Weight of the Nation:

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INVESTMENTS IN HEALTH I: ACHIEVING HEALTH EQUITY

Moderated by Johnnie "Chip" Allen, MPH
Health Equity Coordinator
Office of Healthy Ohio
Ohio Department of Health

Shiriki Kumanyika, PhD, MPH
Associate Dean of Health Promotion
University of Pennsylvania School of Medicine

Amelie G. Ramirez, PhD
Executive Director
Salud America
Professor of Epidemiology and Biostatistics
University of Texas Health Science Center at San Antonio

Roberta Duncan
Breastfeeding Coordinator
Navajo Nation WIC

MR. ALLEN: I'd liked to welcome you to the panel investment and health equity panel discussion. Before I introduce you to our distinguished panel, I think it is very important for us to be able to frame the discussion around some very serious and important definitions regarding health equity. Too often our misunderstanding of these key concepts lead to inappropriate responses to this problem. And if we don't do anything else within this session, we want to make sure that we can develop the proper mindset to deal with this issue.

We have to start, number one, to believe that health equity is something within our power that we can all address. The other thing we have to do is start to think about issues of social justice. You can't deal with health equity without dealing with racism. You can't deal with health equity without dealing with sexism

and homophobia. You cannot deal with health equity unless you deal with poverty issues. So often we tend to deal with these issues and we segment them and, because of that, our responses to the problem are often in adequate. We can't afford not to deal with this issue in a serious fashion because, if we fail to do this, we are going to come to another conference like this twenty years from now talking about what we should have done; and if that happens, we have failed in our response.

Okay. We start off talking about health disparities. And what I'm going to do is I'm going to ask that you briefly go over these definitions because too often we use terms of health equity, health disparities and social determinants of health in the same breath. But when we are talking about health disparities, we are really just talking about the differences, the measurable differences in incidences and prevalence of health conditions between groups.

Social determinants of health: Again, these are the root causes of health disparities. Food supply, housing, economic, transportation, social relationships -- these are the things that actually cause the problems that we see in many of the diseases. Now, I just want to say something about social determinants of health. From an academic setting, sometimes we can sit back and say, well, it makes sense that folks who don't have access to good housing or clean water or freedom from racism, we can understand from an academic standpoint why -- how that causes problems. However, I want you to just kind of personalize this from your own standpoint. I don't know about you, but I believe that many of us in this room are one or two paychecks away from financial disaster. It's easy to say that we could look at those people, those poor folks, those folks who don't have anything. But if you think about how many of us are on the brink of losing our jobs, how many of us who may be losing our housing, and what impact it would have on us. If these issues happened to us, we will start seeing some more disparities.

President Clinton talked about it yesterday about how the food bank is seeing more people than ever have been before. So, if you think that somehow or another you can't slide into poverty, not only can you slide into poverty, if you think that you're not vulnerable to that, just look at your 401K statements or look how much value your accounts have and then see how safe you really think you are.

And I just wanted to be able to say that because our ability to not deal with this issue is going to come back home. Chickens will come home to roost. Health disparities are referred to health and equities when they are the result of systematic and unjust distribution of these critical conditions. And when we are talking about this, we really need to think about the fact that there is a social justice component to this. So, again, it's the unfair distribution. That's why we have these issues. Then health equity is the fair distribution of health determinants, outcomes, and resources. How did we get here? How did we go from having our interventions clearly just focus on disparities to work towards health equity?

In our panel discussion, you're going to hear some very good work that our panelists are doing to actually move towards this. "Unnatural Causes" is one of the best educational documentaries that we have. To be able to help now the public health community, the general public needs to understand that poor

health in and of itself is not a consequence -- is the consequence based on what you don't have as opposed to what you do have.

Health equity is not anything new. We see health equities in HIV Aids. We see health equity in every particular disease that we can see. So, while these are not anything new, the fact of the matter is that everybody is talking about it. The World Health Organization and the Solid Facts Document said that this is not just something we are dealing with the United States. It is a worldwide problem. But when we focus the issue of health in equity as relates to the obesity. We can only go to the MRW Report. It just talks about the difference and prevalence rates. But just some of the highlights that they had from the BRFS data and over the three-year period we can see that obesity is bad for everyone.

But when you start thinking about its toll on African-Americans, Latinos and how this disease is impacting us, we really have to make some different decisions and take a different approach to this. But, again, I want you to understand we are only talking about disparities. And when we start talking about disparities and not just about who you are, but we know we have different parts of the country that are experiencing more of this problem than others. The question is: What are we going to do differently? How do we get our minds right? What type of mindset do we have to develop or to address this issue in a proactive manner?

DR. KUMANYIKA: I'm going to talk about what we are doing in the African-American collaborative obesity research network, and I want you to think about the question that Chip just mentioned, you know, "What are we going to do differently to address the disparities?"

You've heard that black women need special attention when it comes to obesity, black women and girls. And I formed ACORN in 2002 to really start the conversation very carefully about this special attention that we need carefully because obesity has negative connotations. We don't want to be stereotyping, increasing stigma, but we need to talk about this problem. And I'm very glad to see that CDC has issued the press release to talk about this. I heard Sanjay Gupta talking about it on T.V. I was scared when I heard "race" and "obesity" and "black women," but, you know, we have to talk about it.

So ACORN was really formed to mobilize interested scholars to try to find the solutions and do some things differently to move this agenda. So, our vision is a community free of obesity-related health problems. And even though the CDC data say 40%, if you look at the Haynes data with measurements, it's actually 50% are over in 1999-2004, and could be 75% of black women with a BMI over 30 if you take a worst case scenario and follow these trends out.

This is particularly concerning because this is not a new problem in black women. The rates were higher before the epidemic compared to a black man and to white women, and so what that means is that if we address this problem now only as well as we addressed it in the general population, we will just have the

old disparity back. So, we really need special attention to not only address the new disparity but to go back and achieve equity.

On to the data for children and black females which was 27% in 2004. Trends may not be leveling off. In fact, possibly going up to 40%. This is especially concerning because this is a new problem. Black girls were not more obese back in the 60's and 70's. And so what this is saying is that something about this epidemic has reached into African-American communities more so than other communities affecting black girls in particular.

So, ACORN started this conversation in earnest in 2004 at a conference sponsored by the CDC and held in Atlanta, and we are very grateful for that support and for their vote of confidence in the mandate, and we tried to convene a very diverse group of scholars to address the question: How can we find effective sustainable, durable solutions to this, to weight, nutrition, physical activity problems in African-American communities? One of the key points that came out of this conference and the subsequent deliberations is that there are many perspectives on this problem, they're all legitimate, and we need to combine and leverage these three different perspectives, the community members and organizations themselves, very important. Equity means talking with people, not talking about people. The community is at the top.

Then there are the researchers who identify with the community, researchers like myself, who see the problem differently from other researchers but also differently from the community, because we are researchers. And then there are the other researchers, researchers in general, and the people who pay for research. And we really do need research to find a solutions to the problems, so we need all of these perspectives at the table.

We also took a look at the traditional focus of obesity research. Energy balance. And we decided that this was much, much too narrow that it did not invoke the people part of the problem. It was problem focused, trying to look at African-American women through the lens of eating behaviors and activity behaviors, and instead we wanted to bring many more disciplines to bare and invoke these different contexts, which I'm going to show you the cultural and psychosocial processes and contextual factors, the historical and social context and also the ones we've heard a lot about at this meeting: The physical and economic environments.

And so ask yourself when you are thinking about why black women and black girls have more obesity, how do these contexts differ in African-American communities compared to white communities? And what factors particularly affect women? Then we also have recognized more recently in looking at this model that many of these behaviors that we are thinking about for energy balance are also kind of hard wired now biologically mediated so it's a bio behavioral focus, not just the cognitive behavioral focus.

I want to illustrate briefly how this works when you think about something like food marketing. So, in the physical and economic environments, we have food prices, we have targeted marketing, and that's one

of our FOSI, the adverse marketing of foods and beverages. And so all of the high calorie foods and beverages, there is well-documented evidence that they are more available. Healthy foods are less available. That they are much more heavily advertised, television, print media, outdoor advertising is a bombardment, and it interfaces with the food prices and these are cheaper foods. So, the advertising and the marketing environment is more adverse. The marketing environment, if you look at the top circle, is also exquisitely tailored to fit with the cultural and psychosocial processes. So, if you have a need, a problem, a view, the marketers will get there, and so it's very nicely tailored marketing, but the irony then comes when you look at history, because historically photo companies, for example, were among the first, along with beer companies, to market to people of color and treat them with respect in the marketplace.

So, it's the irony that there's probably more trust of marketers who come into the community. You've probably seen some of the recent ads for McDonald's in the community showing young entrepreneurs. The irony is that there may be more trust and more community relations between marketers and African-Americans than there are between health care providers because there is distrust of the health care system.

So, the implications for research are many, community focus research. Those of us with some inside knowledge provide the opportunity for community members to speak for them selves. Using ethnography, actual ethnography and using literary works in the humanities and social sciences that actually study families. People-oriented research, not problem-oriented research.

So I just want to say how it all fits together to progress towards more viable solution oriented research that would prioritize community perspectives, community-based solutions that we could then evaluate and see if we could really address the problem. Remember, this is a way of thinking differently. It's not simply a matter of a few food preferences that we can change or a different body image. It's the context that differs that causes the disparity. Thank you.

DR. RAMIREZ: Bienvenidos. I would like to share with you a little bit about Hispanic and obesity in childhood issues. In particular, I would like to share with you a program that's called "Salud America, Preventing Childhood Obesity Among Latino Children."

But before that, I thought I would like to share with you what it was like growing up in a small town called Laredo, Texas, on the South Texas border where my family didn't have a lot of resources, and we were predominately Latinos. Along the border, almost 80% of the families were Mexican-American. They grew up from the depression era, and they were very frugal with what they did have. We rarely went out to a restaurant. Mother made our foods every day, homemade fresh fruits and vegetables. And we never felt deprived. We didn't realize what we didn't have. And I was always amazed at how my mom could feed a family of seven with one fryer, rice, beans and salads. And we were full. You know, we didn't question what we had on our plates. And then after that, we were allowed to go outside and play until sundown.

On weekends, my father had a small ranch and so there we went to play and to learn about farming and ranching and had a great time. And it was just a lot of fun. But things have changed unfortunately for our Latino population. And I would like to show you a glimpse of what it's like today for the Latino families. First of all, they have a lot of health challenges. In terms of the social determinants, our Latino children are some of the most vulnerable youngsters in the United States today. They belong to the group with the highest proportion of obesity and some of the fewest resources. They have low income, the lowest education, and the least likely to have health insurance. And all of these factors contribute to the many health disparities that they are facing and putting them at risk for cancer, obesity and many other chronic diseases.

Today, many of our Latino children don't have safe places to play or sidewalks to walk to school or Hispanic parents. Our Hispanic parents report that their children have more barriers to physical activity than a non-Hispanic, including transportation problems, concerns about neighborhood safety and the expense and availability of local play opportunities. Too few Hispanic children are physically active. Many don't play organized sports and lack appropriate places to play, and yet we have a lot of Hispanic players playing baseball and so forth, so they have the role models. They just don't have the places to go out and do this themselves. Many Latino families often rely on unhealthy fast foods. They don't have the resources to provide their children with fresh fruits and vegetables; and the advertising industry ensures that our kids are lured to the fast foods.

And there are countless other statistics that I could site. Hispanic families often believe that a chubby baby is a healthy baby; that a slim baby must have something wrong. If the average U.S. neighborhoods have a large grocery store or a Wal-mart or a Kroger in their neighborhood, a Hispanic neighborhood may only have one. And urban Hispanic students are three times more likely to have high BMIs. But the bottom line is that Mexican-American children face extremely high levels of childhood obesity and overweight as compared to non-Hispanic whites. But most of our data is only on Mexican-American children, and we need to learn more about our other Hispanic groups. We need to know more about Puerto Ricans, Cubans, Central and South Americans.

And through "Salud America," a National Program funded by the Robert Wood Johnson Foundation, we hope to be addressing some of these issues by building the field of researchers who are seeking environmental and policy solutions to Latino childhood obesity issues. We formed "Salud America" in late 2007. We have more than 1,400 members ranging from researchers to policy makers, to community leaders and local advocates. In late 2008, we surveyed our membership with a Delphi survey to identify research priorities. The process helped yield at the first Latino childhood obesity research priority agenda, which we have used as a guide for request for proposals for our pilot projects. We are really excited that earlier this month we were able to fund 20 pilot investigators to begin their work focusing on Latino childhood obesity issues. We did three rounds of Delphi surveys to get input from all our memberships and we had great representation throughout the United States: with individuals representing 31 states and

Puerto Rico, Guatemala and Portugal. Most participants were from Texas, California, followed by Illinois, Maryland and New York. The research areas are ranked the top three priorities: family, community and schools. And we issued the call for proposals for research projects in these areas that we're addressing the three areas of family, community and schools.

So, let me tell you about some examples of our pilot projects. In the area of family, one of our top priority areas was engaging Latino families and advocates in childhood obesity prevention initiatives at the community and school levels. One of our pilot projects entitled "La Famille en la Cocina" led by Dr. Vega will focus on mother-child communications patterns in eating and nutrition.

With regards to community, our top priority was looking at environment policies, involving collaborations with multiple stakeholders to promote Latino childhood activities. One of our pilot projects entitled "Healthy Tomorrows for Latino Teens" led by Dr. Dudley will focus on evaluating community-based programs to increase Latino teens' healthy eating and exercise and helping to bring similar programs to other groups and also to create an advocacy effort among their state legislators.

The third area was schools and focusing on health, nutrition and active physical education classes as part of the school curriculum for Latino children. In this area, one of the pilot projects will be integrating the "Dance Dance Revolution," to promote urban Latino child physical health and achievement. This program led by Dr. Gao and his team will examine the effects of physical activity video game on Latino activity at recess and after school.

So, what's next for "Salud America"? We really want to work with all our researchers to build the field of policy and environmental research among Latino childhood obesity. We want to support our twenty pilot projects, and we will also do this through our coordinating center. And then we want to bring attention to the issue and we have our own inaugural summit that will occur this September in San Antonio. And then we are also working very closely with the Robert Wood Johnson Center to prevent childhood obesity and coordinating the technical assistance that we will be providing to our pilot projects. And then in terms of what's new from the field, we look forward to working with our many collaborators at this meeting and others to look at digital marketing and the effects that it's having on our Latino youth. We want to look at food advertising and eating behaviors, manual label legislation and transportation issues as well.

I want to give a special thanks to the Robert Wood Johnson Foundation for their support and also for the members of our National Advisory Committee, who have been giving us guidance, and to our consultants, Drs. Green and Odisen. And I look forward to working with all of you because we are just beginning, and we have a lot of work to do. And I encourage you to visit our website <www.saludamerica.org>. Thank you very much.

MS. DUNCAN: I'm going to be talking about our legislation, "The Healthy Start Act." I'm going to be talking about what has been done and by the Navajo Nation Breastfeeding Coalition, and we passed a law in the

Navajo Nation Council. And I'm going to be talking about the Healthy Start Act, Legislation by the Navajo Nation Council where breastfeeding women that are breastfeeding can continue breastfeeding when they return to work. They have flexible breaks now, and they also have a clean private area to breastfeed their babies.

And I'm going to be addressing the social determinants. First talking about breast milk as healthy food, and also education of policy makers, businesses employees and mothers and also freedom from discrimination, which Chip had mentioned was a social determinant and social relationships related to the Healthy Start Act in breastfeeding. Healthy food, the first social determinant I will be discussing. Well, of course, breastfeeding is important today because of the health benefits to moms and babies and, of course, it protects babies from all types of illnesses. It helps in the bonding, and it protects the mother's health also, and it also saves money with our healthcare dollars.

Breastfed babies have less sickness and less ear infections. They have less diabetes for the first year, and they also spend less time in the hospitals. And they have less lung illnesses. They've got less gastrointestinal diseases. Breastfeeding does benefit adults too. Mothers that breastfeed have less type two diabetes. Among the Pima Indians. There was some research done that breastfeeding reduces the risk of diabetes if moms breastfeed more than or equal to two months. If they breastfeed for two months or longer, there is a 20% prevalence of diabetes. If there was some breastfeeding, there is 25%. And if they had never breastfed, there is a 30% prevalence of diabetes. And mothers who breastfeed have less risk of type-two diabetes. In one study, there was 15% less risk of type-two diabetes for every year of breastfeeding.

It also reduces the risk of overweight among young children. If you look at the 10,000 school age children studied in Germany, there was a 12% risk of becoming overweight if they ever breastfed. And if they never breastfed, that increase risk went up to 17.1%. And the risk was less with more time breastfed. You know, when they breastfeed, it's a dose response. The more you breastfeed, the more benefits you have. You have less prevalence of obesity. 23% had overweight or obesity prevalence compared to 64% percent when they are formula fed.

And breastfeeding longer means leaner lives. CDC data estimates a third risk reduction of obesity when babies are breastfed at least eight months, and that's a big difference. And that's one of the biggest benefits of breastfeeding, is that you get the benefits right away, right at the beginning of life than trying to bring the risk down later on in life when you already have all the bad habits, all the weight gain.

We also have good education of our policymakers. We did educate them during this Healthy Start Act and the Navajo Nation Council and the Navajo people. And we went up to the chapters that our children will grow up healthy when they grow up lean and breastfeeding can help. We really tried to get that message out, and I think we were successful because the Navajo Nation passed our Healthy Start Act 640. And we also had another educational piece that supporting breastfeeding is good for business.

Another social determinant I want to address is freedom from discrimination. The reason why we started out this Healthy Start Act is that we found out that returning to work stops a lot of women from breastfeeding, and we realized that it doesn't have to. So, that's why we set out to pass this legislation.

And another social determinant that we address are the social relationships of breastfeeding. We promoted that traditional aspect of breastfeeding. "When a mother nurses her baby, she is giving her child her name, her story and her life's song. A nursed baby will grow up to be strong in body, mind and spirit." And this is from one of our traditional elders, Anne Kahn, from Round Rock.

But there are still barriers to our legislation that we will be addressing. We are really confused about how the law is going to be enforced right now. We do have the Department of Personal Management in our Window Rock area working with the right to breastfeed policy. We are working with the Department of Justice to process the work grievances of employees, the Navajo Nation Labor Commission and the Office of Navajo Labor Relations are working to really define what an abuse of the law is and really what to do if somebody has an allegation that they have been discriminated against because of breastfeeding.

And so making the process work is still our challenge between all these areas and how we are all going to work together to really pull it off. But we do have a key strategy and, of course, our key strategy will help achieve health equity for all. One of the key strategies is to continue to get support from the national level, support in all these areas. They all have breastfeeding statements. They all have a lot of good information about breastfeeding, which we used during the passage of our Healthy Start Act.

We're sponsoring a conference in August for the Navajo Nation businesses and Navajo Nation employers and the tribal programs and informing them that we have a Healthy Start Act and that there is breastfeeding legislation because I don't know if a lot of them are aware of that. And then also telling them how they can go to the work places and support breastfeeding women, and also how we can help them write policies and become a lactation friendly work place. And also how to talk with their employees and teach them how to store milk, how to pump. And, you know, a lot of these issues of how to support women in the workplace it seems more difficult than it really is. They are given strategies on how they can do that.

And, of course, one of our barriers is, of course, our socioeconomic status on the reservation. 42.9% live below the poverty level with the average annual income of $7,269. And in 2003 Navajo Nation reported an unemployment rate of 42%. So, that is a barrier that we are always working with. Our socioeconomic status is very dismal on the Navajo Nation, but we are still trying to address a lot of health iniquities.

"Ben di awee' be ma deelt o'." That means, "Let the mother breastfeed," and that was all of our focus in the Healthy Start Act. Thank you.

MR. ALLEN: What do you all believe is a necessary mindset that our leaders need to be able to implement and sustain these policy environmental changes to eliminate, not only help the disparities, but to achieve health equity as it relates to obesity prevention and control?

DR. KUMANYIKA: I have a two-part answer to that question. I think that the leadership needs to understand that addressing obesity will also address a lot of other health problems. But a lot of other social problems need to be addressed before we can address obesity. And I think it's a two-part issue. It's going to be a good investment, but it requires an investment and that all the treatment dollars and individual programs are not going to work unless we can address, say, the bottom of the pyramid as we just heard.

DR. RAMIREZ: I'd like to add to that in terms of definitely the biggest social determinants are socioeconomic status and that we have to address that. But the other thing is that our funding comes in silos and, you know, we're always just funded for individual programs, and we're not given funding to really encourage partnerships and develop more comprehensive approaches to our communities. And we can't just address the health issue without addressing where the individuals live and so forth. And so I think working collectively we can make a bigger change.

MS. DUNCAN: I agree, and I basically had the partnership issue. Because when I look at the healthy weight for life, it's a comprehensive strategy across a lifespan of American Indians and Alaska Natives. And also the report that was given to the United States HHS and for health advocacy, they do address a lot of areas that of Native American obesity, which is very, very high. You notice that Chip didn't have a lot of information and statistics about the Native Americans. It was Black Americans and Hispanic Americans, and because we don't have data on the Navajo Nation like this type of data. There is data out there, but we, as health professionals, we do have a lot of reservations about it because of the way it's collected.

But it is probably worse than African-Americans and Hispanic-Americans. Just living there growing up there, it's all around. You just see everybody. You know, you just see it. And so I think we are aware of it. I think leaders are aware of it. They do state it in these two documents that I mentioned. However, I don't see much action, like President Clinton says, "Well, what are we going to do about it?" I think we get a lot of words, but we don't really know how to go about adjusting these. You see padlocked playgrounds. You see baseball fields that children want to play at the public schools but they get chased off. So, it's just not meeting, and we do need to collaborate more to address a lot of these issues.

MR. ALLEN: And to what degree do you-all feel that the public health community has necessary understanding and comfort level to address the complex issues surrounding health inequities?

DR. KUMANYIKA:

I think the public health community is ready in terms of interest and motivation, but we don't really teach social change in schools of public health. We're still working on individually oriented solutions, and the new wave of environmental and policy change and social change creation. We have a long way to go with

the tools to actually create social change. So I think that the understanding and comfort level will come as we get more concrete about how do you actually do this and begin to reward that in the system.

DR. RAMIREZ: I'd like to address the health provider side of this question, and it kind of takes us back to where we were. Tobacco, where are health providers understand the issue, that they maybe can promote smoking sensation to their patients, but our providers didn't have the skills to tell them how to go about doing it. And I think that we're in a similar situation with regards to childhood obesity or obesity in general. Our providers know we have a problem, but they don't have the time or the skills to council their patients to how to go about it. So, this is a whole area that we need to work on.

MS. DUNCAN: Yes, I agree. That's just kind of my answer to that. I think we really need to go down to the grassroots people, like we've been saying, and ask them how do we address these, because they know and they have ideas. And that's what we did with the Healthy Start Act, is go down to the people, go down to the chapter level, go down to the communities. And we had people go to the people and say, "Is this important?" And they all voted for it.

So, I think if we get down to that level and really ask them -- "How should we do this? What are your ideas?" -- and to break down the silos that we are all in because people are in aging, people are in diabetes program, people are on WIC, and we are all in our own silos, and we really need to break those down and work together. Because if we don't do that, we're just not going to get anywhere. We give out a lot of bags back home. We give out a lot of pens. But all it has on there is the program name and the 800 number. You know, what kind of health promotion is that? So, I think we really need to break those down and really start talking and get comfortable with each other and start working together, and that's the only way we can address a lot of these health inequities.

MR. ALLEN: We have to understand that the issue surrounding health inequity is very complex. And we have to develop new tools and a different way of thinking, also a different way of doing things. And we must remember that our failure to not do this will have us come back to one of these conferences talking about what we should do as opposed to what we should have done. We thank you.