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Producing the Qualified: Resource Allocation for Lead Abatement in San Antonio

Benjamin C. Gonzalez

A departmental senior thesis submitted to the Department of Anthropology at Trinity University in partial fulfillment of the requirements for graduation with departmental honors.

April 29th, 2020

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ABSTRACT

Although the use of lead-based paint in residential buildings was banned in 1978, many aging buildings still contain hazardous lead content. Government systems have begun treating this environmental hazard as an issue of public health, organizing intervention according to measurable health indicators such as the blood lead level (BLL). As a result, public health norms organize and dictate who receives state assistance in removing lead from their home, constructing a specific demographic of “qualified” recipients of aid. Using qualitative interviews with residents and city officials, this thesis will analyze a local lead abatement program in San Antonio, Texas in order to evaluate how these categories of qualifications are constructed around dominant forms of public health intervention. I find that this production of the qualified translates the material issue of lead-based paint’s existence in structures into a project that is measurable on bodies and populations, making it more legible for a neoliberal system of resource allocation.

PRODUCING THE QUALIFIED: RESOURCE ALLOCATION FOR LEAD ABATEMENT IN SAN ANTONIO

INTRODUCTION

In U.S. cities, aging infrastructure and outdated building materials jeopardize one's ability to live in one's own home safely. Environmental contaminants exist in everyday surroundings, constituting highly toxic threats to physical health that are often difficult to see, yet are constitutive of the very structure in which residents live. Sweeping national policies allocate grant funds intended to abate such toxic hazards and replace them with other materials deemed "safe" by updated standards in an effort to bring living spaces up to code. Of these environmental health hazards in living spaces, one of the most widespread and long-lasting is lead-based paint.

Starting with the nationwide ban on all consumer use of lead-based paint in 1978¹, the federal government began to target lead paint as a "public health" concern (Environmental Protection Agency 2019). This increased focus led to further and more specific policies intended to reduce the burden of disease caused by lead-based paint, including the Residential Lead-Based Paint Hazard Reduction Act of 1992 (Environmental Protection Agency 2016). However, as this thesis will illustrate, rather than repairing toxic lead-based conditions universally, these policies may prioritize resources for certain populations seen as more "at-risk" of long-lasting health

¹ The average blood lead level in children ages 1 to 5 dropped from 14.9 µg/dL in 1976 to 1.7 µg/dL in 2006 (Gould 2009).

consequences². Such national definitions of who is supposed to benefit from lead abatement policies are reflected in local policies which distribute resources at the municipal level.

In San Antonio, Texas, lead-based paint in houses poses a threat to those who still live in or near these homes. Microscopic lead dust particles, released when aging lead-based paint cracks or peels, pose anthropogenic threats that surround vulnerable people. To remove this threat and mitigate harm to residents' health, San Antonio's Green and Healthy Homes (GHH) program offers free renovations to residents with lead-based paint in their homes. This local program, the result of a Department of Housing and Urban Development (HUD) grant, aims to reduce lead risks in privately-owned or rented residential properties (City of San Antonio 2018). However, these resources are only available to households that fall below a specific income level (80% or below HUD's Area Median Income) and have children who are under six years old. Qualifying for this at-risk status requires tax records and proof of income level, restricting the beneficiaries of these resources to those who meet a specific vision of "public health" need³. Only those who fit the description of this program's target population may participate in state-provided assistance to remove the dangerous contaminants from their surroundings.

This thesis aims to evaluate the nationally-defined categories by which people qualify for city resources, which subsequently trickle down into local policies to determine who accesses state-assisted health. I investigate the processes by which contaminants in urban settings are mitigated, removed, and/or tolerated by government institutions, as well as how systems of

² Extended lead exposure in children is associated with effects on stature and cognitive function, among other measures (Needleman 1988, Schwartz, Angle, and Pitcher 1986).

³ The specific requirements for applicants to GHH are outlined in detail below in my analysis, but include requirements related to the age of the home, the age of the child, the family's income level, and proof of ownership.

public health are constructed around a particular ideal of the perfect beneficiary, whether based on measurable health indicators or “marketable” goals that may guarantee funding. As lead exposure and its social characteristics become a growing area of study⁴ within medical anthropology and sociology (Muller et. al 2018), so too has the importance of knowing the process by which governments seek out clients and target specific populations to benefit from public health resources. I argue that this prioritization process transforms the material issue of environmental health hazards into a reification of public health norms that rely on efficiency and the maximization of health outcomes on the bodies of specific populations.

A Lead-threatened Neighborhood in Flux

This thesis will focus predominantly on the Dignowity Hill neighborhood, on the East Side of San Antonio. The East Side developed out of freed slave settlements dating back to the 1870s, and has long been a historically-black residential area (Davis 2017). Bordered to the west by Interstate 37, Dignowity Hill lies just outside the Central Loop of highways that enclose Downtown. What was once a relatively low-income neighborhood has, in the past few decades, become a more attractive spot for affluent homeowners looking for a neighborhood close to the downtown area. Long-time residents have seen property values and taxes skyrocket in recent years as new businesses like the Alamo Beer Company have moved in. From 2013-2018, the median home value in Dignowity Hill increased 210 percent (Brezosky 2017, McNeel 2012, Olivo 2018). In 2014 Dignowity was designated by the Obama administration as part of a 22

⁴ Much of this research focuses on the racial and ethnic inequalities in lead exposure, and how these toxic structures are intensely stratified (Muller et. al 2018).

square mile Promise Zone, a status that grants the area priority in receiving grant funding for revitalization and “ladders of opportunity” (City of San Antonio 2014). This newfound attention to the neighborhood from affluent homeowners, federal designations, and local programs make Dignowity Hill a tumultuous site of change in a previously-neglected area.

However, despite the increasing renovation and construction, Dignowity Hill children suffer from high levels of lead in their blood⁵. This area is also the site of more frequent lead-based paint abatement than the rest of the city, due to the age of the housing stock (Collinger 2019). Most structures in this historical district were built before 1978, meaning many of them are painted with lead-based paint which is in the process of chipping or flaking. Houses that are renovated by city programs or developers look remarkably more refurbished than many of the neighboring houses, further complicating the hybrid nature of Dignowity Hill as an area of older, deteriorating homes, newly-constructed affluent homes, and previously-hazardous refurbished homes. These different houses and rented properties create a mosaic of various housing conditions: AirBnBs sit next to abandoned homes, and large barking dogs roam the front yards of houses next to historically-protected mansions. This patchwork of disparate dwelling spaces reflects a moment of uncertainty for the future of the neighborhood. The housing stock of Dignowity Hill is conditioned by historic district restrictions, opportunistic investors, long-time residents, and renovation projects, coalescing in a neighborhood that suffers disproportionately from toxic building materials. Therefore, understanding how homes are categorized for renovation in this neighborhood provides insights into how public health policies play a role in

⁵ In 2017, 3.33% of children in Dignowity Hill were reported as having dangerous levels of lead content (more than 5 µg/dL) in their blood, according to state data (Collinger 2019).

shaping the cityscape; only the houses that contain “qualified” residents can access renovation assistance and attain a “developed” or “safe” status.

The Pursuit of Applicable Clients

The San Antonio Green and Healthy Homes (GHH) program is administered by the San Antonio Neighborhood and Housing Services Department (NHSD). Their goal, after receiving the federal HUD grant money which funds the program, is to seek out households that meet the eligibility requirements as outlined in the grant. City employees then guide qualifying households through the bureaucratic processes of retrieving paperwork and agreeing to certain conditions before contracting the renovation to begin. Unlike other home repair programs offered by San Antonio NHSD which function on a first-come, first-served basis⁶, GHH struggles to find many applicants without extensive advertising. Because the grant only applies to a limited subset of the San Antonio population, NHSD gives talks, lessons, organizes outreach campaigns, and partners with other city programs to try to maximize the number of qualified people reached by GHH’s resources. The leaders of NHSD are intimately familiar with all of the complicated conditions and terms of the program’s grant requirements, and spend much of their working hours explaining the ins and outs of the program to those who might potentially benefit from it.

By interviewing the city employees involved with finding and processing clients, I came to better understand how local policies construct lead-based contamination as a threat to public health, and the processes they require to enact change and replacement of aging infrastructure.

⁶ The most popular of these is the Owner-Occupied Rehabilitation program, which gives out loans for home repairs to address hazards.

The ways in which policies allocate resources for managing toxicity speaks to how state systems in the United States create a public health ideal to which policies adhere. These analyses, in combination with the perspectives of the residents affected, aim to better situate large-scale public health policies in local environments, and examine how this specific city department sees its role in providing resources to residents in need. These local techniques paint a particular picture of who is the most in danger in a lead-contaminated home, allowing for a deeper investigation of how the city aims to develop “healthy homes” through lead abatement.

LITERATURE

Housing and Lead in Environmental Health

Much has been written in the field of public health about the extraordinary significance of housing and neighborhood conditions for health in urban populations. As Shaw (2004) noted in her review of housing’s effect on health, environmental conditions create cumulative health effects that add up over the course of a lifetime. Even without toxic contamination, housing conditions can have profound effects on physical health as well as social or psychological well-being. The built environment is conditioned by a framework of policies which lay out building codes, zoning procedures, and other such legislation which provides a standard by which housing conditions are judged (Perdue, Stone, and Gostin 2003). As is evident in Sargent et al.’s (2003) case study of Massachusetts, local or state governments often intervene in the event of toxic contamination in an effort to restore housing to an acceptably healthy standard.

Environmental justice theory concerning man-made toxins focuses on the importance of historical processes that leave current societies to deal with the aftermath of past negligence or

ignorance of dangerous threats to living spaces (Pellow 2000). Within the study of environmental inequality, lead contamination is often used as an indicator of aging infrastructure that disproportionately impacts populations at the margins of society (White, Bonhila, and Ellis 2016). Not only do these catastrophes primarily affect the most socioeconomically vulnerable, but they may also play a part in perpetuating disadvantage. Toxic environments have recently begun to show associations with decreased social mobility (Manduca and Sampson 2019). Policies and institutions allow such contamination to happen through widespread adoption of infrastructure practices that become the accepted norm and are slow to change (Werner 2006). However, despite these structural factors, the burden of responsibility to restore toxic environments is often placed on the victims themselves, forcing them to organize and prove their situation is sufficiently harmful (Pellow 2007).

Community Understandings of Toxicity

Community perceptions of toxic environments can vary wildly between different geographic and social areas, impacting the ways in which victims conceptualize their issues. As Brown (1992) noted, victims of toxic contamination often rely on “popular epidemiology,” a practice of retracing the issue back to its roots through community cooperation and communication. However, the understanding of the problem can take many different forms. Boi (2001) emphasized how official responses, or lack thereof, from government institutions regarding toxic emergencies can instill “toxic fear” in a community which spreads distrust in policy decisions. “Toxic uncertainty,” on the other hand, is a result of a general community understanding of the threat, but only vague ideas of who is to blame. According to Auyero and

Swistun (2008), this is the result of “relational anchoring” of risk perceptions in which there is no single disaster that points to a clear cause of the toxicity because the effects are slow and build up over time. This is compounded by the “labor of confusion” enacted by major institutions to create uncertainty, in which they take contradictory actions that betray official statements (Auyero and Swistun 2008). This labor of confusion is an intentional strategy employed by government and corporate institutions to further muddy the waters and make it difficult for victims to assign blame for the contamination. Singer (2011) later built upon this concept with the idea of “toxic frustration”: a phenomenon in which victims of toxicity are reasonably certain about the causes of the problem, but try to avoid thinking about it because they are unsure of how to change anything. However, this is not indicative of pure submissiveness of the victims. On the contrary, they want to do something to change their situation but are not sure how. Because of a lack of pull with the leaders responsible, the direct causes of these abstract threats become difficult to encounter by the citizen. Such perceptions around toxic contamination inform how communities respond to threats, as well as how they interact with institutions to receive help in restoring their environment.

The divide between citizens and established experts on contamination is another well-studied area that informs how victims interact with institutions through individual or community activism (Fischer 2000). Barnes (1999) examined how community activists in Brazil calling for support in welfare were seen as less legitimate by government and business institutions when they were more organized. Less-organized movements, though not very effective at enacting changes, were perceived to be more authentic by these institutions because they represented a less-polished voice of the people. Citizen interaction with expertise about

toxic contamination requires community members to obtain information wherever they can find it and distribute it among their fellow community members. Those with lived experiences of toxic contamination then apply expertise they learn through “citizen scientists” to their own situation to enact change (Johnson et. al 2014). Much of this previous literature has revolved around the actions taken by citizens to obtain interventions for environmental hazards. However, this thesis will take a different approach by examining a government system attempting to intervene in a hazard (lead-based paint) that is anthropogenic and invisible to many of those who suffer from it.

Constructing Public Health

Michel Foucault, in his (1976) articulation of biopower, describes the concept as representing a shift from the “right to death” present in Western feudal societies, in which the sovereign exercised power primarily through the mode of subtraction, with sovereign power’s ultimate right to inflict death. Foucault contrasts this with production, in which subjects are produced according to their productivity rather than being subtracted for transgressions against the sovereign. The shift to a biopolitical system puts a new focus on managing bodies through knowledge-making and surveillance regimes, fulfilling power’s new charge to proliferate, channel, and maintain life in its collective instantiation within a society.

Modern biopolitics is organized around statistics and metrics which can be used to describe and apprehend populations, making them available for optimization and adjustment. The Disability-Adjusted Life Year is an example of such a quantitative metric utilized by the discipline of public health to measure morbidity and mortality. The DALY is a numeric

representation of the number of healthy years of life lost to morbidity and/or mortality for a given disease or condition. Developed by the World Bank, this measurement was meant to describe the economic potential blunted by specific diseases and conditions in a form that could be easily compared across countries and diseases/conditions. Subsequently, it was used to inform interventions to minimize the impact of disease on productive life, prioritizing efficiency of human bodies and usefulness to a global system of labor and production (Murray 1994). Anand and Hanson proposed that the implicit values and assumptions enforced by the DALY are flawed: those with physical disabilities whose lives are already considered “lost” by the DALY would not contribute any more to the disease burden if they contracted a disease unrelated to their disability (Anand and Hanson 1997). This, along with other methodological issues, might have severe consequences in how the DALY, invoked to distribute resources according to its measured burden of disease, organizes where the most public health need is located demographically.

Such public health constructions categorize the population into groups and prioritize where resources can be most useful. The dominance of the DALY in public health discourse is a result of its supposed objective and scientific nature. Even though it implicitly involves values about the way suffering should be quantified, it poses as a “rational and unbiased mechanism for conjuring the future.” (Montoya 2013). Moreover, it makes an implicit assumption that suffering *can* be quantified at all. These dynamics which emphasize maximizing bodily productivity of public health are consistent with discourses surrounding San Antonio’s GHH program: in local coverage of the lead abatement grant, a city director stated that they “want those kids to be as competitive as they can be without something out of their control affecting their development or

growth” (Riker 2019). In the following fieldwork and analysis, I will illustrate how these themes coalesce into a particular imaginary of the lead-contaminated home, and how the city utilizes this imaginary to obtain health outcomes they may market as “successful.”

METHODS

Between October of 2019 and February of 2020, I interviewed a variety of actors involved in the lead paint abatement and removal process in San Antonio. This included interviewing city and non-profit employees involved with GHH, as well as walking the streets of Dignowity Hill and interviewing residents who had gone through the GHH renovation process. In some cases, I met these residents by compiling public abatement data and knocking on doors of houses that had been renovated. Other times, I was referred to past GHH clients through city employees or other residents. When meeting with city or non-profit employees, I would meet at their office and speak with them about their particular expertise with the program. These interviews were mostly one-on-one, save for one interview with two “promotoras” who worked as a team to promote the GHH program. I met with residents who had participated in GHH in their renovated homes, where they would show me specific areas where work was done. Sometimes, other family members would be around the house and would share their own experiences during the renovation process. Finally, I attended one lead inspection and risk assessment (LIRA) at a home that was not enrolled in GHH but another home repair program offered by NHSD. I shadowed the contractors leading the inspection as they explained their process, and also asked the residents some questions about their experiences. For the sake of

confidentiality, all of the names of the residents and city employees have been changed, and all identifying information has been omitted.

I also collected observational data on over thirty homes in Dignowity Hill that had been renovated through GHH. I primarily took these notes while walking door-to-door around different houses, but I also took notes within the homes of resident informants, paying special attention to how their houses compared to neighboring houses. Other information I collected involved looking over any documents I could find related to the program, including funding notices from HUD, applications from NHSD, and media materials given by NHSD to promote GHH. These data helped me gain an understanding of the institutional structure around GHH and the methods by which city employees encounter and interact with residents

CENTERING THE CHILD IN A LEAD-BASED HOME

National Priorities Becoming Local Realities

Since 2000, the City of San Antonio Neighborhood and Housing Services Department (NHSD) applied to and received federal grant funding from HUD to remove or remediate lead-based paint in houses. Under the program entitled San Antonio Green and Healthy Homes (GHH), NHSD removes or remediates lead-based paint from around 70 houses per year, and has remediated over 1,600 houses over the program's lifespan (Huertas 2019). NHSD reapplies for HUD grant funding every three years, and according to one city official involved with overseeing the program, the awarded grant money continues to increase every three-year funding period. This official, whom I will call Wesley, was one of my main informants from the city and had been working with GHH almost since it began. When he first told me that the funding for

GHH was increasing every grant period, it took me by surprise. In an era where the federal government is actively cutting grant programs for housing⁷, it seemed improbable that a fully-funded renovation program for low-income residents of houses with lead-based paint would consistently receive increased federal funds. When I asked Wesley about this increase in funding, he could only offer speculation as to why the federal grants were growing:

It could be that the head of HUD now is Dr. [Ben] Carson, so he's a doctor who understands. Maybe he's allocating more funding [to lead abatement] because he knows about health effects on children... and then [HUD] has to pitch it to Congress, and Congress has to agree, so I'm sure they're increasing the funding with better justifications and needs assessments.

I pressed Wesley on other potential explanations: could it be a result of inflation? Of increasing labor costs for the renovations? Wesley flatly rejected these possible reasons, stating that GHH requests funds by calculating the total cost of renovation per house in different areas of the city, and that HUD has been funding enough for more homes every funding period.

Of course, the HUD grants that fund GHH are not without specific requirements regarding the types of residents that may apply. As outlined by NHSD, only households who met the following HUD grant conditions can apply to receive assistance from GHH:

1. *House must be built prior to 1978⁸; AND*
2. *House must be located within the City of San Antonio; AND*
3. *House must be structurally sound to receive assistance; AND*

⁷ President Trump's 2020 Fiscal Year plan proposed an 18% cut in HUD funding, over 9.6 billion dollars (National Low Income Housing Coalition 2019).

⁸ All consumer use of lead-based paint was banned in 1978 (Environmental Protection Agency 2019). While a positive test for lead content in the home's paint is not listed in these initial qualifications, the city will only carry out the renovation if the house is, after a Lead Inspection and Risk Assessment conducted by city contractors, found to contain a hazardous amount of lead content in its paint (City of San Antonio 2018).

-
4. *A child age 5 and under must reside in the home or spend at least 6 hours per week in the home; AND*
 5. *Have a clear title to property; AND*
 6. *Must be current with property taxes; AND*
 7. *Household must meet [fiscal year 2018] HUD established Income Guidelines for families earning 80% or below of Area Median Income⁹.*

As I will illustrate in this and the following section, federal guidelines attached to the grants which fund GHH restrict who may apply according to demographic categories. These restrictions are justified through dominant discourses regarding the maximization of “positive public health” outcomes. They shape the nature of the GHH program and provide normative structures of health upon which the moral impetus driving housing renovations is founded. Despite the fact that lead-based paint exists in certain houses regardless of who lives in them, certain kinds of residents are given priority based on medical knowledge created and sustained by public health institutions.

Wesley’s speculation regarding the reasons why GHH continues to receive increased federal funding is notable for its clear reliance on widely-accepted priorities about the hazards of lead-based paint. Lead poisoning is often discussed in regard to its impact on children, despite the fact that prolonged lead exposure can have detrimental effects on adults as well (Schneitzer 1990). Medical and sociological literature on the subject of lead and lead exposure has long

⁹ For a family of four, this income limit is \$53,450 (City of San Antonio 2018, Table 1). The 2017 median household income of Bexar County (which contains San Antonio) was \$54,575. The 2017 median household income of Dignowity Hill was \$24,744 (UT Health 2017).

focused heavily on the child as the object of concern, analyzing lead's effects on growth, education, and other health outcomes (Swartz, Angle and Pitcher 1986, Needleman 1988, Miranda 2007). Wesley's belief that HUD's renewed interest in lead-based paint was due to Secretary Ben Carson's experience as a medical doctor relied on an assumption that, at least in this specific issue, doctors could better assign resources where they are needed using the "objective" criteria of health outcomes. This assumption that the program's system of prioritization is based on objective medical knowledge serves to further legitimize GHH as an executive program accomplishing needed tasks for the sake of public health and safety. By referencing "health effects on children" as the primary justification for funding a program like GHH, Wesley incorporated the local renovation of houses within a broader national mission of preserving child development. As he explained, child health is a powerful justification that plays well in political arenas ("HUD has to pitch it to Congress"), and therefore is a useful tool for making sure GHH warrants sufficient funding.

Ong (2006) has discussed the neoliberal exceptions allowed by nation-states to competitively position themselves in the global marketplace. These spaces of exception, such as China's special market zones within their socialist economic structure, re-engineer political standards to favor neoliberal modes of optimization. Such neoliberal exceptions reorganize citizenship into the allocation of benefits and rights according to people's marketability rather than their membership in a state. In the realm of health interventions, this phenomenon takes the form of relying on population-level data to determine how to "best" assign resources.

Montoya's (2013) analysis of HIV/AIDS intervention in Vietnam describes the transition from an "enforcement" model to a US-led model of "adherence," which relies on newer

“technoscientific knowledges” to calculate risk and cost-benefit analysis. He calls this incorporation of neoliberal tendencies which value rational optimization into humanitarian intervention an “economy of virtue,” in which non-governmental organizations (NGOs) trade in virtue, or moral good, for symbolic and real capital (Montoya 2012). While Montoya applies his analysis to the specific ways humanitarianism operates in Vietnam to gain credentials and win resources, I borrow similar concepts to describe the ways in which local San Antonio systems, both governmental and non-governmental, translate the material issue of lead-based paint into a virtuous pursuit of positive public health outcomes for the sake of the child. These public health outcomes, which are measurable indicators of “success” in individual houses, are transferable into capital used to maintain, sustain and legitimize public programs.

The marketability of child health was obviously an important part of GHH’s legitimacy, as Wesley’s insistence that it justified strong federal funding implied. Neoliberal modes of calculating and maintaining maximum benefit to health was a tool of NHSD to give GHH a legitimate purpose in the national pursuit of improving child health. Technoscientific knowledges inform these local priorities, placing their mission in line with the scientific community’s insistence that children must be saved from lead exposure to protect their development as productive citizens. Although the guidelines previously listed are determined by the federal grant requirements of HUD, it is the local government systems like NHSD which operationalize these national priorities and give them life through public events, programs, and interventions. As the next section will illustrate, the focus on children’s health in relation to lead permeated the variety of promotional materials and events held by the city to reach potential residents of contaminated houses.

Familiarizing the Home

To promote the various housing renovation programs offered by the city, the Neighborhood Housing Services Department (NHSD) holds various community events designed to find eligible families. Early in my fieldwork, I attended one such event hosted at a local church's community center. Entitled "Day of the Living Lead," the event was a Halloween-themed housing hazard awareness fair in which families were encouraged to bring their children to enjoy Halloween face-painting, pumpkin-carving, music and other activities. Lining the edges of the room were booths staffed by NHSD and non-profit employees associated with housing renovation and assistance programs. The event was fairly popular: almost every booth was occupied with adult residents (of which there were around thirty) asking questions and picking up flyers, while their children played in the center of the room. Over the sound of youthful playing and laughing, residents of potentially hazardous homes could learn about city programs that offered various levels of funding for renovation depending on the type of hazard. Among these programs was Green and Healthy Homes, offering fully-funded renovations to households who met the conditions listed in the previous section.

All of the information about application requirements and timeline of GHH was available in a relatively raw form to families via a myriad of paper handouts and city employees explaining the guidelines. By offering kid-friendly attractions, the event freed parents' attention and allowed them to evaluate their options for home improvements and hazard removal. Despite the dry, dense nature of the bureaucratic programs being advertised, the overall tone of the event was welcoming and fun-loving, marketing GHH and other programs as initiatives that are

especially child-centric. The tables that were not advertising housing programs belonged to child-related services and programs, such as the afterschool education and health program Head Start. Although the issue of housing hazards is not specific to homes with children, and multiple programs in attendance offered their services to households without children, this event centered the child as the primary beneficiary of state-assisted housing renovations¹⁰.

This intentional focus on the child permeated community events such as the one described above, as well as various media distributed by NHSD. Once during an interview with Wesley, the NHSD employee, he opened a drawer full of old GHH media materials and handed me a DVD. On the disk label were the cartoon faces of four characters under the title “Molly’s Adventures in Safety, Volume 1: Lead.” This ten-minute animated educational cartoon follows Molly, a child who investigates an anthropomorphic house who is feeling “sick,” and eventually finds signs that the house may contain lead in its paint, such as flaking paint on windowsills and dusty areas (Figure 1). A live-action adult “scientist” explains to Molly how these are signs of lead paint in the house. The scientist then shows the team of kid investigators real footage of workers replacing the paint on the exterior of a house. The cartoon house is then cured, ending Molly’s investigation. Before fading to black, the DVD shows before-and-after pictures of houses renovated by GHH¹¹. It then displays the “Lead Safe San Antonio” campaign logo above a notice indicating that the cartoon was the result of funding from the “2007 Lead Hazard

¹⁰ It is also important to note that the detrimental impacts of lead are also cumulative, meaning those who are exposed to lead over longer periods of time (such as the elderly) may face more severe consequences. This, however, may not be readily apparent in the public health vision, due to the way metrics such as the DALY are calculated.

¹¹ Similar images appear frequently on information sheets and brochures for GHH, showing newly-painted “after” houses next to older, dilapidated-looking “before” houses.

Reduction Demonstration grant awarded by HUD's Office of Healthy Homes and Lead Hazard Control."

I linger on this piece of promotional-educational material to illustrate the extent to which San Antonio NHSD insists on spreading the word about lead hazard in houses through engagement with children. Rather than finding houses to renovate by looking only for parents, GHH utilizes a bottom-up approach which positions the child as the primary agent upon which lead hazards pose a threat. In "Molly's Adventure," no adults are shown to be living in the house. The only people inside are Molly and her team of other kids and cartoon animals. These narratives about the child transform the contaminated "house" into a sick "home"; Green and Healthy Homes is not just fixated on fixing non-living houses, but living homes which are composed of children living in unhealthy surroundings. By offering housing services information in the context of a child health issue, the Halloween event and the educational cartoon equated the physical living space of the house with the social unit of a child-bearing family. Thus the material issue of the deteriorating living structure becomes a moral mission revolving around protecting children's healthy development.

Such a mission of maximizing and sustaining human life, as discussed previously, is predicated upon a specific set of biomedical knowledge which claims objective truth over the hazards lead poses to child health. This medical legitimacy is a tool for gaining resources and credentials for programs like GHH, but it relies upon health metrics collected by various agencies at different levels of the state. These metrics, at a population level, are reportable to federal agencies to warrant funding from HUD and other sources. They compose the scientific knowledge which justifies state intervention in renovating houses. At an individual level, they

qualify different houses for assistance from GHH by assigning metrics like child blood lead levels, which, though measured in a person, are attributed to a house instead. The following section will explore how qualification relies on meeting these sufficiently hazardous measures of ill health.

Discovering the Afflicted

As part of their outreach campaign to find more affected residents, Green and Healthy Homes partnered with Family Service Association (FSA)¹² to hire two “promotoras,” women who led block-walking campaigns primarily in the East Side of San Antonio. This focus on the East Side was likely influenced by the previously mentioned “East Side Promise Zone” federal designation, which gains the area preference for grant funding. For ten years starting around 2009, the promotoras went door-to-door to houses that were constructed prior to 1978. Using city records to find these houses, they would inform the residents about the GHH program. Because houses without child residents could still qualify if a child spent at least 6 hours per week there, the promotoras would visit any houses built before 1978, regardless of the recorded household makeup. If interested, the residents would be walked through the application process. The promotoras carried portable image scanners to scan documents like bank statements and identification in order to submit their application to NHSD and begin the lead testing process if found eligible.

¹² FSA is a local non-profit focused on providing families in San Antonio with social work, counseling, and fundraising for various local charities (Family Service Association 2016)

I interviewed these two women, Rita and Carolina, after multiple city employees had mentioned their diligent work and the high number of “clients” they brought into the program. During our conversation, Carolina was typically the first to answer my questions, and would occasionally look to Rita for confirmation about certain details or anecdotes about their time block-walking. They were clearly experienced community workers who thoroughly enjoyed interacting with the residents they worked with: though it wasn’t part of their job description, they often followed up with eligible residents to see how their renovation was going. These promotoras had the most regular face-to-face interactions with residents relative to anyone I spoke to, and seemed to have endless stories about block-walking. When I asked about the most difficult parts about finding willing residents, Carolina informed me that for the first two years of their work, the children living in the homes had to be tested for blood lead content before their application could be accepted.

At first, [the residents] didn't want the children to be poked¹³, because at first you needed to have the child tested for lead. And that was one of the policies, asking, “Do you want to have the children tested?” [The fear of the test] really didn't make sense because if you want your child to be healthy and you have to, you would want to know. Right?

Carolina looked to Rita at this moment, who confirmed the information about the lead test and, presumably, Carolina’s sentiment about the logic of fearing the test. As Carolina described it, the blood test posed a significant barrier to residents entering the program, because it required their children to have their finger pricked for a blood test, and many parents “didn’t want to hear their child cry.” This perceived reasoning for parents’ hesitation to agree to the

¹³ The blood test necessary to check the blood’s lead level requires the child’s finger to be pricked.

program seemed illogical to Carolina, who placed value in the collection of data for the sake of knowing how safe the surroundings are, especially for the sake of the children. However, as Carolina then explained, this requirement of a blood test for eligibility was discontinued, leaving only a house lead inspection as a requirement to confirm the lead hazard. From then on, the promotoras' duty was only to walk them through the application and process their paperwork without the blood test referral. The only types of measurements required to qualify for GHH at this point (around 2011) were fiscal and institutional qualifications, requiring residents to prove their ownership of the house and their income level, in addition to having a child of age 5 or younger. By meeting these qualifications, residents could then go ahead with the lead inspection and risk assessment by city contractors.

Although I had heard about Rita and Carolina's work from several people, it was not until I spoke with them that I was informed that they were no longer working with GHH, as of October 2019. "The funding, for us, just ran out," Rita said without much more knowledge of why. "Things changed [at GHH] throughout the years," Carolina later offered. "Starting two years ago, we weren't block-walking no more, because [GHH] was coming out more in the media and news. So that's the way we were getting applications. [Residents] were coming to the [NHSD] office and we would process their application there."

The initial vague understanding of why they were no longer partnered with GHH ("the funding just ran out") coupled with an understanding of the changing ways GHH encountered residents was mirrored in another interview I had with Christina, an NHSD employee involved with outreach at GHH. Since she worked directly with the promotoras quite often, I asked if she knew why they were no longer partnered with GHH. After shaking her head, she told me,

exasperated, “That would be a management question,” then describing the changes that GHH’s outreach had undergone shortly after.

“At the beginning, that's what [the promotoras] would do. Block-walking. I would go block-walking with them sometimes. And I think the program has really evolved since that time. You know what I mean? ‘Cause a lot of times people don't want to answer their door... And we leave flyers and stuff and they'll, a lot of times they'll call us back, but I think now that the program, like I said, it's evolved to where we piggyback off of [other programs], we've got strong partnerships with Head Start.”

Instead of block-walking, Christina described how GHH now had a more established reputation and partnerships with other programs on which they would “piggyback.” For example, if other programs like NHSD’s Owner-Occupied Rehabilitation¹⁴ were dealing with a house that was found to have lead and occupied by a child, GHH would be notified and would provide funding for the lead abatement. Similar to Carolina, Christina noted differences in how residents encountered Green and Healthy Homes in recent years. Rather than going door-to-door and seeking out applicants, the program was receiving referrals through partnerships and word-of-mouth. More specifically, Christina repeatedly pointed out that their partnership with Head Start, the afterschool early education program, was an especially fruitful pathway through which families are referred to GHH.

¹⁴ Unlike GHH, this NHSD program only offers loans instead of grants for home renovations, and is a more limited-scope project.

GHH receives many referrals based on child blood lead levels (BLLs) from Head Start, which works¹⁵ with 3,236 children ages three to five. When I spoke with Dawn, an employee at Head Start who worked directly with GHH through Christina, she explained that starting in 2013, Head Start began providing free onsite lead tests (the same finger-prick tests that were no longer a GHH prerequisite in 2011, according to Carolina). Ninety-nine percent of Head Start families, Dawn explained, are on Medicaid, and by Texas law, children on Medicaid are required to have their blood lead levels tested at two years of age. Because most children arrive at Head Start at age three or four, Head Start tests them again for free and refers those with elevated blood lead levels to GHH. This primarily involves one of Head Start's Family Support Workers notifying them of their child's elevated BLL and informing them about GHH's services. If they agreed, they would direct them to the application process for their home.

Through the partnership with Head Start, blood lead levels once again became a measure through which GHH discovered new residents and collected the data necessary to make the lead hazard legible to systems of biomedical knowledge. They now had a method by which the health threat to children could be explicitly quantified and assigned to a home in an effort to label the household "sick" and in need of amelioration. Under the previous recruitment strategy, GHH could only collect information relating to home ownership and income, and then test the house. This sequence shifted in 2013, allowing NHSD to center the child's health as the present danger rather than the material status of the house. As this became a more effective recruitment strategy, the promotoras' block-walking became a less relevant technique. Instead of spending money

¹⁵ This work primarily involves early education, but families at Head Start are also assigned a Family Support Worker who meets with them to address comprehensive needs. The program also offers complementary health screenings and other services.

hiring people to knock on the doors of older houses and find out if children frequented them, NHSD now had access to quantitative health data on the children themselves. Such a change in the sequence is, presumably, a more cost-effective measure for GHH, since Head Start handles the lead testing and refers them to NHSD. Besides material efficiency, this strategy more directly rephrases the threat of lead housing into terms of the body, measurable by doctors, and treatable with the right intervention. With this shift, the mechanism of recruiting residents for lead abatement is explicitly organized around biological data considered to be the target of intervention, rather than around the housing data.

HOMES AS COLLECTIVE INVESTMENTS

The Construction of a Client

During almost all of my interviews with city employees who worked with GHH, they typically referred to the residents who were receiving home repairs through GHH as “clients.” In this paper, I have opted to use the term “residents” in my own descriptions, as I believe it describes a more neutral position in relation with the state. The word “client” (instead of “grantee” or “beneficiary”) implies a type of willing exchange between the resident and the state program. To me, this is a misnomer for participants in a program that provides renovations free of charge to the resident. In this section, however, I discuss the types of commitments requested of residents, which often act as barriers to potential applicants and spread fear or confusion about what the city “wants” with homes that participate in GHH.

Despite multiple attempts to find the contact information of any residents that qualified for GHH but were unable or unwilling to go through with the application, I was unable to meet

with any. The city only keeps records of houses that were renovated, and I was unable to find any informants who could connect me to an unwilling resident. Instead, my information about worries or barriers to the program stems from meetings with four different residents who were fully processed through GHH and had their houses renovated. These interviews took place in their renovated houses, where they were able to show me the specific places where work was done. All of these homes were located in or near the Dignowity Hill neighborhood on the East Side of San Antonio.

Jennifer's house was filled with the sounds of small children babbling while they ran around the living room and kitchen. The house had been renovated about three months prior, so the exterior was still visibly refurbished in certain areas with a fresh coat of paint and new materials around the windows. In front of the door were a few steps and a handrail. Because we had had to wait to meet until Jennifer got off of work at a nearby school, we were meeting shortly before dinner. Jennifer's son and his wife (who live with Jennifer and were the parents of the two small children) were sitting at the small kitchen table adjacent to the living room where I sat across from Jennifer on a couch. When I asked if I could record the interview for my notes, all three adults agreed and apologized repeatedly for the background noise. As I asked questions about the process of GHH and their experience engaging with the city, Jennifer's son often jumped in eagerly to provide supporting information, looking to his wife to further substantiate certain details about dates or names.

Although GHH is first and foremost concerned with lead-based paint, they will also repair other minor hazards in or on eligible homes free of charge. In every interview with residents, I noticed they tended to focus on these auxiliary renovations as the primary change that

impacted their everyday life¹⁶. In most cases, these changes fixed long-standing issues that they had wanted to fix for a while but could not due to the labor, time, or financial costs. Jennifer spoke extensively about how helpful the new steps and handrail were for her late husband, who had had a disability. However, Jennifer was also aware of the present threat of decaying paint in her home: she witnessed her grandchildren ingesting some of the paint flakes coming off of the windowsill. While she was not aware that it was lead-based paint until the city hired contractors to inspect the house, she knew that ingesting the paint could be dangerous and was excited to have the city replace her windows.

However, when she first heard of GHH by seeing a flyer, Jennifer was very hesitant to apply.

“I thought it was something where they would charge you for it,” she said. “You know how some people, they say, ‘it’s free,’ but it’s *never* free” (emphasis hers).

“When they told me about it, I said, ‘look online, sounds too good to be true!’ Jennifer’s son added, laughing. “But I looked online and went to the [NHSD] office, and I told [my family], ‘this seems legit.’”

Despite their initial concerns, they were both extremely satisfied with the process and results of GHH. Because the renovations only took place on the outside of the home, they were able to keep living inside while the month-long project took place. Jennifer and her son both remarked on how accommodating the workers were and how the process to fill out the paperwork was relatively simple, even though they did have to submit forms multiple times

¹⁶ This is unsurprising, given that lead contamination is a much less visible threat than the problems fixed by the auxiliary renovations.

because the first ones were outdated. While all of my resident informants had generally positive sentiments about the program, Jennifer and her family were the most enthusiastically grateful for the renovation and the relatively streamlined process. They were also the most recent recipients of GHH renovations of my informants. In this case their initial skepticism that it was “too good to be true” that a program would renovate their house for free was overruled by Jennifer’s son’s personal investigation into its legitimacy. He did not clarify what had made him change his mind besides speaking with NHSD representatives and looking at information available online, but he was willing to become one of GHH’s “clients” after certifying for himself that it was in his family’s best interest.

I found that all of my resident informants mentioned a family member who assisted them through the application and renovation process at GHH. In fact, none of the residents I spoke with were actually parents of the children who qualified the home for the program, but were grandparents who either had grandchildren living in the home (as was the case with Jennifer) or simply watched over their grandchildren in the home on a regular basis. In all of these cases, the “clients” were not the primary caretakers of the children, but additional caretakers who still qualified for GHH because of the heightened lead exposure to their grandchildren. Even though the elderly are not the intended demographic to be impacted by this policy, their status as a caretaker of children still qualified their home to be sufficiently hazardous to warrant renovation. By letting the city come remove the lead-based paint threat, these grandparents received needed changes, such as Jennifer’s home’s steps and handrail. The justification for qualification with GHH never revolved around these structural changes or even only the lead itself, but their relationship to a child who was coming into contact with lead. As I mentioned, the removal of

the lead threat often was not the biggest perceived benefit by the resident, but rather the additional benefits that came with renovations, such as improved insulation due to the new windows.

The perception that the renovations were free and easy were not shared by every informant I spoke with. Linda, another grandparent of two children who had the interior and exterior of her house renovated, remarked on the extensive effort she put in to both qualify for the program and adapt to the renovations. Because the renovations were also inside the home, Linda had to move all of her belongings out of the house and live with her daughter while they renovated.

It's a lot of work. It's not easy, you don't just make an application and you're in. It's very extensive. I broke my ankle one week before I had to move out, and [the city] doesn't help you. It's not part of their deal. So it was very extensive, my neighbors helped [me move out] a lot.

To Linda, one of the prices of the program was the physical labor required to accommodate the renovations, including moving out of her home by herself. She relied heavily on neighbors and her daughter to get through the renovation process. Unlike with Jennifer, GHH representatives never updated Linda on the progress of the renovation, so she often had her daughter drive her by the house to check on it herself. Sometimes, she would ask the workers how the construction was coming along. She described her experience as much more independent, remarking multiple times about the amount of time it took up in her life. She had heard about the program through neighbors whose houses were renovated, but had had to wait until she was retired before she could fully commit the time necessary to apply and go through

the process. Her biggest difficulties came from lack of accommodation and the labor necessary to allow the city to fix her house.

Whenever I asked NHSD employees about the biggest barriers residents who wanted to apply to GHH faced, their answers were uniformly about bureaucratic requirements which were complex or daunting, such as all the paperwork necessary to apply. But these perceived difficulties from the city side were not reflected in the experiences of the residents with whom I spoke. Their primary challenges seemed to be logistic ones, like making sure the program was legitimate, or moving out of the house on their own. This disconnect could likely be due to the types of residents I interviewed. They had all been successful clients who received the intended benefit from GHH. Those who may have had more trouble with paperwork and policies may have been more likely to drop out of the application process, and thus were not captured by city data.

Among these bureaucratic challenges I heard about from NHSD, the most challenging was the “restricted covenant” requirement. This covenant signed by the resident ensures that the residents remain the owners of their property for five years after the renovations are completed. If the owners wish to sell the property before the five-year period is over, they must pay the City of San Antonio back a prorated portion of the grant funds used to renovate the property. In the following section, I will analyze this policy in particular, the difficulties that come with it from the city’s point of view, and the underlying justification for such a requirement.

Protecting Investments

During my fieldwork, I often waited in the lobby of the San Antonio Neighborhood and Housing Services Department (NHSD) to meet with city informants. This small waiting area by the front door of the building featured a few rows of chairs next to the reception desk where visitors, like me, awaited meetings with various government officials to discuss programs regarding home remediation, financing, or other housing services. One mid-December afternoon while waiting for my appointment to begin, I saw a city employee and a civilian enter the lobby from the main office area behind the reception desk and sit across from each other at a small table in the corner of the waiting area. The city employee spoke with the woman across from her in a cordial but professional tone as she walked her through the final paperwork necessary for applying to the Green and Healthy Homes (GHH) lead abatement program. She started with the page for the five-year “restricted covenant” to which all GHH applicants must agree. The applicant, who appeared to be in her 60s or 70s, was familiar with the covenant and did not have many pressing concerns about it, except for one scenario, which she asked about after a moment of hesitation:

“I don’t know if this is too morbid to ask, but what if I die? What happens to the covenant on the house then?”

The NHSD employee calmly explained that, if eligible under the income guidelines, her next of kin to inherit the home would take over that covenant. Otherwise, the city would charge the prorated cost of the renovations, depending on how many years were left in the agreement. Seemingly satisfied with the answer, the resident agreed to sign the restricted covenant. As they

finished the paperwork and the client picked up her purse to leave the building, she thanked the employee multiple times.

“I’m so glad the city has this program. It’s usually so expensive to do those repairs,” she remarked. “Thank you for the early Christmas present!”

Wesley had previously informed me that the restricted covenant was not a part of the GHH application when the program first started in 2000. According to him, the city had encountered early problems after renovating homes without such an agreement: homeowners would be more likely to sell their home soon after the renovations, and landlords would often raise rent for tenants and force them out of their newly-refurbished dwelling space. To Wesley, this was a failure of the program in its early stages because the people benefiting were not necessarily the children who had qualified the house for renovation. As a result, the city, with approval from HUD, developed the restricted covenant in an effort to make sure the child lived in the renovated space.

“If they were to sell the property, you know, we can reclaim some of those funds according to a depreciation value that they put in those five years. So we can recuperate some of those funds that we invested in that property if they were to put it up for sale.”

This method of, as Wesley referred to it, “protecting our investment,” was a main source of anxiety for those considering applying to GHH, according to him and other NHSD employees I spoke to. Many applicants would go through the entire application process up to the covenant, but would drop out. This was especially true among renters, according to Christina, because they were often not planning on staying in their rented property for five entire years. Among homeowners, the most common concern was that the city would try to take ownership over their

property, which Wesley dismissed as ridiculous. “The city hates taking property,” he pointed out, laughing.

The restricted covenant seemed to be the main area where the exchange between residents and the city took place. NHSD saw these residents as “clients” because they were agreeing to stay in the house for five years, and in return the city would renovate their home through GHH. Wesley’s repeated references to GHH as an “investment” in each home seemed to express that the city expects that renovations actually benefit the children who are the target beneficiary of the program. Once again, GHH’s mission is not to remediate the existence of lead-based paint wherever it exists. To be considered a success, the child must directly benefit from the renovated surroundings. It is only when this “investment” into child health has been fulfilled after five years that the client has completed their end of the bargain. While this deal drives some away from going through with the application, as Wesley and Christina described, those who do sign the agreement see the program as more or less a one-sided transaction. The woman in the NHSD lobby who I witnessed signing the covenant seemed to feel like she was receiving a gift from the city, and informants of mine such as Jennifer initially found the program “too good to be true.” While the city sees these residents as clients who are fulfilling a contract, the residents more commonly imagine themselves as beneficiaries of a free city service.

Such a disconnect speaks to the conflicting ways in which this specific political relationship is conceptualized in the eyes of residents versus city employees. To residents, GHH is a type of state benefactor that doles out resources to those qualified. However, to NHSD, GHH’s purpose is to provide their clients with a home with sufficiently “healthy” surroundings, based on scientific measures designed to quantify the threat, such as blood lead levels or lead

inspection results. Through these quantifiable health outcomes, and the signing of the restricted covenant, the city tries to maximize the “positive health effects” of removing the lead on the specific population they want to benefit the most.

CONCLUSIONS

Lead-based paint abatement is not only about the repair of toxic infrastructure, but the development of healthy bodies within the homes. Permeating every level of San Antonio’s Green and Healthy Homes is an insistence on protecting the child. Dominant medical discourse prioritizing the child as the primary “at-risk” victim of lead exposure grants GHH additional moral weight to their agenda of renovation. This virtuous justification for the program is not only defined by the program’s requirements for applicants, though that does play a role by narrowing down who benefits from GHH to only houses containing children under six years of age. NHSD employees also play an active role in reifying the association between child health and removing lead from the home: promotional events and materials to find more applicants are catered towards children and position children at the center of the issue. In doing so, GHH translates the material threat that lead-based paint poses into a threat to the very development of a healthy family. Green and Healthy Homes, as its name implies, is not interested in repairing houses, but repairing and maintaining the “health” of the child’s home, which encompasses the people living inside it.

I found in my fieldwork that this mission to maintain the bodies residing in the lead-contaminated home is enforced through an idea of exchange that positions the residents as “clients” who have a responsibility to remain in the house for at least five years. Though the

residents I spoke to did not see themselves as offering anything to the city in return for the renovation, NHSD employees saw each house renovated as an “investment” in children’s health that they expected to be carried through for a certain amount of time. The fact that simply removing the lead from a structure in the city was not a sufficient measure of success speaks to the insistence on making sure state resources were applied to the “right” population: children in low-income families. Using the language of investments, NHSD expects certain “returns” through the accomplishment of sufficiently “healthy” environmental standards for children.

Unlike many previously-studied toxic hazard interventions, which are often demanded by citizens who can see the consequences of their contaminated surroundings, lead-based paint is a hazard which is largely invisible to its victims. Thus, Green and Healthy Homes represents a top-down approach which enables the state to define how resources are allocated according to its own priorities. The “client” relationship enforced by GHH politicizes the space of the home into a site where families are responsible for keeping the child in their newly-renovated environment. Whether they know it or not, residents “owe” the city a positive health outcome and are expected to remain living in the home because it reflects poorly on the city if their resources do not go to their specific kind of family. Such dynamics transform lead-based paint into an issue of ownership, payment and debt in which the resident is responsible for carrying out the “healthy” choice of not moving out. Even though the city has no legal ownership over the home, it becomes a site of collective investment in which taxpayer-funded government programs are attempting to purchase a healthier status for the children living in clients’ houses. If clients break this agreement, they must pay back the cost of investment, allowing the state to “recoup” their funds and apply them elsewhere. Such notions of maximizing health benefits by the most

cost-efficient methods reflect a dominant neoliberal status quo among institutions of public health. Each individual project of renovation is an investment which must see returns in the form of healthier families, turning lead-based paint into not just a physical threat to all human bodies, but a threat to the child's status as a productive member of the city's socioeconomic fabric.

APPENDIX**Table 1.** Income limits for qualification to apply to Green and Healthy Homes, based on 80% of HUD’s established guidelines for Area Median Income (City of San Antonio 2018).

Size of Family	Income Limit
1	\$37,450
2	\$42,800
3	\$48,150
4	\$53,450
5	\$57,750
6	\$62,050
7	\$66,300

**Figure 1.** Screenshots from “Molly’s Adventures in Safety, Volume 1: Lead.” Images captured from public media materials by the City of San Antonio Neighborhood and Housing Services Department (2007).

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