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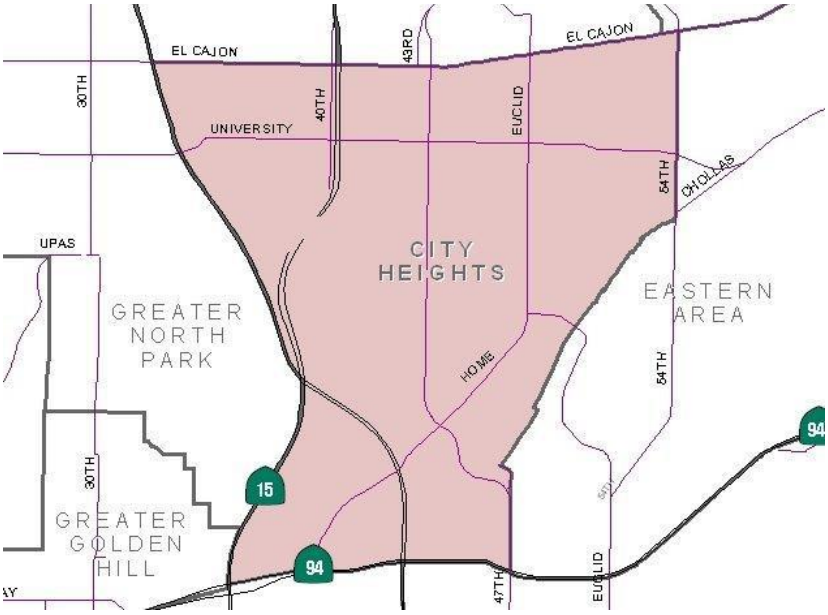

Evaluating E.F.F.E.C.T.

Ethnic
Food
Focus
Engagement and
Community
Ties in City Heights

Revised Final Report

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Executive Summary

Food security is a basic need for individual and community health. In many communities food security is an issue, as the availability and access to healthy items through a robust food system may be limited, and residents may lack information about the importance of eating more nutritious foods. Moreover, in communities that serve multiple ethnic populations, food preferences may vary significantly, further exacerbating food security concerns. In this study, we explored the City Heights food system through the perceptions of local food-focused organizations and residents. Specifically, we used mixed methods to draw out organizational personnel and residents' perceptions, then explored the markets they mentioned by auditing their healthy foods offerings. We especially asked, do smaller ethnic markets create a sense of resilience in communities with limited food systems?

When speaking to local food organizations, issues of trust, safety/security, cultural traditions, and joint programming opportunities were cited as salient issues for understanding food issues for City Heights. As they discussed residents' cultural traditions, clearly these organizational representatives saw them as both assets and barriers to addressing food security.

So that we could get a better understanding of residents' perceptions, we conducted two phases of focus groups with local residents. In the first phase (June 2014), we met with three groups of Vietnamese (9), Somali (8), and Latino/a (10). After the first phase, we reported our initial findings back to the representatives of the local food organizations. They encouraged us

to conduct a second phase of focus groups. In the second phase (July 2015), we conducted focus groups with a mixed racial group (11), Latina/o (8), Burmese (15), and Karen (11).

The seventy-nine residents overwhelmingly agreed the ethnic food markets play a strong, positive role in creating a healthier food system for this poor, immigrant community. As each element of our study will reveal, residents repeatedly told us they felt they could purchase healthy foods locally – supplemented by trips to large supermarkets and wholesale markets – and our audits of those stores confirmed the presence of healthy foods. While the system has gaps, as we shall discuss, the markets do provide an important resource.

Across the various ethnic populations, residents were concerned about the food that was available to their children at school. This issue was also mentioned by members of the expert panel, albeit to a lesser degree. As the one area outside of the direct control of the parents, the food environment at local schools may be an area in need of support by Price Charities.

Project Overview

As we become increasingly concerned about the health of populations, one issue that is of critical importance is food security. The World Health Organization defined food security at The World Food Summit of 1996 as "when all people at all times have access to sufficient, safe, nutritious food to maintain a healthy and active life". . . both physical and economic access to food that meets people's dietary needs as well as their food preferences. Food security is built on three pillars: 1) food availability—sufficient quantities of food available on a consistent basis; 2) food access—having sufficient resources to obtain appropriate foods for a nutritious diet; and 3) food use—appropriate use based on knowledge of basic nutrition and care, as well as adequate water and sanitation. In many communities food security is an issue, as the availability and access to healthy items through a robust food system may be limited, and residents may lack information about the importance of eating more nutritious foods (WHO: http://www.who.int/trade/glossary/story028/en/).

Moreover, in communities that serve multiple ethnic populations, food preferences may vary significantly, further exacerbating food security concerns. A review of the literature shows significant variations in the traditional diets enjoyed by the immigrant groups that make their homes in City Heights. However, what the populations have in common is the tendency to develop unhealthier diets the longer their tenure in the United States. (Please refer to Appendix A for the directed research findings on ethnic food by USC students, Phanthira

Taratikhumporn and Eilen Mena—Ethiopian food only).

In this study, we explored how residents in City Heights perceive their food security and their assessments of life in the City Heights community more generally. In previous research, we have examined the manner in which communities perceive their nutritional environments, especially their understanding of the role of different food markets and restaurants. However, this research has focused on communities of African Americans and Latinos, as has most of the literature on this topic. In this study, we propose to explore how the multi-ethnic/racial community of City Heights fits with standard models of food security, food cultures, and alternative food systems. Our research question is: do ethnic enclaves, such as City Heights, suffer from the same food insecurity represented in other poor minority areas, or do they have protective resources growing out their reliance on markets specific to their ethnicity and alternative food resources, such as farmers markets or fresh vegetables and fruit (FVF) trucks (not typically found in many other American poor communities)?

We completed this project by engaging in the following tasks:

1. We created a participatory process of information gathering around resident's understanding of their food security, and their perceptions of City Heights, and related topics, such as their involvement with other community organizations, and multi-cultural interactions through a series of seven focus groups—with native born and foreign born blacks; native and foreign born Hispanics; native born and foreign born Vietnamese; a mixed race English speaking group; and two groups of foreign-born natives of Burma (Burmese and Karen). The goal here was to hear

from each of the ethnic populations that are represented in the City Heights community. Becky Modesto and Price Charities' staff was generous enough to make connections with residents, relying on the Charities' trusted position within the community. In addition, a subset of these community residents provided translation for project data collection instruments, as well as simultaneous translation of focus group responses.

2. We conducted a focus group with key stakeholders in the area of local food provision to learn from them their views of the current community-based nutritional resources and multi-cultural interaction.

3. Food outlets identified in 1 were surveyed to document the availability of healthier food options, including fruits and vegetables, low-fat, low-salt and other healthier options, as well as their price.

Methods

Over the span of the grant, we employed a mixed methods approach to learning about ethnic foods in City Heights. In anticipation of the study, we met with Richard Parks, Becky Modesto, and Howard Greenwald to learn more about a study conducted on City Heights' food banks, and their role in ensuring food security for low-income residents of City Heights. After this meeting, we strongly felt that we needed to move cautiously given the extent of previous work

in this area in City Heights. So we proposed to Becky that we meet initially with a group of stakeholders from key local organizations to discuss our interests and get a sense from them their thoughts on food access concerns for City Heights. More directly, we wanted to gauge the experts' sense of food inequities and issues, especially for vulnerable minority and immigrant populations.

Next, we conducted seven focus groups with City Heights residents. Each focus group was conducted in a different language – English, Spanish, Vietnamese, Somali/Ethiopian, Burmese and Karen -- so that local residents, especially recent immigrants from these communities would feel comfortable. In addition. each participant completed a short profile questionnaire, allowing us to create a general profile of the participants.

One of the questions asked during these focus groups was, where do you shop? We compiled the responses, creating a universe of food markets serving the community. Using this list, we conducted an audit of the foods available in these markets, utilizing an instrument developed as part of the REACH (Racial and Ethnic Approaches to Community Health) grants funded by the CDC.

For the purposes of this study, we categorized the food markets into five categories: Supermarkets, offering a wide range of ethnic and non-ethnic foods; Ethnic Markets, offering a narrower range of foods, focusing on one ethnicity (such as Mexican); Hybrid Ethnic Markets, offering a wider range of foods from multiple ethnicities; Convenience Stores and Liquor Stores, the traditional stop-gap providers of very limited goods. While the focus group participants

admitted that they went to the last two categories occasionally for food items, when we asked them where they shopped, they did not mention any stores in the last two categories.

In our store audits, we surveyed 15 stores that the focus group respondents reported shopping at – we only did those stores in the City Heights area (we did not survey Costco as none of the members of our survey team had a membership card, Walmart and a couple of other big box stores located outside the area). Appendix B provides the location of the audited stores. Unfortunately, our researchers ran into an unexpected difficulty with two of the smaller stores – the names of food items and the prices were in languages they did not read, so we have removed Gonzalez Northgate Market and Minh Hong Market for some aspects of the results reported below. We do not believe that the removal of these stores negatively affects the outcomes, save that if we had them, they would only support further our overall finding that ethnic markets are protective features of low-income community food systems.

A number of residents also mentioned the local farmers' market as an additional source of groceries. They did not mention vegetable and fruit trucks, but one participant did mention that he regularly gardened in a local community garden. We did not audit these sources.

The three elements of the study – the expert panel, the focus groups, and the market audits – allow us to gain a reasonable portrait of the current food system that residents are using to feed their families. As a result, we produced a narrative discussing what we learned as well as a set of detailed

maps of the local food systems as defined by local residents and secondary data sources.

Results

Summary

When speaking to local food organizations, issues of trust, safety/security, cultural traditions, and joint programming opportunities were cited as salient issues for understanding food issues for City Heights. When we spoke to residents, we discovered that the ethnic food markets play a strong, positive role in creating a healthier food system for this poor, immigrant community. As each element of our study will reveal, residents repeatedly told us they felt they could purchase healthy foods locally – supplemented by trips to large supermarkets and wholesale markets – and our audits of those stores confirmed the presence of healthy foods. While the system has gaps, as we shall discuss, the markets do provide an important resource.

Expert Panel

In December, 2013 we met with representatives from the following local food focused organizations and service providers: San Diego Unified School District Food Services Department, the San Diego Hunger Coalition, San Diego County Health and Human Services Agency, San Diego WIC and the City Heights Wellness Center. Representatives from IRC, a major player in the local food security arena were invited and were interested in attending, but

couldn’t due to their own organizational retreat planned for the same date.

As a result of the December meeting, we moved forward with our proposed field work and focus groups after adding a few questions to the focus groups and do some additional preliminary research on previous studies given the conversation. In particular, issues of trust, safety/security, cultural traditions-as both barriers and facilitators, and opportunities for joint programming were mentioned by the participants as areas that we explored in greater detail.

In March 2015, we presented our findings from the first phase of our focus groups to the expert panel. Several people from the first meeting were unable to attend, and so the group was a mixture of people we had already addressed, and those who knew very little about the project. At this meeting, several individuals asserted that our findings did not reflect the reality of the City Heights food system. They strongly encouraged us to conduct a second set of focus groups with residents who were connected in various capacities with their organizations. We thanked them for their efforts, and did conduct four more focus groups as a result.

Focus Groups

Phases: We conducted two phases of focus groups. The first occurred in June 2014, the second in July 2015. As noted above, we are indebted to Price Charities for organizing attendance at these focus groups, but we also acknowledge the role of local organizations in supporting especially the second phase.

Participants: First Phase: On June 8, we had back-to-back-to-back focus groups with Vietnamese (9 participants), Somali (8 participants), and Latino (10 participants), residents. Each of the sessions was provided in the participants' primary language, with Becky Modesto having identified individuals to translate the focus group questions and participant surveys (see the report's appendices) and to provide immediate translation during the focus groups.

The mixed ethnicity participants were almost all women from low-income families (90% under $25,000 household income). A majority had less than an elementary school education (65%), mostly lived in rental housing (85%), and had been in City Heights for over a decade (average 11.9 years). They shopped for relatively large families (average of 3.9 persons, ranging from 1-6).

Second Phase: On July 9, 2015, we returned to City Heights, thankful once again for the support and aid of Price Charities and Becky Modesto. We conducted four back-to-back-to-back-to-back focus groups: first, with a mixed race (Anglo, Black, Latino) English speaking (11); second, with a Latino (8); third, with a Burmese (15); and finally with a Karen (a minority group within Burma) (11).

The mixed ethnicity participants were mostly women (68%), although about a third of the participants who were surveyed were men (32%). About 90% of the participants come from low-income households (under $25,000 household income) and a majority of them (52%) had

lived in City Heights for less than a decade.

The most disparate difference between the two phases was their length of residence in City Heights. While the participants in the first phase and in the first two second phase groups (English speaking, Latina/o) on average had lived in the area for a considerable time, the last two Burmese/Karen groups were largely filled with recent immigrants.

Results

We have combined the results from the two phases of the focus groups. Overall, we found that the two groups differed only slightly on most items. The most significant difference was that the second group of focus group participants was generally, although not uniformly, less concerned about school lunches than those in the first round. We will highlight other examples of differences, but we emphasize that, although our expert panelists warned us that the second group would express a much harsher opinion of the City Heights food system, generally they mirrored opinions stated in the first phase.

Nutritional Customs: Healthy Meal: In each focus group, we asked them to define a healthy meal. While each group in the first phase came up with different definitions, all groups shared some characteristics. The Latinos and Vietnamese gave quite similar answers, focusing on specific items, such as vegetables, fish, grains and rice, meats, and fruits. The Somali group took a very different approach, arguing that a healthy meal should be “fresh organic, not processed

food, essential vitamins, clean food, taste good, Halal." The participants across all groups largely agreed that a healthy meal consisted of a balanced meal, freshly cooked, and including high quality ingredients

In the second phase, almost all of the participants agreed a healthy meal should have fruit and vegetables. The first two focus groups emphasized poultry, grains and rice as being part of a healthy meal; while the third group (Burmese participants) expressed that a healthy meal was defined by their doctors and had low carbohydrates and low cholesterol. Many of the Latino participants in the second focus groups stated that a healthy meal was one that was easily accessible and affordable in their area.

Thus, while details differed, the groups largely held the same opinion of a healthy meal, with the exception of the focus by second phase Latinos' focus on affordability.

Cooking Healthier at Home: We first ask them if they cooked at home, ate out, or ate fast food out for the 21 meals in a typical week. The vast majority, 75%, said that they ate at least 12 meals at home, with just about half (48%) saying they ate 18 or more meals at home. In the first phase focus groups, very few people ate out at all, and even fewer ate at fast food restaurants. While 40% of participants reported they ate at fast food restaurants, no one said they ate more than 2 of 21 meals a week there, and only 82% of them said they only ate once a week.

In the second phase of focus groups, the rates varied by group. The English speaking and

Latina/o groups were far more likely to eat away from home and at fast food restaurants than

the Burmese or the Karen. Indeed, the Burmese and Karen groups ate an average of just over 17 meals at home. Most participants said that at most they ate out twice a week, and the vast majority said they ate fast food once a month. In contrast, the other two groups averaged 14 meals at home, with three quarters of participants (77%) reporting they ate out at least once, and typically more a week. However, even here, save for a couple of outliers, the vast majority of participants who ate at fast food restaurants (69%) ate there only once or twice a week.

Second, we asked them if they had taken measures to cook healthier meals at home. Again the groups in the first phase almost unanimously responded yes. They have tried a wide variety of strategies, including reducing salt and fat, broiling and steaming instead of frying, increasing the amount of vegetables and reducing the amount of meat (and getting fresh meats rather than prepared). Pretty much everyone agreed on trying to use healthier oils, such as olive oil, and substituting real fruit for sugar and alternatives.

Table 1. Have You Tried To Make The Meals You Cook Healthier In Any Way?*

Focus Group	Yes	No	NA
1.1	10	0	0
1.2	6	0	2
2.1	10	0	1
2.2	8	0	0
2.3	8	0	3
2.4	11	0	0

* During the first round of focus groups, group 1.3 did not provide a tally.

Participants in the first two groups in the second phase stated that they did. They have tried a variety of strategies, including replacing vegetable or canola oil for olive oil, baking meats and fish instead of frying or deep frying and including more vegetables when they cooked meats. One participants in the second focus group stated that she created her own flavored drinks with lemon and cucumber instead of buying sugary drinks for her or her children. Another participant in the second focus group stated that she recreated meals that she buys out in the home in an effort to make them healthier, including tacos and burritos for her and her children.

School Food: Unfortunately, the groups in the first phase generally worried about the foods that their children were getting at school. The Somalis were particularly concerned that the meats were not halal, but just about all these parents feared the food was not very healthy. They reported spoiled food (they specifically mentioned bad apples) at schools as well as regular servings of pizza, burgers and other unhealthy recipes, and protein bars for breakfast (the kids don't like the bars). A few participants also mentioned that sometimes the schools simply ran out of food, which should certainly be another area of concern around food availability at school.

When talking to the groups in the second phase about food in schools there was some disparity between participants. The first two groups discussed issues with the meals that their kids were

being served at school, while the last two groups believed that nothing was wrong with the food in the schools. The first two focus groups voiced concerns about how badly the food tasted for their children and many participants expressed how they would serve breakfast at home and a second lunch afterschool because their kids were not enjoying the meals that their school served. One participant in the first focus group stated that her son had actually gained weight from eating the food in the schools. Members of the second focus group stated that the schools falsely advertise healthy meals but served their children pizzas and burgers. Burmese participants in the last focus group stated that many of their children throw out their school meals instead of eating them because they do not like and are not use to school food.

Markets: *Where You Shop*: We asked participants whether they shopped at supermarkets, ethnic markets, hybrid ethnic markets (offering more than one ethnic foods), convenience store, liquor store, or farmers' market. As recent studies have suggested, participants in the first phase focus groups reported that they were willing to travel to shop at better markets, and did not rely heavily on convenience or liquor stores for their groceries. Virtually everyone (81%) shopped at the supermarket (96% of first phase participants), save for the Karen group, where no one reported shopping at a supermarket on the pre-focus group questionnaire. A very substantial majority (68%) also shopped at their ethnic market, while only about a third shopped at the hybrid ethnic market (34%, although first phase participants were much more likely, at 88%) and the convenience store (28%), and a small minority (10%) shopped at the liquor store. Strikingly, over half (56%) shopped at the farmers' market on a regular basis. The

results suggest the powerful role the ethnic markets play in supplementing supermarkets for these low-income residents.

Shopping for Healthy Foods: All three focus groups in the first phase agreed that they were easily able to shop for healthy foods in City Heights. As with many other low-income communities, one reason was that they supplemented what they bought at conventional stores by attending a farmers' market, and mostly ate at home rather than spending on eating out. While the participants in the Somali focus group emphasized how they eat together, and that helps them ensure healthy meals, the Latinos and the Vietnamese both noted that local markets stock goods that help them cook healthfully.

All four focus groups in the second phase also agreed that they were easily able to shop for healthy food in City Heights. The Burmese participants specified that they could meet their food needs in City Heights, except for a sour leaf that is only available for three months out of the year and Durain fruit. Most participants in the other groups supplemented what they bought at conventional stores by shopping at farmer's markets. One Burmese participant in the third focus group had a plot of land and grew food in a local community garden.

This finding was perhaps the most surprising, given our conversations with the expert panelists. The seven focus groups agreed that they could relatively easily shop for health food in City Heights.

Table 2. Would You Say That It Is Easy For You To Eat A Healthy Meal In City Heights?

Focus Group	Yes	No	NA
1.1	7	1	1
1.2	7	0	1
1.3	9	0	1
2.1	7	4	0
2.2	8	0	0
2.3	15	0	0
2.4	11	0	0

Individual respondents reported getting to markets in multiple modes. Almost eighty percent (78%) of participants in the first and second phase focus groups reported that sometimes they walked to at least one market to get groceries. While about one-third (32%) of the first phase participants sometimes drove alone to one or more markets, relatively few (20%) of the second phase participants did so. Almost half (48%) of the first phase participants reported sometimes carpooling with one or more people to get to the market, while the percentage dropped considerably (18%) among the second phase. Almost a third of first phase participants (28%) reported sometimes taking the bus, but only 20% of second phase did so. While twenty percent of first phase participants reported asking the store van to pick them up or return them, only 1 person in the second phase groups agreed.

In our preliminary discussions with Price Charities and others in the neighborhood, we heard repeated concerns about safety, so we asked if people feared walking or going to the store. The answers were generally, no in both phases of focus groups. They recognized that the time of

day (daylight is far safer) and the exact location of the market matter, but no one said they would not walk to the store, and our findings on the pre-focus group questionnaire reinforce their comments. The Vietnamese respondents did raise concerns about "reckless drivers," while most groups mentioned they knew of spots to be careful around because of gangs. The Latinos respondents mentioned the store vans as a good alternative, and complained that the store bags were often very thin given the length of their walks.

Table 3. If You Walk To The Store, Do You Ever Worry That You Wouldn't Be Safe Either Going There Or Coming Back With Your Groceries?*

Focus Group	Yes	No	NA
2.1	11	0	0
2.2	8	0	0
2.3	8	0	3
2.4	11	0	0

* During the first round of focus groups, we did not tally answers to this question.

In our effort to better understand the role of ethnic markets in City Heights, we asked a series of questions about what the respondents bought where – specifically, did they only go to supermarkets and their own ethnicity's markets, or to other ethnic markets? The groups in the first phase all agreed that they often bought from their own ethnicities (especially the Somalis), but that they all branched out to other ethnic markets and to American supermarkets to get certain types of food or to ensure the food they bought was fresh. The Somalis answered the question, how much do you buy from your own ethnicity, with a simple, "a lot," while they responded regarding other ethnicities, "a little." However, when asked to list the stores they frequented, they mentioned a wide range, both inside and outside City Heights (including Sam's Club, Costco, and a range of supermarkets mentioned above).

Table 4. Do you purchase food from cultures and ethnicities other than your own?^

Focus Group	Yes	No	NA
1	9	0	2
2	3	0	5
3*	NA	NA	NA
4*	NA	NA	NA

^ During the first round of focus groups, we did not tally answers to this question. Groups came to consensus: 1.1 Yes, sometimes; 1.2. only a little; 1.3, only a little (less than 1.2)

* No numeric count is recorded, although members mentioned Asian, Latino, and farmers' markets as examples

Other ethnicities were not so dramatic in their statements. The Vietnamese reported the least

loyalty to Vietnamese ethnic markets. Essentially, they stated and restated, they went where they could get the best food, including mostly supermarkets. As they reported, the "Korean and American market food are fresher than Vietnamese." The Latinos agreed, stating that they buy rice, noodles, and sauces from the Chinese, and flour from the farmers' market.

Table 5. How Much Food Do You Buy That Is Already Pre-Packaged From Restaurants, From Grocery Stores, Or Other Places?^

Focus Group	A Lot	In Between	A Little	Never	NA
1.1*	0	0	4	4	0
2.1	6	4	0	0	0
2.2	0	0	4	0	4
2.3	0	0	12	0	3
2.4	0	0	0	11	0

^ Only the first group in the first round provided a tally, the others gave specific answers to the question rather than categories.

*The participants agreed on "little" or "none" so we have split them between the categories

Many of the participants in the second phase focus groups bought food from big chain supermarkets as well as ethnic markets but only if the supermarkets did not have certain items

or produce that they wanted. A couple Latino participants in the second focus groups shopped at Asian ethnic markets for seafood and rice. One participant in the first focus group stated that stores like Ralph's and Vons are ethnic due to the variety of food that they offer. He even stated that he would actually like a "good old American supermarket" in City Heights.

Prepared Foods: Strikingly, given recent recognition of the role prepared foods play in supermarket profits and American diets, all three focus groups in the first phase reported that they don't purchase much prepared foods. The Latinos argued, the prepared foods "don't taste the same," while the Vietnamese admitted they do buy stuff "as a last resort." The Somali's agreed that some things could be purchases, such as cookies, cheese, and mixed vegetables.

Restaurants: Conversely with the markets, Table 1 makes it clear that the restaurants named by the respondents suggest how poorer neighborhoods struggle with a combination of fast food and franchise restaurants – although supplemented by mom-and-pop ethnic restaurants. When asked why they liked the restaurants they frequented, focus group respondents reported a combination of one has more vegetables, while another offers my ethnic foods. The concerns about health come through in comments suggesting reasons for liking a restaurant, more vegetables, more variety, and greater freshness.

Table 6. Restaurants Named by Focus Group Respondents

50 Seconds Restaurant	Japanese food
Arab restaurants	Mystic Grill Pizza
China Buffet	Olive Garden
Chinese food	Pat & Oscars
Chuckee Cheese	Soup Plantation
Costco salads	Subway
Hometown Buffet	Vietnamese restaurants

Favorite Restaurant: Perhaps not surprisingly, when asked participants in the first phase focus groups for their favorite restaurants, they listed most non-ethnic restaurants by their names, and then simply named their ethnic favorites as a group, Japanese, Arab, and Vietnamese. Most surprisingly to us was how few Mexican or other Latino restaurants respondents named. Indeed, unlike both the Somali and Vietnamese respondents who named ethnic restaurants related to their culture (or nearby), Latino respondents named conventional American chain restaurants ranging from Hometown Buffet to Chuckee Cheese and Japanese and Chinese ethnic restaurants.

The majority of the participants in the second phase of focus groups mostly ate at home rather than eating out and if they did eat out it was to treat themselves a couple of times in the month, buying food for their kids, trying out a meal from another ethnic group, or because they were in a rush and had no time to cook meals for themselves. One Burmese participant in the third focus group stated that if he did eat out, he would eat out in restaurants that served Asian

cuisine as a way for his meals to stay in his ethnic group. Some of the restaurants that they attended included: McDonalds, 777, Soup Plantation, Olive Garden, Panda Express, Jack in the Box, Hometown Buffet, Wing Stop and Subway, which members of the second focus group of Latino participants stated was the healthiest restaurant in City Heights.

Thus, both groups generally named a very similar set of restaurants, agreeing that few of them in City Heights were especially healthy.

Ask for Healthier Preparation: We asked the focus group respondents if they ever ask that something be made healthier. The Somali's pointed out a key barrier when they stated that when they asked if it could be made healthier, the restaurant workers responded, it is healthy. However, one respondent did say s/he did ask that the fish be grilled rather than fried. The Vietnamese agreed with the Somalis that culturally asking cooks to change their foods was inappropriate, but they did state they asked for more vegetables and to take things out they did not like. And at least one Latino respondent sent meals back for being too fatty, having soggy vegetables, and too much grease.

Most participants in the second phase stated that they just replace certain items in the meal like a salad for French fries instead of asking for the food to be made in a healthier way or to have certain sauces be removed from certain meals. Burmese participants in the last two focus group stated that if something seemed unhealthy they would just not order it at all.

Thus, the groups generally did not ask for a healthier preparation.

Overall: When we asked if participants in the first phase of focus groups wanted any changes in the local food system, somewhat surprisingly, the Somalis and the Vietnamese both focused their comments on the schools. The Somalis wanted more halal in the schools, and the Vietnamese responded that the food is not healthy, and kids "need healthy food for nutrients and growth." The Latinos focused on the availability of healthy foods in markets and restaurants, worrying that they had no substitute for McDonalds, and worried that the closing of Albertsons would leave an important vacuum. Finally, both the Somalis and the Latinos expressed concerns about food prices.

In the second phase of focus groups only the first two focus groups really voiced concerns. The first group wanted more organic food establishment options in City Heights, such as Trader Joes, Sprouts or Whole foods. The second group wanted better quality produce as well as more affordable healthy food options. They voiced concern over the cheaper food in City Heights being unhealthy McDonald's burgers. The last two focus groups, which were full of many newly arrived immigrants stated that they had no complaints and worried, "what if change is for the worst."

Market Audits

Student researchers used our validated instrument to check on a wide range of issues related to the 15 food markets identified in City Heights by the focus group respondents. As we noted above, the students were unable to answer some questions about specific fruits and vegetables since the prices and names of the items were not in English. However, we have incorporated the full sample throughout most of the results.

As noted above, we divided the 15 markets into three categories: supermarkets, ethnic markets and hybrid ethnic markets. Table 2 identifies the markets placed in each category.
We did not include Costco, again due to the lack of the membership card, Sam's Clubs or other markets outside City Heights in our sample.

Table 7. City Heights Markets Mentioned In the Focus Groups

Supermarkets	**Ethnic Markets**	**Hybrid Ethnic Markets**
Smart & Final	Vien Dong Supermarket	Gonzalez Northgate Market
Sprouts Farmers Market	Super Mercado Murphy's	Zion Market
Whole Foods	Pancho Villa Farmer's Market	99 Ranch Market
Traders Joe's	Minh Huong Supermarket	
Food 4 Less	Murphy's Market	
Ralph's		
Foodland Mercado		

The audits reveal why the food systems literature repeatedly argues for the importance of

access to supermarkets for all urban residents. In our sample, Table 3 shows that supermarkets were much more likely to carry ground turkey (80% supermarkets versus 33% hybrid ethnic markets and 40% ethnic markets), regular and low-fat cheeses (100% versus 33% and 0%), regular and low-fat yogurt (100% versus 33% and 60%), non-fat milk (100% versus 33% and 80%), and low-fat dressing (100% versus 33% and 60%).

Table 8. Meat and Dairy Availability by Market Type

	Skinless	Ground	Whole	1% or	Non-fat
Market Type					
Supermarkets	86%	86%	100%	100%	100%
Ethnic Hybrid	100%	33%	66%	66%	33%
Ethnic	100%	40%	80%	80%	80%

All the stores (save one ethnic market) carried both regular cookies and regular potato chips, key items that add unnecessary calories to diets. Given the role of sweets in adding calories and sugar to people's diets, the difference between stores was especially clear for low-fat cookies (86% versus 33% and 20%), although low-fat potato chips was low across the board (14% versus 33% and 0%).

We did find some positive results: most stores carried not only whole chicken (100% for all), but also skinless chicken (only one supermarket did not carry this item). The same result was true for fresh fish, available from almost all the stores, save two supermarkets. Further, a wide range of stores carried 1% or 2% milk (100% versus 66% and 80%). Lower fat milk is a very positive alternative for most adults. And, all the stores carried soy milk, an item which we found in older studies was rarely available in smaller stores.

Similarly, all the stores carried healthy oils – olive or canola – as well as whole wheat bread (save one ethnic market). Reflecting comments by some focus group respondents, the larger stores were much more likely to carry brown rice (100% versus 100% and 40%), while all of them carried white rice. Perhaps surprisingly, tofu was not available in all stores (71% versus 100% and 60%). Perhaps the greatest availability being at the hybrid ethnic stores does reflect their drawing from multiple cultures.

Quite surprisingly, our student researchers found that all the stores offered the basic fruits

(apples, oranges, bananas), but that when they added up the number of fruits available, the supermarkets actually proved not to be the most accessible for the widest range of fruits. Instead, the hybrid ethnic markets offered a much wider selection than either the supermarkets or the small ethnic markets.

Table 9. Fruit Availability by Market Type

	101 or More	71 to 100	31 to 70	1 to 30
Market Type				
Supermarket	14%	14%	43%	29%
Ethnic Hybrid	100%	0%	0%	0%
Ethnic	20%	0%	60%	20%

We found the same relationship was true when we counted the types of vegetables available in stores (Table 5). The supermarkets actually proved to have the least selection compared to both the hybrid ethnic markets and the smaller ethnic markets.

We did find that all the stores seemed to have good fruits and vegetables, with few reports of damaged, mushy, or dirty items across the stores. One researcher did report a number of flies in the fruit section at one store, but did not report that the fruit was bad.

Finally, we asked the student researchers to record prices on a selected number of items, including bread, milk, chicken breasts, yogurt, and potato chips, to see if consumers using

smaller ethnic markets paid a premium for the convenience of the store. The results from their audits are listed in Table 6.

Generally, we found that, not surprisingly, supermarkets are indeed less expensive, and small ethnic markets are most expensive. As with most cost studies, however, we found anomalies to the general rule. Most strikingly, a 1-pound chicken breast was $0.67 cheaper in the ethnic markets than it was in the supermarket. Similarly, a low-fat yogurt was almost the same price in the supermarket and the hybrid ethnic market. However, for a loaf of white bread, a quart of milk, or a 16 ounce bag of potato chips, the supermarket was considerably less expensive.

Table 10. Vegetable Availability by Market Type

	101 or More	71 to 100	31 to 70	1 to 30
Market Type				
Supermarket	14%	0%	57%	28%
Ethnic Hybrid	100%	0%	0%	0%
Ethnic	20%	40%	40%	0%

Overall, the store audits revealed that the City Heights food system is well served by its ethnic markets. They provide easy access to a wide range of vegetables and fruits. These items may be more expensive but not exorbitantly so. And, as we found from the focus group responses, City Heights residents are quite savvy at shopping in multiple stores to get what they need at reasonable prices.

Table 11. Food Pricing by Market Type

	White Bread	1%-2% Milk	Potato Chips	Chicken Breast	Low-Fat Yogurt
Supermarkets	$2.23	$2.23	$3.10	$3.42	$0.91
Ethnic Hybrid	$2.49	$2.49	$4.02	$3.12	$0.89
Ethnic Markets	$2.39	$2.41	$3.49	$2.75	$1.22

Summary and Recommendations

The study found that ethnic markets play a largely positive role in creating access to fresh vegetables and fruits in the low-income community of City Heights. The findings of each component of the study reinforced the presence of a wide range of healthy foods. And, the respondents in our focus groups generally expressed an ease at finding and using healthy foods in their diets.

In general, participants in the focus groups took a positive view of the food system in City Heights. They largely had good access to food markets that provided high quality, fresh

vegetables and fruits within walking or easily traveled distances. Although quite poor as a group, they did not express concerns about the environment aggravating any food availability issues. And, they responded to the very commercialized food system of America by largely cooking at home, which research has shown to be an important protection against overweight and obesity.

However, the responses were not all so positive. Not only did the focus group respondents repeatedly express concern about school food and worries about prices, a close reading of their answers suggest that they travel pretty wide distances to get all the healthy ingredients they need. The repeated references to Sam's Club and Costco, neither of which are located in City Heights, remind us of the burden low-income community residents bear in ensuring that their families have healthy meals. And, the repeated references to greasy, fatty foods from national franchise chains reinforce this perception.

Overall, though, residents have adapted to their environment, as recent literature is suggesting is true in many low-income communities, to develop sources of healthier foods. Regarding recommendations to Price Charities, three points are worth highlighting ever as we continue to learn more about the City Heights food system:

First, a considerable number of shoppers rely on the presence of the local farmers' market as part of their food system. We strongly encourage Price Charities to support the continuation of

this valuable source of vegetables and fruits.

Second, while a large majority of shoppers were able to walk to local markets that serviced their food needs, the system appeared fragile. The loss of a single food market, especially one of the ethnic markets, could severely compromise the food system in City Heights. We strongly encourage Price Charities to continue to work with local markets to encourage the availability of fresh vegetables and fruits, and their financial viability.

Third, the concerns with food in school expressed by multiple participants may be an opportunity for greater engagement or investment with the San Diego Unified School District. The representatives of that system with whom we met during the expert panel showed considerable interest in working with other organizations to promote healthy foods at school, and to respond to community concerns.

Appendix A

Ethnic Food Access and Barriers in City Heights, San Diego

Ethnic Food Access and Barriers in City Heights, San Diego

Phanthira Taratikhumporn

Food access is having sufficient resources to obtain appropriate foods for a nutritious diet. Culture and ethnic play an important role in assigning and allocating proper food access for different populations. City Heights, San Diego becomes the new melting pot for different ethnic groups, especially for Mexican, Somali and Vietnamese communities. Culture diversity defines City Heights. The new waves of immigrants escalate the concern for ethnic food access in the immigrant population. Many immigrants try to adapt into the American's lifestyle including the unhealthy eating habits. American foods usually consist of cheese, meat, butter, egg, bread, milk and soda which are high in cholesterol, sodium or sugar levels. Most of the ethnic groups came from a healthy diet system, but when they acculturate to the American culture, they soon develop unhealthy diet pattern. How can City Heights help prevent the immigrants from developing the unhealthy diet pattern?

This question raises a significant concern for City Heights. Due to the high cost in health care expenditure from chronic diseases that can be prevented by healthy eating and exercise, City Heights wants to look into providing healthy ethnic food access for the population. By providing appropriate ethnic food access for the new immigrants within the community may encourage the continuation of healthy diets for the immigrants in the long run. This research studies three different ethnic groups of immigrants in City Heights: 1. Vietnamese Cuisine 2.

Mexican Cuisine 3. Somali Cuisine. By studying the different ethnic foods and barriers to healthy eating among the three dominant immigrants will help City Heights evaluate ethic food access issue and provide the most positive and effective food outlets for the community.

Vietnamese Cuisine

Vietnam locates at the easternmost country on the Indochina Peninsula in Southeast Asia with the population of over 90 million. China, Laos and Cambodia are the neighboring countries, therefore, Vietnamese cuisines appears to be similar and influenced by Southeast Asian Countries. According to the CNN Health, Vietnamese cuisine is voted to be one of the top ten healthiest ethnic cuisines in the world (Corapi 1). Vietnamese foods also tend to use a lot of fresh herbs, vegetables and seafood with the cooking techniques that use water or broth instead of oils (Corapi 1). Traditional Vietnamese flavoring includes basil, mint, lemon grass, ginger, garlic, anise, onion and cilantro that help aid digestion and fight disease-causing (Corapi 2). These are some of the standout qualities of Vietnamese food which are lower in calories and healthier than the typical American cuisine. This emphasizes the importance of incorporating Vietnamese's traditional foods into the market in City Heights to help promote the continuation of healthy eating habits for the immigrants.

Since 1975, about 600,000 Vietnamese refugees have immigrated to the United States, and the trend of Vietnamese immigrants coming to the States has never stopped since then (Nguyen 472). City Heights experiences an increase of Vietnamese immigrants. Immigrants try to adapt into the new environment by alternating their ethnic food diets to American diets. For

example, a study on Vietnamese in Vietnam and Hawaii stated that “while older [immigrated] Vietnamese people still prefer a traditional diet, many parents complain that their children eat poorly, preferring western fast foods with few fruits and vegetables…and quickly adopt American standards” (Nguyen 473). This shows that immigrants’ children are more susceptible to change to the American diets than the older generation.

According to the study of “Food Habits and Food Preferences of Vietnamese Refugees Living in Northern Florida,” the eating habit survey of 260 Vietnamese refugees residing in Northern Florida resulted as: “the respondents still preferred the Vietnamese cuisine, but factors such as income, length of stay in the United States, exposure to news media, food availability and relative prices of food might have influenced their change in food habits” (15). In order to help the Vietnamese immigrant to keep their healthy diet, City Heights should provide affordable traditional food access for the new immigrants. By adapting the American unhealthy diets will create more susceptibility for the new immigrants to develop chronic diseases which have a higher cost in the long run. Traditional food is a powerful symbol in maintenance of ethnic identity and cultures. By encouraging and helping the immigrants to keep their traditional healthy diets, City Height can benefit from acculturating Vietnamese’s healthy food diet into the community as well.

Mexican Cuisine

Mexico is the southern neighboring country of the United States. Mexican cuisine is influenced by the Spanish conquers in the early 1500s when they bought foods such as pork, rich chicken, wine, garlic and onions (Gulezian 1). Their most common ingredients are corn, beans, chilies, avocado, tomatoes, cheese, tortillas and spices. Although the consumption of meat and animal products are popular in Mexico, they are often limited due to cost (Romero-Gwynn et al. 6). Therefore, Native Mexicans eat less meat than the Americans. Fruits and vegetables are also abundant in Mexico's rural areas, including: bananas, guavas, papayas, mangoes, melons, pineapples, oranges and limes (Tucker 1). Since vegetables and fruits are cheaper than meat, Native Mexicans consumes more vegetables and fruits than meat. In the American Journal of Epidemiology, the study of Mexican American 1,449 women and 1,404 men aged 25-64 years shows that Mexican Americans born in Mexico consumed significantly less fat and significantly more fiber; vitamins A,C, E and B6; and folate, calcium, potassium and magnesium than did those born in the United States (Dixon, Sundquist and Winkleby 4).

This study shows that Mexican Americans usually changed their traditional food diet to American diet as time progresses. Since Mexican Americans living in the United States become more acculturated, their diets may become less healthy, increasing their risk of cardiovascular disease, obesity and diabetes along with the rapidly growing group of Americans (Dixon, Sundquist and Winkleby 5). This survey indicates that Mexican Americans living in the United States are more likely to consume diets that have adverse effects to their health and ethnic cuisine dietary advantages. Therefore, City Heights should also encourage New Native Mexican Immigrants to keep their traditional healthy diet by providing affordable ethnic food access in their local markets.

Somali and Muslim Cuisine

Somalia is located at in the Horn of Africa with bordering countries and ocean: Ethiopia to the west, Djibouti to the northwest and Indian Ocean to the east. The country has been affected by a civil war since 1991 and the situation has been further aggravated by prolonged droughts (Unicef 1). Due to the political instability, food insecurity and extreme poverty, Somalia has some of the highest malnutrition rates in the world (Unicef 1). Many Somalis migrate to City Heights as refugees. Since almost all Somalis are Muslims, Somali dietary associates with their religious practice. Somali immigrants' diet include halal and haram foods (Haq 1). Halal foods include "all plants and some animals if they conform to the religious method of slaughtering such as: lamb, goat, camel, cow, and chicken are halal animals" (Haq 2). The Islamic mode of slaughtering involves two steps: 1. Mentioning the name of Allah before beginning the slaughter 2. Severing of the throat, wind pipe and the jugular veins in the neck, without cutting the spinal cord (Haq 2).

Haram foods are forbidden goods or drinks, including pork, blood, and animals not slaughtered in the proper way, alcohol and drugs, and foods containing ingredients obtained from other haram foods (Haq 2). Religion highly influences Somali's dietary practices. Muslim dietary practice is the test of obeying God. However, in United States, the markets rarely carry any Halal meats, which can be problematic for the new immigrants to follow their religious

practices. Meanwhile, most migrated Somali parents like to cook and eat Somali foods, their kids prone to diverge to fast food diet in the United States which leads to obesity (Haq 4). This shows that American's diet creates an adverse effect to Somali immigrants as well as the Vietnamese and Mexican Immigrants. Somali and Muslim food access can be a challenge for City Heights to provide due to the Halal and Haram food restrictions. However, the ethnic food access can help Somali immigrants to continue their healthy diets. Ethnic food access is worth making accessible to Somali community.

After researches on different ethnic food in City Heights, the study conveys that City Heights should provide the three dominant ethnic food accesses to the immigrant communities in order to promote the continuation of healthy eating habits. However, language and income barriers in the immigrant communities may prevent immigrants from making healthy food choices. Therefore, City Heights should also consider language and low-income barriers in the ethnic food access implementation plan.

Ethiopian Cuisine

Ethiopia locates in the Horn of Africa bordering Somalia and Djibouti to the east and Sudan to the west. In the 1970s and 1980s the United States saw a wave of African immigrants mostly from Ethiopia. A 1980 U.S. legislation redefining "refugees" enabled the Black Caucus to secure slots for Ethiopians and Eritreans in the U.S. especially those seeking asylum from the traumatic baggage of famine, due to droughts and civil war at the time (Cohen). Many Ethiopian refugees

and immigrants began to settle in Washington D.C. and other urban areas in the United States (Kloman).

Ethiopian meals begin with the washing of hands in a water basin, due to the lack of utensils used in the eating of the meal; one is to eat with only the right hand. The meal ends with hand washing as well (Kloman). Ethiopian food is served on top of Injera, a moist, spongy bread, made in sheets out of ground tef and is typically served alongside a hot stew. Injera bread is torn in order to scoop up bites of food (Jacobi). Tef is a good source of vitamins and minerals including Iron (Almgard) and is native to Ethiopia. A single serving of Injera typically has 379 calories because it is cooked in a pan with vegetable oil and 4.2 grams of dietary fiber (Dannie).

A typical Ethiopian meal includes lentils, potatoes, peas, green beans, carrots, onions, chicken, lamb and beef served on top of Injera (Kloman). Atakilt Alicha, an Ethiopian stew, that is often served alongside an Injera meal is made out of potatoes, carrots and green beans, simmered in a mild sauce of onions, ginger, turmeric and garlic (Kloman). Two key ingredients that are ubiquitous to Ethiopian cuisine are kibeh, or Ethiopian butter, flavored with cardamom, nutmeg, cinnamon, ginger and other native spices and berbere, a mix of spiced herbs that include cumin, chili powder and cardamom (Forman). Another Coffee is also a very important part of Ethiopian diet and is often served after every meal (Kloman.)

About a third of Ethiopians practice Islam, so their dietary practice reflects that of their religious

practice. Similar to Somali's who practice Islam, Muslim dietary religious practice includes Halal and Haram foods (Haq). Halal foods include "all plants and some animals if they conform to the religious method of slaughtering such as: lamb, goat, camel, cow, and chicken are Halal animals" (Haq). The Islamic mode of slaughtering involves two steps: 1) Mentioning the name of Allah before beginning the slaughter and 2) Severing of the throat, wind pipe and the jugular veins in the neck, without cutting the spinal cord (Haq). Haram foods are forbidden goods or drinks, including pork, blood and animals not slaughtered in the proper way, alcohol and drugs and foods containing ingredients obtained from other haram foods (Haq). Religion highly influences Somalis' dietary practices. Muslim dietary practice is the test of obeying God.

Barriers to Food Access

Language Barriers

Language barriers in food choice can be problematic for the non-English speakers in an English-speaking country. Most of the food labels and nutrition factors are in English. Without being able to read the food labels or get a nutrition education, the immigrants will develop Western nutrient-poor food choices. Due to Western nutrient-poor foods that are fiercely marketed to consumers coupled with limited nutrition knowledge can lead to an increase in the consumption of nutritionally poor foods in the immigrant communities (House et al. 1). This shows that media fiercely influenced the non-English speaking immigrants in food choices. Media may advertise bias and obscure nutritional facts to the immigrants. Without being culturally informed about healthy eating in a new food environment may lead immigrants to

poor food choices as the result. Moreover, in the Nutrition and Dietetics research in "Perceptions of Food Risk and Trust in Non-English Speaking Immigrants," the study indicates that immigrants from non-English speaking countries are at greater risk of developing chronic disease than non-migrant populations (House et al. 1). This highlights a gap in language barrier to understand the new culturally appropriate food information within the non-English immigrants. Besides providing ethnic food access, how should City Heights guides immigrant consumers to healthier alternatives in the American culture and food environment? The recommendation section will address the solution to solve the language barrier issue to food access for the immigrants.

Low-Income Barrier

Another big issue in providing appropriate food access is affordability or low-income barrier to food access. One of the biggest challenges for the immigrants is unemployment and low-income status. In the qualitative study of immigrants experience upon resettlement in the United States from the *Journal of Hunger and Environmental Nutrition*, the participants were asked which food items they started eating after coming to the United States:

> "Soda beverages and/or fruit drinks were the most common items. Another common item was milk, which a majority of the participants reported drinking only after coming to the United States. In terms of other changes, all participants reported eating more

> meat after resettlement. The main reasons indicated were easy availability of meat in the United States and comparatively cheaper cost than what they were accustomed to paying in their country of origin. An indirect reason was the higher cost of traditional vegetables from small ethnic stores. Participants felt that they got a better value for the price they paid for meat than for vegetables. Many reported that they grew their own vegetables and did not pay for them in their homeland; hence, spending money on vegetables in the United States proved difficult." (Dharod et al. 187).

The interview with the immigrants shows the shift of eating more meats than vegetables due to cost value in the United States. In their homeland, vegetables are free commodity grown at their backyards versus the higher cost of traditional vegetables in the United States. Since meats usually cost more than vegetables in their homeland, immigrants' consumption of meats increases. Immigrants value and want to pay for meats more than for vegetables. Immigrants' perspective on cost affects their food choices. In addition, their low-income status and unfamiliarity with regular American food have been shown to cause high rates of nutrient food shortage in the immigrant population.

> Moreover, Liberian woman commented, "'many times we did not have any money, so we would go to lake, catch fishes and exchange some for rice.' Another woman from the highlands of Vietnam said, 'we grew vegetables in backyard, we mainly bought salt, fish oil and sometimes animal fat from the market'" (Dharod et al. 189).

In their homeland, fresh produces can be accessible within their environment without cost. The vegetables and meats are organically grown in the natural environment. In contrast, in the United States, immigrants need to make money in exchange for healthy and fresh foods. Plus, organic vegetables cost even more than the regular vegetables in the local market. Lifestyle in the United States is significantly different than their homeland's lifestyle and values. Since most of the immigrants are usually in the lower income level, they will have hard time adapting to paying more for healthy food. Therefore, City Heights should also consider the price sensitivity in healthy food access for the immigrant communities.

Recommendations

Ethnic Food Access: Due to the barrier in ethnic food access, City Heights should integrate ethnic food options into the local markets. Researches on different ethnic food in City Heights convey that City Heights should provide the three dominant ethnic (Vietnamese, Somali and Mexican) food accesses to the new immigrant communities in order to promote the continuation of healthy eating habits. Without access to ethnic foods, the immigrants would acculturate to the American nutrient-poor diets. The cost of healthcare expenditures due to nutrient-poor diseases will be higher cost than providing local access to ethnic foods for the immigrant communities.

Nutrition Education Groups: Not only should City Heights provide ethnic food access, but the

city should create nutrition education groups for the immigrants to learn from Somali, Vietnamese and Hispanic dietarians. This program will help reduce the language barrier in food access within the immigrant communities in City Heights. The nutrition education groups will help encourage and educate immigrants to eat healthy food. Without education, the immigrants will not know what types of food are good or bad for their health. A good example of the nutrition education group is from the Harborview Medical Center (HMC). HMC created 70 nutrition education groups for Somali pregnant and postpartum women, infants, and children up to age five (Haq 1). Nutrition Education Program lasted for 2 years, and the study group shows: 41 percent of the families who attended the education group reported eating more than three servings of vegetables, 97 percent of the families who attended the education group reported understood education, 70 percent reported that they liked the group, 95 percent reported they enjoyed the group interaction (Haq 6). This shows that nutrition program benefits the Somali community in many different ways such as: creating a sense of community within the ethnic group, educating the ethnic group on nutrition diets, and helping the ethnic eat healthy foods. The program became a successful model for changing the community to healthy diets. According to the community group survey, the most impactful nutrition classes are: “Basic Nutrition Education, Childhood Obesity, Dietary Treatment of Nutritional Anemia, Snacking and Dental Health, Diet and Exercise, Preparing Healthy Snacks, Introducing Veggies to Preschool Children, Bean Cookery, Cross-Cultural Diets, and Breast-feeding Education” (Haq 6). These classes will help the immigrants to be educated in their children’s health as well. City Heights can follow the HMC Nutrition Education Groups to create a sense of community among different ethnic groups of immigrants and help support the immigrants in healthy living.

Healthy Food Vouchers**:** In addition to the nutrition education group program, City Height should provide healthy food vouchers for the low-income immigrants in order to eliminate the low-income barrier in food access. By encouraging immigrants to eat healthy food, the city can help prevent diet related health problems such as diabetes, childhood obesity, feeding disorders, lipid abnormalities, eating disorders, and anemia (Haq 3). These are the common diseases within the immigrant communities in which they all have high healthcare expenditure in the United States. In the WIC Clinic at Harborview Medical Center Study, the nutrition education program plus food vouchers show significant success in shifting the unhealthy diet patterns to healthy diet patterns. In this two-year program, the study proves that "41 percent of the families who attended the education group reported eating more than three servings of vegetables and 61 percent of patients attending the groups redeemed their gifts farmers' market checks to buy fruits and vegetables" (Haq 4). This shows that by providing families with healthy food vouchers with the support of nutrition education groups can meaningfully change the unhealthy food consumption to healthy food consumption.

Conclusion

In conclusion, this research has addressed the ethnic food access concerns in City Heights and concluded that City Heights should provide ethnic food access for the immigrant communities due to the following reasons:

1. Encourage the continuation of healthy ethnic food diets
2. Lower healthcare expenditure due to poor-nutrient related diseases
3. Enable the immigrants to practice their religious and culture traditions

However, aside from ethnic food access issues, City Heights should also consider the significant impacts of language and low-income barriers to nutrient food within the immigrant communities. In order to help reduce the tension and stress for the new immigrants in adapting into the new environment, City Heights should offer Nutrition Education Group Program in three different languages: Vietnamese, Somali and Spanish. This program will help educate and create a sense of community for the immigrants to acculturate to City Heights. In addition, the immigrants will also receive a healthy food vouchers by attending the nutrition education groups. The food vouchers will help and encourage the low-income immigrants to adapt into the healthy diet system. All in all, City Heights can benefit from this program by creating healthy communities to save on the healthcare cost expenditure in the long run.

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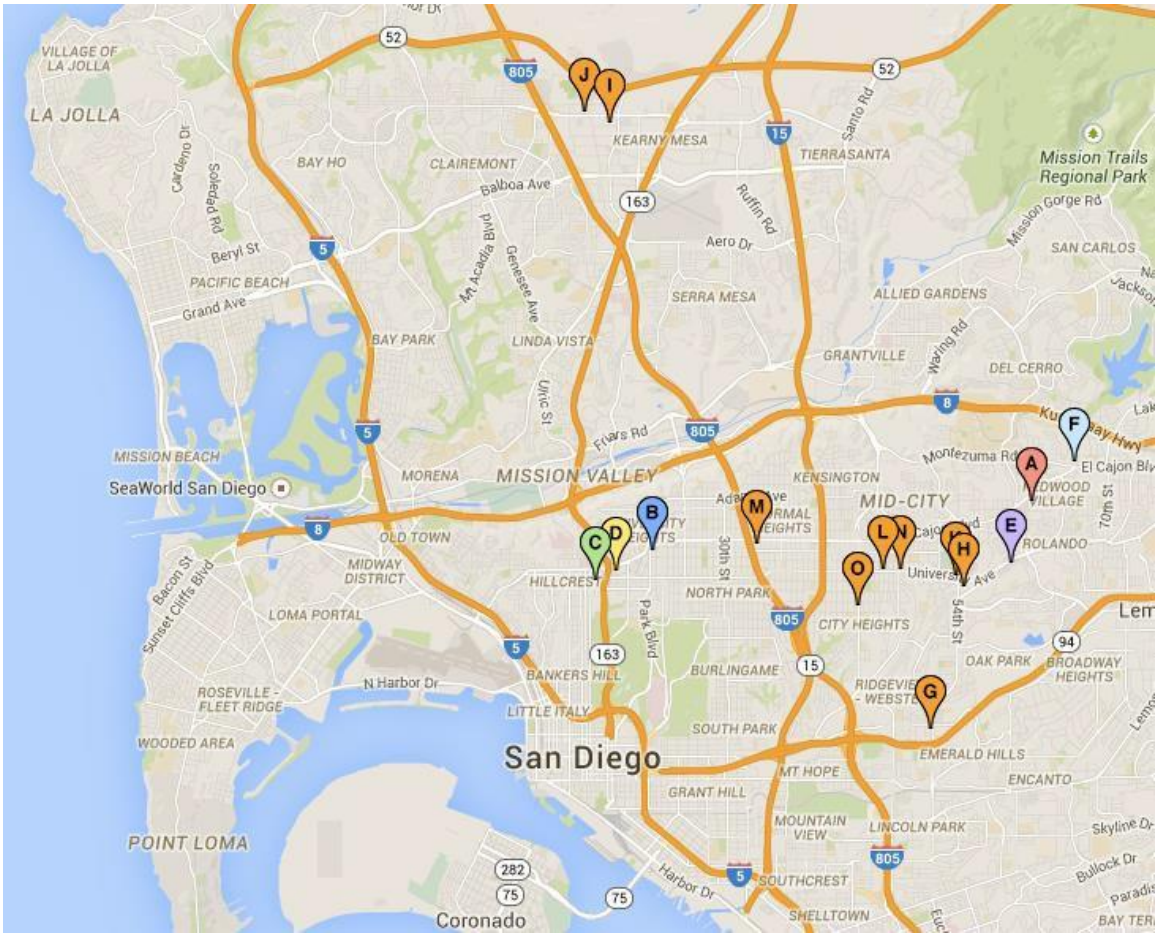
Appendix B

EFFECT Market Audits City Heights, San Diego



	Market Name	Street Address	City	State	Zip Code
A	Smart & Final	6235 El Cajon Boulevard	San Diego	CA	92115
B	Sprouts Farmers Market	4175 Park Boulevard	San Diego	CA	92103
C	Whole Foods	711 University Avenue	San Diego	CA	92103
D	Traders Joe's	1090 University Avenue	San Diego	CA	92103
E	Food 4 Less	5975 University Avenue	San Diego	CA	92115
F	Ralph's	6670 Montezuma Road	San Diego	CA	92115
G	Foodland Mercado	5075 Federal Boulelvard	San Diego	CA	92102
H	Gonzalez Northgate Market	5403 University Avenue	San Diego	CA	92105
I	Zion Market	7655 Clairemont Mesa Blvd	San Diego	CA	92111
J	99 Ranch Market	7330 Clairemont Mesa Blvd	San Diego	CA	92111
K	Vien Dong Supermarket	5382 University Avenue	San Diego	CA	92105
L	Super Mercado Murphy's	4580 University Avenue	San Diego	CA	92105
M	Pancho Villa Farmer’s Market	3245 El Cajon Boulelvard	San Diego	CA	92104
N	Minh Huong Supermarket	4029 Euclid Avenue	San Diego	CA	92105

O	Murphy's Market	3596 Fairmount Avenue	San Diego	CA	92105