

Healthy cities and communities

By engaging local residents and developing institutional partnerships to address a broad range of place-based environmental, economic, built-design and other social determinants of health and illness, healthy cities and communities aim to improve health and reduce health disparities, especially in more vulnerable populations and neighborhoods.

In the healthy city framework, communities are respected for the local knowledge and assets they possess and are enabled to further refine and leverage these for greater impact in partnership with public health professionals, urban planners, transportation engineers, and environmental regulators, as well as with a broad range of civic and advocacy groups, such as housing coalitions, community development corporations, bicycle associations, urban gardeners, racial justice and immigrant rights groups. Increasing complexity, exacerbated by the disruptions of climate change, elicits strategies for pragmatic social learning across boundaries.

Healthy community work addresses the causes of widespread scourges, such as diabetes, asthma, and cardio-vascular disease that are not reducible to genetics, lifestyles, or health care access, as important as these are, and are not effectively preventable and treatable by acute medical care and overspecialization.

Healthy cities locate participatory and collaborative governance, as well as youth engagement and leadership development, at the center of strategies to enhance health, promote equity, and anchor resilience strategies in the face of climate disruption.

History

The term “healthy city” was coined in its contemporary version by Leonard Duhl, a physician and professor of public health and planning at the University of California-Berkeley speaking at an international conference in Toronto in 1984. This soon led to the Toronto Healthy City Project and the World Health Organization (WHO) Healthy Cities Project, the latter eventually growing to several thousand urban partnerships worldwide.

In the U.S., healthy cities initially drew upon various sources, such the community health center and community action programs of the 1960s, with their distinct emphasis on participatory democracy, as well as upon the women’s health movement, self-help groups, and assets-based community development in subsequent decades. In the 1980s, Mary Pittman, a student of Duhl from UC Berkeley, utilized healthy city practices within the San Francisco department of public health to address a broad range of factors impacting those with HIV/AIDS, such as evictions from apartments and firing from jobs; she enlisted stakeholders from business and real estate to respond more equitably, which in turn helped friends, lovers, and churches to better assist with care.

From the late 1980s, healthy city and community projects were promoted through the National Civic League. NCL had modest funding from the Public Health Service (PHS) at the U.S. Department of Health and Human Services (HHS), which developed an office of healthy communities. Projects such as Healthy Boston, which grew to 21 neighborhood-based multi-

stakeholder coalitions across the city and one citywide LGBT Youth group, emerged at the city level. State projects developed in South Carolina, California, Colorado, Indiana, and Massachusetts.

The Coalition for Healthier Cities and Communities (CHCC) formed in 1996 to further promote the model, and within two years some 450 organizations had affiliated. A core partner was the Hospital Research Education Trust (HRET), which is the research arm of the American Hospital Association. Its staffing proved critical to the coalition but could not be sustained over the longer run. While CHCC had to disband, healthy cities and communities work has continued to be promoted through the American Public Health Association, the Centers for Disease Control and Prevention, the Interfaith Health Program, and through many schools of public health and city and county public health departments.

The [Robert Wood Johnson Foundation](#), the [California Endowment](#), the [Colorado Trust](#), and the [Northwest Foundation](#) have funded healthy communities projects and partnerships.

The healthy cities approach has had to address a long history of health planning and city planning that have valorized segmented professional and administrative knowledge over the everyday experiences and capacities of communities, although there have also been important exceptions, such as those of Progressive Era women in the settlement house and “city housekeeping” movements.

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Social determinants of health

Healthy city approaches draw upon research that examines the distribution of disease and wellness across populations, as well as the causes of patterns and inequalities, especially as these may be embedded in contexts reflecting geographic segregation and hazard clustering, racial and economic injustice, cultural and institutional marginalization, and similar factors.

Place and neighborhood assume key importance in terms of spatial access and distribution of various benefits and harms, as well as contexts where meaning, relationships, and action are generated. Thus, access to affordable and safe housing, nutritious food, transportation to work, active recreation, and social networks, among other factors, configure opportunities for healthful living, while proximity to hazards, such as toxic sites, dangerous school crossings, and high crime areas, increase risk and impair wellness.

Core features and practices

Healthy cities build upon concepts and practices that one finds in various community organizing and community building fields, yet also develop these in distinctive ways. Here we outline several of these.

Social capital

This term refers to stocks of social trust, norms, and networks that people can draw upon to solve common problems. *Bonding* social capital are those forms that draw upon relatively tight networks, such as neighborhoods or church congregations, while *bridging* social capital links actors across these boundaries, as in an ecumenical and multi-racial faith-based coalition across a city or across congregations in poorer inner-city neighborhoods and wealthier suburban communities.

Linking social capital provides connections upwards in larger systems of power and authority, such as a community organization’s links to responsive bank officers who might engage in one-on-ones in the local community and open doors to better mortgage lending, or a neighborhood health coalition’s links to responsive staff in a public health department willing to collaborate and to further connect them to staff in other agencies.

For healthy community work, social capital can provide:

- *social support*: networks of care that extend to neighborhoods, congregations, self-help groups, AIDS patients, youth organizations, seniors, LGBT groups, and young women and girls resisting sexual violence.
- *information*: flows of timely, relevant, and trustworthy information, which can include health information, but also environmental harms, such as environmental sources of asthma, lead poisoning, and other toxics.
- *norms of healthy behavior*: social networks that encourage specific activities, such as walking and biking, and discourage others, such as smoking and excessive use of alcohol.
- *skillful action*: shared relationships, trust, and narratives can motivate protest, develop strategic mixes of community organizing and collaboration, and help build institutional partnerships that provide resources and regular channels for voice.

General reference:

CivicGreen Glossary: [social capital](#)

Local knowledge, street science, and participatory community-based research

Healthy city work values local knowledge, lived experience, and diverse ways of knowing, and accords plausibility to causal theories generated within local networks. It likewise places a high value on discipline-based scientific methods, but interrogates these to add neighborhood, ethnic, racial, gender, and cultural context, as well as potential cumulative impacts of multiple risk factors and pathways. Local institutions, such as schools and workplaces, can also serve as venues to generate local knowledge and as partners in broad healthy community strategies.

Since professional and lay people always have partial and plural perspectives, and since local knowledge is fallible, the goal is to develop mutual interrogation of various methods to develop “street science,” to borrow Jason Corburn’s term, in the interests of enabling pragmatic action and problem solving. Relevant knowledge and expertise for addressing community health is thus co-produced through distinct yet interrelated discourses, and professional science itself is refined as a result. Critical knowledge is generated at the community level, but also through broader health and environmental justice movements. Street science aims to democratize knowledge and power.

Community-based participatory research (CBPR) for health, of which street science is one type, is a collaborative approach that equitably involves all partners in the research process, recognizes the distinct strengths that each brings, and seeks to leverage knowledge for community action to improve health and social equity. Approaches within CBPR vary along

a spectrum, with some focused on pragmatic action, civic capacity building, and changes in institutional practices, while others broadly articulate “emancipation” as a goal. To be sure, there is much shared ground along this spectrum for enriching health research through participatory action and no single model defines one best way of proceeding.

At its best in terms of defining pathways of institutional capacity building, CBPR becomes incorporated into various assessment protocols and action tools of federal agencies, such as the U.S. Environmental Protection Agency (EPA), the Centers for Disease Control and Protection (CDC), the National Institute of Environmental Health Science (NIEHS), the Department of Housing and Urban Development (HUD), the U.S. Department of Agriculture (USDA), and the Indian Health Service, as well as state, county, tribal, and city health agencies, medical institutions, and other agencies (transportation, planning) whose policies impact local health. A CBPR interagency working group (IWG) coordinated work across eleven federal agencies for several years in the early 2000s.

Likewise, such agencies provide grants to local groups and capacity-building intermediaries that train and empower various community groups, community health worker networks, and collaborative designs among them and other institutional partners. The Affordable Care Act (2010) authorizes the CDC and the Secretary of Health and Human Services to award such grants to promote the community health workforce.

Some methods for generating local knowledge and street science are:

- *community health workers*: trusted women and men from local communities trained to conduct in-home health surveys to deepen local knowledge, facilitate discussion of results in public forums, and help residents manage asthma, hypertension, diabetes, and other chronic health problems, as well as maternal and infant care. In Latino communities, such women are often known as *promotoras de salud*. Community health workers, who go by various other names and work in many kinds of communities and tribal jurisdictions, build individual and community capacity, including for social support and advocacy. The potential exists for funding community health workers through Medicaid reimbursement.
- *local monitoring*: such as personal air monitors worn by youth in West Harlem to take air samples at home, in school, and on street corners in a respiratory illness and asthma study coordinated by WE ACT for Environmental Justice, in collaboration with the Mailman School of Public Health at Columbia University. Students also counted trucks, buses, and cars at intersections where they wore the monitors.
- *community risk maps*: developed by residents to show the concentration of specific kinds of hazards and facilities at the block level. Examples might include foul odors, watery eyes, and shortness of breath near bus depots or sewage treatment plants. These maps are sometimes drawn by high school students with comic-book names such as the Toxic Avengers in Brooklyn, who utilized skulls to indicate hazardous sites. Such amateur maps might be combined with sophisticated and participatory Geographic Information Systems (GIS) data and official data in the Toxic Release

Inventory (TRI), required since the passage of the federal Emergency Planning and Community Right-to-Know Act (EPCRA) of 1986.

- *narratives, photos, videos, murals*: can provide insight into how local communities perceive threats in ways not captured by aggregate data, as well as ways in which people take action, from protest to social support networks to participation in established channels or new collaborative projects.
- *community advisory board*: multi-stakeholder group that oversees the research process and helps ensure equitable and appropriate participation and relevant findings. Complex dynamics and forms of trust are developed and tested in this setting and through other activities of partnerships. A civic engagement survey might be part of the process of locating challenges and opportunities. Community health workers might be part of stakeholder boards, as in the diabetes CBPR project among the Bangladeshi American community in New York City.

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[Community-Campus Partnerships for Health](#)

CivicGreen Glossary: [democratic professionals](#).

Community design

The built environment has major impacts on community health and health equity. It can restrict access to safe and regenerative places to walk and play and can generate injuries and air pollutants through automobile and truck traffic. It can configure spatially concentrated food deserts where nutritious and affordable food is unavailable and where local residents and especially children rely disproportionately on fast food and other diets conducive to obesity and diabetes. The built environment can restrict mobility and social ties among seniors, with impacts on both physical and mental health, and it can exacerbate urban heat island effects.

Healthy cities and communities work recognizes that the built environment can also promote health, well-being, social ties, and equitable opportunity. It builds upon movements to redesign, which utilize a variety of frames, but tend to overlap considerably and include an important role for civic engagement and partnerships. Among these approaches is new urbanism, smart growth, transit-oriented development, complete streets, safe routes to school, age-friendly communities, active living by design, community gardening, just food, and green building.

Among the many components for healthy community design are the following:

- *bicycle paths*: to encourage biking to school, work, and shop, as well as for recreation. Dedicated bike lanes and racially equitable access are critical. Bicycle associations and coalitions are in the forefront of advocacy and often collaborate with city transportation departments on routes and design features. Federal funding, beginning with the Intermodal Surface Transportation Efficiency Act (ISTEA) of 1991, has provided funding as well as additional requirements for public participation. See **CivicGreen Glossary:** [bicycle association](#).

- *sidewalks and crossings*: improvements to facilitate walking to school, work, and shop, as well as for exercise. Age-friendly design and safe access for seniors and people with disabilities, and for what AARP calls [livable communities](#).
- *public transit*: robust, accessible, and affordable to enable access to work opportunities and other social activities and to further encourage biking and walking to transit stops.
- *public spaces*: add benches, planter boxes, trellises, and murals to enhance everyday street interaction. Community input into design and a sense of shared ownership for maintaining improvements and preventing defacement and criminal activity. Community design charrettes for larger projects that might include various public spaces, as well as for regional efforts, such as the Atlanta Regional Commission’s Lifelong Communities Initiative. “Biophilic cities” aim to connect people with nature along many dimensions (birds, gardens, parks, rivers), with physical, cognitive, and emotional benefits. See [Project for Public Spaces](#).
- *mixed income and multi-use development*: to promote equitable access to safe and green housing and a mix of job opportunities. Age-friendly cities and aging-in-place options for seniors. Cities can introduce new zoning codes and mandate inclusionary zoning. The Twin Cities Metropolitan Council in Minnesota provides [livable communities grants](#) to encourage local innovation.
- *food access*: community gardens, access to supermarkets, farmers’ markets, “just food” strategies, planning for “community food infrastructures,” food as part of comprehensive plans. Associations such as the Pennsylvania Horticultural Society can develop leadership, training, and funding for citywide strategies, as in Philadelphia, and citywide systems, such as P-Patch in Seattle’s department of neighborhoods, can provide the institutional framework for local civic efforts. Youth engagement opportunities are plentiful. Multi-stakeholder partnerships, as in the Healthy Kids, Healthy Communities partnership in Buffalo, and food policy councils can develop local and county food strategies.

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CivicGreen Glossary: [democratic professionals](#); [urban and community forestry](#).

CivicGreen Professionals: [architects](#).

Case studies

Cases of healthy community work are plentiful, although some are relatively brief, dated, and/or not evaluated in terms of impacts. Nonetheless, they provide insight into processes, toolkits, and partners. Some are quite elaborate and complex; here we provide a few summaries.

Eastern Neighborhoods Community Health Impact Assessment (ENCHIA)

In November 2002, the Mission Anti-Displacement Coalition, which had developed a widely supported “People’s Plan” for community development, zoning, and land use in this San Francisco neighborhood, met with staff of the department of public health (SFDPH) to explore how health impact assessment might be utilized to further enrich their work. The process they developed led to a collaboration of more than two dozen civic groups with SFDPH and the planning department, which had just released a new zoning plan for the city’s Eastern Neighborhoods, covering the Mission District, Showplace Square-Potrero Hill, and South of Market. Other city departments (parks and recreation, transportation, police, parking and traffic, redevelopment) joined as well, as did several members of the board of supervisors (city council) from these areas.

The nonprofit groups and civic alliances ranged widely and included community and economic development, employment, low-income investment fund, housing, family resource center, neighborhood council, service workers union local, ethnic association, bicycle and walking, food, youth, land trust, architecture, hospital, and neighborhood parks (Corburn, “Civic Innovation,” 50, for a list with full names and representatives).

These groups and agencies met monthly in a consensus-based collaborative process for nearly two years to develop a vision of a healthy city and the ENCHIA toolkit, with indicators for measuring healthy development. This tool was subsequently utilized across the city and the SF Bay area. Several highlights of the process, tools, and goals are the following:

- *governance structure*: stakeholder council, technical advisory committee, and a planning group with sufficient funding and staff resources, as well as training for lay residents on the council.
- *land use impacts*: identify and analyze the likely health impacts of various land uses and zoning codes, as well as other impacts, such as on housing and jobs.
- *research*: includes expert testimony, secondary data from various city departments, interviews, narratives of local workers and residents, analytic models, and community dialogue events. The technical advisory committee reviewed consensus recommendations, but did not make decisions.
- *public presentations*: to neighborhood meetings, public hearings, media, decision makers.
- *healthy city vision*: this was formalized under seven categories:
 - *environmental stewardship*: renewable energy sources, green infrastructure, clean air and water, productive use of previously contaminated sites (brownfields).
 - *community participation*: in data collection, decision making, monitoring, and evaluation, as well as open and transparent discussion of trade-offs. Focus groups and interviews (e.g. with seniors and youth) to complement public meetings.
 - *transportation*: multimodal, including biking, walking, and affordable and accessible public transportation, with safer streets and sidewalks.
 - *housing*: affordable, safe, stable, and in mixed-income communities of friends and neighbors; green building but avoid gentrification.
 - *healthy economy*: opportunities for diverse skill levels, with living wages, health insurance and other benefits; local and sustainable businesses.

- *public safety*: safe and walkable streets and sidewalks, clean and accessible public spaces, and absence of crime and violence; practical ways to address racism and discrimination.
- *public infrastructure, goods and services*: quality schools and childcare; safe parks, playgrounds, sports/recreation areas, and spaces for festivals and concerts; active street life and commercial districts; community services and resources for youth and seniors; disability access.

References:

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CivicGreen City Desk: [San Francisco](#).

Combating asthma in Williamsburg

El Puente is a school- and community-based youth development nonprofit founded in 1982 in the Williamsburg section of Brooklyn, New York City, which began to address the problem of asthma and other environmental health issues in the 1990s. It now operates through six “leadership centers” in schools, neighborhoods, and public housing projects in the broader area of North Brooklyn. Among its current programs are academic enrichment, performing and visual arts, sports, health and wellness, one-to-one mentoring and internships.

El Puente first began to address asthma as an organizational representative to the community advisory committee of the NYC Department of Environmental Protection’s community benefits program. Students, many of whom suffered from asthma, challenged the sampling procedure of studies based on one local hospital that they rarely visited. In their science classes, they developed alternative sampling methods and then partnered with a nonprofit that had expertise in community epidemiology, which in turn engaged students to survey their peers and family members. Asthma was a major cause of school absences and hospital admissions.

As their own survey began to show asthma to be a top health concern in the community, the NYC Department of Health, with the support of community groups and physicians, launched a childhood asthma initiative across the city. Research in other neighborhoods, such as Harlem (conducted in collaboration with Columbia University) showed vulnerability among African American and Latino children. In the broader Greenpoint/Williamsburg area,

Hasidic, Polish, and Slavic groups in the environmental coalition (formed against a proposed incinerator) balked at such a public health survey for various reasons: cultural appropriateness among Hasidic Jews, strategic emphasis on other issues (truck traffic, waste-transfer stations, and sewage treatment plants) among Poles. El Puente thus proceeded as a Latino initiative.

While the epidemiology of asthma remained unsettled, some investigations pointed to the role of dirt, dust, mold, humidity, and mildew that instigate harmful allergens and which are, in turn, often associated with poor housing and other conditions, such as air pollution. El Puente, with funding from the Nathan Cummings Foundation and later from the city (under the guise of asthma education), worked with Community Information and Epidemiological Technologies (CIET) to develop a research methodology combining qualitative and quantitative methods, which included:

- *four surveys*: between 1995 and 2000, hundreds of households and several thousand individuals were surveyed.
- *training*: for 50 high school students from El Puente Academy, 5 teachers, and 5 El Puente staff. The academy is a NYC charter public school within the city's community school model.
- *epidemiological software*: utilized Epi Info to analyze data.
- *teams*: one adult teamed up with one student to conduct each initial in-home survey, usually with the head of the household; students also helped with translation, where necessary.
- *health promoters*: called *promotoras de salud* in Spanish, 10 adult women with long-standing community ties and a demonstrated passion for community health, were then hired and trained to conduct the in-home surveys, lead discussions over interpretations of results, and help residents manage asthma and other health problems. Public health professionals from Hunter College, CIET, and the NYC department of health developed training in the etiology of asthma, epidemiological methods, survey methods, and how to facilitate community meetings on health.
- *focus groups*: the *promotoras* led focus groups to uncover deeper meanings, stories, and explanations, including the importance of control over one's health and that of family members. Stories included workplaces where potentially dangerous air pollutants were present (laundries, beauty salons, dry cleaners, small textile sweatshops). Focus groups provided the context for previously passive women to develop public narratives, additional networks of support to manage asthma, and to share home remedies (queried, however, by professionals for potentially toxic ingredients). The aim was to make disease management a community-building activity, rather than an isolating and scary experience.

- *street art*: El Puente Academy students painted a large mural on a building in the middle of the community depicting harms, causes, and remedies, as well as community organizing as a collective action strategy.

The difficulty this project had in influencing policy on a larger scale had various sources, including competition among groups in the city over very limited foundation and government funding. In subsequent years, community-based environmental health coalitions have become more prevalent and some forms of funding and institutional support have increased.

References:

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El Puente [website](#).

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