COMMUNITY ORGANIZATION, HOUSING, AND HEALTH: A PERSPECTIVE FOR PUBLIC HEALTH WORKERS*

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THE IMPORTANCE OF ADEQUATE HOUSING for the maintenance of health has been widely recognized by a variety of national and international organizations. For example, the International Conference on Primary Health Care held in Alma Alta, U.S.S.R., in 1978, and sponsored by the World Health Organization and the United Nations Children's Fund, declared that safe, sanitary, and decent housing was a necessary element in the provision of primary health care.[1] As early as 1949 the United States Congress passed a Housing Act that asserted that the "general welfare and the security of the Nation and the health and living standards of its people—require a decent home and a suitable living environment for every American family."[2] In 1986 the American Public Health Association and the U.S. Centers for Disease Control published recommended minimum housing standards designed to "protect and promote the health and well-being of occupants of residential structures and those who may reside in the immediate vicinity of such structures."[3]

Translating this recognition of the links between housing and health into the reality of healthy housing for all has proved problematic and substantial portions of the world's population, in both developed and developing countries, continue to lack adequate—or even any—shelter. In the United States, the focus of this report, various strategies have been used to improve housing. These include regulatory approaches, typically embodied in building, housing and health codes, state supported or subsidized public housing, financial and tax incentives to encourage private developers to produce more middle and low-income housing, legal action to force government or landlords to

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improve housing conditions, and social action or community organizing initiated to lead to better housing conditions. These are not mutually exclusive strategies, and all are currently being used here in New York City.

In this report I shall explore the relationships between community organization, housing, and health. More specifically, I hope to answer two questions: What role can community organizations and organizing play in improving housing conditions related to health? How can public health professionals assist community organizations in this role?

CASE HISTORIES

Three brief anecdotes illustrate how community organizations can address unhealthful housing conditions. In 1971 Mt. Sinai School of Medicine and the East Harlem Environmental Extension Service, Inc., a coalition of neighborhood housing groups, property owners, tenants, and job-training groups, established a program to train "super" superintendents to reverse the decay of housing in East Harlem and to eliminate health and safety hazards in residential buildings.[4] After two months of class room and on-the-job training, the superintendents, called environmental extension agents, were ready to work under contract with building owners. Services provided included preventive maintenance and minor repairs of boilers and elevators, rodent and pest control, and health and safety education for tenants. The program was financed by several state and city agencies and supported by the Service Employees International Union. Like so many community programs, this project died after a few years from lack of funding.

Bronchial asthma, while not caused by poor housing, is exacerbated by such conditions as inadequate heating, cockroach infestation, dust and walks up many flights of stairs due to broken elevators. To address these problems, the Asthma Self-Management Project at Columbia-Presbyterian Medical Center, a program designed to help families manage asthma more effectively, invited tenant organizers to meet with parents of asthmatic children to describe their rights as tenants and to assist them to improve housing conditions in their buildings. A few parents went on to organize rent strikes to force landlords to correct violations of heating and safety standards.[5,6]

The third example is the New York City Coalition to End Lead Poisoning, an advocacy organization of health workers, housing organizers, and lawyers. During the past six years the Coalition has issued reports on city lead poisoning control programs, organized community educational campaigns on lead poisoning, filed a lawsuit against the city for its failure to enforce existing laws on lead poisoning, assisted homeless families to monitor lead

paint violations in city shelters, prepared budget proposals for new funding for lead poisoning prevention, and educated city legislators about the issue.[7] In part as a result of these activities, new resources have been allocated for prevention, city housing and health departments have begun to cooperate more closely, and several new community based programs have been implemented.

These three illustrations demonstrate that it is possible to link housing and health issues at the community level and to involve neighborhood organizations in working for healthier housing. At the same time it must be acknowledged that generally community organizations have not identified healthier housing as a high priority. Despite the increasing deterioration of housing in New York City during the past decades, there has not emerged a strong housing movement nor a public health movement that has identified improved housing as a major goal. While a detailed analysis of the housing movement is beyond the scope of this paper, the potential role that community organizations can play in creating healthier housing and some of the obstacles they face in doing so will be explored.

Improvements in the quantity and quality of housing, both prerequisites for healthier shelter in New York City, require three elements: capital to finance the improvements, political leadership to win resources and to implement large scale programs, and a population willing and able to maintain housing over the long term. As the Wallaces have described, each of these elements has been in short supply in New York City during the last 15 years with respect to providing housing for low and moderate income people.[8] To state the obvious, the reason so many people still lack healthful shelter in this city is not because government or developers failed to consult public health experts about how to make healthier housing. Nor is it an absolute lack of capital for building. After all, between 1981 and 1987 about 45 million square feet of new commercial space was built in Manhattan alone, an increase as large as the total office space in Boston and San Francisco combined.[9] Rather, the failure to provide healthful housing is a political failure, a failure to mobilize sufficiently to force powerful national and local elites to reverse their priorities.

By themselves, of course, community organizations cannot solve our housing problems. They lack the capital and the political muscle. But as part of a more comprehensive strategy, they have much to offer. First, community organizations in low and middle income neighborhoods consistently identify housing conditions as an important problem. While the current media focus on drugs has made that the primary concern during the last year or two,

housing has been on the priority list of most poor neighborhoods in New York City for at least a decade. Unlike federal officials, business leaders, or even most public health experts, community residents and the organizations that represent them do not need to be convinced that improving housing conditions is an important goal.

Second, community organizations have the potential to mobilize their constituents to exert the political pressure that can lead to changes in political priorities. Several major social movements of this century, most notably the civil rights movement of the early 1960s, depended on community organizations for resources, support, and an institutional base. Similarly, much of the recent political mobilization in African-American communities in New York City depends on such community organizations as churches and neighborhood associations.

Third, community organizations are not limited by a categorical approach to problems. Too often, public health professionals define themselves as experts in a single substance or issue: lead, asbestos, or indoor air pollution. Such an identification helps to identify the specific health-damaging properties of a particular substance but may have limited value in the larger goal of creating healthier housing. Because community organizations are not committed to a particular issue, they can move back and forth from lead poisoning to lack of heating to high rents, choosing the problem most likely to contribute to effective mobilization. This flexibility is especially important in the political arena, where most of the critical decisions about housing are made.

Community organizations often have two other important assets that enable them to play an important role in health education. One is credibility with their constituents; the other is familiarity with relevant values, beliefs, and channels of communications. Since community residents, especially in oppressed communities, often distrust (with good reason) government initiated health campaigns, community organizations may be more effective, for example, in educating parents about childhood lead poisoning. At another level, neighborhood organizations may also identify enough specific obstacles blocking progress in their area that they can plan the most effective strategy to press for improvements in local housing conditions.

Still another advantage of community groups is that they can work on several levels: in an individual building, block, or neighborhood; in the community as a whole; or even as part of a city-wide network or coalition. They can thus link specific improvements in a particular apartment or building with larger policy and legislative issues. When a single organization can be active on several levels, it is easier for participants to understand the connections between these activities.

Finally, and perhaps most important, community groups can play an important healing function within low income neighborhoods. Wallace and others have eloquently described the devastation wrought on poor neighborhoods in this city in the past 15 years.[8] Housing deterioration, arson, drugs, AIDS, crime, and poverty have ripped apart families, neighborhoods, and communities in this city. An experimental and epidemiologic literature documents that feeling in better control of one's life can help to prevent a variety of physical and mental health conditions. Social support can both provide a buffer against the health consequences of social stress and help to prevent or minimize the impact of a variety of acute and chronic illnesses. Rebuilding New York City's neighborhoods will require more than new buildings or fixing up old ones. It will require rebuilding the social networks and community supports that help a neighborhood to survive and prosper. No one is better equipped to assist in this task than the community organizations that are already struggling to meet the needs of poor New Yorkers.

Despite these advantages, community organizations face formidable obstacles in making lasting contributions to healthier housing. Most have a relatively short half-life, making it difficult to sustain campaigns over time. They can be coopted or bureaucratized by government support or selective hiring of grassroots leaders, undercutting militancy and commitment. Given the multiple problems facing poor neighborhoods, numerous issues compete for attention, also diverting groups from any single issue such as housing. Finally, community groups are a tremendously heterogeneous category. They have different class and ethnic identifications, battle over turf, and often display the same prejudices as other institutions within our society.

In advocating a stronger role for community organizations in creating healthier housing, I am not arguing for "a thousand points of light." Lights run on electricity, not human spirit; they need power lines and generators, not rhetoric. If we expect people to hold up the point of light for longer than it takes for a photo opportunity, then the torch bearer needs food, shelter, and a decent wage. Community organizations are no substitute for government programs to ensure decent housing and healthful living conditions in communities in this city and this country. But, unless we combine a program for rebuilding the physical and economic infrastructure of our cities with one to rebuild and sustain the human infrastructure of our neighborhoods, our success in creating healthy cities will be limited.

In concluding, I want to make some specific recommendations as to how public health professionals can assist community organizations in their struggles for better, safer housing and healthier living conditions. In doing so, I hope to suggest some connections between the modest goals described in my

three anecdotes and the more ambitious aim of rebuilding a healthy city.

First, public health is both a scientific and a political enterprise. We need to acknowledge both of these roots. As scientists, we are right to design rigorous studies to document the health consequences of varying levels of exposure to a toxic substance. But, as public health advocates, we need to use other tools to reach our ultimate goal of improved health status of the population. Each year about 1,000 children are diagnosed with lead poisoning in New York City; many additional cases go undetected. We do not need more research to lower this toll; we need the city to enforce consistently and rigorously existing housing and health codes. This will require more resources and a new political commitment, outcomes that require a different level of public health intervention.

Second, public health people need a broader, more comprehensive view of the links between housing and health. There is a lot of empty space between the grand declarations about the rights to healthful housing quoted at the beginning of this talk and specific assistance we can offer on such problems as asbestos, lead poisoning, or tuberculosis. Developing such an agenda will require ongoing dialogue between housing organizers, planners, architects and activists, and public health professionals and activists. It will also require trying new approaches and evaluating them. None of the programs described in the earlier anecdotes were evaluated so we do not yet have a sense of what interventions lead to what outcomes. At least initially, qualitative ethnographic evaluations will probably be more useful than quantitative ones looking at health outcomes. At all stages of this dialogue it will be important to include public officials who can fund and implement innovative programs.

Third, even among ourselves, we need to define research and action agendas on housing, health, and community organization that transcend our specific disciplines. It is unfortunately rare that epidemiologists, planners, architects, health educators, and physicians talk with each other about these issues. Out of such discussions as well as an ongoing interdisciplinary dialogue might come a more systematic effort for scientists and health and housing professionals based in universities to provide ongoing training, technical assistance, and consultation to housing groups. Such cooperation would also strengthen students to play a more vital role in these problems and particularly train students to work collaboratively with community organizations. New York City has a diverse array of university programs on housing-related issues but very little history of cross-institutional cooperation.

Fourth, we need to find new ways to look systematically at the relationships between the consequences of bad housing and no housing. Isolating

homelessness as a separate issue from housing with its own set of experts and its own agenda raises the specter of a permanently homeless population with its own health care system. Again, community organizations may be able to play an important role here, particularly as the city disperses homeless people throughout its neighborhoods.

Finally, we need to find new, or sometimes resuscitate old, ways of bringing new players into the housing and health arenas. A variety of new initiatives could help both to assist some people to improve their housing situations and to educate new constituencies: housing clinics in neighborhood health centers or district health centers, health experts in the Department of Housing Preservation and Development, neighborhood and citywide networks of housing and health activists, a university consortium on housing and health, and training workshops on housing and health for tenant organizers.

The first steps we need to take are really very modest. Dramatic improvements in housing conditions in this city await the mobilization of a social movement not yet born. Working now to understand better how to link housing and health at the community level, to train housing and health activists and professionals about the two issues, to launch small scale experiments and demonstration projects, these seem like realistic goals for the present period. They are also exactly the kind of prenatal care that will help the nascent social movement to a healthy birth.

Discussion

PARTICIPANT: You mentioned the Housing Act of 1949. We also had the Full Employment Acts, at least three of them I can think of, various environmental laws, some child welfare acts, most recently the Technology Competitiveness Act of 1988. Why is it that whenever we publish—whenever we, after much agitation and trouble, have such laws on the books, they immediately catch a terminal case of nonfeasance?

DR. FREUDENBERG: I find the arguments of Piven and Cloward persuasive. I think as social movements fight for changes in legislation, they need to maintain their militancy so that they can monitor implementation of the legislation. I think that is very important in how we talk about what our goals are. Our goals cannot be simply to get this or that piece of legislation passed, though we might want to do that, but really to contribute to building a movement that can maintain a lasting involvement in some of these issues. Easy to say and hard to do.

DR. ULLMANN: Why does the interest flag, then? Don't people want to turn these pious wishes into reality?

DR. LANDRIGAN: Maybe a classic example can be seen in the field of occupational health. Navarro from Hopkins has analyzed the vigor of the occupational health movement in different countries and qualitatively finds a very close correlation between the proportion of the work force in the country that is unionized and the efficacy and adequacy of occupational health. Compare, for example, the Scandinavian countries, where something like 90% of the work force is unionized, with incredibly strong occupational health movements; Germany and France somewhere in the middle; Britain about 40% unionized and falling under the present administration there, and relatively weak and decaying governmental activities in occupational health.

In this country, with less than 20% of the work force now unionized during the past nine years, the budget for the National Institute for Occupational Safety and Health has been cut 55%, budget for OSHA about 35%. Buildings collapsing in Bridgeport, miners being killed in West Virginia—it is clear the sustainability of the effort depends absolutely on the underlying organization.

DR. DEBORAH WALLACE: Another factor in the equation about how efficacious laws are has to do with how hostile the enforcing agency is to that law. So, to take occupational health and safety as a model, we are supposed to have an employee occupational health and safety act here in New York State. From some of my clients, though, who are public employees, we have found it extremely difficult to get enforcement. The inspectors come without the proper sampling equipment, and they say, "Well, we can't document any violations here." It takes an extraordinary effort, even when workers are unionized, to get any kind of enforcement. So, if the fine laws we pass are received by a hostile enforcement agency, it is very, very difficult to get any action with them.

PARTICIPANT: I support what you are saying about community organizations and making the connection with health professionals. One community that we should reach out to is the homeless groups themselves. I hope that a representative from Tompkins Square Park can come here tomorrow to hear what is being said. They need to know what is being said in the academic and scientific community about them and their situations and we need to hear what they are saying.

They came to speak to the New Jersey White Lung Association, to the asbestos victims in New Jersey a month ago. One of the things that really identified and brought the two groups together was when the homeless organizer said, "We want to speak for ourselves. We don't want other people speaking for us." The victims understood immediately because they have had other people speak on their behalf.

DR. HOPPER: I want to make sure I understood. As part of the ongoing dialogue between technicians on the one hand and community organizations on the other, do you mean that to apply to the level of individual studies as well, as I am assuming? That is, the kind if questions we put to these issues and how we define problems and variables and how you measure things should in part be informed by folks who know that stuff.

I cannot tell you how many studies I have reviewed on dimensions of problems that have, to my mind, no relation to how I have seen that thing at least, on the street. In particular, your comment on evaluation studies. So many of them now are measuring outcomes that have no relation to whether or not there was in fact an effect of a given intervention. Defining what a positive effect is, it seems to me difficult without some input from the folks actually part of the place that implemented and was affected by this intervention. I want to add my endorsement to that kind of partnership.

DR. GANS: A brief comment: introductory studies, which is all a sociologist is capable of. I was around when the 1949 Housing Act was passed after many years of pushing and shoving, as late as 1949. "Decent, safe and sanitary housing," which is the great line, was the preamble, which has no legislative power whatsoever. It was a sop for us rabble-rousers. The law itself, of course, the money—the second thing, how much money is there for it?

The money—that Housing Act was for urban renewal. All the things that happened with urban renewal began with that dreadful Housing Act which had the lovely preamble and all the bad enforcement and appropriations policy. One needs a law plus appropriations. Forget the preamble. Read the law and find out what the appropriations are.

DR. FREUDENBERG: And what we really need are movements to get both those things.

PARTICIPANT: I want to just add some comments on community organizations as a vehicle. I think is very important and very interesting but we should remember what has happened to the movement over 20 years. It has gone from being advocacy and protest to developer. In part, that is because of funding. It is a big problem. You do begin to build housing in the Bronx. You begin to see very clearly you cannot manage it and it runs down. But you have no funding for the social organizer and the person who checks. You cannot get the money for this.

The other thing I wanted to mention is that there is a lot of attention to public/private linkages and there are some positive aspects to this. Some community organizations are being helped to develop linkages with hospitals

to look at such common problems as housing and community, and this is really an interesting ground to think about because it can go two ways, obviously. You do not want these organizations, whether created to do this work or whether they are coming into a partnership, to be captives of the institutions. That is fertile soil for potential right now. The hospitals need the organizations as well.

PARTICIPANT: I want to ask a question that relates very much to what Dr. Wallace said.

A lot of what has been happening over the last 20, but particularly the last four or five years, impacts dramatically on a community's ability to organize. During the 1960s much more broad-based and dramatic community organizing went on in probably a less dramatic threat to their situation. In fact, many communities have gotten substantially worse in a variety of ways. Yet you and other people said that the community organization has not kept pace.

I wonder if you have a sense of where the new organizing is really going to come from and whether or not, in fact, somehow this disruption or whatever has made it such that these communities really cannot organize any more? Is it that they are so disorganized or whatever, the combination of being co-opted and whatever has made it very hard now for them to do it? Why aren't we seeing that kind of response?

DR. FREUDENBERG: You said two different things. One, it is very hard to organize in low income communities, and the other, you can't do it. I would agree it is very hard but strongly disagree that you can't do it.

I am tremendously impressed by the strength and resourcefulness and resilience of the community groups I work with around health issues in neighborhoods throughout the City. I have yet to find a community that does not have dozens of organizations ranging from one-person organizations to much larger ones working and struggling with very minimal resources to improve conditions.

I think that the reality is that those groups have lived in a very hostile political and economic environment for at least the last two decades here in New York City. This environment was shaped both by local and national policies and by negative attitudes toward advocacy groups and community groups.

I think in New York City there is an opening with a new administration to define a different attitude and a different role for community organizations in both monitoring the city's delivery of services and helping to, as I said, rebuild social support and community networks. The people are there, the

organizations are there, the interest is there. They know what to do and what they need are some resources.

In some cases, the resources that will let them move to another step are modest: one staff person; going from not having a staff person to having a staff person. All the problems of co-optation and becoming captives of the organizations, of course, are there. It is never just one thing or the other. An institution will try to co-opt a group because it has something to offer, and a group will look to an institution because it has something they need.

We need to make specific analyses in each case. What are the potentials? They will not always be as much as we want, but something will happen. And then look at the larger environment of how we can develop programs and policies within the institutions where we work to support that and nurture the effort that is going on.

DR. DUHL: I just wanted to extend your notion of community organization to tie it into something Dr. Hopper had mentioned. If we focus our community organization primarily on victims and on people having difficulty, we shall lose the game because we have to organize in those other populations that are changing the economic scene, the political scene, and the social scene. That is why "Nimby" is taking place. There is a complete fragmentation of our activities as well as the fragmentation of the population.

When we talk about a social movement, it cannot be a social movement just of the poor. It has to be social movement which really shows that it is in everybody's best interest, in a strange way they have to do something about it, that the problems we have been talking about are really critical to be problems of these other groups, and that unless we can find ways to tie these together in a much larger level of community organization than we have been talking about up to now, we shall not be able to face it. That becomes politics. It is a new form of politics.

DR. FREUDENBERG: And I think there are some models, very early, beginning models of doing that. I think the environmental movement is a movement that, as it is developing in urban areas and among lower-income people, has the potential to cut across class lines. AIDS organizing in some places cuts across class lines. We need to look to the models and strengthen those beginning efforts.

DR. DUHL: Except I would add it shouldn't stay alone, say, environmental, because the environmental issues are the same as the broader health issues, the housing issues, and economic development issues. Until we start pulling all the multiple strands together and sort of defragment the society,

society will remain fragmented. We have to defragment and pull it together in another way or we are not going to deal with the issues.

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