

common market



Mind the Gap: Turning Access into Action

“First Food Good Food” Project Summary

Table of contents

| | |
|---------------------|---|
| Introduction | 1 |
| Project Description | 2 |
| Findings | 3 |
| Secondary Themes | 4 |
| Conclusions | 5 |

CREDITS

Credits: This article was authored by Kimberly Seals Allers with additional support from Tatiana Garcia-Granados, Haile Johnston, Christiaan Morssink and Natisha Muhammad
Report Layout: Molly Riordan and Catherine Gonzalez





Beyond an overly simplistic, “if you build it, they will come” approach, truly effective interventions also target behavior changes. Access alone is not enough. All marketing specialists know that. Therefore, a weakness in current policy of improved access is the lack of understanding on can influence decision-making in vulnerable communities, especially the decisions towards a better and healthier diet. Hence the new question should be: “Instead of simply building supermarkets, how do we actually build desire, desire for fresh, for healthy, for feeling good?”



Low-income urban and rural communities face ever more limited opportunities to purchase healthy food.

Shunned by large food retailers, and often without cars or convenient public transportation options, residents in these underserved communities find only fatty and highly processed foods sold at convenience and corner stores. As a result, lack of access to healthy food resources in such neighborhoods is directly associated with a high prevalence of diet-related chronic diseases, such as diabetes, obesity, and cardiovascular disease. The U.S. Department of Agriculture, in charge of the nation's food security, has mapped thousands of these locations across the country, affecting over 23.5 million Americans, almost all low-income, low-access areas.

For years, this situation has worried many people—consumers as well as policy makers. Change has been demanded; and indeed change is happening. Community advocates, policymakers, consumer groups, and other stakeholders are advancing many innovative programs and policies. Improving corner store options, creating mobile farmers markets, encouraging urban agriculture, these policies aim to turn the tide, transforming “food deserts” into more oases-like conditions by providing improved

access to affordable healthy foods. Yet, eliminating food deserts alone may not fully solve the problems regarding healthy eating and healthful diets.

A 2011 study published in the Archives of Internal Medicine showed no connection between access to grocery stores and more healthful diets using 15 years' worth of data from more than 5,000 people in five cities. A more recent study published in Health Affairs examined the impact of adding a new supermarket to a “food desert” in Philadelphia—part of the Pennsylvania Fresh Food Financing Initiative-- a statewide program whereby around 88 new stores have opened up in underserved communities throughout Pennsylvania. This six-month pilot study by Steven Cummins from the London School of Hygiene and Tropical Medicine, found that the interventions moderately improved residents' perceptions of food accessibility, but it did not lead to changes in diets, as measured by fruit and vegetable consumption, nor on the average body mass index. Both studies are part of a growing body of research on the critical intersection of food access and actual, consistent, behavioral change.



Beyond an overly simplistic, “if you build it, they will come” approach, truly effective interventions also target behavior changes. Access alone is not enough. All marketing specialists know that. Therefore, a weakness in current policy of improved access is the lack of understanding on how it can influence decision-making in vulnerable communities, especially the decisions towards a better and healthier diet. Hence the new question should be: “Instead of simply building supermarkets, how do we actually build desire, desire for fresh, for healthy, for feeling good?”

While much attention is given to improving equitable access to healthier food, more attention needs to also be directed toward our youngest, our newborn. Infants need full access to their most nutritious first food—breastmilk; access that is completely made possible by the mother. However, in a similar pattern to food deserts, far too many vul-

nerable communities are also “first food deserts.” That is, these are areas without easily accessible support for breastfeeding mothers, with culturally developed biases, and with high levels of aggressive infant formula marketing.

Given strong structural, cultural and systemic barriers to breastfeeding, women cannot successfully breastfeed. Mothers need local support and “first food friendly” environments. (Breastfeeding among low income, African American women: power, beliefs and decision making. *Journal of Nutrition*, 2003) Mothers who want to breastfeed, and we want all mothers to do so, need to be supported wherever and whenever they eat, play, work and worship. Instead, particularly in disadvantaged African American communities, too many infants are being fed formula, without any medical directive.

“ However, in a similar pattern to food deserts, far too many vulnerable communities are also “first food deserts.” That is, these are areas without easily accessible support for breastfeeding mothers, with culturally developed biases, and with high levels of aggressive infant formula marketing. ”

In first food deserts, where breastfeeding is low or absent, there is a strong prevalence of high infant mortality rates and poor infant and child health metrics—including higher rates of acute ear infections, stunting, upper respiratory infections and childhood obesity. In those deserts, infants are 2.4 to 3 times more likely to die before age one.

In Philadelphia, infant mortality for black, non-Hispanic babies is 14.8%, nearly triple the 5.5% rate for white, non-Hispanic infants, and strongly related to income and first food deserts. Babies benefit from the proven immunological and anti-inflammatory properties of breastmilk that protect against several illnesses and disease and their mothers need to know and apprehend that knowledge

On both ends of the life course, from the cradle to old age and the rocking chair, the question remains how we close

the gap between access and action when it comes to food. At the community level, we need to look beyond supermarket carts to the environmental culture, from what's on the shelves, what's in the street, to understand what actually influences purchasing habits.

We must delve deeper to better understand why a mother chooses bottle over breast in order to maximize impact of future interventions and improve infant health outcomes. As each community differs in culture, resources, influencers, assets and deficiencies, the one constant is the desire to give vulnerable children the best possible start. Having a successful and healthy future begins by creating a supportive first food environment and then by ensuring that every child and every family develop healthy food habits for their lifetime.

Infant, Neonatal, and Post-Neonatal Deaths, 2005 - 2010

Table M4
Infant Deaths, Neonatal Deaths, Post-Neonatal Deaths
By Mother's Race/Ethnicity: Philadelphia, 2005 - 2010

| Category | 2005 | | 2006 | | 2007 | | 2008 | | 2009 | | 2010 | |
|----------------------|-------|------|-------|------|-------|------|-------|------|-------|------|-------|------|
| | Count | Rate | Count | Rate | Count | Rate | Count | Rate | Count | Rate | Count | Rate |
| All Infants | | | | | | | | | | | | |
| All Race/Ethnicities | 250 | 11.3 | 257 | 11.2 | 269 | 11.4 | 237 | 10.0 | 230 | 9.8 | 246 | 10.7 |
| White, Non-Hispanic | 41 | 7.4 | 43 | 7.5 | 32 | 5.5 | 37 | 6.2 | 42 | 7.2 | 32 | 5.5 |
| Black, Non-Hispanic | 159 | 15.3 | 178 | 16.7 | 179 | 16.6 | 152 | 14.1 | 156 | 14.6 | 156 | 14.8 |
| Asian, Non-Hispanic | 6 | 4.5 | 6 | 4.4 | 11 | 8.0 | 8 | 5.9 | 9 | 6.9 | 4 | 3.1 |
| Hispanic | 36 | 10.3 | 23 | 6.1 | 28 | 7.1 | 33 | 8.3 | 19 | 4.7 | 34 | 8.9 |
| Neonatal | | | | | | | | | | | | |
| All Race/Ethnicities | 170 | 7.7 | 189 | 8.3 | 166 | 7.0 | 162 | 6.8 | 153 | 6.5 | 168 | 7.3 |
| White, Non-Hispanic | 32 | 5.7 | 34 | 6.0 | 24 | 4.2 | 23 | 3.9 | 29 | 5.0 | 22 | 3.8 |
| Black, Non-Hispanic | 101 | 9.7 | 126 | 11.8 | 97 | 9.0 | 101 | 9.4 | 103 | 9.6 | 103 | 9.8 |
| Asian, Non-Hispanic | 5 | 3.7 | 5 | 3.7 | 9 | 6.6 | 6 | 4.5 | 7 | 5.4 | 3 | 2.3 |
| Hispanic | 25 | 7.2 | 18 | 4.8 | 20 | 5.1 | 26 | 6.5 | 11 | 2.7 | 20 | 5.2 |
| Post-Neonatal | | | | | | | | | | | | |
| All Race/Ethnicities | 80 | 3.6 | 68 | 3.0 | 103 | 4.4 | 75 | 3.2 | 77 | 3.3 | 78 | 3.4 |
| White, Non-Hispanic | 9 | 1.6 | 9 | 1.6 | 8 | 1.4 | 14 | 2.4 | 13 | 2.2 | 10 | 1.7 |
| Black, Non-Hispanic | 58 | 5.6 | 52 | 4.9 | 82 | 7.6 | 51 | 4.7 | 53 | 5.0 | 53 | 5.0 |
| Asian, Non-Hispanic | 1 | 0.7 | 1 | 0.7 | 2 | 1.5 | 2 | 1.5 | 2 | 1.5 | 1 | 0.8 |
| Hispanic | 11 | 3.1 | 5 | 1.3 | 8 | 2.0 | 7 | 1.8 | 8 | 2.0 | 14 | 3.6 |

Rate = deaths per 1,000 live births.

Race/ethnicity information was unavailable for some infants.

(Source: CDC 2012. *Infant Mortality Statistics from the 2008 Period Linked Birth/Infant Death Data Set*. National Vital Statistics Reports. Table 2).

Project Description

During the course of the Kellogg Food and Community Fellowship, 2012, breastfeeding advocate Kimberly Seals-Allers and good food champion Haile Johnston arrived at a startling revelation. Although we worked on seemingly unrelated issues, we were facing the same barriers in our work in low-income communities. Both of us had spent years providing access and education around healthy choices and were frustrated by the slow change in behavior that we observed in the people with whom we worked. How were people making decisions to adopt behavioral changes? We recognized a common need to understand the influencers in decision-making among members of the communities we sought to serve.

As we began working together to seek answers to this critical question, we realized that there was a deep intrinsic connection between the two social movements that promoted breastfeeding (the First Food movement) and nutritious food (the Good Food movement). We began to work in earnest to pursue the “whole life good food continuum.”

Funding from the W.K. Kellogg Foundation provided the opportunity to explore these issues in a deeper and more systematic way. Kimberly and Haile, built a leader-

ship team consisting of Tatiana Garcia-Granados, MBA, Co-Founder and Executive Director of Common Market, Christiaan Morssink, MPH, PhD, Adjunct Professor in Public Health Policy & Administration at the University of Pennsylvania School of Medicine, and Natisha Muhammad, MPH. The data collection in the field was coordinated by Kimberly Seals-Allers and Natisha Muhammad. Natisha Muhammad also was the coordinator of the team of interviewers, made up of students recruited from La Salle University, the University of Pennsylvania, and among community members.

The First Food Good Food Project of Common Market set out to better understand the key influencers of decision making for infant feeding options and personal eating habits in the Strawberry Mansion community of Philadelphia in order to more significantly impact the overall health and vitality of vulnerable mothers and children. Our goal was to better understand the local factors, attitudes, people, places, cultural nuances and perceptions that guide food choices throughout the life continuum—from how we feed our babies to how we feed ourselves.

To do this, we used an ethnographic, community interactive, descriptive research model to conduct a compre-



hensive environmental scan of the neighborhood. We used Ostrom's AID framework to analyze the key policy influencers in the "Action Arena" of food choice. We interviewed on-the-ground stakeholders including breastfeeding advocates, nurses, African American civic organizations and community organizers. Working with local residents and MPH students from local universities, we completed on-the-street surveys, canvassing shopping malls, bus stops, businesses and health centers. We held focus groups for men and developed more in-depth surveys with mothers, for informing a richer tableau of understanding facts. In addition, local media scans covering a 12 month period were conducted to better understand what messaging around breastfeeding and food choice were being received in the community.

The First Food Good Food project draws on learnings from previous WKCF-funded, community-focused pilot projects in Birmingham, AL, Jackson, MS, and New Orleans, LA where a participatory research approach was used to create an on-the-ground community assessment tool specifically for first food research. Borrowing from these earlier pilot projects, our data collection instruments included seven surveys comprised of: healthcare professionals, hospitals, employers, childcare facilities, mothers, public places, and man-on-the-street. The surveys were based on The Surgeon General's Call to Action to Support Breastfeeding recommendations and targeted people and places that were most influential on a mother's choice to breastfeed.

We used secondary data sets to describe the physical/material conditions of the lived environment of the breast feeding moms, and we measured the attitudes of neighbors to by doing focus group interviews, surveys, and an adapted photo-voice test. We did in-depth interviews with community members- primarily the mothers, but also health care providers, grocery store owners, police, bar and restaurant owners, social workers, church leaders and educators. We checked exposure to mass media and advertisements as well. We tried to do in-home interviews, but learned community members were not comfortable with interviewing at home, preferring instead to meet at public places.

RESEARCH SPOTLIGHT: ETHNOGRAPHY

An ethnography is a research method within the realm of sociology. Ethnographies focus on the discovery of contexts, processes and meanings within cultural systems through the collection of field notes. These notes are taken while the researcher has immersed themselves in the socio-cultural context, and are exclusively observational. Field notes from an ethnography are then translated into a detailed case study.



Findings

Three overriding themes and several secondary themes emerged from our data that will provide the materials for future intervention in this neighborhood on decision-making and food choice, using a community-owned and based, participatory action research perspective. Our data collection created solid block of knowledge and we believe our method can be used as a replicable community assessment model.

THE POWER OF SELF

The mother is the primary “policy-maker” in infant feeding decisions and she is directly influenced by her social support network. Our findings reveal that there are multiple influential and motivational hierarchies for mothers and in the community overall on a variety of choices, including healthy food. Borrowing from Maslow, we assert that esteem and self-actualization are important drivers or conditioners for decision making around food, including for African American, low-income women. We opine that when women feel good about themselves they feed themselves and their infants better. Low levels of self-actualization and self-efficacy, heightened by debilitating socio-economic conditions preclude women from seeing a bright future for themselves or their babies.

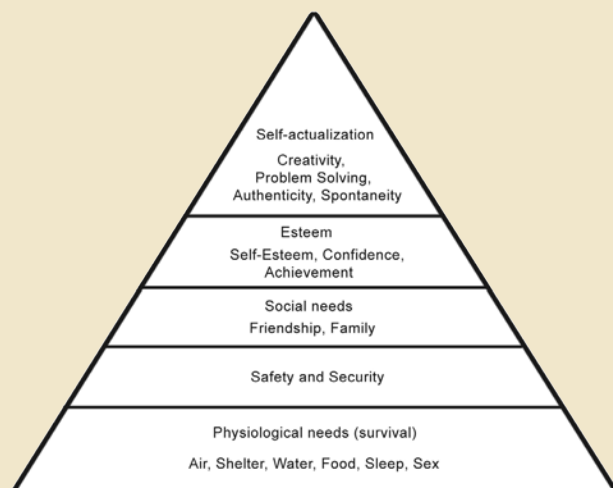
In those circumstances, mothers are more likely to formula feed. Many times, their decision to formula feed was based on a fear that their own milk would be of low quality due to their own poor diet. On the other hand, African American women with high levels of self-actualization were empowered to go against the status quo in the community, to defy societal and familial norms, and breast-feed, not being influenced by the opinions of others.

Thus, our interventions should tap into the historical gestalt within the African American community of strong, resilient and progressive women and frame breastfeeding as an empowerment tool and a good start for achieving other accomplishments in life. Such efforts should also provide positive, aspirational “mom” role models for parenting in general, understanding how other women were key influencers both positively and negatively.

“I had saw my friend and she had breastfed. She has two kids. She looked so nice. Her body. . .everything looked so nice. Everything went back. She said, “that’s what that breastfeeding will do!” So, I said, “well, Girl, I am going to be breastfeeding, too.”

MASLOW’S HIERARCHY OF NEEDS

Maslow’s Hierchy of Needs is a theory detailed by Abraham Maslow in his book Motivation and Personality (1954). His theory involved a pyrimad of concepts that a human must achieve in order to reach self actualization. From bottom to top: physiological needs, safety & security, love & belonging, self esteem, self actualization. One must acheive each need starting from the bottom of the pyramid in order to reach the peak. Examples of those whom Maslow believe had become self actualized are Eleanor Roosevelt and Fredrick Douglass.



This approach is supported by growing evidence connecting self-efficacy with breastfeeding duration. Improving self-efficacy and self-actualization can impact youth and adult food decisions as well.

Women who had a positive breastfeeding experience also reported a sense of pride:

"Now she don't have no problem latching on at all, she finds it on her own actually. She so smart. I was so sick. That's why they gave her the bottle at first. That's why it took her so long to latch on to me. It was frustrating. They would wake me up at all types of night in the hospital. It was difficult at first, I would get frustrated. But when I came home, I said, 'let me try it.' And then, my nipple don't hurt no more when she get on it, so I don't mind now that it feels good. She just come right on it. She finds it on her own. I mean she let's me know she wants it. I be like, 'this baby is so smart!' She finds it on her own. I would lay her on me, 'cause the doctor told me they like skin on skin touch and I would pull up my shirt and I pull up her. . .and she would find her way to...I be like, 'this baby is crazy!'"

Several men reported negative attitudes toward women in their community. Yet, when men don't appreciate the

women who are mothers to their children, they are less likely to support breastfeeding or trust the mother to do so correctly. Therefore, improving the self-esteem of mothers and their collective neighborhood perception by men can increase male support for breastfeeding and other positive parenting strategies.

BODY & RACE POLITICS

Mothers in our pilot community overly report issues related to the sexual nature of the breast and concerns of exposing themselves in public. *"I'm like, I can't do it. 'Cause I would be so embarrassed. I don't want nobody to see my boob."* Men expressed similar issues concerning their wife or partner potentially exposing herself in public.

"'Cause my boyfriend talkin' 'bout some, 'don't let us be on the bus and you pull out your breast on the bus...' and I was crackin' up. I was laughin'. I said, 'I'm not pulling out my breast on no bus.'"

Due to the perceived sexual nature of the breast in the modern western society, women fear breastfeeding in public. Some stated that it "not safe" to breastfeed as if exposing a perceived sexual object could spark unwanted attention or sexual advances. Others said that exposing their breast would be viewed as a sexual threat to other women.

“ Half these women don't care that much about their babies. They don't want to breastfeed because they want to drink and smoke. ”

—African American man
Security guard at local sneaker store

Both breastfeeding and eating wholesome foods were over reported as “acting white” and a strong sense of maintaining their racial identity in their community pervaded many conversations:

Interview Question: Who stereotypically breastfeeds and has good nutrition?

Respondent answer: White people. I’m just saying. White people because I don’t see a lot of Black people breastfeed.

LISTENING TO WIIFM (WHAT’S IN IT FOR ME?)

Much breastfeeding messaging has focused on the benefits of breastfeeding with little analysis of the cost/benefit ratio to mothers. Compared to the aggressive marketing of formula as quick and convenient, women report that breastfeeding takes time. Subsequently, in a food desert, finding healthy options takes time. And without basic cooking skills, preparing a meal from fresh ingredients (even if you can access them) takes even more time.

Meanwhile, low-income women are known to have multiple responsibilities in the extended family and in the community, making time a more precious commodity. The

high time demands associated with exclusive and extended breastfeeding may lead to an untenable situation for women who work or attend school. At the same time, the stress of poverty has been proven to be an overriding factor in health outcomes over poor food choices. In the “make ends meet”, ‘how do I get through today’ environment of many vulnerable communities, the long term health benefits may not seem worth the time investment right now. When a mother is preoccupied with the choice of paying an electricity or water bill or can I pay rent and purchase school supplies, the immediacy of these pressures may make it more difficult to think about how eating choices or first food choices will affect health five to 10 years from now.

Given these factors, future breastfeeding interventions should focus on creating immediate benefits and rewards for increased breastfeeding and making healthier food choices. When mothers can see more immediate benefits to prolonged breastfeeding for their families and themselves, they are more likely to continue to do so. If these benefits can be linked to reducing some of the day-to-day pressure of poverty and near-poverty then the potential for success is exponential.

“ ...future breastfeeding interventions should focus on creating immediate benefits and rewards for increased breastfeeding and making healthier food choices. ”

Secondary Themes

GRANDMA KNOWS BEST

As a highly matriarchal culture, African American parents and grandparents remain highly influential on decision making. As a seventeen year-old breastfeeding mother of a newborn, who lives with her grandmother, grandfather and uncle shared:

"I have a lot of influences. Like, my grandmom, she tells me stuff. I tell her, 'but my doctor said...' and my grandmom says, 'I raised so many generations, I know.' So I listen to my grandmom and the doctors. And, I listen to people who have kids."

Grandmothers and other older relatives were also extremely influential around broader food choices—'how grandma made it' and passed down ways of cooking superseded using healthier recipes or modifying cooking habits to be more health conscious.

LACK OF NUTRITION KNOWLEDGE

In general, Americans are fed conflicting messages about what is considered healthy eating. One day a study touts Vitamin X, the next day it recommends Superfood Y. These messages are particularly confusing in low-income commu-

nities with limited food options and limited resources for accessing factual information. In these environments, food myths can quickly become reality.

In like manner, breastfeeding myths about what breastfeeding feels like and "sagging breasts" become a community "fact" when there is no one or no place to correct mistruths. Greater education and a cultural understanding of what constitutes "healthy" eating is needed, as the concept of healthy can be personal and relative to other factors.

Interview question: What has made you change your eating habits?

Respondent answer: "Education...? I'm going to also say Dr. Oz. Yeah, the media. 'Cause I watch the news and watch Dr. Oz when I get a chance and I see what he—like they were just saying the other day that you don't even know—like your fruits and vegetables have so many, like sprays on them—what is it—pesticides—we put like 15 different pesticides on them and you wouldn't even know. So he said it is always best to get organic even though it is a little more expensive. He said it's always best to go with organic or Halal."



Conclusions

Understanding the complexities of food choice and food access, particularly in under-resourced communities, requires concerted effort on the part of food advocates, breastfeeding advocates and social justice advocates. Communities are in dire need of a cultural shift, not simply another well-stocked supermarket or a funded support group.

Just as a life course perspective has been applied to several areas of study in maternal and child health, a life course perspective including how we feed ourselves and how we feed our young, needs to be included in the current dialogue about creating a healthier America. The persistent gap in food access in vulnerable communities and the correlation to high rates of diet-related diseases need not exist. Similarly for the lingering racial

disparity in breastfeeding rates that often correlate to poor infant health and high infant mortality rates.

However, closing these gaps will take a deeper understanding of not just types of innovative programs needed, but a deeper understanding of the mental, physical and social health of the people they aim to serve and the places where they live. That includes understanding the key influences and marketing messaging they are most likely to respond to and a local knowledge of feelings of self-efficacy and self-esteem.

There must be a stronger connection between the individuals served and the historical, sociological and economic context of their lives. It is only in this structural and cultural framework that true social change can take place.





This article is accompanied by a larger report which includes the related literature review, research methodology and more advanced findings. To find out more, contact Common Market at info@commonmarketphila.org.

commonmarketphila.org

Design: www.anagramist.com. Photos © Common Market except where noted. Printed on recycled paper.