

# Transforming the Urban Food Desert From the Grassroots Up A Model for Community Change

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Confronted by continuing health disparities in vulnerable communities, Community Health Councils (CHC), a nonprofit community-based organization in South Los Angeles, worked with the *African Americans Building a Legacy of Health* Coalition and research partners to develop a community change model to address the root causes of health disparities within the community's African American population. This article discusses how the CHC Model's development and application led to public policy interventions in a "food desert." The CHC Model provided a systematic approach to engaging impacted communities in support of societal level reforms, with the goal to influence health outcomes. **Key words:** *African Americans, community change models, food desert, public policy*

**D**ESPITE IMPROVEMENTS in health outcomes, the divide between minority populations and their white counterparts persists.<sup>1,2</sup> Continuing health disparities demand we go beyond traditional practices to develop policy and programmatic interventions. Research into social determinants of health enhances the socioecological model

(SEM) and creates a multidimensional perspective on individual, relationship, community, and societal influences on behavior. Despite progress in understanding the social determinants of health, their translation and practical application for improving health outcomes is often missing.<sup>3</sup>

This examination describes how Community Health Councils (CHC) and the African Americans Building a Legacy of Health (AABLH) Coalition, leveraged funding to develop and implement a model for community change. The model was developed to understand, assess, and translate the impact of social determinants of health on chronic disease into change at the individual, community, and societal levels. This case study links the development of the CHC model to 2 policy innovations: (a) *Market Opportunities* that provided incentives for food retailers, and (b) the Los Angeles City Council's South Los Angeles fast food *Interim Control Ordinance* (ICO).

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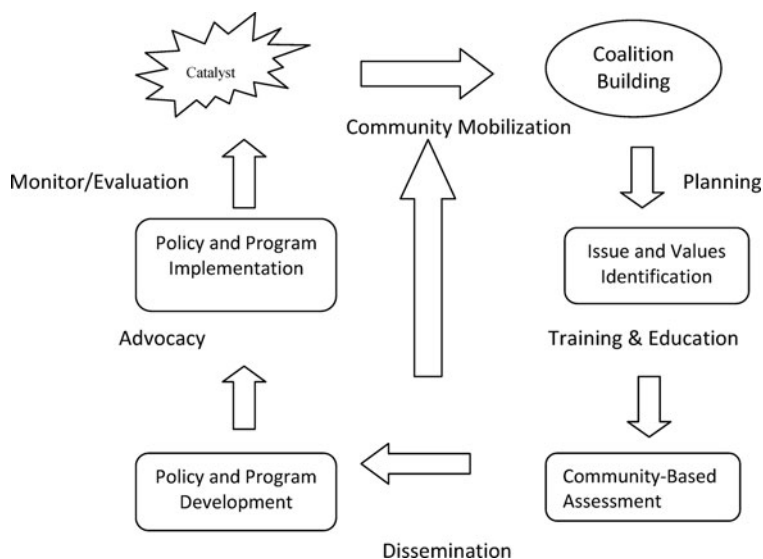
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## BACKGROUND

Disparities in health are embedded in the interrelationship of racism, culture and



**Figure 1.** CHC model for community change.

the historical, economic, and political structures that define the experience of African Americans and other racial and ethnic groups in the United States. The emergence of the obesity epidemic underscores the structural challenges that racial and ethnic communities confront when trying to sustain a healthy lifestyle, since access to healthier nutrition options and safe places for physical activity are often constrained.<sup>4</sup> These social constructs add critical dimensions to the physiological and behavioral risk factors conventionally associated with the disease.<sup>4</sup>

The CHC model for community change was based on scholarship that connected the social determinants of health to disparities in individual health outcomes.<sup>3,5-7</sup> (Figure 1) Social determinants of health are defined as “the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels, which are themselves influenced by policy choices.”<sup>8</sup> Understanding the role of social determinants took on particular urgency in the last decades of the 20th century as a generation of research documented that individual health outcomes differed by place, by race

and ethnicity, and by the level of poverty in neighborhoods and households.<sup>1,2,4</sup>

The CHC model was an effort to respond with policy innovations to these societal inequities. Researchers and community activists realized, as Wilkinson and Marmot<sup>6</sup> had written, if “policy fails to address [the impacts of social determinants], it not only ignores the most powerful determinants of health standards in modern society, it also ignores one of the most important social justice issues facing modern societies.”

**CHC MODEL FOR COMMUNITY CHANGE**

In 1999, CHC brought together organizations and individuals into the AABLH Coalition to combat health disparities with a focus on cardiovascular disease (CVD) and diabetes within the Los Angeles County African American communities. The CHC was awarded the Centers for Disease Control and Prevention Racial and Ethnic Approaches to Community Health (REACH) 2010 and REACH US cooperative agreements from 1999 to 2007, and from 2007 to 2012, respectively. These funds were used to develop and implement a Community Action Plan (CAP) that targeted 17 zip codes, representing roughly

35% of all African Americans living in Los Angeles County. The CVD mortality rate within the target area was 68% higher than the countywide average. The diabetes mortality rate within the target area was 37.9 per 100,000, almost twice the overall county rate.<sup>9</sup>

The CHC model evolved as the Coalition developed its response from a traditional, individual behavior approach to an innovative, institutional practices and policies approach that focused on community and societal change. The model allowed for a process to examine and assess the impacts of social determinants of health and helped to identify and develop policy and systems changes that would support improvement in the health outcomes of the target populations (Figure 1). Multiple methods were used to measure efforts of the AABLH Coalition, including participant surveys and structured interviews, meeting minutes and processes (which included developing the issue agenda, action items that coalition members volunteered, and additional follow-up on those actions at subsequent meetings), nutrition resources assessments, and ultimately, how the assessment results were used to mobilize various stakeholder groups.

At the core of the AABLH Coalition and the CHC model were the values of social justice, equity, and self-determination that support empowerment in vulnerable communities. As Baxamusa<sup>10</sup> has noted, the empowerment “process is not only multidimensional, taking on a different form in different people, contexts, and time; it is also multilevel: individual, organizational, and community.” The CHC model was dynamic, not static, building upon the knowledge gained from past interventions and innovations.

Through the CHC model, we implemented a community-based participatory approach tailored to each of the Coalition’s activities.<sup>11</sup> The CHC model built upon 3 of the 4 SEM levels of change.<sup>12,13</sup> Actions at the first level seek to transform the *individuals’* behavior to bring about an improvement in individual health status.<sup>13</sup> For the CHC model, this has meant recruiting and engaging residents in

discussions of the food environment in South Los Angeles, educating them on the importance of access to healthy food options, and mobilizing residents to talk to other residents, local food retailers, and their elected officials. Creating an awareness of the inequities in the local resource environment (and their health consequences) was the *catalyst* needed to start the change process.

The second level of the SEM, *relationships*, has a focus on families and networks and attributed only a marginal role in our project. AABLH was more interested in ways by which actions at the community and societal levels could influence individual behavior.

The third level explored the *community* settings with a focus on infrastructure that supported and/or impacted individual and community health. The CHC model sought to find ways to promote change in community culture by altering dynamics between intermediary institutions and populations they serve. This has involved working with a host of organizations with interests in South Los Angeles including local public agencies (e.g., public health, economic development), community-based and faith-based organizations, and private developers and businesses. The focus was on building a coalition that would be the center of all project activities, including issue and values identification, community-based assessment, policy and program development, and implementation. More importantly, since the coalition involved the relevant stakeholder groups and organizations, it was deliberately designed to strengthen the interrelationship between organizations and collaboration across sectors.

Finally, the *societal* level consists of factors that “create social and cultural norms,” including “the health, economic, educational, and social policies that help to maintain economic or social inequalities between groups in society.”<sup>13</sup> The CHC model focused on using bottom-up, community-based strategies to influence institutional programs and policies, and public policy reforms. A combination of traditional and nontraditional strategies were used to promote policy change.

Activities ranged from community meetings, writing letters to local officials, and local media outlets to community-based assessments of the resource environment, as well as ongoing conversations with food retailers and developers. With support from community residents and AABLH Coalition members 2 local policies have been adopted to date: (a) Market Opportunities: incentives for Food Retailers, where the AABLH Coalition gave input to public officials in developing an incentive package which has already led to an increase in the number of supermarkets and sit down restaurants in South Los Angeles; and (b) the Los Angeles City Council's South Los Angeles fast food ICO, which places a moratorium on new stand alone fast food restaurants in South Los Angeles.

To continue to assess the persistence and effect of institutes and structural racism at the societal level, the project is involved in ongoing efforts to monitor and evaluate the implementation of the adopted policies. This involves continuing to monitor relevant public agency meetings and city council hearings, interviews with key stakeholders, surveys with community residents and AABLH Coalition members, changes in existing food resources, and the development of new food resources in South Los Angeles.

In sum, the CHC model allowed the coalition not only to identify how systems and policies affected populations inequitably, but also to develop strategies that combat these inequities. Moreover, the CHC model prepared the community to play an active role in the implementation and evaluation of the relevant strategies. Additional details on the CHC model and its application are provided below.

### **APPLYING THE MODEL**

Residents' concerns with the quality of food in South Los Angeles actually occurred before the federal government's REACH 2010 initiative. In fact, concerns about the role of liquor stores, the loss of grocery stores in the nutritional resource environment of South Los Angeles, and later the rise of the obesity epi-

demically propelled action by advocates starting as early as the 1980s.<sup>14-16</sup> Advocates successfully promoted regulations that mandated liquor stores to obtain a conditional use permit; a process that promised to limit the number of new stores in the community. Later, a coalition of community groups tried unsuccessfully to persuade the major grocery chains to return to South Los Angeles.

More than ever, residents of South Los Angeles and their children needed improved nutritional resources to provide healthier food options and improve lifestyle choices.<sup>17-19</sup> The AABLH Coalition began to focus on policy and environmental change, and the experience and knowledge gained by the coalition would serve as a catalyst for the next stage of project development.

Berkowitz and Wolff<sup>20</sup> define community coalitions as groups "involving multiple sectors of the community, coming together to address community needs and solve community problems." The building and sustainability of an active and broad-based coalition was at the core of the CHC model. The coalition was the essential vehicle for engaging the community, expanding community leadership, and diffusing knowledge. As a coalition's membership may change with time and activity, its composition must reflect the diverse interests of the target community. Ultimately, 44 organizations and 77 individual coalition members were involved in the development of the CAP that defined the project goals, objectives and work plan. The members represented community service organizations, public health agencies, disease specific voluntary associations, academic institutions, faith-based organizations, and private sector vendors including hospitals, health plans, and consulting firms. Taking on various roles and responsibilities, these organizations reported their participation was due to preexisting relationships with CHC and/or their strong interest in health and health care for underrepresented groups.<sup>21</sup>

The AABLH Coalition mobilized different stakeholders as new data, conditions and circumstances demanded, reflecting the

dynamic nature of the CHC model. Although the original group was largely from the public health and community services sectors, non-traditional partners joined as the strategies and focus shifted to institutional and societal levels. These partners included the Los Angeles City Planning Department, Community Redevelopment Department, elected official offices, and the grocery store industry.

For the AABLH project, the development of the CAP served as a tool for building consensus around the activities as well as defining the issues to be addressed, strategy, and approach. Linking societal level issues like racism, economics, and culture with individual level behavioral and physiological risk factors was fundamental to the AABLH approach. Three strategic directions provided the framework of the CAP:

- **Recreating Community Norms through Education and Prevention:** intended to increase the social and organizational support system within the African American community for creating a healthier lifestyle.
- **Economic Parity through Community Development:** intended to increase access to resources that improve the health status of the community.
- **Policy and Institutional Change through Community Empowerment:** intended to increase the community's authority to develop policies that regulate behavior and delivery of services.

The strategic directions reflected the Coalition's belief that the question was not merely "do people have the will to change their health supportive habits?" but rather, "does the environment encourage or discourage healthy behavior?" As such, the AABLH Coalition plan went beyond conventional intervention practices and moved toward creating access to healthy nutrition. Knowing the environment and documenting its assets and liabilities for protective health behaviors were the first steps in a process that has yielded targeted policy interventions that have the potential to create a more supportive environment for healthy living. It is argued here

that the individual health behavior changes that are needed to improve health outcomes are inextricably linked to nutrition and physical activity resources that form the context in which such choices are made. As a result, the changes associated with policy interventions enhance healthy living and could lead to improved health outcomes. An assessment *by the community* of the community's resources and built environment was essential. The central principle of the assessment process was that the community partners worked collaboratively at every stage of the assessment from deciding what resources would be assessed, to how the resulting information would be analyzed and disseminated. The approach allowed CHC and its partners to use these assessments as a vehicle for building community awareness, community capacity, and ultimately policy advocacy.

A systematic assessment of the nutritional resource environment in South Los Angeles was conducted to gather baseline data.<sup>22</sup> The AABLH Coalition in partnership with university researchers and CHC staff developed a set of procedures and instruments that were used to complete 2 waves of assessments of the food markets and restaurant facilities in South Los Angeles in comparison to the West Los Angeles area, which has a larger white population and is more affluent than South Los Angeles (Figure 2).<sup>22-24</sup>

The assessments confirmed what many residents of South Los Angeles already knew; their health supportive resource environments had critical gaps compared to West Los Angeles. Specifically, food markets were significantly less likely to carry items needed for a healthy diet such as fresh fruits and vegetables, and restaurants were significantly less likely to prepare healthy foods and allow food substitutions such as brown rice for French fries. As the Table 1 shows, each grocery store and restaurant served more people in South Los Angeles than in West Los Angeles. In addition, South Los Angeles had fewer supermarkets as a percentage of all markets, and a greater proportion of fast food restaurants than West Los Angeles.<sup>23,24</sup>

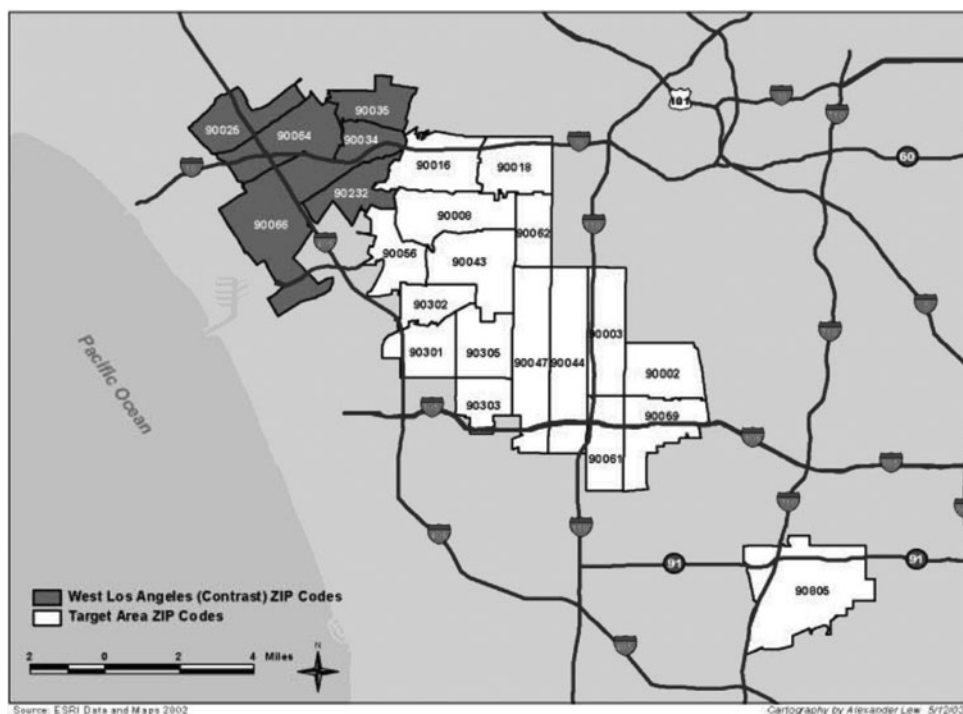


Figure 2. AABLH target and comparison areas by ZIP codes in Los Angeles.

The assessments galvanized the AABLH Coalition. First, the process empowered several local churches to participate in the surveying methods or to conduct community surveys and to work within the Coalition more

Table 1. Nutritional Resource Environment of Project and Comparison Areas, 2002-2003

Community Context	South Los Angeles	West Los Angeles
People per Grocery Store	5957	3763
Supermarkets (% of Total Markets)	5%	29%
People per Restaurant	1910	542
Fast Food Restaurants (% of Total Restaurants Surveyed)	25.6	11.2

energetically. Second, the results emboldened residents to speak with their neighbors and policy makers about the assessment results, and their implications for the community’s health. Third, systematic documentation of the disparity between South Los Angeles and the comparison area brought attention from multiple media outlets, including the *Los Angeles Times* and other community newspapers, radio, and television. Finally, the assessments created the justification for policy change, through procedural shifts such as the creation of an incentive package and through local legislation.

The development and articulation of the policy and program development was based on the analysis of the community assessments. The strategy was examined from the vantage point of multiple stakeholders to ensure appropriateness and relevancy in connecting the problem to possible solutions. Along with other groups in the public health movement,<sup>4,15</sup> the Coalition crafted public

policy interventions and changes in the urban planning processes to evoke a community and societal response to the chronic disease burden in the African American community.

## RESULTS

Two local policy changes that resulted from the AABLH Coalition's implementation of the CHC change model in South Los Angeles. Policies include: (a) *Market Opportunities: incentives for Food Retailers*, a multiagency incentive package, that intends to attract new grocery stores and sit-down restaurants into vulnerable communities; and (b) an Interim Control Ordinance that halts permits on opening new fast food restaurants to allow local residents and public officials time to develop a plan to manage the local food environment in an effort to improve health outcomes.

### Market opportunities: incentives for food retailers

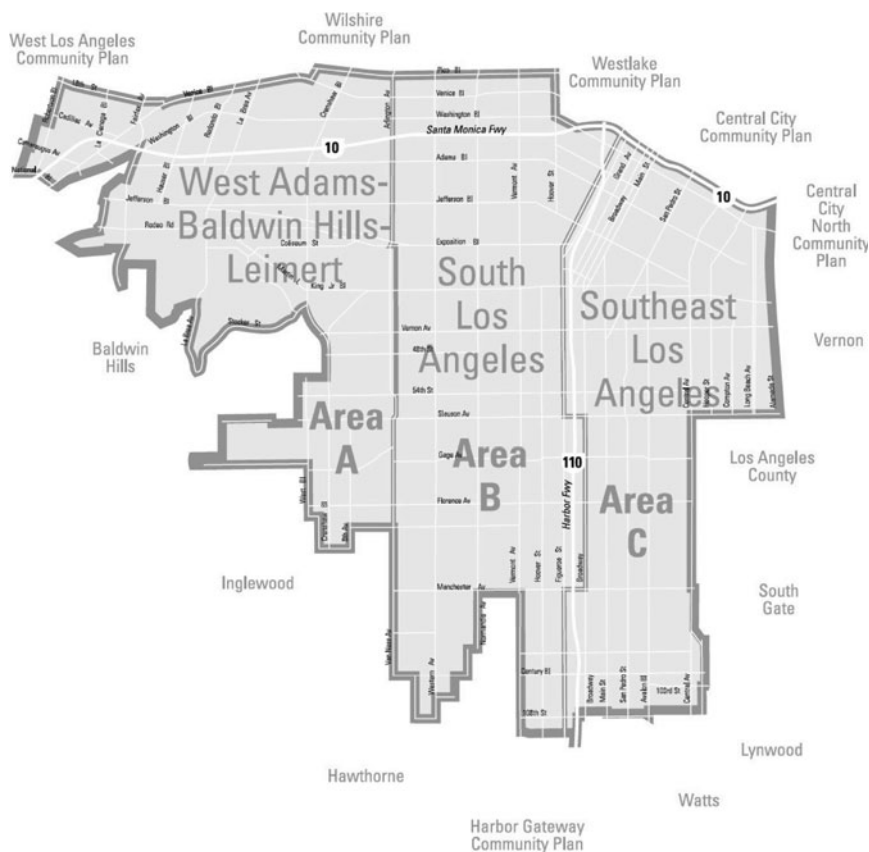
The AABLH project convened representatives from public agencies that addressed economic development and planning concerns, private developers, and food retailers to develop strategies for bringing in new vendors to provide healthier options to South Los Angeles. The community was educated on the general development process and the specifics of land assembly, redevelopment practices, and the barriers to development success. Research used by the City of Los Angeles Community Redevelopment Agency documents that within a 2-mile radius of 5 intersections in South Los Angeles, residents were spending \$119 million to \$260 million annually on food for the home and another \$74 million to \$173 million on food outside the home.<sup>25</sup> Given the data and the assessments, the AABLH Coalition was able to argue the "business case" for the need for additional financing and policy options to sustain healthier nutritional resources in South Los Angeles. Equally important, the assessment information was used to make the "political case" for policy change, as the results were shared with South

Los Angeles elected officials and their representatives. Moreover, South Los Angeles City Council representatives consistently attended meetings convened by the AABLH Coalition.

The elected officials convinced city departments to develop an incentive package that supports the development of new markets and sit-down restaurants in under resourced areas like South Los Angeles. As a result, the motion was approved in November 2006, during the Los Angeles City Council review and vetting processes. The package did not include dramatic new financial commitments. Instead, the departments and community advisors crafted a package that highlighted existing resources, incentives, and programs related to financing, energy discounts, planning, and technical assistance. The incentive packages are available to grocery stores with at least 12 000 square feet; restaurants with seating capacity for at least 30 persons; and produce markets that dedicated 90% or more of their floor space to fresh fruits and vegetables.<sup>25</sup>

Efforts to expand use of the incentive package included the South Los Angeles Community Redevelopment Agency developing a marketing strategy for the grocery store component of the food retail incentive program and the AABLH Coalition organizing a food market symposium.<sup>26</sup> In April 2009, the symposium brought together over 100 people representing supermarket companies, government, and economic development officers to discuss possible deals for new markets in vulnerable communities. Representatives from 1 food market chain that participated in the symposium were among those corporations committed to opening stores in South Los Angeles.

In September 2009, a Superior Grocer store was included in the Central Village Apartments mixed-use project. This \$26 million project included a \$3 million investment from the City of Los Angeles. A Fresh & Easy Neighborhood Market opened in February 2010 as part of a mixed-use development, in which the city invested \$5 million of the \$42 million total development costs.



**Figure 3.** Fast food interim control ordinance boundaries.

**South Los Angeles ICO**

Fast food restaurants play an adverse role in the obesity epidemic and chronic diseases.<sup>27,28</sup> To illuminate this issue in the South Los Angeles community, the community assessment and public testimony by AABLH revealed to elected officials the importance of such an ordinance to community well-being.<sup>22,24</sup>

On May 2007, City Council members introduced an ordinance to prohibit the establishment of new fast food restaurants in South Los Angeles for at least 2 years. The ICO, prevented new stand-alone fast food establishments from opening in 3 South Los Angeles community planning areas (Figure 3). The 3 planning areas—West Adams-Baldwin Hills-Leimert Park, South Los Angeles, and Southeast Los Angeles—are the segments of the city

covered under the ICO. More importantly, these community planning areas are used by public agencies as they make development decisions regarding particular communities and are currently being updated. Consequently, the ICO also has allowed the South, City of LA Department of City Planning and the AABLH Coalition time to research additional means to improve access to healthier food and to prevent further land use associated with the overconcentration of fast food restaurants.<sup>29</sup>

The ICO was extended through September 2010. The lack of healthy nutrition resources in South Los Angeles fueled the adoption of the ordinance and has been translated by the City of Los Angeles Planning Department, into possible “healthy eating zones” in South Los Angeles. Suggestions from the AABLH Coalition and others were developed into a series



of recommendations to be included in proposed Community Plan updates in South Los Angeles and presented to the Council in 2011. Consideration is also being given to extending the regulation of fast food restaurants to the oversaturation of convenience stores.

## CONCLUSION

There is evidence that institutional and structural racism continues to affect the health of racial and ethnic communities and limits success at the societal level.<sup>30</sup> More analysis is needed to examine the extent to which the practices, policies, and systems for the allocation of resources create advantages based on race.<sup>4</sup> However, influencing policy at both macro and micro levels is a comprehensive means of tackling the social determinants of health. This approach required relationship building, perseverance, and patience. The CHC model for community change utilized multidisciplinary collaboration, assessments, strategic planning, and other components that showed promise as effective methods for solving complex public health issues. Research indicates that interventions that improve the social and physical environments are more likely to show lasting positive health outcomes.<sup>31</sup> By empowering collaborators, the CHC model shifted power to community partners who had gained knowledge and skills. Since these partners are largely from vulnerable minority communities, the CHC model in part addresses intractable structures surrounding race and class embedded in the typical policy making processes.

Achieving policy change does not necessarily insure effective policy implementation.

In both the cases of the ICO and the multi-agency incentive package, the policy and regulations were successfully moved through the policy process. Yet, the incentive package has had only minimal impact so far. The moratorium only laid the foundation for further work in the community plans, which has been stalled by budget cuts and concerns in the City of Los Angeles Planning Department. More support should be placed in policy efforts and city planning processes, as they have the potential to significantly change community supports for healthier options. The link between policy and planning efforts to develop healthy places and health outcomes continues to be an empirical question. As such, the AABLH Coalition will continue to collaborate with City Planning, the Community Redevelopment Agency, the Metropolitan Transit Authority (METRO), and other public agencies as they revise community and transportation plans for South Los Angeles. CHC and its partners are also working with the Los Angeles Department of Public Health and local foundations as they work to create a healthier South Los Angeles. Ongoing evaluation will track long-term health outcomes.

Finally, applying the CHC model of community change not only empowered the Coalition and community residents to speak with authority to policymakers, but they also learned the need to adapt in a changing environment. Even as the policy environment evolved, the AABLH Coalition continued to focus on food issues with renewed confidence, knowledge, clarity, and policy innovations. As such, we believe the lessons learned in this local project underscore the value of an engaged and empowered community voice.

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