



Rural Voices



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R U R A L H O U S I N G & H E A L T H



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Increasing health awareness ...

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Allergens and lead-based paint ...

AND MORE . . .





Dear Friends,

A home can affect the health of its occupants. Conversely, residents' health considerations can impact the design and construction of their homes, as well as their need for convenient, affordable services. The articles in this issue of *Rural Voices* examine these links between housing and health for low-income rural Americans.

The importance of these housing-health connections is increasingly recognized. In fact, Housing and Urban Development Secretary Mel Martinez proclaimed October 2002 as Healthy Homes Month.

The articles presented here take a variety of approaches. Some describe the assortment of housing and health issues that can affect a particular part of the country or a particular population: Appalachia, the border colonias, Indian Country, farmworkers, and homeless people. Others address specific housing-related health concerns, providing practical advice for developers of affordable rural housing in dealing with lead-based paint and other indoor allergens.

It is striking that every article in this issue not only explains a problem, but also either describes successful activities addressing the problem in rural America or proposes new solutions. Health and housing issues are solvable. The experts and practitioners who have contributed to this issue of *Rural Voices* prove that.

Sincerely,

Debra Singletary, Chair

William Picotte, President

Moises Loza, Executive Director

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Increase Rural Housing Production, HAC Tells Committee

Millions of new homes are needed throughout rural America, HAC president Bill Picotte told the Housing Subcommittee of the Senate Banking, Housing and Urban Affairs Committee in September. "We need at least 1,700 new homes" just on the Cheyenne River Sioux reservation in South Dakota, said Picotte, who is executive director of Oti Kaga, Inc., a nonprofit housing organization on the reservation.

"Rural rental housing may face the biggest crisis," Picotte continued, noting that nearly two-thirds of the housing need at Cheyenne River is for rental units. In fact, the bipartisan Millennial Housing Commission found renters with extremely low incomes have the greatest housing need throughout the



United States. USDA's Section 515 rental housing production program has been extremely useful on the reservation, but funding for the program has been cut so drastically that it now appears units are leaving the program faster than new ones are being built.

"Increasing funding for [current federal housing programs] is vital," stated Picotte. He urged Senators also to consider a number of new proposals for both ownership and rental housing, including a homeownership tax credit proposed by the Bush Administration, creation of a federal housing trust fund as a source of new funding, and production bills introduced by Senators Christopher Bond and John Edwards.

Picotte's testimony is available on HAC's website at www.ruralhome.org/picotte.htm.

HAC Receives New SHOP Funds

The Department of Housing and Urban Development has awarded HAC \$6.38 million in Self-Help Homeownership Opportunity Program funds to help local organizations produce sweat-equity housing. The money will help produce 638 homes for families who help build their own and their neighbors' houses.

HAC will loan the SHOP money to local housing groups to prepare sites for self-help housing development. It has already completed the application process, receiving 53 requests totaling over \$9 million. HAC will announce its loan decisions at the National Rural Housing Conference in December.

HAC has received SHOP funds from HUD every year since the program began in 1996, and has committed more than \$39 million under the program, including monies repaid to HAC and re-loaned to community organizations. The loans are expected to help produce new affordable homes for more than 4,400 rural Americans.

Board Members Receive Lifetime Achievement Awards



Bill Powers



David Lollis

Two long-time members of HAC's board of directors recently received separate Lifetime Achievement Awards. The National Community Capital Association chose David Lollis for the first such award it has ever given, and the Congress of California Seniors honored Bill Powers.

"These awards are both well deserved," said Moises Loza, HAC's executive director. "Dave Lollis has been a pioneer in community development finance, and Bill Powers has spent decades working for issues that matter to seniors. Both of them have also contributed greatly to HAC, and we are honored to have them serve on our board."

HAC To Distribute Capacity Building Funds

For the second time, the U.S. Department of Agriculture has selected HAC to receive funds from its Rural Community Development Initiative. HAC will match the \$700,000 RCIDI grant with an equal amount raised from other sources, creating a \$1.4 million program.

HAC will use the funds to help local groups build their capacity to develop affordable rural housing and community facilities and to increase economic growth. The money will be used to provide grants and technical assistance to about 47 groups to help them with a range of activities such as financial management and fundraising. USDA's application process required the participating groups to be identified in advance, so HAC is not able to accept additional funding requests at this time.

Updated CRA Guide Available

A newly updated guide from HAC explains how the Community Reinvestment Act works and provides case studies showing how rural organizations have used it to produce better housing in their communities. CRA requires federally insured financial institutions to help meet the credit needs of their entire communities, including low-income people. It has been an important tool to help affordable housing developers obtain financing from banks and savings and loan institutions.

A Guide to the Community Reinvestment Act for Housing in Rural America is available on HAC's website at www.ruralhome.org/pubs/publist.htm#credit. Printed copies may be ordered from HAC for \$8 each, including postage and handling.

Everyone in town knew Jimmy. Everyone knew that he was crazy. He walked around Hazard every day, stopping in for a soda at the Food Mart. He was often homeless, in and out of the psychiatric hospital, and in and out of jail. During one of his admissions to the psychiatric hospital, Jimmy was linked up with a case manager from the community mental health center and a family mental health advisor from Hazard Perry County Community Ministries. They started contacting Jimmy on a daily basis and helping him out with medication access, keeping counseling appointments, grocery shopping, and other tasks. They helped him fill out an application for a single-room unit at High Street Housing, owned by the Hazard Perry County Housing Development Alliance.

Jimmy's first several months at High Street were rough for him, the other residents, and the involved agencies. Due to his mental illness and other health problems he forgot a lot of things — to take his keys with him when he left the building, to turn off the stove, to put food away, and to not just let his cigarettes and ashes drop wherever they might in his apartment.

Together, Community Ministries, the Housing Development Alliance, and Jimmy created a plan to help him maintain his residency. Jimmy and his family mental health advisor figured out some safe places for spare keys, hired someone to help him clean his apartment, and got him on a regular schedule for shots of his medication instead of having to remember to take pills each day.

The Housing Development Alliance unplugged the stove and installed a microwave, and they removed the carpet and put in linoleum. Jimmy has now been a resident for two and one-half years. After a history of spending months each year in the psychiatric hospital, he has not been admitted in two years. Everyone is amazed at the change Jimmy has made in his life.

Coordinated Health and Housing Services Work in Rural Kentucky

by Jennifer Weeber and Scott McReynolds

Safe, decent, and affordable housing with appropriate accommodations and support services enabled Jimmy to stabilize and improve his quality of life. The same is true for many other people in Perry County, Ky. This mountainous county is located in the heart of the eastern Kentucky coalfields. Just under 30,000 people live here, 5,000 of them in the county seat of Hazard. The natural beauty of the tree-covered mountains and gentle streams is juxtaposed with areas of logging and various forms of strip mining.

The area is one of both great challenges and many opportunities. Twenty-seven percent of the population lives at or below the federal poverty line. The area median income is \$23,786. Much of the housing stock is old and is becoming increasingly dilapidated. In the mountainous terrain, basic infrastructure is expensive to obtain and maintain. Perry County and the rest of southeastern Kentucky have some of the highest rates of heart disease, diabetes, asthma, and cancer in the nation. Health reports often refer to this area as “coronary valley.” Southeastern Kentucky is one of the few parts of the country where one can still buy five-gallon buckets of lard at the grocery store. Smoking is allowed in most public places and the smoking rate — even among teens — is one of the highest in the country. People engaged in the traditional industries of coal mining and logging often suffer from black lung and a myriad of other physical ailments triggered by their working conditions. Nearly one-third of the population does not have health insurance.

It is clear to people working on these issues that poverty, healthcare, and housing are inextricably linked. Any strategy to effectively address one of these issues must address all of them. Any strategy must also include the community in defining the problem and in creating the solution. It is hard work, but it is essential that folks (nonprofits, healthcare agencies, academic institutions, the faith community, the business community,

ected officials, affected persons, and others) come to the table together, leave their territorialism at the door, roll up their sleeves, and get to work. In Perry County this has not necessarily meant a lot of meetings with a lot of people. It has meant some meetings, some chats over coffee at the local café, some pounding nails, some grant writing, and many other forms of dialoging and moving towards a solution.

Perry County is rich in history, in the sense of rootedness that people feel, in the way the community comes together to address problems with homegrown solutions. It is home to nonprofits such as Hazard Perry County Community Ministries and the Hazard Perry County Housing Development Alliance, to the largest hospital within the Appalachian Regional Healthcare network, to the University of Kentucky Center for Rural Health, to a multi-faceted community mental health center, to a strong faith community, to an involved business community, and to many people who want the very best for their family and their community. These groups have been collaborating for years to combat poverty, poor health status, and poor housing conditions. They created a continuum of care system, providing a range of services to homeless people in Perry County, before HUD mandated one. They continue to coordinate efforts to address these issues through such programs as the Southeast Kentucky Community Access Program (SKYCAP), a national model for health access and a holistic approach to healthcare, and Rural Health Outreach, a program designed to improve the quality of life of chronically mentally ill adults.

Often at the center of efforts to address housing and healthcare is Hazard Perry County Community Ministries. Uniquely positioned as both a housing organization and a service organization, Community Ministries walks in both worlds, talks both languages, and often serves as a bridge between the two. It operates several childcare centers, an emergency shelter, a crisis aid program, transitional housing, case management for persons who are homeless, a health outreach program, and a welfare-to-work mentoring program.

Most recently Community Ministries has begun to work with other community partners, including Harlan Countians for a Healthy Community and others in neighboring Harlan County, on implementing a Healthcare for the Homeless program. This partnership creates an avenue for addressing these issues on a regional level.

Community Ministries' approach to case management, transitional housing, health outreach, and other programs is holistic. Families and individuals are understood within the context of their housing situation, their health status, their employment



Photo by Jennifer Weeber

Terry Thies of the Hazard Perry County Housing Development Alliance and Bill stand in front of High Street Housing in Hazard, Ky. Terry manages the building, which provides single-room occupancy units and support services for residents.

status, education level, family situation, and other factors. Staff recognize that in order to help families move forward economically, all of these factors must be considered. They are trained to assess housing, education, health, and other needs, to access services that will help families to meet those needs, and to understand the languages of these different arenas.

In many ways, community development is really at the core of Community Ministries' work. According to Gerry Roll, executive director of Community Ministries, "It all goes together. In order to have healthy communities, we need healthy families. In order to have healthy families we need affordable housing, affordable and quality childcare, affordable and quality healthcare, jobs that pay decent wages, and much more."

Making this happen goes far beyond creating programs within Community Ministries or in collaboration with community partners. It means setting an example, initiating dialogue within various segments of the community, providing support to other groups, and involving the entire community in making it happen. Roll and other staff make certain that healthcare and childcare are discussed in housing circles and that housing is discussed in healthcare and childcare circles. They are involved in groups such as the local Industrial Planning Board, the Chamber of Commerce, and Rotary. This involvement creates opportunities to talk about housing, healthcare, childcare, and other factors in the context of job creation and the business community.

The Hazard Perry County Housing Development Alliance grew out of the community's desire to address housing issues. Initially created by Community

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Photo courtesy of the Texas A&M Colonias Program

Promotoras and Environmental Health Awareness in the Colonias

by Marlynn L. May, Irma N. Ramos, and Kenneth S. Ramos

Given their deep local knowledge — most live in the communities within which they work — promotoras are able to establish trusting relationships with residents in the effort to decrease disease rates and increase service utilization.

More information, along with a version of this article that includes source references, is available at <http://chud.tamu.edu>.

Health and housing are symbiotically related in the colonias along the U.S.-Mexico border. These rural communities adjoin areas of major agricultural production and often lack public water, waste management, and transportation infrastructures. As a result, outdoor and indoor pollution combine with poor housing conditions and inadequate services to challenge the health of colonias residents. One useful step towards improving their health is community-based health education, demonstrated in a project developed by the Texas A&M Colonias Program in partnership with the Texas A&M Center for Environmental and Rural Health.

HEALTH AND HOUSING IN THE COLONIAS

The U.S. Environmental Protection Agency defines colonias as “U.S. rural settlements with substandard housing and poor living conditions along the U.S.-Mexico border” that lack some or all of the following: paved roads, sewer systems, electricity, gas, clean water, and/or health care services. Colonias are always located in low population density areas, a fact that helps explain why they are so often without infrastructure. They exist, as one researcher puts it, in an “administrative no-man’s land.”

Prior to 1950, much of the land now occupied by colonias was a vast expanse of ranches and farms. In the 1950s, with almost no regulation by county governments, landowners began to sell off poor quality tracts of land (especially tracts prone to flooding or erosion) to their farmworkers and to immigrants from Mexico. One of the defining characteristics of colonias is that nearly all of the residents own a plot of land on which they live. They are, quite literally, true stakeholders in what happens in their communities.

There are major benefits in being able to own land in a colonia and build on it. Most low-income border residents cannot afford to buy land and a house in a suburban development, or even a rural development, on either side of the U.S.-Mexico border. The opportunity to buy land in a colonia, therefore, is to have the chance to build a home, at one’s own pace and as finances allow.

One of the major drawbacks to buying and building on a colonia lot is that the homes are located in settings where environmental conditions are poor. Although the majority of colonias now have water piped to the community, not all residents are able to access it because of added costs; few have waste management systems. Some residents have septic systems, but most rely on cesspools, run-off, or another unimproved form of waste management. Thus, along with

being stakeholders they are also victims of unmanaged environmental waste.

In the Lower Rio Grande Valley (Cameron, Willacy, Hidalgo, and Starr counties) there are more than 1,000 colonias with a population of over 350,000 residents. Several state and federal agencies have conducted extensive environmental monitoring here. A small-scale pilot project by the EPA monitored indoor and outdoor air, food, house dust, water, and soil, and detected low levels of pesticides in each of the media sampled, except public drinking water. In some of the homes, elevated levels of pesticides were detected during the summer months. Since many of the detected pesticides have both domestic and agricultural usage, it was difficult to establish the exact source of these materials. In general, the EPA found that levels of chemicals in outdoor air in the lower Rio Grande Valley were comparable to those observed in other locations in the United States. Another study, however, observed agricultural pesticides in both outdoor and indoor air, with greater concentrations indoors of household pesticides and volatile organic compounds, such as propane and butane. Colonias residents are particularly vulnerable to these potential environmental hazards because they are too seldom protected by modern sanitary and water facilities.

Recognizing these conditions, the Texas A&M Center for Housing and Urban Development's Colonias Program, in partnership with the Texas A&M Center for Environmental and Rural Health, initiated an extensive education and outreach project aimed at informing the residents of Cameron Park, a colonia located adjacent to Brownsville, Texas, about environmental hazards and what to do about them.

We knew from the outset, based on the experience with promotoras in CHUD's Colonias Program and from research, that low-income Hispanic people rarely turn to health care professionals for health-related information. Instead they seek out peers or authority figures within their own social networks. Effective delivery of health information begins with emotional and psychological methods such as establishing rapport with a client, becoming a friend and a health partner. Therefore, the Cameron Park education and outreach project was built on a foundation that involved indigenous community outreach workers — *promotoras* — in its design and implementation.

PROMOTORAS AS COMMUNITY EDUCATORS

The word *promotora* is a Spanish term for a lay community educator. Promotoras are widely used for health outreach in Mexico, Latin America, Africa, and Asia. In the United States, promotoras are commonly found working along the U.S.-

Mexico border and in rural areas within which access to health care is severely limited or non-existent and where they have been shown to be effective health educators. They may also be involved in community organizing and development projects.

Promotoras are indigenous community builders, contributing to the development of social networks within colonias, and networks between colonias and the outside world, most specifically outside service providers. Promotoras bridge gaps in culture, social class, and education between providers and residents. It is a two-way process. They not only take knowledge of the community and translate it with

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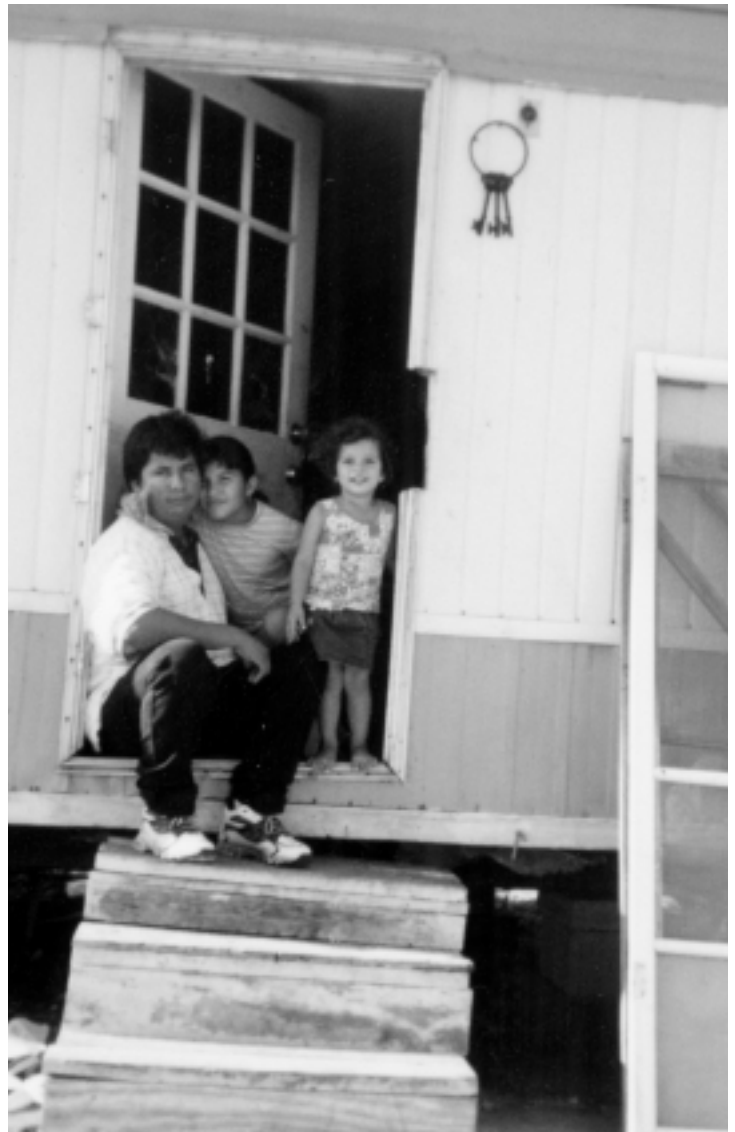


Photo courtesy of the Texas A&M Colonias Program

FROM PAGE 5 service providers; they take knowledge of the service providers and translate it with community residents. “Translating” between two, often contradictory, worlds requires that Promotoras have dual competency, capacity for understanding and communicating in ways few others have.

Given their deep local knowledge — most live in the communities within which they work — promotoras are able to establish trusting relationships with residents in the effort to decrease disease rates and increase service utilization. Moreover, their impact often reaches beyond direct health benefits to other areas of community building.

Communication skills emerge as one of the most important promotora competencies. Within the colonias along the U.S.-Mexico border, lack of effective communication between residents and providers is identified as a major factor in service underutilization. By establishing personal communication and trust rather than relying on form letters and phone calls, promotoras can work to overcome any fear or mistrust of authority and can reach households lacking telephone service.

THE PROJECT

Promotoras stood at the heart of the Cameron Park environmental health educational outreach project. What was needed was clear and accurate communication to colonia residents of scientific knowledge about environmental health to the residents. The Cameron Park promotoras had to put their dual competency skills to work to learn, translate, and interpret scientific knowledge in the vernacular of their fellow residents.

To accomplish this goal we used a “train-the-trainer” approach. CERH staff created a curriculum specifically for the Cameron Park project, focusing on environmental hazards specific to the Lower Rio Grande Valley. Scientific experts taught the Cameron Park promotoras using a curriculum of 11 topics on environmental hazards and what can be done to protect against them. Following the 11 training sessions, the promotoras and the project’s principal investigators from CHUD and CERH worked collaboratively to develop a strategy that called for them to reach every resident of the community with information about environmental hazards and health.

Through informational meetings in residents’ homes, the community resource center, and in community organizations — all organized by the promotoras — they took to the community what they had learned and translated in the train-the-trainer sessions. Over the course of three months, they were able to reach two-thirds of the Cameron Park residents, face-to-face, with information about environmental health and the home.

A number of the solutions conveyed by the promotoras to the communities are housing-related. For example, since residents without water lines must store supplies of clean water, the promotoras provided information about what containers are appropriate, described the importance of labeling them properly, and strongly emphasized the need to boil water before using it. Residents were encouraged to install window screens or repair damaged screens to keep potentially disease-bearing insects out of their homes. Similarly, education sessions also discussed the need to remove outdoors containers or debris such as tires where standing water could collect and provide a breeding ground for mosquitoes.

THE OUTCOMES

Did it work? There are three ways by which to assess the effectiveness of the community education.

The first is the value added for the promotoras themselves. Every one of them successfully passed a test after each train-the-trainer session reflecting their competent grasp of the information presented. They came away knowledgeable about hazards and remedies.

Second, the quality of their knowledge was tested experientially as they helped to create the curriculum and the pedagogies that they would use to “translate” the information with their fellow residents in Cameron Park. The fact is that the promotoras took the lead in this phase because it is they who know the modes of communicating that work best in their community.

A third level of assessment is to know whether the local knowledge base in Cameron Park about environmental hazards and protections against them was increased. To assess this level, we worked collaboratively with the promotoras to develop a pre- and post-test research project to measure the extent to which local residents had gained knowledge. The data for this assessment are currently being entered and readied for analysis. Results are not yet available, but will be reported at a later date.

Finally, the value of this project was highlighted when we were invited to replicate it in another colonia in the Lower Rio Grande Valley. That replication is now in progress, led by one of the promotoras who participated in the Cameron Park outreach.



MARLYNN L. MAY is director of the Colonias Program Field-Based Research and Learning Center and distinguished lecturer in urban planning at the Texas A&M University College of Architecture. **Irma N. Ramos** is director of the Community Outreach and Education Program at the Texas A&M University Center for Environmental and Rural Health. **Kenneth S. Ramos** is director of the Center for Environmental and Rural Health and professor at the Texas A&M College of Veterinary Medicine.



Photos by Dennis G. Smith II of NAIHC

HEALTH AND HOUSING

Danger Lurks at Home in Indian Country

by Raven Miller

Until policymakers start making real funding and federal program changes, many First Americans have little choice but to continue living without things that most Americans would call necessities: clean water, electricity, and a safe place to call home.

Dilapidated, unsafe, and unhealthy housing conditions are everyday realities for most Native Americans living on reservations. Many live in homes that lack plumbing and clean running water and are severely overcrowded. Conditions on some reservations are comparable to those of developing countries. Despite the immediate threats posed by these unsafe and unhealthy housing situations, the best solutions are also time-consuming, expensive, and require legislative change.

OVERCROWDING

Overcrowded homes have more occupants than there are rooms and for most residents on tribal lands overcrowding is a way of life. Because there is an inadequate supply of decent, affordable housing, and because new homes are costly and built slowly, many tribal housing authorities have extensive waiting lists. For many people in the Native community, what little housing exists is out of reach, increasing the likelihood of overcrowding and health-related consequences. Census Bureau data reveal that overcrowding occurs in 32.5 percent of tribal homes, a far cry from the 4.9 percent of all American homes

that are overcrowded.

According to a study by the National American Indian Housing Council, overcrowding typically affects low-income and unemployed people, single parents, and families with young children. NAIHC found that on some tribal lands, there are homes as small as 400 square feet with 20 or more residents.

NAIHC's report, *Too Few Rooms: Residential Crowding in Native American Communities and Alaska Native Villages*, highlights a situation in which one housing unit contained a single mother, her boyfriend, four children, and one grandchild. In Native tradition, to take care of your brother is to take care of yourself — which may be the motivation behind inviting more people into an already overcrowded home. In many cases, overcrowding is further exacerbated by high unemployment and poverty rates in the Native community.

The spread of disease is one of the most troubling consequences. With many people sharing the same kitchen and bathroom facilities, there is ample opportunity for disease to spread. From a simple cold to conjunctivitis and lice, living in close quarters exposes occupants to a

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FROM PAGE 7 variety of health concerns — including the health habits of other residents.

Non-smokers are exposed to second-hand smoke, which leads to respiratory problems, asthma, and both ear and sinus infections. When drug and alcohol abuse enter the picture, children and elders are at risk for abuse. The same is true for homes with domestic violence, a situation often aggravated by the stress of overcrowded living. Living with someone who suffers from depression or mental illness can be stressful as well, and made more difficult by overcrowding. For tribal occupants in this situation, there is nowhere to go.

While the obvious answer to overcrowding is to provide more and better housing for Native people, that is easier said than done. Resolving the overcrowding in Indian Country must first become a priority for policymakers.

NAIHC's executive director, Gary Gordon, said, "There are no easy answers to the problems of overcrowding, and change depends on increased federal funding, economic development, and more flexible federal programs. This is not meant to undermine the importance of increased funding, which is the key to improving the overall quality of life for Native people living on reservations."

MOLD GROWTH IN THE HOME

Most Americans are aware of the legal and health aspects surrounding lead paint and lead poisoning. While lead remains a significant problem, there is a more common enemy found in many American homes: mold.

Mold grows fastest in moist, humid conditions, particularly in warm climates, in homes lacking air conditioning, or in improperly maintained dwellings with leaky windows or cracked walls. In homes across the nation and throughout Indian Country, claims have been made that toxic or black mold has caused property damage and illness. Mold has spurred a flurry of lawsuits across the country, with some lawyers calling it the "asbestos of the new millennium."

Most lawsuits link mold with such health symptoms as asthma, brain damage, and respiratory problems. There is no viable scientific evidence to support those claims, however. In any case, for homeowners in Indian Country, it is often too expensive or not possible to take preventive measures. Fortunately, a new federal bill (H.R. 5040) could publicize the dangers of mold, assist victims, and require further examination of the link between mold and illness.

NAIHC has asked for federal assistance to eliminate the mold damage caused to homes on tribal lands. Some tribes



Photo by Dennis G. Smith II of NAIHC

have taken things into their own hands. The Turtle Mountain Band of Chippewa sought federal funding for the mold damages found on homes and for emergency housing. Some residents of the Blackfeet Indian Reservation claim that homes built by the U.S. Department of Housing and Urban Development (HUD) in the 1970s and 1980s have structural problems — plumbing leaks and unstable foundations — that have caused mold growth. Residents in these homes insist also that the wood foundations treated with copper arsenate can be linked to cancer deaths, headaches, and respiratory problems, health concerns that are not mold-related.

To combat mold, HUD has allowed its lead paint funding to be used for mold damage, and has encouraged its staff to draw attention to the hazardous materials found in homes. Nevertheless, overall funding for the purpose of home safety must become a greater priority.

WATER, SEWAGE, AND OTHER INFRASTRUCTURE PROBLEMS

Although the Bureau of Indian Affairs and HUD have built homes on tribal lands for decades, an inadequate number have been produced, and many of those homes are too small and lacking in quality. Compounding the problem is the lack of decent infrastructure. Most Americans living in urban areas barely give a second thought to paved roads, sewage, water, and electricity. Not so on reservation lands.

Reservation dwellers experiencing infrastructure problems are further irritated by homes lacking indoor plumbing, kitchen, and bath facilities. The 20 percent of Native people on reservation lands without indoor plumbing live with severe compromises in their quality of life.

Tribes such as the Navajo have many members living in

homes lacking both indoor plumbing and running water. On other reservations, residents may have water, but it is contaminated. These residents risk being afflicted with diarrhea, Hepatitis A, and even dehydration, since it may seem better to go thirsty than to drink unsafe water. Unclean water also affects personal hygiene and inhibits food preparation.

A 1998 General Accounting Office report on the limited number of homeownership opportunities on trust lands noted that some homes on the Navajo reservation are in such remote areas, infrastructure can cost \$20,000 per home.

Indeed, the location of tribes can affect the quality of life in Indian Country. Indian reservations tend to be in isolated or rural areas. In cold climates, such as in Alaska Native villages, there is little or no access to roads during the long winters. In warmer areas, many tribes are located in geographically inaccessible places, or have unpaved roads, making it a challenge to truck in housing materials. This means Native people are unable to get the supplies they need to repair homes, leaving

residents vulnerable to rodents — known disease carriers — or to the elements.

The congressionally mandated report on American housing by the Millennial Housing Commission recommended that infrastructure be funded by Indian Health Services and the Rural Utility Service. The MHC also called for more funding to eliminate “health and safety hazards” in Indian Country.

NAIHC’s Gordon explains, “In many cases, tribes are forced to choose between building new homes to eliminate overcrowding or replacing bad homes. Another dilemma is the fact that new homes cannot be built without basic infrastructure. So, until policymakers start making real funding and federal program changes, many First Americans have little choice but to continue living without things that most Americans would call necessities: clean water, electricity, and a safe place to call home.”



Raven Miller is the communications specialist at the National American Indian Housing Council. She can be contacted at rmiller@naihc.net or 202-789-1754.

FROM PAGE 3 Ministries to help with a transitional housing project, the Alliance now builds new homes, rehabilitates homes in need of repairs, develops rental housing, and offers various forms of financing.

Alliance members are acutely aware of the relationship between housing and healthcare. They have found that a number of persons who have applied for housing have tremendous healthcare costs. They view this as a challenge to nurture grant sources and to develop flexible pools of money so that families in these situations can be helped. They find themselves taking referrals from Community Ministries’ health outreach program, the health department, and other agencies for people whose housing conditions are having a negative impact on their health. In turn, they refer clients to these same agencies when they realize a health need with the client.

They have replaced countless numbers of coal and wood stoves and kerosene heaters with electric heating systems for persons with breathing problems including asthma and emphysema. They have built numerous ramps for persons with mobility impairments. The exterior of Susan’s home was modified to allow her easy egress from all rooms after she obtained a prosthetic leg. A ramp was built, doors were changed, and

landscaping created a gentler slope from her house.

The Alliance has also modified new home designs. Mable is able to care for her elderly mother at home because her house plans were modified to take into account her mother’s hospital bed and her need for linoleum for both mobility and sanitary reasons. The Housing Development Alliance understands the importance of support services to the housing and healthcare link, and works to maintain relationships with those providers.

“Linking housing and healthcare was not an epiphany nor even a formally developed philosophy,” according to Scott McReynolds, executive director of the Housing Development Alliance. “It just makes sense as we looked at what pieces are needed for healthy communities.” For Jimmy and the rest of Perry County, it makes sense to take a holistic view of individuals and communities. It makes sense to address the challenges of high poverty rates, poor health status, and poor housing conditions in a combined strategy. It makes sense to work together as a community to create and carry out this strategy.



SCOTT MCREYNOLDS is executive director of the Hazard Perry County Housing Development Alliance. Jennifer Weeber works at Hazard Perry County Community Ministries.

Photos courtesy of Rural Community Assistance Corporation



EDITOR'S NOTE An article in the Winter 2000-2001 issue of *Rural Voices* described the Rural Community Assistance Corporation's Agricultural Worker Health and Housing Program. This article provides an update, including an evaluation of the program as well as case studies of successful projects. This article was excerpted from the December 2001 issue of RCAC's publication, the *Pacific Mountain Review*.

Improving the Lives of Agricultural Workers

by Shoshana Zatz, Ron Dwyer-Voss, and Hector Fernandez



Under AWHHP, decent, affordable housing is considered the foundation for improved health. The program funds models that exhibit extensive community collaboration and agricultural worker participation.



RCAC'S AGRICULTURAL WORKER HEALTH AND HOUSING PROGRAM

The Rural Community Assistance Corporation established the Agricultural Worker Health and Housing Program in 1999 with a \$31 million award from the California Endowment. Through this program, RCAC allocates loans and grants to partnerships between health and housing organizations that effectively link health programs with affordable housing for agricultural workers, their families, and their communities.

Under AWHHP, decent, affordable housing is considered the foundation for improved health. The program funds models that exhibit extensive community collaboration and agricultural worker participation. In the first four rounds of funding, RCAC awarded more than \$18.5 million to 38 innovative partnerships and strategies to improve the health and housing of California's agricultural workers. Partnerships have been able to leverage AWHHP loans with other funding sources to initiate the building of over 700 new affordable housing units in rural agricultural communities, helping to improve the living conditions of over 2,100 agricultural workers and their families. In addition, funded partnerships have designed health improvement strategies to serve more than 14,000 farmworkers and their dependents through various health service projects. Projects are located in all major agricultural regions of California, from as far north as Crescent City to San Diego in the south.

The AWHHP required partnerships between health and

housing organizations, which must be nonprofits or public agencies. The partnerships applied for loans of up to \$1.5 million for financing capital costs related to the construction or rehabilitation of housing, health facilities, or community facilities for agricultural workers. Loans were made for construction of new buildings; expansion, modernization, renovation, remodeling, and alteration of existing buildings; and purchase of initial fixed or moveable equipment.

In most cases, the loans were coupled with Health Improvement Grants of up to \$200,000 for up to three years. The Health Improvement Grants are being used for programmatic and operating costs related to health improvement activities linked with agricultural worker housing. Health activities can be in the areas of medical, dental, mental health, public health, community health, and/or preventive health.

Capacity and Partnership Building Grants of up to \$40,000 were also awarded with the aim of developing resident-based, community collaboratives and emerging nonprofit organizations to plan and prepare for AWHHP and other funding. The grants are for building the capacity of organizations and agricultural workers in their efforts to create collaborative health and housing strategies.

To qualify for these loans and grants, each applicant was required to demonstrate that its project met a number of guiding principles, including:

- ▶ *agricultural worker involvement* — agricultural workers must be meaningfully involved in developing and designing the proposal and in long-term project implementation and management;
- ▶ *partnerships* — AWHHP is based on partnerships between nonprofit organizations and/or public agencies with programs that collaborate with other organizations and agencies, including schools that impact agricultural workers; and
- ▶ *long-term sustainability* — programs should continue providing housing and health services after AWHHP funding is depleted.

EVALUATION

RCAC is now beginning to evaluate AWHHP-funded projects. Through this process, RCAC helps award recipients develop an evaluation infrastructure that will be a valuable and indispensable tool. RCAC's evaluation team works with agencies to design a successful evaluation process.

Perhaps the most unique aspect of the evaluation process is agricultural worker involvement. While other programs leave out agricultural worker involvement

CONTINUED ON PAGE 13

Successful Case Study

Numerous success stories have developed in the two years since RCAC began funding AWHHP projects. The following case studies illustrate some of those successful projects and their positive impacts for agricultural workers.

Tulare County is in the agricultural belt of California's Central Valley, and consistently ranks among the top three most lucrative agricultural counties in the state. Ironically, its very mix of abundant land and labor also makes Tulare County one of the most economically disenfranchised counties in the state.

Twenty miles east of Highway 99 are the bustling communities of Cutler and Orosi, also known just as Cutler-Orosi. More than 15,000 of Tulare County's residents live here. When Sister Mary Ann Tippet arrived in Cutler in 1997, she quickly became acquainted with local civic leaders and with workers in the community. Sister Mary Ann provided local mothers and their children rides to and from out-of-area health clinics. Given the limited health services within the community, it is not uncommon to encounter families who travel as much as 50 miles for health care. Sister Mary Ann was convinced that the greatest single need in the area was a reliable health clinic.

There was also a concerned group of professionals, small-business owners, and community leaders in Cutler, who in 1998 formed what is now known as the Cutler-Orosi Taskforce. The need to upgrade and expand Cutler-Orosi's housing stock was their highest priority.

When Sister Mary Ann and the Cutler-Orosi Taskforce convened, they recognized the community need, but they also understood the challenges of realizing their vision of an improved community on their own. In fall 1998, Sister Mary Ann and the taskforce contacted Self-Help Enterprises, an experienced housing developer, and invited SHE staff to attend one of their regular meetings.

The partners sat down to discuss local concerns and soon concluded that health and housing were the most pressing issues within the community. SHE quickly conducted a market study of the area. RCAC's AWHHP created a unique opportunity for the community and SHE to solve health and housing needs in the community. AWHHP would create, among other things, the financing, the creative space, and the community involvement to make such a project possible.

Cutler Villa by Heriberto Rosales

The Family HealthCare Network of Tulare County joined the team as the health provider. In fall 1999, SHE, FHCN, the Cutler-Orosi Taskforce, and Sister Mary Ann Tippet were awarded a \$20,000 AWHHP grant to continue to construct partnerships and develop capacity for their project.

Within a year, the partnership had enlarged to include an organizer from Valley Catholic Charities, members of the local unified school district, and, most importantly, agricultural workers from the local community. SHE and FHCN held joint meetings to consult and work out concepts and plans for the health and housing project. About 15 of the agricultural worker participants made up the Cutler Project Advisory Committee, which gave project recommendations to both the housing and health partners. Their thoughts and ideas were so valuable that the project health clinic, which had been originally planned at 3,000 square feet, was doubled to its present size of 6,100 square feet, to accommodate the demand for a variety of health services.

When the partnership's housing project was past the land acquisition, site-control and architectural layout phases, it was time to give it a name. The advisory committee felt that a divinity of sorts had been at play, and named it in honor of the local Virgen de Guadalupe church — the future housing complex was named Villa de Guadalupe.

A year after the original small grant was awarded to this collaboration, they had received more than \$8 million in construction financing from several different housing programs. SHE completed a 60-unit multifamily project in April, which took one week to rent up. The SHE and FHCN partnership submitted an application for a capital loan and a health improvement grant with AWHHP and was awarded funding. FHCN used much of that award for construction and initial operation of its newest health facility, which is adjacent to the housing project. The project is a model of comprehensive quality health and housing services, and it has brought national attention to a once obscure county.

FROM PAGE 11 entirely, RCAC views workers' input and participation as vital in project planning and implementation and in developing an evaluation infrastructure.

Ultimately, individual award evaluations will be combined to tell a story about the AWHHP program in California. Collective evaluation results will contribute meaningful data to

an overall understanding of the AWHHP and its impact on the health and housing of agricultural workers.



RON DWYER-VOSS, HECTOR FERNANDEZ, HERIBERTO ROSALES, SANDRA PEREZ SCHWARTZ, and SHOSHANA ZATZ work for the Rural Community Assistance Corporation.

Successful Case Study

Raisin City, southwest of the city of Fresno, is home to some 4,700 residents. The city is surrounded by acres of agricultural land, and a majority of the residents in Raisin City earn their living working in the fields. During the peak season, the farmworker population nearly doubles. Decent, affordable housing is needed in Raisin City, as well as housing for migrant, seasonal farmworkers.

In the fall of 2000, the school district brought in a mobile medical unit for weekly health services. However, regular access to healthcare for all residents is greatly needed in Raisin City.

Raisin City residents rely on wells for their domestic water needs and individual septic tanks for sewage disposal. Since a majority of septic systems are in need of repair and many have failed, it is not uncommon for ponds of gray water to spill into residents' back and side yards.

Several years ago, the Raisin City Elementary School failed state drinking water standards and was mandated to truck in drinking water. Citizens were concerned because their domestic water well quality had never been tested, and they were concerned about the quality of the water their children were consuming at home. After several community meetings, residents were determined to develop a community drinking water system to purify water for domestic use.

The West Coast Mennonite Central Committee, Inc., comprised of agricultural workers, residents, the elementary school, California Rural Legal Assistance, and Frente Indígena Oaxaqueño Binacional, applied for a capacity and partnership building grant

Raisin City MCC Community Development Project

by Sandra Perez Schwartz

from the AWHHP. The application was approved, and the organizing group hired local resident Lupe Zuniga as its outreach worker.

Zuniga met with residents, surveyed the community and, with help from CRLA, brought in Self-Help Enterprises to explore the possibility of testing individual water wells. SHE provided Raisin City with a grant for \$3,400 to pay for random tests on 33

water wells. All the wells failed at least one of the health standards for contaminants. Most of them tested positively for two and four contaminants. More than 40 percent of the households have had problems with sewage disposal systems, including back-ups and liquid waste overflow.

"RCAC and MCC have brought hope to the tiny community of Raisin City," said Zuniga. "By providing what I consider to be the base for community development, they have helped open new doors to help our disadvantaged residents. The continuing support of RCAC, MCC, and SHE will enable us to continue with much-needed resources for future homes and health services."

In addition to the AWHHP and the SHE grants, the Raisin City MCC Community Development Project received a \$34,000 Community Development Block Grant from the County of Fresno for a preliminary water system design. The Fresno Regional Foundation provided a \$7,500 grant for preliminary design and other fees. Momentum is gaining in Raisin City; the feasibility of building better housing hinges upon the development of a community water system.

Hard To Reach

RURAL HOMELESSNESS AND HEALTH CARE

by Pat Post

Despite the severity and complexity of their health problems, access to health care for homeless people in rural areas is seriously limited by three primary obstacles: lack of transportation, lack of health insurance, and the unavailability or inaccessibility of health services.

Large numbers of visibly homeless persons in metropolitan areas have caused some to conclude that homelessness is primarily an urban problem. On the contrary, it is also a serious and growing problem in rural communities throughout the United States. In some rural counties, the incidence of homelessness per 1,000 population is proportionately comparable to or greater than that in New York City, Los Angeles, and Washington, D.C. For small towns with few health and social services, the burden of homelessness is particularly heavy.

The relationship of rural homelessness to health begins with the fact that the reported health status of rural U.S. residents in general is worse than that of urban residents. Notably, in most rural counties, adults are 20 percent more likely to die from heart disease; death rates among men with chronic obstructive pulmonary disease are 30 percent higher, attesting to the high prevalence of smoking in rural areas; and suicide rates are nearly 80 percent greater for males age 15 and older. Rural residents get less professional medical attention than residents of metropolitan areas, more of them lack health insurance, and fewer physicians practice in rural areas. The number of specialists and dentists decreases markedly as urbanization decreases, in all regions of the United States. Few statistical analyses are available comparing the health status of rural and urban homeless populations. Nevertheless, clinicians

report that similar health problems seen in both rural and urban clients are more advanced in their rural homeless patients, who have had little or no health care and who are diagnosed with more untreated, chronic health problems.

Homeless people in rural and urban locations share many of the same health risks. Exposure to the elements, environmental pollutants, infectious disease, frequently overcrowded living conditions, and the chronic stress inherent in finding food and shelter increase their risk for poor health. Lack of a permanent address complicates their access to entitlements. Financial and transportation barriers, prejudice, and stereotyping limit their access to mainstream health services. The geography of homelessness may vary, but its consequences are remarkably the same.

To put flesh on the bones of rural homelessness, we asked service providers in a variety of rural settings to describe the clinical conditions that seem to distinguish their rural homeless clients from others, and to specify obstacles that prevent these individuals from obtaining the services they need.

HEALTH PROBLEMS

Clinicians we consulted specified these health conditions as most frequently seen in their rural homeless clients:

- *mental health and substance abuse problems* — post-traumatic stress disorder; drug use (varying by region and population, with alcohol, methamphetamine, and prescription drugs most often mentioned)
- *chronic medical conditions* — hypertension, heart disease, diabetes, obesity, chronic obstructive pulmonary disease, asthma
- *infectious diseases* — hepatitis C, respiratory and intestinal infections (much less TB and HIV/AIDS than in urban areas)
- *disabilities* — secondary to mental illness, occupational injuries, and trauma
- *skin problems* — foot lesions, frostbite, poison oak

Though familiar to most homeless health care providers, these problems are often more advanced and complicated in homeless persons from remote rural areas, as the following example illustrates.

Clinica Sierra Vista Homeless Program, based in Bakersfield, Calif., is one of the few Health Care for the Homeless projects serving a large rural population. Although the HCH clinic is located in a metropolitan area, its mobile health care unit travels all over Kern County, spanning 8,000 square miles of mountains, desert, and agricultural land, much of it sparsely settled. Unemployment rates in some communities are as high as 20 or 30 percent.

The HCH outreach team serves several distinctive groups of rural clients, says homeless coordinator Marie Aylward-Wall. Among them are 40,000 mostly Hispanic migrant farmworkers who come to the area during harvest season, May-October. Most live in orchards and fields or along canal banks; some live in more urban areas, doubled up in motels. These undocumented immigrants are very skittish about receiving services, says Aylward-Wall. One Sunday, the mobile outreach team found a 47-year-old diabetic farmworker living in the desert with gangrene up to his knee. They transported him to the emergency room, where his leg had to be amputated.

At least 600-700 Vietnam veterans are estimated to be living in the desert and mountains. The HCH serves about 350 of them at any given time. “This is the hardest group to reach and the most reticent,” says Aylward-Wall. Many of these clients have untreated post-traumatic stress disorder with overlying drug problems. Already on drugs when they returned from the war, they have been self-medicating ever since. A number of these individuals have advanced diabetes and hypertension. Bad foot lesions are often seen in untreated diabetic alcoholics. Hepatitis C is also very common among homeless veterans. “In those we have tested, the average prevalence of hepatitis C is 60-65 percent, compared to 30 percent in other homeless clients,” she reports.

ACCESS BARRIERS

Despite the severity and complexity of their health problems, access to health care for homeless people in rural areas is seriously limited by three primary obstacles: lack of transportation, lack of health insurance, and the unavailability or inaccessibility of health services — particularly specialty care, mental health services, and substance abuse treatment. These access barriers are not unique to rural homeless people, but they are more severe.

TRANSPORTATION. Limited or no access to public or private transportation makes health care access virtually impossible for many homeless rural residents. Severe geographic barriers, such as mountainous terrain or vast distances from available services, exacerbate this problem. “Many rural areas don’t even have buses,” notes Jan Wilson, homeless health care coordinator at Valley Health Systems, Inc., Huntington, W.Va. “Even if you are only ten miles away from a health center and don’t have a car, that’s a serious barrier.”

SECONDARY AND TERTIARY CARE. An insufficient provider network exacerbates this problem, says Wilson. Even where primary health care is available there is a scarcity of specialists. Many local hospitals have closed

CONTINUED ON PAGE 16

Recommendations from Rural Service Providers

Rural service providers interviewed for this research proposed a number of ways to improve the health of people living in rural areas who are homeless or at risk of homelessness:

IMPROVE SHELTER ARRANGEMENTS: Provide temporary shelters as alternatives to costly motels. Provide services for homeless women in domestic violence shelters.

ENSURE ACCESS TO BASIC HEALTH AND SOCIAL SERVICES: Provide transportation assistance to homeless people. Provide school-based clinics and service centers for women. Improve responsiveness of mainstream health care professionals to homeless people. Increase public funding in rural areas for dental care, services to undocumented immigrants, hepatitis C treatment, and follow-up care.

REACH OUT TO REMOTE AREAS: Use community networks and indigenous workers to facilitate homeless outreach in remote rural areas. Establish permanent clinic sites in remote areas. Improve interagency collaboration and service coordination within and among rural counties.

IMPROVE BEHAVIORAL HEALTH CARE ACCESS AND QUALITY: Improve responsiveness of community mental health clinics to homeless people. Increase public funding of integrated mental health/substance abuse services in rural areas. Follow standardized substance abuse treatment guidelines. Track use of frequently abused prescription drugs (e.g., OxyContin).

IMPROVE ACCESS TO SPECIALTY CARE: Reduce the cost of specialty care. Prohibit “cherry-picking” by mainstream providers and private insurance carriers. Educate homeless clients about Medicaid eligibility requirements/procedures and help them apply.

EXPAND HEALTH INSURANCE COVERAGE: Expand Medicaid eligibility. Restore eligibility for disabling substance abuse disorders. Exempt homeless people from managed care. Provide presumptive eligibility for homeless persons. Mandate universal coverage.

ENSURE CULTURAL COMPETENCY: Provide an interpreter at every clinic site serving persons with limited English proficiency. Focus on clients’ immediate and perceived needs. Educate faith-based service providers about the needs of homeless people.

PREVENT HOMELESSNESS: Advocate for a living wage and affordable housing. Integrate housing and health care. Guarantee maintenance of transitional housing services. Give lower-income applicants priority for Section 8 housing and maintain stable rental fees over time. Educate adolescents about pregnancy and substance abuse prevention in school-based clinics.

FROM PAGE 15 because of lower Medicare reimbursements and fewer patients who are eligible for Medicaid following welfare reform.

HEALTH INSURANCE. Even where it exists, specialty care may not be available to patients without health insurance. “Single homeless adults aged 30–55 fall through the cracks in Wisconsin,” says Mary Clay Santineau of Starting Point, in Chippewa Falls, Wisc. “Most aren’t eligible for Medicaid, and general medical assistance, in the few counties that offer it, isn’t enough to help,” she says. “The only clinic in Chippewa County that sees clients on a sliding scale is so full that it turns away one-third of the people seeking services. Many families need \$70–\$80 medications to treat attention deficit hyperactivity disorder, diabetes, or mental illness, but can’t afford them; so they get off their medications, crash and burn, and can’t maintain regular housing.”

ALCOHOL AND DRUG TREATMENT. Lack of available and adequate substance abuse treatment is another serious barrier, adds Wilson. “There aren’t enough medical detox beds for indigent patients, even for those who want treatment, which often lasts only 24 hours.” The only clients able to get long-term substance abuse treatment are those willing to wait as long as a month who haven’t been in treatment too many times before, she says.

Except for one AA group in town, there is no substance abuse treatment or therapy available for homeless people in Beatty, Nev., says Brian Lane of Beatty Medical Center. “We deal with addictions through crisis management alone,” he says. Mentally ill clients must be referred to the HCH project in Las Vegas, 120 miles away. Most often, they are referred to the emergency room at the nearest hospital, also in Las Vegas. “If an emergency occurs, we use a volunteer ambulance service; if it’s a real emergency, we can get a helicopter from Vegas,” says Lane.

MENTAL HEALTH CARE. Mental health care is virtually nonexistent in rural southwestern Tennessee, except for that provided by community mental health centers, says Minnie Bommer, Children and Family Services, Covington, Tenn. “Not many low-income people go to CMHCs except those mandated to go because of disruptive behavior.” Psychiatric referrals and psychotropic medications are hard to come by, even for clients who qualify for TennCare, Tennessee’s Medicaid managed care program, because psychiatrists are in short supply and few will accept TennCare enrollees.

MANAGED CARE. Managed care is a huge barrier for homeless people, particularly transients, agrees Edith Iwan of the Western New Mexico Group, which serves the tiny town of Thoreau. She recounts the experience of a Native American family that brought a two-month-old baby to the clinic last winter with respiratory syncytial virus, contracted from an older sibling. The baby had stopped eating, started to lose weight, and needed oxygen and medical care. Getting care was a logistical nightmare, even though the child was on Medicaid, because the family had moved frequently and did not understand how to access the managed care system. The baby ended up in the only available hospital, 30 miles away, after clinic staff had struggled to locate needed service providers within the appropriate managed care network. Native Americans (but not other homeless people) have since been exempted from Medicaid managed care in New Mexico.



PAT POST is communications manager and policy analyst at the National Health Care for the Homeless Council. This article is excerpted from the October 2001 issue of *Healing Hands* (www.nhchc.org/Network/HealingHands/2001/October2001HealingHands.pdf), which is an abbreviated version of *Hard to Reach: Rural Homelessness & Health Care*, available at www.nhchc.org/Publications/RuralHomeless.pdf or for \$10 from NHCHC, 615-226-2292.

Coming to Grips With Lead-Based Paint

by Don Ryan

Achieving the national goal of ending childhood lead poisoning by 2010 depends on making housing safe from lead hazards.

Lead poisoning remains one of the foremost environmental health threats to young children, despite substantial progress over the past two decades. While lead poisoning is typified by concentrated “hot spots” of poisoning in large urban centers, several states have found higher lead poisoning rates in rural areas. Lead poisoning in childhood can have lifelong consequences, including learning disabilities, loss of IQ, attention deficit, and behavior problems. No effective medical treatment exists for lead poisoning. Achieving the national goal of ending childhood lead poisoning by 2010 depends on making housing safe from lead hazards.

Lead-based paint is the primary source of high-dose exposures to U.S. children. Since the United States did not ban lead in residential paint until 1978 (about 50 years after many other countries enacted regulations), almost 40 percent of our entire housing stock is burdened by lead. Properties built before 1950 are much more likely to have lead-based paint,

higher concentrations of lead in paint, and lead-based paint on more surfaces. Lead paint is more likely to be on exterior surfaces than interior, more likely on woodwork than walls and ceilings, and more likely in kitchens and bathrooms than other rooms.

IMPORTANT LESSONS LEARNED

Over the past decade, research and experience have increased understanding of the sources and pathways of exposure from lead-based paint and developed more cost-effective options for hazard control and prevention. Some of the important lessons learned include:

- ▶ The risk for lead poisoning varies enormously across the housing stock.
- ▶ While deteriorated lead-based paint is the major source of lead poisoning, lead-contaminated dust is the foremost pathway of exposure.

Regular visual checks for signs of paint deterioration are an important tool.

- ▶ Lead dust contamination comes from deteriorated lead-based paint, paint repair, and renovation work that disturbs

Watch Out for Peeling Paint

CONTROL, CONTAIN, AND CLEAN UP LEAD DUST

Keep paint in older housing intact.

- Perform regular maintenance.
- Do regular visual checks for peeling paint.
- Avoid disturbing intact paint.

Safely repair peeling, cracking, chipping paint.

- Lay plastic over floor and belongings.
- Separate the work area from residents.
- Use tools that don't spread dust and paint chips.
- Work wet — mist with water when scraping.
- Clean up debris as you work.

Avoid unsafe work practices that spread lead dust.

- Don't burn or torch using an open flame.
- Don't machine-sand, grind, or sand-blast without HEPA control.
- Don't use a heat gun operating above 1,100°F.
- Don't dry-sand or dry-scrape (except near electrical outlets).

Remove lead dust/debris after work.

- Vacuum with a good vacuum (not a shop vac).
- Wet scrub to remove lead dust, changing rinse water often.
- Seal all debris in plastic bags and throw away.

lead-based paint, and lead particles that are tracked in from outdoors. Lead dust settles on floors and other surfaces and gets on children's hands and toys and then in their mouths.

▶ Simple paint repair projects using conventional scraping and sanding techniques can generate high levels of lead dust. Modest changes in work practices by painters and remodelers can contain, control, and clean up lead dust.

▶ Because lead dust can be invisible, dust testing is the only way to be sure that hazards are not left behind to poison a child. Lead dust is measured by wipe samples that environmental laboratories analyze, usually at a cost of \$5 to \$10 per sample.

WHOSE JOB IS LEAD SAFETY?

Because the risk to children living in properties that contain lead-based paint varies enormously, lead-safety tools and delivery systems need to be calibrated to the specifics of the situation. For high-risk properties, the challenge is to identify deteriorated paint and lead dust hazards before exposure occurs and target concerted action to make these units safe (or demolish and replace them). Projects designed to eliminate identified lead hazards permanently are defined as "lead abatement," which must be done by specially trained contractors certified by the Environmental Protection Agency or the state. Some activities to provide shorter term control of an identified lead hazard can be performed by noncertified persons who understand the basics of lead safety.

For lower risk units, the challenge is to repair deteriorated paint safely, correct the causes of paint failure, follow lead-safe work practices to avoid creating lead dust hazards, and improve maintenance to keep paint intact. In addition, replacing older dilapidated windows as part of capital improvement projects can reduce lead hazards as well as save energy. Regular painters and contractors with "basic training" in lead-safe work practices can perform these activities most effectively.

HUD and EPA have approved several training courses in lead-safe work practices for maintenance staff, painters, and

FOR ADDITIONAL INFORMATION

For more information about lead-safe work practices, read the fact sheets at www.centerforhealthyhousing.org/html/resources.htm and HUD's "Lead Paint Safety: A Field Guide," available in English and Spanish, at www.hud.gov/offices/lead/index.cfm (or order the Field Guide by calling 800-424-LEAD).

To obtain HUD's *Regulation on Lead-Based Paint Hazards*, interpretive guidance and other current information, visit www.hud.gov/offices/lead/index.cfm, or call 800-424-LEAD.

To identify trainers and training courses for lead-safe work practices, sampling, and other lead services, visit www.leadlisting.org or call the Lead Paint Compliance Assistance Center toll-free at 866-483-1012.

To find out more about state and local government suits to hold lead paint manufacturers accountable, visit www.aeclp.org.

rehab contractors. While these short courses do not qualify trainees as lead experts or abatement contractors, they teach the modest changes in work practices that are needed to control, contain, and clean up lead dust during maintenance, paint repair, and remodeling work.

HUD's new lead-safety regulation relies heavily on this cost-effective approach and generally allows property owners alternatives for compliance. In most situations covered by the rule, lead inspections are not required. Permanent "abatement" is required only in limited situations: public housing developments and units receiving more than \$25,000 in federal rehabilitation assistance. In most other situations, contractors doing rehab projects funded by CDBG and HOME can meet lead-safety requirements either by having workers trained in lead-safe work practices (a four- to six-hour course) or having the project supervisor certified as an abatement supervisor (four days of training).

HUD's regulation places strong emphasis on lead dust controls, including universal requirements for clearance testing after rehab or paint repair projects. Clearance testing provides a low-cost performance-based standard to document that lead dust hazards are not left behind. To expand capacity for clearance testing, EPA has created a new one-day "sampling technician" course, which many states are now recognizing. Local community development agencies and housing authorities can contract out for clearance testing or train their own staffs and qualify them as "sampling technicians." Housing quality inspectors and code inspectors could also be trained and could sample for lead dust hazards when deteriorated paint is identified and after it is repaired.

NEXT STEPS

Housing providers and advocates in rural areas can help to advance lead safety while preserving housing affordability in several ways. Local governments, community organizations, multifamily housing providers, and trade associations can

endorse lead-safe work practices and include performance-based lead-safety criteria in contract specifications. Agencies and associations can offer the free “short course” in lead-safe work practices to rehab contractors, maintenance workers, and in-house staff. These groups can help overcome state regulatory obstacles that threaten rehab and make clearance testing more difficult and costly than necessary. New collaborations of advocates for affordable housing and children’s health could make healthy housing a national priority and win greatly increased resources to subsidize rents and upgrade substandard proper-

ties. Finally, more and more cities, counties, housing authorities, and school districts are taking legal action to hold the lead paint manufacturers accountable for knowingly marketing a poisonous product. Advocates for affordable housing and public health need to work together to ensure that proceeds from these suits are targeted to controlling lead hazards in low-income, highest-risk properties.



DON RYAN is executive director of the Alliance to End Childhood Lead Poisoning, which is based in Washington, D.C. He can be reached via e-mail at dryan@aeclp.org.



RURAL VOICES

ruralvoices@ruralhome.org

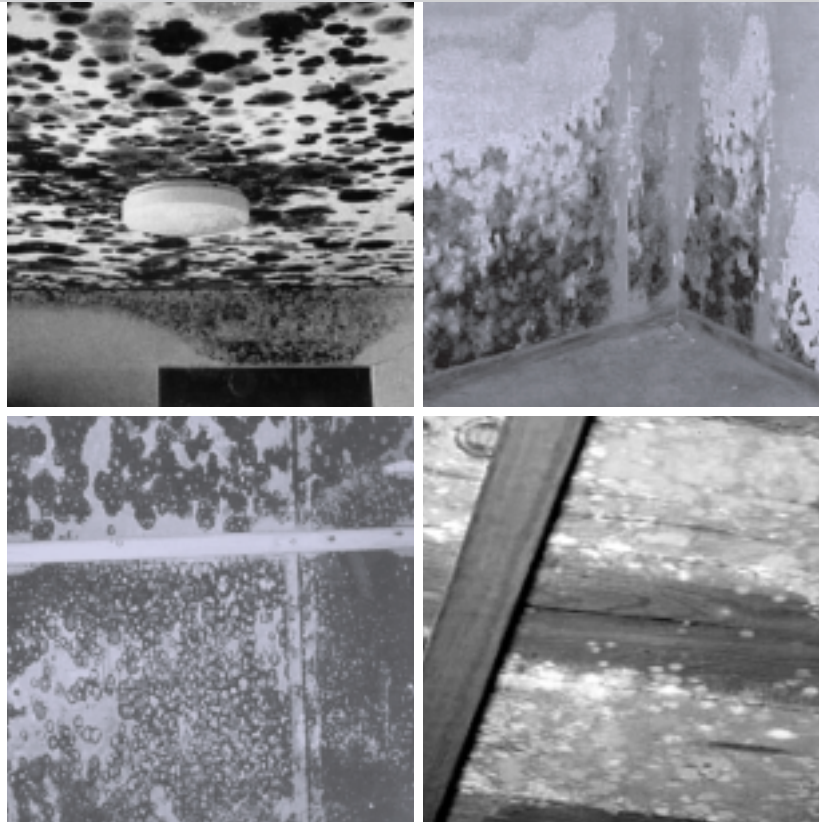
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The Housing Assistance Council (HAC) is a national nonprofit corporation founded in 1971 and dedicated to increasing the availability of decent housing for low-income people in rural areas. HAC strives to accomplish its goals through providing loans, technical assistance, training, research and information to local producers of affordable rural housing. HAC maintains a revolving fund providing vital loans at below-market interest rates to rural housing developers. Developers can use these funds for site acquisition, development, rehabilitation or new construction of rural, low- and very low-income housing. HAC has a highly qualified staff of housing specialists who provide valuable technical assistance and training, and research and information associates who provide program and policy analysis and evaluation plus research and information services to public, nonprofit, and private organizations. HAC’s subsidiary, Rural Housing Services, Inc. (RHS), syndicates rural housing developed with the Low Income Housing Tax Credit.

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| 1025 Vermont Avenue, NW, Suite 606 Washington, DC 20005 TEL 202-842-8600 FAX 202-347-3441 E•MAIL hac@ruralhome.org | 10920 Ambassador Drive, Suite 220 Kansas City, MO 64153 TEL 816-880-0400 FAX 816-880-0500 E•MAIL midwest@ruralhome.org | 615 Peachtree Street, NE, Suite 1130 Atlanta, GA 30308 TEL 404-892-4824 FAX 404-892-1204 E•MAIL southeast@ruralhome.org | 3939 San Pedro, NE, Suite 7-C Albuquerque, NM 87110 TEL 505-883-1003 FAX 505-883-1005 E•MAIL southwest@ruralhome.org | 131 Camino Alto, Suite D Mill Valley, CA 94941 TEL 415-381-1706 FAX 415-381-0801 E•MAIL susan@ruralhome.org |



Photos courtesy of ERT Associates

Creating Affordable Allergen-Free Housing

WHAT RURAL DEVELOPERS NEED TO KNOW

by Jack Anderson

Rural developers engaged in the rehabilitation of older homes and the construction of new homes have an ideal opportunity to create healthier housing for their clients.

Experts are just beginning to realize the importance of housing conditions to residents' health. Over the last decade, child asthma cases have doubled in the United States and many researchers estimate that these cases are associated with exposures to allergens in the home. Mold, pests, pets, dust, cold air, and dry heat all can trigger asthma. When these conditions are present, a child is more likely to experience an allergic reaction. Therefore, any efforts to reduce or eliminate these exposure sources can also reduce the potential for childhood asthma.

Rural developers engaged in the rehabilitation of older homes and the construction of new homes have an ideal opportunity to create healthier housing for their clients. By

making simple and cost-effective modifications to current renovation practices and adopting new construction techniques, developers can minimize or eliminate exposure to sources that may lead to respiratory distress, including asthma. These practices and techniques can also help achieve energy efficiency. Important techniques for achieving healthier housing include minimizing moisture, promoting adequate ventilation, properly exhausting combustion appliances, eliminating entry points for pests, and providing smooth, easily cleanable surfaces.

RENOVATING AND REMODELING OLDER HOUSING

Whether a developer is performing gut rehab or undertaking more modest housing code repairs, there are a number of mea-

asures that can contribute appreciably to a healthier residential environment, while adding minimal cost to the overall project.

First, every effort should be made to reduce or eliminate sources of moisture or water infiltration, which can cause mold. Leaky plumbing fixtures and pipes need to be repaired or replaced. If an older roof is not being replaced, it must be patched to stop leaks. Any water- or moisture-damaged plaster, drywall, insulation or other substrates that cannot be thoroughly dried should be replaced to eliminate the possibility of mold growth. Gutters, downspouts, leaders, and splash blocks must all be functional so that rainwater is directed outward from the structure. If needed, re-grading of the surrounding soil may be necessary to assure that the ground slopes away from the foundation, thereby limiting the potential for water absorption through foundation walls.

New bathtub and shower enclosures should be built using non-absorbent materials that resist moisture and provide a good air barrier. Paper-faced gypsum board should be avoided. If not being replaced, bathtubs and showers should be re-caulked with a high quality silicone sealant.

Damp basements should not be occupied as living spaces unless moisture has been controlled or eliminated. A dehumidifier may be necessary to remove excess dampness due to the reaction of cooler moist masonry floor and wall surfaces with the warmer surrounding air. It may not be advisable to install carpeting in basements since it can serve as a breeding source for mold. Carpeting should also be avoided in bathrooms and kitchens, where wetness is normally anticipated.

Crawl spaces with dirt floors are a source of moisture infiltration for a home. Therefore, a vapor barrier, such as heavy-duty polyethylene plastic sheeting, should be installed over the bare soil and a minimum of one foot up perimeter walls.

Controlling the flow of warm air into attic spaces is important, particularly during winter months when condensation can form due to cool and warm air mixing. This condensation, coupled with insulating materials, can generate mold. Holes and bypasses into the attic should be properly sealed or closed off to prevent this warm airflow. Also, for homes in warmer climates, attic vents should be installed both high and low near the ridge board and the soffits. This, too, will help eliminate moisture and mold growth in the attic.

Exhaust fans should be installed in bathrooms and kitchens and vented to the exterior, thereby reducing interior moisture in these rooms and the potential for mold. Dryers should also be vented to the exterior because of the moisture generated during drying cycles.

Additional Resources

Additional resources and information are available from the following organizations to help rural developers create healthier residential environments:

- ▶ Advanced Energy, Inc., 909 Capability Drive, Suite 2100, Raleigh, NC 27606, 919-857-9000, www.advancedenergy.org.
- ▶ Affordable Comfort, Inc., 32 Church Street, Suite 204, Waynesburg, PA 15370, 800-344-4866, www.affordablecomfort.org.
- ▶ Building Science Corporation, 70 Main Street, Westford, MA 01886, 978-589-5100, www.buildingscience.com.
- ▶ Camroden Associates, Inc., 7240 East Carter Road, Westmoreland, NY 13490, 315-336-7955, www.camroden.com.
- ▶ Conservation Technologies, Inc., 4804 Oneota Street, Duluth, MN 55807, 218-722-9003, www.conservtech.com.
- ▶ Environmental Health Watch, 4115 Bridge Avenue, #104, Cleveland, OH 44113, 216-961-4646, www.ehw.org.
- ▶ University of Minnesota Cold Climate Housing Program, 2004 Folwell Avenue, St. Paul, MN 55108, 612-624-2767.
- ▶ U.S. Department of Housing and Urban Development, Office of Healthy Homes and Lead Hazard Control, 490 L'Enfant Plaza, Room 3206, Washington, DC 20024, 202-755-1785, www.hud.gov/lea.

Second, to eliminate the possibility of carbon monoxide poisoning, combustion appliances must be properly exhausted to the exterior. In the case of furnaces and water heaters, a trained professional should test the units to make certain that there are no interior exhaust leaks and that the units are functioning efficiently. Carbon monoxide detectors should be installed near these appliances and in the primary living space, particularly near where bedrooms are located.

When gas stoves and ovens are used for cooking, a power vented fan or range hood should be installed and exhausted to the exterior. This will reduce the potential for carbon monoxide poisoning from an improperly operating stove or oven.

Third, to control entry of rodents and birds, corrosion-proof materials should be installed that close or seal off holes and small openings on the exterior. Exhaust vents

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FROM PAGE 21 should be covered with mesh screen to prevent animal entry yet allow for proper venting of appliances or fans.

To control pests such as cockroaches, removing potential food sources is key. Although residents are typically responsible for storing food in closed containers and properly disposing of garbage as far away from the unit as possible, steps can be taken to seal entry points to limit pest access. For example, a silicone sealant can be applied between gaps in baseboard moldings, and floors and wall surfaces.

Fourth, although residents typically prefer carpeting, smooth and easily cleanable floor surfaces such as vinyl sheet goods, tile, wood, and wood laminates make it simpler to remove dust. Carpeting, even in areas not normally subjected to wetness, can serve as a reservoir for moisture, mold, and dust mites. Therefore, providing smooth floors limits a potential exposure source of allergens and enables residents to clean more effectively to further reduce allergens.

NEW CONSTRUCTION

Most of the suggested modifications to current housing rehabilitation practices also apply to new construction. Additional techniques can further limit asthma allergen sources when building new housing units.


In homes with forced air heating and cooling systems, return ductwork should be sealed to limit negative air pressures that pull contaminants from exterior sources. Additionally, ductwork in

unconditioned spaces should be insulated to limit potential moisture and mold development and pest infiltration. When possible, ductwork should not be installed in attics, crawlspaces, or garages.

Cold-water plumbing lines should be insulated with foam pipe insulation to limit condensation in warmer climates. Lever-type shut-off valves should be installed for washing machine hook-ups and water heaters to minimize any water damage in the event of a hose break or other failure.

When installing exterior siding over house wrap, such as Tyvek, drainage planes should be created too so that rainwater is shed away from the siding and wrap. New windows and exterior doors should have pan flashings to direct rainwater away from wall cavities. Again, eliminating potential moisture sources reduces the likelihood of mold growth.

SUMMARY

These suggestions are by no means comprehensive. But by making these simple, relatively inexpensive modifications to housing renovation and new construction practices, rural developers can help limit residential exposures to asthma-producing allergens. 

JACK ANDERSON is director of program management and training at the National Center for Healthy Housing. Information for this article was obtained from "Remodeling Guidance for Healthy Homes," adopted by the Asthma Regional Council of New England, and various materials written by Building Science Corporation and Ellen Tohn of ERT Associates. The author is indebted to these organizations.

Appropriations and Authorizations Stalled in Congress

by Joe Belden

In Washington some of the issues of the moment are still-delayed appropriations for FY 2003, lame duck sessions for the 107th Congress, and the shape of the new Congress. With Republicans winning the Senate on November 5, a new cast will emerge in the 108th Congress for USDA rural housing and HUD programs. Sens. Richard Shelby (Ala.) and Wayne Allard (Colo.) are in line to become chairmen of the Senate Banking Committee and its Housing Subcommittee. On the Appropriations Committee, Sens. Ted Stevens (Alaska), Christopher Bond (Mo.), and Thad Cochran (Miss.) will likely return to the chairs of the full panel and the VA-HUD and agriculture subcommittees. In the House less will change, although Housing Subcommittee chair Rep. Marge Roukema (R-N.J.) is retiring. It is unclear who will succeed her. Rep. Barney Frank (D-Mass.) is moving up to become ranking minority member on the full House Financial Services Committee.

The election results also mean that final decisions on FY 2003 appropriations bills may not come until January or later. Neither of the spending bills for HUD and USDA housing have moved beyond passage by the Appropriations Committees. Housing and most other federal programs have been operating under continuing resolutions (CRs) since the new fiscal year started on October 1. At press time, the fourth such CR is in effect until November 22. Lawmakers returned to work November 12 and are expected to approve another CR lasting into January.

The outlines of spending for fiscal 2003 are in place, but there are differences still to be worked out in congressional negotiations. Both the House and the Senate Appropriations Committees have completed their 2003 spending bills for USDA (S. 2801, H.R. 5263) and HUD (S. 2797, H.R. 5605), but the legislation has not been taken to the floor in either body. The legislative reports that accompany the bills — and often have more accessible information — are, for USDA, H.Rept. 107-623 and S.Rept. 107-223, and for HUD, H.Rept. 107-740 and S.Rept. 107-222.

HUD. Separate 2003 appropriations bills for HUD cleared

the Senate Appropriations Committee in July and the House Appropriations Committee in October. The bills fund not only HUD but other agencies such as the Department of Veterans Affairs, EPA, NASA, the Neighborhood Reinvestment Corporation, and the CDFI Fund. With one major exception in the House bill, HUD programs received mostly the same level of funding as in 2002 or increases. Big gainers included homeless assistance, public housing operations, lead hazard control, and units for elderly people and people with disabilities.

The biggest cut is in Section 8 vouchers, where the committee expressed frustration over unspent funds from prior years. The Self-Help Homeownership Opportunity Program (SHOP) received \$28.5 million in the House and \$22 million in the Senate. The HUD Office of Rural Housing and Economic Development (RHED) received \$25 million from both House and Senate. The HUD budget, released in February 2002, had for the second year proposed to eliminate RHED. Both committees chose not to fund HUD's proposed \$16 million Colonias Gateway, noting that it does not have authorizing legislation. The House bill provides \$200 million for the HOME downpayment assistance initiative. The Senate not did provide any funds for this initiative. Thus a compromise in negotiating differences might be the House agreeing to more vouchers and the Senate to some level of funding for downpayment assistance.

USDA. During July, both the Senate and House Appropriations Committees passed FY 2003 spending measures for the Department of Agriculture, including the Rural Housing Service and other Rural Development programs. Some programs received healthy increases, and there is generally less variance between House and Senate than in the HUD bill. As with HUD, neither bill has gone to the full House or Senate, and the ultimate solution may be an omnibus spending package.

Both committees rejected the Administration's proposed steep cuts in the Section 515 rental and Section 502 direct homeownership programs. In the Senate version, Section 515 would reach its highest level since the

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FROM PAGE 23 major cuts of 1994, rising from \$114 million in 2002 to \$120 million in 2003. Of the 515 total, \$40 million is for new construction, \$60 million is for repair of existing units, and \$20 million is for incentives for long-term use and nonprofit takeovers. Both bills would provide increases for rental assistance, farm labor housing, Section 504 repair loans, and Rural Housing Assistance Grants. The Rural Community Development Initiative would be continued for another year in both bills.

More details are available in the *HAC News* editions of July 29 and October 11, available at www.ruralhome.org or from HAC.

AUTHORIZING LEGISLATION. Appropriations are the bread and butter of all programs, but probably the main excitement for housing advocates this year has been action on H.R. 3995, a major housing reauthorization bill sponsored by Rep. Marge Roukema (R-N.J.) and others. During the summer the House Financial Services Committee at first approved and then disapproved the inclusion of a national affordable housing trust fund in H.R. 3995.

Originated as H.R. 2349, the trust fund was offered as an amendment to H.R. 3995 by Rep. Bernie Sanders (I-Vt.). This new fund would tap Federal Housing Administration mortgage insurance surpluses to build low-income rental housing in mixed income settings and promote homeownership. The target is to produce, rehab, and preserve at least 1.5 million units by 2010. A remarkable nationwide advocacy effort led by the National Low Income Housing Coalition supported the trust fund and will continue in 2003. To replace the Sanders amendment — and keep it off the House floor — the committee

passed a program that would provide federal matching funds to existing state and local housing trust funds.

H.R. 3995 also includes a change that will allow prepayment of Section 515 rental projects and possible displacement of tenants. A late change to that amendment requires that appropriations for vouchers be in place to help any displaced tenants. Among many other provisions, H.R. 3995 would also reauthorize the SHOP program and raise the SHOP per-unit spending cap to \$15,000. The new Congress will continue work on H.R. 3995 (with a new number). The Senate has its own bill that will also be reconsidered next year.

Few authorizing bills for housing programs have passed in this Congress and none are likely to pass in the lame duck sessions still pending. One law that is near completion is S. 1210, a bill that reauthorizes for five years the basic HUD Indian housing program (block grants to tribes under the Native American Housing Assistance and Self-Determination Act, or NAHASDA). First passed in 1996, NAHASDA replaced the former HUD Indian housing program. HUD estimates that 25,000 new units have been built under NAHASDA. The reauthorization bill has passed both houses of Congress and at press time is awaiting President Bush's signature.

Another important rural item is that HUD has begun to push a bill that would create the department's \$16 million Colonias Gateway — and thus allow it to receive appropriations.



JOE BELDEN is deputy executive director of the Housing Assistance Council.

To view the full text of the bills and reports visit the legislative information web site at thomas.loc.gov.

Each issue of *Rural Voices* profiles members of the Housing Assistance Council's board of directors. A diverse and skilled group of people, HAC's board members provide invaluable guidance to the organization. We would like our readers to know them better.



JOSEPH DEBRO

Joe Debro is one of only two members of HAC's board who have served since the organization's creation in 1971. (Charles Davis, profiled in the last issue of *Rural Voices*, is the second.) He joined the board as the representative of the National Association of Minority Contractors. An

engineer and construction specialist, Debro's previous housing experience had included rural housing development in North Carolina, where he worked with Lauriette West, who was later also elected to HAC's board.

Born in Mississippi, Debro has spent most of his life in California and holds degrees in biochemistry, bacteriology, and engineering. He began a biochemical engineering career but changed direction after he purchased a fourplex apartment building, moved it out of the path of a new highway, and discovered he enjoyed construction. He is now president of Trans Bay Engineering and Builders, an engineering and building construction firm working in rural and urban areas worldwide.

Serving on HAC's board has given him the opportunity to fight some good fights, Debro says. He is passionate about issues such as ending discrimination and "teaching people not to be poor."

HAC has "a great history, a great staff, and a great board," Debro states. He believes HAC has become more conservative than it once was, and he would like to see the organization return to the "cutting edge" of affordable housing development. He has never ceased to be proud to be a member of HAC's board, however, believing that HAC has always done — and continues to do — very useful work.



RICHARD LINCOLN

Dick Lincoln says that over his nearly 30 years on HAC's board he has seen an evolution in the approach to affordable housing in the United States. A system that once emphasized deep government subsidies has shifted to a more entrepreneurial approach, he states, focusing on

partnerships between government, the private sector, and the non-profit sector. He believes that significant progress has been made in improving the housing conditions of low-income rural Americans, but that much work remains for HAC and other housing organizations.

"HAC quickly became and has remained the premier organization that focuses national attention on rural poverty and housing," Lincoln notes. He is pleased that while HAC is a "national force" it also continues to assist specific developments at the local level.

Lincoln began his tenure on the board as a representative of the National Governors' Conference (now the National Governors Association), where he was employed in the early 1970s. He is now senior vice president of Irgens Development Partners in Milwaukee, developing mixed use properties in Wisconsin and Illinois for residential and commercial uses.

"I've been on this board for more than half my life," Lincoln marvels. He notes that serving on HAC's board has been "extremely gratifying" personally as well as professionally, because he has developed close friendships with other board members and staff.

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