Transcript for "Community-Level Interventions to Improve Food Access and Health"

Featuring Darcy Freedman

Hosted by David Chancellor

In this podcast, Case Western Reserve University Associate Professor Darcy Freedman discusses her work on food access and health, with a focus on two studies that took place at the Right Choice, Fresh Start Farmers' Market in Orangeburg, South Carolina.

February 2015

[Chancellor] Hello, you're listening to a podcast from the Institute for Research on Poverty at the University of Wisconsin–Madison. I'm Dave Chancellor.

For this podcast, we're going to talk about community-level interventions related to food access and health.

I was fortunate to catch Darcy Freedman after she gave a talk at IRP in the fall of 2014. Freedman is an associate professor at the Case Western Reserve University School of Medicine in the Department of Epidemiology and Biostatistics where she also serves as the Associate Director of the Prevention Research Center for Healthy Neighborhoods. Her research focuses on engaging with community members to help create healthier environments and reduce health disparities, particularly those related to food insecurity. So with that, we'll turn to Professor Freedman to learn more about her perspective on the issue of food-related interventions.

[Freedman] For me, when I think about food assistance, I'm thinking about a population that is disproportionately burdened by a variety of health issues. Food assistance programs are potentially a strategy to improve diet and to improve access to foods, and so I'm interested in seeing how that could potentially be realized in a better way.

[Chancellor] When we think about people with food insecurity who have difficulty accessing healthy food, a lot of the analysis in recent years has been on food deserts and the idea that there's something geographical in nature about this problem.

[Freedman]The fact that we're now at a point where many Americans even know what food desert means, it's a part of our lexicon, it's a part of our common language. Congress is mandating that we actually map and assess food desertedness across our country. It's a sign of, on the one hand, a movement

among policymakers that there's more to diet and health than just the individual-level behavior. There's something about where we live and the opportunities we have available to us within our communities to access foods that influences that decision, ultimately what we end up putting in our mouths. So I think that that's really exciting because it's shifting the blame, if you will, away from individuals.

[Chancellor] But at the same time, Freedman cautions that we should be careful in how we think about food deserts because there's likely more going on than just lack of a grocery store. So, in some ways, a place's status as a food desert is really just symptomatic of a host of other issues related to poverty, inequality, and poor health.

[Freedman] What does it mean when a community doesn't have access to a full service supermarket? Or the quality of foods available in local stores is very poor or saturated in unhealthy things? You can buy any variety of Cheetos or malt liquor or tobacco but there's nary an apple or banana. The logical step that we've seen in many ways is to say "ok, let's put a store in the community," without really thinking about why is it that this community lacks a grocery store, a full service grocery store?

What is it that drives that sort of systematic process of food desertedness? It's not a random thing and so I think the point that I wanted to make in the talk today is that there is more to the table than just it's missing and then let's add it. Kind of that idea that the problem of food insecurity is lack of food, therefore a can drive is a good solution because a can drive is providing people with food. Similarly, the problem is that you don't have a store in your community, therefore the solution is to put in a store. It's a much more complicated intervention strategy, but it's not necessarily getting at the complexity of why we don't have a store here in the first place.

[Chancellor] In addition, developing intervention strategies is further complicated by the social dimensions of food. Freedman says that even if structural issues, like lack of a grocery store, are addressed, a person might not choose to get their food there.

[Freedman] If my people have been denied access for so long because of structural factors, it's physically not available, it's economically inaccessible, and now it's put in front of me, it doesn't mean now it's socially acceptable. There's this long history of research within community psychology and social psychology around this idea of food for us and food for them and the way that people were able to create their identities by categorizing food in that way. We're all doing that anyway, really. Religions are created, think of all the rituals and the social aspects of who we are that are created through food. Populations have done that, communities have done that. When they didn't have access and there was adoption of a new way, it doesn't necessarily mean that's a good way or a healthy way, or related in any way to your historical food ways, but was an adaptation to the reality of your of your world, of your social world.

[Chancellor] A key interest of Freedman's is learning how to promote healthier food choices in a community where structural factors have resulted in limited access and social factors might be driving unhealthy diet behaviors. So, Freedman and her colleagues wanted to test whether these sorts of barriers could be overcome by bringing a produce-only farmers' market to a community, and doing so in a way

that made use of resources that were already there and targeted people who had the most to gain from eating more fruits and vegetables.

[Freedman] I had been doing farmers' market research before I came to South Carolina and a lot of the work I had done had really been geared toward youth development and farmers' markets and farmers' markets associated with Boys and Girls Clubs. And as part of that work, an interest of mine was trying to think about how does a model work in a setting where you're mostly thinking about health? The doctor is one place where, fairly ubiquitously we're thinking about our health when we're in that context. So what would it mean to take this thing called a farmers' market and put it within the context of healthcare delivery and potentially integrate the idea of the market as a strategy within the context as a strategy for preventive medicine, kind of that Hippocrates notion of 'let thy food be thy medicine and thy medicine be thy food.' How do you implement that, enliven that in this health-centered context?

[Chancellor] Freedman and her colleagues ultimately developed a farmer's market in Orangeburg, South Carolina, a mostly rural county where there was a high rate of diet-related health conditions. And Orangeburg was home to a Federally Qualified Health Center or FQHC, which was where the farmers' market, called the Right Choice, Fresh Start market, was located. In early observations, the researchers began noticing that health center staff were able to interact with their patients in a different and less-hierarchical way at the farmers' market, so there was a change in the structure of these healthcare relationships. But there was still the question of whether the strategy of locating the farmer's market in the context of health care delivery would actually lead to people eating a more produce-rich diet—leading to better health outcomes—so they began looking for a way to measure this.

[Freedman] What's going to be the most compelling information to guide future efforts around this type of intervention strategy? And it was clear among the health center staff in particular at the FQHC, they wanted to know what was the influence of this farmers' market on the health of their patients and in particular their diabetic patients. And so we looked at, over the course of the season, before the market, midway through, and after the market ended, what were the dietary practices of a random selection of diabetic patients from the health center?

[Chancellor] For their first study, Freedman and her colleagues provided vouchers worth up to $50 over the course of a season to diabetic patients that could be used to shop at the farmers' market. The vouchers weren't valid elsewhere.

[Freedman] It was basically like free money they could use to shop at the farmers' market and we hypothesized that people who would improve their diet the most would be those that not only used the money they received as a part of the study but also were dipping into their own pocket to shop at the market. So it's kind of this really moving forward on a behavior change -- it's worth your own money to do it. Contradictory to what we had hypothesized, we found the people whose diet changed the most in terms of improvement in fruit and vegetable consumption were those diabetic patients who did not spend one dollar of their own money at the market. They relied exclusively on the incentive provided by the study to shop at the market.

[Chancellor] As it turned out, the group with the greatest changes in their diet was also very low income. This finding seemed to indicate that another barrier to making healthier food choices, in addition to structural factors and social factors, is just having the money to buy the food.

[Freedman] It was almost as if that economic barrier was the most pervasive barrier for them. There was a strong interest, there was a strong desire for the foods, but they literally did not have the extra money to do it. When that was availed to them, they used the money and consumed the food. At least based on their reports, they were eating the produce. I think for us as a part of that research, it became clear that this idea of incentive could potentially be a key strategy to improve diet among the lower-income population.

[Chancellor] This study then led to a larger incentive-based endeavor called the Shop N Save program. The Shop N Save program provided farmers' market customers one five dollar match per week if they spent five dollars or more at the farmers' market using any federal food assistance money such as SNAP, WIC, or other programs. The actual trial period of the Shop N Save program lasted for one season at the market and they found that a majority of the customers that enrolled in the program had not previously shopped at the farmers' market. Additionally, there was a significant uptick in the use of federal food assistance money at the market when the Shop N Save program was in operation and the overall receipts at the market saw statistically significant growth during that season.

[Freedman] And there was a lot of opportunity then to think about policy. And we did think about policy and what was the influence of that in terms of the sustainability of the market, not only in terms of bringing customers back and this idea of repeat usage, but also in terms of the economic vitality for these small-scale farmers participating in the program. So I think what we did in this particular project was to start small and when we had the lessons that made sense to us -- the questions were being driven by the community, when we started to interpret it, we started to see it made sense within that context, to think about, 'well, let's go to the next level. What would be a broader level strategy to build on this lesson?'

[Chancellor] Freedman's work, which is ongoing, shows how addressing the needs of food insecure communities, and in turn addressing health concerns, is a complicated thing to do. So, overcoming structural barriers to access alone is not likely going to lead to success. Ultimately, for these kind of interventions to be successful, they also need to operate in a way that makes sense, socially and financially, within the context of the community.

Thanks to Darcy Freedman for talking about this work with us. You've been listening to a podcast from the Institute for Research on Poverty.