The NIFA GusNIP’s Food as Medicine (FAM), a produce prescription program, is a recent strategy on a national level that promotes better health outcomes by ensuring community access to fresh, nutritious produce. Corbin Hill Food Project (CHFP) was one of the initial seven national recipients of a FAM grant in 2021, and of a subsequent enhancement grant in 2022, to develop innovations to its FAM project. As a BIPOC led organization, CHFP was the only organization in New York state to receive a FAM award in 2021.

The FAM strategy recognizes that nutrition is a critical determinant of community health. However, it is important to acknowledge that financial means and access to healthful food options are also part of this interplay and is a positive step forward. To this point, FAM should not be considered a silver bullet solution to overcome our community’s many health and wealth disparities. It is a positive step forward that brings numerous challenges with it and begins with the relationship between health institutions working in Black and Brown communities. This is crucial given the ongoing discussions within the Black community regarding community sovereignty in decision-making.

CHFP seeks to link both theory and practice with the underlying assumptions as it implements its Farm Share distribution. CHFP’s approach incorporates a community’s lived experience that speaks to safe spaces both in its food distribution and the data collection settings and methods required for the FAM project. The linking of theory, practice and the examination of underlying assumptions often challenge the traditional existing relationship in how clinics and hospitals relate to our communities.

The FAM programs are primarily driven by health institutions, from clinics to hospitals to insurance companies, that can result in a top-down approach in defining what is healthy and nutritious for our community, and how best our community should be served. Often, in these types of decision-making hierarchies, Black and Brown communities are viewed as a monolith and its existing traditions and practices may be discounted and even deemed unhealthy in and of themselves. As FAM programs look to serve these communities, it is critical that we ask: How are the lived experiences of Black and Brown community members being incorporated and respected in the FAM service delivery and data gathering models?

CHFP has adopted a home delivery model, where distribution takes place within the building complex where residents reside in subsidized and supportive housing. This is consistent with recent studies on how best to meet the food needs of Black consumers, as convenience is ranked among the top three most important considerations when shopping among Black respondents. This is in contrast to non-Black people surveyed who ranked convenience seventh in importance according to the Nourishing Equity study (June 2022). It also recognizes that 20 percent of communities of color over the age of 60 in NYC have some form of disability, and so home delivery should always be part of an ecosystem of food access. Distributing food where participants reside also acknowledges that food and community are strongly linked from a
cultural standpoint in Black communities and such a distribution model, when coupled with food
demonstrations held at the distribution site, can build community cohesiveness.

The home delivery model speaks to the concept of safe spaces for the FAM community CHFP is
serving. The concept of safe space is also linked to who, how and where clinics and hospitals
should operate within CHFP’s FAM program. FAM requires the collection of health data on a
voluntary basis, however sharing health information is not a precondition for participating in
FAM. Common practice is that those involved in such programs have to travel to the clinics and
hospitals to “be screened and registered” in order to be part of a program. Yet research evidence
strongly suggests that meeting people where they are can have a positive impact on health
outcomes. A recent study shows positive health outcomes for Black men being provided health
service at Black Barber Shops. Following this model, Tulane University will be placing
community health service workers in some four dozen Black churches based upon the concept,
“If you can see patients in a comfortable, community-based environment, that may be superior to
having the patient come into the hospital clinic for services.” As was recently pointed out by the
Fund for Health Equity, 80% of what happens to a person’s health occurs outside a doctor’s
office. In addition, one has to acknowledge the historical lack of trust that Blacks have of
medical institutions as being safe spaces. The role of community health workers remains
important; however, their roles revolve around connecting people to health and other services. In
the absence of institutional staff coming to community sites to collect data and enroll
participants, CHFP staff has taken on that function.

As FAM unfolds across the country, this is an opportune time to reexamine assumptions,
acknowledge and pay homage to respected community beliefs, and perhaps, even, refine
traditional program practices. While this piece speaks to linking theory and practice to safe
spaces, convenience and access, and data collection, there remain a number of larger questions
around FAM that are worthy of discussion among policy advocates, politicians, funders and the
Black community:

● How do Black communities define FAM?
● How do Black communities define nutritious food?
● How does one account for the historical shaming of Black food as one defines nutritious
  food?
● How do medical institutions, currently at the forefront of implementing FAM, address the
  reality that though our communities are Black, they are not monolithic, but rather can be
  best understood as different communities within our community?
● Does FAM’s top-down approach led by health institutions allow for ownership of the
  program within communities?
● Is there community sovereignty within FAM?
● What structures will be created such that communities can empower themselves to
  become decision-makers not just advisors regarding their health and wellness?
● Given medical institutions are the primary recipients of FAM funding, is there a
  possibility that FAM will become a model in which institutions define what is best for
  our communities?
● What would FAM look like if it were to be a bottom-up community-based model?
One asks these questions since the momentum generated by FAM as a solution to our community health parallels the momentum generated around solutions that address food deserts. As Kenneth Kolb states in his book Retail Inequality, Reframing the Food Desert Debate, “the scholars, the media, the policy advocates and politicians decided that we knew best what people in urban food deserts needed.” Anthropologists Ashanté Reese and Psyche Williams Forson and others have shed light on how Blacks shop debunking an abundance of scholarly research on food access and food deserts (food apartheid), while the USDA continues to define food deserts by a mileage formula.

One cannot simply dismiss the conceptualization that providing access to food is now being reframed as health and food- Food as Medicine or the fact that the FAM approach often continues an emphasis on individual behavior change and fails to address the structural and systemic inequities that lead to poor health outcomes in the Black community. The scholarly work has begun as exemplified by the recently published 169-page report with its 2,500 citations by the Center for Food as Medicine. However, to maximize FAM’s health impact will require further examinations of assumptions, and the expansion of knowledge from many of the Black anthropologists and Black cookbooks that provide the historical framework with which to define nourishing food. It also provides a framework for innovations and practices by which FAM can best incorporate the lived experiences of the Black community it will be serving. This is both a call to action by BIPOC leaders to take ownership of the narrative in which we define what the Black community wants from FAM, and also a call to action for funders and policy makers as to how they can better serve BIPOC led organizations.

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