

# FOCUS<sup>®</sup>

The magazine of the Joint Center for Political and Economic Studies

## *The Health of Women of Color: National Policies and Programs Can Make a Difference*

By *Wilhelmina A. Leigh*

In all societies throughout the world, women play unique roles as creators and preservers of life and health. Not only care givers but also bread winners, women of color in the United States encounter challenges that complicate their lives and limit their ability to fulfill these roles for their families and themselves. Representing one-third of all women in the United States, women of color are Hispanic (or Latino), or are non-Hispanic (or non-Latino) and either black or African American, American Indian and Alaska Native, Asian, or Native Hawaiian and Other Pacific Islander. Challenges emanating from immigration status, poverty, discrimination, racism, and cultural phenomena shape the lives and health of women of color. Although outcomes vary by racial/ethnic group and condition, the health of women of color generally is worse than that of white women. Similarities in the circumstances of women of color, however, suggest ways to craft policies to improve their health.

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# Playfair

While 2005 has been a year with its share of disappointments—one need only reflect upon the dispiriting news of repeated ethical lapses among some members of the U.S. Congress and other national leaders, the disasters inflicted by a string of hurricanes, and the continually mounting loss of life in Iraq—2006, like any New Year, offers the prospect of improvement and progress. Both the difficulties of 2005 and the optimism of 2006 are illustrated by articles elsewhere in this Magazine.

All of us mourned the death of Rosa Parks in 2005. As John Lewis points out in the lead article, the story of Rosa Parks is that of a single act of courage under extremely dangerous circumstances; it is also an act that changed the Nation forever and whose power to inspire each new generation of Americans continues unabated.

Similarly, Ambassador James A. Joseph's interview concerning the Louisiana Disaster Recovery Foundation holds out the promise that finally the Nation and the region will come to grips with the realities of rebuilding, renewing, and reinvigorating. There is much that is hopeful in the planning and activities underway for the resurrection of New Orleans and the restoration to a better life of all elements of her population, although these efforts are just at their beginning. There are other reasons to be hopeful about the promise of the coming year. One year ago, in the January/February 2005 edition of the Magazine, Thomas Playfair was introduced in this column. Readers of that issue will recall that the original Thomas Playfair was the legendary Ted Berry of Cincinnati, the first African American to be a member of that city's City Council, its first black Vice Mayor, and eventually its first black Mayor.

Theodore Moody Berry was both a local elected official and a national statesman. Under his leadership, Cincinnati was one of the incubators of the idea of the Community Action Program, which was later adopted by R. Sargent Shriver to be the centerpiece of President Lyndon Baines Johnson's War on Poverty, itself a lynchpin of his Great Society. Ted Berry was called to Washington D.C. to oversee the implementation of the community action program concept on a national basis as assistant director of the Office of Economic Opportunity in the Johnson administration. He also oversaw the establishment and first five years of operation of Head Start, the Neighborhood Legal Services Program, and several other related initiatives.

This past week in Cincinnati another generation of black elected leadership took the stage. A second Ted Berry, the son of the first, was installed as an elected Judge of the Municipal Court of Hamilton County, the Court of general jurisdiction in Cincinnati. Several generations of black leadership, elected, appointed, as well as grassroots, were present in the large ceremonial courtroom in the Municipal Court House there on Main Street. The current Mayor of Cincinnati, Mark Mallory, was present, as was his brother William Mallory, an elected municipal Judge, and their father, the senior William Mallory. The senior Mallory had teamed up with the first Ted Berry decades ago to bring a lawsuit challenging the discriminatory impact of Cincinnati election practices on the ability of black Cincinnati voters to participate fully in the political process.

Among the presiding judges at the ceremony was Nathaniel Jones, former longtime general counsel of the NAACP and now Senior Judge of the United States Court of Appeals. In his remarks, the new Judge Ted Berry acknowledged that he and all of his generation of black leaders stand on the shoulders of the generation of his father, the senior Mallory, and Judge Nathaniel Jones. They also stand on the shoulders of Rosa Parks, John Lewis, and a host of others, a number of whom were present in that courtroom.

The prospect of a new generation of leadership is always a hopeful one. A particular aspect of new and emerging leaders is that they bring enthusiasm, talent, and a new spirit of commitment. When their gifts are combined with the wisdom, competence, and experience of the current generation represented by, among others, the National Caucus of Black State Legislators who met in Washington in December, and the group of black elected officials who will be meeting at the Joint Center in Washington in February, the outlook is particularly promising.

Our challenge for the coming year is to ensure the realization of that promise by working with new, emerging and current leaders to continue the assault on the national problems of race, poverty, and injustice. Our goal must be to assure that our Nation realizes, as Congressman Lewis points out in his article on Rosa Parks, that, despite our many apparent divisions, we are—all of us—one people bound on one national journey to a common destination: a place of decency, equity, and opportunity, and that either all will arrive together or none will.

*Thos. Playfair*

*Thomas Playfair is a pseudonym for the president of the Joint Center for Political and Economic Studies.*

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1090 VERMONT AVENUE, NW • SUITE 1100  
WASHINGTON, DC 20005

TELEPHONE (202) 789-3500  
FACSIMILE (202) 789-6390  
E-mail: [focusseditor@jointcenter.org](mailto:focusseditor@jointcenter.org)

[www.jointcenter.org](http://www.jointcenter.org)

# The Health of Women of Color:

## National Policies and Programs Can Make a Difference

(Continued from front cover)

### Latinas or Hispanic American Women

The nearly 20 million Latinas currently residing in the United States are the largest group of women of color. Although the dominant Hispanic populations in the United States are Mexican, Cuban, and Puerto Rican, Latinas also have immigrated to the United States from Spain, Central and South America, and the Caribbean. Most of the Latino population (91 percent) in the United States is urban, and more than three out of every four Hispanics (77 percent) live in seven of the most populous states—California, Texas, New York, Florida, Illinois, Arizona, and New Jersey.

Among Latino subpopulations, physical appearance, educational and income levels, and health all vary

*Challenges emanating from immigration status, poverty, discrimination, racism, and cultural phenomena shape the lives and health of women of color.*

greatly. For instance, if measured by the incidence of low birthweight among infants and the use of cigarettes or illegal substances, Mexican American women have better health—and Puerto Rican women have worse health—than other Latinas. Obesity is a problem, however, shared by about three-fifths of Latinas of Mexican, Cuban, and Puerto Rican origin. The generally better health of Mexican American women is viewed as paradoxical because these females have lower average levels of education than other Latinas. Infection with HIV (human immunodeficiency virus) or AIDS (acquired immunodeficiency syndrome) tends to be a problem primarily among Latinas who are less-acculturated (i.e., less accustomed to norms and mores of U.S. society), and who lack knowledge

about the disease and its transmission or about how to negotiate safe sex with their partners.

### Black or African American Women

The 19 million African American females represent the second largest group of women of color. Still residing primarily in the South—the region of embarkation for the African slaves from whom most African Americans are descended—black women in this region report some of the worst health outcomes for this group. For example, the incidence of HIV/AIDS among African American women is greater in the Southeast than in other regions. Overall, African American women have high rates of obesity, diabetes, lung cancer, and hypertension. Although the incidence of breast cancer

among African American women is lower than among white women, their death rate from this disease exceeds that for all other women. They also are more likely than all other women to give birth to low-weight infants or infants who die, and to die themselves during childbirth.

Since the 1965 immigration reforms, the black or African American population has included increasing numbers of immigrants from Africa (e.g., Ethiopia, Nigeria) and the Caribbean (e.g., Haiti, Jamaica). Many of the health concerns of these more recent black immigrants are not recognized or adequately addressed in this country due to both cultural and language differences. Native-born black women, however, are more likely than their foreign-born counterparts to give birth to low-weight infants. The

large and persistent disparities between health outcomes for African American women and white women have many causes, among them poverty, racism, discrimination in the delivery of healthcare treatments and services, and low health literacy.

### Asian American Women

The more than six million Asian American females in the United States include women belonging to larger and better known populations (such as Chinese, Filipino, Asian Indian, and Korean), as well as women about whose health much less is known (such as Bangladeshi, Hmong, and Laotian). Most Asian women live in the western states, although concentrations also are found in Illinois, New Jersey, New York, and Texas.

Asian American women are less likely than other women of color to smoke, or to be HIV-positive, obese, or diabetic. Nevertheless, their health varies considerably by subgroup. For example, women of Japanese origin are the most likely among Asian American women to report receiving early prenatal care (i.e., in the first trimester). Although prenatal care data also are available for Filipino and Chinese women, national data are not available for Hmong women, and the findings for Asian Indian women are paradoxical. Asian Indian women are nearly as likely as Japanese women to begin prenatal care early (80 percent and 90 percent, respectively), but are much more likely to give birth to low-weight infants. In addition, cultural norms and the perceived lack of cultural competence among Western-trained physicians result in low rates of preventive screenings (such as mammograms and Pap smears) among many Asian women, and contribute to their development of avoidable conditions such as cervical cancer.

### American Indian and Alaska Native Women

There are more than one million American Indian/Alaska Native females in the United States, most of whom

belong to one of 200 state recognized or 562 federally recognized tribes. Although they share a history of forced relocation, confinement to reservations, and loss of their traditional ways of life, their socioeconomic, cultural, and health circumstances today vary considerably across tribes. Nonetheless, high percentages live in poverty both on reservations and in urban areas, and American Indians/Alaska Natives have high death rates from diabetes. In addition, obesity, smoking, alcohol-related illnesses, and unintentional injuries occur more frequently among American Indian/Alaska Native females than among other female populations.

Access to health care is a challenge for American Indian/Alaska Native women. Although American Indians/Alaska Natives who belong to federally recognized tribes and reside on or near the reservations in the 12 Indian Health Service (IHS) areas are eligible to receive health care through IHS clinics and hospitals, the estimated 57 percent of American Indians, 53 percent of Aleuts, and 39 percent of Eskimos who live in urban areas do not have access to these services. Urban Indian clinics and other health programs receive only one percent of the IHS budget, which is too little to meet the needs of urban American Indians and Alaska Natives.

### **Native Hawaiian and Other Pacific Islander American Women**

Native Hawaiian and Other Pacific Islander women (mainly Samoans, Guamanians, and Tongans)—the smallest group of women of color, with an estimated population of nearly 200,000—also are diverse in origins and in health needs and outcomes. Native Hawaiian women, the largest subpopulation in this category, report some of the highest rates of overweight and obesity among women of color. Along with obesity, they are beset by gestational diabetes and are more likely to give birth to low-weight infants than many other women of color.

Similar to their American Indian/Alaska Native counterparts, Native Hawaiian

women have endured cultural dislocation and the loss and degradation of their indigenous ways and languages. These losses have shaped their approach to the use of healthcare facilities and services and, thus, some of their health outcomes. For example, Native Hawaiian women often enter medical treatment at late stages of diseases and only when self-care and traditional practices have not brought relief. The women of color who live on other Pacific Islands face additional challenges in receiving health care, such as the great distances that some of them must travel for anything other than primary care.

### **Policies and Programs**

Although women of color have diverse origins and characteristics, their healthcare needs are largely affected

***Racial/ethnic data collection could help make a compelling case for establishing and maintaining a diverse and culturally and linguistically competent health sector workforce that matches the clients served.***

by a few major policies and programs. Examples include immigration laws, eligibility rules for federal health insurance programs, mandates for the collection of data on race/ethnicity and primary language, and the availability of practitioners and facilities to provide healthcare services.

Immigration policies govern the arrival on U.S. shores of populations from Latin America, Asia, Africa, and other places throughout the world. Once new arrivals are in the United States, their immigration status becomes a determinant of eligibility for health insurance programs such as Medicaid (the major public program providing health insurance and long-term care for low-income people) and Medicare (the federal health insurance program that provides services for the population that is 65 years and older and for eligible persons of all ages who have disabilities). Because many women of color are

either low-income or elderly or both, the Medicaid and Medicare programs serve them in large numbers. Restricting access to services in either of these programs—as budget-cutting proposals often do—can have direct bearing both on the health of women of color and on the well-being of their families.

A prerequisite for meeting the health needs of women of color is to know who they are and where they are. Although no federal statutes prohibit collecting and reporting data about race/ethnicity and primary language in the health sector, and collecting such data is legal under Title VI of the Civil Rights Act of 1964, few statutes mandate it. In addition, only 22 states mandate the collection of race/ethnicity data, and there is little standardization among states in the information collected.

This knowledge could enable health

practitioners and facilities such as hospitals to provide services (e.g., oral language translation) that meet the needs of the many culturally diverse groups that populate our nation. In addition, racial/ethnic data collection could help make a compelling case for establishing and maintaining a diverse and culturally and linguistically competent health sector workforce that matches the clients served. As policymakers deliberate about changes to critical policies and programs, they would be wise to bear in mind the disproportionate impact that these changes are likely to have on women of color. □

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*Wilhelmina A. Leigh is a senior research associate at the Joint Center. This article is based upon the Women of Color Health Data Book, created by the Joint Center for the Office of Research on Women's Health at the National Institutes of Health, U.S. Department of Health and Human Resources.*

# ECONOMIC REPORT

## Improving Labor Market Outcomes for Low-Income & Low-Skill Workers

By Margaret C. Simms

Unemployment in January 2006 dropped to 4.7 percent, the lowest overall rate since July 2001. Some have suggested that this rate points to robust economic growth this year. Whether this turns out to be the case or not, however, the unemployment ratio between African American and white workers is likely to remain around two to one. To address this uneven ratio, vigorous implementation of a variety of public policies is needed. Effective public training programs represent one such key policy area. Policy analysts in the workforce development field have begun to examine how public policy in this area needs to be revised, revamped, or completely overhauled in order to provide opportunities for current and future members of the labor market across their work lives, including the growing non-white segment of the workforce. To that end, they are examining past programs to see what has worked and what has not.

### Public Training Programs to Alleviate Poverty

The largest public program to provide low-skill workers with training operates under the Workforce Investment Act (WIA). Research completed at the Joint Center and at the Center for Law and Social Policy (CLASP), however, indicates that the public employment system is not providing the most disadvantaged workers with the types of services that would serve their needs. In fact, a recently released CLASP report on the declining share of low-income adults in WIA training programs shows that the public system is providing fewer training services to the most disadvantaged than in prior years. According to the CLASP analysis by Abbey Frank and Elisa Minoff, the share of WIA training program enrollees who face barriers to employment has sharply

declined since 1998. Between the last year of the Job Training Partnership Act (1998) and the most recent WIA reporting year (2003), the proportion of those leaving training who are low-income has dropped from 96 percent to 68 percent.

The authors attribute this decline to several features of the WIA training program. Because the performance measurement system places emphasis on employment placement and retention upon program exit, operators may avoid providing services to those who are less likely to be placed. In addition, the lack of a specific goal for serving low-income individuals and the particular sequencing of activities (training can only be accessed after other services prove unhelpful) may translate into fewer low-income people participating in the training programs. These results are consistent with findings from the Joint Center's examination of racial disparities in WIA programs. The CLASP report identifies two WIA reauthorization provisions that take the program even further in the wrong direction by eliminating low-income workers as a priority in times of limited resources and tightening the definition of low income.

### Programs that Work

Two recent reports offer program options that could be effective in preparing low-skill workers for the workplace at the state and local level. A report by Public/Private Ventures (P/PV), *Promoting Opportunity*, offers insights into how selected states revamped their workforce development systems to alleviate poverty after welfare reform was implemented. The other report, *The Right Jobs: Identifying Career Advancement Opportunities for Low Skilled Workers*, by Jobs for the Future (JFF), provides a guide for identifying job opportunities in local areas and the skills

and training needed to prepare for them.

Public/Private Ventures identified five states—Colorado, Florida, Oklahoma, Oregon, and Washington—that were interested in developing retention and advancement strategies for their low-skill workers, especially those who were leaving welfare. Over a four-year period (1998–2002), the organization worked with the five states to add these strategies to local workforce development efforts and assessed the impact that they had on labor market outcomes for low-skill workers. Most of the programs involved the use of group workshops or case management to support workers after they had been placed in jobs. These included discussions of on-the-job issues such as communication, stress management, career planning, and money management. Some programs also had pre-employment skills training, and a few provided guidance and support for employees who wanted to get further training while employed. Most of the individuals enrolled in the programs were female (86 percent) and approximately one-third were African American.

Nearly one-half of the enrollees lived in a household with no other adult and many faced numerous barriers (e.g., child care issues, lack of skills, language, substance abuse) to steady employment. In spite of these barriers, over 90 percent were employed in the year following their enrollment in the program and half were employed the entire 12 months after enrollment. Annual earnings were higher and reliance on public assistance was lower than prior to program enrollment. Participants' economic position improved, with rates of poverty dropping significantly and household assets increasing.

Public/Private Ventures identified three elements that were important for program participation: a defined job retention and advancement program structure with a specific set of activities; activities to address challenges and opportunities as they arose; and consistent incentives for participation. These features were exhibited in three programs—Families in Touch (Miami, FL), Up with

Wages (Salem, OR), and Step Ahead (Portland, OR)—each of which used different approaches. The Miami program (which probably had higher minority enrollment than the other two programs) held support group sessions in participants' neighborhoods. Incentives for participation in the Miami program included child care, time off from work, and meals. Those who attended three of the four sessions per month got a \$50 cash award, which they were encouraged to put into a savings account.

In spite of partial success at the local level, P/PV found that efforts to develop state policies that would support these retention and advancement strategies were limited. Among the greatest challenges were getting employer buy-in and sustaining state interest due to limited capacity and declining budgets. Only three of the five states made meaningful efforts and, in 2004, only a few local efforts were still operating, with Florida as the sole state still committed to this approach.

While the P/PV report focuses on job retention for workers who cannot take extended time off for training, the Jobs for the Future report places more emphasis on extended training and preparation for new careers. JFF took a "how to" approach, providing operators of employment and training programs a step-by-step guide for identifying promising employment opportunities, training and preparation routes, and strategies for "making the case for investment."

Identifying promising employment opportunities requires analysis of the future job market. What occupations are likely to have the largest number of job openings? What are the starting wages for these jobs? What preparation is needed to obtain and advance in them? Which ones are within the reach of individuals who do not have four-year degrees? JFF used occupational data from the Bureau of Labor Statistics to identify potential job categories for further analysis. The key factors in this identification process were earnings (the jobs needed to pay at least \$25,000 in annual income), minimum educational attainment (two years of post-secondary education or less), and availability of employment (at least 20,000 new openings

per year at the national level).

Sixteen occupations were selected for analysis of regional variation in job growth, prospects for offshoring, and risk of technological change. Once this was done, the next step for local workforce development practitioners would be to look at the nature of work, hiring practices, accessibility of training programs, and long-term career advancement. In JFF's report, six occupational clusters were examined along these lines: nurses, customer service representatives, automotive and truck technicians, computer support specialists, building trades, and commercial drivers of heavy vehicles.

The report offers recommendations for successful program operation and lessons for policymaking. The recommendations for practitioners include: local and state workforce planning agencies need to go beyond the published numbers to customize their projections; successful programs must provide skills, work experience, and employer connections all in one package; career counseling needs to be provided so that workers can navigate the promotional pathways in occupations that are accessible but have career ladders; and workplace-based skills training programs and incentives for participation must be offered. Policy recommendations include the development of a public-private financing vehicle; state targets for participation of low-income working adults in publicly-funded occupational education programs, as well as sanctions for not meeting those targets; and the evaluation of programs and allocation of funding toward those that are found to be most effective, regardless of program sponsor.

## Conclusion

The P/PV and JFF reports provide evidence that effective programs for moving low-skill workers into the job market and up career ladders can be developed. They primarily focus on low-skill workers who might be at or near the beginning of their active work life. There are other segments of the workforce that need attention as well. For example, recent changes in the economy, especially

retrenchment in manufacturing and related industries, are affecting older workers. The needs of workers who are nearing the end of their work lives are quite different from those of young workers.

Addressing these various needs would require additional resources to implement and maintain effective programs of the type described here. Unfortunately, recent trends in public funding and program design are toward less targeting of those with the greatest need and fewer incentives to serve them. President Bush's budget proposals for FY 2007 combine several employment and training activities, including WIA adult, WIA displaced worker, and WIA youth programs into one funding stream called Career Advancement Accounts. According to Labor Secretary Elaine Chao, self-directed accounts would be targeted toward individuals in need of employment assistance—primarily out-of-school youth, low-income adults and dislocated workers—but could be used by others as well, for example, current workers and part-time students. If enacted, this change would lead to less targeting and even fewer resources than are currently available for these programs (down by \$630 million in FY 2007). ?xml: namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

Over a five-year period, the Center on Budget and Policy Priorities estimates that the president's projected plan for education, training, employment, and social services initiatives would lead to cut of \$52.7 billion in discretionary programs. This does not bode well for those without the skills for today's labor market. Unless there is a significant shift in current resource allocation, many who are projected to be larger segments of the workforce in the coming decades people of color, women, and older workers will be consigned to low-wage work and the economy will suffer due to underutilization of that workforce. □

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*Margaret C. Simms (msimms@jointcenter.org) is vice president for governance and economic affairs at the Joint Center. For more information on the CLASP report: [http://www.clasp.org/publications/decline\\_in\\_wia\\_training.pdf](http://www.clasp.org/publications/decline_in_wia_training.pdf); the P/PV report: [http://www.ppv.org/ppv/publications/assets/188\\_publication.pdf](http://www.ppv.org/ppv/publications/assets/188_publication.pdf); the JFF report: <http://www.jff.org/jff/PDF/Documents/RightJobs.pdf>.*

# POLITICAL REPORT

## The Political Repercussions of Hurricane Katrina

by Chester Hartman

As of this writing (mid-February), the postponed New Orleans elections are scheduled for April 22, with a May 20 run-off if needed. The mayor's office, the entire seven-member City Council, and the sheriff and tax assessor's offices, as well as some possible voter propositions, are all on the ballot. It will be a very closely watched election not only for what its results say and portend for the city's future, but also because of the likely unprecedented (at least for American elections) details of voting procedures, given the vast geographic dispersion of the electorate.

While the population flow back into the city is slow and somewhat unpredictable, in very rough terms only some 200,000 of the 500,000 pre-Katrina New Orleanians will be in the city on April 22. The big questions are who those voters are and how, where, and whether they will vote.

### Demographic Changes

The first question can be reliably answered, at least in general terms: the city's white population—about one-third of pre-hurricane New Orleans—suffered far less damage and displacement, and those who had to leave were in a better position to return quickly. Conversely, the two-thirds of the city that was African American evacuated in far higher proportions and is far less able to return. These people are now scattered in large numbers in such cities as Houston, Jackson, and Atlanta, but are all over the map, from Rhode Island to Alaska. To the extent that place affects ability and willingness to vote, the cards are already well stacked. If one adds to those new realities the consistent data that voting rates are higher for whites and for those with higher socioeconomic status, the racial disparity is magnified.

Prior to the hurricanes, New Orleans was one of the most solid centers of black political power in the country. Of the state's seven congressional districts, only

New Orleans has an African American majority. Four of the nine African Americans in the State Senate are from New Orleans, as are one-third of the State House representatives, and five of New Orleans' city councilors are African American. If some of the projections/plans for a city with radically changed demographics are realized, the city will have far less representation and power in Baton Rouge, and might even wind up with a population too small to constitute a congressional district (which in turn could lead to the creation of a new majority African American district elsewhere in the state). Beyond the state, still to be solidified relocation patterns could affect Houston, Atlanta, Jackson, and other locales where ex-New Orleanians decide to stay in large numbers.

### Displaced Voters

The other big question is how and whether the far-flung dispersed population—as well as those who will be in New Orleans on Election Day—will vote.

First, consider those who stayed or will have returned to the city. Some 300 of the city's 442 parish electoral precincts suffered storm damage. Extensive consolidation into a far fewer number of polling places is mandated. This raises problems of crowding, lines, and inadequate staffing; people whose lives are still disrupted and full of hassles are not likely to stand around, possibly for hours, waiting to cast their vote. Beyond that is the transportation issue: consolidation of voting places means longer trips for most voters—trips made very difficult by the city's still broken public transit system.

In terms of the larger population of displaced people, big questions exist about how and whether they will vote. Never in the nation's history has there been an election in which so large a portion of the electorate must vote, if they vote at all,

by absentee ballot—a system that tests both the will and capacity of the voting mechanism as well as the voter.

One option for those going back and forth to their former homes, but not finally returning to the city, is to vote early in person; a 2005 state law change gives voters that right. Another potentially important option is the fax machine. Louisiana law requires that absentee ballots be received by mail at least four days before the polls close, but it allows ballots to be faxed. Knowledge of this should be widely disseminated, along with practical access to fax machines and, if need be, transmission cost coverage or reimbursement. At the other end, all Registrar offices must be equipped with fax receipt capability—funds for which could be made available via the Help Louisiana Vote Fund.

The threshold issue is notification and communication: how to reach these people, how to get them ballots, and how to facilitate their actual voting. FEMA's proven incompetence includes its inability to assemble a reliable list of evacuees and their mailing addresses, added to which is its refusal to provide the list to candidates. In any case, traditional campaigning is made virtually impossible given the dispersed population, which will certainly reduce turnout. State law in effect as of this writing (it may be amended in the special legislative session that just began) requires first-time voters to vote in person, thus disenfranchising those evacuees trying to vote for the first time—a serious impediment to the democratic process. An additional complication is that, for many evacuees, their residential location is transient, especially those forced to leave hotel rooms previously paid for by FEMA. Where will they go? Will they let FEMA or election officials know their new address? The U.S. mail system is still far from reliable. Aggressive efforts by the media, FEMA, community organizing groups such as the Association of Community Organizations for Reform Now (ACORN), and others can and should play a key role. As the president of the League of Women Voters of New

Orleans put it: “If they can have elections in Afghanistan and Iraq, we can have them too.”

An unanswerable question is the extent to which there will be voter apathy among those no longer in New Orleans. For some, absence may only increase their fervent desire to return and their understanding of the political importance of the vote in order to achieve that goal. For others, the longer they stay away, the more they may turn cynical and less oriented to their former city and neighborhood. Voter turnout among absentees will be the key determinant of the election outcome, as well as an important signal of future population trends.

The problem could be ameliorated by universal voter registration overseen at the national level, as exists in nearly every modern democracy. That would enable citizens to be registered to vote, no matter where they lived, in an automatic process administered by nonpartisan, independent officials. Even more “radical” would be the creation of a Constitutional right to vote. Other ways to facilitate absentee voting include the adaptation of provisions already in place to allow voting by military personnel and overseas citizens; extension of the voting period; and making absentee ballots available online and at public locations such as DMV sites, libraries, and post offices. Highly exaggerated concerns about fraud are adequately addressed via certification and perjury penalty notices.

Like many other problems that Katrina brought out into the open so forcefully, reforms that are needed to address these issues provide a model for much wider application.

## The Mayoral Race

The mayoral race is at the center of attention. Mayor Ray Nagin has not done himself any favors with his “chocolate city” remark or with his reference to the deity. He has not come even close to achieving a Rudy Giuliani-type response to the disaster, which evoked near-universal admiration for the Big Apple’s mayor. Lt. Gov. Mitch Landrieu’s formal announcement of his candidacy is expected within days of this writing. For the first time since 1978, New Orleans may very

well have a white mayor. When Landrieu’s family name and connections—son of the city’s last white mayor, brother of the state’s senior U.S. Senator—are added to the new racial makeup of the likely electorate, a white mayor is by far the most likely scenario. This prediction is supported by the popularity of former Mayor Moon Landrieu, as well as Sen. Landrieu and Lt. Gov. Landrieu himself among black voters. On top of all of this is the unhappiness expressed by black New Orleanians about the recommendations of Mayor Nagin’s Bring Back New Orleans Commission. Probably the only question is whether Landrieu will win by a majority on April 22 in order to avoid a run-off.

Run-off elections have their own downsides: turnout usually falls off, especially among poor and minority voters; the second-round election costs the city a lot of money; and the process of sending out and returning absentee ballots creates additional difficulties. Louisiana law already provides (although only for military and overseas voters) a ranked-choice ballot, whereby if the voter’s top choice is eliminated and does not advance to the run-off, his/her vote goes toward the highest-ranked candidate who is in the run-off. (The system, called Instant Runoff Voting, or IRV, already is used in San Francisco, CA, Burlington, VT, and other places.)

As of this writing, it appears that there also could be several propositions on the ballot concerning the shift of land-use and financial accountability authority from the City Council to bodies appointed by the mayor. Given the racial implications of the likely election results—a City Council with an African American majority and a white mayor—control over these vital elements may become racially coded as well.

## Longer-Term Effects on Political Representation

The potential longer-term effects of Katrina on political representation in New Orleans and the state of Louisiana extend beyond the April/May period. The city’s seven-term congressman, William J. Jefferson, is implicated in bribery charges that, combined with what appears to be significant erosion of his electoral base, could well unseat him in the November

general elections. As a member of the Ways & Means Committee, Congressman Jefferson wields considerable power, and his replacement would weaken the city’s clout in Washington.

Congressman Jefferson is not the only politician who has cause to worry about the longer-term impacts. Both Governor Blanco (in 2003) and Senator Landrieu (in 2002) won by relatively small margins—margins that were largely, if not totally, due to the African American vote. A reduced black electorate in the state could significantly endanger their reelection.

An additional, more worrisome longer-term impact is redistricting caused by Katrina-related population shifts. Rebuilding/repopulation will undoubtedly be a protracted process, extending beyond November 2006. Existing congressional districts (especially New Orleans, but perhaps others in the state, as well as in Alabama and Mississippi) may wind up under-populated, especially if absentee voting procedures are inadequate. Will the “Texas Model” come into play, with a redrawing of congressional districts in between decennial censuses? One possibility, suggested by civil rights attorney Kristin Clarke-Avery and her late colleague Tulane law professor M. David Gelfand, is postponement of federal elections, possibly throughout the Southeast. While a federal statute states that a uniform date is to be set throughout the country for biennial House elections, a 1982 Federal District Court case (*Busbee v. Smith*) held that under certain circumstances—for instance, in the case of a “natural disaster”—they can be held at other times. Given the Justice Department’s role in approving voting procedures under Section 5 of the 1965 Voting Rights Act, that may be an avenue to explore.

Katrina, Rita, and Wilma had an enormous impact in many areas, not the least of which is on the political front. □

*Chester Hartman (chartman2@aol.com) is Director of Research at the Washington, DC-based Poverty & Race Research Action Council. He is a member of the Long-Range Planning Task Force of Governor Blanco’s Louisiana Recovery Authority. He is co-editor of the forthcoming volume of essays There’s No Such Thing As a Natural Disaster: Race, Poverty & Katrina.*

# HEALTH REPORT

## Public Health and Housing Mobility: Fair health through Fair Housing

by Gail C. Christopher

*Social justice and equity have been central to the mission and vision of public health because health is a prerequisite for human development. The idea of a basic public responsibility for social health and welfare and the responsibility of those in public health to be advocates for social justice and collective action has been the foundation of public health... and health is a collective public good that is actively produced by institutions and policies.*

— *Health Equity and Social Justice: A Guidebook for Local Public Health Agencies*,  
the National Association of County and City Health Officials

Health is a prerequisite for “life, liberty, and the pursuit of happiness.” As reported in the September/October 2005 issue of *Focus*, there is an emerging health justice or “fair health” movement in this country, which acknowledges the central role of historic racial discrimination and social injustice in persistent health disparities. Fair Health as a concept acknowledges the individual’s inalienable right to equal opportunity for a healthy life, as codified in international law and embodied in founding documents of this nation. A public health approach to health disparities will focus less on finding fault in individuals and more on offering solutions (such as Medicare, Social Security assistance, and/or housing mobility) that begin to distribute societal resources more equally across socioeconomic groups.

As the links between low socioeconomic status, concentrated poverty, and poor health outcomes become more widely understood, proponents of the elimination of health disparities through public health interventions will see housing mobility as an important contextually-based intervention strategy. Contextually-based health interventions, such as air bags, fluoride water treatment, or moving people to low-poverty and better resourced communities, do not depend exclusively upon individual resources and behavioral changes. Rather, they change environmental factors and, as a result, put individuals and families at a reduced risk for mortality and morbidity.

The link between socioeconomic status and mortality is well established. Debate still exists concerning exact cause-effect relationships, but the correlation between low education levels, low income, and excess mortality are documented throughout history and in diverse cultural contexts around the world. In “Fundamental Sources of Health Inequalities,” Bruce Link and Jo Phelan argue that it is the persistence of these associations—regardless of historic period, country, healthcare delivery system, and/or local culture—that sheds light on the causative aspect of the relationship between socioeconomic status and mortality. Despite vast differences in the places, populations, cultures, and eras in which it has been studied, the irrefutable nature of low socioeconomic status as a fundamental underpinning of excess mortality, morbidity, and health disparities emerges. At the same time, disease does not flow directly from income, educational, or occupational status; other mechanisms involving behaviors and environmental exposure must also be present. By enabling families to move from areas of concentrated poverty to low-poverty neighborhoods, housing mobility addresses many of the mechanisms of the socioeconomic status-disease correlation.

In her groundbreaking October 12, 2003, *New York Times* article, “Ghetto Miasma — Enough to Make You Sick,” Helen Epstein clarifies that it is not just drug overdoses or guns that cause high rates of death in neighborhoods of

highly concentrated poverty. Rather, it is chronic diseases such as stroke, diabetes, kidney disease, high blood pressure, and certain types of cancer. In exploring the relationship between where people live and health, she cites research results from programs such as the Department of Housing and Urban Development’s Moving to Opportunity for Fair Housing (MTO) project to demonstrate that when families move to better neighborhoods, the health of children and parents improves. There were fewer asthma attacks, and lower rates of depression and anxiety. In the end, Epstein reiterates that a deprived environment causes stress, and stress coupled with other deprivations causes poor overall health.

It is in the best interest of the nation to accelerate progress in eradicating racial and ethnic health disparities. Tackling inequalities in health has been clearly stated as an overarching aim of the nation’s public health policy. Healthy People 2010 is a comprehensive set of disease prevention and health promotion objectives for the nation to achieve over the first decade of the new century. Created by scientists both inside and outside of government, it identifies a wide range of public health priorities and specific, measurable objectives. The overarching goals of Healthy People 2010 are to improve quality of life, increase life expectancy, and eliminate health disparities. Progress has been too slow, however. Progress can be accelerated by achieving stronger collaboration between advocacy and professional communities concerned with achieving social justice. The housing mobility advocates and public health advocates for social justice must begin to work together.

In its 2002 report, “Reducing Health Disparities through a Focus on Community,” PolicyLink (a national advocacy organization that works to advance policies to achieve economic and social equity) proposed a framework based on emerging research to describe how social, economic, and physical environments in neighborhoods

affect health. The report asserts that neighborhood factors influence health in at least four ways: (1) direct effects on both physical and mental health; (2) indirect influences on behaviors that have consequences; (3) health impacts resulting from the quality and availability of health care; and (4) health impacts associated with the availability of “opportunity” structures. For example, high air pollution levels have been associated with disproportionate childhood asthma rates among urban minority children. Poor neighborhood lighting and high crime levels may discourage outdoor physical fitness activities such as power walking or jogging to help prevent obesity. It is well documented that medically underserved areas, with too few doctors and healthcare professionals, have higher emergency room utilization rates and poorer preventive healthcare practices. Finally, the absence of adequate educational and employment opportunities is associated with more gang activity, crime, and associated alcohol and drug abuse. Research shows that the health of children and adults has improved markedly when families moved from impoverished neighborhoods with high crime and inferior housing to more economically stable communities with a better quality of life.

Connecting the researchers, advocates, and practitioners within these two distinct sectors—housing and public health—will require several specific strategies.

- Both groups must see the clear advantage of collaboration. Related information dissemination, publications of related research results, forums, and web-based interaction can help to facilitate needed communication across professional sectors.
- Both groups must translate the issues to reflect their own professional values and mandates. In particular, public health leaders can show how housing issues and housing mobility policies relate to the ten essential functions of public health agencies, which are as follows:

- (1) Monitoring health status to identify community health problems
- (2) Recognizing and investigating problems and health hazards in the community
- (3) Empowering people by informing and educating them about health issues
- (4) Mobilizing community partnerships and actions to identify and solve health problems
- (5) Developing policies and plans that support individual and community health efforts
- (6) Enforcing laws and regulations that support, protect, and ensure safety
- (7) Linking people to needed personal health services and assuring the provision of health care when it is otherwise unavailable
- (8) Ensuring a competent public health and personal healthcare workforce
- (9) Evaluating effectiveness, accessibility, and quality of personnel and population-based health services
- (10) Conducting research to reveal new insights and innovative solutions to health problems

- Housing mobility experiments and policies must vary enough to be adaptable in different regional and economic contexts. What works in Chicago will have to be modified or adapted to fit the laws and imperatives of a community in California or Texas, for example. Best “adaptation” practices should be disseminated.
- The health benefits and positive results of housing mobility interventions must be clearly portrayed to diverse constituencies, particularly to policymakers, legislators, developers, educators, and health officials.

Results of experiments such as HUD’s MTO project indicate that it is in the best interest of the health of families to move them and/or assist them as they relocate to better, low-poverty neighborhoods. But this form of social intervention cannot be widely duplicated or expanded as a public health policy until its benefits are more widely perceived. Therefore, an expanded constituency for housing mobility is needed, and public health advocates for social justice are ideal partners. Furthermore, what are currently viewed as essential public health functions need to be re-examined to determine intersections with housing mobility concepts.

As Alonzo Plough reminds us in his article “Promoting Social Justice Through Public Health Policies, Programs, and Services,” any public health practice that competently addresses the impact of social injustice on health will go beyond affecting individual behavior change; it will enable more effective and accountable public and private decisions concerning the basic needs of groups of people who have poor health due to discrimination based on race, income, ethnicity, language, or sexual orientation. Access to affordable housing in low-poverty or mixed-income neighborhoods is one of the basic needs that should be addressed. This nation’s housing voucher program has a natural constituency among public health practitioners and researchers committed to social justice. Like the Fair Housing movement, the Fair Health movement requires strong coalitions and complementary efforts that engage many disciplines. □

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*Gail C. Christopher (gchristopher@jointcenter.org) is vice president for health, women and families at the Joint Center, and director of the Joint Center Health Policy Institute. For more information on HUD’s Moving to Opportunity for Fair Housing project: <http://www.hud.gov/progdsc/mto.cfm>; on the 2002 PolicyLink report: <http://www.policylink.org/Research/HealthDisparities/>; on *Healthy People 2010*: <http://www.healthypeople.gov/default.htm>; Link and Phelan, in *Policy Challenges in Modern Health Care (2005)*; Plough, in *Social Injustice and Public Health (2005)*.*

# THE REDEFINING READINESS LOCAL DEMONSTRATION PROJECTS: *Fixing a Fundamental Flaw in Disaster Preparedness*

by Roz D. Lasker

Suffering and death characterize all disasters. But in the aftermath of Hurricane Katrina, Americans are coming to recognize that large numbers of people suffered and died unnecessarily in spite of our nation's massive investment in emergency preparedness. The people who were hardest hit by this hurricane were disproportionately poor and black. Why did planners fail to foresee or address the difficulties that these people experienced? If people of other races or classes had been similarly at risk, would we have been better prepared to protect them?

One year before Hurricane Katrina, The New York Academy of Medicine released the findings of a rigorous research study, *Redefining Readiness: Terrorism Planning Through the Eyes of the Public*, which help to answer these questions. The study, which was national in scope and paid special attention to the perspectives of African Americans, identified a fundamental flaw in our nation's approach to disaster preparedness—a flaw that makes it impossible for planners to determine which groups of people would be most vulnerable in particular emergency situations, regardless of who those people are. Currently, planners routinely develop instructions for people to follow *without* finding out whether it is actually possible for them to do so or whether the instructions are even the most protective action for certain groups of people to take. When planners do not understand the barriers that make it difficult for people to protect themselves in certain ways, communities cannot organize in advance to address the life and death issues that their residents will face.

## Many of us are at risk

With Hurricane Katrina, the people who suffered or died in New Orleans were predominantly poor, African American, infirm, and elderly. Many of these people could not evacuate from the city on their own. In 2003, a Louisiana State

University survey predicted that this would be the case and we now know some of the reasons why: lack of transportation, lack of money for gas and lodging, impaired mobility, and concerns about looting.

In the case of other disasters, different groups will bear the brunt of uninformed planning. The *Redefining Readiness* study looked at two types of terrorist attacks—a dirty bomb explosion and a smallpox outbreak—from the perspective of the people who would need to be protected in these situations. In a dirty bomb attack, people downwind from the explosion would be instructed to protect themselves from dust and radiation by staying inside the building they were in. But the study found that many people who are responsible for children or others who would not be with them at the time

***Currently, planners routinely develop instructions for people to follow without finding out whether it is actually possible for them to do so or whether the instructions are even the most protective action for certain groups of people to take.***

would not be able to do that unless they knew that they and their loved ones were in places that had prepared in advance to take good care of them during the crisis. Unfortunately, that condition is not met now. Very few work sites, schools, and shops are prepared to function as safe havens should the need arise, and even fewer places know the kinds of preparations that would actually make people feel safe.

In a smallpox outbreak, the study found that a large proportion of the population would not follow instructions to go to a public vaccination site. That reaction makes a lot of sense for the 50 million people in this country who are at risk of developing life-threatening complications if they either get the smallpox vaccine or come into contact with someone who has recently been vaccinated. Current plans

do nothing to protect this group of people, which includes pregnant women, babies under the age of one, people who have ever had skin diseases like eczema, people taking medicines like prednisone, people undergoing chemotherapy or radiation for cancer, and people with HIV/AIDS.

## Better outcomes are possible

Part of the tragedy of disasters is that a lot of suffering can be avoided if communities organize in advance to identify and address the issues that make it hard for people to protect themselves. The outcome in New Orleans would have been very different if school buses (which ended up rusting under water) and military planes (which flew in after the fact) had been mobilized before the storm hit to evacuate disabled residents

and those without cars, or if prescribed debit cards had been pre-issued to poor residents to use in the event of a disaster.

Better outcomes can be achieved in other disasters, as well. In a dirty bomb explosion, many more people would be able to protect themselves by “sheltering in place” if work sites, schools, and shops prepared to care for the people inside in ways that made them (and the people who are otherwise responsible for them) feel safe. In a smallpox outbreak, communities could protect uninfected people who are at risk from the smallpox vaccine by organizing to make it possible for them to stay at home—the only safe place for them to be and a place where most people want to be during an outbreak of a deadly contagious disease.

The only way to achieve these outcomes, however, is to tap into the

common-sense knowledge of community residents to discern what needs to be done to protect them in emergency situations. The *Redefining Readiness* study found that one-third of American people are extremely or very interested in personally helping government agencies and other community organizations develop such plans. Teams in the four *Redefining Readiness* local demonstration sites—in Chicago, Illinois; Savannah, Georgia; Carlsbad, New Mexico; and rural southeast Oklahoma—are now creating a process to make that possible.

### **Communities need to learn from the public in order to protect the public**

To fix the critical flaw in traditional preparedness planning, the *Redefining Readiness* demonstration sites are instituting a bottom-up process, in which the real-life perspectives of the people who need to be protected in disasters form the basis for community planning. This new approach recognizes that it is not possible for planners to develop instructions that people can follow or response strategies that protect the greatest number of people unless they first understand what community residents would face when disasters strike.

The first phase in this process is a series of small group discussions that look at emergencies through the eyes of the people who live and work in the community. The discussions are designed to reveal the barriers that make it difficult for people to protect themselves in two kinds of disasters: (1) explosions releasing toxic chemicals or radioactive dust (such as a dirty bomb); and (2) contagious disease outbreaks (such as pandemic avian flu, SARS, or smallpox). In action teams that will be formed after the discussions are completed, community residents, private sector organizations, and government agencies will work together to develop strategies that can address these barriers.

Because many people around the country are interested in *how* communities can actively engage their residents in disaster preparedness, The New York

Academy of Medicine is planning to share the manuals that the demonstration sites are using in their work. The manual for the first phase of the process gives a detailed description of what it takes to organize and conduct small group discussions with community residents, paying special attention to practices that ensure that (1) a large and representative group of people participate in the discussions (including those from the most disenfranchised groups); (2) participants are able to express what really matters to them during the discussions; and (3) the community has a complete and accurate record of what everyone says in the discussions.

It is worthwhile to point out that these small group discussions differ in important ways from more traditional public engagement approaches, such as focus groups, public hearings, and town hall meetings. Rather than asking community residents to think about disaster preparedness in the abstract or to comment on technical plans, the

### ***As Hurricane Katrina demonstrated, we are sacrificing large numbers of people without letting them know that they are being sacrificed and without giving them an opportunity to work with others in the community to prevent that from happening.***

discussions use scenarios that enable people to explore the barriers they would face if they tried to protect themselves in certain ways. The discussions draw upon the experiential knowledge of community residents rather than their ideological or political views, and the aim is to reveal all of the issues that are important to people rather than to achieve consensus. Through this process, residents have an opportunity not only to identify issues that they care about, but also to build the relationships, networks, and strategies that their communities need to address these issues.

### **Do we have the will to fix the problem?**

Since the *Redefining Readiness* demonstration sites are so diverse—including urban and rural communities

with African American, Hispanic, Native American, and Caucasian populations—the bottom-up process that the site teams are instituting should be adaptable for use by many communities around the country. That is unlikely to happen, however, unless policymakers recognize the need to make a fundamental change in the way that communities prepare to respond to disasters.

Decades ago, James Baldwin warned us: “You cannot fix what you will not face.” What we need to face now is the fact that our nation’s current approach to disaster planning is unconscionable. As Hurricane Katrina demonstrated, we are sacrificing large numbers of people without letting them know that they are being sacrificed and without giving them an opportunity to work with others in the community to prevent that from happening. Grounding disaster response strategies in the real-life perspectives and experiences of the people who need to be protected is a dramatic change in course, but it is the only way to ensure that the billions of dollars that

our nation is investing in emergency preparedness protect as many people as policymakers hope and the American public deserves.□

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*Roz D. Lasker, M.D. (rlasker@nyam.org) is director of the Division of Public Health and the Center for the Advancement of Collaborative Strategies in Health at The New York Academy of Medicine. The full report of the Redefining Readiness study is available at [www.cacsh.org](http://www.cacsh.org). The manuals developed by the local demonstration sites will also be available at [www.cacsh.org](http://www.cacsh.org) upon their completion. Joint Center senior research associate David A. Bositis served as co-investigator in this study, and the Joint Center co-hosted the press briefing at which the study’s findings were released.*

## A Wake-Up Call for Local Elected Officials: *Are We Really Prepared for Local Disasters?*

by Otis S. Johnson

As Mayor of the City of Savannah, Georgia (population 131,510), I have been very concerned about our community's readiness to respond to natural and terrorist threats. We are a major port with one of the most active container facilities in the country. Thousands of containers from around the world come into our port each day. These containers could carry devices that contain smallpox or a radioactive "dirty bomb," and yet only a small percentage of the containers can be checked. We are home to Hunter Army Airfield, which is the launching platform for the U.S. Army's 3<sup>rd</sup> Infantry Division stationed at Fort Stewart, Georgia. The 3<sup>rd</sup> ID has been one of the most active units in the Iraq war. We have a huge natural gas storage facility, bridges, and other ready-made targets for a terrorist attack. In addition, we are on the Atlantic coast hurricane alley. These concerns are exceedingly troublesome for a mayor in a post-9/11 world. Other mayors and local officials around the country face similar challenges to the safety of their residents.

Since the September 11, 2001, attack on the World Trade Center, billions of dollars and thousands of hours have been spent to prepare the United States for terrorist attacks. Yet, although Hurricane Katrina was a natural disaster and not a terrorist attack, the storm proved once again that we are not ready to handle large-scale catastrophes. No level of government was adequately prepared, even with days of warning, to adequately respond to what Katrina brought to our shores. We were not ready, and innocent people—mostly poor and black—died or are still suffering because of poor planning and an even poorer response to the aftermath of the disaster. What happened in New Orleans, Louisiana, is a lesson for all elected officials tasked with emergency preparedness.

Most of the time and money that was poured into preparation for a crisis such as a terrorist attack was spent by experts buying equipment, training first responders, and conducting table-top and simulation exercises on how we should respond to an

attack involving biological, chemical, and radiological weapons. Federal and state-level agencies, as well as national organizations such as the American Red Cross, did most of the planning. Local government and private sector organizations took their cues from leaders at the national level. In all of this planning, the residents who would be most affected by a terrorist attack and who would be expected to respond to emergency situation instructions were not consulted or involved—in my community or anywhere else. In a society that depends on "experts," most people did not question whether or not we were really prepared. In spite of the findings of the 9/11 Commission Report, which most people did not read, we assumed that we were prepared because the experts of the federal Department of Homeland Security said that we were.

This sense of security was challenged in 2004, when The New York Academy of Medicine released the findings of a research study, *Redefining Readiness: Terrorism Planning Through the Eyes of the Public*. This national study challenged the readiness of our communities to adequately respond to a terrorist attack using smallpox or a dirty bomb as weapons. The findings indicated that: 1) "Far fewer people than needed would follow protective instructions in these two terrorist attack situations," and 2) "One reason for this lack of cooperation is that *many people would be seriously worried about something other than what planners are trying to protect them from.*" According to the study, two-fifths of Americans would be "seriously worried about what government officials would say or do." This concern was especially prevalent among Hispanics, African Americans, and other low-income people. Most of our urban areas are heavily populated with members of these groups, and current plans would place these groups in the most at-risk category during any kind of disaster, including natural disasters like hurricanes. One year after the release of the *Redefining Readiness* study, the Hurricane Katrina disaster in the Gulf Coast

validated the study's findings.

Since I had worked with the team that produced the *Redefining Readiness* report before becoming Mayor of the City of Savannah in 2004, I was well aware of how difficult it can be to get residents to comply with governmental directives. In 1995, I observed how poor residents resisted leaving their homes when there was a major chemical fire at Powell Duffryn Terminal, Inc., which required the evacuation of a neighborhood in Savannah. Some residents did not believe that they were in danger and did not want to go to shelters. Language barriers made it difficult for many Latinos to understand the instructions and trust the people who were asking them to leave their homes and the few valued possessions that they had.

I experienced the challenges of a total evacuation of Savannah-Chatham County on September 14, 1999, due to the threat of Hurricane Floyd. I learned that many people would not follow instructions and that we must be ready to deal with "latent effects"—the unanticipated results of well-intended actions. Such latent effects occur when the total evacuation of communities is ordered due to the danger of the deadly storm surge associated with a major hurricane. In the case of Hurricane Floyd, a 100 percent mandatory evacuation for the 230,000 residents of Chatham County was ordered by local officials, based on the advice of the director of the Chatham County Emergency Agency (CEMA). Only 65 percent left the area in advance of Hurricane Floyd.

Although Chatham County was spared a direct hit by Floyd, if the storm had hit Savannah, the remaining 35 percent (80,500) most likely would have faced the same horrific experience of the people in New Orleans. There was the same massive gridlock on Interstate Highway 16 going west out of the city that the people of New Orleans and Houston experienced this summer during mass evacuations. The eastbound line was empty and was not reversed to handle the sudden influx of westbound traffic. Now there are crossover lanes and exit gates to reverse the flow of traffic as needed during a future evacuation. With Hurricane Floyd, people without transportation were asked to gather at our Civic Center, just as the

people of New Orleans gathered at their convention center. Unlike New Orleans, however, Chatham Area Transit Authority and Chatham County public school buses were used to move residents to predetermined sites out of the path of the hurricane. Yet, there was still confusion and disorganization at some of the shelters during the three days that residents stayed in them.

The confusion that characterized the disasters of 9/11 and Katrina at the national level, as well as the chemical fire and Hurricane Floyd at the local level, taught me important lessons about preparedness and the way that residents respond during times of crisis. Since Katrina, we have made sure that residents are working with our local emergency management team to improve communication and coordination with neighborhood leaders to ensure that better evacuation plans are in place for the future. Although our community learned certain lessons from past experiences, it is not clear that many local officials have accepted the importance of involving residents in disaster planning.

On November 28, 2005, the *Nation's Cities Weekly*, a publication of the National League of Cities, reported on a video conference and webcast held that month for city leaders "to discuss key challenges of dealing with natural disasters and to share the lessons learned from recent disasters they faced." Among the key conclusions reached by the conference participants were:

- Every city and town must have a comprehensive plan and local elected officials must be familiar with that plan.
- Cities and towns must be ready to operate alone (without state or federal help) for five to seven days.
- Intergovernmental compacts and agreements must be in place well before an emergency strikes.
- Personal relationships—mayor to mayor—are vital in an emergency.
- Citizens should be part of the first responder team.

I did not participate in the conference. I wish I had. Yet, although the key conclusions are all crucial components of better emergency planning, they do not emphasize the importance of resident involvement. Allowing citizens to be part of the first responder team is not the same as enabling residents to fully engage in all aspects of the emergency response planning process.

The results of the *Redefining Readiness* study provide a perspective on resident involvement that I am using in Savannah. Organizations like the National League of Cities (NLC) and the U.S. Conference of Mayors should organize workshops to share the findings of the study with their constituents. The National Black Caucus of Local Elected Officials (NBC-LEO), representing the over 9,500 black elected officials currently in office, and the National Conference of Black Mayors need to provide opportunities for their members to learn strategies that they can use to properly engage their constituents—especially the many poor residents and people of color that most of them represent—in meaningful planning for terrorist attacks and natural disasters. Working with and through these organizations would enable the development of the personal relationships recommended by the NLC conference participants. Black elected officials have an added responsibility to use their positions to make sure that the people most affected by disasters have their voices heard and respected during the planning and program implementation processes. It is clear to me that the poor and black people of New Orleans did not have any voice in the process of planning for hurricanes that would strike their city.

The *Redefining Readiness* team is conducting a demonstration project based on the study's findings. I am grateful that Savannah has the opportunity to participate—along with other pilot sites in Chicago, Illinois, Carlsbad, New Mexico, and rural Oklahoma—in creating a process that will use the common-sense knowledge of residents to find out what needs to be done to protect them in emergency situations. Residents can provide valuable insights into how they view events and how they would respond to these events, which planners do not have.

I believe that, if the residents of New Orleans had been involved in response planning for a hurricane of the magnitude of Katrina, many lives could have been saved. By learning from the demonstration project about how to put resident involvement into practice, we can enable local elected officials to be truly ready for future disasters in their communities.

I have made a personal commitment to work with the Savannah resident team that is participating in the *Redefining Readiness* demonstration project. I want to make sure that our community takes full advantage of the opportunity to develop a new democratic process that can be used not only for dealing with disasters, but also for authentic resident involvement in any planning or activity that affects their lives. Through their own personal involvement, elected officials must show that this process of resident engagement will be the new model for how local planning is conducted. I will be an advocate within organizations, such as the ones mentioned above, to encourage the sharing and use of the findings of the *Redefining Readiness* study and the demonstration project among other elected officials. I will seek opportunities to share what we are learning in Savannah and the other demonstration sites at the annual conferences and meetings of these organizations.

From a public accountability standpoint, local officials have both a need and a responsibility to remedy the current flaws in emergency planning. This will be a difficult task due to the culture of planning in this country. We depend too much on national and state "experts," as well as the usual planners at the local level, to tell us what we should do. Their plans, though well-intentioned, brought us the tragic response to Katrina. As local elected officials, we should work not only for a better way to respond to disasters, but also for a new way to exercise democracy in America—both of which we can achieve by changing the way we involve residents in planning. □

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*Otis S. Johnson is mayor of Savannah, Georgia.*

# The Gulf Coast Evacuees Who Won't Return

by Michael R. Wenger

In recent months, New Orleans Mayor I.C. Ray Nagin has been logging thousands of miles, imploring residents displaced by the aftermath of Hurricane Katrina to “come home.” But more than three-quarters of New Orleans’ pre-Katrina population of 500,000 remains scattered across more than 40 states. A recent study by Brown University projects that as many as 70 percent of the residents will settle elsewhere. In fact, according to John R. Logan, a professor of sociology and director of the study, as much as 80 percent of the black population of New Orleans will not return due to the costs of relocating back home, the fact that some neighborhoods are not being rebuilt, and the desire for a fresh start in new surroundings.

Therefore, while attention remains focused on the equitable rebuilding of New Orleans and other Gulf Coast communities devastated by Hurricanes Katrina and Rita, the future of those who will not return cannot be ignored. Cities like Houston and Atlanta, the two cities that are hosting the largest number of displaced Gulf Coast residents, must confront the challenges of how to effectively cope with the sudden influx of tens of thousands of new residents and how to integrate them as seamlessly as possible into the life of the city. At the same time, the new residents must find ways to pick up the pieces of their lives and start from scratch to establish themselves and their families in unfamiliar surroundings. It will not be easy for either the receiving communities or their new residents.

Directly after the storm, receiving communities had little choice but to focus on meeting immediate needs for, in some cases, upwards of 100,000 people. These needs included food, clothing, temporary shelter, emergency medical care, mental health services, and infant care for the legions of people who arrived bewildered and disconcerted, with little more than the clothes on their backs. As the magnitude of the disaster became clear and the unresponsiveness of government agencies, particularly the Federal Emergency Management Agency (FEMA), persisted,

these communities were forced to come to grips with the likelihood that many of the Gulf Coast evacuees could not or would not return to their homes. Grappling with the new challenges has only begun to test their patience and creativity, particularly as their fiscal capacities are stretched beyond their limits.

The primary challenge is finding adequate permanent shelter for the new residents. Until people are settled in a place that they can call their own, the sense of apprehension about the future remains. Uncertainty about where one is going to live makes it more difficult to search for a job, help children settle in new schools, determine transportation needs, establish a budget, and begin the long process of rebuilding shattered lives.

Yet, in most communities, affordable housing in safe neighborhoods is at a premium—a situation not helped

***Uncertainty about where one is going to live makes it more difficult to search for a job, help children settle in new schools, determine transportation needs, establish a budget, and begin the long process of rebuilding shattered lives.***

by FEMA’s uneven and frustrating decision-making process. The agency has been insensitive in setting deadlines for people to find permanent housing, excruciatingly slow in providing the necessary resources, and captive to regulations that are simply inadequate to meet the needs. One result is that many evacuees remain in hotel rooms whose costs run as high as 30 percent more than the cost of renting a quality apartment. According to Robbie Ashe, Intergovernmental Relations Manager for the city of Atlanta and its designated Hurricane Katrina Coordinator: “There has been a preoccupation with regulations rather than the welfare of evacuees.” Ashe warns that, as the transition drags on without a solution for the housing needs of the displaced families, adjustment to a new life becomes increasingly difficult. In addition to the spiraling costs, he notes, “the lack of decision-making ability by FEMA is creating a grave danger of a new underclass.”

Once the housing issue is resolved,

getting children settled in school is the next major challenge. With many school systems bursting at the seams and unprepared for several thousand additional children, overcrowding looms as a major problem. Furthermore, the entrance of so many new students in the middle of the school year places unique burdens on teachers and school administrators to adjust curricula and personnel to meet the needs of these students, locate additional textbooks and equipment, and other such concerns. The incoming students face equally difficult challenges in adjusting to new surroundings and new teachers, while continuing to deal with the trauma of having lost their homes, friends, and sense of security.

Complicating matters is the inadequacy of federal funds to assist these receiving school districts. The Hurricane Education Recovery Act authorized \$645 million for schools nationwide to deal with approximately 370,000 displaced students. The legislation called for schools to

receive a maximum amount of \$6,000 for each displaced student and \$7,500 for each displaced student with a disability. According to the National School Boards Association, however, the appropriated funds may well be inadequate to provide amounts even remotely close to these targets. For example, the Houston Independent School District estimates that it costs the district \$180,000 a day and as much as \$30 million for the year to educate the approximately 6,000 students it has inherited as a result of Hurricanes Katrina and Rita. The largest cost is for additional teachers, but additional security, counseling, and busing also are consuming considerable amounts of money. Through early January, the district had received \$164,000 in state funds and had applied for, but not yet received, assistance from FEMA.

Settling children in schools as quickly as possible is important for several reasons. First, of course, is the need for continuity in their learning and for stability in their lives. Placing the

children in school also frees the parents to do what they must to establish a stable family environment in their new location: make their new home livable, establish clear routines, and return to the work force.

The challenge of finding employment differs in difficulty, depending on the availability of jobs in the receiving community and on the previous employment experience of the job-seeker. Fortunately, cities like Houston and Atlanta have relatively healthy economies and can absorb additional workers into their labor forces. In Houston, as well as in Baton Rouge and Lafayette, Louisiana, and in Dallas, Texas, the local chambers of commerce have offered jobs fairs and training programs to unemployed workers. The U.S. Department of Labor launched a job bank for employers nationwide to help recruit and hire workers affected by the storms. Several states set up on-site one-stop career centers at large shelters to assist with the process.

Atlanta, compared with other receiving cities, seems to have encountered less difficulty with regard to job training needs. Atlanta's new residents, according to Ashe, tend to be people who were among the working poor in New Orleans and, therefore, better prepared to re-enter the work force than those who were unemployed. "A significant number of the people who came to Atlanta were not the poorest of the poor. Many had private transportation or other resources to get them here, and they are likely employable without a significant investment in training," he said. Nonetheless, irrespective of the work readiness of

adult evacuees, the challenge of matching experience to jobs remains a daunting one.

Associated with the trauma of starting life over again after losing virtually all of one's possessions is an unpredictable state of mental health. While many families are adjusting well, others are struggling. Atlanta dispatched police and fire department chaplains to shelters in order to counsel evacuees, and many faith-based institutions are working with evacuees on a regular basis. Additional challenges that complicate a new beginning for families include such things as coming to closure with insurance companies, obtaining family medical records from physicians whose offices may not be functioning, getting a new drivers license, furnishing a new residence, buying entire new wardrobes, and figuring out what to do with cherished possessions left behind, including homes on which mortgage payments are still due even though the houses are uninhabitable.

All of these challenges will tax both the staffs and the financial coffers of the receiving communities. A common complaint is that the federal agencies—again, FEMA is the main culprit—have been extraordinarily slow in providing assistance and/or reimbursement, and in some cases, have refused to provide either, claiming that regulations prohibit it.

Atlanta's City Council appropriated \$1 million to be used for relief and relocation efforts, but, according to Ashe, the most worrisome impact has been on the non-profit community. For example, the Atlanta Community Food Bank utilized 40 percent of its annual budget in one and one-half weeks because they made

the decision that "they simply would not let people go hungry." Other non-profit organizations have made similar investments despite the uncertainty of federal reimbursement. Ashe worries that the non-profit community cannot sustain this level of effort indefinitely without a substantial influx of additional resources. FEMA's behavior "would be comical," he observes, "if it were not so deadly serious."

Over the long term, a host of additional challenges likely will arise from the effort to integrate new residents into existing communities. Will the resources be there? Will the long-time residents accept the new residents? How long will it take the new residents to overcome their trauma and establish and adjust to their new lives? What will be the long-term impact of their resettlement on the communities—both those receiving and those left behind? While rebuilding New Orleans and other Gulf Coast communities equitably and ensuring the right of return for all Gulf Coast residents remain important goals, the Gulf Coast evacuees who will not return also demand our attention, as the challenges that they and the receiving communities confront will, in many ways, be no less daunting. □

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*Michael R. Wenger (mwenger@jointcenter.org) is a program development consultant for the Joint Center. He is former director of the Network of Alliances Bridging Race and Ethnicity (NABRE) for the Joint Center and former deputy director for Outreach and Program Development for President Clinton's Initiative on Race.*



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