Rebuilding a healthier New Orleans

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The Journal of the Royal Society for the Promotion of Health 2006; 126; 256
DOI: 10.1177/146642400612600609

'It has given me more opportunity to buy fresh, healthy food.'
'The co-op is the most colourful place on the square.'
'It is a good place to meet other people on the estate.'
'I don't feel so isolated when I come down here as I see other people.'

SUCCESS FACTORS

The early successes of the co-op were due to the community development approach, CNA, strong partnership engagement and the substantial commitment of local volunteers.

While the initial idea had come from GTPCT, local residents were soon won over and became involved in directing the project. This came about via the evidence-based orientation of the CNA, which systematically and objectively documented community facilities, enabling residents to express their views. The CNA remains the centrepiece of the model as it establishes the need, the lack of affordable access to fresh fruit and vegetables, drives interest in the project and provides volunteers ready to be trained. The CNA also explores accessible green space, transport, sports and physical activity facilities in addition to food access.

It was essential to plan for the sustainability of the project from the very beginning and the intention was always that the co-op stalls would become self-funding.

THE FUTURE

As we write this in May 2006, another three stalls are being established throughout Greenwich. Now that the co-op is a cross-borough operation, a new business plan is being developed to provide the strategic direction for the fast expanding operation. Larger scale evaluation will be built in to future development.

If the business plan predictions are successful the Greenwich Community Food Co-op will be financially sustainable and independent of external funding by 2009 with an annual turnover in excess of £500,000.

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As I write, workers are still discovering bodies in New Orleans. They are hidden in attics or under mud-covered furniture, in a few of the tens of thousands of flooded houses that last fall were inspected briefly or not at all, and are finally being found thanks to persistent relatives or house gutting crews. The state health agency currently counts 1577 hurricane-related deaths, although that number may rise somewhat when more deaths from evacuees are added.[1]

Hurricane Katrina was far from the only cause of preventable deaths in New Orleans, though. Before the storm, New Orleans was one of the unhealthiest cities in the USA. With approximately 5000 deaths per year in a population of approximately 460,000, it had an age-adjusted mortality rate 24% higher than that of the USA as a whole.[2,3] This statistic suggests that nearly 1000 of those 5000 deaths every year were preventable, or that about every 18 months as many New Orleans residents died of preventable diseases as died during the huricane.

While the mortality rate was higher in pre-Katrina New Orleans than in the nation as a whole, the leading killers were the same: cardiovascular diseases, cancer and injuries. These causes arise in large part from a very

small number of health-related behaviors, particularly smoking, lack of physical activity, poor diet, alcohol consumption, driving accidents and the use of guns. Rather than classifying deaths by the diseases recognized by physicians, it is often more useful to classify them by the underlying behaviors and exposures that lead to these diseases. Estimates by the US Centers for Disease Control and Prevention are that 18% of deaths in America are caused by smoking-related diseases, 17% by the combination of unhealthy diet and physical inactivity, 3.5% by alcohol consumption and 1.2% by firearm use.[4] No one has produced estimates like this for New Orleans, but it is reasonable to assume that the ranking of the leading unhealthy behaviors is similar.

These behaviors themselves are very much influenced by the world in which we live every day.[5] For example, it is not hard to understand how people who live in sprawling car-dependent suburban neighborhoods become less physically active, or how people without easy access to grocery stores selling fresh fruit and vegetables would eat fewer of them.

Before Hurricane Katrina, New Orleans was a particularly unhealthy environment. Outside of the city center, and hidden to tourists, were large, predominantly poor neighborhoods that supermarket chains avoided in favor of more profitable areas. To fill the gaps left by the supermarkets, small family-owned stores made money by selling items with long shelf-lives and high profit margins: mainly cigarettes, beer or fortified wine, soft drinks and salty snacks such as potato chips. People growing up in these neighborhoods whose families do not own cars can only be expected to have unhealthy diets and high rates of smoking and drinking. As the New Orleans city government with its declining tax base navigated from one financial crisis to another, services dropped off, so neighborhood parks fell into disrepair, sidewalks were not maintained or were non-existent, street lights were non-functional, vacant houses became blighted, vacant lots became covered with trash and crime rates nearly topped the nation. To put it mildly, this environment did not encourage outdoor physical activity; more often it frightened residents into staying indoors, often engaged in the distinctly unhealthy behavior of watching television.

As devastating as Hurricane Katrina was to New Orleans, it also offers an unheard-of opportunity to fix these problems and promote health. Several billion dollars in federal reconstruction funds are headed toward the city, and city planners are now drawing up plans on how to spend them. While most of the funds will be used to help individual homeowners rebuild their houses, there may be enough left over for rebuilding much of the common infrastructure. If the planners and elected leaders understand the concepts of healthy neighborhood design and care about residents' health, the city can rebuild its infrastructure in ways that will positively influence the most important determinants of health. To promote physical activity, the city can rebuild or renovate sidewalks, neighborhood parks and playgrounds, and include cycle lanes on newly repaired streets. To reduce crime and violence and make people less fearful of outdoor physical activity, the city can repair street lights, build in other features that increase the 'natural surveillance' in crime-prone areas, demolish blighted houses, and clean up graffiti and debris. To promote consumption of healthy items and reduce addiction to tobacco and alcohol officials can revise neighborhood zoning to limit the number of stores that sell cigarettes and liquor and can create financial incentives for stores to sell fruit and vegetables.

These changes are also what most residents want. Our research team is just finishing a survey of returned and displaced residents regarding their priorities for the rebuilt neighborhoods. On the top of the list are low crime rates and good street lighting, and not far below are well-maintained sidewalks, parks or playgrounds, and grocery stores.

It is far too early to determine if the idea of health-promoting neighborhoods will influence the rebuilding of New Orleans. There is a powerful tendency to rebuild neighborhoods exactly as they were; even when they were profoundly unhealthy. But the city has an opportunity to build things better now, an opportunity that other poor cities in the USA do not have and that will not exist for long in New Orleans. I believe health specialists are obligated to argue as strenuously as we can for rebuilding a healthier New Orleans. Besides leaving a legacy of the hurricane that could benefit city residents for decades, preventing needless future deaths might just be the best way to pay our respects to the people who perished in the storm.

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Community-led safe motherhood advocacy, Ratanakiri, Cambodia

BACKGROUND

Cambodia is one of the poorest countries in South East Asia and has been severely affected by war and over 30 years of political instability. Recent surveys, including the 2000 Demographic and Health Survey (DHS)[1] in Cambodia testify to the poor quality of health services and resultant fragile health status of the population.

The worst health indicators are to be found in the remote and isolated north-eastern province of Ratanakiri, where malaria, tuberculosis, vaccine preventable diseases, intestinal parasites and diarrhoeal diseases are endemic. Indigenous people or 'highlanders' comprise 65% of the population, split among eight different indigenous hill tribes. Marginalized through poverty, physical remoteness, language and cultural barriers, indigenous groups have little access to services or essential information, and are not generally functionally literate in Khmer (the official language of Cambodia). The precarious health and nutritional status of indigenous people in Ratanakiri is exacerbated by the degradation of natural resources, diminishing food production, rapid deforestation, internal migration and land loss/confiscation. Health Unlimited has been implementing a primary healthcare programme in Ratanakiri for over 14 years, aimed at promoting equity in access to health services.

MATERNAL HEALTH

Ratanakiri has the highest maternal mortality rates in Cambodia. Only 14% of women in Ratanakiri have access to skilled attendance during delivery, compared to 32% across Cambodia as a whole.[1] Eighty per cent of women do not receive antenatal care. The national average is 55%.[1] Sample surveys conducted by Health Unlimited[2] suggest that rates of maternal mortality are also higher than the national average of 437 per 100,000 live births. Insufficient capacity and resources within the health service have combined with other factors such as user fees and discrimination to inhibit access. A strategy for tackling preventable maternal mortality clearly needed to be defined.

The importance of empowering communities in order to improve health outcomes and tackle inequity in health services has been well documented.[3] Empowerment is of particular relevance in the case of women, owing to their role as the primary caregivers within most cultures globally.[4] Enabling indigenous communities (and primarily women) to demand change was considered key to addressing maternal mortality, and wider health concerns within vulnerable indigenous communities. Analysis suggests that there is a clear correlation between 'an effective functioning health system' and 'successful efforts to reduce maternal deaths'.[5]

ACTION RESEARCH TO ADVOCACY INITIATIVE

Action research combines research with social action. It aims to raise consciousness and increase awareness, while undertaking qualitative analysis.[6] Health Unlimited began to implement the Action Research to Advocacy Initiative (ARAI) in early 2005. The project aims to tackle preventable maternal (and, indirectly, child) mortality and morbidity through increasing levels of community participation in defining health policy and practice.

The main objectives of the project are to:

- Analyse the range of barriers and facilitators that affect access to publicly