

Public Markets and Community Health: An Examination

Prepared for: **Project for Public Spaces**

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I. INTRODUCTION & BACKGROUND

A. ABSTRACT

It has been increasingly recognized that farmers markets and public markets (“markets”)* play an important role in public health beyond providing fresh fruits and vegetables. Some markets are providing health information and linkages to critical health-related services, some are the outcomes of the products grown in community gardens, some initiate youth education and empowerment, and some are directly linked to community development corporations. Overall, markets are, or can be, neighborhood destinations and public-gathering places where community members are provided with a mechanism to participate in collective action towards strengthening social networks and enhancing civic engagement.

Further, markets also serve the role as the agent within a larger community network – for economic revitalization, upward mobility, individual empowerment and social integration of demographically dynamic local communities, connections between our farms and communities to create sustainable food systems, and bridging between urban and rural landscapes. Thus far, the potential influence of markets on health has not been fully recognized, nor has this potential been fully realized. A number of serious health issues around the country, such as obesity, diabetes, cardiovascular diseases, and respiratory diseases, affect people of all ages and socioeconomic classes. Moreover, such issues disproportionately hit marginalized and disadvantaged populations. Such health issues distress the overall well-being of a community’s residents and is a significant hindrance on the economic stability and levels of civic participation of both markets and community residents.

The Ford Foundation and Project for Public Spaces (PPS) commissioned this summer study to examine the markets’ role in achieving broader impacts of health based on the following premise:

- 1. Markets have a significant potential to contribute in economic development as well as social development of a neighborhood and the people;**
- 2. The degree of success in such development efforts depends on the status of the community health.**

The following were established as the main objectives of the study:

- 1. How can the institution of public and farmers markets influence the health challenges of the twenty-first century? Can they play a role to help alleviate some of the hurdles of social determinants?**
- 2. How can public health influence markets to help realize the “double bottom-line”: The market profitability and the community health achievement?**

Sections I-B describes the background of Ford Foundation’s focus on community development for dynamically transitioning neighborhoods and accounts for its interest in this research; Section I-C offers the summary of the literature review part of the research.

Section II-A lays out the justification of the ecological model as our theoretical foundation, and Section II-B the organization of the research including the two roundtable discussions, site visits and phone interviews.

Section III-A details the result of our roundtable discussion, as follows:

1. The potential ways or mechanisms by which public markets can impact and influence community health, which then got constructed into our *Market-Health Continuum*;

2. Key stakeholders who could be important institution players in addressing community/public health concerns in the context of the markets; and
3. Various programmatic possibilities that markets and their partners can take to facilitate the development of social capital and civic engagement in market communities, focusing on the neighborhood level of the *Market-Health Continuum*.

Section III-B analyzes and summarizes the site visits & phone interviews conducted throughout the summer.

Section IV-A further explicates the Section III-B by presenting observations and reflections on the site visits and phone interviews, as well as some lingering considerations on how to go forward upon the completion of the research.

Finally, in Section IV-B, a set of recommendations are given in two parts, addressing the main objectives of the research: **Structural Relationships** with alternative sponsorship roles suggestions, and **Neighborhood Change Mobilization** suggestions. We are hopeful that markets may be in a ripe position to take on the task of alleviating some of the burden of social determinants of health and thereby advancing the neighborhoods' and their residents' economic and social statuses. As well, public health sector, within the framework of social determinants of health, can play a leader role in facilitating and mobilizing such a movement by the means of collaboration with community economic development sector and the markets.

** We use the general term "markets" throughout this document to indicate both public markets and farmers markets.*

B. INTRODUCTION

Ford Foundation's Active Public Space Development Initiative for Shifting Sands Communities

The commissioned summer study is the Ford Foundation's effort to 1) define public health impact within the context of community development and 2) connect the economic benefits of markets as an active public space to their potential health impacts. Community development – the organized effort to address structural inequities, building assets of poor and marginalized communities to improve their quality of life in the places and regions where they live and work – has profound history with Ford Foundation's commitment dating back to the 1950s. The Community Development field in the United States grew out of the Civil Rights Movement of the 1950s and 1960s, led by African Americans and their allies to address rural and urban poverty, social injustice and race disparities in the United States.

As the face of poverty has changed during the last 50 years, the community development field has evolved toward more sophisticated programs for addressing these dynamics. The 1960's saw the rise of community development corporations (CDCs), invested by foundations and federal government. The field matured in 1970s and 1980s, as banks and other prominent financial institutions emphasized physical development and technical proficiencies to go to scale, while the focus moved away from the eradication of poverty, and economic and racial injustice. This process placed a greater premium on the production of physical outputs such as affordable housing units and commercial shopping centers. Community organizers embarked on a parallel but different track to address festering social inequalities that remained from the 1960s. These advocates turned their attention to new forms of injustice such as the lack of access to financial services and discriminatory housing practices. By the last decade of the twentieth century, community development field was confronting a host of new challenges – globalization and the loss of regional competitiveness, changing demographics of neighborhoods with new class and race dynamics, new migrations, fiscal stress on older suburban communities, and the rise of environmentalism and the growing awareness of environmental injustice. Community development actors and practitioners were challenged to develop a greater understanding of the regional forces that continue to generate concentrated poverty and widening inequity in race, class and gender in cities, suburbs and rural areas.

In sum, equitable distribution of wealth and a rise in people's social capital were not necessarily predisposed by achievement of community economic development. It would then be fair to say that the 1990s' emphasis on sparking investment in distressed neighborhoods has given way to the twenty-first century emphasis on managing growth.

Ford Foundation's Common Assets for Communities Portfolio within the Community and Resource Development Unit includes Active Public Space Development initiative. It pursues two distinct strategies to nurture social integration and upward mobility opportunities for low-income families within communities experiencing market pressures and significant changes in demographics:

1. To overcome the social isolation and concentrated poverty by supporting mixed-income real estate development that combines place-based physical improvements with explicit people-based interventions.
2. To reposition the use of public space, to transform dormant or underutilized public space from a passive amenity into an active community asset that promotes individual economic mobility as well as social cohesion.

The strategies focus on the interplay between physical development and social and human development within communities experiencing dramatic shifts in demographics and market forces. It is not enough for poor communities to try to lift themselves up by their boot straps. In order to address the challenges of poverty, such communities must seek to gain access to a fair share of society's common access. At the same time, communities must seek to build common assets, social, financial and physical capital in local institutions and neighborhoods.

The influence of public space, in particular, on the field of community development has largely centered on its role as an amenity to complement affordable housing and commercial or institutional development, such as schools or public health clinics. Public space is also used to mitigate anticipated impacts resulting from high-density development.

Active Public Spaces such as public markets are being examined through this portfolio as a possible resolution for several longstanding dilemmas, the essence of which is the accelerated changes in the mix of peoples, places and institutions within neighborhoods undergoing transformation. Such dilemmas include the following:

1. People vs. Place: This classic dilemma has new dimensions as we see increased fluidity of market forces, populations, and land uses. The Foundation is characterizing such neighborhoods as *Shifting Sands Communities (SSCs)*. It is believed that a balanced approach to the development of people and place should focus on resolving temporal challenges that misalign complementary, but separate, development objectives.
2. Formal vs. Informal Economies: Community economic development approaches have traditionally been premised on linear upward mobility paths from the informal to the formal sectors. Over the last decade, new measurement tools have emerged to more fully capture economic participation and value within SSCs. However, points of intervention particularly for conventional community development corporations (CDCs) and community development financial institutions (CDFIs) remain elusive. The Foundation through its Active Public Space Initiative is targeting dynamic places such as public markets as key venues to support the convergence between the formal and informal economies.
3. Stock vs. Flows: The field has seen recent advances in research methodologies to examine precise changes within shorter intervals in neighborhood, community and regional indicators. Such refinements allow analysts and practitioners to evolve from more traditional stock analysis to the measurement of flows. A priority funding area for the Foundation is research and reflective practice on three central outcomes related to mixed-income, mixed-race development. The Foundation is focusing on understanding and advancing the relationship between resiliency, social integration and upward mobility.
4. Individual vs. Community Assets: The assets framework is central the Foundation's approach to community development. Much work has been done domestically and globally on managing natural assets and on building financial assets to benefit the poor while responsibly preserving resources. However, the interplay between common and individual assets is a new frontier that is beginning to be explored through cross-programming.

Community Development, Public Markets and Public Health

A notable area of challenge is in promoting widespread civic participation across race, class and age. In particular, a trend has been observed that dominant voices drown out those of the marginalized. The marginalized is mostly poor, but not necessarily; they are always socially isolated. It has also been noticed that there are significantly more impediments that the marginalized encounters than the middle class – be it employment, financial wealth, housing, education opportunities, health as broadly defined, etc. – and they have less resources to overcome such impediments. Within the context of the public markets and public health in the transitioning neighborhoods (so called "Shifting Sands Communities"), this summer study idea was prompted to investigate whether any of them has health challenges and concerns that preclude them from:

1. Adapting to or surviving in the changing neighborhoods at the individual level,
2. Benefiting from them to achieve upward mobility at the individual level, and/or

3. Actively participating in civic engagement and towards social integration, making sure their voices are heard, therefore shaping the future of the neighborhood at the community level.

The following hypotheses are therefore emerging:

1. Can investments in more active public space in transitional neighborhoods elevate the voices of the poor?
2. What is preventing them from fully participating in civil society?
3. What interventions are needed to level the playing field?
4. Can the community development sector embrace public health approaches to promote more equitable neighborhoods?

Are public and farmers markets ripe for building bridges that link community development and community health in transitional neighborhoods?

C. GENERAL BACKGROUND

Social Justice and Social Determinants of Health

Social justice is the foundation of public health¹. As defined by the World Health Organization (WHO)², health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The focus of public health – the science and practice of protecting and improving the health of a community – intervention is to *prevent* rather than treat a disease, through means such as preventive medicine, health education, control of communicable diseases, application of sanitary measures, monitoring of environmental hazards, food security, adequate and affordable housing, economic stability, community development, civic engagement, human rights, safety and social justice. Public health as a discipline arose as an organized governmental and public response to the negative consequences of industrialization. The notion was powerfully articulated by nineteenth century proponents of “social medicine,” who noted strong relationships between health and the dire housing circumstances, poor sanitation, inadequate nutrition and horrendous work conditions that the poor had to endure at that time. This social pattern of the industrialization age led Rudolf Virchow, a German physician and the “Father of Modern Pathology”, to declare that “public health and medicine is a social science and politics is nothing else but medicine on a large scale. ...if medicine is to fulfill her great task, then she must enter the political and social life. Do we not always find the diseases of the populace traceable to defects in society?”³

Nevertheless, this perspective has not always remained prominent. In the late twentieth century, the decline in infectious diseases shifted the public health focus to non-communicable diseases and individually based biological and behavioral risks for ill health. While this perspective has been enormously successful in providing information that has helped reduce individual risk, and thereby improve population health, its dominance has also promoted downplaying of social conditions as fundamentally important causes of ill health. Social factors were viewed as *clues* or *outcomes* instead of *causes*. This approach fails to explain social gradients – gradients in morbidity and mortality associated with socioeconomic stratification. The social gradient in health refers to the fact that inequalities in population health status are related to inequalities in social status⁴. Such gradient is one of the dominant features affecting the health situation of all industrialized countries, and the famous Whitehall Study of British civil servants showed that amongst people who are not economically poor, there is a social gradient in mortality that runs from the bottom to the top in each society⁵. Members of lower social “strata” experience worse health by virtue of their social positions, and in turn the less health individuals tend to drift into lower social positions⁶. In brief, the social gradient in health status may be attributed not only to socioeconomic and demographic indicators factors such as household income, education level, employment status, age, gender, and domestic status, but also to factors linked to people’s social status such as stressors, control, self-esteem, social support, and social involvement.

A revitalization of interest in social and economic factors in health has therefore occurred in the recent years, within social epidemiology and medical sociology. Instead of reckoning social conditions as mere correlates or clues pointing the way to true causes, part of the field of public health claims that social conditions are fundamental causes of health inequalities. As social and economic inequality widens more dramatically and becomes impossible to ignore, the connection between the vulnerability of people who live on the margins and the importance of working together collectively as a community for the public

¹ Krieger, Nancy and Anne-Emmanuelle Birn (1998). ‘A Vision of Social Justice as the Foundation of Public Health: Commemorating 150 Years of the Spirit of 1848’, *American Journal of Public Health*, 88(11): 1603-6.

² This definition was part of the Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States and entered into force on 7 April 1948. The Definition has not been amended since 1948.

³ Virchow, Rudolf. 1848/1985. *Collected Essays on Public Health and Epidemiology*. Cambridge: Science History Publications.

⁴ Kosteniuk, J., Harley D. Dickinson. 2003. Tracing the Social Gradient in the Health of Canadians: Primary and Secondary Determinants. *Social Science & Medicine*. 57: 263-276

⁵ Marmot, M., G. Davey Smith, S. Stansfeld, et al. 1991. Health Inequalities Among British Civil Servants. The Whitehall Study. *Lancet* 337: 1387-1393.

⁶ Wilkinson, R. G.(1994). The epidemiological Transition: From Material Scarcity to Social Disadvantage? *Daedalus*, 123 (3), 61-77.

good has become more salient. A clearer picture is emerging of the relationship between community-level well-being, resources for basic infrastructure, economic equality and good health.⁷

Social determinants of health, the “causes of the causes”, are the socioeconomic conditions that influence the health of individuals, communities and the society as a whole. They not only determine whether individuals stay healthy or become ill (in the clinical sense – narrow definition of health), but also the extent to which a person possesses the physical, social and personal resources to identify and achieve individual aspirations, satisfy needs and cope with the environment to become upwardly mobile. They include both the quantity and quality of a variety of resources, such as:

- Affordable housing,
- Employment/unemployment and job security,
- Standard of living,
- Social status gradient,
- Availability and quality of mass transportation,
- Education,
- Social services,
- Crime rates,
- Air and water quality,
- Forms of economic development,
- Racial/ethnic (in)equality,
- Income level,
- Poverty,
- Workplace conditions,
- Social inclusion/exclusion,
- Social cohesion/support, and
- Food security.

Without equal access to these social determinants, individuals not only become more vulnerable to stress and disease but are also more likely to lack access to resources that enable them to fulfill their capacities and experience well-being. This phenomenon is even more amplified in the communities going through change, as those with the greatest burden and vulnerability do not have the voice to participate in shaping the dynamically transforming community. They will eventually lose out from the compounding stress – physical, mental and social – in addition to the survival struggle they face. Why, then, the unequal access? What is it that some people do not have that some others do?

Democracy, Health Disparity and Food

The Nobel Prize-winning economist Amartya Sen argues that overcoming these problems of inequity is a central part of the exercise of development. In his words, “development requires the removal of major sources of unfreedom: poverty as well as tyranny, poor economic opportunities as well as systematic social deprivation, neglect of public facilities as well as intolerance or over activity of repressive states.”⁸ Emancipating individuals from poverty – poor material conditions (economic poverty) as well as the lack of social participation (social poverty) – requires actions at the societal level. This leads to successful development, offering freedom and building democracy.

Sen also points out that “the close link between health and economic and social development means that we can examine health to tell us if a society is fostering well-being in its members.”⁹ The causes that give rise to this social gradient in population health within a society come from broader perspective. And health is an important indicator, or a symptom, of such underlying root causes. Therefore, certain signs

⁷ Institute of Medicine. *The Future of the Public's Health*. Washington, D.C.: National Academy Press, 2002.

⁸ Sen, Amartya. 1999. *Development as Freedom*. New York: Alfred A. Knopf

⁹ Sen, Amartya. 1992. *Inequality Reexamined*. Oxford: Oxford University Press.

of population health, such as the current obesity epidemic, reveal the level of economic and social disparity, and thus society's ill-being.

Taking the example of obesity – it is the number one risk factor for poor health in the United States. Nationally, the proportion of obese children has tripled since the 1970s with approximately fifteen percent of all children falling into this category¹⁰. The situation among adults is also distressing. As many as thirty percent of US adults are considered obese (BMI¹¹ > 30) and an additional thirty-five percent are overweight (25 < BMI < 30)¹². Obesity in adults is associated with a long list of chronic diseases that include diabetes, hypertension, cardiovascular diseases, arthritis, stroke, depression, and some cancers. Compounding the resultant pain, suffering and death are the greatly increasing costs to society in terms of human loss and medical expenses. Recent estimates place the annual direct medical costs of the epidemic at \$92.6 billion, and preventable deaths related to physical inactivity and poor diet are increasing.^{13,14}

Nevertheless, national data are often inadequate to describe the magnitude of the obesity epidemic in some US communities such as certain immigrant or ethnic communities of low-income level. For example, national studies show that the status of East Harlem residents' health is significantly poor when compared to the national average. Stricken by a heavy burden of illness and mortality, East Harlem health ranks in the bottom ten compared with forty-one other New York City neighborhoods¹⁵. One in five young and old East Harlem residents has diabetes, and as much as forty-five percent among the public housing residents¹⁶. This is the result of chronic shortage of affordable and accessible healthy food (malnourishment) for all of East Harlem's residents and habitual consumption of large numbers of calories (unbalanced overeating). Further, this result is intimately linked to the neighborhood's poverty and poor economic development.

The issue of obesity takes our attention to food. Food – and food security – is one of the social determinants of health as mentioned above – what we eat and how we eat contributes significantly to mortality, morbidity, and steeply rising health care costs. Poor nutrition is a risk factor for four of the six leading causes of death in the United States – heart disease, stroke, diabetes and cancer¹⁷. In conjunction with these data, it is also interesting to note that fifty percent of United States premature mortality is caused by behavior factors and twenty percent environmental factors¹⁸. In sum, a majority of individual health problems are caused by behavioral and environmental factors, which is then molded and constrained by food deficiency of the community.

Social Exclusion and Social Capital

In many communities, social exclusion is closely linked to poverty or deprivation in a population. Social exclusion refers not only to the lack of economic resources but also incorporates the notion of the process of social marginalization. The term also relates to cultural aspects of exclusion and discrimination, and refers to the relationship between the included and excluded. In brief, social exclusion is about multi-dimensional disadvantage in different degrees. Generally speaking, those who are more socially included

¹⁰ Federal Interagency Forum on Child and Family Statistics. *America's Children: Key National Indicators of Well-Being*, 2003. Federal Interagency Forum on Child and Family Statistics, Washington, DC: US Government Printing Office, July 2003.

¹¹ Body Mass Index (BMI) is a number calculated from a person's weight and height. BMI provides a reliable indicator of body fatness for most people and is used to screen for weight categories that may lead to health problems. A BMI from about 21-25 is considered normal; a BMI between 25-29 is considered overweight; and a BMI over 30 is considered obese.

¹² National Health and Nutrition Examination Survey 1999-2002.

¹³ Finkelstein EA, Fiebelkorn IC, Wang G. National Medical Spending Attributable to Overweight and Obesity: How Much, and Who's Paying? *Health Affairs* 2003; W3:219-226.

¹⁴ Mokdad AH, Bowman BA, Ford ES et al. Prevalence of Obesity, Diabetes, and Obesity-Related health Risk Factors, 2001. *Journal of American Medical Association* 2003; 289:76-9.

¹⁵ New York City Department of Health report – Community Health Profile (www.nyc.gov/html/doh/downloads/pdf/data/2003nhp-manhattanc.pdf)

¹⁶ BBC news "New York City's Battle Against Diabetes" on January 26, 2006 (news.bbc.co.uk/2/hi/americas/4643704.stm)

¹⁷ Anderson RN, Smith BL. "Deaths: Leading Causes for 2001" *National Vital Statistics Reports* 52(9):1-85. Centers for Disease Control & Prevention, National Center for Health Statistics.

¹⁸ Institute of Medicine. *The Future of the Public's Health*. Washington, D.C.: National Academy Press, 2002.

have greater access to resources – economic mobility, educational opportunities, social networks, health information and health care – and those who are excluded are denied these.

Relatedly, social capital refers to resources such as the norms, the social networks, and the inter-generational, inter-personal and community relationships that result from being closely engaged in the society to which one belongs. Further, such resources enhance the individual's or a group's ability to function and achieve a given set of desired goals and objectives.¹⁹ Since the beginning of the industrial age, as income disparity, poverty and economic disadvantage started affecting the poor inner-city communities experiencing rapid demographic transitions (especially African American), the residents experienced neglect, abandonment, crime and ill-health, thus destroying the social networks. Disinvestment and displacement – through urban renewal, gentrification and tension caused thereof, etc. – caused Africans, aborigines and other minorities, rural peasants and city dwellers to be disassociated from the place they reside. In cutting the roots of many people, language, culture, dietary traditions and social bonds of the peoples are destroyed. Such displacement results in “root shock”, the traumatic stress reaction to the destruction of all or part of one's emotional ecosystem.²⁰ Once in a vicious cycle, individuals and thus the community to which they belong, become even sicker and more depressed, and thus more stressed and isolated, and so on.

Such phenomenon is intensified in the context of shifting sands communities. The current situation in New Orleans post-Katrina is the ultimate example of such “root shock”, in such a circumstance. Though caused by a natural disaster, the landscape of its aftermath is closely connected to the community's previously existing poverty and the lack of social capital. Since the disaster, the entire community is forced upon migration, severed of social ties between and among families, friends, and neighbors. A persisting state of instability and disorder for such a disadvantaged population, without remedy, led the community into a downward spiral of social disintegration. This social exclusion has given rise to behavior attributable to crisis, both in New Orleans as well as in the new communities for the evacuees. Nowhere is this more evident than the current crime and conflict amongst youth in Houston, Texas.

The following diagram summarizes the process and outcome of social exclusion and lack of social capital. Factors inducing stress leads to different aspects of social exclusion, followed by affected individuals and groups and the indicators (i.e. symptoms) of the social exclusion. There is a well-established link between poverty (economic and social) and poor health – those who are socially excluded and thus lack social capital experience worse health outcomes than the general population, thereby polarizing the health distribution in the population.

¹⁹ Fullilove, et al. The Family to Family Program: A Structural Intervention with Implications for the prevention of HIV/AIDS and Other Community Epidemics. *AIDS 2000*; 14(1):S63-S67. Lippincott Williams & Wilkins.

²⁰ Fullilove, Mindy Thompson. Root Shock: The Consequence of African American Dispossession. *Journal of Urban Health*. March 2001: 78 (1); 72-80

Process and Outcome of Social Exclusion

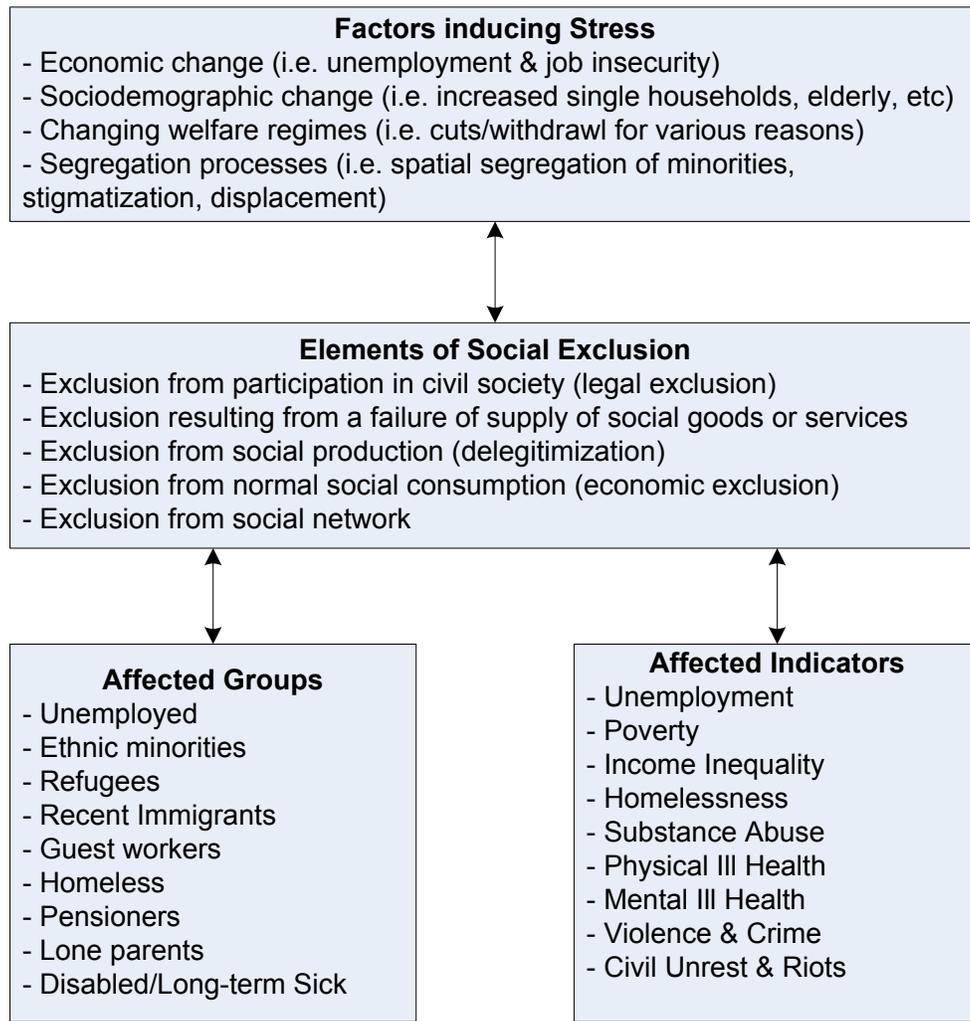


Diagram 1: The Process and outcome of social exclusion (source: adapted from White 1998)²¹

Placemaking and Public Markets

The influence of public space on the field of community development has recently emerged as an important consideration, though this has traditionally centered on its role as an amenity to affordable housing and commercial or institutional development, such as schools or public health clinics. City planners have more recently employed public space according to the New Urbanism design principles from the 1980s and 1990s in comprehensive neighborhood revitalization plans for distressed communities.²² The goal of new urbanists is to reform real estate development and urban planning to improve people's quality of life in a sustainable way, often through the creation of compact, walkable, mixed-use communities.

Project for Public Spaces (PPS), known for its work on the design, management and revitalization of public spaces, was founded as a non-profit organization in 1975 to build upon the pioneering "Street Life

²¹ White, P. 1998. *Urban Life and Social Stress*. In: *The New Europe: Economy, Society and Environment* (ed. D. Pinder). Wiley, Chichester.

²² Katz, Peter. 1994. *The New Urbanism: Toward an Architecture of Community*. McGraw-Hill, New York.

Project²³ of writer and sociologist William H. Whyte. A movement has been initiated by him, on promoting small urban spaces as important venues for defining city centers.²⁴ Since then PPS has developed a unique process for transforming public spaces, termed "Placemaking", through which community members interact with, assess, and improve their public spaces, thereby elevating their significance in building strong communities.

As part of PPS' work in influencing the way cities and towns approach public spaces – from parks, plazas, and squares to roads, transit stations, or civic buildings – public markets have emerged as a major initiative. Public markets create vibrant public spaces while also having broader social impacts: as microcosms of their communities, markets contribute to job creation, the improvement of health issues, and the creation of safe public spaces. At the same time, mature market operators and analysts have cited the lack of a coherent set of strategies to position public markets as catalysts to effectively build both individual assets for vendors while also serving as a broader community asset – whether to cultivate an active public space for a diverse set of stakeholders or improving the physical and mental well-being of community members.

In 2002, with support of the Ford Foundation, PPS conducted research to gain insight on the potential for public markets to build social cohesion and upward mobility opportunities²⁵. The research revealed how markets provide both a low-cost entry point for new businesses and a focal point for bringing diverse groups of people together. Using these findings as a departure point, and with continued support from the Ford Foundation, PPS focused on positioning public markets as active public spaces that promote economic opportunities within neighborhoods experiencing dramatic shifts in demographics and market forces. In the meantime, Ford Foundation made standalone, exploration grants to five other market grantees throughout the United States²⁶ in addition to PPS, to stir up the interest in this emerging initiative and to establish the new program's paradigm. This grant opportunity helped institute and solidify broader relationships and partnerships with various sectors, including community economic development, public and farmers markets practitioners and public sector, to address neighborhood-based social and economic issues.

The heart of this program model has crystallized into the *Public Markets & Communities* paradigm by late 2003 (*Diagram 2* – see next page), which is a meshing of the operating needs of the market with its broader impact on and connection to the community. In other words, it highlights how community assets can be leveraged to the advantage of a market; how a community can utilize the public market to address significant community problems; how the assets of a market can be leveraged to the advantage of the community; and how a market can contribute to catalyzing and increasing investments in the community and leverage additional retail activity on adjacent or nearby sites. PPS' initial research for Ford demonstrated that these links exist, and that markets have significant broader impacts that could be enhanced through targeted support. The paradigm illustrates that the overlap and intersection between the more internal market goals and the external community development goals can result in innovative new solutions and mutually beneficial partnerships. These collaborations create more opportunities for markets, community agencies and businesses to not only better achieve their goals, but also to do research, policy work, communication development, and broader outreach.

By 2004, PPS solidified a working partnership with the U.S. Department of Health and Human Services Office of Community Services (OCS) to identify joint grantees through separate but complementary solicitations based on this established paradigm. In partnership with OCS, PPS' request for proposal (RFP) program sought applicants looking to develop three elements for their market projects:

²³ Street Life Project is an ongoing study of pedestrian behavior and city dynamics, and eventually to Whyte's book called "City: Rediscovering the Center" (1988), a knowledgeable and subversive guide to human behavior in Manhattan.

²⁴ Whyte, William H. 1980. *The Social Life of Small Urban Spaces*. Project For Public Spaces, New York.

²⁵ *Public Markets as a Vehicle for Social Integration and Upward Mobility*. Project for Public Spaces. September, 2003.

²⁶ The five other grantees include Neighborhood Development Center (Minneapolis, MN), Community Farm Alliance (Louisville, KY), Grove Arcade Market Foundation (Asheville, NC), Esperanza Housing Development Corporation (Los Angeles, CA), and Crescent City Farmers Market (New Orleans, LA).

- 1) Internal economic sustainability of market operations and vendors;
- 2) Links to broader community issues; and
- 3) Animation of the public spaces (“placemaking”) at and around markets to provide civic participation opportunities across race, class and gender.

The initial RFP also sought out projects where the public market would serve transitional communities undergoing substantial changes²⁷ in demographics or real estate values. The complementary RFP released by OCS encouraged rural and urban community development corporations (CDCs) to create projects providing employment and business development opportunities for low-income people.



Diagram 2: Public Markets & Communities: A New Paradigm

In 2005, PPS established another partnership with the W.K. Kellogg Foundation, from which PPS secured new funds to assist farmers markets, especially in low-income communities, become more economically sustainable and community-centered. A new RFP was issued for grants including Kellogg support and

²⁷ Called “Shifting Sands Communities”, explained in Section I-B.

continued Ford support. Another emphasis on this round of grants, which upholds Ford's objective, was to call on state and regional farmers market associations and more metropolitan-based market networks to create blueprints for developing networks of farmers markets to advance food and nutrition programs within metropolitan regions. This was established with the vision of linking urban and rural communities through the shared institution of farmers markets. Support for such linkages was intended to help develop region-wide strategies for building local food systems for both rural and urban communities.

Public Markets and Public Health

Public markets are distinguished from other forms of food retail through three characteristics. Public markets:

1. have public goals (to be elaborated in the "Roundtable Discussion" section);
2. are located in the community and/or create a public space in the community; and
3. are locally owned, independent businesses²⁸.

Although increased food access for low-income neighborhoods is a primary or proximal goal of many public markets, markets also serve to build a sense of community by creating lively public gathering places and offering entrepreneurship opportunities for low-income residents. Public markets can serve to provide a sense of community and place in a neighborhood. However, the coordination of public markets typically requires staffing and management support which can be costly and necessitate extensive public subsidies for even the most successful markets.

In the last decade or so, it has been increasingly recognized that farmers markets and public markets play an important role in building connections in our farms and communities, functioning as bridges between urban and rural landscapes. Markets also serve the role as an agent for economic revitalization, upward mobility, individual empowerment and social integration of low-income, demographically dynamic local communities. Public markets have also been the mediums for the social and economic deterioration of urban centers, when many urban supermarkets relocated to lower-rent suburban areas in the 1970s and 1980s, leaving the poorest urban residents without convenient and affordable fresh food. Since then, cities have taken an interest in public markets as key connecting points for food, land and culture, and also a major stimulant for local economy and neighborhood revitalization by forging links between consumers and producers.²⁹ The number of markets has grown tremendously to reflect such recognition, by 111% from 1994 to 2004, for a total of over 3,700 markets³⁰.

It is also interesting to be reminded that public markets dominated discussions in city council meetings during the late nineteenth century America, the preservation of urban health, construction of streets and waterworks, and the beautification of cities. Especially with the threats to public health by the infectious diseases rampant in the cities full of immigrants and industrial workers, public markets were the central place where urban planning and public health interconnected intimately.

Nevertheless, most research points to the non-health benefits of markets, and much less is known about how markets influence health. As mentioned earlier, a number of serious health issues around the country these days – obesity, diabetes, cardiovascular diseases, and respiratory diseases, to name a few – affect people of all ages and socioeconomic classes (especially low-income). Not only do such health issues distress overall well-being of the community residents, especially children, they are also a significant hindrance to the economic stability (income generation) and civic participation of the residents as well as the markets.

²⁸ Project for Public Spaces and Partners for Livable Communities. Public Markets as a Vehicle for Social Integration and Upward Mobility: Report prepared for the Ford Foundation. September, 2003.

²⁹ Tangires, Helen. 2003. Public Markets and Civic Culture in Nineteenth-Century America. Baltimore: Johns Hopkins University Press

³⁰ National Farmers Markets Survey. 2004. United States Department of Agriculture.

II. METHODOLOGY

A. THEORETICAL FOUNDATION

Social Ecological Model

This research is conducted on the foundation of the social ecological approach in which health is viewed as a function of individuals and of the environments in which individuals live, including family, social networks, organizations, communities and societies.^{31,32,33,34,35} This is consistent with the social determinants theory, that there are multiple determinants of health, and linkages and relationships among the determinants are emphasized. Individual behavior is influenced by determinants at these various environmental levels. The social ecological paradigm focuses on the inter-relationships among individuals with their biological, psychological and behavioral characteristics and their environments. These environments include physical, social, and cultural aspects that exist across the individual's life domains and social settings. A nested structure of environments allows for multiple influences both vertically across levels and horizontally within levels.

A complex web of causation for health problems with social and biologic “spiders”³⁶, and therefore comprehensive and multi-level interventions, is emphasized by this model. The simplified schematic to summarize this theoretical model is shown below.

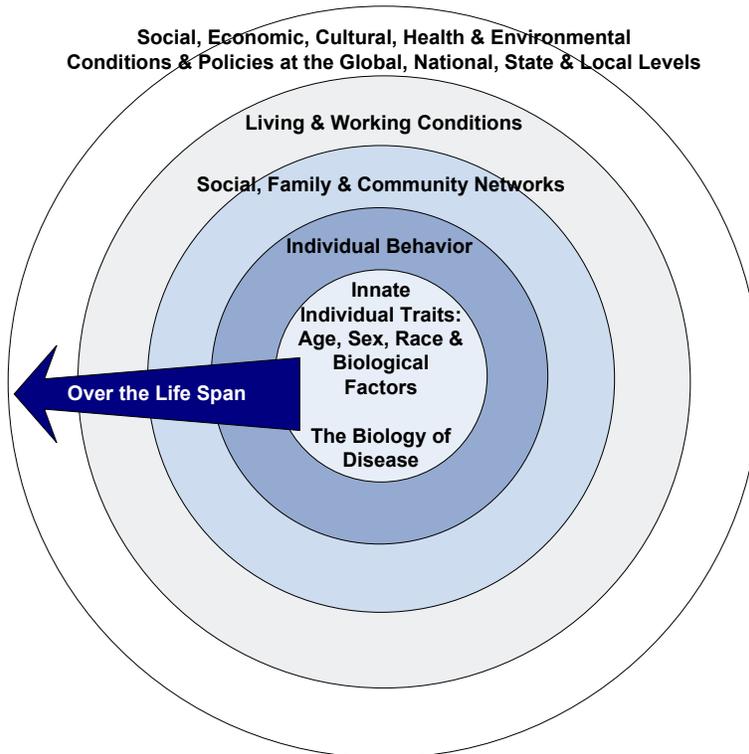


Diagram 3: Social Ecological Model of Community Development

³¹ Stokols, D. 1996. Translating social ecological theory into guidelines for community health promotion. *American Journal of Health Promotion*, 1996 March-April; 10 (4): 282-298.

³² Berkman, LS & Kawachi, I. 2000. *Social Epidemiology*. New York: Oxford University Press.

³³ Marmot, M. 2000. Social Determinants of health: From observation to policy. *The Medical Journal of Australia*. 172, 379-382.

³⁴ McLeroy, KR. An Ecological Perspective on Health Promotion Programs. *Health Education Quarterly*. 1988; 15 (4): 351-377

³⁵ Wethington, E. An Overview of the Life Course Perspective: Implications for Health and Nutrition. *Journal of Nutrition Education*. 2005 May-June; 37 (3): 115-20.

³⁶ Krieger, N. Epidemiology and the web of causation: Has Anyone Seen the Spider? *Social Science and Medicine*. 39(7): 887-903, 1994

The philosophical underpinning is the concept that behavior does not occur within a vacuum. The model takes into account the synergistic relationship of human behavior in the environment at multiple levels, while presupposing that changes at the social environment level can lead to large changes in individual behavior. All levels of influence are embedded - the higher-order systems (outer circles) set constraints and provide inputs to lower-order systems, and the lower-order systems provide inputs to systems at a higher level. It assumes appropriate changes in the environment will produce changes in individuals and support of individuals in the population essential for implementing environmental changes.

For the purpose of our research, the public market has adopted the social ecological model as the “agency” at the macro level, which could influence community’s health at various levels and capacities. As schematically depicted below, we view the markets as the nexus, “enabler”, or “focal point”, in community health improvement and thus in social advancement.

Adapted Ecological Framework for Public Markets and Public Health

Ways in which Markets Can Be the Agency to Influence Community’s Health

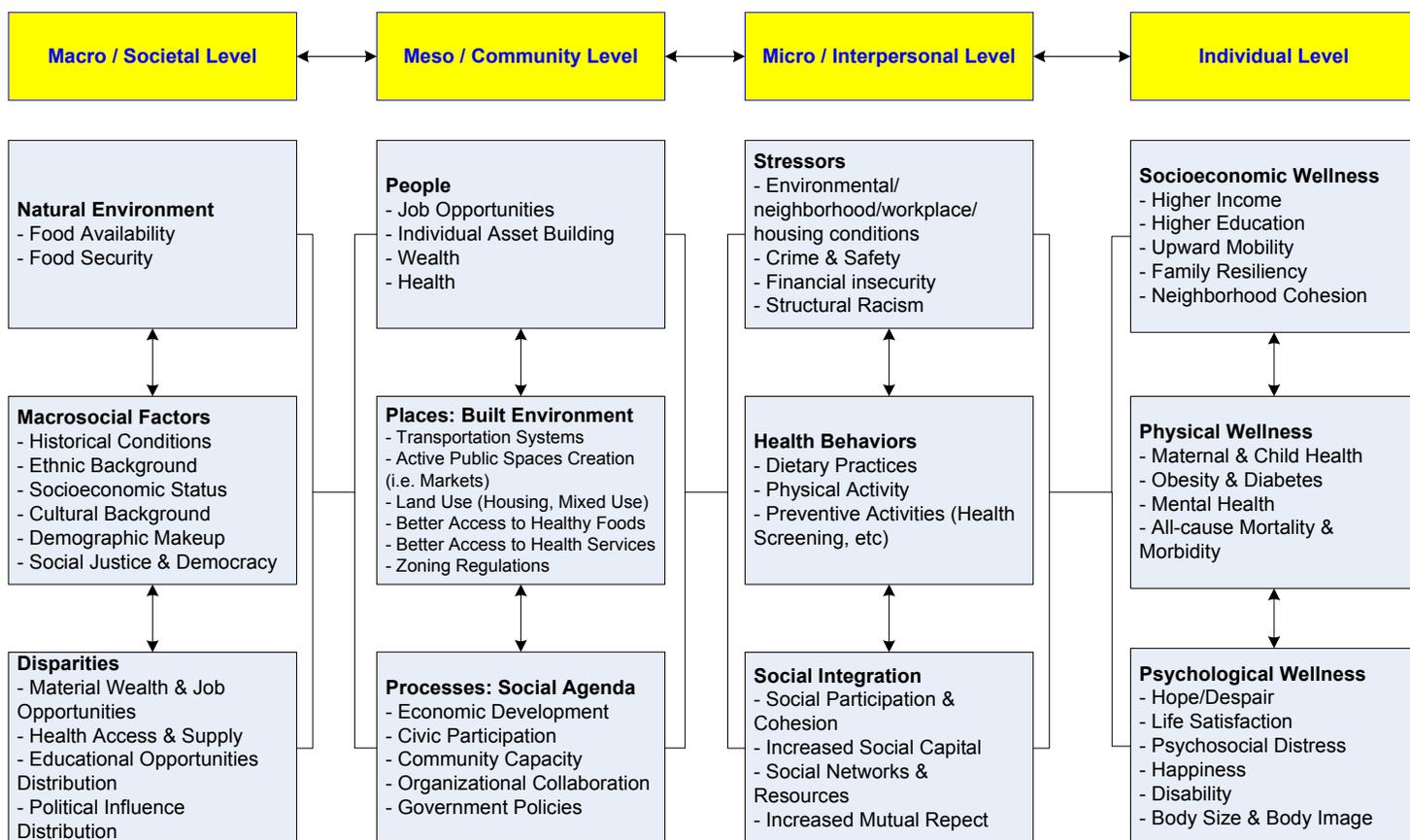


Diagram 4: Ecological Framework for Public Markets and Public Health³⁷

³⁷ Adapted from *Social Determinants of Health and Environmental Health Promotion* diagram by M. Northridge and A. Schultz. *Sorting Out the Connection Between the Built Environment and Health: A Conceptual Framework for Navigating Pathways and Planning Healthy Cities*. *Journal of Urban Health*: 80(4). 556-568. December 2003

B. SUMMER RESEARCH & STUDY DETAILS

A research team was organized to better understand and articulate the possible pathways in which public markets can influence public health. At the end of the four-month study, this position paper describes strategies, programs and services that may be adapted by the Ford Foundation to develop a program plan for connecting public markets with public health.

The core of the study was based on the following:

- Thorough literature research on
 - Farmers markets and public markets, in both policy and current practices
 - Neighborhood-based economic development cases
 - Public health, with the focus in social epidemiology, medical sociology and health policy
 - Environmental, economic and human impact on community health, both in general and within the community development and markets context
- Roundtable Discussions
 - Two-part, day-long meetings with attendees comprised of professionals from various sectors including New York City Department of Health, New York State Agriculture and Markets, New York City Housing Authority, Columbia University Mailman School of Public Health, New York University, the Ford Foundation, the W. K. Kellogg Foundation, Robert Wood Johnson Foundation, and the PPS' Diversifying Public Markets and Farmers' Markets Initiative Advisory Board members, which include diverse public markets professionals. The list of attendees is provided in the Appendix.
 - The purpose was to educate one another about the possible benefits of public markets development and public health, to develop a framework for further understanding, and eventually to access multi-sector professionals to brainstorm together about programmatic and strategic ideas for market-health collaboration. The summaries are documented in Section IIIA.
- Site Visits
 - To examine the existing markets' best practices, successes and challenges in incorporating various levels of public health initiatives in addition to their primary goal of selling produce and goods.
 - Each site visit consisted of the markets and local area tours followed by a series of meetings with local professionals from various sectors.
 - The following are the list of the site visits conducted (mostly in chronological order).
 - Flint Farmers Market, Flint, MI
 - Santa Teresa Medical Center Farmers Market, Santa Teresa Medical Center, San Jose, CA
 - Fruitvale Farmers' Market, Oakland, CA
 - Mandela Foods Cooperative, West Oakland, CA
 - Mo'Better Food, Mandela Farmers Market, West Oakland, CA
 - People's Grocery, West Oakland, CA
 - Trenton Farmers Market, Trenton, NJ
 - Camden Community Farmers Market, Camden, NJ
 - Wenatchee Valley Farmers Market Association, Wenatchee, WA
 - Mount Vernon Farmers Market, Mount Vernon, WA
 - Pike Place, Seattle, WA
 - Midtown Global Market, Minneapolis, MN
 - Homegrown Chicago Farmer's Market, Chicago, IL
 - The Lower East Side Girls Club Farmers Market, New York, NY
 - Bissel Gardens and Farmers' Market, North Bronx, NY

- Taqwa Community Farm and Farmers' Market, Bronx, NY
 - West Farms Farmers' Market, Bronx, NY
 - South Bronx Community Farmers' Market, Bronx, NY
-
- Phone Interviews
 - Surveys and interviews of market managers, health organizations and other leaders of the market community to assess 1) the status of the shifting sands community in which the market or the organization operate – what kind of socioeconomic barriers exist for the people; 2) what the markets' role and the mission are, and 3) what community-based partnerships exist or what stops them.
 - We contacted all of PPS' Category 2 farmers market grantees to whom we did not make site visits, select grantees of Categories 1 and 3, and few other non-grantee contacts. The call summaries are documented in Appendix B, and the analysis in Section IIIC.
 - The calls were guided by the interview questionnaires (Appendix F and G), the information of which were pre-researched by the team and which were rarely given to the interviewees to fill out on their own.

III. FINDINGS & ANALYSIS

A. ROUNDTABLE DISCUSSION SERIES

ROUNDTABLE DISCUSSION I

On June 20, the first of the two roundtable discussion series on “Public Markets and Community Health” took place at PPS. Followed by the “Public Health 101” and “Public Markets 101” presentations for the respective counterparts, the attendees formed two small groups to conduct an hour-long discussion each on two topics, the summary of which is articulated below.

The first group explored the potential ways or mechanisms by which public markets can impact and influence community health, and developed a list of nine categories, as follows:

A. Increases Access to Healthy & Nutritious Foods

- Need to assure that some percentage of the offerings are health options
- Increases and improves access to fresh / nutritious food for all people
- Diversify diets
- Organic health benefits
- Increase access, both in terms of getting to the market (public transportation, walking, etc.) as well as being able to purchase goods at the market (in terms of pricing, cultural appropriateness)

B. Provides Health Information & Education

- Everything from pamphlets to interactive classes
- Provides a venue for health information / messages / promotion / services
- Reinforce notion of food
- Provide education and information in various formats (not just reading materials - also videos for social service agency offices, etc.)

C. Supports Opportunities for Healthy Behavior & Health Promotion

- Offers a range of exercise possibilities, including classes
- Venue for various physical activities; Supports healthy behaviors
- Encourage breastfeeding, mother-child exercise routines, healthy child development activities
- Constructive family activities

D. Provides Venue for Health Services

- Screenings
- Health monitoring
- Social service and entitlement program linkage

E. Increases Social Inclusion & Social Interaction

- Increased socialization, community member interaction and possible social supports

F. Increases Community Pride & Loyalty (Social Capital)

- improved sense of community, a place worth investing in
- tends toward more group participation and less isolation

G. Increases Civic Capacity

- Increases community's collective capacity to solve problems (collective efficacy)
- Creates a “community” infrastructure that can address broader health issues – can build organizational relationships

H. Increase the Economic Opportunities

- Individual economic opportunity
- Positive community economic impact
- Raise income level

- Lower food costs
- Strengthening local neighborhoods leads to local economic development (improve health outcomes)
- Secondary economic impacts to community

I. Green Space Conservation & Placemaking Promotion

- Preserves green space outside town/city
- Green space benefits
- Contributes to environmental health – preserve open space, farmland
- Creates a neighborhood destination to walk to, and for public gatherings
- Preserves green space IN cities, as well as outside of them, through work with gardens and urban agriculture projects.

We have organized the above nine groups into a continuous array of market-health collaboration, categorized by individual (“micro”), neighborhood (“meso”) and societal (“macro”) level integration. We refer to it as the “*Market-Health Continuum*”, as shown below (Diagram 5). The individual level requires the least market-health integration, and the societal level the most. It should also be noted that the nine groups are not necessarily sequentially dependent in either directions. This arrangement is also configured (see Diagram 6) to resemble the ecological model of community development (Diagram 3).

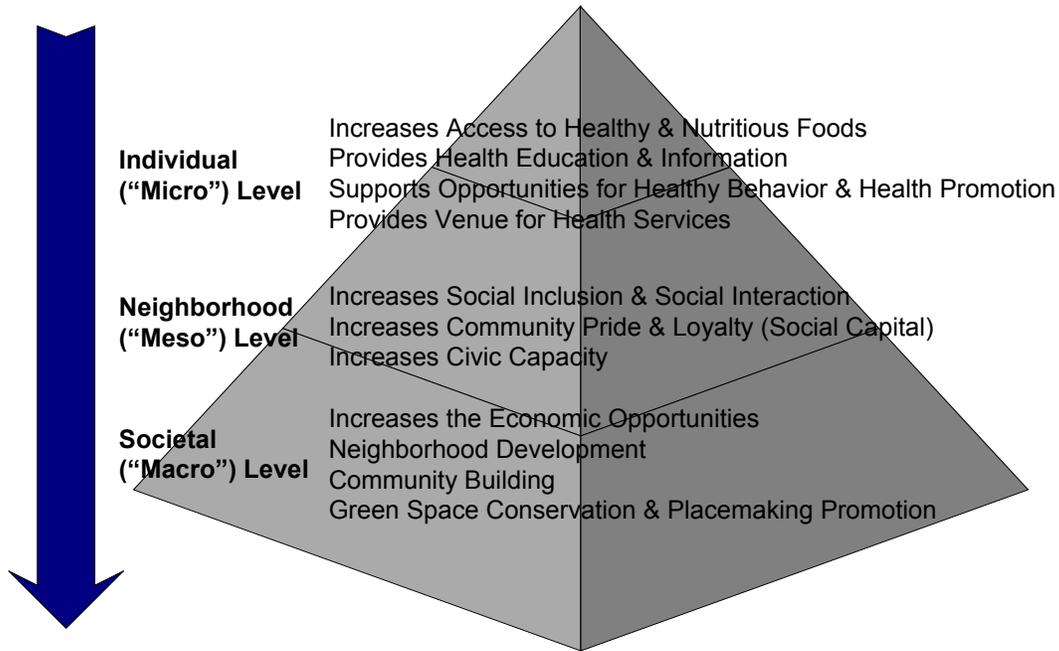


Diagram 5: Markets and Health Integration: Market-Health Continuum

The second group identified a list of key stakeholders that markets must collaborate with and that could be important institution players in addressing community/public health concerns. Each of these groups of stakeholders creates an opportunity for broader community impacts, but requires resources and can be challenging to manage.

1. Government as a crucial player

- It is important to make government an ally, because markets are enabled by various government resources such as streets, parking space and marketplace. Markets are then allowed to make creative use of public spaces made available to them.

- b. Government can also be a serious restraint, with its regulating capacity. Therefore, it is crucial to get to know the regulatory authority – local mayors, city councils, transportation dept, and other power holders – early on and communicate with them and build support. Constraints need to be identified early on, from the planning phase.
- c. In its effort to approach the government, markets should emphasize potential economic appeals: they promote business opportunities in the local community, incubate small businesses, promote tourism, protect and save small farms, and can play a conduit role for the community environment and health improvement.

2. Community resources

- a. Public and local TV news and programs, local newspapers, websites, Thurs edition of Weekend events, etc.
- b. Entertainment and fun are important elements for market promotion in:
 - i. marketing the businesses of the vendors and small farms;
 - ii. raising awareness on healthy eating and healthy living in tangible ways; and
 - iii. offering the market as the “nexus” of community socialization, or as a “public message board”

3. Schools and School-related programs

- a. Can affect the students on the nutritional level – help manage the surplus
- b. Can play a role on the educational level – help develop good lifelong habits of healthy eating and healthy activity
- c. After-school activities in health eating and active living at community-based organizations would be key complementary programs.

4. Foundations

- a. Could play a major role in sponsoring demonstrations and disseminating the results of such demonstrations, to help legitimize what those demonstrations intend to accomplish.
- b. Could also help develop managerial leadership in the markets
- c. Could be the beginning point of the collaboration/integration with
 - i. public sector – governments and city/county health departments, housing authority, etc.
 - ii. non-profit sector – CBOs and faith-based organizations focusing on public health, housing, environmental issues, seniors, children, etc; and
 - iii. private sector – commercial banks, small businesses, etc.

Without such collaboration efforts, markets would be faced with a huge managerial challenge, as it is already challenging enough to run the daily tasks of the markets.

- d. Could fund various research initiatives, including measuring impact of existing research/programs and piloting new ones – will help overcome mainstream market barriers.

5. Quasi-governmental organizations

- a. Community planning boards
- b. Economic development agencies
- c. Transit authority
- d. Local government organizations (tax increment reinvestment zones, public improvement districts, municipal management districts, sports authority, Port authority, cultural districts, business improvement districts, merchants associations, historical preservation authorities, redevelopment authorities, etc.)
- e. Equitable development practitioners

ROUNDTABLE DISCUSSION II

The second Roundtable took place on July 24 at the Ford Foundation, concluding our Roundtable Discussion Series. At the first Roundtable, we established the “*Market-Health Continuum*” (See Diagram 5) of the potential ways or mechanisms by which public and farmers markets can impact and influence community health. We have also identified key stakeholders with whom markets could collaborate and who could be important institutional players in addressing community health concerns. At the second Roundtable, we started with the following set of hypotheses, offered by Miguel Garcia of the Ford Foundation:

1. Can public spaces in poor transitional neighborhoods elevate the voices of the poor?
2. What is preventing them from fully participating in civil society?
3. What interventions are needed to level the playing field?
4. Can the community development sector embrace public health approaches to promote more equitable neighborhoods?
5. Are public/farmers markets ripe for building bridges that link community development and community health in transitional neighborhoods?

Our objective for the July 24 Roundtable II was to discuss the following:

1. What are we trying to accomplish, following the June 20 Roundtable I discussion?
2. What are the programmatic and strategic options for markets and public health groups?
3. What organizational capacities within markets and public health groups are needed?
4. How do we evaluate and monitor performance?

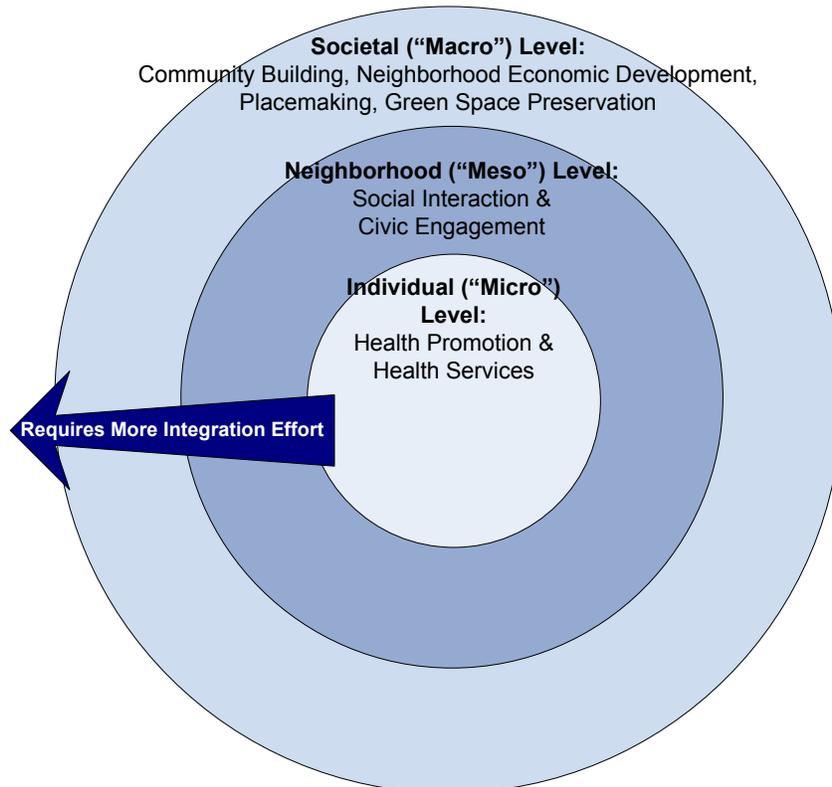


Diagram 6: Markets and Health Integration Scheme

We divided into two groups to discuss various actions that markets and their partners can take to facilitate the development of social capital and civic engagement in market communities. We focused on the “Neighborhood” (see Diagram 6 above) level of the *Market-Health Continuum* from our last discussion – increasing social inclusion and interaction, increasing community pride and loyalty, increasing civic capacity and promoting mutual respect. For clarity’s sake, the programmatic and strategic ideas within the Neighborhood level are organized into three categories of primary beneficiaries: i) demand side, ii) supply side, and the iii) community as a whole. In other words, the immediate and direct benefit of each programmatic and strategic option under the “demand side” would be for customers and local residents; primarily for farmers and other local vendors under the “supply side” ; and for both players simultaneously under “community as a whole”, It should be noted that these categories are not to be viewed as stand-alone, rather are inter-dependent with one another.

Supply Side: Market Sustainability and Capacity

Potential Programs & Strategies	Challenges
<ul style="list-style-type: none"> - Bring in institutional partners to host and guarantee revenue (i.e. via institutional purchasing) - Program to build organizational and managerial capacity - Forming 501(c)3 “Friends of Market” organization to help fundraise, promote, etc. - Help markets have expanded mission of including the community - Training programs and professional development for farmers and vendors as well as market staff. - Value-added business development - Local and regional collaborative between farmers can help meet high demand for product - Facilitate more cooperation among farmers – help them realize the greater value of having more vendors at market. - Identify or encourage new farmers with racial or ethnic linkages to communities the market serves. - Expand FMNP and food stamp program 	<ul style="list-style-type: none"> - There will be people who are not a part of an institution. (e.g. socially, culturally or linguistically isolated residents, developmentally challenged people with limited mobility, etc.) - People wear many hats in fulfilling market responsibilities each week, spreading organizational capacity thin. - Difficult for low-income markets to attract farmers - WIC/Senior FMNP coupons can only be used for certain foods/produce. - Different institutional purchasing power of “public” vs. “private” institutions (i.e. public schools vs. Kaiser) - Mindset of “this is a staff-person’s job” with no staff, but the community not picking up help. - Demand on farmers often exceeds supply.

Demand Side: Social Integration & Social Capital Building for Customers & Local Residents

Potential Programs & Strategies	Challenges
<ul style="list-style-type: none"> - Collaboration with informal/unincorporated associations (grassroots, community groups, such as young mothers group, high school bridge club, seniors game group, etc.) as well as with more institution partners. - Programs for/with senior centers with special transportation arrangements. - Welcome diverse people to the market by inviting local grassroots and religious groups for specific programs - Programs that promote inter-generational interaction (e.g. youth-run delivery service, family playgroups, etc.) - Collaboration with affordable housing programs → customer base likely eligible for FMNP coupons to be redeemed at the market; community gardeners selling at the market. 	<ul style="list-style-type: none"> - Heavy dependency on volunteers if markets are the initiator of the programs - Hard to measure tangible outcomes - Fractured neighborhoods do not necessarily bring together people to form associations. - Must make the healthy choice the easy choice, to be able to bring people together first. - Bring in community participation early on in the process of planning the program.

Community: Civic Capacity & Engagement of the Community as a Whole

Potential Programs & Strategies	Challenges
<ul style="list-style-type: none"> - Youth empowerment through urban agriculture programs - Voter registration - “This is My Space” Promotion, to create community loyalty and sense of ownership, by market partners such as local media, CBOs, local government, etc. - Market place as a general space for civic engagement (i.e. public spaces in which you don’t have to buy). - “Buy Local” campaign for the consumer; get farmers involved. - Programs allowing space at market for people to meet, organize, and create associations that would otherwise be difficult to form in fractured neighborhoods. - Stimulate support for FMNP by elected officials - EBT being introduced to more markets bringing socioeconomically diverse group. Puts technology in markets for debit and credit cards. This helps bring awareness to legislators. 	<ul style="list-style-type: none"> - How do you engage folks who are not already engaged for various reasons? - Need to define the target population (community residents’ demographics, etc.) first, and then the needs (cultural, economic, social), in order to be able to create programs that cater to the community’s specific need. - Need to find and be able to effectively engage the local leadership in the community to spark interest in market for various social reasons.

In summary, from the two roundtable discussions, we have ascertained that public markets have varying degrees of capacity and/or interest in expanding beyond the primary focus of selling local goods, not to mention any additional goals market organizers and communities have already placed on the market. To incorporate the public health component as a realistic and empowering strategy into the public market realm, we need to make the case for how this expansion in mission will translate into an increased bottom-line (or double bottom-line of market profitability and community health achievement) for the markets themselves. Existing community services, especially health entities (broadly defined, private or public), may not yet see public markets as a critical neighborhood asset building vehicle, nor see them as strategic partners in developing a healthier community. Similarly, existing public markets, including those who have embarked on “public health” programs within their markets, may not yet see health entities as their strategic partners in maturing the markets into more economically viable ones. Therefore, efforts to educate and link both sectors will be necessary. Finally, programmatic possibilities to support them may take diverse forms of collaborations and partnerships, which we hope to explore and identify further by the end of the summer.

For each category of potential programs and strategies, there is a set of challenges posed in order for successful implementation to happen. Key questions were asked to clarify the fundamental target and goals of the upcoming RFP to be designed, such as:

1. Are there specific community attributes that foster successful markets?
2. Would it be effective to set some criteria, or parameters, for the type of communities where we can make the desired market-health connection?
3. Who is the target audience? Is our aim to support agriculture, or provide affordable fresh produce to the community? Or is it both?

B. SITE VISITS ANALYSIS

In this section, we have put together a brief analysis from eighteen site visits and twelve phone interviews that were conducted this summer. The “lessons learned” from the site visits as well as the phone interviews are incorporated in Section IV: Conclusion & Recommendation. The purpose of this part of the research is to examine the existing markets’ best practices, successes, challenges and opportunities in incorporating various levels of public health initiatives in addition to their primary goal of selling produce and goods. It is also to find examples that are scalable and replicable. We tried to generalize much of what we learned from each visit, to incorporate throughout this paper, especially in the Section VI: Discussion and Recommendation. For brief narratives on all the site visits and phone interviews, please see the Appendix A and B. Please note that we included only brief summaries of what seems to us to be the core learning points specific to each site or call.

The markets we have included in our research are extremely diverse in terms of their leadership, customer base, physical facility, missions and strategies. They also have varying degrees of managerial capacity and interests in going beyond an outlet for vendor’s goods toward finding ways to reach a “double bottom-line” – market profitability and community health achievement. For many markets, this seems to be either the crucial point of empowerment or stumbling block.

There are many barriers to a market’s success in achieving the “double-bottom-line.” Some markets have great interest as well as capacity, but have difficulties convincing and/or educating the vendors or the neighborhood residents. Some markets reckon the importance of civic engagement but do not yet have the knowledge or momentum to make the leap. Some have not been quite successful in establishing the “health agent” role in the community simply due to the lack of capacity and support or the dire state of the community. Finally, some markets have the extraordinary creativity and resourcefulness in deploying their health programs while getting the community’s buy-in.

The past experiences and diverse goals of various markets provide a supportive foundation for building more targeted public health functions within the market. Further, there are varying degrees to which markets are or can be dedicated to achieving public health goals, as defined by our *Market-Health Continuum*. Applied to the nature of a “continuum,” it is not essential to establish the “Individual” level first to advance to the “Neighborhood” and/or “Societal” levels, or vice versa. In general, those who have established strong connection and partnerships with local health entities and community-based organizations are better positioned to take on the community level public health intervention programs. Simultaneously, having intentional points of entries and attraction to draw local consumers also enhances their participation at all levels.

All of the markets reviewed for this research are based in the community – some have a permanent physical space, but many do not. Regardless of the quality or the size of the space, people tended to connect with the market “gestalt” and view the experience of shopping at the market as a significant event. Some markets have physical facilities that naturally designate themselves as gathering places, such as Pike Place in Seattle, Flint Farmers Markets in Michigan, and Midtown Global Market in Minneapolis. Most farmers markets create public spaces even without established facilities. Overall, generally speaking, people’s traction to a market does not seem to be strongly correlated with whether or not there is a permanent physical presence of the market. This is especially true where there is a strong partnership entity involved. Finally, not only does the physical space of a market differ from one to the next, the origin of markets and the array of services and activities they engage in also differ widely.

Many of the smaller markets started with community gardens and continue to include gardens as part of their produce. For example, Bissel Garden and Taqwa Community Farm in the Bronx both turned junk yards into beautiful, successful community gardens before creating the market as a place for the community residents to sell their produce. To supplement the garden grown fruits and vegetables, local farmers were also invited to be vendors in the market to provide a more diverse product mix for customers and strengthen the market.

Some include youth development opportunities that teach the techniques of farming and the value of food security issues to the next generation. They seek to empower youth to advocate for the community and take a leadership role in preserving minority farms. The People's Grocery in Oakland runs a Food & Justice camp for neighborhood children where they go away for a week, work on a farm and learn about the environment. This program has created a network of empowered youth that are both vendors at the store, future farmers for the community and advocates for better food within neighborhoods. Further, both the People's Grocery as well as Mo' Better Food, both located in West Oakland, teach local youth how to appreciate farming on acres of land in the Sunol Water Temple Agricultural Park sponsored by the San Francisco Public Utilities Commission and the nonprofit group, Sustainable Agriculture Education (SAGE). "This concept is to keep small farms close to the city while teaching urban dwellers, especially children, about how their food is grown, and providing outdoor recreation where they'll feel connected to the land."³⁸

Community development corporations (CDCs) have a long history of creating and running public markets. Often they see these as a first phase for the development of a more substantial super market. For example, the Unity Council is a non-profit community development corporation committed to enriching the quality of life of families in the San Antonio and Fruitvale neighborhoods of Oakland. Unity Council's primary focus has been to create a healthier and safer community for families and residents by implementing and managing integrated programs addressing the economic, social, and physical development. Of a number of human service and development programs, they sponsor a public and farmers' market on the newly built grounds of Fruitvale Village. The Fruitvale Public and Farmers' Markets provide fresh produce to the neighboring communities and promote business incubation, expansion and job creation in the heart of the Fruitvale commercial district.³⁹ Similarly, Wenatchee Valley Farmers Market Association recently engaged in the downtown redevelopment project headed by Kamkon, whose first phase of construction will include a new facility for the farmers' markets vendors. Supported by the Mayor, the city of Wenatchee will use the market as the incubator of the community economic development. In another example, the Uptown Development Corporation (UDC), a non-profit downtown development group, runs Flint Farmers Market in Michigan, after a struggle with the City on who should run the market.

In some cases, individual markets are joining together to create market networks that can strengthen their capacity to work with more farmers and expand their reach into more communities. This was evident through Just Food's market network, Brooklyn's Bounty, that works with a number of different organizations – Added Value & Herban Solutions, East New York Farms!, Urban Oasis Farm at Kingsboro Psychiatric Center, Wyckoff Farmhouse Museum, Cornell Cooperative Extension, and Greenmarket/Council on the Environment of NYC – to organize and distribute produce from area farmers. For example, the Urban Oasis Farm is a plot of land farmed by recipients of the Kingsboro Psychiatric Center where they also sell their products in a weekly market as part of the rehabilitation program at the Center. To subsidize the product mix in the market, the market coordinator picks up produces from local farmers at a nearby market that also participates within the Brooklyn's Bounty network and sells the produce at the Urban Oasis market. Such movement is becoming increasingly popular – there are also other examples with a similar principle, such as Farmers' Market Federation of New York, and Wenatchee Valley Farmers Market Association.

Markets established in ethnically-oriented, low-income communities often serve not only as the sole source of sustenance and nutritious food but also as the main cultural nexus and social gathering place. Among many examples, Homegrown Chicago Farmers' Market offers culturally relevant health education, local entertainment, and ethnic arts and crafts fair to the predominantly Puerto Rican community, in addition to selling ethnic ingredients that are otherwise difficult to find elsewhere. In another example, Mo' Better Food of the Mandela Farmers' Market features local African American farmers and serves a predominately African American customer base in West Oakland.

³⁸ Ness, C. (2006). Farming for food, education. San Francisco Chronicle. San Francisco: B-4.

³⁹ <http://www.unitycouncil.org/services11.htm>

More directly, we find that health organizations are actually organizing and managing public markets as part of a larger strategy to promote health in their community and their employees. The best known example is Kaiser Permanente, a leader in this field and currently running a total of twenty-five farmers markets located in California, Hawai'i, the Northwest, Denver, and Georgia, with additional markets being planned.⁴⁰ Another example includes the three markets as part of the Community Health Market Alliance network led by the Camden Area Health Education Center, Inc. (AHEC) in New Jersey. Other markets promote community health by working collaboratively with local health organizations, such as the Fruitvale Market in Oakland, which works in collaboration with the Native American Health Center and La Clinica de la Raza, which offer WIC enrollment to their customers. Similarly, Mount Vernon Farmers Market works closely with Skagit Valley Hospital to host the market at the hospital lawn, and has a permanent stand for the WIC program and food banks, run by Skagit County Community Action Agency.

Not only do health organizations run markets, but in some cases, they are also working to create purchasing practices that support small and local farmers. For example, Kaiser Permanente's Oakland Medical Campus recently began a program to change the supply patterns of food and food distribution in their community. They have created a network with small, local farmers to provide fresh produce for their patients' meals. Ten farmers, with a focus on ethnic minorities, will send crops directly to Kaiser's central kitchen. Kaiser's project seeks to address the question of a future in sustainable agriculture and the livelihood of small farmers in California.⁴¹ For now, Kaiser is happy to announce that a local Hmong farmer has his cherry tomatoes featured in the salads of patients' tray meals. In another example, the Mandela Food Cooperative in West Oakland is also working on supporting local farmers and views themselves as a conduit in creating a healthy and sustainable food system by engaging in corner store conversion efforts. Essentially, one way the Mandela Food Cooperative is creating a sustainable food system is buying the leftover produce that is unsold at the end of the market day from the local farmer and bringing it to a local corner store to be sold in place of alcoholic beverages.

For success in the market-health integration efforts, health organizations and other non-health organizations can act as the "connector" entity for the market and the rest of the community. Small farmers markets such as Mount Vernon Farmers Market in Washington are sometimes well-positioned to play that role themselves due to the small size of the community and a certain level of cohesion that results from the community's unique circumstances. The Market Foundation of Pike Place in Seattle is an exceptional model of bringing social service agencies such as the senior center, medical clinic, food bank, childcare and the public development authority, to serve the Market District and the surrounding area. Further, the Consortium to Lower Obesity in Chicago Children (CLOCC) and Camden Area Health Education Center (AHEC) has a strong connection with their market's operations, direct health programs, as well as the neighborhood-level activities.

In another example, the Richmond Medical Center farm stand in California and Interstate Campus market in Oregon are examples of the community collaboration model of Kaiser farmers' markets, which identifies community organizations as the "connector" entity for the market and the rest of the community. In Richmond, the county health department announced a request for proposals (RFP) looking for a community organization to establish farm stands in West Contra Costa County. The local organization, EcoVillage, received the funding from the county health department to purchase a van, which is used to drive to local farms to pick up produce to be sold at a farm stand on the Richmond Medical Center campus. In Oregon, the market established an advisory board consisting of members from Kaiser Permanente, local neighborhood associations, and other members from community benefit programs, who planned the mission of the market for a year before the market opened. The goal of the market is to continue to expand its community-base and eventually turn this market from Kaiser entirely to the community. One way this market attempts to successfully engage the community is by opening one booth as the "community booth," in which different community organizations are welcomed to be featured in the market each week.

⁴⁰ (2006). Kaiser Permanente Farmers' Market Resource Guide, 2nd Edition: 1-52.

⁴¹ Ness, C. (2006). Chez Kaiser's food revolution Hospital experiment putting locally grown produce on patients' plates. [San Francisco Chronicle](#). San Francisco: A-1.

We found that, in accordance with our *Market-Health Continuum*, the “Individual” level intervention programs play necessary roles in initiating and furthering the community level programs. Each of the markets that we observed indicates activities that promote greater community health. Many offer health education opportunities, such as cooking demonstrations, nutrition information, food subsidy programs information, health screenings, and more. For example, the Santa Teresa Medical Center Farmers’ Market in San Jose, California, distributes health information sheets with all the produce offered in the market, healthy recipes developed by Kaiser Dieticians, and a program called “Cookin’ the Market” in which local chefs demonstrate how to prepare healthy meals. The Camden Community Farmers’ Market park mobile health and mobile vision screening units near the market and local medical students offer blood sugar tests and referral to care services. The Growing the South Madison Community Farmers’ Market in Wisconsin is strategically located within walking distance of the Madison Health and Family Services at one site and the Dean Hospital and St. Mary’s Hospital at a second site. They also offer a Healthy Eating basket giveaway by donating thirty baskets of food to local families.

From our research, markets also seem to be more inclined to establishing “Neighborhood” level interventions when approached by another entity, as opposed to the markets reaching out themselves. For example, the WIC/FMNP/Food Stamps programs are found to play an especially significant role in mobilizing civic participation, for both supply-side and demand-side in economically challenged communities. With such a program, barriers to success include increasing WIC/FMNP enrollment, improving the redemption rates of coupons, educating consumers, and/or establishing EBT machinery and infrastructure, in addition to other struggles to benefit underserved community residents more effectively. Thus, some community organizations collaborate with the market to provide various social services and create linkages to such services. For example, the Mandela Food Cooperative runs farm stands at Senior Centers throughout Oakland to provide elderly populations with fresh produce and a place for the elderly to utilize their Senior FMNP coupons. In another example, the Allen Street Farmers’ Market in Lansing, Michigan, working in partnership with the Department of Human Services, sent a letter and map to the market to all Lansing residents eligible for Food Stamps announcing that the market accepts food stamps. As a result, Food Stamp and EBT transactions increased from an average of \$6 per day to \$189 per day in 2005. Having a permanent presence certainly increases the WIC utilization and facilitates information dissemination, as it is the case for Mount Vernon Farmers Market collaborating with Skagit County Community Action Agency. The challenge seems to be with the EBT utilization that markets struggle for different reasons. Inadequate infrastructure, in terms of the physical setup, financial burden and insurance plans, is indeed a major hurdle. The additional and perhaps more difficult challenge emanate from the lack of consumer education to encourage healthier eating habits. This reinstates inherent and structural issues described in the Section I.

Overall, although the markets in our research often recognize their role as a public gathering place some of the “Individual” level health integration opportunities, they do not yet seem to employ deliberate approaches to foster more community-oriented, civic engagement. Rather, there seems to be an assumption that community engagement occurs “naturally” as the public space is made active. We also learned that more often than not, the markets do not directly connect what they are already doing with aspects relating to the “Societal” level of health integration, such as requiring only locally grown products to be sold at the market. Overall, it is clear that markets make up a diverse group with complex and varied histories and background, multiple objectives and selective visions while offering both tremendous health improvement opportunities and creating significant challenges for addressing prevention. This section highlighted some of the different facets markets are utilizing to meet the “double bottom-line” within the *Market-Health Continuum*. Other “ingredients” for success are elaborated further in Section IV: Conclusions & Recommendation, under the “Reflections & Considerations” section (page 26). Also, for more details on the missions, programs, and challenges of different markets, please refer to the Appendix A and B.

IV. OBSERVATIONS & RECOMMENDATIONS

A. REFLECTIONS & CONSIDERATIONS

The summer study has brought out a wealth of information and wisdom through intense literature research, roundtable discussions, and soliciting guidance from leaders of various industries. It should be underscored, however, that the overall discussion of our research and the recommendations here have been impacted to a great extent by what we experienced and observed directly on site as well as from communicating with the practitioners throughout the summer. The following three lingering considerations, posed at the end of the Roundtable Discussion II (page 19), are addressed here based on our observation.

1. Are there specific community, place and people attributes that foster successful markets with health programs?

We find that **active community engagement and participation** is an indispensable key to success. In addition to improving a neighborhood's physical food and activity environment, changing the social environment and norms around the issues is also a necessary component of changing behaviors and successful community development in a holistic way. Interventions stand little chance of success if low-income families are not offered the opportunities to spend their money and allowed the time to partake in the process. Not only can the community residents provide invaluable insights on the precise needs of their neighborhood, but they also benefit directly by getting involved (through the means of food-related activity, or through community-based or faith-based organizations or religious entities' activities). The process of doing so empowers the people by helping develop emotional attachment to the place itself ("it's my home") as well as remove judgment, condemnation, or guilt, thereby cultivating strong ownership to the place to make the process truly community-based. Such human capital development, in addition to economic and physical development, makes the community socially, economically and culturally vibrant; it may be the missing piece in many gentrified communities where markets do not live up to their potential.

Part of the key to success for neighborhood participation is partnering with community institutions that are already in place, so that they can take ownership of the process. Such **effective organizational collaborations and partnerships** is also crucial for success. Whether it is community organizing to mobilize the residents' participation, community-based organizations serving seniors and children, county departments of health that facilitate various health promotions and healthy eating initiatives, or hospital systems that buy local farmers' produce in bulk, the markets seem to thrive most as part of such collaboration networks. The caveat seems to be that various organizational efforts need to collaborate together under the common goal.

With a successful market, existing community services, especially health entities (broadly defined, private or public) see public markets as a critical neighborhood asset building vehicle, and therefore as a **strategic partner** in developing a healthier community. Similarly, existing public markets, including those who have embarked on "public health" programs within their markets, definitely see the health entities as their strategic partners in maturing the markets into more economically viable ones.

A key to success also necessitates a **dedicated group of market leaders** (e.g. market / market association boards) who have a clear, long-term vision for the market, the entire community, and the commitment to carry out the declared mission. From what we have seen, it is almost always the biggest challenge to convince the supply-side to be engaged in any activity beyond the "selling". The market leaders are in the best suited position to mobilize the farmers and vendors to develop the market, because they can offer the profitability incentives to the supply-side by playing the intermediary role between the supply-side and the demand-side.

The existence of **political champions** to create or steer the local political will has proven to be crucial in a market's relationship with the local government. For example, in the effort of community

revitalization, we have seen that markets tend to be promoted as the “anchor” of the business most effectively via an advocate who is him/herself part of the local government. Having such a “voice” is significant help for the market to be recognized through the allocation of resources. Efforts initiated solely by the markets tend to be an uphill battle without such political champions’ advocacy. Similarly, having **proactive healthcare partners** (health education center, hospitals, health agencies, etc) who reach out to the market and not the other way around, almost always leads to success. Such political champions could be useful in engaging healthcare institutions as partners to public markets, or vice versa. In addition, due to their complex nature, there are different elements of the political landscape that need to be organized and mobilized for support. Political champions can play the role of rallying disparate elements to support this complex set of relationships.

Regardless of the size of the market, a successful market operation at the Individual and Neighborhood level always requires the “**connector**” who brings in various community partners. We have seen that the “connector” candidates range from the market itself (the market manager, for smaller markets), county health department, locally based healthcare system, to local community foundation or market foundation.

Well-balanced strategies seem crucial to **empower the supply-side and demand-side in tandem**, so as to benefit the entire surrounding community. Expectedly, there seem to be many institutional and policy-level challenges that prevent the markets from doing so; however, we have seen successful cases where markets gave priority to tasks over which they could take the leadership, such as consumers and farmers education on health and Food Stamps programs, or forging relationships between the two sides through various programs.

2. Would it be effective to set some criteria, or parameters, for the type of communities where we can make the desired market-health connection?

Yes. One clear criterion would be that the program will serve “a shifting sands community” – parameters on what defines such a community may be important to establish. In general, it would be a community whose dynamic changes are affecting the people to the point that they are concerned. Another important criterion for the grant program is who the main recipient of the grant would be. In other words, would the market be the center of the proposed public health activities, or would it be part of the larger community coalition where the market space play the center role? Finally, it may also help to define a separate set of parameters for i) urban and rural communities, ii) the size of the community, iii) the type (and the size) of the market, iv) different ethnic communities.

3. Who is the target audience? Is our aim to support agriculture, or provide affordable fresh produce to the community? Or is it all of the above?

The aim of this study, as articulated in the Section I, is to help the constituents of the community to become healthier to the end of better social integration and gaining social capital. The “target audience” is both **supply-side** (i.e. local vendors and farmers) as well as **demand-side** (i.e. customers and local neighborhood constituents). To that end, our aim is to support agriculture so that that the supply-side constituents can expand sales and help facilitate the regional food distribution, to provide affordable fresh produce to the community so that the demand-side constituents can get access to better food. A well-balanced relationship between the two sides is important for the sustainability of the community’s well-being.

B. RECOMMENDATIONS

In making the overall recommendations, innovative approaches are essential to the success of creating market-health programs. When addressing the social determinants of health that require interventions at all levels of the ecological model, thinking through a different lens, from bottom-up, outside-the-box, connecting “unusual suspects”, structural interventions, or any other of a number of approaches will be useful. Since “health” is broadly defined for the purpose of our work, innovative programming, partnerships, and planning are all required in developing creative thinking for promoting community health through the avenue of markets. With that in mind, the following is the list of key complementary recommendations for the implementation of market-health programs.

Alternative Sponsorship Roles: Structural Relationships

1. Market-health programs should build upon the primary foundation that **a market is a business enterprise**. The producers (supply-side) play a crucial role in this premise. Therefore, it is important to make the “business” case for such programs, whether through the greater purchasing power of institutional buyers, support new and existing “value-added” business development, FMNP/food stamp opportunities, capacity building for farmers and the market as a whole, etc. It seems therefore critical to find the health “anchor” institution to serve this role. The institutional purchasing power to empower the supply-side must also be coupled with an institutional support for the demand-side to ensure the balanced trade activity. Direct collaboration with the U.S. Department of Agriculture (USDA) would be crucial to help increase the redemption rate of the Food Stamp Program and mobilize the market activities.
2. It is necessary to stress **building on the existing social, economic and physical assets** in the communities. Similarly, we need a place where there is already a ground for leadership, both for the market itself and for the communities. Managerial and organizational capacity of the market is a critical success factor. Community-based planning is a powerful approach that could make use of markets as the venue. Successful strategies would include helping different groups and organizations identify the markets as a place to collaborate with rather than placing responsibility on markets to do all the reaching out. From what we have seen, it is not effective to put the market in charge of the coordinating effort for the Neighborhood level of program implementation – markets’ limited capacity and/or expertise do not allow for such a role of the master-coordinator outside the market. Instead, the markets should be the main venue and one of the partners in the collaboration, where the main “connector” role is played by another entity. Who should be that “connector” entity will vary for each neighborhood, contingent on its unique situation and inclination.
3. It is important that health entities (broadly defined, private or public) see public markets as a critical neighborhood asset building vehicle, and the markets see the health entities to help them achieve the “**double bottom-line**” as mentioned earlier. There are markets, market associations and farmers alliances who are ready to make the leap to the next level from selling fresh produce and supporting the supply-side only – finding an entity who could play the external “connector” or “broker” role seems most appropriate. Similarly, health entities are searching for a link to penetrate into the neighborhood residents. Efforts to educate and link both sectors will be necessary. It is also important that the “health entities” are distinguished into the medical care ones and health promotion/cultural wellness ones. For the most holistic program implementation, the market would need both kinds of the health entities. Health screenings and free/subsidized primary care services are a key draw for low-income, uninsured and/or undocumented individuals at many of the existing markets, and they may be the only point of entry in many communities. Health promotion and cultural wellness programs are also a critical complement and partner to the medical care services, to establish a comprehensive health system for the neighborhood constituents.
4. We should also seek **partnerships and collaborative opportunities to work with public entities**, such as state/city/county departments of health, housing authorities (public or private), and federally-funded programs (WIC FMNP, Senior FMNP, EBT/Food Stamps). It is also important to identify who the non-traditional communities/partners are that need to be involved in this process. Partnership-

building with both associations – unincorporated, informal – and larger, more formal organizations needs to be distinguished and given the credit for its track record of success. Such partnership should not overlook local knowledge that is practical, to complement outside “experts” to build a strong and sustainable relationship.

The following diagram on the next page summarizes the four recommendations:

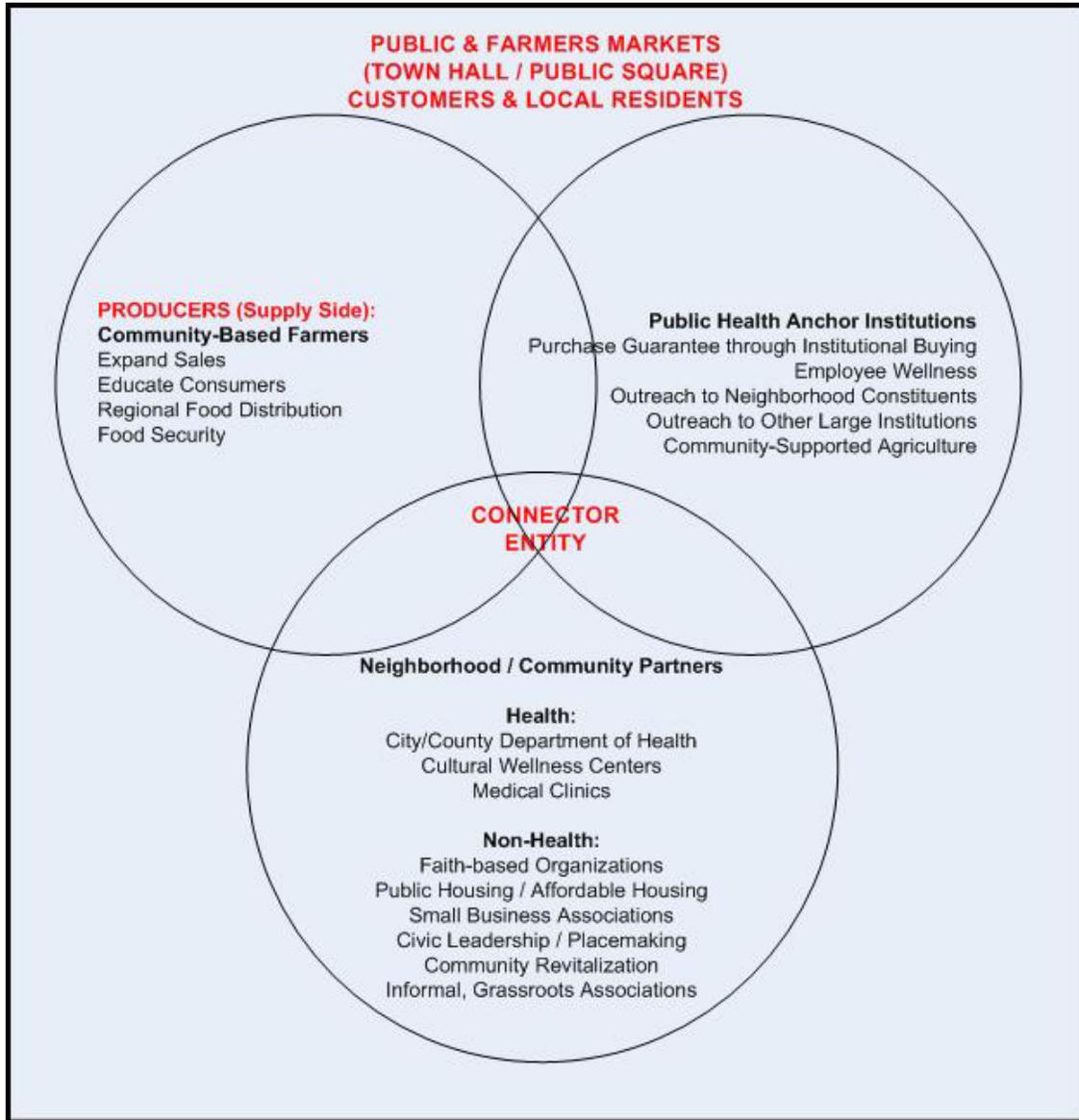


Diagram 7: Market-Community-Health Partnership

Neighborhood Change Mobilization

- Community health is all about relationships. As we concentrate on the Neighborhood/Societal outcomes, it makes sense to view markets as a more **intentionally and proactively** designed social *organization* or a **public sphere**, like the “**town squares**”, rather than just a “naturally evolved” gathering place. Through various active sales, community services, active topic tents (social tents, theme tents; mini town hall meetings, etc) and the like, people can come together and galvanize in non-crisis circumstances with civility. Social support and cohesion can be enhanced through these

mutually beneficial relationships and, in turn, social exclusion, segregation, and vulnerability can be decreased. This will hopefully increase the likelihood of a healthier and more engaged citizenry within the shifting sands communities.

6. It is also necessary to build intentional and strategic programs to enhance social norms, economic norms, and cultural norms in tandem, instead of assuming that one aspect automatically supports the other(s). As witnessed by the various phases of community development in the United States since the 1950's, community economic development does not necessarily accompany other essential ingredients of community's overall well-being. All of the aspects are equally crucial for success, and one does not necessarily precede or succeed the others. Similarly, **individual empowerment alone will not bring success without the proper community empowerment accompanying the process.** Without proper planning for such a balanced development, the ill effects of gentrification will afflict the community. Efforts to build social integration in individuals will provide an opportunity for increased understanding and mutual respect across race, ethnicity, gender, age, and generation within the community. Community economic development alone would not be able to accomplish this, as argued in the paper – community development actors must engage the external and larger regional and forces that impact the outcomes of reducing poverty, while building the internal and individual capacity of key constituencies. When there is such a balance and nexus between individual asset building and the community asset building, the market can be effective in ensuring the well-being of both supply-side and demand-side. For example, individuals can increase sales, while being educated and persuaded into the larger social movement; consumers can get access to fresh and nutritious food and health services while having their voices heard.
7. Strong **evaluation** that rigorously measures the impact of different neighborhood strategies on the process needed to effectively implement the strategies would be necessary in establishing a measure of the varying degrees of success across neighborhood interventions. It is acknowledged that it is difficult to define “success” – whether quantitatively or qualitatively – due to the complex nature of the “causal web” of social determinants of health. It has been shown that truly inclusive participation does not just mean large numbers turning out to meetings, and that the qualitative results mean little unless put in the context of each community's status and condition. The most effective way to define the measurements of success (i.e. health impact) seems to be through community-based participatory research. It may also make sense to take a creative approach, to work closely with the local government agencies and public health professionals to take advantage of the existing community programs. A strong recommendation needs to be made to put in place both quantitative and qualitative participatory research protocol. Such approaches should focus on individual outcomes for various constituents from both the supply-side (e.g. increased sales by vendors and producers) and the demand-side (e.g. access to culturally appropriate food). Finally, there needs to be some measures of civic engagement by the more vulnerable population from the neighborhood, who is empowered to overcome the individual health challenges while being civically engaged through the public sphere of the market.

Proponents of this recommendation should engage local research institutions to ensure credible methodologies, data (quantitative and qualitative) collection assessment, and analysis. Finally, efforts for just-in-time policy and decision-making processes that link community and local leadership need to be incorporated

8. Lastly, funding entities, who may be interested in mobilizing market-health programs, should ideally assemble a comprehensive group of representatives, in order to set these recommendations into action. Such representatives, or advisory board, should be comprised of the supply-side (vendors, farmers, producers), demand-side (consumer advocates, community development professionals), public health professionals as well as selective market managers and practitioners. Programs for different implementation localities should be uniquely catered to their own needs, and this “working group” should conduct planning efforts accordingly.

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B. DIAGRAMS

Diagram 1: The Process and outcome of social exclusion

Diagram 2: Public Markets & Communities: A New Paradigm

Diagram 3: Social Ecological Model of Community Development

Diagram 4: Ecological Framework for Public Markets and Public Health

Diagram 5: Markets and Health Integration: Market-Health Continuum

Diagram 6: Markets and Health Integration Scheme

Diagram 7: Market-Community-Health Partnership

APPENDIX

Public Markets & Community Health: An Examination

APPENDIX A

Public Health 101 Glossary

Active Living

A way of life that integrates physical activity into daily routines

Agency

The capacity for deliberate individual action. Notion that people are volitional agents who are capable of making a difference in and changing the social systems they inhabit.

Assessment

Includes the surveillance, needs identification, case finding, monitoring, and forecasting of health problems within a population.

Body Mass Index (BMI)

A mathematical calculation used to determine whether a person is overweight or obese. BMI is calculated by dividing body weight in kilograms by height in meters squared.

Built Environment

The part of the physical environment made by people for people, including buildings, parks, waterways, transportations systems, open spaces, etc.

Centers for Disease Control and Prevention (CDC)

One of the 13 major operating components of the Department of Health and Human Services (HHS), which is the principal agency in the United States government for protecting the health and safety of all Americans and for providing essential human services, especially for those people who are least able to help themselves.

Community Based Participatory Research (CBPR)

- A type of research in public health that is a partnership approach to research that equitably involves, for example, community members, organizational representatives, and researchers in all aspects of the research process.
- Partners contribute their expertise and share responsibilities and ownership to enhance understanding of a given phenomenon, and to integrate the knowledge gained with action to improve the health and well-being of community members.

Control

The reduction of disease incidence, prevalence, morbidity or mortality to a locally acceptable level because of deliberate efforts. Continued intervention measures are required to maintain the reduction.

Cultural Capital

- Involves the competencies, skills, and qualifications individuals accrue and possess because of their social position, such as class status. Due to its association with the class structure, valued cultural capital is that which converts into economic advantage.
- Cultural capital can be attained through various means:

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- “Cultivated dispositions” valued by the dominant class, usually acquired through socialization, and usually expressed as forms of speech, appreciation, understanding, style (including accent and dress)
- Locally valued books, music, scientific aptitude and competence, etc. – or, again, the insignia of class (ways of dress, recreational choices, housing amenities and fashion)
- Credentialing systems of education, such as degrees and certification

Ecological Model

- Comprehensive theoretical framework and health promotion model that is multifaceted and concerned with environmental change, behavior, and policy that help individuals make healthy choices in their daily lives.
- It takes into account the physical environment and its relationship to people at individual, interpersonal, organizational and community levels. The philosophical underpinning is the concept that behavior does not occur within a vacuum.

Ecological Fallacy

The bias that may occur because an association observed between variables on an aggregate level does not necessarily represent the association that exists at an individual level.

Epidemic

The occurrence of cases of an illness, specific health-related behavior, or other health-related events, with a frequency clearly in excess of normal expectancy, in a clearly defined community or region over a defined period of time.

Epidemiology

The study of the distribution and determinants (risk factors) of health-related states or events in specified populations, and the application of this study to the control of occurrence of diseases and health problems.

Equal Access Principle

A principle for the just and egalitarian distribution of health care:

- Demands that every person who shares the same type and degree of health need be given an equally effective chance of receiving appropriate treatment of equal quality so long as that treatment is available to anyone.
- Does not say that society must provide any particular medical treatment or health care benefit to the poor; only that if anyone in society can get a treatment/benefit, everyone should be able to get it

Food Insecurity

- "The inability to acquire or consume an adequate diet quality or sufficient quantity of food in socially acceptable ways, or the uncertainty that one will be able to do so" (Davis and Tarasuk).
- Includes problems in obtaining nutritionally adequate and safe foods due to a lack of money to purchase them, or the limited availability of these foods in geographically isolated communities (Campbell).

Fundamental Causes

- Theory that seeks to explain health disparities and differential burden of disease in populations.
- Socioeconomic status, racism, and sexism are significant barriers to accessing basic resources that promote health and well-being.

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- Individuals and communities with greater economic wealth, access to resources, and stronger, more extensive social networks have better health than impoverished communities with weak and fragmented social networks do.
- Resources such as knowledge, money, power, prestige and beneficial social connections that determine the extent to which people are able to avoid risks and adopt protective strategies so-as-to reduce morbidity and mortality over time. (Phelan & Link).
- The most important fundamental causes are SES, race, and gender

Gentrification

- The process whereby dilapidated neighborhoods are restored and refurbished, usually in conjunction with changing demographics and an influx of wealthier residents.
- Attempts to control gentrification include
 - Affordable housing
 - Inclusionary zoning
 - Rent control

Globalization

- The process by which social, political, economic and cultural forces are increasingly integrated around the world.
- Characterized by time-space compression, acceleration of global flows, massive urbanization, restructuring of global political economic system.
- Used to describe how human beings are becoming more intertwined with each other around the world economically, politically, and culturally.

Harm Reduction

- An approach to addressing risky behavior that places priority in minimizing the negative consequences rather than eliminating the behavior itself.
- A pragmatic and humanistic approach to diminishing the individual and social harms associated with risky behaviors. It seeks to lessen the problems associated with risky behaviors through methodologies that safeguard the dignity, humanity and human rights of people.

Health

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (World Health Organization).

Health Belief Model

A psychological model that attempts to explain and predict health behaviors by focusing on the attitudes and beliefs of individuals. Based on the understanding that a person will take health-related action if that person:

1. Feels that a negative health condition can be avoided,
2. Has a positive expectation that by taking a recommended action, he/she will avoid a negative health condition,
3. Believes that he/she can successfully take a recommended health action.

Health Impact Assessment

“A combination of procedures, methods, and tools by which a policy, program, or project may be judged in terms its potential effects on the health or a population, and the distribution of those effects within the population.”

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Steps include:

- *Screening* to identify which health impacts should be assessed and which populations are affected.
- *Scoping* to identify which health impacts should be assessed and which populations are affected
- *Assessing* the magnitude, direction, and certainty of health impacts
- *Reporting* of results to decision makers
- *Evaluating* the impact of the HIA on the decision-making process

Healthy People 2010

- A set of health objectives for the nation to achieve over the first decade of the new century.
- Builds on initiatives pursued over the past 20 years, including the 1979 Surgeon General's Report, Healthy People, and Healthy People 2000: National Health Promotion and Disease Prevention Objectives. Implemented by the federal government with partners from more than 400 health organizations

Inequity

Differences of a specific type, origin, and consequence.

- About privilege and disadvantage;
- Social or cultural origin: which is to say it's the meaning or interpretation that are given to certain differences rather than others [skin color rather than eye color] that turns them into distinctions that matter); and
- They make a difference in exposing people to harms and wrongs.

Inequity are inequalities that are

- *unnecessary* (they're not inevitable side-effects of otherwise good practices),
- *avoidable* (they can be changed), and
- *unjust* (they unfairly penalize some and benefit others).

Level of Prevention

- *Primary* – reduce the occurrence of disease in people who do not yet have it (e.g. health education, vaccinations, diets, etc)
- *Secondary* – reduce the progress of disease by early detection and intervention to reverse consequences (e.g., mammography and other screening programs)
- *Tertiary* – intervention to minimize impairments and disabilities from disease or to help patients adjust to irreversible conditions (e.g. palliative care in hospices, physical therapy, etc.)

Life Course Perspective

Theoretical framework that suggests that throughout the life course, exposures to disadvantageous experiences and environments accumulate, increasing the risk of adult morbidity and premature death.

Local Meaning

- The significance that a community (however defined) attaches to a given phenomenon such as a behavior, a risk, or an illness.
- Important to understand because a public health intervention that misunderstands local meaning may be misguided or counterproductive.

Macro-social Factors

Conditions that contribute to the social determinants of health, such as historical conditions, political and economic orders, ethnic and cultural background, and human rights doctrines.

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Metabolic Rift

- The Marxist idea that the spread of the capitalist mode of production results in humans interacting less directly with their natural environment from which they derive their sustenance, which in turn leads to its exploitation. (Foster, 1999; Marx, [1867] 1976, [1863–65] 1981)
- This lack of direct interaction with the environment reduces individuals' tendency to act in the best interest of their environment.

Mixed Use

Different, compatible land uses located within a single structure or in close proximity to each other.

Moderate Physical Activity

Activities such as walking, bicycling, gardening and housework, done in short spurts of 8-10 minute increments that, when accumulated over the course of the day, equal 30 minutes of activity. On a regular basis (three to five times a week) this type of activity can result in substantial health benefits.

Monitoring

A population-based surveillance system designed to identify and systematically track indicators and behaviors in order to detect and give warning of change.

Neo-materialist Perspective

- The theory that health inequalities result from differential accumulation of exposures and experiences that have their sources in the material world.
- Refers to both *individually held* and *socially available* resources: a combination of negative exposures and lack of resources held by individuals, along with systematic underinvestment across a wide range of human, physical, health and social infrastructure.

New Urbanism

A set of development principles to create more human-scaled places intended to increase accessibility and decrease reliance on the automobile as the primary mode of travel.

Obese

Defined as those with 20% (or more) extra body fat for the age, height, sex, and bone structure determined by the BMI, or a BMI of 30 or more.

Overweight

Defined as those with a BMI of 25 to 29.9.

Pandemic

Epidemic that occurs over a wide geographic area.

Placemaking

Local efforts involving city government, the business community, residents and other stakeholders to identify and revitalize underutilized public spaces. The process upgrades existing public spaces through small-scale, short-term projects such as traffic calming, pedestrian improvements and street furniture.

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Perverse Integration

- The income-generating activities that are normally declared a crime in a given context.
- A social dynamic led by processes of social exclusion and develops as the dichotomous *other* to the unfair, but “legitimate” economy (Castells).

Polarization

A specific process of inequality that occurs when both the top and the bottom of the income or wealth distribution grow faster than the middle, thus shrinking the middle and sharpening social differences between the two segments of the population.

Population at Risk

All the inhabitants of a given area that have the potential to develop the outcome of interest.

Population Health

The health of a population as measured by health status indicators and influenced by social, economic, and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services.

Public Health

- The science and practice of protecting and improving the health of a community, as by preventive medicine, health education, control of communicable diseases, application of sanitary measures, and monitoring of environmental hazards.
- Public health is a human right.

Public Health Nihilism

- The belief that broad social reforms, rather than interventions to change individual or proximal risk factors, are the best (if not only) way to achieve public health success
- The belief that targeted interventions will lead to only temporary and limited success.

Psychosocial Perspective

- Theory (Wilkinson) that the social gradient in health outcomes is the result of the perception of one’s perceived social rank, such as income inequality, which produce negative emotions that are translated in the body by induced stress and poorer health.
- Thought to operate through a physiological pathway: activation of the hypothalamic pituitary-adrenal axis and raised basal cortisol levels.

Relative Deprivation

Indicated if a person

- does not have X,
- sees some other person or persons, which may include himself at some previous or expected time, as having X (whether or not this is in fact the case),
- wants X, and
- sees it as feasible that he should have X (Runciman).

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Screening

Presumptive identification of unrecognized disease or defects by the application of tests, examinations, or other procedures that can be applied readily. Screening programs are important for the secondary prevention of morbidity and mortality.

Sedentary

Physically inactive.

Smart Growth

Growing a community in a way that protects farmland and open space, revitalizes neighborhoods, keeps housing affordable and provides more transportation choices.

Social Capital

- Resources that people are able to access and mobilize by virtue of their formal or informal membership in groups.
- "The aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition." (Bourdieu)

Social Determinants of Health

Sociological factors that contribute to the health of individuals. Such as, income inequality, social inclusion and exclusion, employment and job security, working conditions, contribution of the social economy, early childhood care, education, food security, housing.

Social Exclusion

- "The process by which certain individuals and groups are systematically barred from access to positions that would enable them to autonomous livelihood within the social standards framed by institutions and values within a given context" (Castells).
- Is a process, not a condition, so boundaries of who is excluded may change over time

Social Gradient

- Indicates that inequality itself, not simply poverty, including the context and intervening variables, such as material and psychological causes, is the source of health disparities that ultimately contribute to morbidity and mortality.
- It is the observed differential in health outcomes according to position in a social hierarchy and persists throughout the hierarchy with "no clear point with good health above and poor health below"

Social Network

Cultivated relationships – are the means by which resource access and mobilization takes place.

Social Organization of Risk

- The idea that exposures to negative outcomes, such as poor health, are not random, but are the result of the ways that society as a whole is structured.
- Refers to many dimensions of society: economic, political, cultural, etc.

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Socioeconomic Status (SES)

- Position within in a social hierarchy that is strongly determinative of health status
- A composite measure typically consisting of income, level of formal education, and occupation, all three of which are usually closely correlated

Social Welfare

- Refers to people's well-being and to systems that are designed to provide for people.
- All collective interventions to meet certain needs of the individual and/or to serve the wider interests of society.

Spot Map

Map showing the geographic location of people with a specific attribute, e.g., elderly persons living alone. The making of a spot map is common procedure in the investigation of a localized outbreak of disease.

Structure

- The formal or informal rules and resources in our lives, such as the institutions and norms, which empower or constrain social action and tend to be reproduced by that social action.
- The social conditions that shape our lives.

Structural Violence

- Harm done to individuals and groups by social, political and economic forces related to globalization and the rise of informational capitalism.
- Not random; entails a moral judgment that such harmful inequalities are unjust and part of the public health mandate to reform them.
- Forms of structural violence include:
 - Economic underdevelopment and poverty due to global restructuring
 - Geographical dislocation
 - Gender oppression
 - Racial and ethnic oppression
 - Age-related power inequalities

Surveillance

- The continuous and systematic collection, collation and analysis of data and the timely dissemination of information of those who need to know so that action can be taken.
- The purpose is to allow for the detection of unexpected changes in disease incidence.
 - *Passive Surveillance* – physicians, labs and hospitals are required to report diseases from the list of reportable diseases.
 - *Active Surveillance* – (during outbreaks) requires periodic phone calls or personal visits to the reporting individuals/hospitals/labs to obtain required data.
 - *Sentinel* – “early Warning System”

Susceptible

A person or animal not possessing sufficient resistance against a particular pathogenic agent to prevent contracting infection or disease when exposed to the infectious agent

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The Fourth World

- Pockets in the current global economy characterized by misery, social exclusion and extreme deprivation because they have been left behind by the rise of informational capitalism.
- Characterized by inequality, polarization, poverty, individualization, exploitation of workers, and perverse integration.
- These areas can be found anywhere people are excluded from the possibility of linking up with flows of information, wealth, or power.

Well-being

- Can also be referred to as Quality of Life
- Includes many components.
 - i.e. standard of living, the amount of money and access to goods and services that a person has; and,
 - Freedom, happiness, environmental health, and innovation.
 - These are far harder to measure and have created an inevitable imbalance as programs and policies are created to fit the easily available economic numbers while ignoring the other measures, which are very difficult to plan for or assess.

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APPENDIX B

Public Market & Farmers Market 101 Glossary

BID: Business Improvement Districts

A Business Improvement District (BID) delivers supplemental services such as sanitation and maintenance, public safety and visitor services, marketing and promotional programs, capital improvements and beautification in a designated area. BIDs are funded by a special assessment paid by property owners within the district. BIDs can sponsor markets in efforts to develop economy in certain areas.

CDC: Community Development Corporation

A CDC's goal is to improve the community and economic vitality of a specific area. Markets can be a tool for generating community and economic activity, especially when part of larger city improvement plans, such as improved public transportation access. CDCs are not-for-profits that often supplement city/state services as government programs are reduced.

Community Food Assessment

A Community Food Assessment (CFA) is a tool individuals and organizations can use to assess and map out what types of food buying options exist in certain neighborhoods. They are a powerful way to show what types of nutritional resources exist or are needed in neighborhoods, and help demonstrate the need for, as well as mobilize efforts, for improvement of the food system. Assessments can bring diverse stakeholders together to research their local food system, publicize their findings, and implement changes based on their findings.

Community Food Projects Competitive Grants Program

CREES – The Community Food Projects Grants Program, operated by the USDA, is a source of funds to assist with the development of farmers' markets and addressing food access and outreach issues within low-income communities. The grants are intended to help eligible private non-profit entities with a one-time infusion of Federal assistance to establish and carry out multipurpose community food projects. Projects are funded from \$10,000-\$300,000 and from one to three years. These are one-time grants that require a dollar for dollar match in resources, either in cash or in-kind contributions.

Community Garden

A community owned and/or operated plot of land that is divided up for individuals or families to garden. Gardens provide opportunities to grow nutritious food at low cost. Gardens can contribute to local economy by allowing gardeners to sell their produce at farmers markets.

CSA: Community Supported Agriculture

Consumers buy a share in a local farm or garden, usually paying at or before the beginning of the season and, in return, receive a weekly supply of produce that is harvested throughout the growing season. Paying upfront for the season gives farmers cash to start the season, and provides CSA members with access to fresh, local food. Participants can pick up their produce at specific locations (sometimes markets) or the farm, or have it delivered during the growing season. The number of farms with CSA programs nationwide grew from about 1,000 in 1999 to more than 2,000 in 2004, according to the Rodale Institute.

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Direct Marketing

The process of selling directly to the public. An example might be a farmer selling at a farmers' market, farm stand or selling and delivering directly to a restaurant or store. This method of marketing returns more to the seller, avoiding the wholesale market and the 'middle man' expenses. Through various channels, offers small food business an opportunity to develop a close connection with their consumers while keeping distribution and marketing expenses to a minimum.

Distribution Center

A central location where farmers can store products over variable periods of time, helping to reduce travel time and trips, and expenses.

EBT: Electronic Benefits Transfer

Refers to the way in which the federal Food Stamps program now distributes its benefits. Recipients use a plastic card (that looks like a debit/credit card) that is swiped at the grocery store when making purchases. Benefits are electronically transferred to the store via a land phone line. At farmers markets, where electricity and land phone lines are not always available, a wireless device is used to swipe the card and transfer benefits. Having wireless technology at farmers markets allows Food Stamp recipients to shop at farmers' markets, and it expands the capacity of the market to also accept credit and debit cards.

Outdoor markets and produce stands do not usually have the electricity and phone lines needed for all eligible food vendors to process electronic benefit transfers. Many such markets are developing methods to allow food vendors to sell eligible food products to EBT cardholders and to outreach to customers using EBT to make them aware of the new opportunities at the market.

Economic Impact Assessment

A study to measure how a market impacts the local economy it is located in. It measures how much income the market generates for farmers and vendors, as well as for businesses surrounding the market that are more highly frequented on market days or that people become aware of when visiting the market and are drawn back to on non-market days.

Farm to Institution

A type of direct marketing in which farmers sell their product to local private, public, or non-profit institutions, increasing their revenue by avoiding the wholesale market and distribution chain, and providing the institution with fresh, local food. In some cases, these types of programs can develop from farmers markets that initially were located at the institution or work as an expansion of a farmers market service, but often they are separate from market activities. Two example programs are:

Farm to Hospital

A type of direct marketing in which farmers sell their produce directly to hospitals (in the same region) that in turn use the produce in their cafeterias and eating facilities.

Farm to School

A national organization as well as a term for a type of direct marketing in which farmers sell their product directly to schools (in the same region) who serve the product in their cafeterias.

Farmers Market Resource Guide (USDA)

A list of grants, programs, and other financial and information resources available from public and private organizations, published by the Farmers Market Consortium (FMC), a new collaborative effort between USDA and government agencies, the Project for Public Spaces, and private foundations.

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FMNP: Farmers' Market Nutrition Program

The FMNP was established by Congress in 1992 to provide fresh, unprepared, locally grown fruits and vegetables to **WIC (Women, Infants and Children)** participants, and to expand the awareness, use of, and sales at farmers' markets. In fiscal year 2004, 14,050 farmers, 2,548 farmers markets and 1,583 roadside stands were authorized to accept FMNP coupons. Coupons redeemed through the FMNP resulted in over \$26.9 million in revenue to farmers for fiscal year 2004 (up from \$24.2 million in revenue to farmers for fiscal year 2003).

The FMNP is administered through a Federal/State partnership in which the Food and Nutrition Service (FNS) provides cash grants to State agencies. The FMNP is administered by State agencies such as State agriculture departments or health departments or Indian Tribal Organizations. State agencies develop plans to operate the program that are approved by FNS.

Federal funds support 100 percent of the food costs of the program and 70 percent of the administrative costs. States operating the FMNP must match the Federal administrative funds allocated to them for administrative costs by contributing at least 30 percent of the total administrative cost of the program. Indian State agencies may receive a lower match, but not less than 10 percent of the total administrative cost of the program. The matching funds can come from the following sources: State and local funds, private funds, in-kind contributions, similar programs, or program income.

State agencies administering the FMNP can partner with other organizations, such as Cooperative Extension Programs, local chefs, farmers or farmers' markets associations, and various other non-profit or for-profit organizations to provide nutrition education and/or educational information to FMNP recipients.

FMPP: Farmers Market Promotion Program

A grant initiative created in the 2002 Farm Bill to increase domestic consumption of agricultural commodities by developing, improving, and expanding domestic farmers' markets, roadside stands, community-supported agriculture programs, and other direct producer-to-consumer market opportunities (creation was made possible through an amendment of the Farmer-to-Consumer Direct Marketing Act of 1976.)

- Grants can help to increase domestic consumption of agricultural commodities by developing, improving and expanding domestic farmers' markets, roadside stands, community-supported agriculture (CSA) programs, and other direct producer-to-consumer market opportunities
- Approximately \$1 million is allocated for Fiscal Year 2006 for the FMPP, with the requirement that the maximum amount awarded for any one proposal cannot exceed \$75,000.
- Eligible applicants include agricultural cooperatives, local governments, nonprofit corporations, public health corporations, economic development corporations, regional farmers' market authorities and Tribal government.

Food Policy Council

An organization, often grassroots based, that brings together a wide range of community stakeholders to assess policies related to food issues and to improve legislation and funding for programs and systems that increase access to nutritious food and support sustainable agriculture practices through advocacy and campaign developments. Food Policy Councils exist throughout the country and Canada, with new organizations developing daily.

Food Security/Access

Having confidence in one's ability to purchase affordable, fresh, nutritious food, in a location close to where they live, and to maintain a healthy diet for themselves and their family.

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FSP: Food Stamp Program

The FSP serves approximately 10.3 million households and 23.9 million individuals. It provides low-income households with coupons or electronic benefits (EBT) to use like cash at most grocery stores. It provided an average of \$2.1 billion a month in benefits in Fiscal Year 2004.

The U.S. Department of Agriculture administers the Food Stamp Program at the Federal level through its Food and Nutrition Service (FNS). State agencies administer the program at State and local levels, including determination of eligibility and allotments, and distribution of benefits. Recipients can use food stamp benefits to buy:

- Foods to eat, such as:
- breads and cereals;
- fruits and vegetables;
- meats, fish and poultry;
- dairy products; and
- Seeds and plants which produce food for the household to eat.

Greenhouse

An indoor, year-round facility to be used for grow produce and plants. The ability to grow in a greenhouse provides many farmers and farms the opportunity to sell their products year-round and not just seasonally.

Healthy and safe food

Food (including wild foods) that is readily available, not contaminated with pathogens or industrial chemicals, has not entered the environment or food chain without rigorous independent testing and the existence of an on-going tracking and surveillance system (is not genetically modified) to ensure its safety for human consumption.

Local Food System

When all aspects of the production, distribution, storage, consumption, and sale of food are operated, managed, and owned by the community it serves, and when a community can attain food security from the production and consumption of primarily local products.

Locally Grown Food

Food grown within a certain distance from the point of its consumption. There is no standard definition for "local" when it comes to food -- a particular definition of "local" might be based upon county, state, region, watershed, or another boundary. Markets contribute to increased consumption of locally grown food.

Low-Income Community

The U.S. Department of Health and Human Services calculates federal poverty guidelines every year. These guidelines are used by the Department of Agriculture in their funding for programs such as Food Stamps and the National School Lunch program. For example, a family of four (two working adults, two children under 18) has a poverty guideline of \$18,850 in the lower 48 states. A low-income community is any population census tract where at least 20 percent of that population is at or below these guidelines. (U.S. Department of Health & Human Services)

Macro-Economic

Deals with matters of the entire economy in terms of the total amount of goods and services produced, total income earned, the level of employment of productive resources, and the general behavior of prices.

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Market: Public Markets and Farmers Markets

Markets:

- Operate in spaces open to the public (but can be privately owned)
- Serve locally owned and operated businesses

Many different types of markets exist in a wide range of locations. There are:

- **Covered Markets:** markets that are covered by some type of structure.
- **Farmers Markets:** markets at which farmers and growers sell products that they have grown or made, and many markets now include crafts, frequently made by the vendor. Re-sellers can also sell at farmers markets, depending on the markets rules and regulations.
- **Market Districts:** areas of towns or cities that are devoted to different types of markets.
- **Market Halls:** Structures Built for Markets, or buildings that have been converted to house a market.
- **Market Association:** Associations reach throughout a state or region with the goal of connecting farmers, markets and other community organizations. Like Market Networks, they can serve as advocates, helping to foster innovation at the local level, raising awareness of farmers markets' ability to address issues of food security, health and nutrition, and community development, and building new partnerships to expand the number of farmers markets within a state or region.
- **Market Network:** Usually functioning in a metropolitan area, networks often operate, sponsor, and/or facilitate multiple farmers markets and/or public markets. A network helps markets share operating costs, increase economic sustainability and enhance their viability in low-income communities, thereby improving farmers' profits. Networks can also develop broader community partnerships and effect change on a larger scale than individual markets might be able to.
- **Mobile Markets:** markets, usually operated out of a mobile vehicle, that travel throughout a city, town or region with the goal of increasing opportunities to purchase local, fresh food for residents living in areas without access to transportation.
- **Open Air Market:** refers to a market that is in an open, outdoor space, such as a:
 - Park and/or other public space
 - Parking lot/Vacant site
 - Street (with/without adjacent retail)
- **Producer-Only Market:** a market in which the vendors are either also the growers of the food or items they sell or are related to or work on the farm where the items are grown or made. Vendors cannot purchase goods from other places and re-sell them at the market.
- **Public Markets:** can refer to any type of market that operates in a space open to the public and serves the local economy.
- **Wholesale Market:** a market where products are purchased from farmers or other producers and sold in large quantities, usually to restaurants, institutions or distributors, and prices are often lower than if the farmer/producer sold directly to the retail market.

Market Manager

A paid staff person or a volunteer who manages the operation of a market and a multitude of broad-ranging tasks, such as (but not limited to) coordinating all aspects of the market operation, including vendor participation, customer relations, public relations and marketing.

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Re-selling

When vendors buy from other sources other than from what they produced. For example, they may purchase goods at a wholesale site or large public market and re-sell it at a farmers market.

SFMNP: Senior Farmers' Market Nutrition Program:

Established in 2001, the program provides low-income seniors with coupons that can be exchanged in the form of fresh, nutritious, unprepared, locally grown fruits, vegetables, and herbs from farmers' markets, roadside stands and community supported agriculture (CSA) programs. To be eligible, one must be at least 60 years old and have an income of not more than 185% of the federal poverty income guidelines (published each year by the Department of Health and Human Services).

- In 2005, 46 States, U.S. Territories, and federally recognized Indian tribal governments operated the SFMNP, through grant awards totaling \$15 million.
- More than 800,000 eligible seniors are estimated to have received benefits to purchase fresh, nutritious, unprepared, locally grown fruits, vegetables, and herbs from 14,500 farmers at over 4,000 authorized farmers' markets, roadside stands, and/or 215 community supported agriculture (CSA) programs during the 2005 harvest season.
- SFMNP increases the domestic consumption of agricultural commodities by expanding or aiding in the expansion of domestic farmers' markets, roadside stands, and community support agriculture programs.

Small Farm Operators

Ninety four percent of all farms - those with less than \$250,000 in annual receipts who work and manage their own operations.

The Department of Agriculture says small farms are increasing at a rate of 2 percent a year. That figure is based on a 1974 definition, which established a farm as an operation that earns or has the potential to generate at least \$1,000 a year. Today, many hobby farmers and suburban horse farmers meet this minimum requirement and use the distinction to get tax breaks on the land.

Sustainable Food System

Food harvested, produced, processed, distributed and consumed in a manner that maintains and enhances the quality of land, air and water for future generations, and in which people are able to earn a living wage in a safe and healthy working environment by harvesting, growing, producing, processing, handling, retailing and serving food.

Urban Agriculture/Farming

Farming and/or gardening that is done within city limits. Urban Farms can be located in vacant lots or in city parks, and often exist on raised soil beds that rest above pavement. Urban Agriculture facilities provide city residents without access to rural land an opportunity to grow their own food, learn about food systems and increase consumption of healthy products.

Value Added

The marketing of a commodity product in a more direct way. This can refer to farmed products that have been used to make foods, such milk or tomato sauce. Value Added products often sell for more than the farmed product and can contribute to a farmer's income.

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Vendor

An individual selling at a market. Vendors can also be producers (e.g. vendors at “producer only markets” are connected with the people producing the food, but cannot purchase food to re-sell at the market), or they can be hired help who does not also work at the farm.

WIC: Women, Infants and Children (part of FMNP)

A program that provides mothers with low-incomes, and their children under the age of five, with coupons to purchase fresh food at farmers markets. In 2004, the WIC Farmers' Market Nutrition Program provided 2.5 million mothers with low-incomes and children under the age of five with farmers' market benefits. The program was recently funded at \$5.244 billion, \$40 million above last year and \$44 million above the President's request.

- The extreme success of the program creates additional purchasing power in low-income areas, and helps spur the development of farmers' markets.
- States apply to participate in this program, and must provide a 30% match in funds or in-kind services. State agencies may supplement the benefit level allocated by the federal government. The program can be enhanced through Farm Bill allocations and the 2002 Farm Bill granted an additional \$15 million to the WIC Farmers' Market Nutrition Program for the fiscal year 2003, bringing its allotment to \$25 million.

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APPENDIX C

Public Markets & Community Health Roundtable Meetings Attendees (June 20th and July 24th combined)

Academic Institutions

Dr. Lawrence Brown, MSPH Columbia University
Dr. Lourdes Hernandez Cordero, MSPH Columbia University
Dr. Daniel Herman, MSPH Columbia University
Dr. Josh Graff Zivin, MSPH Columbia University
Dr. Michael Gusmano, MSPH Columbia University
Dr. Kate Kraft, MSPH Columbia University
Ms. Connie Moffit, Bastyr University
Ms. J. Robin Moon, Columbia University & Project for Public Spaces
Ms. Elizabeth Nash, Rutgers University & Project for Public Spaces
Dr. Mary Northridge, MSPH Columbia University
Dr. Victor Rodwin, NYU Wagner School of Public Service
Ms. Jarmin Yeh, Columbia University & Project for Public Spaces

Foundations

Jamie Bussel, Robert Wood Johnson Foundation
Linda Jo Doctor, W.K. Kellogg Foundation
Miguel Garcia, Ford Foundation
Jeff Mansour, Ruth Mott Family Foundation
Gus Schumacher, W.K. Kellogg Foundation

Community Development

Catherine Crenshaw, Sloss Real Estate
Don Wambles, Alabama Farmers Market Authority / Member of Farmers' Market Coalition Council

Governmental Departments

Mike Bevins, Bureau of Horticulture and Land Stewardship – Iowa Department of Agriculture and Land Stewardship / Member of Farmers' Market Coalition Council
Ernesto Lozano, New York City Housing Authority
Thomas Matte, Department of Health and Mental Hygiene

Project for Public Spaces Staff

Steve Davies, Project for Public Spaces
Nora Owens, Project for Public Spaces
Ed Maltby, Project for Public Spaces
Julia Day, Project for Public Spaces
Silvett Garcia, Project for Public Spaces
Chris Heitmann, Project for Public Spaces
Arianna Martinez, Project for Public Spaces

Project for Public Spaces Advisory Board

Dave Feehan, President – International Downtown Association
Dr. Minnie Fells Johnson, Former Executive Director of Greater Dayton Regional Transit Authority
Dr. Neal Kaufman, MD, Co-director, Center for Healthier Children, Families & Communities / Professor, Pediatrics & Public Health – UCLA

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Deborah J. Kane, Vice President Food and Farms – Ecotrust

Richard McCarthy IV, Co-founder and executive director of Market Umbrella and the Crescent City Farmers Market

Melinda Newport, Director, Nutrition Services – The Chickasaw Nation

Elvin Alberto Padilla, Jr., Director of Economic Development at the Norris Square Civic Association in Philadelphia

Deena Parham, Independent Consultant

Roy Priest, Independent Consultant, Former president and CEO of the National Congress for Community Economic Development (NCCED)

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APPENDIX D

Markets & Community Health Interview Questions for Markets

Intent of the Interview

It has been increasingly recognized that farmers markets and public markets (“markets”) play an important role in building connections in our farms and communities, functioning as bridges between urban and rural landscapes. Markets also serve the role as the agent for economic revitalization, upward mobility, individual empowerment and social integration of low-income, demographically dynamic local communities. Number of markets has grown tremendously to reflect such recognition, by 111% from 1994 to 2004, for a total of over 3,700 markets.

While most research points to the non-health benefits of markets, much less is known about how markets influence health. A number of serious health issues around the country these days – obesity, diabetes, cardiovascular diseases, and respiratory diseases, to name a few – affect people of all ages and socioeconomic classes (especially low-income class). Not only do such health issues distress overall well-being of the community residents, especially the children, they are also a significant hindrance on the economic stability (income generation) and civic participation of the residents as well as the markets.

With the premise that markets have a significant potential to contribute, certain private foundations’ interest has grown in investigating the possibility of markets’ role in achieving broader impacts including health. Recognizing the importance of community health, funding interest, and the fact that data to assess relevant needs and achievement is sparse, Project for Public Spaces (PPS) has taken on a study initiative to conduct a thorough research on the subject.

As part of the research, the purpose of this interview with the selected markets is to investigate the following:

1. Are there demonstrable records of markets’ influence on the community health, through improved access to affordable and nutritious food, promotion of active living and community-wide programs of various kinds?
2. If “yes”, how have they been achieved? What are the critical success factors? Can others replicate the results? How can we help expand it?
3. If “no”, what can be done to integrate the connection between your market and community health? What are the needs and impediments? What are the opportunities for improvements?

At the end of our phone interviews, we will compile the data into a list of existing practices by the interviewed markets towards the integration between community health and markets. We will construct a “continuum” model of such integration, which we will use as the basis of our programmatic design for markets-health integration. We appreciate your participation in advance, and hope to get to know your market more intimately through this opportunity.

I. Respondent

1. What is your role with the market?
2. How long have you been involved in this market?
3. How long have you been involved in the public market field?

II. Community & Customer Base:

1. What is the demographic of people who shop at your market, roughly estimated, in terms of:
 - a. Ethnicity?
 - b. Education Level?
 - c. Age Groups?

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- d. Gender?
2. Is there any language other than English spoken at the Market, by customers, vendors and/or market managers?
3. What have you done to try to attract these folks?
4. Do you feel your market/vendors sell products needed by the community? In what ways? What is missing?
5. What are the most purchased/demanded foods, services, etc?
6. What are the main two places people go to buy their food in this area?
 - a.
 - b.
7. How do people get to your market?
 - a. by foot
 - b. public transportation
 - c. their own vehicles
 - d. specialized van service
 - e. other

III. Current Programs & Services:

1. Is there a component of the community that you want to attract to your community that may not be well-represented?
2. What are the three most critical health or social issues facing your community right now? (i.e. obesity, immigration, joblessness, etc.)
 - a.
 - b.
 - c.
3. What is the area like that surrounds your market (i.e. housing, commercial, empty, being developed, church, etc.) Follow-up questions could include:
 - a. Is there a health center within a 5 minute drive?
 - b. Is there a bike path/bike rack to lock bikes near the market?
 - c. Is there a park within a 5 minute drive?
4. How active is your market with the USDA Food Stamp program?
 - a. Is your market equipped with EBT machines? Please describe in detail.
 - b. What is the percent estimation of redemption rate for:
 - i. food stamps?
 - ii. WIC?
 - iii. Senior FMNP?
 - c. What are some of the known issues to achieve better utilization and redemption rates of the program(s)?

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5. During the past year, were there any partnerships you have established between your market and external organizations? The following are some of the examples:

	(Check all that apply)
Farmers Alliance or Markets Network	
Fed/State/County/Local Government Agencies	
Community Development	
Rural (Farmers) Development	
Schools & Child Care Programs	
Health/Medical agencies, organizations and Hospitals	
University/Research Organizations	
Senior Programs	
Food Banks	
Housing	
Urban agriculture groups	
Transit Agencies	
Chambers of Commerce	
Neighborhood/Downtown Revitalization Programs	
Youth development programs	
Economic Development Agencies	
Community Greenhouses/Gardens	
New immigrants support groups	
Hispanic advocacy groups	
Other (please specify):	

6. During the past year, have you had any of the following programs or services provided at your market?

- a. Health Food Promotion

Please describe

- b. Health Education (such as the following examples)

	(Check all that apply)
Chronic disease awareness	
Population-specific (age-group, gender, ethnicity, and SES) programs	
School programs	
Cooking demos and classes	
Nutrition classes	
Exercise classes	

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How to make healthy choices – food, lifestyle, smoking	
General info about health issues, providers and services	
Themes & Events	
Other (Please specify):	

c. Health Screening Program

	(Check all that apply)
Blood pressure checks	
Diabetes Screening	
Cholesterol	
Mammograms	
Other (Please specify):	

d. Other Programs

	(Check all that apply)
Health insurance sign-up	
Social service sign up i.e. WIC, Head Start	
Other (Please specify):	

7. (Following 8) How did they work?
- Which is/are most successful, in terms of:
 - Number of customers participation
 - Level of vendors' support
 - What kind of challenges have you experienced?
 - Did you work in any partnership? Which?

8. During the past year have you had any special programs at your market, such as the following examples?

	(Check all that apply, and describe)
Concerts	
Public lectures	
Public debates	
Comedy programs	
Theatrical performances	
Other (Please specify):	

9. (Following 10) How did they work?
- Which is/are most successful, in terms of:
 - Number of customers participation
 - Level of vendors' support
 - What kind of challenges have you experienced?

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c. Did you work in any partnership? Which?

10. How are decision made about which type of programs and services your market participates in?

- a. Governance committee decides
- b. Anyone can buy space
- c. Manager decides
- d. Other _____

13. How does the market advertise? Who is responsible for this?

IV. Involvement in Community/Neighborhood

1. Do you or a representative from your market participate in any of the following?

	Never	Sometimes	Always
Local community board meetings			
City planning coalition			
Community change partnership			
Other (please specify):			

2. How is the market viewed by the community?

V. Vendors

1. How interested are your vendors in supporting/participating in community health activities?

Not at all										Extremely Interested
1	2	3	4	5	6	7	8	9	10	

VI. General Background & Demographics of the Market:

Note: This section should be separated from the Question List the interviewees will receive. Pre-interview assessment should be done from the interviewees' proposals and other relevant documentation, to get as much of the following information as possible.

1. Did the market start with any missions or goals (expand on its history)?

2. What type of market is it? (Circle all that applies)

Covered / Open-Air
 Farmers / Public
 Producer-only / Re-sell / Wholesale
 Market District / Market Hall / Market Association / Market Network

3. How long has the market been operating? What is your market season? How often does it operate?
 Market hours?

4. What is the financial scheme of your market?

- a. Funding sources and strategy

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- b. Revenue sources
5. How is your market managed? Who are the decision makers?
6. What types of food do your vendors sell, and how many vendors per category?
 - a. Fruit
 - b. Vegetables
 - c. Meat
 - d. Cheese
 - e. Flowers
 - f. Baked Goods
 - g. Prepared Food
 - h. Other?
7. What types of vendors does your market have? How many each?
 - a. community gardeners
 - b. youth gardeners
 - c. small or mid-sized farmers
 - d. fresh food/value added
 - e. prepared food
 - f. other
8. Where do your vendors come from?
9. How many minority vendors do you have, and rough percentage of each?
 - a. Asian American & Pacific Islanders
 - b. African American
 - c. Latino
 - d. Caucasian
 - e. Other?
10. How many immigrant-run vendors do you have?
11. How many female-run vendors do you have?
12. How many male-run vendors do you have?
13. What is the demographic of people who live in your market area* in terms of the following? (Rough estimate)
 - a. Ethnicity?
 - b. Education Level?
 - c. Income Level – Low / Middle / High?
 - d. Age Groups?
 - e. Family composition?

* Please define the “market area” by distance (roughly, which neighborhoods/villages shop at your market?), as well as the amount of time it takes to get to the market (by foot or via various transportation means).

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APPENDIX E

Markets & Community Health Interview Questions for Health Organizations

1. Has your health organization worked with non-traditional health partners?
If so, in what ways and can you give us examples?
 - i. What motivated you to participate in these non-traditional health adventures/partnerships/efforts?
 - ii. What was the most successful part of this experience? Or, 3 most successful results of this experience.
 - iii. What were the 3 most challenging aspects of this experience?
2. If no, what type of organizations and issues do you work with?
3. Have you been involved in any community/neighborhood development or revitalization efforts? If so, what did you do and how?
4. What other community outreach and health education services does your organization conduct that might be successful in a public market?
5. What are the health issues of the community surrounding the market?
6. As a health institution, what type of community programs do they have?
7. What are the 3 most prevalent chronic diseases for the population they serve? Does that match the population that will visit the market?
8. What is the % of uninsured that they serve or uninsured in the area? Where do they get their health care? Is there a free health clinic somewhere around the market? What type of follow up care is usually provided at the clinic and within their institution?
9. The market could be a very important place for getting people enrolled in Medicaid and other entitlement programs, do they have a system for doing that? Have they had experience with enrollment in other community settings?
10. What are their wellness activities? Where are these provided?
11. Many health care institutions are required to have a community benefit program, what do they include in community benefits?
12. Health care institutions are facing many challenges so getting them to think non-traditional and prevention might be difficult, however, there are examples emerging everywhere that are doing just that. You might want to talk about what they do for prevention versus what they do for acute care. Prevention activities may be easier to provide in a community setting. Acute care may not be so easy, however, health screening is possible as long as follow up is available.