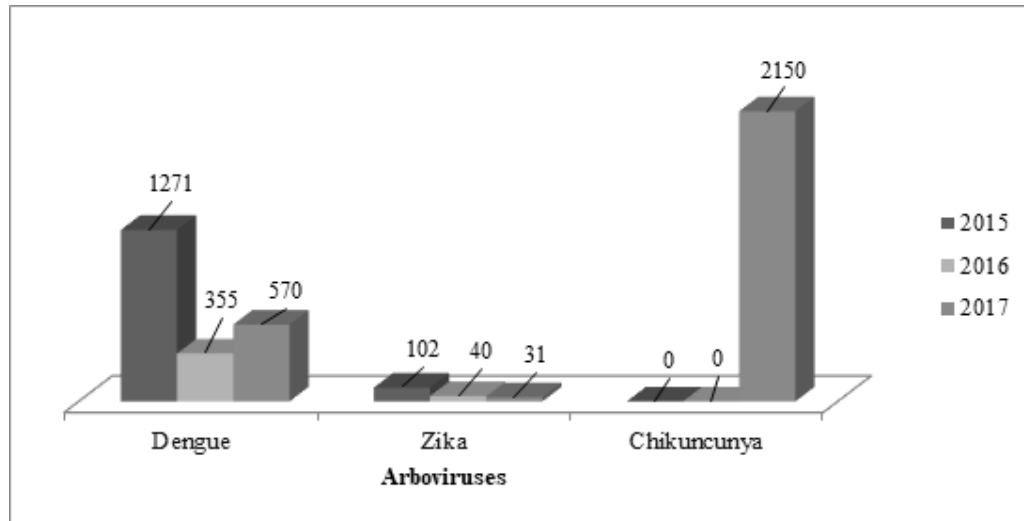


Figure 3. Incidence of cases of arboviruses between 2015 and 2017 in Maracanaú

Source: Developed by the author

Legenda: Dengue fever, zika and chikungunya

Observing the graphic, the number of confirmed cases of arboviruses in 2015, 2016 and 2017 are evident, and in 2015 the most worrying is dengue fever and in 2017, chikungunya. According to the Report of Municipal Health Management, 2017, Primary Care performs actions of education and health about this topic with the population, as well as health agents and endemic agents visit people in order to guide and find mosquito breeding sites.

This incidence enabled the following reflection over the territory diagnosis. It is noted that the community is not sufficiently appropriated of their territory, and the performed educational practices through the equipment are not resolute and didactic to fulfill the aim of decreasing the mosquito proliferation. This phenomenon suggests the need to make the community participatory and qualified in the mosquito control process.

To make it happen, the community must appropriate their street, neighborhood and city. Appropriation is understood as an exercise of “domain” over space, and it is through it that the person/envi-

ronment interaction can make the human being project themselves into the space and change it, creating their own place. When we are in a place that we consider as ours, the possibility of identification with it increases, and the actions of care become more resolute, enabling empowerment actions regarding healthcare with the surroundings.

FINAL CONSIDERATIONS

The territory diagnosis performed through the SDOH enabled to identify the first interventive facts for the effectuation of a Healthy City Project in Maracanaú. The documentary analysis showed a city with excellent coverage of Basic Health Units, Social Assistance Network, varied education and health actions, but it was noted that no document evidenced community participation in the action planning process. Health actions are planned and executed by management without the adequate understanding of territory demands, generating egalitarian actions for

all neighborhoods, not providing resoluteness. These actions are in the sphere of biomedical, sanitary and drug strategies that hinder the appropriation of the community on its surroundings, bringing the perception that caring for the city is the duty of management alone.

The Healthy City Project is structured in an inverse model to what was found, the lack of popular participation can be exemplified in all analyzed data, and it is a problem that needs urgent dialogue. It is necessary that the public power allows and motivates the community to express their difficulties and reflect about them in a search for solutions. Planning must not be established only according to administrative criteria without considering the local reality with its due social, epidemiologic, cultural vestments, etc. But it might be built through partnerships between the public power and community, fostering a culture of well-being through community nets, reorganization of health services, among others.

This study is not free of limitations. The first one refers to data divergences of the reports of the municipality secretaries and the State, the lack of data mapping for neighborhoods, hindering the territory diagnosis with microspatial peculiarities. It limited a deeper study of the city areas with greater or lower social vulnerabilities, which could give access to plan a healthier, more effective city. However, it is reinforced that this study did not aim to generalizing results, but to explore this reality.

A second limitation refers to the type of information in the analyzed reports with tabulations of only quantitative data, not mentioning methodological and operational descriptions of actions performed in the territories. This fact questions whether the applicability of these actions occur in partnership with the community. Therefore, it is suggested that detailed research is carried out in order to analyze the perception of community regarding health actions in the city, with representative samples, to evaluate fragilities and potentialities of urban territory, aiming at a Healthy City Project.

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