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Urban redevelopment and neighborhood health in East Baltimore, Maryland: The role of communitarian and institutional social capital

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Abstract
Using qualitative research methods, this paper explores the role of social capital in affecting the health of an urban neighborhood undergoing redevelopment in East Baltimore, Maryland. Descriptive secondary data on redevelopment, health, and social capital in East Baltimore, Maryland and health in Baltimore City, Maryland are presented. The authors show how the private institution driving redevelopment in this neighborhood affects and is affected by the social capital of this community (communitarian and institutional forms of social capital). Next, primary ethnographic data from informal/unstructured interviews, focus groups, a listening project, and in-depth key informant interviews are presented. These data show how local government affects the institutional social capital in this community. The qualitative results describe a current state:public relationship in East Baltimore that reflects insufficient institutional social capital (i.e. power to influence government institutions) in this community. Data show a community with minimal bridging social capital with the state government or the private developer in their community. Furthermore, residents feel that the bonding social capital between some community associations leads to mistrust of community leaders who represented them at negotiations with the state or the large private developer. This framework is used to evaluate how the political, economic and cultural context of a community affects its social capital and in turn the health of neighborhoods undergoing redevelopment.

Keywords: *social capital, urban health, community health, urban redevelopment*

Introduction

This paper focuses on how social capital (communitarian and institutional) may affect the health of a community during the process of redevelopment in an urban neighborhood.

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The definition of social capital used here is offered by Woolcock and Narayan (2000) as 'the norms and networks that enable people to act collectively'. Although we do believe that 'cohesion' or 'integration' are preferred terms to 'capital' (Muntaner & Lynch, 2002), we maintain the current terminology of 'social capital' to be consistent with other studies. The intent of this paper, then, is to provide secondary and primary data showing how the norms and networks of a community (in East Baltimore, Maryland) undergoing urban redevelopment may affect the health outcomes. Though some literature exists describing social capital and neighborhood health, the role of social capital in affecting neighborhood health during periods of urban redevelopment has not been addressed (Cattell, 2001).

In order to assess how social capital may impact on the health of this East Baltimore neighborhood during a period of urban redevelopment, we use two different notions of social capital: the *communitarian* and the *institutional*. Communitarian social capital emphasizes civic engagement in non-governmental organizations and reciprocal, trusting relationships among community members (Portes, 1995; Putnam, Leonardi, & Nanetti, 1993). Institutional social capital on the other hand states that, 'the vitality of community networks and civil society is largely the product of political, legal, and institutional environments' (Woolcock & Narayan, 2000, p. 2, p. 4, p. 6; see also North, 1990). The communitarian notion does not analyze the role of institutions in social capital, i.e. government, corporations. For this reason, we have included the 'institutional' notion of social capital so as to assess the role of the political and legal systems in influencing health outcomes during the redevelopment process in an urban community.

Thus, the combined communitarian and institutional approach to social capital allows us to incorporate in our analysis many community social processes that contribute to the formation of social capital—race, class, politics, economics, history—which have been missing from recent literature discussion (e.g. Muntaner et al., 2001). It is our attempt to expand the notion of social capital by assessing how institutional and communitarian social capital may play a role in health outcomes during redevelopment in a poor and non-White 'inner-city' neighborhood.

Redevelopment and health

Urban redevelopment is the phrase used to describe a process that occurs in an inner-city neighborhood that has over time undergone a dramatic economic and social decline (Dear, 1976). That is, redevelopment would not occur in a neighborhood that is thriving economically or socially; the neighborhoods that historically have undergone this type of decline have been in urban areas (Dear, 1976; Wright 1995). In the US, this process has been ongoing since the Second World War and continues to occur into the twenty-first century (Wilson, 1996; Wright, 1995). Redevelopment in an urban-city setting (mostly low income and non-White) has direct and indirect consequences on a communities' health. Once redevelopment is initiated, a chain of events follows for residents residing in the targeted area. But before redevelopment occurs, the process of deterioration must have occurred to invite redevelopment. For example, Dear reports on how abandoned houses in a community initiate continued abandonment of other housing units in the neighborhood (Dear, 1976). After the first abandoned or vacant house has appeared, unless the local housing and city planning departments maintain or promote ownership through low-income housing plans or rental plans, then neighboring houses are likewise abandoned or vacated for various reasons (Dear, 1976; Wolch & Dear, 1993). Because of the neglect of governmental services, this core of abandoned areas may lead to a locus for increased

criminal activity, open-air drug markets and increased destruction and further abandonment by nearby residents (Wallace, 1990). This increasing neglect and abandonment of houses results in further decrease of government social services such as sanitation, security, parks and recreational facilities, school upkeep, and subsequent decrease in real-estate tax value in the neighborhood (Wallace et al., 1990). The slow acquisition and boarding up of houses by the developer throughout this period contributes to an area becoming blighted and more likely to remain abandoned. The public health consequence of this process leads to a neighborhood affected by unsanitary conditions, increasing incidences of substance abuse, increasing rates of HIV/AIDS, increasing rates of STDs, and increasing incidence of violence (Acevedo-Garcia, 2000; McCord & Freeman, 1990; Wallace, R., & Wallace, D., 1997). Using ethnographic interviews, Fullilove reported how the process of redevelopment negatively impacted the well-being of inner-city residents who remained in the area (Fullilove, Green, & Fullilove, 1999). She showed that residents had the need to rebuild social ties that had become fractured through the process of redevelopment of neighborhoods they had lived in for many years. This placed a stressful psychological toll on residents to find new communities that were welcoming, and to create new community networks of support (Fullilove et al., 1999).

In the following sections we summarize our current knowledge on the relationship of both communitarian and institutional social capital and community health outcomes.

Communitarian social capital and health

Some evidence exists that communitarian social capital can have an impact on community health. This notion of social capital defines a range of beneficial and non-beneficial consequences for community members dependent on the type of associations between community residents or groups. These associations may be characterized as either 'bonding' relationship within community associations and/or 'bridging' relationships with associations or institutions external to the community (Portes & Sensenbrenner, 1993; Woolcock & Narayan, 2000). That is, if a community group is bonded together so tightly that it does not foster bridging relationships with other groups or does not have access to extensive extra-community ties, they lose the opportunity to benefit from resources offered by the bridging relationships (Barr, 1988; Narayan, 1999; Ross, 2000). Generally, the effect of communitarian social capital is determined by the balance of bonding and bridging relationships (Kaplan & Lynch, 1997; Patillo, 1998; Woolcock, 1998; Woolcock & Narayan, 2000). For example, using ethnographic research, Cattell suggests that though participation in organizations may be beneficial, bridging ties (with external agencies/entities) are necessary for better neighborhood health in the UK (Cattell, 2001). An increasing number of research studies have shown that lack of communitarian social capital and the subsequent lack of participation in organizations are associated with worse community health outcomes (Berkman & Breslaw, 1983; Blakely, Kennedy, & Kawachi, 2001; Cattell, 2001; Kawachi, Kennedy, & Glass, 1999; Rogers, 1966). One instance of communitarian social capital effect on health outcomes occurs during urban redevelopment. Though urban redevelopment is often presented in the context of 'improving' a neighborhood, the unwanted side effects of disruption and displacement of a community persists (Wright, 1995). There is some evidence that this process may lead to increased levels of stress, hopelessness and subsequent negative health effects (Blakely et al., 2001; Fullilove, 1996; Kaplan, 1996; Kawachi, Kennedy, Lochner, & Prothrow-Smith, 1997; Wallace, 1988).

Institutional social capital and health

The 'institutional' notion of social capital holds that when there is 'rampant corruption, frustrating bureaucratic delays, suppressed civil liberties, vast inequality, divisive ethnic tensions, and failure to safeguard property rights', large impediments to the prosperity and health of a community erupt (Woolcock & Narayan 2000; see also North, 1990). The institutional view is important because it incorporates politics and the power of the community or civil society in negotiating its demands with the local government and private institutions within a framework of government intervention (Skocpol, 1995). In public health, institutional social capital has been proposed to explain how power relations between government, capital and labor may impact a community's health (Muntaner, Lynch, & Davey Smith, 2001). In this paper, we show how institutional social capital affects the process of how redevelopment occurs and its subsequent effect on the health of the community.

In the subsequent analysis of the East Baltimore neighborhood, we first review how redevelopment may affect community health directly and through its effect on social capital. Next, we present ethnographic data, and historical and current sociodemographic profiles of East Baltimore and its major private developer and employer in this neighborhood. We also provide secondary data on the make-up of social capital in the three institutional settings that affect the health of this East Baltimore neighborhood: the city government, the major employer and developer, and the community. Next, fieldwork including primary qualitative data from focus groups and interviews with community residents describes the varied roles of the city government, the private developer and employer, and the residents in urban redevelopment. We end by discussing this descriptive and qualitative data and suggest how different forms of social capital may impact on neighborhood health during this process of urban redevelopment.

Methods

Data sources: Secondary

Descriptive data on the history of East Baltimore and the development of the major private employer and developer were obtained from the Alan Mason Chesney Medical Archives (Medical Archives), published historical accounts by Harvey and Lee, and past and present newspaper accounts (*The Johns Hopkins Magazine*, 1950; Harvey, 2000; Lee, 1987). Demographic data on the East Baltimore population were obtained from the Maryland Census data 1990, 2000 and the Baltimore City, Department of Housing and Community Development (Baltimore City Health Department, Baltimore City, Department of Housing and Community Development). Population health data on East Baltimore, Baltimore City and Maryland were obtained from the Johns Hopkins Urban Health Institute, Baltimore City Health Department, the Maryland Department of Health and Mental Hygiene and the Community Health Status Report 1999 (Maryland Department of Health and Mental Hygiene, National Center for Health Statistics). These population health data are presented for comparison purposes and to provide a complete social picture of the entire area, particularly because East Baltimore is geographically a part of Baltimore City and Baltimore City is contiguous to Baltimore County. The private developer and major academic and medical institution referenced in this East Baltimore neighborhood is the Johns Hopkins Medical Institutions. Throughout this paper, this entity will be referred to as the 'private developer', 'academic and medical institution' and/or 'private developer/academic and medical institution'.

Data sources: Primary

We use four ethnographic research methods (informal/unstructured interviews, focus groups, surveys, in-depth key-informant interviews) through participant observer data gathering. The first author lived periodically and worked continuously with residents for greater than 10 (12) years so as to understand better the context of the community. In addition, the residents were aware that data gathering was continuously ongoing (in community meetings, discussions, etc.) with the intent of public disclosure in the future following residents' approval. This community participatory process was utilized continuously so as to assure a community-defined focus in data gathering. Paper and pen was used as the initial form of recording in all data-gathering methods.

Informal/unstructured interviews. The first data-gathering method of informal and unstructured interviews obtained information at approximately 100 local community meetings (between 1992 and 1998). Meetings occurred on a monthly or bi-monthly basis with attendance at any one meeting ranging from 10–70 individuals. Participants usually consisted of community residents with occasional attendance by city council officials, city government housing and health officials, private developers and various issue-specific non-profit organizations. The topic of the meetings varied dependent on current issues in the neighborhood of importance to residents in attendance. Topics ranged from housing, health and redevelopment, to ongoing research in the community, economic decline, child care, schooling, crime, drugs, elderly issues, community organizing, membership recruitment, community development, leadership training, private developers in the neighborhood, city government representation and fund raising. Over this period, informal/unstructured interviews were conducted randomly following full disclosure by the researcher. These interviews could occur after a meeting at a community center, during a ride to the home of a resident, during a visit at a resident's home, at a local market, on a street corner, after church, at a street fair, in a barber's shop, or on the phone.

Focus groups. The second data-gathering method includes three focus groups. Themes from the community meetings were used to develop field guides for the three focus groups (35 participants in total). These topics were used to elicit more detail of community perceptions of the urban redevelopment process and health effects. Focus groups consisted of 8–10 neighborhood residents and 2–3 workers who did not reside in the neighborhood for a total of 35 participants. Age ranged from 25–75 years with 95% African-Americans and 5% White participants; 100% were working class (non-managerial non professional employees).

Surveys. A survey was developed to assess whether health issues were of concern to neighborhood residents. This survey was administered to 50 residents by trained neighborhood residents/workers at three different locations (street fair, street market, supermarket) over a period of two months. The survey asked people to list three major concerns they had in the neighborhood and whether the major developer and employer should play a major role in helping to solve the health problems of this East Baltimore neighborhood.

In-depth key informant interviews. The fourth data-gathering method was in-depth semi-structured interviews with 20 key informants who had worked or resided in the neighborhood over a period of 12–75 years. These interviews were conducted to allow for individual discussion concerning the previously identified themes from the focus groups with specific detail on the current redevelopment plan that was occurring in this East Baltimore neighborhood. Interpretation of the current social capital in this neighborhood was determined using this triangular process of data gathering. The information was separated into the domains of community-network and institutional social capital and evaluated for the consequence on population health in a neighborhood during a period of impending redevelopment. Participants involved in the informal interviews, focus groups, survey and in-depth interviews were briefed on the process and goals of the study and volunteered to be interviewed throughout the period of this study. They were also informed that their information might be published anonymously and that copies would be provided to all 14 key informants, 35 focus-group participants and three neighborhood community organizations.

Results

In the following sections, we present an overview of health, redevelopment and social capital in East Baltimore. This overview also provides a historical context for the East Baltimore community described in this study. We show how community organizations and private and governmental institutions driving redevelopment affect the social capital (communitarian and institutional) of the East Baltimore community. Next, we present primary ethnographic data from informal/unstructured interviews, focus groups, surveys and in-depth key informant interviews. These data examine how government impacts on the institutional social capital of the community and how unwanted redevelopment in an inner-city neighborhood may result in aggregate poor health outcomes.

Health in East Baltimore and Baltimore city

In 1999 a report on an Urban Health Initiative—co-authored by representatives of the local government, the local business associations, and the major neighborhood employer and developer—characterizes the health of the East Baltimore community as 'by most measures, appalling, making East Baltimore one of the least healthy communities in the United States' (Urban Health Council Report, 1999). Though current health indicators of Baltimore city reflect a steady improvement over the previous decades, there still remains a significant gap when compared with other counties of Maryland (Table I). Table I shows that death rates from HIV, homicide, accidents, diabetes and infant mortality in East Baltimore exceed those for the city and Baltimore County as a whole. Reflecting the mental health status of East Baltimore, there have been reports of high prevalence rate of substance, alcohol, mood and anxiety disorders in East Baltimore residents with low financial and physical assets (Muntaner, Eaton, Diala, Kessler, & Sorlie, 1998). When compared with 39 peer counties in the US (grouped on the basis of similar population size and density, poverty and non-White population status), Baltimore city was designated 'most unfavorable' with regard to several birth measures (Table I) (National Center for Health Statistics, Vital Statistics Reporting system, 1995–1997).

Table I. Health Indictors of Baltimore, Maryland.

	East Baltimore	Baltimore city	Baltimore county	Maryland	Peer county: Range[4]
Demographics[5]					
Race/ethnicity[1]					
White	40[6]	31.6	82.3		34.6–99.7
African-American	55	65.4	15.5		0.3–65.4
Other[2]	5	3	2.2		0.1–87.8
Population size	100,000	657,256	720,662		504,591–944,472
Income (annual) <20 K[1]	84				
Completed 12th grade[1]	53				
Unemployment[1]	13	9		5.4	
Medical assistance	50				
Morbidity[1,3]					
Low birth weight (<2500 g)		14.1	8.3	9.1	6.4–10.8
Very low birth weight (<1500 g)		3.2	1.8	2	1.1–2.4
Premature births (<37 weeks)		17.9	12.0	11	9.8–5.6
Teen mothers (<18 years)		10.9	3.0	3.9	4.4–7.8
Unmarried mothers		68.0	27.4	34.9	29.7–48.3
No care in first trimester		35.1	13.6	3.1	12.9–35.1
Mortality[1,5]					
Accidents	3.2	3.0	0.0002*		
HIV/AIDS	4.2	3.1	0.00004*		
Cancers (all)	22.2	23.7	0.2		
Diabetes mellitus	2.9	2.7	0.02*		
Heart disease	26.2	29.1	0.3		
Homicide	4.1	3.0	0.0007*		
Infant mortality (per 1000 live births)	14.3	13.5	6.3	7.4	

Notes: [1]Percentage of population; [2]other = Hispanic, American Indian, Asian Pacific Islander; [3]data obtained from 1999 Community Health Status Report; [4]80% of the peer group for Baltimore city values fall within this range; [5]Maryland Department of Health and Mental Hygiene, 1990, 2000; [6]Baltimore City Planning, 1996; President's Council on Urban Health, 1999. *Inconsistent decimal places are due to the dramatic difference in rates between Baltimore county and East Baltimore.

Social capital in East Baltimore

The local community. The residents of East Baltimore have consistently lived in an antagonistic relationship with the area's major private employer and developer even though they remain the largest employer of these residents (Medical Archives; Urban Health Council, 1999). A history of medical research without sustainable services as well as continuous physical development creeping more and more into the residential neighborhood provides the root of this distrustful relationship (*Baltimore Sun*, May 22, 2001; Urban Health Council Report, 1999). The increased homelessness, loss of healthcare and increased boarded-up housing within the neighborhood while the area's major private employer and developer has continued to expand and grow to fulfill its mission of teaching, research, and healthcare has contributed little in reconciling the historical relationship of distrust (Harvey, 2000).

In the East Baltimore neighborhood, there exist approximately 900 community organizations in a population of less than 90,000 people (personal communication, Johns Hopkins Urban Health Institute survey, 2001). Such a ratio of organizations : individuals suggests a neighborhood without a united force and a fragmented form of social organization, which may lead to little political or economic power (personal communication, Johns Hopkins Urban Health Institute survey, 2001). While some organizations are lobbying and organizing the neighborhood to hold medical researchers more accountable for the way they do

research in the community (adequate compensation, research information returned to the community, studies that reflect the needs of the community), other organizations continue to accept inadequate accountability and compensation from researchers (*Baltimore Sun*, 22 May 2001; Urban Health Council Report, 1999). This lack of accountability results in community organizations competing with each other for ineffective programs and recognition by becoming the 'community representative' for the research institution; a prestigious designation at the number one teaching hospital in the nation but with little power (*US News and World Report*, 2000). In addition, a number of NGOs and university teams often funded by 'liberal' foundations are able to lure community members into short-lived 'research' or intervention projects that further weaken the impact of community organizations. Thus, though community associations exist, bonding social networks are fractured between these associations and bridging networks are specific for targeted community associations that do not necessarily represent the community. Indeed, this is an example of the 'bad bonding' that is described by Woolcock and Narayan (2000).

It then becomes difficult for those community leaders who participate with the major private employer and developer in acquiring property to be trusted by residents who are at risk of being displaced from their homes. Subsequently, they are unable to be true 'community leaders' and to negotiate on behalf of their residents when urban redevelopment and housing dislocation occur (further emphasized in interviews below). This process can be appreciated in the recent redevelopment plan proposed by the city and the same private developer described earlier. In response to the plan's announcement, one local politician tempered his support for the project by urging the private developer to include the community and elected officials in the planning. 'We're absolutely going to slow the process down until all the players, and I'm talking about the community and the elected officials, are part of the process' (*Baltimore Sun*, 17 January 2001). These types of distrustful bridging relations with institutions continue to fracture productive bonding relationships and affect the communitarian and institutional social capital.

Another part of the institutional social capital is the relationship between the community organizations and the government. The historical context of governmental institutional social capital in the East Baltimore neighborhood suggests minimum state support in the form of representation of the community residents' political or economic needs. This lack of institutional support and capital was evident in a recent Baltimore newspaper article regarding an East Baltimore community attempting to renovate houses in its neighborhood. Entitled 'Community wants city to aid in purchase of abandoned houses', a community organizer says 'It takes 18 months to two years to acquire city property, and that's too long . . . if the city can do it (more quickly) for areas like the Inner Harbor, Johns Hopkins University and the west-side expansion, the city can do it for neighborhoods like Oliver' (*Baltimore Sun*, 20 February 2001). These situations reflect little state and city government support for community-based initiatives, suggesting insufficient 'bridging relationships' between community associations and external influences.

The private developer. Within the context of redevelopment displacement and health consequences, the effect on social capital of the developer or firm must be considered (Woolcock & Narayan, 2000). The private developer consists of a School of Medicine, a School of Nursing, a School of Public Health and a Health System. It considers itself an economic anchor in Baltimore city as well as the state of Maryland and a major contributor to East Baltimore due its effect on the economic well-being of every individual, business, institution and business (Table II) (www.jhu.economic).

Table II. Economic impact of major private developer and academic and medical institution.[1]

- Among the 10 largest private employers in the state (Fiscal Year 1997);
  19,700 employees
  600 construction workers employed on projects
  18,200 additional jobs through indirect expenditure
  46% of employees live in Baltimore city
- Constitutes the largest private employer in Maryland
- In 1999, 37,900 Marylanders received paychecks from this institution; almost 43% from Baltimore city
- Generated a total of US$1.8 billion in income for the Maryland economy
- Added over 320 million dollars' worth of new campus construction or renovations in the last 10 years; over US$90 million in expenditures was anticipated for 1998
- Created over US$803 and US$897 million respectively in direct and indirect expenditures in 1997
- Received nearly US$870 million in federal money awarded for research and other projects in 1999
- Received the most federal research money among all US medical schools for nine consecutive years; US$301 million in Fiscal Year 2000
- Projected over US$1.6 billion for economic investment in the East Baltimore areas between 1990 and 2000
- The health systems had 913,400 patients in 1997[2]

Notes: [1]Combined university and health services systems of the academic and medical institutions; [2]the health systems comprise all the patient service entities.
Source: http://www.jhu.economic (accessed 1999).

Table III. Redevelopment history in East Baltimore.

Description of redevelopment	Year
In July 1916, the university began to acquire options on the land between Wolfe and Monument streets, and the local neighborhood was in an uproar (*Fee*, 1987)	1916
Baltimore's first redevelopment project, a cooperative venture between government and private enterprise, has been approved for the immediate vicinity of the Johns Hopkins Medical Institutions (*The Johns Hopkins Magazine*, 1950)	1950
Academic and medical Institution builds dormitory for Medical residents in East Baltimore (*Baltimore Sun*, 1969)	1969
HEBCAC was created in 1994 to navigate the east-side redevelopment plan, conceived by residents, city and state officials and representatives from Johns Hopkins Medical Institutions and Kennedy Krieger Institute (*Baltimore Sun*, 10 December 1998).	1994
Baltimore city government announces a redevelopment plan that would include a 'bioscience park' adjacent to Johns Hopkins Medical Institutions in which JHMI could be a 'key investor' (*Baltimore Sun*, 22 May 2001)	2001

Since 1970, as the national and regional economies shifted from manufacturing to services, many of the high-wage factory and shipyard jobs disappeared with a resultant detrimental impact on East Baltimore (Baltimore City Planning, 1994; Harvey, 2000; Fee, 1987). Currently, poor housing conditions in the form of high housing density, vacancy rates and number of abandoned houses (13%) exist in the East Baltimore neighborhood with higher rates (80%) located in the northern portion just north of the Hospital (Harvey, 2000).

This neighborhood has been undergoing a continued process of urban redevelopment since the 1940s (Table III) (*The Johns Hopkins Magazine*, 1950, JHMI Medical archives, 1996). Recently, an announcement was made by the city government to raze a 35-block portion of East Baltimore immediately north of the academic and medical institutions for mixed-income homes, stores and a 'bioscience park'. The deputy mayor was quoted as saying 'Of the estimated 1700 properties in the 20-square-block study site, about 1000 are vacant houses or lots.... This neighborhood has an extremely high vacancy rate, and the No. 1-ranked medical institution sits in its midst...'. The city and its

Housing Authority own 290 of the properties and the private developer owns 96 (*Baltimore Sun*, 17 January, 22 May, 2001). Regarding Hopkins' role in the 'bioscience park', the Baltimore Sun reported that 'the park, which would be developed and managed by a non-profit corporation but would have close ties to Hopkins . . .' and 'Although the park would not be owned by Hopkins, Schwartz said, she left open the possibility that Hopkins could be a key investor' (*Baltimore Sun*, 31 May 2001).

The government. As mentioned above (and depicted in Table III), the Baltimore city government has a longstanding relationship of working with the academic and medical institutions in planning private revitalization of 'deteriorating neighborhoods' adjacent to it (*Baltimore Sun*, 1969; Urban Health Council Report, 1999). Thus the ability of a powerful institution to be supported by the government affects how effective local community residents can act as civil society in challenging the state to represent their interests. This institutional powerlessness was vigorously echoed at a community meeting hosted by the city to discuss the plan for the new bioscience park: 'There's a mistrust of the city, a mistrust of Hopkins, a mistrust of the process,' said a local pastor and organizer. The ability of this private developer to assure adequate zoning in a residential area for its business interest continues to encourage unchallenged redevelopment and subsequent displacement and abandonment of a community (*Baltimore Sun*, 22 May 2001).

These descriptive historical data show a strong institutional social capital between the city and state governments and the major private developer. This strong bridging institutional social capital between the government and private developer and poor bonding relations with the community leaves the community (civil society) with little hope of negotiating on its behalf and in effect a mere recipient of the states' decisions. The personal interviews below will verify this sense of powerlessness by community members and bring into greater focus the lack of 'good bonding' and 'sufficient bridging' social capital in the East Baltimore community.

Community meetings

Information was gathered over a six-year period through attendance and membership in community organizations' meetings (approximately 100) within the neighborhoods of the East Baltimore community. Meeting settings included churches, community centers, schools (elementary, secondary, high schools), colleges, universities, market places, restaurants, garages, street corners and private homes. During discussion and informal interviews at these community organizations, several issues recurred that could be summarized into two categories: community control and external institutional control (Table IV). These categories allowed for interpretation of the type of social capital in relation to redevelopment in this community. If the community had strong bonding relationships it would feel empowered to control its own outcome. Similarly, if healthy bridging relationships existed between the external forces that participate in the redevelopment process, a perception of control by residents would be evident. Bridging institutional social capital is reflected in government, community and private developer participation at local city council meetings, state legislatures, city planning, housing and health government agencies.

Focus groups

Each focus group discussed a different topic: neighborhood resident involvement in historical and current housing development; role of external influences in determining housing

Table IV. Community meetings: Recurrent themes 1992–98.

Recurrent themes	Community control of neighborhood outcomes	External institutional control of neighborhood outcomes
Private developer systematic acquisition of houses	No	Yes
Increasing number of abandoned houses	Yes	Yes
Power to stem redevelopment by external institutions	No	Yes
Community involvement in redevelopment plans	No	Yes
Abandoned houses leads to trash, rats and drugs	Yes	Yes
No timely dissemination of information about development back to community	No	Yes
City government involvement on behalf of the residents	No	Yes
Detrimental effects of collaboration between city government and private developer to redevelop	No	Yes
Co-optation by the government and private developer of local community members	Yes	Yes
Lack of successful efforts by the private developer/academic and medical institution to improve health in the community	No	Yes
Role of the private developer/academic and medical institution to be a good neighbor	Yes	Yes
Residents as research subjects of the private developer/academic and medical institution	Yes	Yes
Increasing health problems in the community	Yes	Yes
Increasing inequality due to wealth (expansion) of the private developer/academic and medical institution	No	Yes
Lack of health research relevant to community by private developer/academic and medical institution	No	Yes
Co-optation of local political leaders by private developer/academic and medical institution	No	Yes

development in the neighborhood, and health effects of the process of urban redevelopment. Summary concepts of each focus group are presented in Table V under the heading of the different topics. The first focus group discussed the involvement of neighborhood residents in historical and current housing development. These data suggest poor bonding relations within the community organizations as well as ineffective bridging networks between community organizations and external institutional networks. The second focus group discussed the role of external institutions in determining housing development in the community. These data reflect insufficient bridging networks between the community and external institutions. The third focus group discussed the health effects of the process of urban redevelopment and reflects how insufficient bridging networks between community organizations and the academic and medical institutions affect how redevelopment occurs and the subsequent health outcomes of lack of community social capital.

Listening projects

The summary responses to surveys are given in Table VI. The survey asked people to list three major concerns they had in the community and whether the academic and medical institutions should play a major role in helping to solve the health problems of the East Baltimore community. Of the 50 people interviewed, 64% responded that drugs were a major concern, almost 50% named boarded-up/abandoned houses, and 30% mentioned crime. Some 94% of 49 people responded that the major private developer should play a role in helping to solve the health needs in the community. These data further confirmed how the lack of effective communitarian and institutional social capital of a community

influences how its expectations are addressed. That is, if a community maintained good institutional social capital (with the private developer and government), it would be able to influence the institutions that have the ability to fulfill its expectations. Similarly, if effective communitarian social capital was present, good bonding relationships could facilitate bridging relationships to result in greater likelihood of community expectations.

In-depth key informant interviews

Semi-structured interviews were carried out with 20 key informants; the demographics are described in Table VII. These interviews provided information as to how neighborhood residents perceived housing, relocation, health and well-being. Several key themes persisted across all interviews and are consistent with the themes of the focus groups presented in Table V. Illustrative quotes pertaining to each theme are presented below. Interviews also provided information regarding community residents'

Table V. Focus groups: Redevelopment and health effects.

Role of community resident in housing development	Role of external institutions in housing development	Health effects of an urban redevelopment process
Community leaders (from NGOs and churches) had 'sold out' to the government and private developer/academic and medical institution	Private developer/academic and medical institution buying of property since their childhood	Stress from wondering whose block would be redeveloped next and whether they would be able to stay in neighborhood
During the mid-1960s, community leaders were more likely to represent the interest of the community and bring back relevant information to residents	Government is responsible for assuring that housing and health issues are adequately addressed	Private developer/academic and medical institution is interested in using community residents only as 'research subjects' rather than in providing needed healthcare services; grant dollars directed to research
Community participation in city government and private developer/academic and medical institution boards—where decisions on future development and health research were made—did not translate into benefits to the neighborhood	Government in partnership with the private developer/academic and medical institution in helping them acquire real estate to build new clinical, educational and research facilities	Private developer/academic and medical institution acquisition of property leads to intentional abandonment of houses and subsequent drugs and crime in neighborhood
	No systematic process of informing community of redevelopment plans (by city/state government or private developer/academic and medical institution)	Stress from feeling that private developer/academic and medical institution is a 'plantation presence' but have to work there anyway
	Private developer/academic and medical institution could not develop 'wherever' they pleased if they did not have the support of the city government in ensuring acquisition of properties	Private developer/academic and medical institution not interested in providing health care because wants community to remain sick so they cannot fight back (around redevelopment by private developer/academic and medical institution)
		Referral to clinics in Baltimore county, far away from their neighborhoods

Table VI. Listening project.

Question	Response	N = total no. of responses	No.	%
Major concerns in the community		50		
	Drugs		32	64
	Abandoned houses		23	46
	Crime/violence		15	30
	Unemployment		11	22
	Poor health		11	22
	No children's facilities		10	20
Role of private developer/academic and medical institution in solving health problems		49		
	Yes		47	94
	No		2	2

Table VII. Demographics of participants in key informant interviews.

Demographics ($n = 20$)	
Age range (years)	32–74
Gender (female)	13
Income (annual) <US$20 000	17
Race	
African-American	19
White	1
Housing tenure	
Rent	8
Own	12
Relocation status	
Previously	5
Targeted	11
Not currently	4
Health status[1]	
Mental illness	9
Diabetes	12
Hypertension	13
Cancer	4
Heart disease	9
Asthma	8
Emphysema	6

perceptions of bonding social capital between community organizations and bridging social capital between city and state governments and the major developer and employer, and the presence or absence of political or economic power to influence how redevelopment occurred in their community. The names of the participants have been changed to protect their identity.

Regarding perceptions of the health effects of an impending redevelopment process, 17 of the 20 individuals interviewed directly identified at least one health effect. When asked about his health and how he had been feeling after finding out he would have move, Mr Bernard, who had lived in the neighborhood for 20 years said:

> After I found out about the move, I just sat there and stared off in space. I couldn't move; I felt numb. Frame of mind is different; I've lost all hope and its affected my health; you know the human body can take so much; but I'm going to be okay. Sugar is up, blood pressure is up . . . taking two blood pressure pills now. I didn't

realize my sugar was up so high. Dr said I have too much fluid. Dr is telling me to exercise but I'm tight; I'm wound up a bit and I could relax more; but once I find out where I can move and get moved and settled then I'll feel better.

Ms Brown, a 72-year-old woman born and raised in the neighborhood, who was relocated three years ago, responded to this question with:

This neighborhood have all kinds of illness. It's a shame; Johns Hopkins always boast about how they're the number one hospital; well, why don't they help the people around them? They go to all places in the world to help people but they don't even help us . . . they just want us outta here. I had cancer and couldn't get one of those tests to check for it. Now I have lots of fluid in my arms. I can't get around like I use to . . . don't know where I'm gonna move now. But you know, we been sitting and waiting for this to happen. We know that Hopkins is going to take over this neighborhood.

While Mr Bernard's quote illustrates his individual health, Ms Brown's response focuses more on the general health of the community with regard to a history of redevelopment. In addition, both responses illustrate the general sense of powerlessness on the part of residents (a lack of institutional social capital) to influence how and whether their neighborhood is redeveloped. This sense of powerlessness and lack of trust was also reported throughout the history of some of the residents interviewed. For example, Ms Garner (74 years old) was born and raised in East Baltimore:

. . . when I was a little girl in elementary school, they used to tell us that Hopkins was going to take over this neighborhood. Now I'm 74 years old and they really are taking it over. Ever since I was growing up, they always told us that. Guess it's time now. I don't know where I'm going go. What does Johns Hopkins want with all these buildings?

This sense of powerless and lack of control was also evident when residents spoke of the future:

. . . They haven't said anything about our neighborhood being redeveloped yet. I know it's a matter of time. I'm hoping to have enough money saved for when they tell me I have to move. This entire block used to be filled with families. Now there's only three houses not boarded on my block and four across the street.

When asked specifically about community leadership in affecting the current redevelopment process, a typical response was:

The local leaders don't bring the information back to us. Maybe 20 or 30 years ago, that used to happen. But the local leaders don't care anymore. They've been bought out. They won't call meetings to tell us about what's going on. We have to find out about our own community being developed from the television. We ask for meetings to find out from the city what's going to happen, and they tell us to just sit and wait. Sit and wait for what? For them to put a 'condemned' sign on our doors. The longer we wait, the more boarded up houses come up. We have to find new leaders.

This response highlights the poor bonding relationship that exists in the community, thus leading to ineffective communitarian social capital.

Specific questions about the city government's role in acting on behalf of the neighborhood (with regard to housing and community development) resulted in responses like these:

I don't know why we have a housing department if it's not gonna take care of the housing in the city. For over 40 years they watch this neighborhood deteriorate. They just sit and watch the area go down so that some big institution like Hopkins can come and buy it up for little or nothing. Then they come in like some white knight on a shiny horse to rescue us . . . with their cheap price for our houses . . . tell us that we over-invested in our houses.

City council and Johns Hopkins work together; when we go to the city council hearings, Johns Hopkins tells us about some plan for a new building, and asks us what we think. The city council already told them they could develop there because the next day they vote for Johns Hopkins even if we stand up and say that we don't want

> to move. Johns Hopkins is too powerful; the mayor want Hopkins to keep taking this neighborhood over. He's gonna leave his mark that he redeveloped this poor black neighborhood.
>
> Look, once one boarded up houses goes up, the sanitation and all the other services stop coming out. I go to these meetings and they always giving out some number or other to call. I call them over and over again to come and pick up the trash in the alley back there. Once I called about a mattress behind the house; you know they came and picked up that one mattress and left all the other trash that was right there next to it. It's a shame. The city just leave us to deteriorate so that they can condemn the neighborhood and not have to put any energy to help keep us safe.

Of note was the consistent pairing together of the government and the private developer, illustrating effective bridging relationships between these two institutions. These examples also illustrate the lack of sufficient bridging relationships between the community and the external institutions of the government and JHMI.

Similar pairing of JHMI with the government was noted when participants were asked about the role of the JHMI in the neighborhood. Jackie (renting in the neighborhood for 40 years) talked about the increasing development of Johns Hopkins in the neighborhood since she's been living there:

> I remember when Madison Street use to be a one-way street running in the other direction. It got changed because Hopkins wanted it changed. They've been trying to buy this building for over 20 years. Well, the owner finally decided to sell so I have to move now. They gave me 30 days to move . . . after being here for that long. You can't fight them . . . they're like an elephant, sit where they want . . . can do that when you have ties with the government.

One resident, a local community organizer, talked about the need to challenge this history of redevelopment without community input:

> . . . Johns Hopkins is going to take over this whole neighborhood eventually. We have to start organizing the people and tell them that even if their house isn't targeted today, they will be next. We have to be part of the plans they make to redevelop; I didn't use to think that they would eventually want to develop on my block, but now we're the next ones to be developed. They're not going to stop till we're all gone. They don't want us; they want people with lighter skin. They want to build houses that we can't afford and bring people to live here that work and go to school at Johns Hopkins. And the people on the city council do whatever Hopkins want.

Similarly, these examples illustrate the lack of effective bridging relationships between the academic and medical institution and the community, leading to insufficient communitarian social capital.

These in-depth interviews provide a framework for conceptualization of social capital in the East Baltimore neighborhood. These responses are characterized and summarized in Figure 1 to show how these factors impact on neighborhood health in East Baltimore. As with the analysis of the focus groups and community meetings, responses can be categorized into domains of community networks, the state participation in the community social capital and the private developer participation in the social community networks. Within the networks dimensions, these interviews suggest few or no bonding relationships within the community owing to lack of trust and apparent corruption. This dynamic results in a lack of communication of accurate information regarding housing and community development amongst residents. The bridging relationships that do exist appear insufficient to facilitate timely discussion to inform major redevelopment projects that are being planned in the neighborhood by the city and state and private developers. These insufficient and ineffective bridging and bonding relationships characterize the dimension of networks/community social (Figure 1).

Within the context of the institutional analysis of social capital, it is apparent that the community members perceive little support from the state government with regard

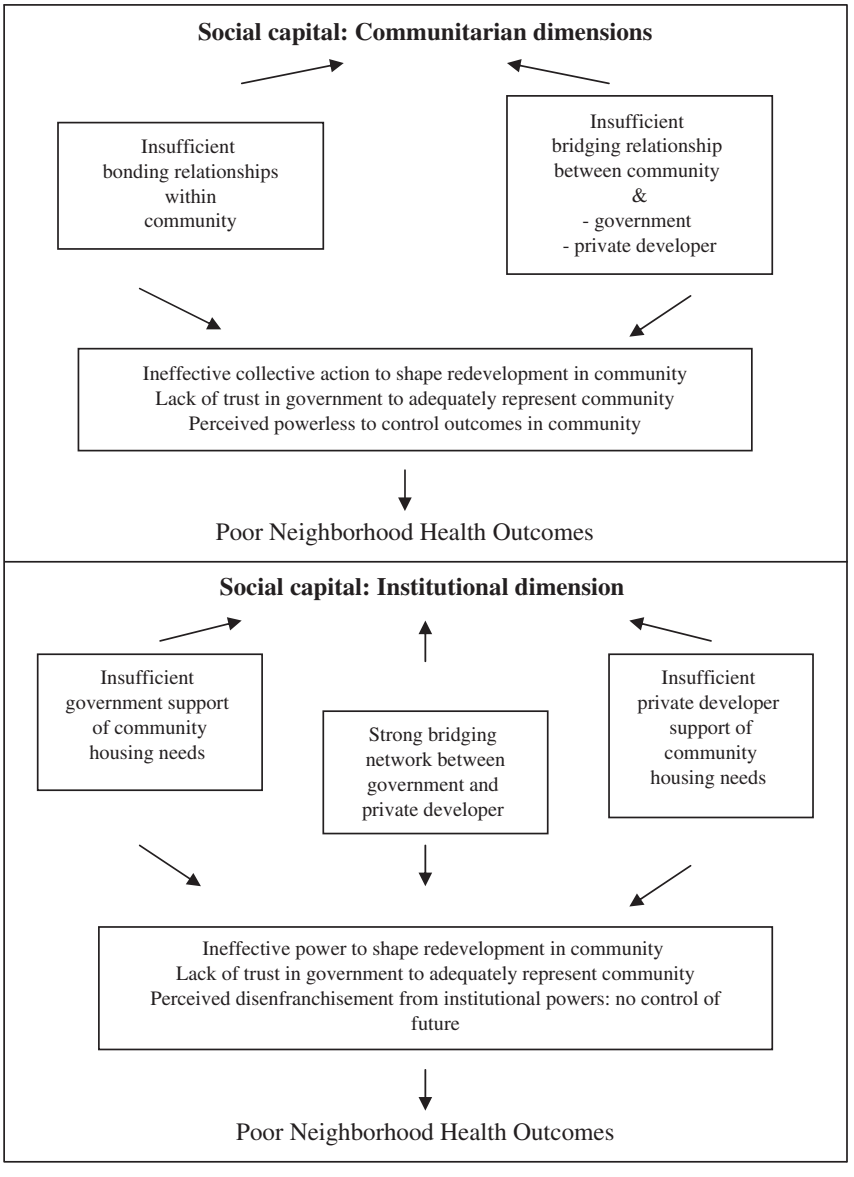

Figure 1. Summary of social capital, redevelopment and neighborhood health in East Baltimore, Maryland.

to their housing needs. This is further substantiated by the support that residents see being bestowed by the state to large private developers. This leads to a perceived collaboration between the state and the large private institution, which is expected to act in ways that do not benefit the housing needs of the community members (see Figure 1).

Discussion

Our different methods of qualitative data gathering revealed several recurrent themes on bonding and bridging social capital and its relationship to community health. These

themes present a community that felt it had minimal positive influence via bridging relationships with the state government or the private developer to shape effective urban redevelopment. Furthermore, residents felt that there was no social bonding between community associations, and expressed mistrust of the community leaders who represented them at negotiations with the government and the private developer.

Communitarian social capital emphasizes a relationship between bonding and bridging relationships to facilitate effective collective action (Woolcock & Narayan, 2000). Our analysis also accounts for the possible negative effect of strong bonding relationships between community associations chosen by the city as partners, which simultaneously exclude other associations from the process. This type of bonding social capital is especially detrimental when the interests of the community are not being represented by these associations, which may have stronger bridging relationships with the government and the local developer than with the community.

The institutional view of social capital focuses on how the political, legal and institutional environments affect the social capital of a community. Overall, our study shows negative institutional bridging relationships evidenced by insufficient government support of East Baltimore community needs and an excessive influence of the local developer on the government. Residents perceived the government as collaborating with the private developer in acquiring land for its development, forcing them out of their homes and destroying their community. In addition, the bridging social capital between the state and large private developer in initiating redevelopment in the neighborhood has resulted in resident distrust toward local government institutions, as they are held accountable for the failure to address their rights of real-estate ownership. Moreover, our findings are congruent with previous observations in East Baltimore and elsewhere indicating that when redevelopment results in the displacement of residents without assurance of adequate shelter, the health of community residents suffers through mental disorder, exacerbation of chronic illness and subsequently premature death (Broussar, 2000; Cattell, 2001; Cockerham, 1998; Fullilove, 2001; Muntaner et al., 1998).

These patterns of redevelopment within urban communities continue throughout the United States (Brion, 1991; Wright, 1995). In Chicago, redevelopment of the central area and other selected neighborhoods often occurs under the leadership of institutions such as universities and hospitals, which, operating with the full support of the state, has resulted in the replacement of many low-income areas by higher-income ones (Brion, 1991; Wright, 1995). Washington, DC, Detroit, Hawaii, Birmingham, Atlanta, and Boston, Cleveland have undergone similar redevelopment projects that have directly and indirectly led to displacement (Brion, 1991; Broussar, 2000; Wright, 1995).

Our findings suggest that the fields of community development, urban planning, and the federal, state and city agencies involved in housing and urban development should pay more attention to the public health consequences of urban redevelopment. They call for a thorough assessment of the extent of health consequences of displacement secondary to redevelopment. Future research could concentrate on effects of redevelopment on community members who are displaced and those who stay in the community. Another area for future studies suggested by our analysis is the assessment of community health outcomes in cases where community organizations have stronger bridging relationships with local governments (e.g. participative democracy—Lowy, 2000).

We have attempted to describe the effect of redevelopment in a community where unequal power of the stakeholders is evident. Whether social capital is necessary to

understand this process is still unclear (Lynch, Due, Muntaner, & Davey Smith, 2000; Tendler, 1995). However, it seems that unless social capital incorporates the role of institutional economic, political, and class and racial inequalities in its analysis, it may miss crucial factors that affect the ability of a community to effectively shape urban redevelopment and ultimately its own levels of population health (Muntaner et al., 2001). Thus, responsible institutions (public and private) should be accountable to politically organized communities that may be able to influence them. For example, Tendler's work in Northeast Brazil shows that only when there were sufficient bridging relationships between government health workers and community members was there successful implementation of government health programs (Tendler, 1995). The combination of responsive public institutions and organized communities that can influence them (effective social capital) could lead to effective policy that serves the interest of all stakeholders in a more egalitarian manner.

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