HEALTH MATTERS OLINDER: HEALTH NEEDS AND PRACTICES IN OLINDER NEIGHBORHOOD

A Project Report

Presented to

The Faculty of the Department of Anthropology

San José State University

In Partial Fulfillment

Of the Requirements for the Degree

Master of Arts

By

Mercedes Ramans

December 2014

SAN JOSÉ STATE UNIVERSITY

The Undersigned Graduate Committee Approves the Project Report Titled

HEALTH MATTERS OLINDER: HEALTH NEEDS AND PRACTICES IN OLINDER

NEIGHBORHOOD

By
Mercedes Ramans

APPROVED FOR THE DEPARTMENT OF ANTHROPOLOGY

_____
  Dr. Roberto Gonzalez, Department of Anthropology   Date

_____
  Dr. Charles Darrah, Department of Anthropology   Date

_____
  Dr. Jan English-Lueck, College of Social Sciences   Date

ACKNOWLEDGEMENTS

ABSTRACT

This report documents the health needs and practices of an ethnically diverse community in one of the neighborhoods of the city of San José. This ethnographic project was designed to learn about the health beliefs, concerns and needs of the Olinder residents in order to identify specific areas of concern regarding health matters among the residents of the Olinder community. It was also designed to explore the resources participants view as accessible to them, and to organize a list of recommendations for CommUniverCity to address the needs of community members. Based on the interviews I was able to identify six themes: (1) the environment; (2) health insurance; (3) prevalent illnesses in the community; (4) nutrition; (5) resources; and (6) community cohesion and preparedness. After analyzing the interview themes, I was able to produce a report (in both English and Spanish) that was presented to a CommUniverCity official and a Resource Guide that was created for use by members of the Olinder neighborhood. The data from this report will be used by CommUniverCity for grant writing as well as organizational purposes for future health related events and community outreach in educational workshops.

TABLE OF CONTENTS

         A. Community Director Letter
         B. CommUniverCity Project Report
         C. Resource Binder

I.   INTRODUCTION AND PROJECT OBJECTIVES

I conducted ethnographic interviews with a group of 10 women who are residents of the Olinder neighborhood during the months of July 2013 to October 2013. My work explored how Latina women from this community experience and deal with health issues in their personal lives as well as in their community .The aim of this project was to try to understand health and illnesses as lived experiences rather than a statistical documentation based on percentages. My inspiration for this project was my maternal grandmother. She was a very strong woman, who spent her life battling chronic diabetes. Before her passing, I would often talk with her about her illness. She told me that her experience with diabetes was different from some people because she had health insurance. The medicine she needed required frequent visits to the doctor. She also had the support from her family and peers that allowed her to manage the disease. I began to think about how Latino people dealt with such relative issues without the availability of health insurance. This initial experience allowed my curiosity to develop into the ethnography of how the Latino community in Santa Clara County deals with health issues. In this report, health services that are available for Latinos will be discussed, specifically in regards to the affects that limited access has on their resources. In addition, how do individual community members address their own personal health issues?

My interest in medical anthropology brought in another element to this examination, which was the cultural experience and beliefs that affect how people experience health and illnesses. What do they think about their diseases, what causes them, and what preventions can they take to decrease their chances of developing these diseases?

Project Objectives

My project objective was to learn about the health beliefs and the concerns and needs of Olinder residents. The project's aims were to identify specific areas of concern regarding health among the residents of Olinder and explore the resources participants view as accessible to them.

The findings from this project might improve health outcomes in this community by identifying, from the community's perspective, barriers to health care and services. The goals of the project were to explore residents' biomedical and cultural understandings of the causes and management of their health concerns using anthropological methods.

Project Description

Health Matters Olinder is an applied research project that used ethnographic and anthropological qualitative methodologies to learn about health disparities as the lived experiences of real people. This project was requested by the organization CommUniverCity San José. This is a community partnership organization that works with

Figure 1. Five Wounds/Brookwood Terrace neighborhoods and location

community members of Olinder neighborhood to better their communities through grassroots approaches. The organization wanted to use the data collected to apply for grants to bring resources to the community that help address health issues. The person who oversaw the project was Reina (pseudonym), the Community Director of the McKinley Neighborhood Center. Her role in CommUniverCity San José is to oversee projects and programs to deepen resident engagement. Reina was particularly interested in working on the project because she works with residents in the implementation of neighborhood programs dealing with education, health, neighborhood environment, safety, and access to food (CommUniverCity 2014).

The initial idea for this project came through collaboration with Dr. Guadalupe Salazar of San José State University. Over the years, she became interested in doing research about health disparities. She shared with me how she would be launching a research project that would focus on health disparities and how these are addressed or dealt with a particular community. The project came out of a series of town hall meetings that took place in 2009. In those meetings, residents of the Olinder neighborhood shared their growing concerns about health.

Over the years, there had been several other students who were involved in this project; however, there was a language barrier that many of the students faced. The majority of the community members in Olinder are Latino; therefore, they predominantly speak Spanish. Reina was pleased to know that I could carry on a conversation in Spanish, as well as understand what was being conveyed to me. Professor Salazar and I met with Reina, and I interviewed her about project outcomes and an action plan. We decided that I would be working with the group *Salud*.

Salud is a group of ten to fifteen women who are mothers and community members of Olinder neighborhood. They hold meetings in the school sites to discuss health issues and concerns that they have in order to be better informed about resources and to tackle their

problems. This group is similar to the *Campeonas* group from McKinley School. This is a group of Latinas who meet to discuss health concerns for their children as well as to gather knowledge and resources to help their community (Duenas 2012:3). *Las Campeonas* had already been in contact with SJSU students, and they inspired other women in different schools to form social support groups that involve parents in schools. At Olinder Elementary, this group became to be known as *Salud*. In my initial meeting with Reina, she described to me certain basic aspects and interests of the group. This group formed through the school, so the person in charge of overseeing the activities of this group is a school employee, Mrs. Beatris (pseudonym), who is the parent liaison at Olinder.

My early involvement with *Salud* was not really welcomed by the parent liaison. In the early stages of carrying out this project, I found out that conflict among stakeholders could create obstacles for a researcher. While Reina and CommUniverCity were enthusiastic to begin working on Health Matters Olinder, the parent liaison at Olinder Elementary became a strong gate keeper who would not allow me to talk with the women of *Salud*. In the eyes of Mrs. Beatris and the school staff at Olinder Elementary, the ethnographic interviews were too personal and intrusive of the lives of their schoolchildren and their families. I had several meetings with Mrs. Beatris to explain the process, ethical matters, and the ways that we might work together on this project. However, all the meetings came to a halt. Mrs. Beatris was simply not interested in collaborating with me. I was never allowed or given the opportunity to meet or talk directly with the school principal. Mrs. Beatris was my point of contact with the school staff, and she was not very helpful at building rapport with the school. At the same time that everything was happening with Mrs. Beatris, I was told by Reina to report to her periodically regarding my project status, especially my dealings with Mrs. Beatris.

Reina persuaded me to keep working on this project, and suggested that instead of interviewing the women from the *Salud* group, I might consider interviewing residents of Olinder neighborhood, who are mostly Latinas. She offered to introduce me to members of the community and suggested that together we could find women willing to participate in the project. Changes to the project included:

1. Sample population: Shift focus from members of *Salud*, to women residents of Olinder neighborhood.

2. Interview location: Instead of carrying out observations and interviews at school, I would be observing events organized by CommUniverCity related to health, and I was given access to the neighborhood centers to conduct interviews.

Working with the Parent Liaison was not unproductive; it was through my meetings with Mrs. Beatris that I was able to formulate the deliverables to the client (CommUniverCity). Important questions and resources that are required in anthropological consultation were concepts raised and developed during the initial *Salud* negotiation with Mrs. Beatris. Possessing the knowledge of available resources and the appropriate communication channels are key concepts derived from those meetings. Knowing how and where people received their information about the health resources and services can help the community have better health outcomes.

Community advocates and parent liaisons play a critical role in schools, for staff, parents, and students alike. However, a caveat with associating this role to a sole person has its implications. All too often, this role is filled and almost immediately affected by multiple tasks, limited time, wherein an overdependence on this individual becomes overwhelming. To mediate this issue, I worked towards filling the void by creating achievable deliverables. The first

deliverable is a tool for spreading information to members and residents; this took the form of a

resource binder that includes information about current and available resources, contact

information, and the locations of resources. The second deliverable is a project report that

outlines the research design, data collection, as well as the major findings and interpretations of

the data. Finally, the project report recommends improvements and services.

II.   HISTORY OF COMMUNIVERCITY SAN JOSÉ

In order to gain a deeper understanding about the resources that are available to the Olinder neighborhood residents, I needed to first understand the relationship between CommUniverCity San José and the neighborhoods the organization works with. CommUniverCity San José began in 2005. Under the credo "everyone deserves to live in vibrant communities" city officials, neighborhood residents, and San José State University staff began working together to build support channels and networks for the communities surrounding the university. The organization wanted to help community members, as well as college students, gain experience at bringing social change and empowering all the members of the larger city of San José community (CommUniverCity 2014). The organization works side by side with community members to rally and organize campaigns and projects to rebuild the communities by creating community projects to decrease gang violence, urban plan better spaces, as well as improve health and food security. Since the creation of the organization, community engagement has been the core value that the organization holds dearest. Projects demonstrate collaborative partnerships between the citizens of San José, the organization, and the academic sphere represented by San José State University. This collaborative partnership has allowed members of the community to take on leadership roles and to voice their concerns, as well as to apply collective action to bring about changes sought out by residents.

This organization had been able to carry out projects and maintain strong relationships with San José communities, because they have taken the time to get to know the community members. The neighborhoods that they provide services for are some of the most financially challenged neighborhoods in the city of San José. Olinder neighborhood is part Central San José. According to U.S. and the city's census information, 51.6% of the people living in Central San

José are Hispanic, and nearly two thirds (60.4%) of households in the area are low income, earning less than 80% of the Area Median Income (AMI) (CommUniverCity 2014). The presence of CommUniverCity in these communities continues to foster civic engagement, learning, and leadership for all and future residents of these neighborhoods.

III.   LITERATURE REVIEW

One problem that health care professionals face is the gap between the knowledge produced by research and the translation of this research into interventions and policies to improve the health of various groups, especially minority communities and other disadvantaged populations (Viswanathan et al. 2004: 1). Community-based participatory research (CBPR) is a recent approach used in health and environmental research.

The purpose of this type of participatory research is to increase the value of studies for both researchers and the community being studied (Viswanathan et al. 2004: 1). One of the unintended outcomes of much scientific research is that while researchers gather and create new knowledge, the communities studied are left out of the benefit from that knowledge. Community-based participatory research provides more power to the communities studied. In my own project, I wanted to use and apply the residents' information to fill the knowledge gap between researchers and community members about resources needed to reduce health disparities. Listening to informants as they shared their experiences and developing a resource binder based on a community needs assessment allowed for a collaborative measure of how access to resources affect health disparities. The collaboration between researchers and community members deeply impacted the understanding of the community's unique circumstances, their needs (as seen and told by community members), which guides researchers to build an accurate framework for testing and adapting the best practices or interventions in addressing the community's needs (Viswanathan et al. 2004: 1). For example, during the interviews I asked 10 women residents to think about the ways that they can improve their health with their everyday practices. In doing so, the 10 project participants evaluated the resources within health services that are needed or could be improved by providing testimonials and concrete examples. Some of the women identified the need for nutritional classes as a means of

preventative health. Others identified community fitness classes, such as Tai-chi or Zumba, as a means to bond with other women while exercising.

In the U.S., most health researchers are trained in the biomedical paradigm. However, biomedical approaches miss the context for illness, which is strongly founded upon core cultural values (Ritter and Hoffman 2010:13). The main purpose of this project was to try to find out from the community members' perspective the health concerns of Latinos living in this community. Next I wanted to understand how community members understood these illnesses, and finally to identify the resources are being used by community members. Understanding and applying theories of health and illness can help health care practitioners to better understand how people receive and respond to prevention programs, treatment, and health education messages (Ritter and Hoffman 2010: 5).

Medical Anthropology

Medical anthropology is the study of human health and disease, health care systems, and biocultural adaptation. The discipline analyses and compares the health of regional populations and of ethnic and cultural areas, both prehistoric and contemporary (Brown and Barrett 2009:1-5). The application of medical anthropology to medical research can help address some of the issues that create health disparities in populations around the world.

Different societies use different systems of meaning to describe and respond to illness. Anthropologists who look at illness from an "emic" perspective attempt to understand health and disease from the perspective of a particular culture. By gaining an emic perspective on a culture, medical anthropologists can further understand that notion of "embodied personhood," the relationship of cultural beliefs and practices in connection with health and illness to the perceptive human body (Brown and Barrett 2009:11). In my own research, I applied medical

11

anthropological concepts to comprehend how members of the Olinder neighborhood experience and understand illnesses such as diabetes, obesity, and hypertension. Physicians and medical practitioners face the challenge of delivering optimum care to an increasingly diverse U.S. population. Leading organizations and medical facilities recognize that there is a need for increasing cultural competence among health care providers (Helman 1991:5, and Santillan 2014:1). The reduction of health disparities can also be achieved through recognizing that culturally appropriate actions can be predicted based on a provider's awareness that culture is relevant to medical care and that negative preconceptions can hinder the effectiveness of health care delivery (Brown and Barrett 2009:15; Liao 2011:2-10). For example, in my research I learned that most of the participants talked about diabetes as the "sugar disease", but some of the women interviewed talked about more cultural practices and beliefs, such as the traditional cooking practices that are based on high caloric and sugar contents. For example, they talked about Christmas and the cooking practices that take place during this season. One woman in particular said: "You know it's hard to limit your sugar, I mean especially around Christmas, because we try to follow traditions in the family, like cooking *tamales*, *buñuelos*, and even the hot drinks. I am trying to keep family tradition but at the same time I have to limit my family from certain food items, because too much of those items are simply not good for our health."

Understanding health is not simply having a grasp of biomedicine or biology; it requires knowledge about the way people experience health through culture, the social environment, and how these affect illness (Helman 1991:5-20; Ritter and Hoffman 2010:1-5). The study of social and environmental contexts can contribute to a fuller understanding of health issues and access to health resources (Whittemore et al. 2004:87-90).

Health and the Environment

Ecological theory explores the interactions of humans with the physical environment. One of the intended outcomes of this ethnographic project is to identify cultural beliefs about health and illnesses as well as the perceived resources available to community members that have positive outcomes in their health. The study of geographical barriers allows researchers to see the connection between the physical environment and its impact on health (Amesty 2003:41). For example, people living in urban areas categorized as "dangerous" are negatively impacted in their health and behavior to do physical activities. In her research Amesty found that geographical barriers are physical constraints based on urban structures locations and proximity to resources (i.e., exercising facilities) and the effects of the physical environment in the behavior of people in relation to "health habits" (i.e., regularity of physical activity). In the United States, 60% of all adults are inactive or under-active (Amesty 2003:42-45). The amount of physical activity undergoes correlates to the amount health issues that individuals can have (Walsh et al. 2003:129-132, Ward 2004:840-845, and Whittemore et al. 2004:87-90). Many of the project participants described several of the observations made by Amesty in their own lives. They felt that their community is not safe, therefore they preferred to not venture outside of their homes to do physical activity in their neighborhoods such as running or walking on their side walks, instead they felt safer doing other activities that require spending money such as going to the gym. All of the project participants reported that their neighborhood parks are exercising facilities that can help improve their health outcomes and they themselves would use them regularly if they had more safety features such as park lights.

Social Capital

Much of the research that focuses on Latinos reports that the majority of Latinos living in the U.S. live in low-income areas (Santa Clara County Public Health Department 2012; Duenas

2012: 10-13, Office of Minority Health 2013). These low-income areas often have limited resources for addressing health concerns. Bourdieu's social capital theory is one that explores how people interact and create bonds with one another to create and share information or knowledge as well as support systems.

Another aspect of Bourdieu's theory explores, why people create and maintain relationships. Bourdieu explained that people form and keep relationships of various kinds because of their perceived benefits, such as an exchange in knowledge and under certain circumstances emotional support (Bourdieu 1986:251-252). Social capital can then become a form of social status based upon participation. The more time people spend building and maintaining those relationships, the more access they have to economic and cultural capital (Bourdieu 1986:251-252). Studies suggest that immigrants living in the United States face hardships in social arenas of American society (Nandi et al. 2008:2011-2015). Nandi et al. found that the more access to social resources and the more health commitment of immigrants are linked with greater admission to proper health care services. Residents of Olinder neighborhood have excellent social capital networks that are strongly maintained through their participation with the organization CommUniverCity. For example, the two community wide events that took place during the fall exemplified the use of community networks to organize the events and to disseminate information. Attendance for the health fair was what I considered low. Only about 25 families from the Olinder neighborhood came to the event, yet the event organizers were not discouraged. A fellow resident explained to me: "It doesn't matter if one person or 100 people shows up, the ones that come are here to represent and absorb the information that is being said by the presenters. The rest of the community will get the information through us the people that

attend because we care enough to make sure everyone knows what is happening in our community."

The issue of social capital is important in minority communities. Minority groups living in the U.S. face unfamiliarity with social system, barriers to resources, and even language barriers. Social capital also has effects on health. A growing body of research has found that the presence of social capital through social networks and communities has a definite quality on health (Ichiro et al. 1999:1187, Hawe and Shiell 2000:872-875, Ziersch et al. 2005:71-73). Social capital affects health risk behavior in the sense that individuals who are embedded in a network or community rich in support, social trust, and information have resources that help achieve health goals. For example, a person who is sick with cancer may receive information, money, or moral support he or she needs to endure treatment and recover. Inversely, a lack of social capital can impair health. Additionally, lack of social capital can worsen health outcomes and have negative effects in communities (Bolin et al. 2003:2379-2382 and Asslund et al. 2010:1-3). In the case of the Olinder residents, social capital can be used positively to influence community members' health. One example of a positive use of social capital in their neighborhood has been the introduction to healthier food products through the establishment and community participation in projects such as garden-to-table and community-wide fruit picking.

These programs provide community members access to organic homegrown fruits and vegetables. For example, the program garden-to-table, helps community members to organize create and maintain community shared urban gardens within their living corners. Past research in the central San José neighborhoods suggests that residents of these neighborhoods had very limited access to healthy eating choices (Duenas 2012: 10-13). Overall, the stores that sold produce to the neighborhood residents sold inadequate over priced products. Neighborhood

residents collaborated with CommUniverCity to form campaigns that changed the products sold in their local community shops. The impact of these services in community members lives has been great. The 10 women that participated in Health Matters Olinder never mentioned a lack of diverse food options. In fact, all of the women talked about the food drives and how important eating fruits and vegetables are part of their families' routines.

IV.   METHODS

Throughout the project, I used a combination of observations and semi-structured interviews. Conversations and observations were recorded in my field notes. The informants were asked to participate in interviews exploring their beliefs and practices regarding health and illness. The location of the interviews was determined based on proximity to interviewees' homes. Reina allowed me to use CommUniverCity's two community centers in order to reduce the intrusion into the interviewees' personal space. These locations allowed community members the familiarity of an already known location and allowed me the ability to explore one of the information resources available to community members.

The interview questions focused on asking Latina women their experiences with health and illness, as well as identifying resources available to them. The interview instrument had 30 questions. The sections included: demographics, medical services, cultural beliefs about illnesses, health education, and miscellaneous questions.

The interviews ranged from 45 to 90 minutes in length. I created an interview schedule that allowed me to interview 10 women in two weeks. Since the interviews were held in the summer (when many people tend to spend time with their families), I made sure that I came prepared to greet not only my interviewees but also their children. I found that by providing entertainment (puzzles, coloring books, etc.) for the children that accompanied the mothers, the interviews were conducted smoothly and free of interruptions.

Interview Coding Process

The coding process in the interviews allowed me to develop and explore domains in my qualitative data. To develop the codes, I thoroughly read each interview and utilized a systematic color coordinated method to organize themes with commonality among all of the interviews.

This was strategic because as it familiarized the researcher with specific issues rather than relying on coding analysis or software programs. This measure by way of analyzing codes provides a holistic and nuanced method that is lost when programs and softwares are employed. There were six major themes, or categories that developed during analysis: environment, health insurance, illnesses, nutrition, resources, and preparedness.

Participant Observation

Participant observation was used to explore network relationships amongst community members and members of the organization CommUniverCity. I was interested in learning about how information about health issues and services get dispersed throughout the community. I had the opportunity to experience the collective work in creating and maintaining networks based on the purpose of community outreach by observing two community wide events. The two events were the Annual Health Fair 2013 (which took place in September 14, 2013) and Safe & Green Halloween 2013 (which took place on October 25, 2013).

I was particularly interested in seeing what resources and organizations visited the events, what services were provided, and if community members actually visited or used the resources available to them. I then proceeded to take notes about how many people were around the event and what they were doing.

In preparation for both events, I attended four organizational event meetings, each of then lasted three hours. I spent twelve hours observing how members of CommUniverCity organized both events. The purpose of these meetings was to report to Reina on what each project coordinator was doing and at what phase of their projects they were. Through attending the informational meetings, I was able to identify some of the resources that the event coordinators used. Such resources included listing possible volunteers to help run the event and organizations

that could provide information about the specific areas of concerns (i.e., a dentistry company that

provided free services). I spent a combined amount of eight hours conducting observations for

both community wide events. Four of those hours were allotted to CommUniverCity's

informational meetings, two hours were spent on actual note taking, and two hours were spent

surveying community members about their opinions about the events outcomes and areas of

improvement.

V. RESEARCH FINDINGS

The findings gathered from this project tell a more holistic story about community members, their struggles, their beliefs and their activism and involvement with one another. Based on the 10 interviews I conducted, I was able to distinguish six themes that highlighted community members concerns with health and wellness. The six themes are: (1) the environment; (2) health insurance; (3) prevalent illnesses in the community; (4) nutrition; (5) resources; and (6) community cohesion and preparedness. All the names used to describe the project participants and their interviews are pseudonyms.

(1) The Environment

Many of the interviewees discussed in detail how the social and physical environment of their community affected their health. Descriptions of the social environment were based on observations made from the interviewee's point of view about their community's social environment. Camila, a resident of Olinder, described the social environment of her neighborhood, in which she recognized that while community members have strong bonds with each other, there are forces that influence the well being of community members. For example, she understood gang activity as a community wide concern.

> I think that the environment, and gangs are the priority concern for our
> community members, how should I describe this, there are many people who have
> nothing to do (the nothing meaning they are involved in activities that are not
> productive for the community), and our other concern is keeping our community
> clean.

Gang activity is one of the prevalent concerns for many of the parents in this neighborhood. When asked how gang activity affected their health or why it was a concern,

some community members, like Camila Diaz, viewed gangsters as people who loiter and who contribute nothing to the community. In regards to health, she attributed gangster activity as an increasing stress factor for community members who worry about neighborhood safety.

The other concern expressed by community members involves the physical conditions of the environment such as pollution and neglect from community members (i.e., having their living spaces crowded with garbage, not picking up yard waste, etc.). Such is the case for Renata. Renata is the mother of two young girls who attend the local elementary school. Renata's concern with the environment is rooted in her children's asthma problems. In her interview, she explained that the lack of recycling and air pollutants such as tobacco smoke around her neighborhood are triggers for asthma attacks. "The environment and recycle is a big problem. Our environment is not healthy; there is a lot of garbage and bad people. Sometimes people smoke a lot and that contaminates the city and health."

I asked Renata to provide some clarification about "bad people" in the community and their relation to the environment. She explained that "…bad people…you know neighbors that simply throw garbage on the street, they are not concerned with the environment or bettering our community." Similar observations about air pollutants and the increase of garbage were made by other community members who also concluded that the lack of recycling and the increase of pollution also correlated with higher rates of asthma and allergies.

The relationship between the social environment and the physical environment was also a topic discussed by community members. Some of the people interviewed felt that physical features of their landscape, for example, the lack of streetlights, the increasing rates of litter, and the presence of gangs, made their neighborhood environment unsupportive for community wellness. The exercising facilities such as the community parks are seen as unsafe for children,

constant parental supervision is needed. One interviewee in particular explained: "Even though we live across the street from the park, I don't let my children play in the park by themselves even during day light. I need to be present. I don't feel it is a safe place."

Another interviewee said:

> Here we have two public parks. One is smaller than the other one, but the large one as my family calls it has very big open fields of grass. There is no security on these open fields. No fences around the fields. Anyone can come and go as the want. I don't think the parks are safe, so my kids are limited in going to the park and getting exercise, because they can only go when I am there or my husband and we are always working, so I don't think they get as much exercise as they need.

Parents in particular are forced to look for other resources that allow their children to exercise.

(2) Health Insurance

The interviewees who participated in this project all reported that health insurance is difficult to attain for many community members. This might not be true as of now because the Affordable Care Act (ACA) has passed, but while I was conducting my research, the ACA had not yet been implemented. Seven out of the 10 community members reported having trouble procuring health insurance. Sofia is a resident who talked about her financial struggle and how she had to be resourceful in order to take care of her husband's illness without health insurance. "I use the computer and the Internet like the webpage WebMD, so that I can keep track of my husband's health issues. I look up how to make healthy meals; you know recipes, rather than frequently spending money to visit the doctor."

Sofia is one of the many community members who reported looking for other means to

address health concerns. With regards to her husband's high blood pressure, she talked about using technology to look for information about ways to lower high blood pressure. Sofia is a returning resident of this neighborhood. She has moved several times to other parts of the Bay Area as well as to other states but that she always comes back home to this neighborhood because of the ambiance and roots that her family has there. She is a mother of two children. Her struggle with health is based on economics. Although her children are insured through a program offered at the children's school, Sofia and her husband lack health insurance. Therefore, Sofia and her husband are always stressed when either of them becomes sick because they do not have health insurance.

> My husband was diagnosed with high-blood pressure but he has never checked
> his blood pressure. When he was diagnosed, we received a medical bill of
> $800.00. He was told that he had to take medication to lower his blood pressure
> for the rest of his life, but because of the costs, we have not followed through.

One interesting observation about the discussion of health insurance for community members is that while the majority of adults reported lacking having health insurance, all of the adults reported that their children have health insurance. Julieta explained: "Here in the school (she is referring to the nearby elementary school) we get sent many sheets of paper that tells community members about services, for example how to get and enroll with Medicaid." Julieta mentioned that because the school provides parents with the paperwork and information on how to get health insurance for their children they actually do it. However, she mentioned that health insurance for adults is not a topic that is covered by the schools. For many of the community members interviewed, the biggest priority was covering the health needs of their children. Inquiries about adult health coverage on the other hand are left entirely too personal pursuits.

The information provided by the schools comes from the state created programs that provide for children but not adults, at least not those deemed healthy and able to work outside the information sphere of schools and directly contact the organizations that provide such services.

On the other hand, while some people reported having the information available to them about how to enroll in health insurance programs, they found the paperwork frustrating and vexing, making their experiences with health coverage research unappealing. Such is the case of Florencia:

> Look, even when we first arrived here, we had Kaiser through my husband's job. After 2001 when jobs went down. My husband lost his job and we lost all of our insurance, therefore we applied for Medicaid and we have been re-applying ever since. Now, since the month of September my husband applied to a new job where he gets paid a little bit more, I believe we are no longer covered because our family makes a little more money. Recently, even though we received the letter to reapply for Medicaid I did not fill it out because I don't think we qualify, because our family has a little more money. So, at this moment, we don't have anything. We are waiting for my husband to get health insurance through his job; they told him since the month of November that they would provide him with insurance. But half a year or more has passed and we have nothing.

Florencia's interview highlights the lack of information and understanding about the available programs. Rather than talking with a representative of Medicaid, she believes that making more money cancels her coverage. Another resident talked about the misinformation about the medical insurance programs:

> Yes, I am interested in getting health insurance for myself as well as for my

daughter. You see my husband gets it from work, and my son who is born here

gets it too, but my daughter and I don't. I know there is information here at the

school, but when I asked for the paper work and took it home, it was too

confusing. I would like someone to sit down with me to help me fill out the paper

work. There just never seems to be time or the right person to help me.

Overall members of this community identified these reasons as to why they have no

health insurance: it is too costly, it is too much hassle to apply for it, and there is a lack of

information about coverage plans and assistance. For many members of the community, the

thought of a spouse or family member needing serious medical treatment or even examinations

leaves them feeling anxious. They are insecure about how to deal with costly medical

emergencies.

(3) Prevalent Illnesses in the Latino Community: "The Big Three"

Diabetes, high blood pressure, and obesity remain three of the biggest health concerns for

this community. Four out of the ten interviewees expressed these concerns for their children. In

regards to parental concerns on children's health outcomes based on the topics of diabetes,

obesity, and high blood pressure, the project participants expressed lessening concerns for their

children. One person in particular explained: "One of my concerns is my daughter. She is

overweight. I would like to take her to a nutritionist, she can have that help of going to a

nutritionist but I can't, because I don't have health insurance." Even though her daughter could

potentially develop diabetes and high blood pressure by being overweight, her daughter can still

visit a doctor to manage and maintain a healthy living style. Sofia, however, lacks health

insurance therefore; she was the only person that could help her daughter. Many of the project

participants reported the health concerns for their children but they were not at the top of their

priorities because they felt that the children could be treated. However, adult health concerns are left unregulated and untreated because they have lack of access to coverage, which raises the cost of treatment.

The narratives taken from the interviews reported high levels of concern about adult diabetes, obesity, and high blood pressure. For some community members, their experiences and knowledge about such diseases and illnesses came through personal experience from having such illnesses or by having familiarity with these illnesses because they affected some of their family members. Nine out of ten people interviewed know someone in their families who have diabetes or have died because of diabetes and its complications. Five out of the ten people interviewed have been told by a medical professional that they are at risk or they already have diabetes.

In order to understand these illnesses, I asked the community members to define the illness and think about causes, as well as to think what can be done at a personal level to reduce risk of developing these illnesses.

The interviewees' responses were almost unanimous. 90% of the people interviewed made the connection between poor nutrition and lack of physical activity to developing these illnesses. Physical activity and nutrition also shaped the way people conceptualized illnesses. For example, the definition of diabetes is based on the community members' understanding of sugar consumption. All of the interviewees described diabetes as *la enfermedad de azucar* meaning the sugar illness. Diabetes was defined by all community members as the sugar illness, repeatedly they mentioned how over eating sugar resulted in someone developing diabetes. Some members talked about over consumption of sugar products and lack of exercise as reasons for development of diabetes, but factors such as genetics, carbohydrate intakes, stress and other factors were not mentioned. Other community members saw diabetes as a side effect of their life style. One

participant in particular talked about diabetes as a side effect of stress. Jimena explained:

> I think stress causes diabetes and other illnesses. I would like to live a life
> healthier without problems. But here in this country it is difficult because we have
> a lot of stress. But it is difficult, because everything causes us stress, like not
> having money to pay the rent, work, even not having your cell phone at hands
> reach causes people to be stressed.

This community member talked about her worries with work, economics, and even technology. Later on in her interview, she made the connection about how business at work and at home reduced the amount of time that she could spend doing physical activities and how this made her less healthy and even more stressed out. Another interviewee attributed her poor health to lack of time: "I don't think of myself as a healthy person because I simply don't have time to take care of myself." I asked her to explain what she meant about "time to take care of myself" and she explained: "Well I am not talking about nutrition, I make time to cook, I cook plenty of healthy things, but you always hear about exercising and how much you need to exercise, and I just don't get enough exercise. I am too busy working, running around from work to home, picking up my kids." This interviewee attributed her business as a health barrier. She talked about following a good diet, and the importance of physical activities, but she felt that she was lacking support to get the adequate amount of exercise to be healthy.

High blood pressure was also regarded as a side effect of having bad eating habits and not enough exposure to physical activity. Some of the interviewees attributed high blood pressure to the over consumption of greasy food and high levels of salt. High blood pressure is perceived to be a health outcome that was only talked about for adult members of this community. There was no mention of children with high blood pressure; it was solely focused on the adult experience.

Obesity on the other hand is a concern for children and adults alike. All of the community members agreed that healthy eating habits and actively participating or doing some sort of physical activity are the best preventative measures that a person can do in order to be healthy. While the "Big Three" are the priority concerns for members of this community, other health topics were reported throughout the interviews. These topics included women's health in relation to reproduction, breast cancer, cancer in the broader sense (i.e., skin cancer, pancreatic cancer, etc.), and dental health.

(4) Nutrition

By talking about their health concerns, community members were able to think about the causes of the illnesses that affect their community. All of the interviewees identified nutrition as a problem and a solution strategy. Many community members kept referring to "good nutrition." Their definition of good nutrition can be summed up as reducing the consumption of junk food, and eating fruits and vegetables. The interviewee's definition of junk food is food that was high on sugar, greasy, and not prepared at home. The community's understanding about nutrition was also talked about in two separate categories; nutrition for children and nutrition for adults. The majority of the community members talked about nutritional concerns focused on their children, and how there is an overall struggle to get younger children to make healthier choices about meals to consume at school and at home. As one interviewee phrased it:

> Sometimes, even though one wants to give food that is healthy, the child does not
> want to eat it. I want to give it to him (meaning her child), not because I am trying
> to be mean but rather because it's good for him. On the other hand, if your partner
> simply wants to give him a slice of pizza…because it is quicker or simply because

my son really likes this, (the partner) wants to give the child everything that he likes, but this is not what it is best.

This community member talked about several important issues that involved personal choices. The first point that this interview excerpts highlights is how parents struggle between providing healthy food vs food their children like to eat. Many of the interviewees' defined junk food (pizza, hamburgers, potato chips, and sweets) as their children's preferred foods. These junk food items were deemed unhealthy by community members because they were not fruits or vegetables and meals that are not homemade (i.e., premade meals that are purchased outside of the home at restaurants or are frozen meals). The other problem community members described with junk food is that these products are within reach of their children. All of the interviewees talked about kids having easy access to junk food in the schools as well as home. One interviewee talked about her child's friends as enablers for junk food. "Even though, I don't purchase any junk food in my house, when my kid goes to school or hangs out with her friends, she is still eating junk food, because other kids bring that unhealthy food to school or they themselves have it at home. It is hard to get her to make better choices because her friends don't follow the same choices as she is used to at home."

Unlike many of the other interviewees who talked about "parents" as the solution to children's nutritional problems this interviewee saw nutrition as a problem of both the child and the parents. She provided a solution by saying that it is important that children and parents alike learn about nutrition. Four out of the ten people interviewed talked about how they were the main responsible figures in their household with regards to following nutritional guidelines. For example, one interviewee talked about her family's consumption of fruit and how although she and her husband always make sure that fresh fruits and vegetables are available at their table,

these often go unconsumed if she does not take the initiative to cut and serve this items right at the center of her dining room table. This interviewee is interested in having access to more educational opportunities to engage families in healthy eating habits. All of the community members interviewed revealed some interest in bringing in nutritional classes as a resource for community members.

(5) Resources

The perceived notion that defines a resource is interpretative and relative. As a researcher, my definition of a resource was very different to the definition shared among the community members interviewed for this report. By providing the research defined version of a resource as any person, place, or thing that provides support for healthier outcomes the community members discussed the different resources they knew about, the resources they utilize, and the resources they would like to bring into their neighborhood. The women interviewed talked about a variety of resource that I then categorized into four groups types of resources: exercising facilities, information, medical centers, and shopping centers (in relation to food consumption and nutrition). I will now discuss each of these.

Exercising Facilities

The interviewees talked about two types of exercising facilities. The first type they mentioned was the "no-cost" locations and the "pay" locations. These no-cost locations were identified as local parks and home based exercising experiences. The local parks are exercising facilities because they are places where people can get some sort of exercise by walking to the parks, or by engaging themselves on some of the resources found at the parks to do exercise, such as tennis courts, trail-roads, etc. The other-no cost exercising facility that some community members talked about were at home activities. Their houses were viewed as the primary

locations where activities could be carried out. For example, one interviewee talked about how she and her daughters would get their exercise by dancing in their homes to music. Other at-home activities included gardening, doing chores, and physical exercise routines such as "work out videos."

The pay locations were identified as actual gym facilities. Some community members reported knowing about and having access to these centers by information being sent to their homes about lower-income membership opportunities. The few interviewees that talked about enrolling themselves or their children in pay-exercise facilities mentioned having to look for these resources because they felt that the no-cost facilities such as the parks were unsafe.

Information Centers

All of the people interviewed referred to their local community centers as information hubs. They explained that the community centers are the places that they visit in order to find out information about events that are going on in the community or as distribution centers for actual resources. Other informational centers that were discussed included the local schools. Schools are perceived to be information centers because through their children attending the schools, the parents are informed of services via letters, pamphlets, and even phone calls. There was no actual mention of organizations that provided information to the community with the exception of CommUniverCity.

Medical Resources

Most of the interviewees viewed their doctors as their main medical resource. Only the women who lacked health coverage mentioned local clinics and events that provide different medical resources such as blood screening, oral hygiene, and vaccinations. The no-cost facilities mentioned included planned-parenthood clinics.

<u>Shopping Centers</u>

Many of the community members reported personal preference for some shopping centers versus others. What this meant is that rather than focusing on the products sold at the store, they focused on the store ambiance and interior design. For example, one interviewee explained how she disliked going to the shopping center "*Mi Pueblo*" because, "Everything is so tightly packed, I feel like a mouse on a maze, I also don't like the music that they play so I try to avoid going to that store". The focus of the shopping centers discussion was also guided by the budget of the families. They frequented stores where they could get the most out of their money. For example, one store that was frequently mentioned was Walmart. It is the preferred store because of their bargain sales. People whose main mode of transportation is driving provided a more detail list of other stores that they frequented and the reasons why they like to frequent those locations. One interviewee in particular listed nine stores, while the average of the interviewees would mention four stores.

Once the interviewees identified resources, I then asked them to talk about some of the barriers that they face when trying to gain access to resources. The biggest barriers talked about were modes of transportation, information, and personal preference. Further discussion about barriers to resources is covered in map analysis.

(6) Community Cohesion and Preparedness

One concern that many of the project participants revealed in the interviews was the lack of cohesion or community support for certain issues that are important to many of the residents. For example, many people talked about how they felt unsafe in their neighborhood. Some people felt that discussion about community safety had been overdone, but no action had been taken. They attributed this to the lack of community support. Four interviewees proposed the

recommendation of creating an informal neighborhood watch. Adults living in the neighborhood would participate in watching small children when they are playing, reporting suspicious activity, and keeping the neighborhood environment safe and clean.

The other issue with community cohesion is that many of the people interviewed felt that their neighborhood is not prepared to deal with emergencies via natural disasters. Their concerns are based on lack of participation in community events. For example, when workshops were offered to do disaster preparedness, only two people showed up. One interviewee commented: "Even though in the last town meeting there was discussion about disaster preparedness, and Reina provided a class for the neighborhood residents to attend, at no cost, only a few people showed up". Six interviewees felt that the neighborhood is not truly united; they want more community structure and familiarity with each other. Community solidarity was identified as an important element to keep the safety of the community members from outside forces such as natural disasters and gang activity. In order to address the issue of community participation, I asked the project participants to describe the ways in which they have been informed about events. They described the use of flyers, letters, phone calls, and face-to-face invitations. I then asked the interviewees to tell me about their preferred method to receive information or invitations. Almost all of the people interviewed reported face-to-face mode of communication as the preferred and most successful way to inform community members. They reported a bonding experience when they talk to each other. It's a way to know how each member is doing and to gather any other information that they might want to know about the event and the people involved. The face-to-face approach was highlighted to be extremely important to raise community participation in workshops and events; however, this did not mean that they wanted the other forms of communication to stop. The community members interviewed gave praise to

the schools, and how helpful the information that is submitted through the school is for them to be informed about what is happening in their community.

Map Analysis: Perceived Proximity of Resources.

While the interviews concentrated in discovering what the community members viewed as resources, the map-survey activity focused in identifying barriers to the access of the available resources. The biggest barriers addressed in the interviews were mode of transportation, information, and personal preference. The map-survey analyzed these categories by evaluating the accessibility of the resources measured by distance, and the amount of resources listed by the project participants. Two assumptions were made about these variables; 1) in the case of accessibility, I assumed that the interviewees would refer to distance in measure of lengths (i.e., miles). This was not the case since there was an inconsistent reporting of measures such as the use of miles, blocks, and time (reporting of distance through how long it took them to reach their destination). While there was opportunity to get clarification from community members by saying "how would you approximate the distance in…" the majority of the time the interviewees would continue to make their statements using the initial measure of distance that they used the first time. 2) The other assumption that I made was that the quantity of resources that the people interviewed reported is a measure for the information and knowledge that they have about resources.

1. Measure of Resource Accessibility

Whether or not a resource was used was impacted by the amount of time or total distance that it would take the interviewees to have access to it. Furthermore, the interviewees' concept of accessibility to a resource is affected by their mode of transportation. This was explained by some people who measured distance not in length, but instead in time. The residents that

described walking as their primary mode pf transportation only made trips to get resources that were far away from their homes when necessary because getting to that resource took too much time.

The category of mode of transportation refers to what is the person's primary method of travel to get to resources. Seven out of the ten people interviewed said that their main mode of transportation was done by car. Because either they or their spouses drove, they reported knowing and using more resources, especially in relation to the shopping centers. People who reported using public transportation or walking as a means to get to resources reported less variety of resources available to them. For example, individuals whose main mode of transportation is walking, often only mentioned local shopping resources such as the store "*Mi Pueblo*." In relation to having access to good sources of nutrition, the people who walk talked about resources offered to the community. The resources include: the program garden to table, participating in the community with fruit picking activity, and the food truck (a program for McKinley School that is sponsored by Cal Fresh and Food Harvest, that brings fresh produce, dairy, and other nutritional items comes to the school gymnasium and hands out these supplies to people of the community). Drivers; however, emphasized variety of products, like buying things that they can only get at certain stores such as types of brands of cleaning products, food items, etc. What was conveyed in the interviews was finding better pricing in certain items, and the shopping experience itself was more self-gratifying when they frequented stores that they liked.

Exercising facilities are also affected by the accessibility of resources. All of the project participants listed the community parks as exercising facilities, however; the people who listed driving as their main form of transportation were often the people who also mentioned using gyms, services like the YMCA as and other recreational exercising facilities such as martial art

studios and dance studios (i.e. ballet, Folkloric dancing , etc.). These resources are specifically accessible to only drivers because, they are located at least 20-25 minutes' drive from their homes.

Although some resources are available at a walking distance the preference about where to shop only creates more barriers since the shops the project participants favor are not always situated within the proximity of their homes. The preference of some stores over others deals with the store culture, whether workers were friendly, prices of things, and even how the stores are decorated. While the interviewees who drove reported having more options available to them because they can move around freely without dependency of public transportation. People whose main form of transportation is walking also talked about personal preference. Within a walking proximity are local shops such as *Mi Pueblo*, however; some of the community members who listed walking as their main source of transportation talked about disliking the physical structure of the shops (meaning how they are arranged in the interior) and the brands of products sold. One interviewee voiced her dissatisfaction with the store *Mi Pueblo*: "I don't like to shop in that store. I don't like their products, the meat is not the best quality meat, their dairy products are too expensive, and I dislike the smell of the cleaning products they use. I take the bus instead to another store". This interviewee expressed her dislike for the store clearly. She commented about her dislike of the product quality, pricing, and even the supplies that the store uses to clean the business. She also identified that although she does not drives she prefers to spend money and more time to ride the bus to go do her purchases at another store. What this means is that personal preference can in fact have a negative impact for the resources a person has in this community. Although there are nearby markets at a walking distance, residents purposely avoid these shops removing these resources from their daily lives.

2. Measure of Knowledge about the Resources

The number of resources reported was also affected by the information that community members had about resources. Drivers in general talked about knowing more medical services that are free and frequenting these services because they have easier ways of transportation. On the other hand, people who walked had more knowledge of local services that are provided by local organizations. The people who reported walking were also the people who are mostly involved in finding more information about resources. This probably has to do with the fact that the residents who walk spend more time and energy getting to resources; therefore, I assume that in order to decrease the amount of energy and money spent traveling most people would spend time researching resources that are closest to them. This was an important assumption that I made that affected me when I was creating the resource binder because I wanted to find local resources that did not require residents of this neighborhood to travel to other cities or counties.

Another aspect of the resource analysis that I implemented for these surveys was my personal geographical exploration of the areas identified as "exercise facilities" in the surveys and interviews. All of the participants listed the two parks around the neighborhood as their main resource for doing physical activities. Therefore, I decided to do geographical surveys of both parks. I spent one hour observing how people from the community interacted with the park environment, what activities they carried out, and most importantly the conditions of the environment and the effect that these physical attributes of the landscape had on how the parks were perceived and actually used by community members.

Physical Attributes of Park A and Park B

Park A is located near McKinley Elementary School. Community members often refer to this park as "the big park", because it has wide-open spaces – used to organize community wide

37

events. During my time in the field, I saw the park's open grass fields used as a soccer fields and picnic areas for families. Since the location of the park is next to a school, community members have access to the school blacktop areas that include basketball hoops, tether polls, and other blacktop related activities such as the foursquare game. Other amenities in this park include benches and street lamps. A small playground for school-age children is located within the blacktop area. The conditions of the park amenities are exceptional; because there are very few of them, the community takes exceptional care.

Park B is located near Olinder Elementary School. Community members refer to this park as the smaller park. In my personal spatial analysis of the park, I found that Park B has longer trails for walking and more amenities, yet due to the decreased use of this park for neighborhood events hosted by CommUniverCity, it is discussed as the smaller park. Similar to Park A, the black top area of Park B is connected to the elementary school, however; this school blacktop area has noticeable damage such as potholes and eroded boundary outlines for the basketball courts. The amount of litter and garbage around the park is more evident. Perhaps this is a reflection of the fact that there are more areas for cooking food (i.e., barbeque pits) and resting areas, and this would allow more people to gather and bring outside products that create litter. While carrying out my observations for Park A and B, I noticed that there is also more foot traffic in Park B. More people use Park B because it has another playground, specifically made for toddlers, and other recreational activity areas like a tennis court, and baseball field.

The amount of litter around Park B suggests that more people frequent that park, yet the resources (financial and work force) to maintain Park B are harder to preserve. While I was doing field observations of park usage, maintenance workers were present in Park B not as paid workers but rather as a volunteer service. Community members took it upon themselves to clean

and empty trashcans, and go through recycling processes of containers (i.e., bottles and cans). Park A on the other hand had no litter problems; this is probably because there are not many resting areas or cooking pits. The maintenance of Park A is also done through community members. The preservation of Park A is a work in progress as many people reported the ongoing projects to lobby for more streetlights, and utilizing some of the open field to create a soccer field. However, there were no reports about innovation projects for Park B.

In regards to the accessibility of resources, people who lived near Park A talked more in detail about this particular park rather than referring to Park B. On the other hand, some people felt that both parks were too far away from their own homes. Any physical activity that was done to get to the parks was done in the traveling because they walked to get to the parks. Since both parks are viewed as important exercising facilities that are relatively close to community members, they felt that these parks needed to be protected and that resources (either economic or through volunteer work) should be specifically focused on maintaining the parks for present and future residents living in these areas.

V.   COMMUNIVERCITY SUGGESTIONS AND FUTURE POSSIBILITIES

This project explored the residents' interest on health topics such as diabetes, obesity, high blood pressure, cancer, stress, and family planning. The interviews also explored the project participants' cultural beliefs about sugar consumption, greasy food, and salt intake and how these relate to perpetuating negative health outcomes. Interviewees were asked to understand the causes of their illnesses and think about interventions to help reduce the impact of these illnesses on their health. Community members also identified physical activity, nutrition, and environment safety as barriers that affect their health outcomes. Many of the interviewees had suggestions about enhancing the resources available to the community in order to improve their health outcomes. I will now discuss these suggestions.

1. Educational Workshops Focused On Adult Education.

Many of the interviewees talked about health issues that they face as adults. Although they have access to resources such as information for child health coverage available in their children's schools, no information is made available to the adults about finding health coverage for themselves. The community members interviewed all reported that their children have health coverage, yet this was not the case for all adults. Since all children have access to health coverage, any interventions and programs that focus on health should be aimed at the adults in the community. Four out of the ten residents interviewed had concerns about their lack of health insurance or the instability of their coverage, one great resource to bring to this community would be information about the ACA (Affordable Care Act).There are organizations whose sole purpose is to conduct community outreach to inform residents about ACA. Although this policy has been made a federal law, no member of this community ever brought up the topic of ACA on their own. Other helpful topics to focus on adult education would be discussions about the

prevalent illnesses that affect the Latino population. The interviewees identified diabetes, obesity and high blood pressure as illnesses that affect their community. Any information that could be made available to them about these topics should focus on adult experiences and not children because as one interviewee explained: "We get a lot of information about resources for our kids, through the school. But the school never sends home information about adult resources, you know like getting health insurance."

2. Nutritional Workshops

The interviewees' revealed community-wide interest in continuing nutritional workshops because many reported taking past nutritional classes. The classes covered child nutrition and making smart choices for their children about snack (i.e., reducing high caloric snacks, drinking water versus carbonated drinks, etc.). However, the community members highlighted personal concern for adult and child nutrition. The topics that community members would like to cover include nutritional guidelines, proportioning, and healthy recipes. For example, one interviewee explained: "Yes I would like to take again the nutritional classes that were offered by Reina. You know in these classes we learned many things, but I would like to learn more about how to cook better. Sometimes we get vegetables from the food truck and I don't even know how to cook them."

CommUniverCity would be the sponsor of the nutritional classes or workshops, in the past they offered nutritional classes, the only new setting for the nutritional classes that they already offer would be focusing the classes more on adult health and nutrition. Another organization that can provide suggestions and services for nutritional classes is the University of California CalFresh Nutrition Education Program, (UC CalFresh) a program that provides the

service of nutrition classes for parents of school age children grades k-8th grade that focus on shopping, resource management, food safety and a healthy diet.

3. *Community Safety*

The issue of safety as discussed by some of the people focused mostly on park and neighborhood safety. One resident talked about her growing concern with the parks: "Well, you see the parks are not really safe. There aren't enough lights, it gets dark too quickly, and I just don't feel safe." Many of the residents are interested in putting more lights around the park areas. Neighborhood safety can also be enhanced through neighborhood preparedness. One interviewee explained: "I would like to be more prepared to know what to do in case of an emergency. I don't think our neighborhood is ready to deal with natural disasters, and I think this is something that we need to learn." Offering a class that covers disaster preparedness and prevention can help address this concern. The city of San José offers a great workshop at no-cost that brings in department experts to talk about planning and safety issues. This workshop can become yearly training to community members who are interested, and a means to reformulate safety planning.

VI.   SELF REFLECTION

Working on this project has been a great hands-on experience for me. It was my first contract-based research project outside of the academic projects that I had previously participated in as an undergraduate student. This project influenced my personal as well as my professional life. I set out to complete this project with the notion of helping my own cultural group by helping to identify and voice the concerns of people who already face adversity or challenges in the sphere of health and illness due to their cultural background, gender, age, and socio-economic status. The narratives collected exemplified the topics of adversity, social capital and networking, and how grassroots action can bring about actual change.

While doing the interviews and talking with people at the community events, I learned about dedication to not just bettering oneself but to also looking out for the community. The people in the community have equally met the dedication that the organization workers place on their projects. In the field of anthropology, we are taught that the best way to conduct research is to create bonds and truly learn about people's worlds through their own eyes. This was only made possible through being committed to being there when I was needed by the organization and through mingling with the residents during the community wide events.

Working on this project also allowed me to become a better organized individual. This meant balancing my personal life as well as my academic. Creating a WBS (work breakdown structure) plans allowed me to focus on what needed to be as well as prioritize certain elements that needed to be completed for the project. I was lucky enough to come into a community and a dedicated organization that prides themselves in their work and their relation with city council members, San José State University affiliates, and other communities, and their commitment to bring positive changes to their communities.

On a professional level, this project allowed me to apply my professional knowledge, skills, and abilities in order to construct a research project that could potentially help change the outcome of some of the medical field interventions. My intent is to inform medical practitioners, as well as medical patients about the resources needed to address the health concerns that affect this community. I applied research techniques that I learned in my classes such as community-based research, qualitative, and quantitative analysis of data. For example, the class ANTH 234 inspired me to think outside the box in the kind of survey I wanted to implement in my research. By listening to my archeology peers talk about GIS mapping, I was inspired to incorporate personal narratives with a mapping exercise. I really took the lessons taught by Professor Darrah about bringing about other elements to our own research. I was successful in completing my project because I was able to work and communicate with people from different fields other than my own because I spent time learning about them. I have worked alongside CommUniverCity members, interns, consultants, and other organizations to promote knowledge dissemination about resources that are available to the community. The biggest challenge was to identify ways to meet the intended priority population, and I was able to deliver that information to my client because I listened to what the residents had to say.

Not everything in this project came easily. I learned a lot about myself through my failures. For example, I was excited to utilize the statistical analysis to my data but I soon realized that when I created the survey, I did not consider my variables. The questions I asked were open-ended therefore hard to quantify. Other mistakes I made were in scheduling. I gave myself two weeks to conduct interviews, but I did poorly at allowing myself enough time between the interviews to allow time for people to be late to our scheduled meeting. Sometimes I found myself waiting for my interviewees between 20 to 30 minutes. In one occasion, I had to

ask my second interviewee of the day to wait 30 minutes, because my first interviewee was late. I was not finished with the interview by the time the second one was supposed to start. The process of interview transcription is also something that gave me appreciation and respect for people within my field. I found myself spending a large majority of the time going over the interview recording repeatedly to accurately transcribe what was being said. The other hard aspect of the transcription was translating the transcribed interviews. For future projects that require translations, I will allow myself at least another month to do translations. In this project, I rushed myself to translate the qualitative data. If I learned, anything from this project is to be a flexible person.

The other aspect of this project that is hard is thinking about the future. The residents of Olinder identified key barriers that affect their health outcomes. I wanted to think about what needs to happen in order to bring change to their situations. I really think that this community has absolutely the biggest heart and determination to bring positive change to their neighborhood.

First, they are organized. They have worked before with CommUniverCity in creating campaigns and projects that help put their community in urban planning projects. I think that this success is largely attributed to the residents' dedication and willingness to voice their concerns. At the same time, I think that they do need support from other sources. I think that in order to improve their health and their environment they need more resources that focus on helping out the adults in the community. Many of my interviewees talked about the schools provide a lot of information about children's health services but not sufficient information about adult programs.

Some of these resources may just be monetary funds to help continue providing the programs that CommUniverCity already offers to members of the Olinder community. These funds can be attained through state grants and or creating sponsorships. I think that political

organization and education has already been established in this community. The residents of

Olinder already participate and contribute in many of their community social action programs.

The organization just needs to implement an end of the year evaluation that asks members of the

community what resources and services they liked? What changes would they like to occur? In

short, the organization and the community need to keep an open dialog with each other to have

feedback about their projects success and their failures.

VII.   ANTHROPOLOGY AND HEALTH MATTERS OLINDER

Throughout the project implementation I made sure I utilized the tools and skills I learned in the Applied Anthropology program.

1. Interviews: Conducting interviews is not simply sitting in front of a person and asking questions. There is a finesse in interviewing that involves being a good listener, tone of voice, creating an ambiance that is comfortable for the interviewee. It was thanks to my training in my field methods class that allowed me to practice with my other classmates how to converse with people and make them feel at ease in order to collect information. It was during these practices in class that I learn the appropriateness of probing. When I conducted the interviews, I noticed that many project participants felt nervous. I could tell because they use soft-spoken tones of voice and some even avoided making eye contact with me. One of the best skills I learn in class about interviewing was starting the interview with simple conversation questions what I call demographic questions. For example, my first interviewee began answering my questions simply with "yes" or "no" responses. I could tell that she was nervous, however, once I began asking questions about her family, especially her children she began to feel more comfortable. I notice that by asking demographic questions the interviewees opened up more because these questions are conversation starters. Once I would finish asking the demographic questions, the interviewees were more comfortable and made more eye contact.

2. Participant Observations and Rapport Building: One of the core values I learned from the graduate program was being open to opportunities. I was able to build strong connections with the CommUniverCity as well as with the residents through my participation in the community wide events. I provided services as a translator as well as being involved in the planning of the events and that led me to spend time with community members who are leaders.

47

Rapport building is extremely important because as an outsider people tend to be hesitant to want to talk to someone they do not know. The few opportunities that I had were some of my most priced memories of doing this project. For example, when I provided by translator services for the Health Fair event I had many of the neighborhood residents come up to me and ask me questions about what I had just translated, through this small interaction I was able to introduce myself to community members. Volunteering at the events was also a bonding and learning experience with the CommUniverCity staff. I got to meet and talk with other project coordinators, by helping them organize their information booths. I bonded with many people of the garden-to-table project and they provided helpful information about their program and about resources that they themselves utilize. The use of participant observation allowed me to study residents' behavior and experiences as they used the resources provided by CommUniverCity. For example, during the health fair, I was able to document and see what resources and services are favored by community members. The most visited services that were provided at the fair included the flu-shots, diabetes screening, dental screening, and the free-healthy meals. I was able to use this information, when I was constructing my resource binder by adding information about these services to the binder.

3. *Transcription:* The method of transcribing is a process that is time consuming but learning this skill an applying bit to my work has been quite beneficial because I don't need an expensive program to transcribe my interviews. It has also allowed me to improve my transcribing skills because the more exposed that you are to the process of transcribing the easier that it becomes. Transcribing is the process of transferring the recordings of interview into a written document. Transcribing requires patience, dedication, and most importantly attentive listening.

Through doing the process of transcription, I began to analyze my qualitative data. I heard and read so many times the recording of the interviews that I began to notice common themes among the interviews. I came up with six themes and I proceeded to re-read the transcribed interviews and highlight parts of the interviews where those themes were mentioned. The process of transcription can be overwhelming, but I allowed myself enough time in between interviews to give myself the weekend before I would start the next set of interviews. This made the process more relaxing. I remember my sixth interview was particularly lengthy. This interview lasted 90 minutes. It was the hardest interview to transcribe because it was a lengthy interview. I made the executive decision to divide the transcription into small chunks of time and this helped to keep me focused and happy.

4. *Cultural sensitivity: A*s an anthropologist I learned about cultural sensitivity an applied that to my work. First, as a Latina woman I understood the customs and manners from my own culture. I knew how to greet people, I understood the vocabulary they used, when they made cultural references to food items I understood what they were talking about and that made it easier for me to build rapport with the neighborhood residents. For example, one interviewee was talking about how during the holidays she limits her family from eating certain traditional foods like *tamales or champurrado* (a Mexican corn flour- based hot drink). She looked at me with a puzzled face and she proceeded to ask me if my family celebrated the holidays by eating these items. I answered yes, and then she went on to tell me about how she prepares these foods with healthier ingredients. We shared a connection between the food, the preparation methods, and even the experience about remembering the holidays with our families.

The other setting that I used cultural sensitivity was to understand CommUniverCity's own culture. By spending time with the organization staff, I learned about their mission, work

scope, structure, and how to conduct business with them. For example, I learned that the organization wants to distinguish themselves from other similar grassroots organizations. Therefore, they provide their staff with t-shirts, so when their staff is attending of providing services to the community members, people can recognize their logo and distinguish CommUniverCity's staff from other volunteers and organizations. By wearing the t-shirt to the community, I was approached more frequently by community members who I had not already met. The t-shirt assured community members that I was a trustworthy person because it associated me with CommUniverCity.

3. *Ethics:* A very big part of conducting this research project was following the ethical guidelines of anthropology. Following the ethical guidelines of carrying out anthropological research was very important to my project particularly because I asked questions of very personal and sometimes sensitive topics related to health issues. I also had access to private and controversial information. I remember one interviewee sharing with me her family's struggle with her diagnosis of cancer and her journey to recovery. Since I wanted to make sure that my informants were protected and comfortable sharing information, I decided to assign pseudonyms for my participants. The use of pseudonyms was sometimes hard for me to do because I really appreciate and admire my informants and all of the work they do, they more than deserve to be recognize for all their hard efforts and work to make positive changes in their lives and their communities.

4. *Community-based assessment-through their eyes:* This assessment was collaboration between the residents of Olinder and me. Through their knowledge, I was able to make suggestions for CommUniverCity as to how they can bring more resources and educational workshops to the community. I believe this project was very participatory, the community

members themselves expressed and voiced their concerns and they talked about changes that they would like to be made. The use of knowledge generated by community members can then help health practitioners modify health interventions, resources available, and disseminate prevention strategies focused on decreasing exposure to the top three diseases that affect the Latino community (High blood pressure, diabetes, and obesity). Furthermore, by listening to the participants' interviews I was able to create a list of recommendations and the resource binder that was really welcomed by CommUniverCity. I don't know how community members have responded to the binder because once I exited the field, I did not go back to talk to the residents but I know that Reina, the Community Director, was pleased with my work.

VIII.   CONCLUSION

This project is based on anthropological theory, data collection methodology, and ethics. In the principle of anthropological ethics, the collection methods of data were done through anonymity. The project participants were fully disclosed about the project purpose and the intended outcomes. This project was also applied because the knowledge generated from the project participants, organization members, and researchers were utilized to create a compilation of resources that could be accessed by any community members.

The interviews produced six themes that reflected community members' interest on health topics such as diabetes, obesity, high blood pressure, cancer, stress, and family planning. The interviews also helped to identify cultural beliefs about sugar consumption, greasy food, salt intake, and how these are related to perpetuating negative health outcomes. The other aspect explored by the community members who were interviewed was to understand the causes of their illnesses and thinking about interventions to help reduce the impact of these illnesses on their health. Community members also identified physical activity, nutrition, and environment safety as barriers that affect their health outcomes.

The use of the map survey and the spatial analysis of some of the resources available to the community members, such as the parks, expanded the residents' knowledge about resources and the barriers that stop community members from reaching these resources. Resource proximity and therefore availability was impacted by the residents' mode of transportation and personal preference.

Participant observation focused on exploring residents' social capital networks and its impact on attaining resources. For the most part, information about resources is disseminated through networks of friendship and through organizational networks. Social capital is a strong

motto for community members and for the organization of CommUniverCity. I describe social capital as a motto for community members and the organization staff because they really invest time and effort into maintaining the relationship between community members and the organization staff. The bonds created help to drive and support community ideas, concerns, and to lobby for resources.

One of my last observations as I left the field is that with the changing policy structure of health coverage in California and nationwide, the needs of the community will continue to develop and change. Although I am closing the project of Health Matters Olinder, the scope of the larger project Health Matters continues to be self-sustained. As more Applied Anthropology students pursue interests in this larger project, more necessities of the Olinder community will be identified and address. Furthermore, the applicability of the methods to collect data and the findings themselves can help bring light to other communities who face similar barriers to health.

IX.   REFERENCES

Amesty, Silvia C.
  2003 "Barriers to Physical Activity in the Hispanic Community." *Journal of Public Health Policy* 24(1): 41- 58.

Aslund, Cecilia., Starrin, Bengt., and Nilsson, Kent.
  2010. "Social Capital in Relation to Depression, Musculoskeletal Pain, and Psychosomatic Symptoms: A Cross-Sectional Study of a Large Population-Based Cohort of Swedish Adolescents." *BMC Public Health* 10(1): 715-757.

Bolin, Kristian., Lindgren, Bjorn., Lindstrom, Martin., and Nystedt, Paul.
  2003 "Investments in social capital implications of social interactions for the production of Health." *Journal of Social Science and Medicine* 56(12): 2379-2390.

Brown, Peter and Barrett, Ron.
  2009 Understanding and Applying Medical Anthropology: Edition 2. New York, NY: McGraw-Hill Publishing Company.

Bourdieu, P.
  1986 The Forms of Capital. J. Richardson Education Handbook of Theory and Research for the Sociology of Education: 241-258.

CommUniverCity San José.
  2014 "About Us" (Accessed September, 2014). Available from URL: ucsj.org/about-us/meet-our-team

Duenas, Sabrina.
  2012 "Las Campeonas de Salud: Health Access, Social Networks, and Group Sustainability: An Ethnographic Evaluation." M.A. Project Report, Department of Anthropology, San José State University.

Hawe, Penelope, and Schiell, Alan.
  2000 "Social Capital and Health Promotion: A Review." *Journal of Social Science and Medicine* 51(1):871-885.

Helman, Cecil G.
  1991 Medicine and Culture: Limits of Biomedical Explanation. The Lancet Publishing Company.

Kawachi, Ichiro, Kennedy, Bruce, P., and Glass, Roberta.
  1999 "Social Capital and Self-Rated Health: A Contextual Analysis."*American Journal of Public Health* 89(8):1187-1193.

Liao, Youlian MD, Bang, David PhD, Cosgrove, Shannon MHA, Dulin, Rick BS.
  2011 "Surveillance of Health Status in Minority Communities- Racial and Ethnic

54

Approaches to Community Health across the U.S." *Journal of Public Health Policy* 60(6): 1-43.

McGee, R. Jon and Warms, Richard L.
  2008 Anthropological Theory: An Introductory History (Fourth Edition). New York, NY: McGraw-Hill.

Nandi, A., Galea, S., Lopez, G., Nandi, V., Strongarone, S., Ompad, D.
  2008 "Access to and Use of Health Services Among Undocumented Mexican Immigrants in a US Urban Area." *American Journal of Public Health 98(1):*2011-2020.

National Institutes of Health
  2010 "Health Disparities Defined." (Accessed May 30, 2013). Available from URL: http://crchd.cancer.gov/disparities/defined.html.

Ritter, Lois A. and Hoffman, Nancy A.
  2010 Multicultural Health. MA: Jones and Bartlett Publisher.

Santa Clara County Department of Human Health.
  2012 "The Status of Latino/Hispanic Health: Santa Clara County 2012 Health Report." (Accessed May 5-May 21 2013). Available from: URL: http://www.sccgov.org

Santillan, Flor De Maria Merma.
    2014 "Access to Healthcare, Barriers, Experiences and Disease Perceptions of the Latino Undocumented -Diabetes Mellitus Population in Philadelphia." *Graduate Annual*: Vol. 2, Article 13.

US Department of Health and Human Services.
  2000 Healthy People 2010. Washington DC: US Government Printing Office.

Viswanathan, M. et al.
  2004 "Community-Based Participatory Research: Assessing the Evidence." Agency for Healthcare Research and Quality Publication No. 04: 1-101.

Walsh, Michele E., Katz, Murray A., and Sechrest, Lee.
  2003 "Unpacking Cultural Factors in Adaptation to Type 2 Diabetes." *Medical Care Journal* 40(1):129-139.

Ward, Marcia M., Yankey, Jon W., Vaughn, Thomas E.
  2004 "Physician Process and Patient Outcome Measures for Diabetic Care: Relationships to Organizational Characteristics." *Journal of Medical Care* 42(9): 840-850.

Whittemore, Robin, Melkus, D'Eramo, and Margaret, Grey.
  2004 "Applying social Ecological Theory to Type 2 Diabetes Prevention." *Journal of*

Community Health Nursing 21(2):87-99.

Ziersch, Anna M., Baum, Fran E., MacDougall, Colin, and Putland, Christine.
  2005: Neighborhood Life and Social Capital: The Implications for Health." *Social
  Science and Medicine Journal* 60(1): 71-86.

X.   APPENDICES

Appendix A: Community Director Letter
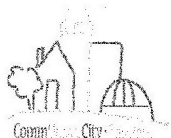
CommUniverCity San José
a partnership for service, learning, and community engagement
651 Macredes Avenue, San José, CA 95116 | (408) 644-3235 | www.cucsj.org
Tax ID: 83-0403915

TO: Chuck Darrah
Department Chair and Professor
Department of Anthropology
College of Social Sciences
San Jose State University

DATE: November 3, 2014

SUBJECT: **Completion of Health Matters project by Mercedes Ramans**

This is to verify that Mercedes Ramans completed her "Health Matters" project with CommUniverCity, a project that examines barriers to health care which contribute to health disparities in our community. Health Matters is a report that articulates the health needs and practices of the community. We will use the data, findings and recommendations from this report to apply for health grants and to design health interventions (projects) that contribute to improving the health outcomes of the community that we serve.

Additionally, Mercedes created two Health Resources binders (one in English, one in Spanish) which will serve as reference manuals and link the Olinder Elementary parents to health resources, programs and services throughout Santa Clara county.

These were the materials received from Mercedes at end of Health Matters program:
- 2 copies of CommUniverCity's Health Matters project report
- 1 copy of Recommendations
- 2 Health Resources binders (1 English version, 1 Spanish version)
- 1 digital copy of resource binder in USB form

The Health Resources binders were delivered to Olinder Elementary School and they are thankful for the time and work that was spent by Mercedes in collecting the resources for these binders.

We thank Mercedes Ramans for her work on the Health Matters project and for helping CommUniverCity find solutions to community-identified health priorities.

In community service,

Imelda Rodriguez
Community Director, CommUniverCity San José
Cell: (408) 644-3235 | imelda@cucsj.org | www.cucsj.org

Appendix B: CommUniverCity Project Report

Health Matters: A Community-based Assessment of the OLINDER neighborhood
Date: Summer 2013- Fall 2014
Project Description: This ethnographic project assessed the perceived views and beliefs about resources and health concerns from the neighborhood member's point of view vs. the actuals with the intended purpose of recognizing need areas and using the data collected to apply for grants that could bring resources to the community.
Project by the Numbers:
- 1 service learner: Mercedes Ramans Applied Anthropology M.A.
  - 46 hours of service
- 10 residents of Olinder neighborhood
  - Amount of time spent with each resident =1 hour for a total of 10 hours.
- TOTAL number of participants= 11
  - TOTAL HOURS (10+46) =56 hours.
- TOTAL FINANCIAL VALUE OF VOLUNTEERS AND SERVICE LEARNERS (56 X $22.14, the national value of volunteer time estimated by *Independent Sector* www.indpendentsector.com) = $1,239.84.
- 1 CommUniverCity staff member who participated in the project.
  - 8.5 staff hours invested in the project

Participants:
Faculty Lead(s):
Name: Guadalupe Salazar
Department: Anthropology
College: SJSU
Course Number: ANTH 108, ANTH 235, ANTH 234
Course Title: Medical Anthropology, Advance Quantitative Methods, and Advance Qualitative Research Methods.

Community Lead(s): This project is based anthropological theory, data collection methodology, and ethics. In the principle of anthropological ethics, I, Mercedes Ramans, the SJSU service learner upheld a document contract with the project participants about abstaining disclosure of their full names and identities. The principle of the data collected was anonymity, as such, I feel it is my professional duty to respect and uphold that contract in order to protect the identity of the project participants.

CommUniverCity Lead: Imelda Rodriguez.
Impact:
 (1) Impact of service learner:
I set out to complete this project with the notion of helping my own cultural group by helping to identify and voice the concerns of people who already face adversity or challenges in the sphere of health and illness due to their cultural background, gender, age, and socio-economic status. The narratives collected exemplified the topics of adversity, social capital, networking, and how grassroots action can bring about actual change. The people in the community have equally met the dedication that the organization workers place on their projects. The field of anthropology teaches that the best way to conduct research is to create bonds and increase community

members' participation. I was lucky enough to come into a community and a dedicated organization that prides themselves in their work and their relation with city council members, Sate University affiliates, and other communities, and their commitment to bring positive changes to their communities.

On a personal level, my inspiration for this project came about from my interest in the medical field, my work with the Hispanic community as a liaison for a school district. Lastly, from my family background and the struggle of a particular family member whose concerns with illness affected my views about how people understand health and illness and how these beliefs in return shape the outcomes of medical treatment. The narratives I collected tell the story of financial struggle and of concerns for family members' health due to illnesses that have been left untreated, and yet they continue to search for alternative ways to treat and ease the symptoms of such illnesses.

On a professional level, this project allowed me to apply my professional knowledge, skills, and abilities in order to construct a research project that could potentially help change the outcome of some of the medical field interventions being targeted to certain cultural groups. With the intent of using, the data collected to inform medical practitioners, as well as medical patients about the resources needed to address the health concerns that affect this community. The medical policy nationwide has begun to change many of the community members who reported a lack of financial funds to pursue health coverage can now have access to many different resources, however, the information that is being generated has not reach this target population. Throughout the project, I have worked alongside CommUniverCity members, interns, consultants, and other organizations to promote knowledge dissemination about resources that are available to the community.

(2) Community members:

This project was largely an assessment of neighborhood residents' health practices, beliefs, concerns, and the resources they perceived to have vs. the actual resources available. This project helped individuals to identify health concerns that they had individually as well as collectively about their family members and community members, as well as the recognition of resources and interventions that are applicable to their situations/concerns. In this process, the participants helped to identify different resources that they would like to bring to their community. The concept of health is something that it is based in the environment, social economic status, and over all cultural context. A majority of residents living in this community are of Latino heritage, therefore this project focused on discussing diseases that predominantly affect the Latino population. Based on the narratives collected, I found that the all project participants share experiences in dealing with diseases such as diabetes, obesity, and high-blood pressure (see findings for further explanations).

The purpose of this project was to identify community health concerns and to identify resources that community members would like to be brought into their communities. This project is meant to be a stepping-stone of other health related projects that can actually create and measure interventions and programs that address the concerns of community members. No follow-ups were made after the interviews.

Outcomes:
The data collected for this project included ten semi-structured interviews. From the interviews six domains were identify as topics of concerns to the community and highlighted by me (the student learner) as recommendations of resources that could be brought into the community (see

appendix domain analysis). By working with CommUniverCity members and other field specialists, I was determine to identify resources that the community members themselves could have access to and rely on themselves rather than on others to address health concerns. The concept of self-reliance inspired me to research and put together a resource binder that is accessible to all members of the community. The binder is a tool that allows access to information about organizations that provide cost free services or reduce price services. The organizations described in the resource binder reflect and take into account the "needs" of the community because they were selected through the criteria and recommendations made by the community members who participated in the project. Furthermore, it is a re-printable, re-distributional, and easy to update tool that helps disseminate information to people who are uninformed or people who are having trouble finding assistance.

The other outcome of this project is the project report and the qualitative data collected from this project. Our hope is that this data can be applied to grant writing in order to bring funds into the community to bring in some of the resources and or interventions that can help community members have better health outcomes.

Project Narrative:

Introduction

Health cannot simply be understood from a medical perspective; health status is the result of a complex interplay of different factors and environments such as family, home, work, schools, neighborhood, and religion. The predominant study of health is strongly founded in biomedicine, however, this manner in which to study health often misses the context for illness that is strongly founded from core cultural values (Ritter and Hoffman 2010). Understanding and applying the theories of health and illness can help health care practitioners had better understand how people receive and respond to prevention programs, treatment, and health education messages (Ritter and Hoffman 2010).

Similarly, research involving the study of health disparities needs to be explored through a more holistic approach that emphasizes different factors and environments. According to National Institutes of Health, health disparities reflect differences in the incidence, prevalence, mortality and burden of diseases and other adverse health conditions that exist among specific populations (www.crchd.cancer.gov). Research has found that racial and ethnic minority populations, in particular, tend to have poorer health outcomes, more chronic disease, and higher mortality than the White, majority population (US Department of Health and Human Services 2000). The Latino population is the third largest ethnic group in Santa Clara County (www.sccgov.org). Health status in this population reflects differences based on gender, age, education, income, and place of birth (www.sccgov.org). Latinos experience both health advantages and disadvantages relative to other racial/ethnic groups. In 2012, the Santa Clara County Health Department found Latinos have higher rates of overweight and obesity than adults' county wide and higher rates of diabetes countywide (www.sccgov.org). Furthermore, socio-economic and environmental factors like limited education, lower incomes, higher unemployment, and living in overcrowded households affect the Latino health and wellness (www.sccgov.org). As a result, the Santa Clara County DPH identified a need for the public health system to expand and adjust to meet the changing health needs of all the residents in the county.

The health care system in the United States has recently undergone some changes due to the increasing number of individuals who remain uninsured, untreated, and at risk of developing or worsening serious illnesses. One major attribution to this problem is the knowledge gap between health care practitioners and the general population. According to the data generated by the Santa Clara County Health Agency 220,000 residents lack health care coverage. Of those 220,000 residents, 55% are immigrants (www.communityhealthparnership.org). The Latino population is the third largest ethnic group in Santa Clara County (www.sccgov.org). Medical researchers agree there is a need for change not only in the way in which research is conducted but also in how the findings are made available to the wider public.

Project Description

The foundation of this project came from the concerns of community members from the OLINDER neighborhood, the collaboration with CommUniverCity, and San José State University in response to concerns brought up by community members in a series of town hall meetings. In the fall 2009, community leaders attended a series discussions that identified topics that affected members from different communities. Among these topics were issues with health. One of communities that strongly suggested health as one of their main concerns were residents from Five Wounds Brookwood Terrace (OLINDER). This community is composed of diverse immigrant groups who face significant linguistic, cultural, and economic barriers to health care that contribute to health disparities and magnify their risks for undesirable health outcomes. Guadalupe Salazar, an assistant professor at San José State University created the project Health Matters, a project that seeks to create opportunities for graduate students in the Master of Applied Anthropology Program and faculty to learn directly from OLINDER residents about their specific health concerns, resources, and agency. Health Matters Olinder is an umbrella project of Health Matters that uses ethnographic and anthropological qualitative research to learn about health disparities as the lived experiences of real people.

Project objectives

This ethnographic project took a grassroots approach to learning about the health beliefs, concerns and needs of the OLINDER residents and 1) identified specific areas of concern regarding health matters among the residents of the OLINDER community, and 2) explored the resources participants view as accessible to them. The goals of the project were to explore residents' biomedical and cultural understandings of the causes and management of their health concerns using anthropological methods. The project seek to foster connections in the community and incorporate service learning in the areas of health, education and neighborhood environment.

Methodology

Fieldwork for Health Matters began during summer 2013. Since this project is grounded in anthropological theory and methodology, the data collected would mostly be qualitative. These qualitative techniques permitted the gathering of information regarding individual and collective health beliefs, practices, and agency. The methodologies chosen to collect data included: participant observation, survey, and semis-structured interviews.

1. Participant observation: I the student service learner observed how community members interact with one another, how information is circulated, and how knowledge is generated.

2. Survey: Each participant was asked to draw and describe their neighbourhood landscape and what amenities are present and/or accessible.

3. Semi-structured interviews: Informants were asked to participate in interviews exploring their beliefs and practices regarding health and illness.

Table 1. Methods

Technique	Variation	Purpose
Participant observation	Pure observer: researcher is not part of setting Data context: behavior Data form: words	Observed relationship between volunteer service providers, event attendants, and organization staff. Observed network relationships in relation to community outreach, How did community members learn about the event? Understand health coverage demographics for this community. Assess services provided and intended outcomes of health fair.
Survey	Method of asking questions: written & in person Types of answer: mixed it will be fixed response & open ended	Identified resources and barriers to attaining those resources. Focused on proximity of resources, locality, and usage.
Interviews	In-depth interviews traditional setting (one-on-one) interpretive: researcher is engaged, conversation style	Interviews identified what are actual health concerns of community members, and to identifying resources.

Interpretation of data/ Findings

The research gathered from this project tells a more holistic story about community members, their struggles, beliefs and finally their activism and involvement with other organizations in order to address community needs and bring forth more opportunities for learning. All of the names used in the findings are pseudonyms. I used Pseudonyms in the interview narratives to protect the privacy of the project participants.

A domain is symbolic category that includes other categories. Based on the 10 interviews I was able to distinguish six domains that highlighted community members concerns with health and wellness. These domains include environment, health insurance coverage, illnesses, nutrition, resources, and preparedness.

1) The Environment

Many of the interviewees discussed in detailed how their social and physical environment of their community affected their health. Descriptions of the social environment were based on observations made from the interviewee's point of view about their community's social environment. In Camila Diaz's interview, she described the social environment of her neighborhood, in which she recognized that while community members have strong bonds with each other, there are outside forces that influence the wellbeing of community members. For example, she understood gang activity as a community wide concern.

"I think that the environment, and gangs are the priority concern for our community members, how should I describe this, there is a lot of people who have nothing to do (the nothing meaning they are involved in activities that are not productive for the community), and our other concern is keeping our community clean." (Camila Diaz Interview)

Gang activity is one of the prevalent concerns for many of the parents in this neighborhood. When asked how gang activity influenced their health or why it was a concern, some community members, like Camila Diaz, viewed gangsters as people who loiter and who contribute nothing to the community. In regards to health, she attributed gangster activity as an increasing stress factor for community members who worry about neighborhood safety.

The other concern expressed by community members involves the physical conditions of the environment such as pollution and neglect from community members (i.e. having their living spaces crowded with garbage, not picking up yard waste, etc.). Such is the case for Renata Estrada. Renata is the mother of two young girls who attend the local elementary school. Renata's concern with the environment is rooted in her children's asthma problems. In her interview, she explained that the lack of recycling and air pollutants such as tobacco smoke around her neighborhood are triggers for asthma attacks. *"The environment and recycle is a big problem…Our environment is not healthy, there is a lot of garbage and bad people. Sometimes people smoke a lot and that contaminates the city and health."* Based on Renata's observations, I asked her to provide some clarification about "bad people" in the community and their relation to the environment. She explained, *"Bad people…you know neighbors that simply throw garbage on the street, they are not concerned with the environment or bettering our community."*

Other community members who also concluded that the lack of recycling and the increase of pollution also correlated with higher rates of asthma and allergies made similar observations about air pollutants and the increase of garbage.

The relationship between the social environment and the physical environment was also a topic discussed by community members. Some of the people interviewed felt that the physical attributions of their landscape, for example the lack of street lights, the increasing rates of litter, and the presence of gangs, made their neighborhood environment unsupportive for community

wellness The exercising facilities such as the community parks are seen as unsafe for children, constant parental supervision is needed. One interviewee in particular explained

"Even though we live across the street from the park, I don't let my children play in the park by themselves even during day light. I need to be present. I don't feel it is a safe place."

Parents in particular are forced to look for other resources that allow their children to exercise.

2) Health Insurance

Seven out of the ten community members reported having trouble procuring health insurance. Even when these community members obtain health insurance, they described it as lacking. Sofia Garza is a resident who talked about her financial struggle and how she had to be resourceful in order to take care of her husband's illness without health insurance.

"I use the computer and the internet like the webpage WebMD, so that I can keep track of my husband's health issues. I look up how to make healthy meals; you know recipes, rather than frequently spending money to visit the doctor" (Sofia Garza interview).

Sofia is one of the many community members who reported looking for other means to address health concerns. Concerning her husband's high blood pressure, she talked about using technology-such as the site WebMD to look for information about ways to lower high blood pressure. Sofia is a returning resident of this neighborhood. She disclosed the fact that she has moved several times to other parts of the Bay Area as well as to other states but that she always comes back home to this neighborhood because of the ambiance and roots that her family has there. She is a mother of two children. Her struggle with health is economic (she worries about having money to pay for the services). Although her children are insured through a program offered at the children's school, Sofia and her husband lack health insurance. Therefore, Sofia and her husband are always stressed when either of them becomes sick because they do not have health insurance. *"My husband was diagnosed with high-blood pressure but he has never checked his blood pressure. When he was diagnosed, we received a medical bill of $800.00. He was told that he had to take medication to lower his blood pressure for the rest of his life, but because of the costs we have not followed through".*

One interesting observation about the discussion of health insurance for community members is that while the majority of adults reported lacking having health insurance, all of the adults reported that their children have health insurance. Julieta Flores explained, *"Here in the school (she is referring to the nearby elementary school) we get sent many sheets of paper that tells community members about services, for example how to get and enroll with Medicaid".*

Julieta mentioned that because the school provides parents with the paperwork and information on how to get health insurance for their children they actually do it. However, she mentioned that health insurance for adults is not a topic that is covered by the schools. For many of the community members interviewed, the biggest priority was covering the health needs of their children. Inquisitions about adult health coverage on the other hand are left entirely to the person. The information provided by the schools comes from the state created programs that provide for children but not adults, at least not those deemed healthy and able to work outside the information sphere of schools and directly contact the organizations that provide such services.

On the other hand, while some people reported having the information available to them about how to enroll in health insurance programs, they found the paperwork frustrating and vexing, making their experiences with health coverage research unappealing. Such is the case of Florencia Kalo.

"Look, even when we first arrived here, we had Kaiser through my husband's job. After 2001 when jobs went down. My husband lost his job and we lost all of our insurance, therefore we applied for Medicaid and we have been re-applying ever since. Now, since the month of September my husband applied to a new job where he is paid a little bit more, I believe we are no longer covered because our family makes a little more money. Recently, even though we received the letter to reapply for Medicaid I did not fill it out because I don't think we qualify, because our family has a little more money. So, at this moment, we don't have anything. We are waiting for my husband to get health insurance through his job. They told him since the month of November that they would provide him with insurance. But half a year or more has passed and we have nothing".

Florencia's interview highlights the lack of information and understanding about the available programs. Rather than talking with a representative of Medicaid, she believes that making more money cancels her coverage. Overall members of this community identified these reasons as to why they have no health insurance: too costly, too much hassle to apply for it, and there is a lack of information about coverage plans and assistance. For many members of the community, the thought of a spouse or family member needing serious medical treatment or even examinations leaves them feeling anxious. They are left insecure about how to deal with costly medical emergencies.

3) The Community's Response to Health Concerns "The Big Three"

Diabetes, high blood pressure, and obesity remain three of the biggest health concerns for this community. Four out of the ten interviewees expressed these concerns for their children. In regards to parental concerns on children's health outcomes based on the topics of diabetes, obesity, and high bold pressure, the project participants expressed diminishing concerns. One person in particular explained, *"One of my concerns is my daughter, she is overweight. I would like to take her to a nutritionist, she can have treatment but I can't".* When I asked Sofia clarification as to what the treatment for overweight meant to her, she explained that even though her daughter could potentially develop diabetes and high blood pressure due to being overweight, her daughter, with insurance could visit a doctor to manage and maintain a healthy living style. Sofia however, lacks health insurance therefore; she was the only person that could help her daughter. Many of the project participants reported the health concerns for their children where there, but they were not at the top of their priorities because they felt that the children could be treated. On the other hand, adult health concerns are left unregulated and untreated because they have lack of access to coverage, which raises the cost of treatment.

The narratives taken from the interviews reported high levels of concerns about adult diabetes, obesity, and high blood pressure. For some community members, their experiences and knowledge about such diseases and illnesses came through personal experience from having such illnesses or by having familiarity with these illnesses because they affected some of their family members. Nine out of ten people interviewed know someone in their families who have diabetes or have died because of diabetes and its complications. Five out of the ten people interviewed have been told by a medical professional that they are at risk or they already have diabetes. From those nine people who reported knowing someone who has diabetes only two of the interviewees were aware of whether their relatives receive treatment for the disease.

In order to better understand these illnesses, I asked the community members to define the illness/think about causations and to think what can be done at a personal level to reduce risk of developing these illnesses.

The interviewees' responses were almost unanimous, 90% of the people interviewed made the connection that nutrition and physical activity were the two causes for developing these illnesses. This connection between physical activity and nutrition also affected how people defined the illnesses. For example, the definition of diabetes is based on the community members understanding of sugar consumption. All of the interviewees described diabetes as the "sugar" disease. They attributed overeating sugar as the main reason that people develop diabetes. All community members defined diabetes as the sugar disease, repeatedly they mentioned over eating sugar. Some members talked about over consumption of sugar products and lack of exercise as reasons for development of diabetes, but factors such as genetics, carbohydrate intakes, etc. where not mentioned. Other community members saw diabetes as a side effect of their life style. One participant in particular talked about diabetes as a side effect of stress. Jimena Alvares explained, *"I think stress causes diabetes and other illnesses. I would like to live a life healthier without problems. Nevertheless, here in this country it is difficult because we have a lot of stress. But it is difficult, because everything causes us stress, like not having money to pay the rent, work, even not having your cell phone at hands reach causes people to be stressed"*.

This community member talked about her worries with work, economics, and even technology based in her reference to cell phones and how some people (as she observed) have the tendency to be constantly handling their cellphones. Later on in her interview, she made the connection about how business at work and at home reduced the amount of time that she could spend doing physical activities and how this made her less healthy and even more stressed out. High blood pressure was also regarded as a side effect of having bad eating habits and not enough exposure to physical activity. Some of the interviewees attributed high blood pressure to the over consumption of greasy food and high levels of salt. High blood pressure is perceived to be a health outcome that was only talked about for adult members of this community. Throughout the interviews there was no mentioned of children with high blood pressure, it was solely focused on the adult experience. Obesity on the other hand is a concern for children and adults alike. All of the community members agreed that healthy eating habits and actively participating or doing some sort of physical activity where the best preventative measures that a person could do in order to be healthy. While the "big three" are the priority concerns for members of this community, other health topics were reported throughout the interviews. These topics included women's health in relation to reproduction, breast cancer, cancer in the broader sense (i.e. skin cancer, pancreatic cancer, etc.), and dental health.

4) Nutrition

By talking about their health concerns, community members were able to think about the causes of the illnesses that affect their community. All of the interviewees identified nutrition as a problem and a solution strategy. Many community members kept referring to "good nutrition". Their definition of good nutrition can be summed up as reducing the consumption of junk food, and eating fruits and vegetables. The interviewee's definition of junk food is food that was high on sugar, greasy, and not prepared at home. The community's understanding about nutrition was also talked about in two separate categories. There is the nutrition for children and the nutrition for adults. The majority of the community members talked about nutritional concerns focused on

their children, and how there is an overall struggle to get younger children to make healthier selections about meals to consume at school and at home. As one interviewee phrased it, *"Sometimes, even though one wants to give food that is healthy, the child does not want to eat it. I want to give it to him (meaning her child), not because I am trying to be mean but rather because it is good for him. On the other hand, if your partner simply wants to give him a slice of pizza…because it is quicker or simply because my son really likes this, (the partner) wants to give the child everything that he likes but this is not what it is best".*

This community member talked about several important issues that involved personal choices. The first point that this interview excerpts highlights is how parents struggle between providing healthy food vs food their children like to eat. Many of the interviewees defined junk food, i.e., pizza, hamburgers, potato chips, and sweets, as the preferred food to be consumed by children. The junk food items were deemed unhealthy by community members because they were not fruits or vegetables and meals that are not homemade (i.e. premade meals that are purchased outside of the home at restaurants or are frozen meals).

The other problem community members described with junk food is that these products are within reach of their children. Unlike many of the other interviewees who talked about "parents" as the solution to children's nutritional problems this interviewee saw nutrition as a problem of both the child and the parents. She provided a solution by saying that it is important that children and parents alike, learn about nutrition. Four out of the ten people interviewed talked about how they were the main responsible figures in their household concerning following nutritional guidelines. For example, one interviewee talked about her family's consumption of fruit and how although her husband and she always make sure that fresh fruits and vegetables are always at their table, these often go unconsumed if she does not take the initiative to cut and serve this items right at the center of her dining room table. This interviewee is interested in having access to more educational opportunities to engage families in healthy eating habits. All of the community members interviewed revealed some interest in bringing in nutritional classes as a resource for community members.

5) Resources

The perceived notion about what is a resource is interpretative. As a researcher, my definition of a resource was very different to the definition the community members I was interviewing had. I decided to provide my own definition of resources as "any person, place, or thing that provides support for healthier outcomes." Once I provided this definition, community members began to talk about the different resources they know of, the resources they use, and the resources they would like to bring into their neighborhood. The people interviewed talked about four types of resources: exercising facilities, information, medical, and shopping centers (in relation to food consumption and nutrition).

Types of resources:

1.   Exercising facilities.

The interviewees talked about two types of exercising facilities. The first type they mentioned was the "no-cost" locations and the "pay" locations. These no- cost locations were identified as A. the two local parks and B. at home exercising experiences. The local parks where seen as exercising facilities because they are places where people can get some sort of exercise by walking to the parks, or by engaging themselves on some of the resources found at the parks to do exercise, such as tennis courts, trail-roads, etc. The other-no cost exercising facility that some community members talked about were at home activities. Their houses were viewed as the

primary locations where activities could be carried out. For example, one interviewee talked about how she and her daughters would get their exercise by dancing in their homes to music. Other at-home activities included gardening, doing chores, and physical exercise routines such as "work out videos."

The pay-locations where identified as actual gym facilities. Some community members reported knowing about and having access to these centers by information being sent to their homes about lower-income membership opportunities. The few interviewees that talked about enrolling themselves or their children in pay-exercise facilities mentioned having to look for these resources because they felt that the no-cost facilities such as the parks were unsafe.

2.   Information centers

All of the people interviewed referred to their local community centers as information hubs. They explained that the community centers are the places that they visit in order to find out information about events that are going on in the community or as distribution centers for actual resources. Other informational centers that were discussed included the local schools. Schools are perceived to be information centers because through their children attending the schools, the parents are informed of services via letters, pamphlets, and even phone calls. There was no actual mention of organizations that provided information to the community with the exception of CommUniverCity.

3.   Medical resources

While medical resources covered a large portion of visiting their doctors, the people who reported having inconstant health coverage mentioned local clinics and events that are brought to the community. The no-cost facilities mentioned included planned-parenthood clinics. The majority of the people interviewed talked about the community events organized by CommUniverCity to bring health service to the community like dental, diabetes screening, and flu shots.

4.   Shopping Centers

Many of the community members reported personal preference for some shopping centers versus others. What this meant is that rather than focusing on the products sold at the store, they focused on the store ambiance and interior design. For example, one interviewee explained how she disliked going to the shopping center "Mi Pueblo" because "Everything is so tightly packed, I feel like a mouse on a maze, I also don't like the music that they play so I try to avoid going to that store". The focus of the shopping centers discussion was also guided by the budget of the families. They frequented stores where they could get the most out of their money. For example, one store that was frequently mentioned was Walmart. It is the preferred store because of their bargain sales. People whose main mode of transportation is driving provided a more detail list of other stores that they frequented and the reasons why they like to frequent those locations. One interviewee in particular listed nine stores, while the average of the interviewees would mention four stores.

Once the interviewees had identified resources, I then asked them to talk about some of the barriers that they face when trying to gain access to resources. The biggest barriers talked about were modes of transportation, information, and personal preference. Further discussion about barriers to resources is covered in map analysis.

6) Enhancing Community's Cohesion and Community's Preparedness

One concern talked about in the interviews was the lack of community cohesion or community support issues that are important to community members. For example, many people

talked about how they felt unsafe in their neighborhood. Some community members felt that discussion about community safety had been overdone, but no action had been taken. They attributed this to the lack of community support. Four of the community members that were interviewed proposed the recommendation of creating an informal neighborhood watch. Adults living in the neighborhood would participate in watching small children when they are playing, reporting suspicious activity, and keeping the neighborhood environment safe and clean. The other issue with community cohesion is that many of the people interviewed felt that the community was not prepared to deal with emergencies via natural disasters. Their concerns are based on lack of participation in community events, for example, when workshops were offered to do disaster preparedness, only two people showed up. These six interviewees felt that the community is not truly united; they wanted more community structure and familiarity with each other.

Community solidarity was identified as an important element to keep the safety of the community members from outside forces such as natural disasters and gang activity. In order to address the issue of community participation, I asked the project participants to describe the ways in which they have been informed about events. They described the use of flyers, letters, phone calls, and face-to-face. I then asked the interviewees to tell me about their preferred method to receive information or invitations. Almost all of the people interviewed reported face-to-face as the preferred and most successful way to inform community members. They reported a bonding experience when they talk amongst each other. It is a way to know how each member is doing and to gather any other information that they might want to know about the event and the people involved. The face-to-face approach was highlighted to be extremely important to raise community participation in workshops and events; however, this did not mean that they wanted the other forms of communication to stop. The community members interviewed gave praise to the schools, and how helpful the information that is submitted through the school is for them to be informed about what is happening in their community.

Participant Observation: Networking and Community Outreach

Health Fair 2013
The purpose of the health fair was to bring health services and resources to community members in a multi-cultural neighborhood. Specially highlighting the services provided by the program of Covered California. Presentations and informational booths were set up throughout the fair in order to spread information about the new health coverage plans.
Safe and Green Halloween
This community event focuses on promoting community outreach for learning about how to protect the environment using recycled material to create Halloween customs. It also served the purpose of engaging community members in planning, coordinating, and bonding to tackle community goals of reducing waste and litter in their communities. As many members of the community talked about they did not feel that their neighborhoods are safe for their children, so they decided to create a community event that provides learning activities, as well as treats for the holiday while maintaining community unity and providing safety services for their children who want to trick-or-treat.

This two community events are huge reflections about how hard this community works to maintain their community social capital and networks. Social capital is built because throughout the planning of both events actual community members are given leadership positions in

organizing/ helping to organize the events. This has a positive outcome in the neighborhood because it affects the behavior of other neighborhoods that can see how successful Olinder has been to promote community unity, individual leadership (by providing residents with positions to lead), as well as organizational renewal of networks. The achievement of the resources gathered to promote the events, plan, and carryout all come from the project coordinators, and employees of CommUniverCity. Through working on partnerships with other organizations and with San José State students and faculty, each person that participates on a project/ event brings a different set of skills and resources for their overall network.

Map Analysis- Reflection of the Perceived Proximity of Resources.

The biggest barriers addressed in the interviews were mode of transportation, information, and personal preference. The map-survey analyzed these categories by looking at the variables of distance that looked at the accessibility of the resources measured by distance, and the amount of resources listed by the project participants. In the case of accessibility, I assumed that the interviewees would refer to distance in measure of lengths (i.e. miles). This was not the case there was an inconsistent reporting of measures such as the use of miles, blocks, and time (reporting of distance through minutes it took them to reach their destination). While there was opportunity to get clarification from community members by saying "how would you approximate… to the distance in…" the majority of the time the interviewees would continue to make their statements using the initial measure of distance that they used the first time. The other assumption that I made was that the quantity of resources that the people interviewed reported is a measure for the information and knowledge that they have about resources.

1.   Measure of Resource Accessibility
        The four categories of resources mentioned in the interviews were impacted by their approachability. Whether or not a resource was used was impacted by the amount of time or total distance that it would take the interviewees to have access to it. Furthermore, the individual concept of accessibility to a resource is affected by the mode of transportation. This was explained by some interviewees who measured distance not in length but time wise. The interviewees that described walking as their primary mode pf transportation only made trips to get resources that where far away from their homes when necessary because getting to that resource took too much time.
        The category of mode of transportation refers to what is the person's primary method of travel to get to resources. Seven out of the ten people interviewed said that their main mode of transportation was done by car. Because either they themselves or their spouses drove, they reported knowing and using more resources, especially in relation to the shopping centers. People who reported using public transportation or walking as a means to get to resources reported less variety of resources available to them. For example, individuals whose main mode of transportation is walking, often only mentioned local shopping resources such as the store "Mi Pueblo." In relation to having access to good sources of nutrition, the people who walk talked about resources offered to the community. The resources include: the program garden to table, participating in the community with fruit picking activity, and the food truck (a program for McKinley School that is sponsored by Cal Fresh and Food Harvest, that brings fresh produce, dairy, and other nutritional items comes to the school gymnasium and ha ds out these supply to people of the community). Drivers on the other hand emphasized variety of products, like buying

things that they can only get at certain stores. There was no further explanation as to what kind of items they purchased at certain stores, what was conveyed in the interviews was finding better pricing in certain items, and the shopping experience itself was more self-gratifying when they frequented stores that they liked.

Exercising facilities are also affected by the accessibility of resources. All of the project participants listed the community parks as exercising facilities, however; the people who listed driving as their main form of transportation were often the people who also mentioned using gyms, services like the YMCA as and other recreational exercising facilities such as martial art studios, dance studios (i.e. ballet, Folkloric dancing , etc.). These resources are specifically accessible to only drivers because they are located at least 20-25 minutes' drive from their homes. Although some resources are available at a walking distance the preference about where to shop only creates more barriers since the shops they tend to like are located far away. The preference of some stores over others dealt with store culture, whether workers were friendly, prices of things, and even how the stores are decorated.

While the interviewees who drove reported having more options available to them because they can move around freely without dependency of public transportation. People whose main form of transportation is walking also talked about personal preference. Within a walking proximity are local shops such as Mi Pueblo, however; some of the community members who listed walking as their main source of transportation talked about disliking the physical structure of the shops (meaning how they are arranged in the interior) and the brands of products being sold. Therefore, they spent more time traveling to further away locations such as Foodmax to shop in stores that they liked.

2.   Measure of Knowledge about Resources

The number of resources reported was also affected by the information that community members had about resources. Drivers in general talked about knowing more medical services that are free, and attending this services because they have easier ways of transportation. On the other hand, people who walked had more knowledge of local services that are provided by local organizations. The people who reported walking were also the people who are mostly involved in finding more information about resources. I believe that the investment in finding information comes from finding nearby resources that will decrease the cost of public transportation and save them time by traveling shorter distances.

Another aspect of the resource analysis that I implemented for these surveys was my personal geographical exploration of the areas identified as "exercise facilities" in the surveys and interviews. All of the participants listed the two parks around the neighborhood as their main resource for doing physical activities. Therefore, I decided to do geographical surveys of both parks. I spent a period of one hour observing how people from the community interacted with the park environment, what activities they carried out, and most importantly the conditions of the environment and the effect that these physical attributes of the landscape had on how the parks were perceived and actually used by community members.

Physical attributes of Park A and Park B

Park A is located near McKinley Elementary School. Community members often refer to this park as "the big park", because it has wide-open spaces - that are used to organize community wide events. During my time in the field, I saw the park's open grass field being used as a soccer field and picnic area for families. Since the location of the park is next to a

school, community members have access to the school blacktop areas that include basketball hoops, tether polls, and other blacktop related activities such as the foursquare game. Other amenities in this park include benches for sitting and street lamps. A small playground for school-age children is located within the blacktop area. The conditions of the park amenities are exceptional; because there are very few of them, the community takes exceptional care.

Park B is located near Olinder Elementary School. Community members refer to this park as the smaller park. In my personal spatial analysis of the park, I found that Park B has longer trails for walking and more amenities, yet due to the decreased amount of open space, it is discussed as the smaller park. Similar to Park A, the black top area of Park B is connected to the elementary school, however; this school blacktop area has noticeable damages, such as potholes and erosion of boundary outlines for the basketball courts. The amount of litter and garbage around the park is more evident. Perhaps this is a reflection of the fact that there are more areas for cooking food (i.e. barbeque pits) and resting areas, and this would allow more people to gather and bring outside products that create litter. While carrying out my observations for Park A and B, I noticed that there is also more foot traffic in Park B. More people use Park B because it has another playground, specifically made for toddlers, and other recreational activity areas like a tennis court, and baseball field.

The amount of litter around Park B suggests that more people frequent that park, yet the resources (financial and work force) to maintain Park B are harder to preserve. While I was doing field observations of park usage, maintenance workers were present in Park B not as paid workers but rather as a volunteer service. Community members took it upon themselves to clean and empty trashcans, and go through recycling processes of containers (i.e. bottles and cans). Park A on the other hand had no litter problems; this is probably because there are not many resting areas or cooking pits. The maintenance of Park A is also done through community members. The preservation of Park A is a work in progress as many people reported the ongoing projects to lobby for more streetlights, and utilizing some of the open field to create a soccer field. However, there were no reports about innovation projects for Park B.

In regards to the accessibility of resources, people who lived near Park A talked more in detail about this particular park rather than referring to Park B. On the other hand, some people felt that both parks were too far away from their own homes. Any physical activity that was done to get to the parks was done in the traveling because they traveled on foot. Since both parks are viewed as important exercising facilities that are relatively close to community members, they felt that these parks needed to be protected and that resources (either economic or through volunteer work) should be specifically focused on maintaining the parks for present and future residents living in these areas.

Broader Impacts

The Broader impact of this project is that the narratives collected from the ethnographic interviews can help change public policy understanding about the current health care system in the United States. As previous research done in the year 2012, the Santa Clara Health Department, found that a large portion of the Latino population is not being served through the current health care programs. The use of the qualitative data will allow researchers and policy makers to address the needs of the Latino community based on their self –identification of concern areas from the interviews and surveys, as well as bring resources.

The shift sin paradigm about medical research and interventions is another broader impact that comes from the exploration of the body of knowledge that community members

possess. This body of knowledge increases researchers' awareness about lifestyles and behaviors that affect community members'. The use of knowledge generated by community members can then help health practitioners modify health, resources available, and disseminate prevention strategies focused on decreasing exposure to the top three diseases that affect the Latino community (High blood pressure, diabetes, and obesity).

Intellectual Merit

The intellectual merit of this project comes from the creation of a new case study that explores how cultural and ethnic identities affects a person understands of health and illness, what treatment they seek, and their behavior. The use of community based research model also brings intellectual merit specifically highlighting the methods and strategies in order to add to the already existing body of knowledge about community based participation research that is new.

Resources:

The SJSU learner provided all resources utilized in this project, no funds, grants, etc. were used to collect data or compensate the project participants. The student learner at no cost provided the materials used. Such materials included pens, pencils, digital recorder, laptop computer, and computer software to help analyze data. These materials were at no cost for to me the student learner because they are materials that I own previously as part of my profession and that I have easy access to because of my association with the school district, and my position as a San José State University Student.

Recognition or Exposure:

In order to expose the intended purpose of the project the student learner participated and collaborated with other project organizers in community wide events such as the 2013 Health Fair and 2013 Safe & Green Halloween. During the Health fair, the student learner provided her services of translation to translate the informational meeting that covered the topic of health coverage plans and the changing policy. A picture can be viewed in the CommUniverCity website under events (link: http://cucsj.org/health-insurance-and-you-an-overview-of-2013-health-fair/). The participation in this community wide event allowed the student learner to capture the use of resources and health area concerns of community members based on the informational booths and health services provided by the event coordinators and partner organizations. The student learner also helped by collecting surveys from the event participants that identified areas of improvement for future health fairs.

Next Steps:

Health matters: Olinder is a small-scale umbrella project to the larger project Health Matters created by Professor Salazar. With the permission of CommUniverCity and collaboration of undergraduate and graduate students from the SJSU department, the project Health Matters can branch of into other student guided projects that focus on different topics related to health, such as chronic illness and food security.

Other Documents or Attachments:
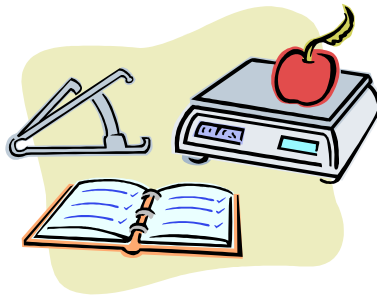Please see attached documents list:
> Recommendations to CommUniverCity
> Resource Binders

Appendix C: Resource Binder

Resource Binder

Assembled by,
Mercedes Ramans
December 2014.

Health & Wellness

Informational Organizations

Goal

The Health Coverage Initiatives Program's goal is to assist patients in our member community health organizations and other individuals to enroll in health coverage programs.

Current Activities

Community Health Partnership (CHP) and participating member health centers and clinics in Santa Clara and San Mateo counties will soon be designated official Covered California Enrollment Entities. As an official Covered California Enrollment Entity, we will be available for in-person application appointments in the near future. Please call to confirm application assistance start date: (408) 556-6605.

Our current activities also include:

- In collaboration with the Santa Clara County Health and Hospital System, screen and assist community health center patients and others to enroll in Valley Care.

- Provide information and referrals for families with children under age 19, to the Healthy Families (now Medi-Cal) and/or Healthy Kids Programs.

- Provide technical assistance and training to member community health center and clinic staff, community based organizations, and other groups regarding eligibility criteria for Covered California, Valley Care, the Medi-Cal Expansion and other health coverage programs.

- In collaboration with SIREN (Services, Immigrant Rights and Education Network), conduct and implement a "Know Your Rights under Health Care Reform" information and education campaign, targeting the medically underserved from Spanish and Vietnamese speaking communities.

Services

Health Coverage Information Line: 408-579-6026
- Provides pre-screening for Valley Care and application assistance for eligible individuals

- Providers referrals to Community Health Centers

- Provides referrals to other health coverage programs and community resources

In-person Valley Care Application Assistance:
- Available at the Community Health Partnership office on Thursdays and Fridays, from 9 am to 4 pm. Call 408-579-6026 to schedule an appointment.

Medi-Cal Administrative Activities (MAA)

In 1995, the MAA program was developed in California to provide a method of federal reimbursement for health related administrative activities currently performed by school districts for children from newborn to 21 years old who are "at risk." Payment is based on the cost of providing eligible health related outreach activities. The categories generally include:
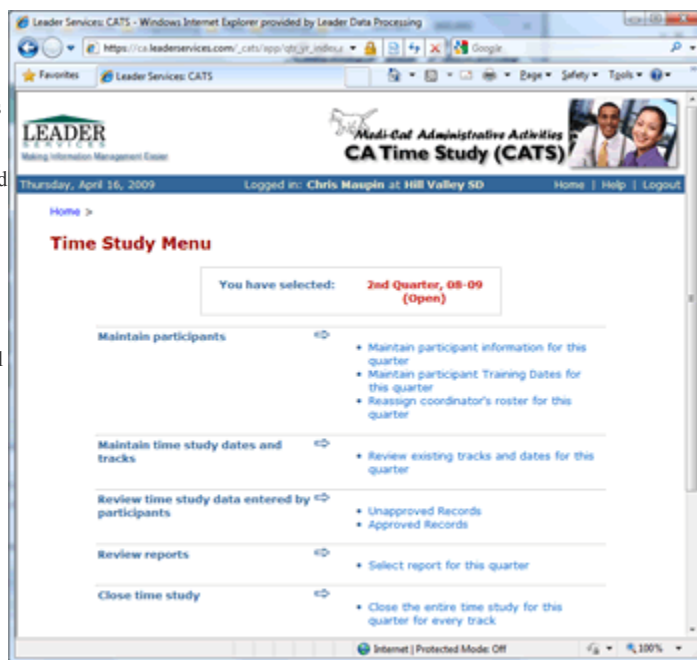
- Outreach/Public Awareness and Information
- Facilitating Medi-Cal Applications
- Referral, Coordination, and Monitoring of Medi-Cal Services
- Transportation-related Activities Supporting Medi-Cal Services
- Translation related to Medi-Cal Services
- Program Planning, Development, and Coordination related to Medi-Cal Services

Leader's CATS web-based time study application takes just minutes a day for participants.

Quarterly, MAA claims for federal reimbursement of activities are submitted based on a week-long time-survey. MAA claims are based on four factors: a time study (personnel time allocated to outreach activities); the Medi-Cal eligibility rate of the district's entire student population; the Federal Financial Participation (FFP) rate; and an analysis of the school's financial records. Schools can receive reimbursement of approximately 50%.

Leader Services facilitates three quarterly time studies used to calculate reimbursements for schools (one of the 4 quarters will be averaged and can be any quarter the district chooses, as long as they participate in 3 other quarters). Leader conducts trainings for participating staff (including training materials) and provides necessary time study forms and/or a web application (CATS) for recording the actual time study. Leader then provides data capture instruments to administrative staff for gathering necessary fiscal information, processing this data in conjunction with the time study results to generate claim documents for the LEA.

Because of the importance of complete and accurate audit files, Leader staff will work with Claiming Units to meet the DHCS requirements and conduct comprehensive reviews of Claiming Units' audit files as part of our services.

To find out more about California's Medi-Cal Administrative Claiming

Health Clinics

School Health Clinics of Santa Clara County

Programs:

- **Weight management**
- **Physical exams**
- **Insurance help**
- **Asthma monitoring**
- **Reproductive health**
- **Immunizations**

Mission Statement
School Health Clinics of Santa Clara County keeps kids healthy and in school by providing high quality, easily accessible primary medical care and preventive health services to low-income children and adolescents. Good health is basic to a child's ability to succeed in school and in life. Yet children are the most medically underserved group in Santa Clara County. As the public safety net of health care services is reduced, families need us more than ever. They increasingly rely on our school-based health clinics to put their children on the road to a healthy future.

School Health Clinics of Santa Clara County
Administrative Offices
Address
School Health Clinics of Santa Clara County
5671 Santa Teresa Blvd, Suite 105
San José, CA 95123
Telephone
(408) 284-2280

Fax (408) 754-0450
e-mail
info@schoolhealthclinics.org

San José Health Center - San José, CA
1691 The Alameda
San José, CA 95126
p: 408.287.7526 | f: 408.971.6963

Operated by: Planned Parenthood Mar Monte

- Request an Appointment

HOURS OF OPERATION

	Mon	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**	**Sun**
Open	8:30am	8:30am	8:30am	8:30am	7:30am	--	--
Close	5:00pm	7:00pm	5:00pm	7:00pm	5:00pm	--	--

Note: Saturday hours vary. Walk-ins are accepted. Please contact the health center for more details.

Languages

English; Spanish; Interpretation by telephone available for other languages. Please notify us in advance.

Health Center Services and Information

Walk-in Services

PPMM Health Centers accept walk-in patients, however it is on a first come, first serve basis, and there is no guarantee you will be seen until you arrive at the Health Center. Scheduling appointments is recommended to ensure you will be seen for the service you need.

If you need emergency contraception (morning after pill), you can walk in any time the health center is open.

Holidays

Our health center is closed for the following holidays:
- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Day

Appointment Information

If you are coming in for an employment or school physical, please bring the required forms with you.

Health Center is in back of the building, parking accessible from the Alameda and Naglee

Payment Information

If you are uninsured, you may qualify for a state-funded program or a lower fee scale.

Fees for services are based on your household income.

We accept the following forms of payment:

- cash
- checks
- money orders
- major credit cards

Payment is expected at time of service.

Medi-Cal accepted.

Insurance Information

Please see the provided list of insurance plans to find out which ones include Planned Parenthood as an in-network provider.

Most health insurance plans now cover prescription birth control, annual wellness exams, and HIV and STI screenings with no copay, and many other services with some copay required. You should contact your health insurance company directly to confirm that the services you are interested in are covered, and what, if any, out-of-pocket costs you are required to pay.

Please be sure to bring your insurance card to your visit.

If you do not have health insurance, visit PlannedParenthoodHealthInsuranceFacts.org to find out how to get more affordable coverage and what to consider when choosing a plan.

PACIFIC FREE CLINIC

OPEN SATURDAY MORNINGS

NEW PATIENTS SEEN FIRST COME,
FIRST SERVED STARTING AT 8:30 AM.

(650) 721 - 2786

Attention: Pacific Free Clinic will be closed on 2/1/14.

The Clinic

Pacific Free Clinic is located at Overfelt High School in San José. To visit the clinic, enter the high school parking lot on Cunningham Avenue at the "Overfelt Adult Education" entrance and follow the signs. We are located at the back of the parking lot, adjacent to the tennis courts.

OUR MISSION

The Mission of Cardinal Free Clinics is to provide culturally appropriate high quality transitional medical care for an underserved patient population and to educate and empower a new generation of health care leaders to proactively address health disparities and improve access to care in their communities.

Open to all regardless of immigration status, the clinic offers on-site medical services in English, Spanish, Vietnamese, and Mandarin Chinese. The Mission of Cardinal Free Clinics is to provide culturally appropriate high quality transitional medical care for an underserved patient population and to educate and empower a new generation of health care leaders to proactively address health disparities and improve access to care in their communities.

Services @ PFC

Complete Health Assessment

Patients undergo complete health assessments through the administration of a comprehensive health questionnaire, appropriate laboratory testing and physician visits.

Referrals

If additional long-term care is needed, Pacific Free Clinic staff will provide referrals to an appropriate health center including, but not limited to, primary care providers and other specialty services.

Medications

We provide prescriptions for low-cost medications from nearby pharmacies for patients under our care.

Laboratory Testing and Vaccines

We provide free blood draw services and laboratory testing for patients under our care. **Please do not eat or drink anything except water for 8 hours before your visit.** This helps us obtain the best possible information about your health. Drink plenty of water (avoid coffee and alcohol) in order to make blood draws easier.

Blood testing for HIV and hepatitis B/C is routinely performed for all patients. We also offer free vaccinations, such as hepatitis A/B and flu immunizations, when available. Typically, the flu vaccine is offered from October to May; the flu vaccine is provided at no cost to all patients and their family members, including children. Other vaccines, including vaccines against hepatitis A/B, are offered at no cost to patients with an urgent medical need. If no urgent medical need is present, patients may be referred to a low-cost community clinic for routine vaccinations.

Health Education
We provide personalized and group health instruction services with a focus on hepatitis B and cardiovascular disease patient education and disease management classes.

Interpretation Services
We offer interpretation and patient advocacy services in Spanish, Vietnamese, Cantonese, and Mandarin Chinese.

No Dental Services
Unfortunately, Pacific Free Clinic does not provide dental services due to limited resources. We can, however, direct you to a number of low-cost dental providers in the Santa Clara County. A list of providers can be found here**.**

CONTACT INFORMATION:

Clinic Location		Office
Pacific Free Clinic		Pacific Free Clinic
Overfelt HS Health Clinic		1265 Welch Rd., MSOB x367
1835 Cunningham Ave.		Stanford, CA 94305-5404
San José, CA 95122		Phone: 1-650-721-2786
Open Saturday mornings	View map of Overfelt HS.	Fax: 1-650-725-9852
		pacific@med.stanford.edu

Other Health Related Services

Mission

Next Door seeks "to end domestic violence in the moment and for all time."
Next Door promotes safety for battered women and their children through emergency shelter; multiple points of entry for victims; individuals, system and institutional advocacy; crisis intervention; education for victims and the community; and the changing of community norms through prevention activities.

Next Door's programs and services are free-of-charge and designed to empower victims and their families. With a short-term goal to provide safety and a long-term aim to prevent abuse, Next Door's programs and services include the following:
Crisis Services (24-hour hotline & shelter); **Support Services (walk-in crisis counseling, community office helpline); Systems Advocacy (legal, immigration, social service help); Family Support Services (support groups**, **children & youth services); and Self Sufficiency (individual case management, financial literacy workshops, the computer lab, HomeSafe affordable housing sites in San José and Santa Clara).**

Contact

Community Office:
234 E. Gish Road, Suite 200
San José, CA 95112
For General Information Only:
408-501-7550
Fax: 408-441-7562
Email: info@nextdoor.org
24-hour emergency hotline for victims: 408-279-2962

For over 100 years, the mission of the YWCA Silicon Valley has been to empower women, children, and families, and to eliminate racism, hatred and prejudice.

Contact Information:
375 South Third Street, San José, CA 95112 •• T: (408) 295-4011 •• F: (408) 295-0608
Office Hours: Monday - Friday 9:00 a.m. to 5:00 p.m. (doors locked for lunch 12:00 p.m. to 12:30 p.m.)

Our Programs & Services
The mission of the YWCA Domestic Violence Department, Support Network Program is to empower our diverse community to live free from domestic violence through the provision of safety, support services and self-empowerment.

About our services:
- All services are confidential.

- Services are for individuals and families; adults, teens and children experiencing, exposed to, or recovering from domestic violence.

- We offer services whether an individual is still in a relationship with a partner who is abusive, is in the process of leaving, or is no longer in the relationship.

- Our services are provided in English and Spanish. Some services may be provided in other languages if interpreters are available.

- All services are free or lost cost. Therapy services are provided on a sliding scale.

- An appointment is required for most services; some services are available on a walk-in basis.

- Most services are provided at our downtown San José office location. Several services are provided at various locations within Santa Clara County, including a small office in Sunnyvale (appointment required).

- Services are provided by professionally trained employees, interns and volunteers. They are collaborative, supportive and skill-based to address the psychological, social, physical and emotional effects of trauma and violence.

- Every effort is made to provide services that are sensitive to the culture of everyone in our diverse community.

Services provided through these Programs:

- Crisis Program

- Counseling & Therapy Program

- Emergency Shelter Program

- La Familia Program

- Legal Advocacy Program

- Victim Advocacy Project

- Human Trafficking Awareness Initiative

Environment

Environment

Environmental Services

Sustainable Environment in San José
San José is dedicated to providing a sustainable environment for its residents and businesses while preserving its beautiful and unique natural habitats. The Environmental Services Department enables San José to respond quickly to new regulations and initiatives while improving customer services such as recycling and garbage collection, wastewater treatment, and the sale of drinking and recycled water.

Our Core Services
- **Water Utility** - Since 1961, the San José Municipal Water System has grown from a relatively small water utility to the fourth largest water retailer in the County of Santa Clara, and now serves approximately 100,000 customers. It is one of three water retailers in the city.
- **Natural and Energy Resources Protection** - Our mission is to protect natural and energy resources and promote enhanced air quality, environmentally responsible land use and conservation of water and energy resources. We also provide technical support in the assessment, investigation, and cleanup of environmentally impaired City properties.
- **Recycled Water** - Develop, operate, and maintain a recycled water system that reduces effluent to the Bay and provides a reliable and high quality alternative water supply.

- **Recycling & Garbage Services** - Collect, process, and dispose of solid waste to maximize diversion from landfills and protect public health, safety, and the environment.
- **Storm water Management** - Protect the health of the South Bay watershed through regulatory programs that prevent pollution from entering the storm sewer system and waterways.
- **Wastewater Management** - Manage wastewater for suitable discharge into the south San Francisco Bay and for beneficial reuse to protect the environment and public health.

Contact:
Kerrie Romanow

200 E. Santa Clara St.
10th Floor Tower
San José, CA 95113-1905

Phone: (408) 535-8550
Fax: (408) 292-6211

WATER UTILITY

Drinking Water
Water Emergencies
To report a water emergency during business hours, please call (408) 535-3500. For afterhours emergencies, call (408) 363-4742.

Water Service in San José
There are three water retailers in San José, each with their own service areas:

- San José Municipal Water System, owned and operated by the City of San José
- San José Water Company, privately owned and regulated by the California Public Utilities Commission
- Great Oaks Water Company, privately owned and regulated by the California Public Utilities Commission

View our service area map to determine whether you are located in the San José Municipal Water System service area, or other San José incorporated areas served by one of the private water retailers.

Customer Service
Visit the Customer Service pages to find out how to pay your bill online, open or close an account, apply for service installations, and more.

Free Water Fixtures

San José Municipal Water System has free water fixtures for its San José customers, including showerheads and kitchen and bathroom faucet aerators. Customers can pick them up in person between the hours of 8:00 a.m. and 5:00 p.m. Monday through Friday at the office at 3025 Tuers Rd. The fixtures are also available at Santa Clara Valley Water District headquarters located at 5750 Almaden Expressway. Customers are limited to two showerheads, one kitchen faucet aerator, and two bathroom faucet aerators.

For more information contact:
Administrative Office

3025 Tuers Rd.
San José, CA 95121

Phone: (408) 535-3500

Preparedness & Safety

Emergency Preparedness Services:

- **Child preparedness**

- **Family preparedness**

- **Special needs preparedness**

- **Pet preparedness**

- **Emergency kits**

San José Prepared

Community Training Opportunities

San José Prepared is a program that offers a free, two-hour Disaster Preparedness Course. In two hours, you can learn:

- About hazards you should prepare for in San José

- About opportunities to become even more involved and disaster prepared

- How to create a family disaster plan

- Ways to reduce the risks of loss and injury before disaster strikes

- What you should include in your personal and family disaster supplies

To schedule a free class for your organization or group, please fill out the Speaker Request Form and email or fax to the contact information included on the form. *All requests will need to be submitted within 14 days advance notice and have a minimum of 10 people in attendance.* Thank you.

For more information, please contact:
Office of Emergency Services
855 N. San Pedro Street
San José, CA 95110
(408) 794-7055

OFFICE OF EMERGENCY SERVICES
San Jose Prepared!
Request Form
855 N. San Pedro Street, San Jose, CA 95110
Phone: 408-277-4595   Fax: 408-277-3345   Email: sjprepared@sanjoseca.gov

For Requestor Use:
ATTENTION: Graciela Hernandez, San Jose Prepared Coordinator

Contact Name:_____

Name of Organization:_____

Type of Organization:
  Neighborhood/Homeowners Association   Senior Center/Organization
  School   Faith-Based   Business   Community Organization   City Dept.
  Other:_____

Office #:_____Cell phone #:_____Fax #:_____

Mailing Address:_____ City:_____Zip:_____

Email Address (please print legibly):_____

Type of Program Requested:

  1 hr Disaster Preparedness Presentation   2hr Disaster Preparedness Presentation

  Booth at a Community Event
  (For community event please attach a flyer and parking instructions with this request form. Thank you.)

Specific Date of Event* (or possible dates):_____
(please do not write "any" day. We need a specific date to reserve on our calendar. Thank you.)
Specific Time of Event* (or possible times):_____

Street Address of Event:_____City:_____Zip:_____

Number of People:_____**Age Group:**_____**Language Needs:**_____
                                      (We will try our best to accommodate your event, but it may NOT be possible)
Comments:_____
_____
_____
_____

For Office Use Only:
DATE CONFIRMED_____**SPEAKER'S NAME:**_____**Record #:**_____

EQUIPMENT NEEDED: Projector   Screen   Table Chairs   Materials
Comments:_____
_____
_____
_____

4/26/12 G.Hernandez

Food & Nutrition

SECOND HARVEST FOOD BANK
of SANTA CLARA *and* SAN MATEO COUNTIES

Who We Are

Second Harvest Food Bank of Santa Clara and San Mateo Counties is the trusted leader dedicated to ending local hunger. Since its inception in 1974, Second Harvest has become one of the largest food banks in the nation, providing food to an average of nearly one quarter of a million people each month. The Food Bank mobilizes individuals, companies, and community partners to connect people to the nutritious food they need. Nearly half of the food distributed is fresh produce. Second Harvest also plays a leading role in promoting federal nutrition programs and educating families on how to make healthier food choices.

What We Do

We provide food efficiently through our innovative direct-service programs (see below) and by collaborating with a network of more than 330 partner non-profit agencies operating at 770 different food distribution sites. Partner agencies include shelters, pantries, soup kitchens, children's programs, senior meal sites, and residential programs.
Throughout the fiscal year, volunteers contributed nearly 310,000 hours of service, which saved us $6.2 million in equivalent personnel costs.

Food Bank Programs

Second Harvest operates direct service programs for seniors, families with children, and individuals:

- **Family Harvest** provides monthly food assistance to low-income families with children.

- **Brown Bag** provides weekly food assistance to low-income seniors.

- **Kids NOW** (Nutrition on Weekends) provides children ages 6-18 with an assortment of food items to take home every Friday.

- **Partners in Need** (PIN) provides weekly food assistance to low-income Food Bank volunteers.

- **Produce Mobile** delivers fresh fruits and vegetables to low-income households with limited access to community markets.

- **Mobile Pantry** delivers food to geographically-isolated communities and those with limited services.

We also help individuals find food assistance programs, learn about proper nutrition, and gain access to resources available to them:

- **Food Connection Hotline** connects callers to multilingual operators who refer them to

local food assistance programs.

- **Nutrition Education** provides nutrition, health, and food safety workshops to agencies and clients.

- **Food Stamp Outreach** helps eligible households apply for food stamps and receive benefits within days.

CONTACT US
Cypress Center
4001 North 1st Street, San José CA 95134

Phone: (650) 610-0800
Fax: (650) 610-0808

Regular Business Office Hours:
Monday - Friday, 8:00 a.m. to 4:30 p.m.