

Map the gap: iteratively bridging theory and practice to address housing insecurity in the urban environment

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ABSTRACT: According to the Robert Wood Johnson Foundation Commission to Build a Healthier America, health and well-being depend more on where we live, learn, work and play than on medical care, which accounts for only an estimated 10 to 15 percent of preventable early deaths (Brawer, R. et al., 2016). Housing insecurity, marked by uninhabitable living conditions, uncertainty regarding capacity to pay rent, and multiple relocations, threatens the physiological and mental health of individuals and overburdens infrastructure (Sandel et al., 2018). Our current research reveals that housing insecurity is exacerbated via disconnects between legal affordances, community-based organization (CBO) responsibility misconception, and a lack of resources. This paper will examine the research and development philosophies and processes which substantiate Map the Gap, a transdisciplinary, in-development mobile-Health intervention/prevention tool intended to reduce the burden of housing insecurity in Philadelphia. The tool takes its name from several efforts currently underway to consider the gap in income required for families to avoid eviction. This research group has developed an emerging framework to approach the community work required to cultivate efficient, effective relationships between Philadelphia residents and the built environment. It is anticipated that Map the Gap will play a critical role in health care and wellness promotion. In addition to enabling Philadelphia residents to access resources which improve the built environment, the human-centered accessible architecture of the Map the Gap system itself will lay the foundation for a Culture of Health, transforming determinants of health into constituents of health, and thus creating new imperatives for design of sociotechnical structures which transcend relational and environmental spaces.

KEYWORDS: Culture of Health, Urban Housing Access, Housing Insecurity, Health and Stress, Design Research for Health

INTRODUCTION

In order to improve health in this country, the health sector must work closely with those who plan and build communities, especially the community development and finance organizations that work in low-income neighborhoods to build child care centers, schools, grocery stores, community health clinics, and affordable housing. From the health perspective, our interest is less about the buildings and more about what happens in them (Lavizzo-Mourey 2012, 218).

Urban families under threat of living without an established address will experience a concurrent threat to their livelihood that can have serious health repercussions (Marcus 1995). To alter the stress levels of urban individuals, we must seek to structurally augment the ways that urban neighborhood environments drive such outcomes (Thoits 2010). A midcentury housing renewal that occurred in many urban American locales created a major housing shortage and countless living spaces that are substandard and unsuitable for urban families to have healthy lives (Jacobs 1993, 3). Within the production of architecture and the lives of many urban inhabitants lie structural inequities that lead to eviction and homelessness (Desmond 2016). To ascertain and address the possible efficient and effective relationships imperative to a city with successful and equitable housing, we ask: How can architecture and housing within the urban environment be democratized? What forms can the vocalizations

and internalizations of civic concern take in a historically disenfranchised community? What assumptions have historically underpinned notions of community and institutional capacity? How have such assumptions translated into power disparities in space making? How can built environment and healthcare architecture be leveraged to de-naturalize disparities and re-socialize a Culture of Health predicated on equity, sustainability, and potential to thrive? This paper will explore these questions through an emergent community framework that has arisen across extended community co-design, feedback and input.

Teasing out the hidden motives in any arena where resistance to change exists builds efficacy and community capacity to change (Kegan and Lahey 2009); the urban housing environment is an especially challenging environment. This research group argues for the examination of inherent politics, policies and possible processes embedded in modern design to discover novel, equitable processes that will create change for the families that bear the burden of current processes. Exploring the transdisciplinary and trans-temporal possibilities which connect data informants, built environment care providers, processors, and recipients, enables this group to develop a community-driven design research process. This process aims to transform a legacy of inequitable development into a cyclic, iterative, democratized design process for urban families in West Philadelphia. In examining models of potential theory and possible practice translations, as well as the ethical obligations which guide design aspirations, this paper serves as a stepping stone to a transdisciplinary approach to the built and social world. The work that drives this paper stems from the desire to achieve stress reduction and enhance health for urban families (Lavizzo-Mourey, 2012, p. 218); this research group approaches stress reduction in the built environment via new solutions to change the residential environment, wherever people may live. Map the Gap, the prototype subject for this paper, is an in-development digital narratively-informed housing decision guidance tool intended to optimize utilization of existing resources (connect people to community-based organizations). The ultimate outcome is to dissolve historical tensions between landlords and tenants. The tool takes its name from urban planning and policy currently underway to consider the gap in income required for urban dwellers to avoid eviction (hraidvisors, 2019). Currently, we have found no other interactive interfaces which allow landlords and tenants to virtually navigate the realities of the housing system, nor smart-applications which advise based on individual circumstance meshed with current data.

Map the Gap is also unique in that it is intended to function as both a primary and secondary prevention tool; while it will serve to prevent homelessness associated with unrepaired rental units, it will also serve as a tool to foster self-efficacy and advocacy capacity thus reducing the risk factors for homelessness. Map the Gap serves to develop and maintain a healthy, workable system. Our plans to develop this tool have been evaluated and informed by an inter-sectoral group of experts, representing a cross-section of leaders in this area. The research group includes Public Health and Architecture practitioners and researchers with considerable experience in the urban built environment and with urban residential issues, including 20-plus years of experience in residential re-design, re-use and repair.

In terms of function, Map the Gap will connect tenants, landlords, community-based organizations, government agencies, and other resources in Philadelphia by 1) providing personalized navigation of Philadelphia's housing system, 2) facilitating communication between parties, and 3) enabling service exchange (a local currency). Map the Gap is intended to be used consistently, with users engaging with various functions at regular intervals, as well as some on a trauma-informed basis. The mobile application will contain both public and private platforms to facilitate these user-system/user-user interactions. The private platform will maintain individual data collected in bulk upon sign-up, and then derived periodically throughout use. Housing system navigation guidance will occur over the private platform, and as a function of data inputted into the private platform. The public platform will serve as a means for communication between landlords, tenants, and CBO's. In addition to providing protected chat spaces for landlords and tenants, calendars with all unit-related responsibilities including unit check-over times, rent collection, unit upkeep, repairs, and

regular meetings will be shared by all users (landlords and tenants alike) associated with each unit.

1.0 A new framework for engagement voice, guidance, channels and dynamics

Confronted with a problem as complex as racism, we cannot afford to let ourselves be constrained by the boundaries of specific disciplines (Essed 1991).

We know that a child's life expectancy is predicted more by his ZIP code than his genetic code (Lavizzo-Mourey 2012, 216).

Well-intentioned attempts to overcome historical legacies of extraction and relations fraught with unhealthy power dynamics between project teams and community participants are often poorly conceived. In addition to the subtle dynamics of community process at play in designing for poorer urban families, there is also an inherent power and privilege dynamic at play in trying to assist in their fight for urban homes and livelihood. This is illustrated by the fact that wealth and privilege related to race is protected by both public and private sector structural policies in our society. Current wealth can be directly traced to eras when institutionalized racism was in fully sanctioned operation across society (Lipsitz 2011, I. 36). For example,

At least forty-six million white adults today can trace the origins of their family wealth to the Homestead Act of 1862. This bill gave away valuable acres of land for free to white families, but expressly precluded participation by (families of color) (Lipsitz 2011, I. 38).

In other words, the finish line to a stable home has never been fairly placed, and as such, solutions must take this into consideration to be successful at realizing equity in both process and outcome.

Such attempts to produce equitable housing, may appear to be ingenuine when pursued in obliviousness of this glaringly oppressive past. This becomes even more urgent when collaborative processes are not transparent and emphasized as critical to outcome production. Thus, it is essential that collaborations between project stakeholders are situated within a Culture of Health paradigm (Lavizzo-Mourey 2012). A Culture of health is defined as:

...(a culture) in which good health and well-being flourish across geographic, demographic, and social sectors; fostering healthy equitable communities guides public and private decision making; and everyone has the opportunity to make choices that lead to healthy lifestyles ("What Is a Culture of Health? | Evidence for Action" 2019).

Society has come to understand that factors that are integral to poverty, such as insufficient education, inadequate housing, racism, and food insecurity, are also indicators of poor health. In our urban environment racism is driven by place in a manner that can be understood through a close study of the urban institutions that deal in wealth, mobility and education. Through the work under-taken in George Lipsitz's "How Racism takes Place", we can recognize that our modern-day spaces reinforce racism through institutionalization, policies, and a physical apportioning of resources through generations to present day that is driven through a paucity of resources, and a basic misunderstanding of the roots there-in (Lipsitz 2011, II. 86–88). Hence, space-making must occur both in a physical and social sense. Pursuing space-making within a Culture of Health framework -- thinking of space-making as a healthcare pursuit -- not only enhances the feasibility of proposed interventions but renders them of shared value with regards to community wellbeing.

At Drexel University's urban health symposium, keynote speaker Dr. Mindy Fullilove elucidated a fundamental problem in healthcare strategy. Historically, Dr. Fullilove elaborated, we have engaged in numerous small campaigns to directly improve health: the crack baby campaigns of the 1980's, the eat-your-veggies campaigns of the 1990's, the anti-obesity campaigns of the 2000's, among others (Drexel University 2017). While superficially these campaigns appear to be beneficent, evaluation reveals their lack of effectiveness in creating sustained good health can be attributed to cultural incompetence. Essentially, these campaigns failed to consider the larger environments of their target populations, and were thus incompatible with the target populations' lifestyles, which existed as a function of inescapable structural climates. Additionally, the campaigns failed to address community priorities (e.g., eating one's vegetables is trivial when one does not have a roof over one's head). Nevertheless, value judgments and assumptions abounded, leaving in their wake a trail of ineffective programs which serve as important teaching points for public health operationalization.

The Map the Gap team appreciates the criticality of redesigning healthcare strategy to address the complex, sometimes obscured, underlying social issues which determine the experience of health; the team also appreciates the need to architect interventions around collaborations which are conducive to empathetic listening, reframing of expertise, and redistribution of resources. Social and physical space-making, more specifically framed as democratic engagement with architecture, serves as a means through which to redistribute historically dispossessed resources both physical (e.g., property, money) and social (e.g., voice). To develop outcomes which are meaningful, academics must reflect on dispossessed power and embrace organizational structures and product philosophies which challenge existing oppressive power structures and redistribute resources in equitable ways. Essentially, healthy social space-making must serve as a foundation and complementary endeavor to healthy physical space-making.

The work of this group thus far has led us to propose a new model of engagement based on four main tenets: *voice*, *guidance*, *channels* and *dynamics*. As shown below, these four concepts draw on the engagement to create opportunities for mutual learning and a change in the balance of power. Most significant is the respect and value placed on lived experience as expertise in this arena, expertise that can guide the creation of new environments. This paper posits an evidence-based need for such structures and philosophies, and offers examples of ways to embody them using the Map the Gap project as a case study and the emerging framework for engagement as a guidepost.

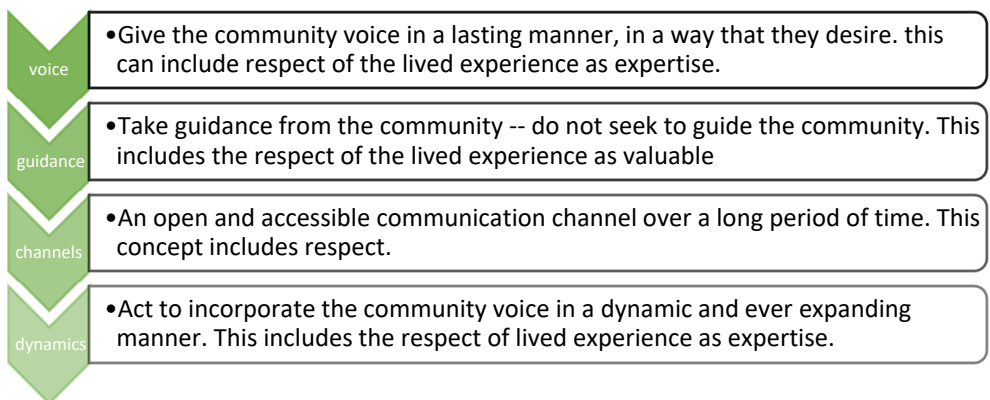


Figure 1: An emerging Framework for Community engagement that honors the urban lived experience as a type of expertise Source: (Authors 2018)

2.0. EMBRACING A CULTURE OF HEALTH:

2.1. Third sector capacity challenge: space, collaboration, and capacity

The complexity of stress within urban housing and the associated health outcomes, call for inter-professional problem solving. These solution oriented partnerships must take place through collaboration across many sectors and disciplines, including public, private and research-oriented organizations (Murphy, Fafard, & O'Campo, 2012). Our government as an organization does not completely serve these "in need" populations especially at the metropolitan level. Thus, regional governments must look to "informal coalitions, alliances, and networks that weave together nongovernmental actors with existing units of government in metropolitan areas (Adams, 2014, p.1)." Such networks are the developing third sector, between private and public (Adams 2014). Many of the challenges that a third sector organization deals with, are related to capacity. Non-profit capacity is defined by Christensen and Gazley as follows:

the processes, practices, and people that the organization has at its disposal that enable it to produce, perform, or deploy resources to achieve its mission (Christensen & Gazley, 2008, p. 266).

Capacity is directly linked to an organization's aptitude for reaching goals, satisfying a mission and satisfying mandates (Christensen and Gazley 2008). An organization's capacity is essentially connected to the ability to operate successfully. Thus, an organization's capacity is intrinsically linked to the success of their collaborative efforts within the urban built environment. From experience, this research group concludes that housing insecurity services are almost exclusively supplied by this type of overburdened third sector organization with deep challenges to its ability to initiate systems-level change. Drexel University is naturally an adaptive environment in which researchers and faculty are encouraged to bring their expertise to bear in creating change at many levels. The strategic plan for Drexel University calls for integrated community-oriented efforts on an unprecedented scale (Drexel University, 2014). This has created an environment in which faculty and students are able to engage with community partners over protracted periods of time.

Capacity and design have a complex relationship that requires an adaptive design practice. Design is adaptive by nature; as more is discovered about a problem or opportunity new tactics and answers are sought (Cross 2001). Iteration is at the heart of design, and iteration is important in this realm. To better understand how leadership in design might build further capacity, we pursue a brief examination of how Complexity Leadership (Uhl-Bien, Marion, & McKelvey, 2007, p. 299) and Adaptive Leadership (Heifetz, Linsky, & Grashow, 2009, Kindle loc. 378) might be a more influential part of the design process to expand the frame for both third sector partners and the designers who are trying to serve them. The ultimate goal is to uncover the parts of those models that have the most in common with design. Complexity Leadership Theory (CLT) (Uhl-Bien et al., 2007, p. 299) is drawn from complexity science. It is, a model for leadership that enables a flexible, creative, and learning-oriented approach to leading and is oriented to what are called Complex Adaptive Systems (CAS) (Uhl-Bien et al., 2007, p. 299).

Complex Adaptive Systems feature three overlapping roles for leaders: "adaptive leadership, administrative leadership, and enabling leadership that reflect a dynamic relationship between the bureaucratic, administrative functions of the organization and the emergent, informal dynamics of complex adaptive systems" (CAS) (Uhl-Bien et al., 2007, p. 305). CLT and CAS afford designers an opportunity to more closely assess process and find opportunities to be more effective when partnering with those in the third sector.

Those that design the spaces that we live in (e.g., architects, urban designers, engineers, and landscape architects) are taught to focus on and solve physical and service-based problems. The frame must be widened for those professions to be effective in the face of the wicked problems faced by our society. In building design, there are several phases of the process that include what is commonly known as Pre-design. Pre-design is defined by the early phases of a design process including initial problem definition and user engagement (Demkin & Architects, 2008, p. 463). The problems of capacity that have been identified by this group require an expansion of the Pre-Design process to include needs assessments, and processes outside of the usual design process. The frame used by designers is often that of reflective leaders; Donald Schon maintained that as designers employ complexity in their practice already and reflection is not far behind:

A designer makes things. Sometimes he makes the final product; more often, he makes a representation—a plan, program, or image. . .the designer reflects-in-action on the construction of the problem, the strategies of action, or the model of the phenomena (Schon, 1991, p.78).

Embedded in this practice is a reflective habit that requires an adaptive sense, and a need to change course in search of solutions. This group integrates CLT and CAS as a way to afford teams and designers an opportunity to more closely assess process and find opportunities to be more effective when partnering with those in the third sector.

2.2. Intersectional outcomes: housing, health, and policy

According to the Robert Wood Johnson Foundation Commission to Build a Healthier America, health and well-being depends more on where we live, learn, work and play than on medical care, which accounts for only an estimated 10 to 15 percent of preventable early deaths (Brawer, R. et al. 2016). Factors such as quality of housing and other environmental conditions have a significant impact on the health of a community. An untreated instance of mould in an older, unmaintained house, can lead to substandard air quality and have a lasting effect on inhabitants physiological, mental, and social wellbeing. According to the Healthy Rowhouse Project, 40% of asthma episodes are due to asthma triggers in the home. Furthermore, socioeconomic factors can compound the effects of substandard housing. Studies have shown that a caregiver's instability, whether in regard to rental payment, multiple relocations, or homelessness, has adverse health outcomes, including child lifetime hospitalizations, poor mental health, and household material hardships (Sandel et al. 2018). The de-prioritization of housing as a constituent of health in the face of resource scarcity persists throughout the life course with devastating consequences (Bennett 2008). Tenants may find themselves at a disadvantage when attempting to deal with home disrepair. A tenant may not be fully aware of the implied warranty of habitability, which states that a landlord has an obligation to maintain habitable (safe, sanitary, and fit) premises, and that if a landlord breaks his/her obligation, a tenant may be relieved of his/her obligation to part or all of his/her rent (Pugh v. Holmes 1978). On a legal front, the majority of tenants are at a disadvantage in tenant-landlord court: In 2016, in Philadelphia, tenants in 92 percent of 22,573 cases filed in court represented themselves (Blumgart, 2017). A scarcity of financial and informational resources, as well as a historical tension between tenants and landlords, perpetuates a system wherein tenants experience disadvantages in health.

While 81 percent of landlords have legal representation, some landlords are similarly vulnerable to tenants (Blumgart, 2017). An uninformed landlord, especially one without the proper rental license, may experience financial instability. Accidental landlords, landlords who have acquired five or fewer properties without the intention of renting them, nor even necessarily being responsible for said properties, comprise much of this vulnerable population. Many have acquired properties through deceased descendants, and many rent as a means to compensate for financial hardship caused by disability. The Department of Licenses & Inspection, investigating a claim by a dissatisfied tenant, may deem a property "unfit for human habitation," rendering the tenant homeless and depriving the landlord of a much-needed source of income (Vargas 2017). A Philadelphia Inquirer and Daily News review of 507 properties deemed "unfit for human habitation" between January 2016 and the end of May 2017 showed that 180 had rental licenses and 34 more had vacant-property-licenses; the rest had no licenses (Vargas 2017). Additionally, when income is compromised by way of unpaid rent, some landlords struggle to address repairs in their units with limited financial means. Furthermore, landlords may run the risk of violating tenant-landlord rights. Evictions are also costly to the public because evictions add even greater occupancy pressure to the emergency shelter system (City of Philadelphia 2018). The system, which is underfunded and strained, is not a navigable or sustainable one. This system is unhealthy, and accordingly must be treated as a constituent of health rather than a determinant of health. Viewing housing through the lens of a Culture of Health (Lavizzo-Mourey 2012) emphasizes equitable access and sustainability, and requires an intersectoral approach to improve outcomes at the intersection of housing and health. Accordingly, the housing system must be examined with respect to structured inequity and a systems-based approach to health. Solutions must draw together inter-sector stakeholders.

3.0. A process-oriented interdisciplinary solution

Map the Gap originated as a collaboration between graduate design and technology students and representatives from several community-based organizations during a course entitled Health and Design Research offered at Drexel University and funded through a grant with a behavioural health foundation. This course encouraged students to integrate epidemiological and design research methods to engage with built environment issues in the urban setting

adjacent to Drexel. At the conclusion of the 10-week course term, students proposed an early-stage version of the Map the Gap tool which involved a physical toolkit intended to aid with home repair as well as a workshop series. The team then took the facsimile of this toolkit to community members and experts for feedback and suggestions.



Figure 2: Final deliverable from course – toolbox for community conversations: Team examined items with community members for possible usefulness.

However, further community centered research revealed socio-structural issues which led the team to believe that the aforementioned intervention was not fit to user needs. The team then engaged in a series of expert interviews through which they worked to map out Philadelphia's housing landscape and identify gaps which result in housing insecurity. These interviews led to iteration upon the original idea of toolkit; a digital toolkit would be more adept at addressing user needs, the team concluded. Collaborations were then forged with diverse community partners which facilitated community buy-in and proved useful when recruiting participants for two focus groups, also called community conversations, intended to elucidate participants' experiences with the housing system, and to guide the identification of useful features for an intervention prototype. The team has worked to build out a community process that engages with participants and benefits them along the way.

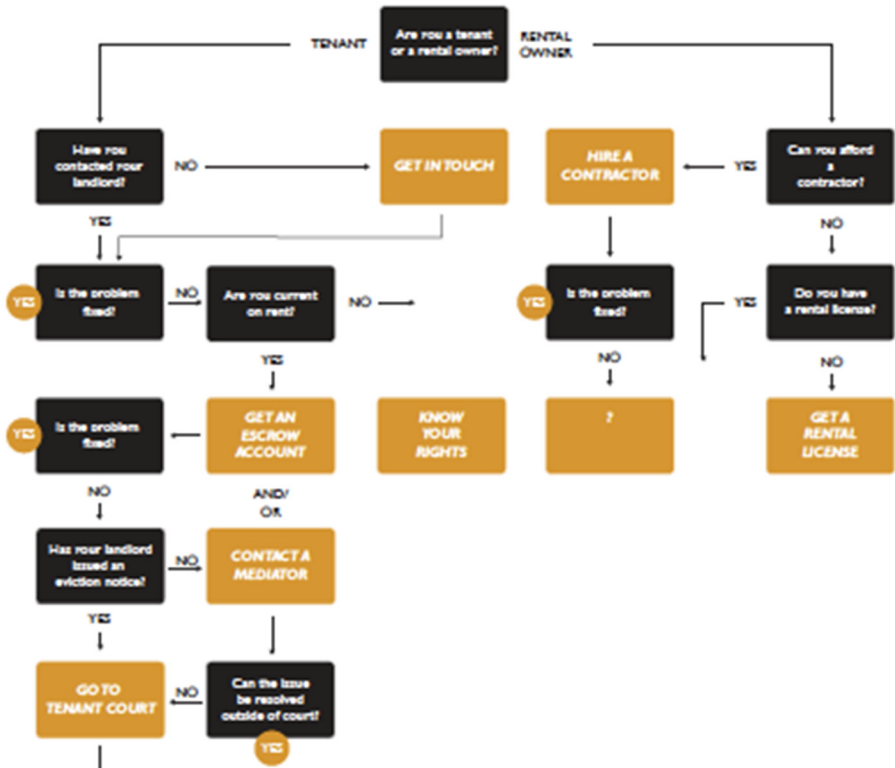


Figure 3: Initial decision tree sketch of Map the Gap service.

The goal of this mid stage team process was to pursue co-design sessions in collaboration with community members. The team then held two information sessions about the project, and two community conversations in which community members engaged in design research activities and explored their experiences with housing resources in Philadelphia. The data garnered from the community conversations and the expert interviews mentioned here is not the subject of this paper, but informs current iterations and conclusions of the Map the Gap digital prototype, and the stance relative to this work. The team plans to engage the community again for testing in several more rounds of development prior to a launch of the Map the Gap tool.

Through both regular data input and trauma-informed data input, Map the Gap has developed multidimensional narratively-informed user profiles, and will allocate guidance accordingly. Users will begin their use of the tool by answering a series of questions to help determine appropriate remedies for home repair, such as making small fixes or getting in touch with a mediator. The interface will also suggest referrals to relevant community-based organizations and additional resources. By providing tenants and rental owners with the tools for successful corrective and preventative adaptation, much of the fall-out that strains relationships and the housing system can be avoided. The goal is to avoid loss of housing and eviction through empowering all parties to address disrepair in their homes. The tool will also enable them to take control of their health and wellness through addressing such issues as contaminants or mould through non-profit care resources that might be more difficult to find without the use of an integrated interface. Homes will no longer simply be places to reside; they will be places to grow a healthy urban family with Map the Gap and the process of home-retention will support healthy social space-making.

The Map the Gap team has made extensive efforts to relocate expertise within the design setting. Initially, an expert interview series was conducted featuring interviewees (e.g., lawyers, government officials) from whom many local residents facing housing insecurity felt disconnected. Thus, the interviewees maintained knowledge-oriented expertise rather than practice-oriented expertise. The Map the Gap academic team sought to reframe community participants as practical experts on their own communities, and to reinforce the notion that their contributions would directly determine the shape and outcome of the project. Thus, in the process of co-designing a built environment intervention, the team produced new norms for social relations and expectations for research conduct and deliverables. Today, iteration remains key to the Map the Gap process. The team seeks to prioritize the value of Map the Gap as a collaborative process (as opposed to simply an in-development product). Map the Gap's value as a social space-making endeavour and potential for feasibility as a built environment modulator is determined by the process that underpins its development.

3.1. Community education of the team

The team received an education into the subtleties of power, race, privilege and community practice through their recent community process. This work in part has led to the framework laid out in the early part of the paper and below. As a part of the development process, an information session about Map the Gap was held in anticipation of a focus group. This information session illustrated the subtle and unique dynamics at play in such a project. This is described here in general terms in order to underscore the many fronts on which such a project can touch community members and reveal systemic issues. Repeatedly, throughout the duration of the information session, privilege and voice were situated front and center by participants who respectfully disrupted the planned talk to critique the team's proposed intervention for epidemic housing insecurity. From participants' input it became clear that unacknowledged dynamics and cultural differences between the Map the Gap team and potential users could seriously undermine the project. The community members gave this group the gift of their openness, honesty, and true perspective. The team took away a renewed approach that has informed further engagement, and the project moving forward. That session preceded others, and the Map the Gap hosts decided to change their approach to all following sessions. Labeling and approach was re-tuned to further meet the potential participants in a way that recognized privilege and power disparities.

The team has clarified the aforementioned framework of: *voice, guidance, channels and dynamics* in part from this experience, and from their combined thirty years of community engagement experience. The community in question is sophisticated and understands their environment through lived experience. The participants were generous with their time, and did receive minor incentives to participate that might help them with their homes, or small incidental inconveniences. This team worked to engage in a way that might help to shift the balance of power to the community members through the developing lens of *voice, guidance, channels and dynamics* whenever possible. The team was educated to operate in the following ways by these valued community voices:

The framework of *voice, guidance, channels and dynamics* will be the guidelines for further engagement. The framework aligns with the Culture of Health paradigm. The framework, in practice, has given participants a power to be heard within the project, and among the milieu of the project practitioners and the community. As this work continues, the team seeks to communicate and create ever more mutually beneficial community engagements that build a third community between project team, and residents.

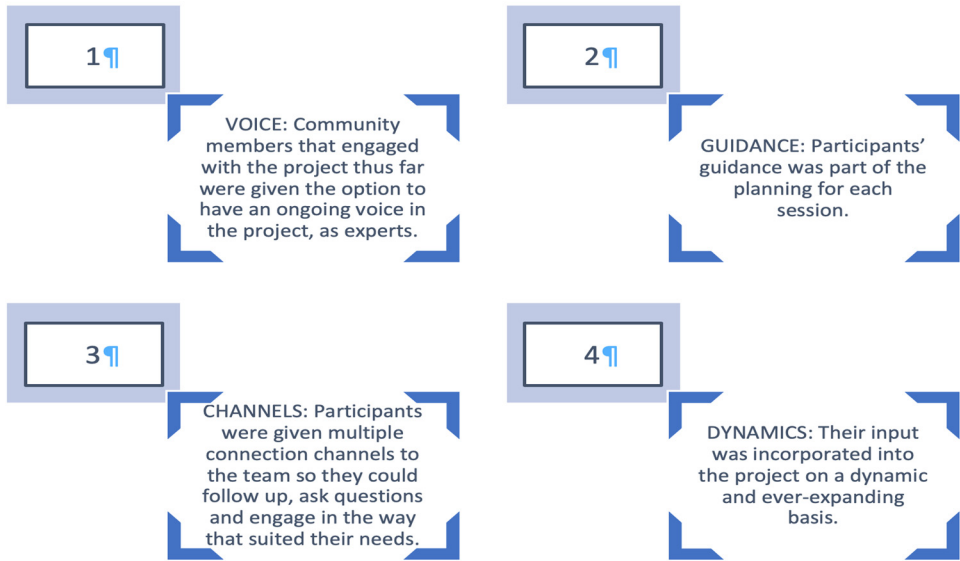


Figure 4: The emerging Framework for Community engagement defined through specific team experiences that honors the urban lived experience as a type of expertise in context with the Map the Gap team's learning from community

CONCLUSION

As stated above, Map the Gap is an in-development digital narratively-informed housing decision guidance tool intended to optimize utilization of existing resources (connect people to CBO's) and dissolve historical tensions between landlords and tenants. This team is a part of a larger research group that works to reduce stress in the urban environment to create healthy family experiences and drive success for a new generation of urban residents. We seek to promote equity, through built environment service-oriented health solutions. Our work is with non-profits, community members, architects, epidemiologists, biologists, writers, engineers, designers, and technologists. Inherently interdisciplinary, the goal is to engage across disciplinary and community boundaries in a manner that is sustained, engaged, respectful and shifts power across institutional limits as much as possible. The emerging engagement framework of *voice*, *guidance*, *channels* and *dynamics* has been synthesized from experience, and study of community driven co-design including the works of Henry Sanoff, IDEO, and many others. This novel approach seeks to include lived experience as expertise in the design process, teaching emerging designers and scholars to interfere with historically driven power and inequity structures, and create a new type of built environment practitioner --one that engages with community within a fundamentally widened frame.

The objective is to use engagement, and "radical listening", the practice of truly hearing those one engages with ("Health In Harmony | What Is Radical Listening?" 2018)(Scott 2017), to drive a new type of health and built environment practice – one that will address health as an experience dependent on a culture which must exist beyond traditional healthcare. Third sector and non-profit partners and their capacity must be a part of this process, and the emerging partnerships here will contribute to a sustained engagement and problem solving, using a widened design frame to drive change in that sector as well. As stated above, we will re-frame housing access and the emerging drive for equity as key components of a new healthcare strategy for urban families.

Again, as a team we ask: How can architecture and housing within the urban environment be democratized? What forms can the vocalizations and internalizations of civic concern take in a historically disenfranchised community? What assumptions have historically underpinned

notions of community and institutional capacity? How have such assumptions translated into power disparities in space making? How can built environment and healthcare architecture be leveraged to de-naturalize disparities and re-socialize a Culture of Health predicated on equity, sustainability, and potential to thrive? We believe this emerging framework of *Voice, Guidance, Channels and Dynamics* holds the potential to explore the answers to these pressing 21st century issues.

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