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This brief is based on a paper completed by Zainab Khan during her internship at the American Public Health Association, Scientific and Professional Affairs, Summer 2003. **The Obesity Epidemic in U.S. Minority Communities** describes the prevalence and effects of obesity among African Americans, Latinos and American Indians/Alaskan Natives and presents information on prevention and treatment interventions. Although the focus is on these minorities, much of the information on intervention and the resource links are applicable to the general population. The paper also describes legislation being considered to address obesity and overweight in general. Links for updating information and resources are provided.

The Obesity Epidemic in U.S. Minority Communities

Background

Overweight and obesity is epidemic in the United States.

- 35% of U.S. adults were overweight in 1999.
- An additional estimated 27% were obese.¹
- 13% of children and adolescents are overweight or obese, and over 10% of younger pre-school aged children between the ages of 2 and 5 are overweight.²
- Overweight children and adolescents are likely to become overweight or obese adults.³

African Americans, Latinos and Hispanics, and American Indians/Alaskan Natives have an increased risk of overweight and obesity and its consequences. (See the article ***The Association of Race, Socioeconomic Status, and Health Insurance Status with the Prevalence of Overweight Among Children and Adolescents***

<http://www.ajph.org/cgi/reprint/93/12/2105> for a comprehensive analysis. See www.cdc.gov for the most recent information on obesity and overweight.)

The health **consequences** of overweight and obesity are immense:

- Approximately 280,000 deaths are linked to complications related to obesity annually.⁴
- Overweight and obesity are risk factors for diabetes, cardiovascular disease, stroke, hypertension, gallbladder disease, osteoarthritis, sleep apnea, and cancer. They are also associated with complications during pregnancy, menstrual irregularity, stress incontinence, psychological disorders such as depression, and increased surgical risk.
- The mortality rate among obese individuals is 50-100% higher from all causes than among normal weight individuals.

The health care **costs** of overweight and obesity reach \$99.2 billion annually.

- Direct health care costs related to preventive, diagnostic, and treatment services reach \$51.6 billion or 5.7% of U.S health expenditure annually.
- Indirect costs such as loss of wages due to illness or disability, as well as lost future earnings due to premature death amount to \$47.6 billion annually.⁵

In 1952 the American Heart Association (AHA) identified obesity as a cardiac risk factor that could be altered through diet and exercise.⁶ Since then the AHA, the federal Public Health Service, the National

Institutes of Health (NIH), and other organizations have issued policy guidelines addressing obesity at regular intervals. *But obesity has increased among the general populace and has reached epic proportions in recent years.* Although federal agencies have attempted to address the obesity problem for a half-century, these efforts have been largely ineffective. *One reason for this failure is the focus on individual behavioral change, as opposed to changing conditions in society and the environment that contribute to the increase in overweight and obesity.*

Since 1980 the US Public Health Service has given obesity priority in its successive 10 year plans to reduce behavioral risks for disease. The implementation activities related to obesity prevention as identified under the Promoting Health/Preventing Disease (1980) and Healthy People 2000 (1990) plans were assigned to various federal agencies, including the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), and the National Institutes of Health (NIH). Yet prevalence has continued to increase.

Trends Contributing to Obesity and Overweight

The U.S. population continues to lead sedentary lives, and to consume more calories than expended.

- Only 3% of the population meets at least four of the five federal Food Guide Pyramid recommendations for the intake of grains, fruits, vegetables, dairy products, and meats.⁷
- Less than one third of Americans meet federal recommendations to engage in at least 30 minutes of moderate physical activity at least five days a week, while 40% of adults engage in no leisure time physical activity at all.⁸

Powerful social, cultural and economic factors encourage overeating and

sedentary lifestyles and discourage changes in these patterns. Mean caloric intake rose from 1826 kcal/day in 1989-1991 to 2002 kcal/day in 1994-1996, while activity levels have changed little if at all.⁹ Although the amount of food consumed is ultimately at the discretion of the individual, massive efforts by food manufacturers and restaurant chains play an undeniable role in consumption of food.

- Mars spends \$68 million to promote M&Ms candies and McDonald's spends \$1 billion annually to promote its products.¹⁰
- Annual expenditures by the food industry for advertising and promotions are approximately \$25 billion.¹¹

National expenditure on public health education and information campaigns pales in comparison.

- The National Cancer Institute spends a relatively meager \$1 million on its 5 A Day campaign, and the National Heart and Lung Institute's Cholesterol Education Campaign has a paltry \$1.5 million budget.

Meanwhile, children are bombarded daily with television commercials hawking soft drinks, fast foods, and snack foods. Schools are sometimes venues for corporate advertising due to compensation contracts with under funded school districts.

Increasingly higher proportions of food are consumed outside the home, now estimated to be approximately a third of daily energy.

- There are about 170,000 fast food restaurants¹² and three million vending machines¹³ selling nutrient poor, high calorie foods.
- Food eaten outside the home is higher in fat, lower in micronutrients and served in increasingly oversized proportions. Many restaurant meals

provide 35 to 100% of a full day's energy requirements.¹⁴

- For just a few cents more even larger servings are offered. It has become more and more difficult to resist the allure of aggressively marketed, cheap and fattening foods.

Environmental factors also contribute to sedentary lifestyles.

The technological advances of the last century, such as the automobile, computers, and other labor saving devices, have reduced energy expenditure. The shift from manual labor to white-collar jobs means that workers expend less energy during the workday and many sit at a desk for 8 hours a day. Comforts like air conditioning and heating encourage us to remain indoors, and entertainment from T.V, computers, and video games replaces outdoor activities for both children and adults. Meanwhile, a decline in funding for schools has led to the elimination or reduction of physical education and sports in many districts.⁸

The structure and planning of our cities and suburbs—the built environment—discourages physical activity. (See American Journal of Public Health, September 2003, Volume 93, Issue 9, <http://www.ajph.org/content/vol93/issue9/index.shtml> for articles.) Residential neighborhoods are typically designed for dependence on the automobile, without access to public transportation, bike paths, and sidewalks, running and walking trails, parks or open spaces. Separation of residential, recreational and commercial activities creates dependency upon the automobile to access workplaces, recreation and shopping. In addition, fear of being a victim of crime discourages people from venturing outdoors or allowing their children to do so.¹⁵

Obesity among African Americans

African Americans have one of the highest levels of obesity in the United States.¹⁶

- 58% of African American men and 69% of African American women are either overweight or obese.¹⁷
- Among Black children 6-11 years of age, 17% of boys and 22% of girls are overweight.¹⁸
- Among African American adolescents 12-19 years of age, 21% of boys and 27% of girls are overweight.¹⁹
- Overweight adolescents have a 70% chance of becoming obese adults, increasing to 80% if one or more parent is overweight or obese.²⁰

Increasing numbers of African Americans are suffering from health problems due to obesity, such as high cholesterol, stroke, asthma, sleep apnea, polycystic ovarian syndrome, and orthopedic problems.^{21,22}

Obesity and overweight has contributed to the high prevalence of Type II diabetes in the African American community.²³

- Approximately, 2.8 million or 13% of African Americans have diabetes.²⁴
- Black people are twice as likely to suffer from Type II diabetes as whites, and 25% of African Americans between the ages of 65 and 74 have diabetes.²⁵
- The highest rates are among Black women: One in four African American women over 55 years of age have diabetes.²⁵
- African Americans also have higher rates of complications from diabetes, such as blindness, cardiovascular disease, end stage renal disease (kidney disease) and amputations.²⁶

Limited access to and poor dietary choices, sedentary lifestyles, cultural norms and low socioeconomic status contribute to the high prevalence of obesity and overweight among African Americans.

- Less than half of all African Americans meet the minimum recommended servings of fruits and vegetables and do not consume enough fiber.²⁶
- African Americans consume more processed and fast foods that are high in fat and calories and low in nutrients. Larger portion sizes also contribute to increased fat and calorie consumption.²⁶

African Americans fall well below the recommended 30 minutes of moderately intense physical activity most days of the week.²⁶

- Among African Americans participating in a USDA Survey, 55 to 75% of females and 30 to 66% of men rarely exercised.²⁶
- African American women appear especially at risk for physical inactivity. Perceived barriers include a lack of time, physical and emotional exhaustion, lack of motivation to be physically active, living in a high crime area, inclement weather, lack of recreational facilities, and an absence of social support.²⁷

African American culture may also play a role in the prevalence of overweight and obesity. Cultural factors affect dietary choices, physical activity and acceptance of excess weight.

- Traditional African American foods tend to be fried and are high in fat, cholesterol, sodium and calories,²⁸ based on a cuisine with roots in slavery when African Americans were forced to exist on the most undesirable parts of foodstuffs provided by their masters.
- Staples of African American soul food include fried chicken, collard greens, fried pork chops, cornbread,

and ribs. Many dishes use large amounts of pork fat, butter and salt for flavor.

- In the past African Americans lived an extremely active lifestyle that may have protected them from the unhealthy effects of a high fat diet. But more sedentary lifestyles have caused health problems related to their diets to surface.
- Acceptance and preference for larger body types may reduce the negative social effects of overweight, particularly upon women. However, this does not mean that obesity or severe overweight is accepted as the norm.²⁹

Although obesity and overweight affect African American men and women across all socioeconomic levels, poverty plays a role in the prevalence of obesity.

In 2000, the poverty rate for African-Americans was 21%, nearly three times the non-Hispanic white poverty rate.³⁰ Low socioeconomic status and corresponding stress and difficulties can contribute to poor dietary choices and high rates of obesity. More African Americans with higher and middle incomes meet minimum dietary recommendations than do those with lower incomes. Similarly, those who are not dependent upon food stamps eat a healthier selection of foods.³¹

Access to safe, affordable, nutritionally adequate food available in socially acceptable ways determines a community's food security. Limited access to healthy and inexpensive foods in poor communities is a major barrier for weight control.

- There are fewer grocery stores with affordable fruits and vegetables close to inner city neighborhoods.³²
- Fast food and processed foods are cheaper and more convenient to obtain than fresh produce and whole grains.³³

- Working parents often don't have time to prepare nutritious foods for themselves or their children.³⁴
- Due to low food security many African Americans in poor communities opt for fattening meals from chain restaurants and convenience stores.³⁵

Another factor contributing to obesity is limited or no access to physical fitness programs and facilities in inner city neighborhoods.³⁶

- Generally, there are limited numbers of parks, open spaces, walking or biking trails in urban areas.
- After school sports and recreational programs are non-existent or limited, and parents may not allow children to play in the streets because of high crime rates.

Several factors in addition to poverty can contribute to difficulty in controlling weight. These include disparities in education and awareness about prevention and treatment of obesity and overweight, as well as a high incidence of depression. In addition there is a lack of negative social pressure to lose weight, a relatively positive body image, and a tendency to engage in weight loss for only short periods of time.³⁷

Obesity is curable and its complications are often reversible. A combination of diet, exercise, social support, medical treatment, and community involvement can be effective in treating obesity. However, treatment options for poor African Americans are limited.

- Black people have a long history of economic deprivation and inadequate health care.³⁸
- High poverty rates and lack of health insurance are barriers to appropriate health care in the Black community.
- African Americans are more likely to report chronic disease than whites

but less likely to see a physician on a regular basis.³⁹

Black patients without a regular doctor are less likely to receive preventative services and appropriate care for diseases related to obesity such as diabetes and hypertension. Furthermore, African Americans are more likely to report negative health care experiences and treatment with disrespect during health care visits. All of these factors add up to poor treatment of obesity, overweight and related illnesses in the African American community.

Interventions among African Americans

Lively Ladies is a physical education and activity intervention targeted to low-income, preadolescent, African American girls in a community-based youth services organization. The program strives to incorporate healthful habits in an enjoyable way. Features of the program that make it successful include taking advantage of existing community-based youth programming, obtaining the support of the organization, and involving parents.⁴⁰

Sisters Together: Move More, Eat Better is based on a pilot program conducted in Boston from 1994 to 1998. The program was based on research showing that Black women preferred receiving information from trusted family and community sources, as well as from the media. Based on these findings, community partnerships were created with churches, barber and beauty shops, health centers, newspapers, and radio stations with a high number of Black listeners. A culturally sensitive intervention campaign resulted in successful weight loss for many of the women involved.⁴¹

Steps to Soulful Living tested the effects of a culturally adapted weight loss program on African Americans. Black women participated for six months and achieved relatively large weight losses, demonstrating that properly tailored interventions can be

effective in the African American community.⁴²

Obesity among Latinos and Hispanics

Latinos/Hispanics constitute nearly 13% of the United States population. Mexican Americans are the largest group, representing 58% of the 35 million Latinos in the U.S. Puerto Ricans were the second largest group, at nearly 10% and Cuban Americans made up more than 3%. Dominican Americans were 2% of the Latino population.⁴³

The Hispanic/Latino community in the United States has been disproportionately affected by the obesity epidemic. For example:

- 66% of Mexican-American women and 64% of men are overweight or obese.^{44,45}
- 27% of male children and adolescents and 19% of females are overweight.⁴⁶

One of the most serious effects of overweight and obesity is diabetes. Among Latinos diabetes rates are almost double the prevalence rate of the general population:⁴⁷

- Almost two million, or 10% of Latino Americans have diabetes.
- Among Latinos between the ages of 45-74, 24% of Mexican Americans, 26% of Puerto Ricans and 16% of Cuban Americans have diabetes.
- 32-40% of Mexican Americans with diabetes suffer from diabetic retinopathy and are up to five times as likely to have end stage renal disease.
- Mexican American women who are overweight also have higher rates of gestational diabetes than non-Hispanic white women.

Many factors contribute to the high rates of obesity and overweight among Hispanics/Latinos, including poor diets affected by acculturation, sedentary lifestyles, and low socioeconomic status.

The traditional Mexican diet is rich in a variety of foods and dishes that represent a blend of pre-Columbian, Spanish, French and more recently, American culture, using foods rich in complex carbohydrates in the form of corn and corn products, beans, rice and breads, and high in protein from beans, eggs, fish, shellfish, beef, pork, poultry and goat. A variety of cooking techniques, emphasizing fresh produce, are used. However, the acculturation of Mexican Americans has led to the predominance of frying as a food preparation method and decreased consumption of fresh produce and other changes:⁴⁸

- The introduction of American style salads and cooked vegetables leads to an increase in the use of fats, salad dressings, margarine and butter, and a decrease in consumption of fresh vegetables.
- The consumption of traditional fruit based beverages is replaced with sugary drinks and sodas.
- The consumption of processed and fast foods high in saturated fat and calories increases with acculturation. Large portion sizes also contribute to high amounts of fat and calorie intake.
- The changes in the Mexican diet often lead to inadequate amounts of calcium, iron, vitamin A, folic acid, vitamin C and other nutrients.⁴⁹

The low socioeconomic status of many Latinos/Hispanics and the consequent stress and difficulties can contribute to obesity and overweight.

- 21% of Hispanics/Latinos live below the poverty level.⁵⁰
- 90% reside in cities.⁵¹

Latinos living in impoverished areas face many barriers to preventing obesity. Their options for physical activity are often limited. Increasing crime in urban areas prevents individuals from venturing out to exercise. Food security in such areas is limited because of the lack of stores with quality food and produce.^{52,53} Instead, there is a glut of fast food restaurants providing cheap food options that are high in fat and calories. Many establishments also offer Americanized versions of Mexican food that are high in sodium, fat and calories and skimp on fresh ingredients.⁵⁴ Health education and interventions that support the traditional diet can be effective in preventing and controlling obesity among Latinos.

Poverty is a major barrier to receiving appropriate health care. While health insurance coverage plays a major role in improving access to health care services in the U.S., Latinos are more likely to be uninsured than non-Hispanic whites.⁵⁵

- Although Latinos make up approximately 13% of the U.S. population under the age of 65, they account for 21% of the uninsured population.
- Latino children under the age of 18 are more than two times as likely to be uninsured as non-Hispanic white children.

The lack of linguistically and culturally appropriate health services also constitutes a barrier to prevention of and treatment for obesity.⁵⁶

- When treating a Hispanic patient, the level of acculturation needs to be assessed and the treatment adjusted accordingly. Determining the individual's primary language is a first step in this direction.
- For non-English-speaking persons, bicultural or bilingual staff and/or medical translators are necessary.

- Neighborhood and Spanish (or other appropriate language) publications should be used for information dissemination and education.
- Literacy levels, in addition to language, must be addressed as well. Latin American immigrants from rural areas may not have had opportunities for basic education and consequently have low literacy levels in their primary language. Their information needs must be met in different media.
- Caring for people within the context of their own families or existing systems, instead of focusing on individuals, is a viable strategy for Latinos, for whom the extended family is very important.

Interventions among Latinos

An example of a culturally competent intervention was conducted in a Latino migrant workers population in Starr County, Texas. Obese Latinas were recruited into support groups that involved local community leaders. Dietary modifications, such as replacing flour tortillas with corn tortillas and lard with other oils, and encouraging walking, were introduced within a community context, resulting in a mean weight loss of nearly five pounds per participant.⁵⁷

California's ***Latino 5- A- Day Campaign*** uses linguistically appropriate materials to encourage Latino families to follow nutrition and physical activity guidelines through culturally relevant, linguistically appropriate, and community-based social marketing.⁵⁸

Hip-Hop to Health Jr.⁵⁹, an obesity prevention program for minority preschool children, brings together schools and communities in reaching out to Latino/Hispanic children. Components of this program were tailored to the developmental and cultural needs of the children and also addressed the needs of the parents. Physical activity and nutrition

sessions with the children were combined with homework assignments to reinforce the principles introduced in the program.⁶⁰

Obesity among Native Americans and Alaskan Natives

The category American Indian and Alaskan Native (AI/AN) refers to people having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment. According to the U.S. census.⁶¹

- There are approximately 2.5 million American Indian or Alaska Natives in the United States.
- Approximately 50% of American Indians live in urban areas, and one third live on reservations or historic trust lands. Of the total population 43% live in the West, 31% in the South, 17% in the Midwest and 9% in the Northeast.
- The ten states with the largest American Indian population are California, Oklahoma, Arizona, Texas, New Mexico, New York, Washington, North Carolina, Michigan and Alaska.
- There are 542 federally recognized American Indian tribes in the United States each with its own traditional and cultural heritage.
- 40% of the AI population belongs within the Cherokee, Navajo, Latin American Indian, Choctaw, Sioux or Chippewa tribe. Cherokee is the largest specified tribal grouping.
- Among Alaskan Natives Eskimo is the largest tribal grouping followed by Tlingit-Haida, Alaska Athabascan, and Aleut.

Obesity has become a serious epidemic in Native American/Alaska Native (AI/AN) communities. Although data on prevalence of overweight and obesity among this

population is limited, targeted studies indicate that the incidence of overweight and obesity has reached critical levels.

- 60% of American Indian women less than 60 years of age are likely to be overweight or obese.⁶²
- 40% of school age AI/AN children were obese in 1990.⁶³
- Among preschool and school age AI/AN children, the rates of obesity and overweight are three times those of other children in the United States.⁶⁴
- 80% of AI women in Arizona and 67% of men were overweight, according to researchers from the Strong Heart Study in 1995.⁶⁵

Many of the health problems of AI/AN are related to obesity—cardiovascular disease, diabetes, end-stage renal disease, gallbladder disease, uterine cancer, and perinatal mortality.⁶⁶

- The adult diabetes rate among AI/AN is two times higher than the national rate, 15% versus 7%. Almost 105,000 Native Americans and Alaska Natives receiving care from Indian Health Services (IHS) have diabetes.⁶⁷
- Pima Indians (Arizona) have the highest rates of Type II diabetes in the world with a prevalence of about 50% in adults older than 35 years.⁶⁸
- Between 1990 and 1997 there was a 30% increase in diabetes diagnoses among the AI/AN population.⁶⁹
- Diabetic AI are four times more likely than other diabetics to suffer amputation and six times more likely to suffer from kidney disease.⁷⁰

As a result of European contact and

conquest, the traditional dietary patterns of AI/AN have changed radically during the past century, becoming much less healthy.

- Traditional AI/AN diets were high in complex carbohydrates and high fiber foods. For example, it has been estimated that the **traditional Pima diet** a hundred years ago was 70-80% carbohydrate, 8-12% fat and 12-18% protein.⁷¹
- The **current Pima diet** is 47% carbohydrate, 35% fat, 15% protein, and 3% alcohol.

The use of wild and homegrown produce has also decreased in the AI/AN diet although some families are still involved in growing fruits and vegetables, maintaining livestock for dairy and meat, raising poultry for eggs, and hunting and fishing. Today AI/AN consume a diet high in refined carbohydrates and sugars, fat and sodium, and low in fruits and vegetables.

- The median AI/AN intake of many essential nutrients is below the U.S Recommended Dietary Allowance.⁷²
- Fry bread, Navajo tortillas, home-fried potatoes, mutton, bacon and sausage, soft drinks, coffee and tea are common staples.⁷³
- Pan-frying or deep fat frying has replaced traditional preparation methods using direct heat.
- The proliferation of fast food restaurants and convenience food stores on and near reservations also encourages consumption of high-fat, high-sugar foods.

As among other U.S. minorities, poverty further limits access to healthful food options. (To read an analysis of the relationship between hunger and obesity, see The Paradox of Hunger and Obesity in

America, <http://www.frac.org/pdf/hungerandobesity.pdf>) **For communities located in remote areas where food costs are high and selection is limited, the effects of poverty are magnified.**⁷⁴

- 26% of the AI/AN population lives in poverty, double the national average.⁷⁵
- Grocery stores carrying affordable fresh produce and nutritious foods are rarely found on reservations, and transportation options are limited.⁷⁶
- Isolation and financial constraints have forced families in rural areas to rely on less expensive, high fat foods, cheap starches and few fruits and vegetables.
- 22% of AI/AN households did not have access to enough food to meet their basic needs over the 1995 to 1997 period.⁷⁷
- Hunger is often cyclical, occurring at the end of the month, when welfare payments, paychecks and food stamps run out. Poor families pay rent and utilities first and use whatever money remains for food.⁷⁸

Often the retaining funds are inadequate and families buy inexpensive, high calorie foods and prepare starchy, high fat meals to fill themselves up. This satiates hunger but also leads to malnourishment due to a lack of essential vitamins and minerals and weight gain due to an excess of calories. The cyclical deprivation can lead to overeating later when there is money to purchase food.

Federal nutrition assistance programs supplement the diets of low-income families both off and on the reservation. These programs include the School Lunch and Breakfast programs, the Supplemental Food Program for Women, Infants and Children (WIC), the Food Distribution Program on American-Indian Reservation (FDPIR), and the Food Stamp Program.⁷⁹ Collectively,

these programs contribute significantly to AI/AN diets as well as to other low-income population in the U.S. (For information about these federal food programs, visit www.usda.gov)

The most widely used programs are the Food Distribution Program on Indian Reservations (FDPIA) and Food Stamp Program; approximately 68% of tribes utilize these services.⁸⁰ FDPIR provides commodity foods to low-income households, including the elderly living on Indian reservations, and to Native American families residing in designated areas near reservations. Unfortunately, the foods have been high in fat and calories. In recent years the U.S. Department of Agriculture has made efforts to improve the nutritional profile of commodities offered, including an updated food package containing a variety of nutritious foods that also appeal to the preferences of tribes with distinct cultures and traditions. Tribes may opt to receive fresh produce instead of canned fruit and vegetables.⁸¹ These changes have made healthy foods more accessible to the AI/AN populations.

The destruction of AI/AN societies and the forced movement to reservations brought about, among other tragic effects, a shift from a very physically active traditional life style to more sedentary activities, with significantly lower caloric requirements.

- There are few recreational opportunities or outlets in AI/AN communities.⁸²
- For many members of this population, physical activity is an important component of the culture, especially in the forms of traditions and ceremonies. However, as a result of urban assimilation, there is less opportunity for such community activity.

Interventions among American Indians and Alaskan Natives

Interventions that encourage the consumption of traditional foods, most of which are low in fat and sugar and have high nutritive value, can have an important effect on obesity and overweight.⁸³

- Traditional foods are a part of numerous celebrations, powwows and religious ceremonies and are regarded as having particular spiritual and social value.⁸⁴
- Traditional foods are thought to represent purity, healthfulness, strength, life and culture.
- Most traditional AI/AN belief systems include concepts of harmony and balance regarding food. Emphasizing traditional belief systems can also aid in obesity prevention.⁸⁵

Culturally appropriate interventions grounded in values and traditions that promote health and well being require cooperation among local and tribal governments, federal agencies, AI/AN community leaders, public health officials, and health care providers. An example of such an intervention is the ***Pathways*** program, a school based primary prevention targeting third, fourth and fifth grade children funded by the National Heart, Lung and Blood Institute of NIH.⁸⁶ ***Pathways*** involves the Navajo Nation, the Gila River Indian Community, the Tohono O'odham Nation, the White Mountain Apache Tribe, the San Carlos Apache Tribe, the Oglala Lakota Nation, and the Sicangu Lakota Nation.

- The ***Pathways*** curriculum includes culturally appropriate school-based lessons that promote healthful eating behaviors and increased physical activity.

- One of the features of the program is a support system for obesity prevention among teachers, food service personnel, school administrators and family.
- **Pathways** involves a school-family advisory team, Family Fun Nights at each school, and education materials taken home by students to their parents.

Resources to Decrease Prevalence of Obesity among U.S. Minorities

Association of State and Territorial Public Health Nutrition Directors: **Guidelines for Comprehensive Programs to Promote Healthy Eating and Physical Activity** was developed to assist organizations at the state and local levels in creating comprehensive nutrition, physical activity and obesity control programs. www.astphnd.org

Federal agencies make available reports, research, surveillance data, funds and educational materials for dealing with the issue of obesity:

Centers for Disease Control and Prevention (CDC) www.cdc.gov

Food and Drug Administration (FDA) www.fda.gov

National Institutes of Health (NIH) www.nih.gov

U.S. Department of Agriculture (USDA) www.usda.gov See Food, Nutrition, & Consumer Services and Food Safety

Population-based Interventions Engaging Communities of Color in Healthy Eating and Active Living: A Review, Yancey AK, Kumanyika SK, Ponce NA, McCarthy WJ, Fielding JE, Leslie JP, Akbar J, is based upon a search of electronic databases and catalogued

studies from 1970 to the present of interventions that address socio-cultural, political, economic, and physical environmental factors. In Preventing Chronic Disease [serial online] 2004 Jan., accessed January 4, 2004, http://www.cdc.gov/pcd/issues/2004/jan/03_0012.htm

Resource Guide for Nutrition and Physical Activity Interventions to Prevent Obesity and Other Chronic Diseases – Although not geared to minority communities, this is a comprehensive resource guide for nutrition and physical activity programs to prevent and control obesity and other chronic diseases. Topics cover obesity prevention and control (including caloric intake and expenditure), increased physical activity, improved nutrition (including increased breastfeeding and increased consumption of fruits and vegetables), and reduced television time. <http://www.cdc.gov/nccdphp/dnpa/obesityprevention.htm>

Prevention through Access and Education

Access to safe, affordable and nutritious foods in socially acceptable ways is essential in improving the African American, Hispanic/ Latino, and Native American diets, as well as that of other population groups. Physical activity must be encouraged. Changes in access and education must be made at multiple levels—communities, schools, media and communication networks, health care providers and self-education by consumers.

Resources for Communities:

Form community coalitions to increase opportunities for physical activity and to increase food outlets that have low-calorie, nutritious and affordable food items.

The Centers for Disease Control and Prevention ***Planned Approach to Community Health*** (PATCH) tool

can be valuable in the process of developing and sustaining action.
<http://www.cdc.gov/nccdphp/patch/>

Under the Healthy People 2010 initiative, the Department of Health and Human Services (HHS) has produced ***A Community Planning Guide Using Healthy People 2010***. This document is a guide to developing an action plan through building community coalitions, creating a vision, measuring results, and creating partnerships. It outlines strategies to help start community activities.

<http://www.healthypeople.gov/Publications/HealthyCommunities2001/default.htm>

Hearts N' Parks is a national, community-based program supported by the National Heart, Lung, and Blood Institute and the National Recreation and Park Association to encourage Americans of all ages to aim for a healthy weight, follow a heart-healthy eating plan, and engage in regular physical activity.

http://www.nhlbi.nih.gov/health/prof/heart/obesity/hrt_n_pk/hnp_ab.htm

The Colorado Physical Activity and Nutrition Program is implementing two community interventions in an area with a large rural population and in the Denver Metro Black Churches www.cdphe.state.co.us/

Through the National Breast and Cervical Cancer Early Detection Across the Nation Program a ***Well-Integrated Screening and Evaluation for Women Across the Nation*** (WISEWOMAN) offers lifestyle and intervention programs to address risk factors, such as obesity, among uninsured and underinsured women.

www.cdc.gov/wisewoman/

Empower families to manage weight and health through skill building in parenting, meal planning and behavioral management.

Promoting Research and Outreach for "Niños" Today

(PRONTO), developed by the National Council of La Raza Institute for Hispanic Health, proposes to increase awareness and accessibility as well as reduce disparities on two important health issues — diabetes and cardiovascular disease — among Latino children and families. Project PRONTO is designed to establish a program model that uses community health workers — promotores de salud; trains a cadre of promotores de salud on asthma, cardiovascular disease, and diabetes; and incorporates a program evaluation methodology Cuéntamelo —“Tell me about it” — to measure impact and outcome at both national and local levels. <http://www.nldi.org/opt01-01E.asp>

The Indian Health Service and the Head Start Bureau have partnered in the development of an initiative, ***Healthy Children, Healthy Families and Healthy Communities: A Focus on Diabetes and Obesity Prevention***, which has focused on obesity and diabetes prevention activities for Head Start children, families, staff and communities.

Encourage healthy eating patterns consistent with the Dietary Guidelines for Americans.

<http://www.health.gov/dietaryguidelines/>

The ***New Soul Food Cookbook*** is an African American cookbook for people with diabetes, with sensational low-fat recipes for

shrimp jambalaya, corn muffins, barbecue pulled pork and more, plus advice for reducing fat, calories and sodium for weight loss and improved health and diabetes control.

http://store.diabetes.org/adabooks/product.asp?pfid=699&dept_id=3

The California **Latino 5 a Day Campaign** (Latino Campaign) was established in 1994 as a statewide social marketing initiative led by the California Department of Health Services and administered by the Public Health Institute in cooperation with the National 5 A Day Program of the National Cancer Institute.

<http://www.dhs.ca.gov/ps/cdic/cpns/at5aday/>

Address the specific needs of minority women who have a higher prevalence of obesity than men.

The Office on Women's Health has developed the **Girls and Obesity Initiative**, serving to identify existing government obesity programs and to adapt these programs toward gender specific guidance for girls.

[Girl and Adolescent Health](#)
[4 Girls Health](#)
[Girl Power](#)

NIH has developed a health awareness campaign called **Sisters Together: Move More, Eat Better** to encourage African American women in Boston to maintain or achieve a healthier weight by increasing their physical activity and eating healthy foods. NIH is currently expanding this program to other sites.

<http://www.niddk.nih.gov/health/nutrit/sisters/sisters.htm>

Create and implement public policy related to the provision of safe and accessible sidewalks, walking and

bicycle paths, and stairs, in inner city areas.

CDC's **Active Community Environments Initiative** (ACES) promotes walking, bicycling, and the development of accessible recreation facilities.

<http://www.cdc.gov/nccdphp/dnpa/aces.htm>

Resources for Schools:

Educate teachers, staff, and parents about the importance of school physical activity and nutritional programs and policies.

The CDC Division of Adolescent and School Health has developed many policy guidelines, intervention programs and resources.

<http://www.cdc.gov/nccdphp/dash/nutrition/index.htm>

[America on the Move](#)TM (AOTM) – a national, grassroots initiative that provides simple, actionable solutions to managing weight – is supported by government agencies, national associations and the private sector.

The CDC has developed [Kids Walk-to-School](#), a guide that encourages individuals and organizations to work together to identify and create safe walking routes to school.

Help students develop the knowledge, attitudes, skills and behaviors to adopt, maintain, and enjoy healthy eating habits and a physically active lifestyle.

Pathways fosters culturally appropriate healthy eating practices and increased physical activity among American Indian children, their families, food service staff, and physical education and classroom teachers. www.nih.gov

California Adolescent Nutrition

and Fitness Program (CANfit)
www.canfit.org

Hip to Health Jr. is an obesity prevention program for preschool minority children in Chicago Head Start programs. The 14-week intervention presents a culturally appropriate dietary/physical activity curriculum that targets preschoolers and includes a family component.
www.ncbi.nlm.nih.gov

Resources for Media and Communications Advocacy:

Conduct a national campaign to foster awareness among African American, Latino/Hispanic and American Indian/Alaska Native communities about the health benefits of regular physical activity, healthful dietary choices, and maintaining a healthy weight, based on the Dietary Guidelines for Americans.

Advocate for culturally sensitive health messages directed toward African American.
<http://www.bet.com/health>

Take A Loved One to the Doctor Day, the third Tuesday of each September, has become a key element of a campaign created by the Department of Health and Human Services to empower individuals in minority communities to adopt healthier lifestyles and obtain access to health care. The focus of the day is to encourage individuals to visit health professional (a doctor, a nurse, a nurse practitioner, or another health provider), attend a health event in the community, or help a friend, neighbor, or family member do the same. HHS and its partners also encourage communities around the country to organize health events on this day.

<http://www.healthgap.omhrc.gov/>

Resources for Health Care Providers:

Educate health care providers and administrators to identify and reduce barriers involving patient's lack of access to effective nutrition and physical activity interventions.

The Health Resources and Services Administration (HRSA) funds the National Center for Cultural Competence, which is assisting in the adoption of culturally competent values and practices at state and local maternal and child health programs.

<http://www.georgetown.edu/research/qucdc/nccc/index.html>

Hablamos Juntos is an initiative started in 2001 by the Robert Wood Johnson Foundation to improve patient-provider communication by specifically addressing language barriers.

<http://www.hablamosjuntos.org/>

Engage physicians in dialogues about racial/ethnic disparities in medical care and to educate themselves in order to address the health needs of minorities while considering tradition and culture.

The Henry J. Kaiser Family Foundation (KFF) and The Robert Wood Johnson Foundation (RWJF) support an initiative aimed at raising physician awareness about disparities in medical care, beginning with cardiac care, in conjunction with the American College of Cardiology Foundation, the American Heart Association, the Association of Black Cardiologists and 10 other national medical, public health, and business organizations.
www.kff.org/whythedifference

Expand clinical services geared towards weight management in minority communities.

The National Centers of Excellence in Women's Health is a program of the federal Office on Women's Health formed to establish a new model health care system whose goal is to improve the health status of diverse women across the life span. Specific programs include a nutrition services program targeted to low income women and some men managed by the Office of Women's Health at the Indiana State Department of Health and Wishard Health Services.

www.iupui.edu/~womenhlt/

A number of Tulane and Xavier University programs are available to assist and treat women diagnosed with obesity.

www.tulane.edu/~tuxcoe/NewWebsite/index.htm

At Harvard University, the **WELL** (Women Enjoying Longer Lives) program is a unique preventive health care and public education program designed for socially disadvantaged women age 45-64 years of all ethnic and cultural backgrounds. Using lay health advisors, women are encouraged to go through screening programs and receive preventive health care at their local neighborhood health center. Among the screenings provided is the assessment of the need for nutrition counseling.

www.hmcnet.harvard.edu/coe/

The University of Michigan Health System has developed **Mfit Supermarket Program** to help guide shoppers to healthier choices in the grocery store. This program is located in stores throughout Michigan, Ohio, and Wisconsin.

www.med.umich.edu/whp

At Wake Forest University the WHCOE has formed a community committee to help plan and implement **Pick Your Path to Health** events. This is a yearlong effort to get more women on a healthy path by addressing the disparities among women of different ethnic groups and providing workable health messages to all women. www.bqsm.edu/women

Resources for Consumers:

Individuals can find information on how to improve their diets and increase their physical fitness from many sources.

http://www.nhlbi.nih.gov/health/public/heart/obesity/lose_wt/patmats.htm

<http://www.health.gov/dietaryguidelines/>

<http://hin.nhlbi.nih.gov/portion/>

http://www.nhlbi.nih.gov/health/public/heart/obesity/lose_wt/phy_act.htm

Government Policy

Targeting the individual with information and education with the expectation that changes in behavior will result is not an effective means to reducing the prevalence of obesity and overweight. Instead, there must be a concerted effort to change government policies that contribute to poor nutrition and sedentary life styles in our society. Policies that contribute to the use of private automobiles over public transportation, poverty, limitation of socioeconomic opportunities and education and fail to appreciate other cultures contribute to the increasing obesity among minorities.

- Government policies impact all aspects of our environment, including residential neighborhoods, schools, workplaces, transportation, food supplies and the media.
- If policy makers focus on policies that promote nutrition and physical activity through education, urban

planning and development, food safety and security, advertising, and access to and quality of health care, then obesity can be prevented and controlled.

Community leaders and lawmakers play a vital role in preventing and treating obesity. Funding is necessary for programs, facilities or campaigns to prevent and control obesity. Taxation and other regulation applied to the food supply are ways to affect consumption of more nutritious food. Many legislative proposals to affect diet and sedentary life styles, either directly or indirectly, are under consideration. Some of these proposals focus on modifications in federal food programs, such as food stamps and WIC. Other efforts focus on the inclusion of obesity prevention and treatment in medical care. Legislation has also been introduced to regulate the sale of “junk” foods.

Food programs funded by the U.S. Department of Agriculture affect the availability and safety of foods for the entire population. Supplemental food programs are intended to address food security for low-income populations. These programs affect access, acceptability and nutritional content. For example, a recent study on the relationship between participation in federal food programs and obesity concluded that *girls in food insecure households had a significantly lower risk of being overweight if they participated in any or all of the programs, including school lunch, school Breakfast, and food stamps.* (Visit http://www.frac.org/html/news/090503obesity_reduction.htm)

Congressional Legislation Resources:

The status of legislation changes continuously. To learn more about new bills and to track pending legislation, visit these sites: <http://www.gpoaccess.gov/>
<http://olpa.od.nih.gov/default.asp> <http://thomas.loc.gov/home/thomas.html>

The summary tables of legislation introduced in the 108th Congress were prepared by Teresa Kim, American Public Policy for Washington Interns, October 19, 2003.

Table 1. Proposed legislation dealing with health promotion, treatment of obesity

Bill Number	Short Title (date introduced)	Sponsor	Partisan-ship (D/R)
S. 1428	Commonsense Consumption Act (7/17/03)	Mitch McConnell (R-KY)	Republican
H.R. 2227	Obesity Prevention Act (5/22/03)	Michael Castle (R-DE)	Republican
S. 1172	IMPACT (House: 2/12/02; Senate: 6/3/03)	Bill Frist (R-TN)	Bipartisan (Dem < Rep)
H.R. 716		Mary Bono (R-CA)	Bipartisan (Dem > Rep)
S. 1201	YMCA Healthy Teen Act (6/5/03)	Lindsey Graham (R-SC)	Bipartisan (Dem ~ Rep)
H.R. 811	SMARTS Health Act (2/13/03)	Eddie Johnson (D-TX)	Bipartisan (Dem > Rep)
H.R. 2024	Medicaid Obesity Treatment Act of 2003 (5/7/03)	Edolphus Towns (D-NY)	Democratic

Table 2. Proposed legislation dealing with child nutrition and federal school lunch programs

Bill Number	Short Title (date introduced)	Sponsor	Partisan-ship (D/R)
S. 870	(Extending funds for fruit and vegetable pilot program) (4/10/03)	Tom Harkin (D-IA)	Bipartisan (Dem ~ Rep)
S. 1367	Child Nutrition Improvement Act of 2003	Mitch McConnell (R-KY)	Bipartisan (Dem ~ Rep)
H.R. 2832	Healthy Nutrition for American's Children Act (7/23/03)	Doc Hastings (R-WA)	Bipartisan (Dem ~ Rep)
H.R. 2592	Healthy America Act (6/24/03)	Adam Putnam (R-FL)	Bipartisan (Dem ~ Rep)
S. 1393	(Reauthorizing fruit and vegetable pilot program) (7/10/03)	Tom Harkin (D-IA)	Bipartisan (Dem ~ Rep)
S. 1392	(Improving nutrition of students under federal nutrition programs) (Senate: 7/10/03; House: 7/25/03)	Tom Harkin (D-IA)	Democratic
H.R. 2987		Lynn Woolsey (D-CA)	Democratic
S. 995	Child Nutrition Initiatives Act of 2003 (5/5/03)	Patrick Leahy (D-VT)	Democratic
H.R. 2626	Farm-To-Cafeteria Projects Act of 2003 (6/26/03)	Fred Upton (R-MI)	Bipartisan (Dem > Rep)
S. 1007	Better Nutrition for School Children Act of 2003 (5/6/03)	Patrick Leahy (D-VT)	Bipartisan (Dem > Rep)

Source: U.S. House and U.S. Senate, 108th Congress, 1st Session, Database on-line, Thomas, Available from <<http://thomas.loc.gov/home/thomas.html>>

State Legislation Resources:

CDC has established a searchable database for information on proposed legislation from all 50 states related to nutrition and physical activity. The database contains information from 2001 and is updated on a quarterly basis. <http://apps.nccd.cdc.gov/DNPALeg/>

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