Final Report
An Evaluation of Communities for Healthy Food

CUNY Urban Food Policy Institute
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Introduction

This report summarizes the evaluation of *Communities for Healthy Food* (CfHF), a place-based approach to expanding access to affordable, healthy food in four of New York City's economically challenged communities. Sponsored by Local Initiatives Support Corporation New York City (LISC NYC), an organization that advances equitable development of historically underinvested neighborhoods, CfHF integrated access to healthy and affordable food into the community development work of neighborhood community development corporations (CDC) that work with LISC to gain access to civic leaders and change makers across government, financial institutions, and philanthropic resources. The purpose of CDCs is to assist and revitalize underserved neighborhoods, often through the building and management of affordable housing and related services. The CDCs participating in CfHF initiated many additional activities including a detailed mapping of community assets, sponsoring resident outreach, nutrition education and cooking classes; creating new or improved healthy food outlets; and generating food sector jobs. Each participating CDC was funded to hire a Community Food Advocate and assigned an AmeriCorps volunteer. LISC NYC provided additional technical assistance and support. LISC NYC also suggested a menu of intervention options but each site had autonomy to select and modify its own activities from this list.

The CUNY (City University of New York) Urban Food Policy Institute worked with LISC NYC and four CDCs to design a rigorous evaluation study to assess short-term changes in individuals, organizations and communities resulting from CfHF. The evaluation team hypothesized that these short-term changes would lead to longer term changes in individuals, organizations, environments and behaviors; ultimately contributing to improvements in health and community development. One goal of the evaluation was to assess the reach and participation levels of various sectors of the populations served by the CDCs to be able to assess levels of exposure to intervention activities. The ultimate aims of the evaluation were to understand how CDCs could engage residents in creating healthier, more equitable local food environments and to document the distinct assets that CDCs can bring to such efforts.

The evaluation measured changes at four levels: changes in individual and household food-related beliefs and practices among residents in the communities served by the CDCs; organizational changes within each CDC; changes in food environments in the communities surrounding each CDC site; and changes in the partnerships between the CDCs and other organizations that participated in CfHF. It assessed changes across all four CDC sites, and at two key points in time: at the beginning of the CfHF project, in 2013-14, and at the end, in 2016-17. Several methods of data collection were employed including surveys of approximately 600 households in 2014 and again in 2017; observations of 42 CfHF activities over four years; 37 interviews with LISC and CDC staff; 18 focus groups with adult and youth community residents; assessments of food environments in the four participating neighborhoods and in two comparison communities; four meetings with CfHF, CDC and LISC NYC staff; and a review of documents and reports on CfHF produced by the CDCs and LISC NYC. Together these methods provide multiple insights into changes at different levels.

CfHF is based on the assumption that healthy food choices and healthy eating are functions of both individual consumer choices and household economic status, and surrounding environments and systems, necessitating action and change at several levels, from individual to community to city, state, and national food policies. The evaluation is based on the theory of change that posits that changes in organizations and community environments contribute to changes in individuals. A key focus, therefore, is to analyze and document changes at these higher levels, rather than simply measure before and after changes in individual participants, a more conventional strategy for evaluating programs that seek only to change individuals. As food policy makers and scholars place new emphasis on the importance of policy and environmental change in improving food outcomes, interventions such as CfHF must be able to demonstrate their capacity to bring about changes at these higher levels if they are to be replicated or adapted for other settings.

Given the decisions not to randomly assign CDCs to intervention and non-intervention arms, not to study non-intervention communities in depth, and not to mandate a tightly standardized intervention across all four communities, the evaluation faced limits in the conclusions that can be drawn. However, the study reported here represents one of the most comprehensive evaluations to date of a multi-site community food intervention in New York City or other big cities and presents lessons relevant to others seeking to implement real-world interventions and carry out affordable evaluation studies.

This report presents findings of the changes observed between 2014, the first year of data collection for this evaluation, and 2017, when data collection ended. Findings are summarized for each of five levels:

1. Changes in individuals and households
2. Changes in organizations: the community development corporations
3. Changes in communities
4. Changes in partners and partnerships
5. Changes in policy

Finally, the report makes recommendations for future work. Readers who want more details on the implementation of Communities for Healthy Food can consult *Communities For Healthy Food: The Toolkit A Practical Guide For Integrating Healthy Food Access And Social Justice Into Community Development*. A more detailed version of this evaluation report is also available from the CUNY Urban Food Policy Institute.

Key Findings

Our evaluation found that across sites, from 2014-2107, CfHF reached tens of thousands of community residents, most of whom were low-income, black or Latino, the populations at highest risk of food-related problems and the group CfHF was created to serve. The participating CDCs achieved this goal by developing and implementing an impressive number and variety of activities, ranging from food pantries, farmers markets, and nutrition education to community chef training, youth development and food justice education. CfHF also nurtured the development of cooperative food businesses in participating low-income communities. Over the course of the project, residents

became more aware of, and involved in CfHF activities and expressed appreciation for the roles CDCs played in increasing access to healthy food and taking on broader issues of social and economic equity as they relate to food and health in their communities.

A key question for the evaluation was to quantify how many people in a defined geographic area were reached by CfHF activities and with what intensity of interaction. We used our household surveys of a sample of community residents to provide an answer. We asked survey respondents about their rates of participation in the six categories of food events discussed in this report (healthy food or nutrition classes in the home neighborhood, healthy food or nutrition classes in another neighborhood, CSA or farm shares, local farmers markets, farmers markets in other neighborhoods and other food activities). The percentage of those reporting a high rate of participation (defined as attending three or more events in the last year) increased from 20 percent in 2014 to 29 percent in 2017, a 45 percent increase. Conversely, rates of no participation dropped from a mean of 31 percent in 2014, to 28 percent in 2017, a decline of almost 10 percent. These data suggest that by 2017, more than 1 in 4 of a population reached by the CDCs (represented by the survey respondents) reported high rates of in food-related activities, a substantial portion of these neighborhoods' population.

Individual Level: Of the 12 indicators of individual and household healthy eating, 11 showed changes in healthier directions and two showed changes in less healthy directions. In 2017 compared to 2014, residents were more likely to report:

- Higher levels of participation in food activities such as healthy food or nutrition classes, CSA or farm shares and farmers markets in their own and other neighborhoods;
- Comparing prices before buying food, planning meals ahead and shopping with a grocery list, and using nutrition facts on food labels to make food choices;
- Positive feelings about their local food environment;
- Eating home cooked meals more frequently and preparing meals at home that are healthy (defined as following the United States Department of Agriculture MyPlate guidelines)
- Eating fruit most days of the week;
- Less consumption of fast food in the past month.

On the other hand, between 2014 and 2017, residents reported:

- No increase in eating leafy green or other vegetables most days of the week, with about a third of the population reporting in both years that they had consumed one or fewer portions in the last three days.

A modest increase in the proportion of residents reporting drinking more than one portion of sugar-sweetened drinks per day. In 2017, survey respondents were also asked to assess changes in their diet in the last year. About three in five respondents reported they had consumed more fresh vegetables and fresh fruits in the current year than the previous year and more than three in five reported drinking on average fewer portions of sugar-sweetened drinks, a different result than the comparison of changes between the 2014 and 2017 surveys. While personal assessments of changes in consumption over time may overestimate the actual amount of change, they suggest that many residents made healthier food choices in the current year than in the past one.

The overall positive direction of changes is noteworthy and warrants celebration. While our evaluation design did not allow attribution of these changes directly to CfHF, it seems plausible that CfHF activities contributed to these important changes. Further support for this finding comes from the observation that in most cases, survey respondents who reported higher levels of participation in community healthy food activities reported higher levels of healthier change than those who participated less. For example, compared to survey respondents with no reported participation in community healthy food activities, those with higher levels of participation were more likely to report consuming fruits or vegetables on two or more of the last three days, eating healthy meals most or all the time, and using their knowledge about food and meal planning most or all the time. However, reported rates of fast food and soda consumption did not vary by level of participation, with about one in five survey respondents in high, moderate and no participation groups reporting high levels of consumption.

Thus, on most indicators, those with a higher level of exposure to CfHF activities changed more than those with lower levels of exposure, a dose-response relationship associated with program impact. However, our research methods do not allow us to determine whether individuals who chose to participate were different in some important way than those who chose not to participate.

Future CfHF activities should focus more explicitly on increasing vegetable consumption and reducing sugary beverage consumption as those two goals are critical elements of healthier dietary patterns and reducing the burden of diet-related chronic diseases in low-income communities.

Organizational Level: Between 2014 and 2017, CDCs expanded their activities and organizational practices that engaged residents in CfHF activities. These included establishing food pantries, sponsoring one-time events or multi-session classes, and organizing farmers' markets or health fairs with partners. Over the course of implementation, CDCs increased opportunities for ongoing volunteering, leadership development, and, in the final year, engagement in community chef training. Further, through changes implemented during the project, in response to concern about over-reliance on unpaid low-income volunteers, by the end of the initiative, CfHF had provided paid positions for several residents.

Over the three years, CDC staff and partners became more knowledgeable about running healthy food programs and the CDCs became better known in their communities for their work in healthy food and food systems change. This change was critical in increasing resident engagement in CfHF activities. Youth became more engaged with CfHF, as CDC staff and partners integrated their prior experience in youth development with their newly acquired food systems knowledge and were able to develop and implement specific healthy food and food justice programs for young residents. By expanding their youth work to include food, participating CDCs mobilized a potentially powerful new asset for improving local food environments and initiated development of new leaders for community-based food work, a valuable resource for sustainability.

CDCs contributed important assets to CfHF, such as land for community gardens, buildings for meetings and healthy cooking trainings; staff and partner investment in the idea of healthy food initiatives at CDCs; and the positive, trusting relationships CfHF staff had with other CDC programs, partner organizations and community residents. CDCs also brought relevant expertise to CfHF: their knowledge of other issues and players in housing, food security, retail, workforce

development, and education opened doors for CfHF staff and enabled the development of more integrated and intersectoral approaches to community development.

CDCs also benefited from CfHF. Sponsoring CDCs met and established relationships with new partners, new funders and different populations in their communities. CfHF deepened a growing CDC interest in taking on the social determinants of the well-being of their communities including the role that food played in creating differences in health, employment, and education between those with better and worse access to heathy food. By taking on this work, CDCs have acquired a new tool for reducing the multiple inequities facing residents of the communities they serve.

Community Level: An important goal of CfHF was to improve the food environments used by community and CDC residents to increase access to healthy, affordable, and high-quality food in the target communities. What changes took place in the local food environment between 2014 and 2017?

Through use of a systematic assessment of the retail food environment, coupled with discussions with residents, CDC staff and partners, the evaluation found that access to healthy food improved in some respects in some of the four target communities, but more generally access and quality declined in these communities. While these observed and perceived declines in local food retail environments had multiple causes beyond CfHF activities, it seems clear that the stated CfHF goal of improving several dimensions of local food environments was only partially achieved. Of interest, data from focus groups and the household survey suggest that residents might have distinguished between different components of local food systems.

One component, labeled here the "community-constructed food environment" includes farmers markets, urban farms, community gardens, Community Supported Agriculture projects (CSAs) organized by CfHF and its partners, food pantries and the institutional food programs operated by or with CDCs. In general, in focus groups and in surveys, community residents reported satisfaction with these food outlets. In addition, between 2014 and 2017, survey respondents reported increased participation in each of the following activities: healthy food or nutrition classes in their own or another neighborhood, CSAs or farm shares, farmers markets in their own and other neighborhoods and other food activities. Overall, the proportion of residents reporting high levels of participation in these activities increased from 20 percent in 2014 to 29 percent in 2017, a 45 percent increase.

The other component, the commercial food environment, included supermarkets, bodegas, fast food outlets, and restaurants. While each of the participating CDCs made some efforts to modify these businesses, they reported less success with this work than in the "community-constructed" food system. In addition, in focus groups in both 2014 and 2017, some residents expressed dissatisfaction with commercial food outlets, finding them too expensive, offering food of poor quality or not treating customers with respect. Household surveys and focus groups found that many residents traveled outside of their communities to find healthy foods at affordable prices and with a quality they trusted.

Over the course of CfHF, residents increasingly found fresh and high-quality produce through the farmers markets established and operated by the CDCs (including those run by youth) during the

growing season. Yet they were compelled to return to the retail stores during winter months, a practice that many lamented due to their concerns about price, quality and service. These findings and the strategies that residents reported to acquire food for themselves and their families underscore the importance of the CDCs' healthy food access and youth development initiatives. Given the high rates of obesity, diabetes and other diet-related diseases in the participating communities, expanding and strengthening "community-constructed" food environments may make important contributions to improved community health and reduction of food-related inequalities in health.

Partnership level: Partnerships were key to the success of CfHF overall and to specific project goals. These relationships between the CDCs and other organizations contributed both tangible goods and services, such as fresh produce or enrollment of residents in benefit programs; and non-tangible assets such as collaboration in program planning or introductions to city officials or funders. Partners also gained from these relationships, particularly in expanding their own programmatic reach to achieve goals that were complementary to those of the CDCs' goals and CfHF.

Characteristics of successful partnerships were: a willingness and ability to collaborate and operate with transparency and trust between partner organizations; a genuine interest among organizational leaders and staff to work with other groups to achieve broader food and health equity goals in low income New York City communities; and a capacity to make and keep commitments for staff time or other resources. These characteristics were particularly important in the context of an increasingly competitive food systems advocacy environment in which organizations compete for grant funding to sustain and expand their programs. Given the CDCs' limited prior experience in food work, partnerships with organizations with a track record in food and food security were especially valued.

Policy Level: The development of New York City's dynamic food policy system over the past decade played a critical role in setting the stage for CfHF. The panoply of new city, state and federal food policies and programs encouraged funders, elected officials, city agencies and nonprofit organizations to become more interested in food and food policy, and more willing to invest organizational resources in these activities. New interest in food policy in New York City helped to strengthen a food justice movement, a food policy learning community and an advocacy coalition for municipal food policy and programs. Each of these intersecting alliances contributed to the creation and implementation of CfHF. In turn, CfHF moved some residents into food activism, promising further developments in policy advocacy. Whether these alliances become stronger or dissipate will have a material effect on the future of CfHF and its successors, and warrants close observation by CDCs, their partners, advocates and policy makers.

In sum, CfHF had multiple and intersecting influences on the food choices and food practices of the individuals and households who participated, on the communities in which the CDCs were located, on the CDC organizations, on their partners and on some aspect of the local food environments. CfHF showed that CDCs can use their expertise, assets and capacity to take up food access, food security and food practices in low income urban communities and engage residents in ongoing activities to improve food-related behaviors and environments. The challenge for the

next period will be to sustain these activities, modify as needed to achieve their full potential and bring to the scale needed to make longer term changes in health and community development.

Recommendations

The evaluation provides insights that may assist those who seek to sustain or replicate initiatives such as CfHF. We present recommendations for program implementation, public policy and research and evaluation.

Program Implementation:

1. A strength of CfHF is that it engages in activities that increase the supply of and demand for healthy food and reduce the supply of and demand for unhealthy food. However, these two approaches could be better coordinated to enhance overall impact. For example, a focused multi-pronged campaign to increase vegetable consumption by coordinating strategies to increase the availability, affordability, acceptability and necessary shopping and cooking skills may lead to more robust changes in this outcome. Similarly, a campaign to reduce the supply and demand for sugar-sweetened beverages may result in more significant and sustained changes. Given the importance of increasing vegetable consumption and decreasing sugary beverage consumption in reducing inequities in the burden of diet-related diseases, these types of focused campaigns may lead to sustainable improvements in health. For these campaigns to succeed, community residents should play a central role in their planning and implementation.

2. Other strengths of CfHF are its high levels of community consultation on strategies, its commitment to engaging in multiple activities, and its insistence on working at several different levels. However, as CfHF moves into a more mature phase, it should consider setting and monitoring more specific goals and allocating limited resources to achieve those goals. For example, as noted, a focused campaign to increase vegetable consumption may have led to changes that better contributed to improved health. Finding the right balance between responding to changing community articulated needs and pursuing specific goals designed to reduce the burdens of inequitable food systems will always be a challenge. Imposing an agenda not supported by the community is unlikely to lead to success but failing to set clear goals may reduce impact and leave inequities unaddressed.

3. CfHF successes depended on its comprehensive asset mapping at the beginning of the project. This process allowed planners to understand the important organizational and community assets and key relationship factors, including issues of trust and expectations among CDCs, residents, and partners. Those seeking to replicate or modify CfHF for their setting should invest in this essential activity.

4. By including an explicit focus on community economic development, e.g., creation of new food businesses to increase access to consistent, non-emergency sources of fresh, healthy, affordable food, CDCs can contribute to healthier food environments and local business development.

5. To strengthen partnerships and make them more efficient, CDCs and their potential partners should spell out what each partner can expect to gain (or lose), prior to formalizing the

collaboration. Funders or other external supporters should seek to understand the needs of organizations that wish to partner with others to increase healthy food in low-income communities and be receptive to supporting the organizational staff time needed for groups of differing sizes to establish and sustain effective partnerships. Mandating partnerships without providing resources to support them breeds frustration.

Public Policy:

1. At its inception, CfHF did not have a policy focus or a policy agenda. Yet it benefited from and responded to a variety of policy initiatives unfolding during its implementation. As CfHF enters its next phase, it should reconsider how best to respond to and advocate for food policies that support more effective community food work. It should explore options for using policy levers more systematically to achieve its programmatic goals. Embracing policy change would represent a shift for CfHF but not for the participating CDCs, some of whom have been active players in housing and educational policy in New York City.

2. An important outcome of CfHF was to engage new cohorts of community residents and leaders in food and food policy. Developing this cadre of leaders into an organized voice for food justice and equity in the food system would add an important new resource for CDCs and for a New York City food movement.

3. Advancing food equity is integrally connected to advancing health, child development, employment, housing, education and other forms of equity. CDCs and LISC NYC should continue to explore how an intersectoral equity agenda could be used to organize and mobilize communities, support policy change and improve the living conditions of those living in the neighborhoods they serve.

4. CDCs and LISC NYC should work with city and state agencies and policy advocacy organizations to create and ground-test measures to address the decline in access to affordable healthy food in low-income communities, particularly in gentrifying neighborhoods. Developing measures of gentrification and strategies to enhance the benefits and reduce the harms of food-related gentrification can assist CDCs to assess the status and future directions of investments in their community and strengthen their capacity for healthy, equitable community development.

Research and Evaluation:

1. To the extent possible, the planning of evaluations should begin at the same time as program planning and evaluators should be part of the program planning team. Early involvement helps to ensure that relevant indicators can be assessed at baseline and that all participants agree on the goals of intervention and its evaluation.

2. Articulating the theory of change of a community food intervention and creating the logic model that illustrates that theory can help to design effective interventions and useful and meaningful evaluation studies. Such exercises can serve as forums in which all program participants define program goals and strategies and identify and resolve differences in approaches.

3. Program planners and funders should identify as early as possible the data collection responsibilities of program staff and evaluators ensure that each party has the training, resources, time and support for carrying out these activities.

4. Developing standard evaluation instruments and outcome metrics that can be used across community food programs will help to build a body of knowledge that can guide interventions and reduce the time each program now dedicates to crafting its own instruments. Funders, program planners and evaluators should collaborate to create such standardized measures.

5. Based on this evaluation, several research and evaluation questions warrant further collaborative investigation by the staff of organizations leading community food interventions, evaluators, researchers and funders. These include:

- How does gentrification influence food environments? What community-led initiatives and public policies can mitigate the harmful influences of gentrification on availability and affordability of healthy food?
- What are most appropriate methods for assessing the cumulative or synergistic impact of multiple food initiatives?
- What digital or other technologies could facilitate data collection and better track participants across multiple intervention activities?
- How can program planners more precisely define their target populations to enable evaluators to define the denominator of the population that could potentially be reached by a community food intervention?
- How can program planners and evaluators best choose appropriate levels of analysis and scale for healthy food interventions? How can they produce evidence that can lead to scaling up of effective interventions sufficiently to have an impact on population health and overall community development?

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