

# GIH

# REVERSING THE OBESITY EPIDEMIC:

*Policy Strategies For  
Health Funders*

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BASED ON A  
GRANTMAKERS  
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ISSUE DIALOGUE

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**EXECUTIVE SUMMARY****REVERSING THE  
OBESITY EPIDEMIC:***Policy Strategies For Health Funders*

**A**s part of its continuing mission to serve trustees and staff of health foundations and corporate giving programs, Grantmakers In Health (GIH) convened a group of health funders and policy experts on November 3, 2006 to discuss policy strategies to reverse the obesity epidemic.

*This report, drawing upon a background paper prepared for the Issue Dialogue and discussion at that meeting, provides an overview of the costs and consequences of the obesity epidemic; presents the rationale for using policy approaches to change food and physical activity environments; and highlights the efforts of health funders supporting policy change in schools, food systems and sustainable agriculture, the built environment, and across communities. It also briefly examines trends and opportunities in health systems, workplaces, and state programs, and concludes with a discussion of challenges and opportunities for moving forward.*

**Overview of the Obesity Epidemic**

The U.S. Surgeon General, Institute of Medicine (IOM), and director of the Centers for Disease Control and Prevention (CDC) have all declared that the U.S. is facing an obesity epidemic and have made it a public health priority. Two-thirds of U.S. adults (over 97 million people) are overweight or obese. Close to 31 percent of U.S. children (over 9 million) are overweight, and childhood obesity has more than doubled in the past 25 years (Hedley et al. 2004; Ogden et al. 2006). Overweight and obese individuals are at increased risk for many chronic diseases and

health conditions, including heart disease, stroke, some cancers, and type 2 diabetes. Annual national health care expenditures related to obesity are estimated to range from \$98 to \$129 billion (IOM 2005).

A 2006 report by the IOM assessing progress in addressing obesity found that many policies and programs are being put in place to increase physical activity and promote healthful eating among children and youth. These interventions, however, generally remain fragmented and small scale, and the current level of investment still does not match the extent of the problem (IOM 2006). Moreover, the lack of

systematic monitoring and evaluation has hindered the development of an evidence base to identify, apply, and disseminate lessons learned and support promising childhood obesity prevention efforts. The IOM's review of progress also noted that foundations are becoming important leaders in the response to obesity.

## Why Pursue Policy Change

Historically, strategies to reduce obesity have focused on individual behavior modification and treatment without addressing the context in which behavioral choices are made. The obesity epidemic has resulted from significant changes to our culture and to the environment in which food and physical activity choices are made, which suggests a number of rationales for using policy strategies to address obesity. Public policy can create behavioral norms and shape the environment in which personal choices are made and provide a mechanism for reaching large numbers of people. There are also several economic arguments to support the development of public policy interventions to address the obesity problem, including consideration of the cost to taxpayers, imperfect information in the marketplace, and recognition that children are highly vulnerable to advertising and marketing and are typically not able to make fully informed decisions of their own. Public health law provides the legal basis for using policy interventions.

## Philanthropic Activities

Some of the most common policy approaches funders are supporting to address obesity seek changes in schools, food systems and sustainable agriculture, and the built environment. Funders are also forging coalitions that bring partners together across sectors including education, civic groups, health care, public health, industry, transportation, and development.

**Schools:** Schools play a leading role in addressing childhood obesity. They present opportunities to teach concepts related to energy balance, good nutrition,

physical activity, and their relationships to health. Schools are prime venues for children to engage in physical education and make healthy food choices before, during, and after school. In recent years, there has been a growing movement to develop school policies that support better nutrition and physical activity for all students, culminating in a new federal requirement for all schools that participate in federal school nutrition programs to have a school wellness policy in place by the beginning of the 2006 school year. Several health funders are at the forefront in promoting improvements to school health policies, focusing on a wide range of activities and approaches including advocacy to restrict access to soda and junk food and promoting more physical activity among students.

**Food Systems and Sustainable Agriculture:** American diets are shaped by relatively easy access to abundant and affordable food, much of it of poor quality, while fresh and locally produced food is unavailable in many low-income areas. Public health advocates argue that current agricultural policy produces large amounts of unhealthful food, and that any public health policies addressing obesity will have limited success unless underlying problems with agricultural policy and overproduction are addressed (Roberts 2005). The farm bill offers an opportunity to advocate for changes to national food policy in America, and efforts are underway at local and state levels to change the incentives that encourage the production and consumption of less healthy foods and enhance access to healthy foods, particularly in low-income areas. Funders are supporting efforts to examine the benefits of local, sustainable food systems; create food policy councils; support farmers markets; and promote other efforts to improve access to healthy foods, particularly in underserved communities.

**The Built Environment:** Community design and the built environment are gaining increasing attention for their role in promoting or inhibiting physical activity. Health professionals are increasingly interested in the question of how community design affects individuals' ability to be active, and what policy changes can facilitate more active communities. There is a growing

movement underway to promote smart growth and active living, which advocates for comprehensive planning to guide, design, develop, revitalize, and build communities that promote public health and healthy communities. Influencing policy on land use is a key strategy of the smart growth movement, along with creating incentives for developers to create communities more conducive to active living. Policy opportunities include zoning, growth management, and incentive programs, and funders are supporting activities to enhance research in this area and increase opportunities for active living.

## Challenges and Opportunities

Reflecting the belief that no single intervention will succeed in reversing the obesity epidemic, many health funders are supporting comprehensive efforts that span several sectors and engage multiple partners. Several participants in the Issue Dialogue discussed the opportunity funders have to mobilize cross-sectoral collaborations, and many examples of funder-supported efforts exist. Public policies targeting health care providers, employers, and state health care programs can also play an important role in addressing obesity. To date, philanthropy has been less active in championing or monitoring these efforts but could do so in the future.

Changing policies is not easy, and as the IOM indicated, the investments so far have not matched the scale of the problem. Funders can be leaders in changing the debate about who is responsible for obesity, and can play a critical role in the adoption of local, state, and federal policies that lead to healthier lifestyles. Funders can also foster development of networks or coalitions that bring together multiple sectors including education, sustainable agriculture, public health, transportation, parks and recreation, development, and urban planning. By supporting data collection, convening, and offering organizational support for coalitions, foundations can provide a neutral meeting ground, motivation, and support for sustained action. Finally, funders can also

support research and evaluation to advance understanding of which strategies are effective. Sharing results with others in the field of health philanthropy and beyond will help us build the evidence base and learn about what strategies are most effective in reversing the obesity epidemic.

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## FOREWORD

*As part of its continuing mission to serve trustees and staff of health foundations and corporate giving programs, Grantmakers In Health (GIH) convened a group of health funders and policy experts on November 3, 2006 to discuss policy strategies to reverse the obesity epidemic. The Issue Dialogue was designed to present a framework for policy approaches that support healthy eating and active living. It also featured small group discussions for funders to learn from peers working in the areas of schools, food systems and sustainable agriculture, the built environment, workplaces, health care systems, and state programs.*

The Issue Dialogue built upon GIH's previous work to support grantmakers in their efforts to address obesity, and provided a forum to continue to learn about the opportunities, barriers, and assets communities have to address obesity, as well as what approaches work best in each setting. This Issue Brief synthesizes key points from the day's discussion with a background paper previously prepared for the participants.

Special thanks are due to those who participated in the Issue Dialogue, especially the presenters: Eduardo Sanchez, Institute of Medicine Committee on Progress in Preventing Childhood Obesity; Larry Cohen, The Prevention Institute; Jeff Levy, Trust for America's Health; Nora Howley, Action for Healthy Kids; Allan Hance, Food & Society Policy Fellows Program; Don Chen, Smart Growth America; Luann Heinen, Institute on the Costs & Health Effects of Obesity at the National Business Group on Health; and Molly Voris, National Governors Association.

Lauren LeRoy, president and CEO of GIH, moderated the Issue Dialogue. Brent Ewig, senior program associate at GIH, planned the program and wrote the background paper. Anne Schwartz, vice president of GIH, made significant contributions to this report. Todd Kutyla, communications manager at GIH, and Claudia Williams of AZA Consulting also contributed to this report.

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## THE COSTS AND CONSEQUENCES OF OBESITY

*By now, most people working in the health field are acutely aware of the size and scope of the obesity epidemic. The rise in obesity over the past three decades has made it a public health priority: its costs and health consequences threaten to reverse decades of progress in improving the health of Americans.*

*The U.S. Surgeon General, Institute of Medicine, and director of the Centers for Disease Control and Prevention have all declared that the U.S. is facing an obesity epidemic.*

*As recognition of the problem has grown, our thinking about its causes and potential solutions has also evolved. Attention has shifted from a focus on individual choices and behavior to the policies, environments, and organizational practices that influence individual choices. This ecological perspective about the epidemic's causes and solutions suggests that a multifaceted, nuanced, and collaborative approach to research, program development, and grantmaking is needed. Health funders can support policy changes to address the obesity epidemic.<sup>1</sup>*

The U.S. Surgeon General, Institute of Medicine (IOM), and director of the Centers for Disease Control and Prevention (CDC) have all declared that the U.S. is facing an obesity epidemic. During the 1960s and 1970s, approximately 14 percent of Americans were classified as obese. That number began rising during the 1980s and increased at a rapid pace throughout the 1990s (Hedley et al. 2004). Today, two-thirds of U.S. adults (over 97 million people) are overweight or obese.<sup>2</sup> Close to 31 percent of U.S. children (over 9 million) are overweight, and childhood obesity has more than doubled in the past 25 years (Hedley et al. 2004; Ogden et al. 2006). The obesity epidemic is occurring in people across all socio-

economic and ethnic groups, although African Americans, Hispanics, and American Indians are disproportionately affected (IOM 2005). The most recent data on obesity suggest that the increases in body weight are continuing in men, children, and adolescents, but may be leveling off in women (Ogden et al. 2006).

Overweight and obese individuals are at increased risk for many chronic diseases and health conditions, including:

- hypertension (high blood pressure),
- osteoarthritis (a degeneration of cartilage and its underlying bone within a joint),
- dyslipidemia (high cholesterol),

<sup>1</sup> For a more detailed discussion of opportunities for funders to engage in health policy work, see the GIH publications, *Strategies for Shaping Public Policy: A Guide for Health Funders* (2000) and *Funding Health Advocacy* (2005).

<sup>2</sup> For adults, overweight and obesity ranges are determined by using weight and height to calculate a number called the body mass index (BMI), with thresholds for overweight and obese. For children and teens, BMI is based on growth charts for age and gender.

- type 2 diabetes,
- coronary heart disease,
- stroke,
- gallbladder disease,
- sleep apnea and respiratory problems, and
- some cancers (endometrial, breast, and colon) (CDC 2006).

Obesity is also linked to rising rates of disability and premature death. While it is difficult to determine the exact relationship between obesity and mortality, an analysis published in *The New England Journal of Medicine* concluded that, due to rising rates of obesity and the resultant impact on longevity, the steady rise in life expectancy during the past two centuries may soon come to an end. This analysis is the source of the widely reported prediction that the youth of today may, on average, live less healthy and possibly even shorter lives than their parents (Olshansky et al. 2005).

The economic costs of obesity are substantial. Annual national health expenditures related to obesity are estimated to range from \$98 to \$129 billion (IOM 2005). Medicaid and Medicare pay approximately half of these costs. Since 1987 the prevalence of obesity among Medicare beneficiaries has doubled and the share of spending incurred by these obese beneficiaries has almost tripled— from 9.4 percent to nearly 25 percent of total spending (Thorpe and Howard 2006).

## Assessing Progress

The IOM, which issued a landmark report on childhood obesity in 2005, published an assessment of progress in preventing childhood obesity in 2006. Eduardo Sanchez, a member of the IOM Committee on Progress in Preventing Childhood Obesity, presented the key findings of this assessment at the GIH Issue Dialogue. He noted that, while the report focused on children, its findings have broader relevance. The IOM found that many policies and programs are being put in place to increase physical activity and promote healthful eating among children and youth. These interventions, however, are generally fragmented and small scale, and the current level of investment still does not match the extent of the problem (IOM 2006b). Moreover, lack of systematic monitoring and evaluation has hindered the development of an evidence base to identify, apply, and disseminate lessons learned and support promising prevention efforts (IOM 2006b).

The IOM also noted that foundations are becoming important leaders in the response to obesity, particularly through support of community-based health and wellness initiatives. It urged funders to provide leadership and sustained commitment, support evaluation of policies and programs, fund applied research that examines family interventions and monitors progress, and partner with government and others to disseminate promising practices.

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## Why Pursue Policy Change?

Historically, strategies to reduce obesity have focused on changing individual behaviors without addressing the context in which behavioral choices are made (Joint Center of Political and Economic Studies and PolicyLink 2004). While personal responsibility regarding nutrition and physical activity is critical, reversing the obesity epidemic demands more than traditional exhortations to eat less and move more. Individuals need supportive environments that facilitate healthy choices. Efforts to change individual behaviors are likely to be more effective if pursued along with changes to the policies that address the environmental factors influencing eating and physical activity patterns. In recent years, a number of leading health groups including the IOM, Surgeon General, and CDC have declared that fully addressing the obesity epidemic requires attention to the public policies shaping these behaviors.

Our nation's experience with food and activity guidelines underscores the limits of informational campaigns divorced from environmental changes. Since the 1950s, federal agencies and private health organizations have issued over 37 versions of guidelines advising Americans to reduce energy intake, raise energy expenditure, or both. Rarely did these guidelines address environmental or social factors, and based on the continuing rise in obesity rates, these guidelines are notable for their ineffectiveness (Nestle and Jacobson 2000).

There are a number of rationales for using policy strategies to address obesity. The obesity epidemic has resulted from significant changes to our culture and to the environment in which food and physical activity choices are made. Public policy can create behavioral norms and shape the environment in which personal choices are made and provide a mechanism for reaching large numbers of people. As the director of the CDC's division of nutrition and physical activity testified before the U.S. Congress, "Given the size of the population that we are trying to reach, we cannot rely solely upon individual interventions that target one person at a time. Instead, the prevention of obesity will require coordinated policy and environmental changes that affect large populations simultaneously" (Dietz 2002). Finally, the economic costs of the epidemic and the failure of the market to provide sufficient consumer information are also compelling rationales for policy interventions.

Public health law provides the legal basis for such interventions, as Mello (2006) and her colleagues argue: "law can be used to create conditions that allow people to lead healthier lives and that the government has both the power and the duty to regulate private behavior in order to promote public health." The basis of this approach lies in the U.S. Constitution's attribution of police powers to the states, which permit them to take both "directly coercive interventions" and to implement policies such as taxes and subsidies that shape behavior.

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This is in addition to the powers that states exercise with respect to taxation of goods and services. Public health achievements, including reductions in lead exposure and smoking rates and safety improvements in the workplace and motor vehicles, can all be attributed to changes in law, regulation, or their enforcement (Mello et al. 2006).

### **Cultural and Environmental Forces Driving Obesity Rates**

Simultaneous changes in food availability, market dynamics, community design, educational priorities, and family life have all combined to upset Americans' energy balance (Anderson and Butcher 2006). While both genetics and individual behavior play a role, the rapid increase in obesity can only be explained by changes in society that have modified calorie intake and energy expenditure (Dietz 2002; Anderson and Butcher 2006).

Unhealthy foods are cheaper and more accessible than ever before. In recent decades, the real price of food has fallen, in particular for energy-dense foods that contain higher levels of fats and sugars. Prepackaged foods, fast food restaurants, and soft drinks—which also tend to be high in fat, sugar, and calories—are all more accessible (Cawley 2006). The share of household spending on food and the nutritional quality of foods consumed have both declined.

Rising wages, time stress, and economics are creating incentives to spend less time preparing foods

at home and to use processed and prepackaged foods (Cawley 2006). One study found that between 1977 and 1995, the share of total calories consumed away from home rose from 18 percent to 34 percent, the share of meals consumed away from home rose from 16 percent to 29 percent, and the total share of food dollars spent away from home rose from 26 percent to 39 percent (Biing 1999). This trend is significant for two reasons. First, foods prepared at home are generally more healthful. Second, consumers are less likely to have information on the nutritional content in meals they consume away from home. Additionally, although possibly responding to market demands, food portion sizes are growing, exceed federal standards, and may contribute to over consumption. A 2002 study found that portion sizes, particularly for packaged foods and beverages, began to grow in the 1970s, rose sharply in the 1980s, and have continued in parallel with increasing body weights (Young and Nestle 2002).

National agricultural policy also appears to contribute to obesity by promoting production of certain commodities at very low prices (Cawley 2006; Bray 2004). In particular, farm policy has been criticized for subsidizing the production of corn, and thereby of high fructose corn syrup (HFCS), which is now common in soft drinks, fruit juices, and many other foods, including soups and sauces. The consumption of HFCS increased more than 1,000 percent between 1970 and 1990 and

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## RECOMMENDATIONS FOR GOVERNMENT ACTION

The IOM has recommended that government at all levels should take the lead to provide coordinated leadership for the prevention of obesity in children and youth.

### Specifically, the federal government should:

- strengthen research and program efforts addressing obesity prevention, with a focus on experimental behavioral research and community-based intervention research and on the rigorous evaluation of the effectiveness, sustainability, and scaling up of prevention interventions. Government should also support extensive program and research efforts to prevent childhood obesity in high-risk populations with health disparities, with a focus both on behavioral and environmental approaches.
- support nutrition and physical activity grant programs, particularly in states with the highest prevalence of childhood obesity.
- strengthen support for relevant surveillance and monitoring efforts, particularly the National Health and Nutrition Examination Survey (NHANES).
- undertake an independent assessment of federal nutrition assistance programs and agricultural policies to ensure that they promote healthful dietary intake and physical activity levels for all children and youth.
- develop and evaluate pilot projects within the nutrition assistance programs that would promote healthful dietary intake and physical activity and scale up those found to be successful.

### State and local governments should:

- provide coordinated leadership and support for childhood obesity prevention efforts, particularly those focused on high-risk populations, by increasing resources and strengthening policies that promote opportunities for physical activity and healthful eating in communities, neighborhoods, and schools.

Source: Institute of Medicine, *Preventing Childhood Obesity: Health in the Balance* (Washington DC: The National Academics Press, 2005.)

now represents more than 40 percent of caloric sweeteners added to foods and beverages. One recent study found that the increase in consumption of HFCS tracks the progression of the obesity epidemic (Bray 2004).

In sum, the typical American's diet today does not meet federal food guide pyramid dietary recommendations. On average, people consume too many servings of added fats and sugars and too few servings of fruits, vegetables,

dairy products, lean meats, and foods made from whole grains. Average daily calorie consumption in 2000 was up 12 percent, or roughly 300 calories, above the 1985 level (Putnam et al. 2002).

Americans are also moving less. More than 50 percent of U.S. adults do not get enough physical activity to provide health benefits, and 24 percent are not active at all in their leisure time (CDC 2005). Multiple factors contribute to increasingly sedentary lifestyles. Walking, riding bikes, and playing outside are not viable options when neighborhoods and parks are unsafe, if there are no sidewalks or bike trails, if people live far from destinations, or destinations are hard to reach because streets are not laid out in a grid structure, as is the case in many suburban areas. Between 1977 and 1995, trips made by walking declined by 40 percent for both children and adults, while automobile trips increased to almost 90 percent of total trips. Children's walking trips to school declined by 60 percent between 1977 and 1995, and children now make only 13 percent of their school trips by walking or riding their bicycles (Active Living By Design 2006). Increasing reliance on cars also relates to community design, greater car ownership, and inadequate transit options. Additionally, many office buildings tend to have inaccessible and uninviting stairwells that are seldom used (Dietz 2002).

Hectic work and family schedules, along with more sedentary work

for many groups, contribute to inadequate physical activity. Schools, under pressure to improve academic achievement, are de-emphasizing physical education and assigning more homework, leaving less time for sports and physical activity. More than a third of young people in grades 9–12 do not regularly engage in vigorous physical activity, and daily participation in high school physical education classes dropped from 42 percent in 1991 to 28 percent in 2003 (CDC 2006a). Meanwhile, screen time (including television, computer, and video games), which might displace more active pursuits and promote poorer food choices because of advertising exposure, has increased.

### **Economic Rationales for Policy Change**

There are several economic arguments to support the development of public policy interventions to address the obesity problem. First, because the costs of obesity are borne by society, particularly through tax support of Medicare and Medicaid, the government may intervene to lower the costs to taxpayers. Second, if the marketplace is not providing sufficient information for consumers to make informed choices, government may intervene to provide consumers with the information they need. The availability of nutrition information is spotty at best and particularly weak in restaurants. One study found that consumers grossly underestimate the caloric content of commonly

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consumed restaurant food items, and expect these items to contain only half of the levels of fat and saturated fat that they actually contain (Eskin and Hermanson 2004). Many fast food chains only provide nutrition information on their Web sites, although some are moving to point of purchase labeling. Additionally, some foods are marketed as healthy, low-fat, or fat-free, but may contain more calories than the fat containing food they are designed to replace (CDC 2006a).

### **Protecting Children**

Just as the tobacco industry has argued against regulation of cigarettes as paternalistic interventions into personal lifestyle choices, some have argued that policies targeting obesity infringe unnecessarily upon personal rights. With respect to children, however, the arguments break down. Not only are children highly vulnerable to advertising and marketing, they are typically not able to make fully informed decisions of their own. It is estimated that children view nearly 40,000 television ads a year, most of them for cereal, candy, and fast food (Kunkel 2002). Such marketing promotes unhealthful food choices and contributes to an environment that puts children's health at risk (IOM 2006b). Policies that help children make better choices, however, need to be crafted in a manner that respects the important role of parents in shaping children's choices (Cawley 2006). Many advocates and policymakers believe that policy interventions to promote healthy choices for children are particularly critical and

have moved to introduce legislation to limit children's access to unhealthy food choices, particularly in schools.



## SCHOOLS

*Schools play a leading role in addressing childhood obesity for the simple reason that they, in the IOM's words, "provide a consistent environment that is conducive to healthful eating behaviors and regular physical activity" (IOM 2005). Schools present opportunities to teach concepts related to energy balance, good nutrition, physical activity, and their relationships to health. Schools are prime venues for children to engage in physical education and make healthy food choices before, during, and after school. Moreover, every school day approximately 28 million children participate in the National School Lunch Program, and 8 million participate in the School Breakfast Program. In recent years, there has been a growing movement to develop school policies that support better nutrition and physical activity for all students.*

The IOM suggests that schools:

- develop and implement nutritional standards for all competitive foods and beverages sold or served in schools. (Competitive foods include any foods other than meals and snacks served through the federally-reimbursed school lunch, breakfast and after-school snack programs.);
- ensure that all school meals meet the *Dietary Guidelines for Americans*;
- ensure that all children and youth participate in a minimum of 30 minutes of moderate to vigorous physical activity during the school day, including expanded opportunities for physical activity through classes, sports programs, clubs, lessons, after-school and community use of school facilities, and a walking and biking to school program;
- enhance school health curricula (including developing innovative approaches to teaching and staffing) and the use of school health services for obesity prevention efforts;
- ensure that schools are as advertising-free as possible;
- conduct annual assessments of students' weight, height, and BMI, and make that information available to parents; and
- assess school policies and practices related to nutrition, physical activity, and obesity prevention (IOM 2005).

Schools have already become a fertile ground for policy activities to promote healthy eating and activity. During the last few years, legislatures in 42 states have considered bills regulating the types of food and beverages that may be sold on school campuses (The California Endowment 2006). Additionally, six states (Arkansas, Illinois, Maine, Pennsylvania, Tennessee, and West

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Virginia) have taken legislative action to support school efforts to collect and report students' BMI levels. These efforts identify populations in need of intervention and help measure progress towards obesity reduction (Trust for America's Health 2006).

There are significant challenges and barriers to implementing policy change in schools. Schools are complex institutions that face both financial and time constraints in meeting all of their students' needs. As pressure mounts to demonstrate improvements in academic achievement, many schools are challenged to find time for physical activity. Additionally, many schools are reliant on revenues from the sale of competitive foods and vending machine beverages to pay for activities such as field trips or the purchase of uniforms, equipment, and supplies not covered in other budgets.

Under the Child Nutrition and WIC Reauthorization Act of 2004, all local education agencies participating in a federal child nutrition program are now required to establish a local wellness policy. This legislation created a window of opportunity for funders to become actively involved in shaping the development, implementation, and monitoring of district-level policy, and to catalyze key partners in their school districts. While these policies were to be in place by the start of the 2006-2007 school year, some school districts are still working on their implementation.

## Philanthropic Activities

Several health funders are at the forefront in promoting improvements to school health policies, focusing on a wide range of activities and approaches including advocacy, evaluation, research, monitoring, and convening. Foundation work in schools has demonstrated that success in changing policies is possible, and is helping to identify some promising practices.

## Supporting Advocacy

Since 1998, The California Endowment has supported the California Center for Public Health Advocacy (CCPHA) in launching an advocacy campaign in Los Angeles and statewide, to inform key policy-makers and other community leaders about the crisis of childhood obesity, and the importance of nutrition and physical fitness for children. Using a coordinated education and advocacy strategy, trained teams (made up of local residents, health professionals, and youth) target legislators and other stakeholders with in-depth information about school-based reforms that will reduce childhood obesity.

CCPHA and its network of grassroots local groups have contributed to significant nutrition policy reforms. CCPHA's advocacy efforts led the Los Angeles Unified School District, the state's largest school district, to ban the sale of unhealthy beverages on all 677 of its school campuses. Following that example, the California State

Legislature enacted the California Childhood Obesity Prevention Act, the nation's most comprehensive state ban on school soda sales, in September 2003. Additional advocacy efforts led to bans on junk foods in schools and public funding to increase fresh fruits and vegetables in school breakfast programs. The California Endowment has published a case study, available on its Web site, entitled *Banning Junk Food and Soda Sales in Public Schools*, that describes the research, advocacy, and media strategies that led to these policy victories (Isaacs and Swartz 2006).

Building on this success, the Alliance for a Healthier Generation—a joint initiative of the William J. Clinton Foundation and the American Heart Association supported by Robert Wood Johnson Foundation (RWJF)—worked with representatives of Cadbury Schweppes, Coca-Cola, PepsiCo, and the American Beverage Association to establish new national guidelines to limit beverage portion sizes and reduce the number of calories available to children during the school day. Under these guidelines, only lower calorie and nutritious beverages will be sold in schools. It will take three years for the agreement to be fully implemented, with new standards in place in 75 percent of schools by the summer of 2008 and in all schools by 2009. The success of the program depends on schools' willingness to amend existing contracts, and the industry has agreed to disclose the progress toward fulfilling the agreement at the end of each school year starting in 2007.

Following the voluntary school beverage agreement, the Alliance also forged an agreement with members of the snack food industry. Five of the nation's leading food manufacturers have joined with the Alliance to support guidelines that help students make healthier food choices. The guidelines promote the consumption of fruit, vegetables, nutrient-rich foods, fat-free, and low-fat dairy products, and place limits on calories, fat, saturated fat, trans fat, sugar, and sodium in foods available in schools, including foods offered outside of the reimbursable meal program such as products sold in school vending machines, a la carte lines, snack bars, fundraisers, and school stores. The companies included in the agreement are Campbell Soup Company, Dannon, Kraft Foods, Mars, and PepsiCo. As with the soft drink agreement, there are plans to monitor the agreement, starting with efforts to collect baseline data identifying the competitive foods offered for sale in schools. Every two years thereafter, through 2011, a similar analysis will be conducted to assess the impact and status of these guidelines in shifting the mix of competitive foods. These reports are expected to be made public.

### **Strengthening School Efforts to Create Healthy Environments**

The Bower Foundation is helping schools across Mississippi respond to the new federal school wellness policy requirement by funding the state Office of Healthy Schools. Even prior to the requirement, the foundation

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funded a grantwriter on behalf of the Mississippi Department of Education to apply for a CDC comprehensive school health grant. The application was denied, which prompted the foundation to work with the state department of education to develop and fund the Office of Healthy Schools for a three-year period.

The Office of Healthy Schools is charged with coordinating all aspects of school health in hundreds of schools in Mississippi. It has been successful in coordinating the previously disparate school health programs and developing consistent school health messages for various target audiences including local superintendents, students, legislators, teachers, school boards, parents, schools, and the state department of education.

Over time, the office has become recognized as the go-to source for information to help individual schools make progress in school health and meet the new requirements for local wellness policies. With foundation support, the office hired a nationally recognized school nutritionist to coordinate efforts to support schools in their policy development. The office, consultant, and foundation worked together to produce a draft guide for the development of school wellness policies and a template that schools could use as a tool to facilitate discussion.

Other funders are also working to improve the school wellness environment. The Sunflower Foundation in Topeka, Kansas made three grants

focused on implementing and improving school wellness policies in 2005. These included \$4,000 to the Kansas State Department of Education to support a statewide meeting for education and health organization leaders to obtain input on model school wellness policy guidelines, and an additional \$150,000 to expand and implement coordinated school health and nutrition projects in Kansas schools.

A key element in the success of the school wellness policy requirement will be support for policy implementation and monitoring. The Community Health Program of the San Francisco Foundation, for example, has created a mini-grants program, Healthy Schools, Thriving Students: Supporting Local School Wellness Policies, to fund school districts to implement wellness policies and increase community participation in implementation and monitoring activities. The program offers grants of \$5,000 that can be used for implementation and evaluation training activities, teacher or parent focus groups, implementation materials and supplies, parent and volunteer stipends, consultants, wellness policy monitor stipends, and child care costs.

The Paso del Norte Health Foundation is providing more than \$4 million over seven years to support Texas elementary schools in their efforts to promote lifetime habits for better nutrition, increased physical activity, and tobacco avoid-

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ance through implementation of the evidence-based Coordinated Approach To Child Health (CATCH) curriculum in El Paso's elementary schools. The curriculum has been implemented in more than 80 schools and reaches approximately 52,000 students and their families. Additional staff including a curriculum specialist, nutrition specialist, and program assistant have significantly increased the technical assistance and support already offered to all CATCH schools. The program is receiving widespread attention and the Texas State Board of Education has unanimously recommended approval of CATCH materials as the diabetes education program that school districts may use under requirements of the Texas Education Code.

### **Supporting Evaluation, Research, and Monitoring**

The Sunflower Foundation also provided a \$95,000 grant to the Kansas Health Institute to conduct a comprehensive assessment of how current district- and school-level physical activity and nutrition policies affect school environments. This assessment was designed to inform state legislators who considered childhood obesity prevention legislation in 2005, but declined to act without a better understanding of the state of current school policies. The project included a survey of school administrators, food service managers, and physical education and health teachers. The Kansas Health Institute and Sunflower Foundation are using the results of this study to begin a

dialogue about potential policy options for Kansas schools. The foundation has convened key stakeholders throughout this process and is considering organizing an informal coalition that can advocate for a policy agenda with the state legislature.

The California Endowment has supported the development of a series of case studies examining the implementation of better nutrition policies in California school districts. The studies utilized environmental assessments, policy analysis, and stakeholder surveys to describe policy development and implementation in each of the study districts, and generated the following advice from stakeholders:

- incorporate strong research and data in the rationale for policy development;
- build a collaborative process that includes schools and community interests;
- set clear definitions of acceptable and unacceptable foods;
- communicate to students, staff, and parents about why change is needed;
- have a well-defined chain of authority for putting the plan into effect and monitoring its success; and
- act preemptively to address potential financial losses (The California Endowment 2006).

## THE ARKANSAS EXPERIENCE

Officials in Arkansas have also recently published some of the preliminary lessons learned from their experience implementing innovative policies. In 2003, Arkansas passed legislation creating a comprehensive program to combat childhood obesity. The major provisions of the law include:

- annual BMI screenings for all public school students, with the results reported confidentially to parents;
- restricted access to vending machines in public elementary schools;
- disclosure of schools' contracts with food and beverage companies;
- creation of district advisory committees made up of parents, teachers, and local community leaders; and
- creation of a child health advisory committee to recommend additional physical activity and nutrition standards for public schools (Ryan et al. 2006).

Robert Wood Johnson Foundation provided support to the Arkansas Center for Health Improvement for the creation of a BMI database and for data analysis to support evaluation efforts of Arkansas' BMI monitoring effort. In a 2006 report in *Health Affairs*, Arkansas officials announced new statewide data showing that, while childhood obesity is still a major threat, the state has halted the progression of the epidemic among its public school students. The lessons they report from this experience include:

- Policy development and implementation can be achieved in a rapid cycle (two to four years) at the state level by identifying and coordinating existing related activities, using both national and local resources, and employing trusted relationships among interested stakeholders and advocates.
- A proposed policy (such as legislation) should be clear in its intent and proposed mechanism for achieving the desired change, yet not attempt to prescribe in detail what the changes must be (for example, creating an advisory committee to recommend rules and regulations provided a mechanism for future change without generating resistance to the proposed legislation).
- Complex issues require the involvement of multiple stakeholders; however, each stakeholder's primary concerns must be recognized and acknowledged to obtain and retain long-term support. For example, schools support child health and disease prevention; however, their primary responsibility is scholastic achievement.
- Requiring but not funding activities in schools not directly related to education may generate resistance; such resistance can be overcome by presenting schools with tools and technical assistance to minimize cost and school efforts associated with implementation.

- State versus local control issues can create tension and resistance to activities regardless of potential benefits.
- Addressing privacy concerns when dealing with sensitive individual health information including BMI information is essential.
- Tailoring local empirical data to provide school- and district-specific information that documents the scope of the problem is critically important to maintaining the program's viability through the first years of implementation.
- Long-term support and programmatic sustainability can be encouraged by incorporating activities into existing state agency work plans and budgets (Ryan et al. 2006).

### **Creating Community Capacity and Leadership**

In California, the HealthCare Foundation for Orange County launched a targeted initiative to address concerns about childhood obesity among low-income families in central Orange County. A \$169,000 grant to a local hospital and community-based organization, Latino Health Access, was used to create teams of community health leaders with parents, students, and staff of four elementary schools. These

teams were tasked with developing and implementing effective policies and strategies to promote sound nutrition and increased exercise for youth at risk. Supporting activities include outreach to children and parents through four partner schools, conducting environmental surveys, and working with parents and school officials on developing options for healthier meals and opportunities for exercise. BMI measurements are used to evaluate the program over the multiyear funding period.

## FOOD SYSTEMS AND SUSTAINABLE AGRICULTURE

*American diets are shaped by relatively easy access to abundant and affordable food, much of it of poor quality. Fresh and locally produced food is unavailable in many low-income urban areas. Moreover, changes in agricultural production have made foods high in fat and sugar the most affordable. One study found that about 40 percent of the recent growth in weight may be due to innovation in agricultural production passed through as reduced food prices (Lakdawalla and Thomas 2002). Efforts are underway to change the incentives that encourage the production and consumption of less healthy foods and enhance access to healthy foods, particularly in low-income areas.*

*Public health policies addressing obesity will have limited success unless underlying problems with agricultural policy and overproduction are addressed.*

### The Farm Bill and U.S. Food Policy

Much of the U.S. food and agricultural policy is governed by federal legislation known as the farm bill. Its provisions generally aim to support the production of a reliable, safe, and affordable supply of food; promote stewardship of agricultural land and water resources; facilitate access to American farm products at home and abroad; encourage continued economic and infrastructure development in rural America; and ensure continued research to maintain an efficient and innovative agricultural and food sector. Agricultural policy in the past 15 to 20 years has broadened considerably to include agricultural trade issues, food safety, food assistance, and conservation and environmental concerns, in addition to the more traditional focus on regulating commodities production (USDA 2005). Officials crafting farm policy face significant challenges in balancing the interests of family farmers, agribusiness, food processors,

consumers, taxpayers, rural communities, environmentalists, and others.

According to some experts, any public health policies addressing obesity will have limited success unless underlying problems with agricultural policy and overproduction are addressed (Roberts 2005). Public health advocates, for example, argue that that current agricultural policy produces large amounts of unhealthful food, imposes a high cost on American taxpayers through public subsidies, hurts small and midsize farmers in the U.S. and the world, harms the environment, negatively effects the quality of life for both agricultural laborers and rural communities, allows processors and retailers to be the drivers in the system, and promotes a diet that leads to chronic diseases and obesity (Roberts 2005). Until recently, concerns about the nutrition and health needs of Americans have been disconnected from those driving agricultural practices and policy (Cohen et al. 2004). Efforts are underway to make these connections by engaging



environmental and health professionals in a movement to support sustainable agriculture as a strategy to improve health, and to incorporate this thinking into the provisions of the farm bill.

Farm policy will be revisited by the U.S. Congress in 2007, creating a fresh opportunity to influence agricultural policy. The farm bill contains hundreds of programs and provisions that have an impact on the food system, and offers a major opportunity to promote changes that might result in healthier food production. Authors of a recent analysis by the Institute for Agriculture and Trade Policy recommend developing a common farmer – public health policy platform that focuses on ensuring a fair price for all crops, keeps small farmers on the land, rewards farmers for producing healthy foods, and expands funding and research in perennial agriculture that leads to a greater variety of grains, healthy oils, fruits, and grass-fed meat and dairy, and less production of sweeteners and unhealthy oils (Schoonover and Muller 2006).

### **Promoting Local, Sustainable Food Systems**

Some advocates are working to create incentives to support the production of healthier foods by emphasizing

the benefits of local, sustainable food systems. This vision builds upon recent successes such as a substantial increase in U.S. farmland that is certified organic and the increased availability of organic foods in conventional supermarkets (Cohen et al. 2004). Organic food is produced without pesticides, synthetic fertilizers, sewage sludge, bioengineering, or ionizing radiation.<sup>3</sup>

Policy options for supporting local, sustainable food systems include establishment of land trusts to preserve farmland, promotion of farmers markets, support for urban and school gardens, development of strategies to promote the purchase of fresh and locally produced foods through public programs such as food stamps and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and implementation of farm-to-institution programs, where public funds are directed to support a preference for local food for public institutions such as schools, hospitals, prisons, or other state agencies.

Some states and cities have created food policy councils to examine the operation of a state or local food systems and suggest improvements. Councils typically include farmers, consumers, anti-hunger advocates and food bank managers, labor

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*Some advocates are working to create incentives to support the production of healthier foods by emphasizing the benefits of local, sustainable food systems.*

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<sup>3</sup> Organic food is not by definition healthier than conventional foods (for example, it may be high in fat or served in excessive portions) and there is little evidence to date that organically produced food is safer or more nutritious than conventionally produced food (USDA 2002). Advocates assert, however, that choosing to purchase organic, locally-produced foods, and advocating for increased availability of healthy, organic foods in underserved regions can complement other changes in food policy (California Certified Organic Farmers 2003).

representatives, members of the faith community, food processors, food wholesalers and distributors, food retailers and grocers, chefs and restaurant owners, officials from farm organizations, community gardeners, and academics involved in food policy and law (NCSL 2005). Their work typically focuses on spurring government action on farmland preservation, urban agriculture, emergency food supply, transportation, markets for locally grown food, food education, child nutrition, and inner-city supermarkets.

Created in 1997, the Connecticut Food Policy Council works on several different aspect of state policy. Its accomplishments include:

- simplifying the application process for food assistance programs by developing a single form to link eligibility for Food Stamps, WIC, the Reduced Price School Lunch Program, and the State Children's Health Insurance Program (SCHIP) across departments;
- collaborating with the Working Lands Alliance and the Save the Land Conference to purchase the development rights to 12 farms in 2000, totaling 1,350 acres;
- eliminating the University of Connecticut's sole source policy that gave all of the university's food supply business to one vendor. Eliminating this requirement helps locally owned businesses compete for university food supply contracts; and
- working with the department of agriculture and department of social services to expand the Food Stamp program to include coupons for use by senior citizens at farmers markets (NCSL 2005).

### **Making Healthy Food Affordable and Accessible**

One recent study found that low-income neighborhoods had four times as many small grocery stores (which are less likely to carry produce and other healthy items) as the wealthiest neighborhoods, but only half as many supermarkets. Poorer areas and non-white areas also tended to have fewer fruit and vegetable markets, bakeries, specialty stores, and natural food stores (Moore and Roux 2006). Under these circumstances, residents often rely on the less healthy choices available at corner stores and fast food outlets (Flournoy and Treuhaft 2005). Morland and her colleagues (2002) report that the presence of at least one neighborhood supermarket is associated with self-reported food intake meeting dietary recommendations. With each additional supermarket in a neighborhood, fruit and vegetable intake increased 32 percent among African Americans and 11 percent among whites living there.

Three of the most promising strategies to enhance access to healthy food in underserved areas are identified in a report funded by The California Endowment entitled *Healthy Food, Healthy Communities: Improving Access and Opportunities Through Food*

*Retailing.* These include developing new grocery stores; improving the selection and quality of food in existing smaller stores; and starting and sustaining farmers markets (Flournoy and Treuhaft 2005).

Farmers markets have become popular in recent years, mostly due to the growing consumer interest in obtaining fresh products directly from a farm. The number of farmers markets in the United States has grown dramatically, increasing 111 percent from 1994 to 2004. There are now over 3,700 farmers markets operating in the United States (USDA 2006). The policy considerations surrounding farmers markets include rules on local space use (zoning), and the availability of developmental funding. Several states are also working on making farmers markets more accessible to beneficiaries of public food assistance programs by linking farmers markets to the USDA's electronic benefit transfer (EBT) system. All states are now using EBT as an alternative for food stamp issuance and, in some cases also for WIC.

### **Philanthropic Activities**

Foundations are supporting a mix of projects and initiatives to enhance and improve food systems, with a focus on making healthier and locally produced foods available to underserved communities.

### **Building Capacity to Advance Policy**

Some funders are exploring grant-making strategies that help promote advocacy for more community-based food systems. Launched by the W.K. Kellogg Foundation in 2000, the Food and Society Initiative is based on a vision of a future food system that provides all segments of society a safe and nutritious food supply grown in a manner that protects health and the environment and adds economic and social value to rural and urban communities. Food and Society projects focus on three primary areas: market-based change, communications, and public policy. Anticipated outcomes include:

- public and institutional policies that support sustainable food and agriculture-based enterprises as vehicles for community, social, and economic development;
- broadened agenda for scholarship in higher education institutions to include engagement with communities and partners to support community-based food systems;
- increased number of farms and acreage that use environmentally sound agriculture systems;
- increased number of economically successful food-related enterprises that are locally owned and controlled, environmentally sound, and health promoting;

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*Some funders are exploring grantmaking strategies that help promote advocacy for more community-based food systems.*

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- increased number of funders and partners supporting community-based food systems approaches; and,
- public debate on the human health impacts of the current food production and distribution systems and their nutrition and diet implications.

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*The Food Trust is helping to administer the groundbreaking Pennsylvania Fresh Food Financing Initiative, an innovative program to increase the number of supermarkets in underserved communities.*

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### Financing Fresh Food Outlets

Foundations can support development of fresh food outlets by providing loans or grants, funding advocates to promote the creation of tax incentives and public funding, as well as supporting incentives for individuals and families receiving nutritional assistance (such as food stamps and WIC) to make healthier food choices. In particular, funders can help assure that new farmers markets and roadside stands are participating in the WIC Farmers Market Nutrition Program. Through this program, eligible WIC participants are issued coupons in addition to their regular WIC food instruments. These coupons can be used to buy fresh, unprepared fruits, vegetables and herbs from farmers, farmers markets or roadside stands that have been approved by the state agency.

RWJF is supporting The Food Trust in Philadelphia, Pennsylvania, which is pursuing strategies to develop new stores, improve selection in existing stores, and support farmers markets. The Food Trust is helping to administer the groundbreaking Pennsylvania Fresh Food Financing Initiative

(FFFI), an innovative program to increase the number of supermarkets in underserved communities.

In April 2003, Pennsylvania passed the nation's first statewide economic development initiative aimed at improving access to markets that sell healthy food in underserved rural and urban communities. The legislation devotes \$100 million of the state's \$2.3 billion economic stimulus package to agriculture projects, including the development of grocery stores and farmers markets. At the same time, the governor created an innovative new fund for the Fresh Food Financing Initiative, which will support the development of 10 new stores.

Along with the Greater Philadelphia Urban Affairs Coalition and The Reinvestment Fund, The Food Trust is charged with implementing the Fresh Food Financing Initiative, offering an \$80 million financing pool for fresh food retailers that locate in communities that are underserved by conventional financial institutions. The initiative will provide a range of financing resources such as predevelopment grants and loans, land acquisition and equipment financing, capital grants for project funding gaps and construction, and permanent financing. An additional program allows corner store owners to apply for funds to purchase or upgrade refrigeration systems for fruits and vegetables. The technical assistance and access to financing provided by the Healthy Corner Store Initiative builds opportunities for small business

owners and creates jobs for local residents, benefiting the local economies of the target communities and the city of Philadelphia as a whole. The program will also increase community access to fresh, nutritious, low-cost food items that are cost-prohibitive for smaller stores to stock due to their limited purchasing power. The Food Trust is also actively promoting the expansion of farmers markets.

### **Teaching About the Link Between Food Production and Healthy Eating**

Funders are also supporting efforts to teach children about the link between food production and healthy eating. The Health Foundation of South Florida, for example, provided a \$13,500 grant to support Miami's Edible Schoolyards efforts to help stem the growing obesity epidemic. A garden program was founded in conjunction with the Slow Food Miami School Lunch Initiative. Slow Food is an organization that offers "the cultivation of taste as a natural way to interrupt the fast food feeding frenzy in an era of bloated portions and epidemic overweight" (Slow Food Miami 2006).

In 2004, the first seeds were sown for the Plant a Thousand Gardens project when Slow Food Miami gave fifteen South Florida schools the materials, expertise, and assistance to install and care for organic gardens. Some of the participating schools planted ring gardens, a garden model that utilizes principles of sustainable agriculture and promotes soil building. According

to program administrators, the garden-to-table approach is innovative because it goes beyond nutrition lessons to offer experiential learning and support that helps children maintain healthier eating habits.

### **Creating Linkages Between the Health and Sustainable Agricultural Sectors**

Some funders have been exploring ways to create linkages between the health and sustainable agricultural sectors. Cultivating Common Ground, for example, a project funded by the Columbia Foundation and the Clarence E. Heller Charitable Foundation, worked to strengthen linkages and understanding between these sectors to support advocacy for a sustainable health-promoting food system (Cohen et al. 2004). Promoting the message that food production and consumption are interrelated in their impact on health and the environment, the project resulted in a recommendation to develop a collaborative movement between the health, sustainable agriculture, and environmental sectors.

The project identified some potentially overlapping goals of the sustainable agriculture movement and public health, including reducing exposure to toxic chemicals in food and its production; increasing production and access to affordable, fresh, local farm products; ensuring a clean water supply; and altering the elements of the food system which favor the production and distribution of highly-processed, high-fat and

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high-sugar food products. It also identified several opportunities for collaboration, including:

- increasing access to healthy foods in neighborhoods and institutions;
- protecting the food system from threats such as bioterrorism;
- opposing common corporate foes;
- reducing antibiotic resistance;
- shifting agricultural subsidies to support production of healthy foods;
- protecting the health of farmers and agricultural workers; and
- minimizing food transport.

Achieving these goals requires a multifaceted strategy that includes public education, media advocacy, and changes in organizational practices and policies related to food production, distribution, and marketing. Suggested mechanisms to promote these activities include engaging the health and environmental sectors in cross-sector collaboration, framing the issues to be inclusive of all sectors, conducting training, and developing campaigns to promote changes in organizational practice and policy (Cohen et al. 2004).

In 2005 the W.K. Kellogg Foundation made four grants totaling \$4.7 million to support the Farm and Food Policy Project (FFPP) to build a conversation about how the significant resources of the Farm Bill can be better used

to create a food system that reduces hunger and obesity, increases access to healthier food, develops local and regional food systems, promotes stewardship, and increases farm and rural prosperity. The project includes 25 funded organizations and more than a hundred additional participating organizations including family farmers, sustainable and organic agriculture groups, rural and urban community leaders, faith-based organizations, environmental and conservation leaders, nutrition and public health professionals, anti-hunger advocates, business leaders, and entrepreneurs.

In November 2006, FFPP released a public statement, endorsed by a broad public interest coalition, identifying core priorities and opportunities for innovation in four areas:

- advancing a new generation of farming and fostering new markets for organic, local and regional, and other healthier and environmentally sustainable products through a comprehensive new and beginning farmer program; increased outreach and assistance to minority and socially disadvantaged farmers and ranchers; business planning and transition assistance for farmers moving into new markets; and grants and loans for value-added enterprises, improved marketing, and regional infrastructure development;
- reducing food insecurity and enhancing public health through strengthened federal food assistance and community food security programs; expanded and improved

nutrition education, including school child nutrition programs to implement wellness policies; and increased access to healthier foods through government food assistance programs and support to reestablish retail markets in so-called food deserts in both urban and rural areas;

- capitalizing on rural community strengths by enhancing rural entrepreneurship and micro-enterprise business development program; a community entrepreneurial development program for local leadership, wealth, and asset creation; and savings incentives for families in rural communities; and
- rewarding stewardship and improving environmental quality by expanding working lands conservation programs and core land retirement programs; strengthening environmental standards linked to farm subsidy programs; encouraging locally led collaborations to solve environmental problems; and creating incentives designed to reward innovation and performance.

## THE BUILT ENVIRONMENT

*Community design and the built environment are gaining increasing attention for their role in promoting or inhibiting physical activity. Public health officials are increasingly interested in the question of how community design affects individuals' ability to be active, and what policy changes can facilitate more active communities. There is a growing movement underway to promote smart growth and active living.*

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### The Built Environment and Obesity

The built environment is defined as all of the buildings and spaces created or modified by people including schools, houses, workplaces, parks, streets, and transportation systems. In recent years, the exodus of urban populations to suburbs has resulted in suburban sprawl, associated with low-density land use, heavy reliance on automobiles for transportation, segregation of land uses, streets laid out in non grid patterns, and the loss of economic and social opportunities for some groups, especially those in inner cities (Frumkin 2002). Older urban residential areas, by contrast, include features thought to be associated with active living such as high levels of residential density, mixed land use, grid street patterns, lower car ownership, and sidewalks.

Only recently have researchers begun to examine how the design of buildings and communities inhibits physical activity and promotes sedentary lifestyles that contribute to the obesity epidemic. A 2002 review published in *Public Health Reports* examined the relationship between sprawl and health looking at eight

measures, including air pollution, heat, physical activity patterns, motor vehicle crashes, pedestrian injuries and fatalities, water quantity and quality, mental health, and social capital. The review found relatively scarce evidence on the health effects of sprawl, and outlined areas where additional research is needed (Frumkin 2002).

A 2003 study published in the *American Journal of Health Promotion*, however, showed the first clear association between the type of place people live and their activity levels, weight, and health. People living in counties marked by sprawling development are likely to walk less and weigh more than people who live in less sprawling counties. In addition, people in more sprawling counties are more likely to suffer from hypertension (Ewing et al. 2003). More sophisticated longitudinal research tracking the impact of community design changes will be needed as communities adopt smart growth and active living concepts.

### Smart Growth and Active Living

Proponents of smart growth advocate for comprehensive planning to guide,



The Institute of Medicine makes the following recommendations addressing the relationship between the built environment and childhood obesity:

- Local governments, private developers, and community groups should expand opportunities for physical activity, including recreational facilities, parks, playgrounds, sidewalks, bike paths, routes for walking or bicycling to school, and safe streets and neighborhoods, especially for high-risk populations.
- Communities should prioritize capital improvement projects to increase opportunities for physical activity.
- Communities should improve the street, sidewalk, and street-crossing safety of routes to school, develop programs to encourage walking and bicycling to school, and build schools within walking and bicycling distance of the neighborhoods they serve.

Source: Institute of Medicine, *Preventing Childhood Obesity: Health in the Balance* (Washington, DC: The National Academies Press, 2005).

design, develop, revitalize, and build communities that have a unique sense of community and place; preserve and enhance natural and cultural resources; equitably distribute the costs and benefits of development; expand the range of transportation, employment and housing choices; value long-range, regional considerations of sustainability over a short term focus; and promote public health and healthy communities.

Smart growth advocates are working to create communities that are more conducive to active living and allow people to be active in daily life by bicycling and walking to workplaces, schools, and shops. Active living advocates are working to revitalize main streets, create more bicycle and pedestrian-friendly neighborhoods, use so-called traffic calming techniques to slow traffic and create a safer environment, and increase the reach

of mass transit. Enhancing community safety is another component of this strategy so that people feel safe while being active.

On the federal level, a coalition of health and transportation groups has worked to integrate health concerns into the federal transportation bill, by improving support for walking and biking, creating a national Safe Routes to School plan, and considering health in the transportation planning process. At the state and local level, considerations include how to forge workable coalitions among many sectors with multiple goals including planning, transportation, housing, economic development, parks and recreation, and health.

Influencing policy on land use is a key strategy of the smart growth movement, along with creating incentives for developers to create

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communities more conducive to active living. Policy opportunities include zoning, growth management, and incentive programs. Smart growth advocates are also pushing for reform of local environmental laws. Some communities are also considering requiring a health impact study before approval of any new construction and advocating for public financing (or public – private partnerships) to fund biking and walking trails, sidewalks, and more pedestrian and bike friendly transportation systems.

### Philanthropic Activities

Foundations are sponsoring a variety of projects promoting community designs that facilitate physical activity.

#### Active Living

Promoting community design to enhance opportunities for physical activity is one of the leading strategies targeting the built environment. Robert Wood Johnson Foundation is funding Active Living by Design, a national program to establish and evaluate innovative approaches that support active living. The program is based at the University of North Carolina School of Public Health in Chapel Hill, with the purpose of promoting changes in local community design, transportation, and architecture that make it easy for people to be physically active.

Active Living by Design awarded grants to 25 interdisciplinary, community-oriented partnerships to develop

and implement strategies that will increase opportunities for and remove barriers to routine physical activity. The projects address four strategies:

- creating and maintaining an interdisciplinary partnership;
- increasing access to and availability of diverse opportunities for active living;
- eliminating design and policy barriers that reduce choices for active living; and
- developing communications programs that create awareness and understanding of the benefits of active living.

#### Promoting Smart Growth Policies

In the mid-1990s, as public awareness about the environmental, social, and economic impacts of sprawl began to grow, the Surdna Foundation, based in New York City, began to complement its existing transportation grants program with support for policy development and advocacy for smart growth. The foundation's transportation work had focused heavily on spending and policy. It complemented this with a few strategically selected advocacy campaigns to mobilize the grassroots and local communities to demand implementation of the new federal policy and use it as leverage for local policy and funding reform.

Over time, Surdna discovered that, at the local level, transportation issues

are integral to the larger smart growth agenda. This led to the launch of a special initiative on smart growth and community livability in 1999. The initiative targeted New Jersey, Maryland, New Mexico, and Salt Lake City, Utah, with the intent of fostering good examples of smart growth in a variety of geographic and organizational contexts. The initiative was funded at approximately \$1 million per year. Smart Growth Initiative grantees were convened twice a year to facilitate a process of shared learning, and a lessons learned monograph was published at the conclusion of the initiative that highlights the activities in each state (Brooks and Parzen 2006).

Most of the Surdna Foundation's policy work centered on analyzing governmental policies and subsidies regarding automobile travel and fostering alternative solutions; strengthening efforts to improve public policy that produces locally sensitive solutions; supporting community involvement on transportation and land use reform; supporting programs that foster open space, park land creation, urban conservation, and other livability issues; and advocating consumer choice in the marketplace. The foundation emphasized efforts to reform transportation policy and spending patterns at the federal and state levels, and made grants to national organizations working on these issues as well as to regional organizations around the country.

### **Increasing Opportunities for Activity**

The Mary Black Foundation serves a rapidly growing county around Spartanburg, South Carolina. After completing a strategic planning process in 2003, a decision was made to invest about 40 percent of annual grants to support active living through both policy and programs. The foundation subsequently invested \$700,000 to support a two-mile section of trail in a downtown area that connects to other trail systems. The foundation worked in partnership with the city of Spartanburg to install the trail on a former rail bed. This trail opened in 2006, and anecdotal evidence indicates that it is being widely used by all demographic segments of Spartanburg's population. A five-year grant to the University of South Carolina will support an evaluation of trail use and identification of additional strategies the foundation can use to enhance use. The foundation is also working with seven neighborhood associations and the county government to support another 12-mile stretch of trails on the west side of the city. Proposals are also under consideration to extend the bike path to connect to a downtown grocery store and an arts district, as well as to add lighting to some trails.

Along the way, the foundation has struggled with the definition of roles between the foundation and the local government. Foundation leaders report that government has been a good partner but the majority of

resources have come from the foundation. Another challenge is assuring safety on the trails. Even though the trail is for daylight use only at this time, there has been one reported mugging of a trail user. The foundation is also trying to promote the trails to all residents, not just athletes, and to promote it as part of an alternative transportation system for the area.

The foundation has used this effort to promote the idea that land use planning decisions need to consider health impacts. Future plans include fulfilling a master plan to further connect trails, and supporting promotional efforts to ensure that people are aware of and continue to use the trails. Finally, the foundation is also spearheading an effort to get Spartanburg designated a Bicycle Friendly City by the League of American Bicyclists. To support this effort, the mayor has organized a bicycle-pedestrian commission. Participants report that just the process of applying for this recognition can be useful for a community because it guides the community through an assessment of efforts in the areas of engineering, education, outreach, and evaluation.

### **Support for Evaluation, Research, and Monitoring**

The RWJF Active Living by Design initiative is complemented by the foundation's Active Living Research program, which stimulates and supports research that identifies environmental factors and policies

that influence physical activity. Active Living Research examines relationships among characteristics of natural and built environments, public policies, and personal levels of physical activity. This program's three primary objectives are to:

- establish a strong research base regarding the environmental and policy correlates of physical activity;
- help build a transdisciplinary field of physical activity policy and environmental researchers; and
- facilitate the use of research to support policy change.

To facilitate this, the program also convenes an annual conference for researchers, policy makers, and funders to share findings and learn about the latest thinking and research methods related to active living.

## HEALTH SYSTEMS, WORKPLACES, AND STATE PROGRAMS

*Health care providers, employers, and state health care programs can all play an important role in addressing obesity. The proportion of employers who provide workplace wellness programs has also increased over time, with a 2001 study estimating that over 80 percent of worksites with 50 or more employees, and almost all large employers with more than 750 employees, sponsor at least one health promotion activity (Riedel et al. 2001). Recently, some states have made changes in Medicaid and health care coverage programs for state employees and initiated wellness programs to foster more healthy lifestyles. To date, philanthropy has not been active in championing or monitoring these efforts but could do so in the future.*

Clinicians clearly have a role to play in addressing obesity. The IOM's report recommended that health professionals routinely track BMI and offer relevant evidence-based counseling and guidance. The U.S. Preventive Services Task Force recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults (U.S. Preventive Services Task Force 2003).

The public policy levers for shaping clinical practice include funding research, requiring insurance coverage, setting payment policies, financing health professions education, and setting the terms of licensing. Several states are now testing some of these strategies to encourage healthy behaviors among their Medicaid and state employee populations. These include providing wellness incentives for beneficiaries, offering tools and incentives to providers, and making changes in benefits (NGA 2006).

In West Virginia, for example, the state is offering Medicaid beneficiaries an optional, extended benefit package including services not traditionally offered including nutrition education and diabetes care management. To receive these services, beneficiaries must sign an agreement to attend scheduled preventive health visits and take medications as directed. The agreement also requires parents to take their children to regularly scheduled checkups, immunizations, and dental exams. Those who follow the agreement receive credits in a healthy rewards account, which can be used for optional health care services. In a move that has been criticized as potentially coercive and counterproductive, beneficiaries who do not sign a contract or do not meet its goals within one year will have their benefits reduced, including possible reductions in coverage for diabetes treatment, cardiac rehabilitation, mental health care, dental care, and substance use treatment (Steinbrook 2006). They could also face caps on

*Health care providers, employers, and state health care programs can all play an important role in addressing obesity.*

the number of prescriptions that would be covered or reductions in other benefits. The new program will apply to about 160,000 children and adults without disabilities, about half of the state's Medicaid population (West Virginia Department of Health and Human Resources 2006).

North Carolina began work in 1998 to enhance primary care case management under Medicaid. Under Community Care of North Carolina, 15 local provider networks throughout the state collaboratively develop care and disease management systems to support beneficiaries. The North Carolina Medicaid program also integrates disease management strategies, public health practices, provider groups, and social services. Each network maintains case managers that work with enrollees and primary care providers to manage asthma, diabetes, and congestive heart failure by developing a care plan. Projects can be piloted within the network; for example, one network provides childhood obesity screenings in schools and community centers to identify and intervene on behalf of at-risk children at an early stage.

In Indiana, the Medicaid program is working with the state department of health to develop the Indiana Chronic Disease Management Program for beneficiaries with chronic conditions, including diabetes, heart disease, asthma, and kidney disease. High-risk individuals are assigned to a nurse case manager who works with the primary care provider to provide one-on-one training in lifestyle changes and

medical self-management. Lower-risk enrollees are served by a call center that is available outside regular office hours and makes proactive calls to encourage compliance. Physicians, case managers, and the call center can use a recently developed centralized electronic medical record for enrolled Medicaid recipients to share claims information, clinical data, and care plans (NGA 2006).

States are also implementing broader wellness and prevention programs to promote healthy habits, understanding of risks associated with lifestyles, disease management practices, and regular physical activity. Many governors have started these initiatives with state employees, as state government is usually the largest single employer and health coverage purchaser in many states. These programs generally fall into four categories:

- programs offering health assessments and monitoring;
- health insurance incentives, ranging from discounts for nonsmokers to financial rewards for enrollees who reach personal health and fitness goals;
- healthy work environment initiatives, such as banning smoking near state office buildings and recognizing healthy worksites with awards; and
- fitness challenges and events, such as weight loss challenges, wellness expos, walking programs, and programs in which employees

receive pedometers if they participate in a fitness challenge or health screening (NGA 2005).

As part of the Healthy Arkansas initiative, for example, the state is creating financial incentives for state employees to lead healthy lifestyles through regular health screenings, reduced tobacco use, increased physical activity during work, and improved nutrition. Preventive services are covered by state employee health insurance, and copayments on many preventive services will be eliminated. State employees receive a \$20 monthly reduction in insurance premiums if they take part in a voluntary health risk survey. During the first months of the state employee self-assessment, 18,000 employees and 4,000 employee spouses took the assessment. The state is gathering baseline data on citizen health to measure progress and challenges. Former governor Mike Huckabee had also proposed deeper discounts for nonsmokers or those who enter a smoking cessation program, maintain normal body weight, and exercise regularly (NGA 2005).

Delaware launched the Health Rewards program in 2003 to encourage state employees to take a proactive approach to health and reduce costs. State employees enrolled in group health insurance programs were offered health assessments, feedback, and fitness prescriptions. Available tests include blood pressure checks, blood work, and analysis of body composition, including BMI calculations. Follow-up assessment are used to monitor

progress. Similarly, Kentucky's Wellness Program offers health risk assessments, which provide employees with summaries of their health risks and lifestyle behaviors and suggestions on how to reduce risk. Health insurance carriers are required to offer these assessments to members of the Public Employee Health Insurance Plan either in person or on-line.

### **Comprehensive Approaches to Obesity**

Reflecting the belief that no single intervention will succeed in reversing the obesity epidemic, many health funders are supporting comprehensive efforts that span several sectors and engage multiple partners. Several participants in the Issue Dialogue discussed the opportunity funders have to mobilize cross sector collaborations, and many examples of funder-supported efforts exist.

### **Healthy Eating, Active Communities Initiative**

The California Endowment's Healthy Eating, Active Communities Initiative (HEAC) is a four year, \$26 million effort focused on reducing disparities in obesity and diabetes by improving food and physical activity environments for children. By engaging community residents, public officials and private business, HEAC aims to build practice models and to mobilize advocates to promote healthier environments for nutrition and physical activity. HEAC has local partnerships in six communities and provides tools

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*Many health funders are supporting comprehensive efforts that span several sectors and engage multiple partners.*

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such as technical assistance, statewide communications and policy advocacy support, research, evaluation and a Web site.

HEAC is designed to demonstrate how collaborative approaches can change environmental risk factors for children and families. The goal is to engage youth, families, community leaders, health professionals, and others in creating healthy environments in order to facilitate healthy choices, particularly in low-income communities. The foundation's experience with asthma and tobacco prevention and other community-based public health programs led to the conclusion that creating healthy eating and physical activity environments in low-income and resource poor communities will require a shift from policies, practices, and norms that foster unhealthy foods and inactivity, to policies and practices that position healthy foods and physical activity as the best options.

Grantees consist of collaboratives that include a school district, a broadly representative community organization and the local public health department. They are asked to work in five different areas: schools, after school, neighborhood, health care, and media and marketing, and are focused on the following activities:

- In schools and with technical support from California Project LEAN, HEAC partners are working to implement recently improved nutrition standards for schools, push for improvements
- In the quality of and participation in the school meal programs, and eliminate marketing of unhealthy foods and beverages. Partnerships are also working to improve physical activity environments in schools by advocating for compulsory, high quality PE at every grade level K-12, and for increased opportunities for non-competitive physical activity.
- After school, HEAC partners are working with school-based and community-based programs to adopt institutional policies and practices that promote healthy eating and increased physical activity, and to foster cooperation with parks and recreation.
- In neighborhoods, HEAC partners, with technical support from Policy Link, are working with local businesses, elected officials, environmentalists, and other advocates to improve access to affordable fresh produce, safe walkways and parks, to improve community design, and limit promotion of unhealthy food.
- In the health care sector, HEAC partners, with technical support from Kaiser Permanente, are training health care providers to engage in community prevention activities, and to incorporate more prevention and promotion into clinical practice.
- In the media and marketing sector, HEAC partners are working to eliminate marketing of unhealthy



products to children, and to encourage promotion of healthy nutrition and physical activity. With guidance from Berkeley Media Studies Group and others, messages, materials, and strategies are being developed to accelerate policy change at the local, state and national levels.

Public health departments have a special role as anchor institutions, accountable for monitoring and controlling conditions that lead to risks for obesity and poor health status. Health departments involved in HEAC are developing internal capacity and skills to strengthen cross-sector partnerships; to advance improvements in community planning and built environments; and to more effectively cultivate policy advocacy to improve community health.

The initiative's hallmark is its collaborative nature working to influence change at the community, and ultimately individual levels; however, the initiative includes other components such as program support to other local agencies for technical assistance, statewide policy advocacy, communications, and public affairs and evaluation. Youth participate in community assessments, as peer mentors in school, and develop as leaders. Selected youth participate in the Statewide Youth Board for Obesity Prevention, gaining valuable lessons about government and policy by doing research, and by developing a policy platform and action plan that reflects youth priorities.

To share lessons and resources, and to build momentum for policy and advocacy work addressing these issues, the HEAC initiative will support the formation of a network of programs, including the community demonstration project grantees. These grantees will implement and evaluate strategies to improve environments for healthy eating and physical activity and to create momentum for widespread changes in policy and practice that will ultimately lead to preventing obesity.

The HealthCare Foundation for Orange County has also recently joined with other funding partners including Kaiser Permanente and The California Endowment to support Community Advocacy: Fresh Ideas on Food and Fitness for Orange County Kids. The focus of this three-year initiative, launched in 2005, is to develop and demonstrate sustainable change in the built environment, achieve policy change in schools and cities, create opportunities for physical activity and fitness, and create environmental change to enhance communities' access to healthy foods. Four implementation grants and one planning grant have been made totaling over \$300,000. In addition, the partnership is providing technical assistance to the grantees in collaboration with the Oakland-based Prevention Institute.

### **The Strategic Alliance for Healthy Food and Activity Environments**

The California Endowment, along with The California Wellness Foundation, is also supporting the Strategic Alliance for Healthy Food and Activity Environments. The Strategic Alliance is a coalition of nutrition and physical activity advocates in California, with staff support from the Prevention Institute for coordination of strategy development, outreach, training, media, and research. Its work focuses on shifting the debate on nutrition and physical activity away from a primary focus on personal responsibility and individual choice to one that examines corporate and government practices and the role of the environment in shaping eating and activity behaviors. The ultimate goal is to benefit the health and wellness of all California residents by promoting environmental solutions and institutional and government policies and practices that support healthy eating and activity.

One of the Alliance's products is an on-line database called the Environmental Nutrition and Activity Community Tool (ENACT). ENACT is a concrete menu of strategies designed to help communities improve nutrition and activity environments on a local level. These strategies are organized into seven environments (child care, school, after-school, neighborhood, health care, workplace, and government) that were carefully selected for their importance to individual and commu-

nity health. The on-line tool can help users conduct assessments and select priorities for changing a particular environment, as well as learn more about best practices and promising approaches strategies to improve nutrition and physical activity environments.

### **The Healthy Eating, Active Living (HEAL) Initiative**

Kaiser Permanente is supporting several community health initiatives to prevent obesity and related diseases through the Healthy Eating, Active Living (HEAL) Initiative. This effort is taking an evidence-based and prevention-oriented approach to connect medicine with community activism and public health interventions for intensive, long-term grantmaking. Over \$20 million has been committed to this initiative since 2004. The emphasis is on environmental and policy change, and the initiatives are in different stages of development in each Kaiser Permanente region to support community organizations and collaboratives working in the area of healthy eating and physical activity.

Areas where intensive, multi-sectoral HEAL efforts are currently planned or underway include northern California; Denver; Cleveland; Atlanta; Washington, DC; and suburban Maryland. Through a collaborative grantmaking model, Kaiser Permanente is also partnering with The California Endowment in the six communities where the HEAC Initiative is in place. While HEAC

is focused primarily on children, the two initiatives both focus on policy, organizational practices, and the built environment in defined geographic communities to make it easier for community residents to access healthy, affordable food and get physical activity as part of everyday life. In addition to its collaboration with The California Endowment, Kaiser Permanente is participating actively with several STEPS to a Healthier U.S. collaboratives funded by the U.S. Department of Health and Human Services, and is undertaking HEAL efforts in partnership with local and regional funders in Colorado, Georgia, Ohio, and Washington state.

### **Consortium to Lower Obesity in Chicago Children (CLOCC)**

The Otho S. A. Sprague Memorial Institute created the Consortium to Lower Obesity in Chicago Children (CLOCC) in 2003 in response to rising childhood obesity rates. Based at Children's Memorial Hospital, CLOCC projects include various grassroots efforts tackling what are perceived to be the root causes of childhood obesity in the Chicago metropolitan area, and include a strong focus on policy change.

CLOCC was built on an ecologic model and recognizes that comprehensive strategies will include family and personal empowerment and policy change across many sectors of government, industry, and society. One of its initial projects is the Illinois Childhood Obesity Prevention

Consensus Agenda, an effort begun in the summer of 2004 and ultimately including over 80 organizations, resulting in the enactment of four new Illinois state laws in 2005. The policy priorities of this agenda included limited reform of the physical education waiver process (SB 88); the creation of the Illinois Food Systems Policy Council (HB 211) to provide economic and policy incentives to businesses promoting equitable access to healthy food options; the establishment of physical activity and nutrition standards for all state administered early childhood programs (HB 210); and the institutionalization of a funding mechanism for Safe Routes to Schools and Parks via transportation system enhancements (HB 733).

CLOCC's goal is to prevent obesity in young children. Its medical director, executive director, and community outreach workers use an evidence-based approach and recognize that one size does not fit all. Its network transcends professional boundaries bringing together hundreds of organizations and individuals to confront this health issue via quarterly meetings, focused listservs, a Web site with various links accessing relevant research, special focus groups and work groups that look at issues such as clinical practices, culture and community, data surveillance and research, government policies and programs, nongovernmental organization policies and programs, and school systems. These groups collaborate to promote awareness and healthier lifestyles.

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## THE HEALTHY EATING/ACTIVE LIVING CONVERGENCE PROJECT

The Healthy Eating/Active Living Convergence Project is a collaborative initiative of Robert Wood Johnson Foundation, W.K. Kellogg Foundation, Kaiser Permanente, the Centers for Disease Control and Prevention, The California Endowment, and Nemours Health and Prevention Services. The effort seeks to create a strategic convergence in and between key strands of an emergent healthy people, healthy places movement in the United States (active living, healthy eating, active community environments, and healthy food systems/sustainable agriculture) for the purpose of leveraging these diverse initiatives' collective impact for the health of people and places.

The project is documenting what is happening around the nation in the domains of healthy eating, active living, sustainable agriculture, and healthy food systems. It is identifying some promising outcomes and examples that are reflective of the best of what is underway now, and examining what needs to happen to accelerate positive change in the health of people and places. It is focused on how health funders and their partners can best address both sides of the energy balance equation (physical activity and nutrition) in the context of the natural, built, social, political, and economic environment.

The project sponsored a survey and key informant interviews with national, regional, and local organizations and funders in 2005 and will soon publish a Healthy People and Healthy Places report that identifies key strategies for accelerating and supporting high-leverage, place-based healthy eating/active living efforts. These strategies include 1) building support for healthy eating/active living policies at the state, national and local levels; 2) promoting and supporting connections and collaborative learning within the field; 3) optimizing and increasing investments in community-based initiatives; and 4) supporting market-based innovations.

CLOCC operates citywide and at the neighborhood level, targeting the built environment, promoting safer neighborhoods, delivering health services, working with providers to focus on prevention and treatment of obesity, and working in specified schools to improve nutrition and physical activity. The CLOCC model is noteworthy, since the program began with 85 partners and now

has more than 1,300 participants including representatives from nonprofits, hospitals, government, and food and fitness companies. Since its founding, the Sprague Institute has invested approximately \$1.2 million, while other foundations, individuals and corporations have augmented this core budget with equal or greater amounts of cash and in-kind support for special projects.

## Healthy and Active Communities Program

The Missouri Foundation for Health is focusing its obesity funding on support of direct program implementation, community education, improved community access, and development of local public policy. In September 2005, 15 grantees were funded through the Healthy and Active Communities program. The foundation anticipates funding an additional 15 projects in 2006. Overall, the foundation has committed \$9 million to support nonprofit organizations or governmental agencies pursuing goals such as increasing community access to physical activity opportunities and healthful foods and developing or strengthening collaborative efforts to implement local public policies that promote physical activity and healthy eating. The program is targeted toward community-based organizations with the specific objective of reaching populations who are at increased risk of developing obesity, such as women and children, racial and ethnic groups, and low-income individuals or families.

## The Food and Fitness Initiative

Food and Fitness is a multiyear national initiative funded by the W.K. Kellogg Foundation that supports community approaches to create and maintain access to fresh, locally grown healthy affordable food and safe environments for physical activity. The strategy is focusing on systems change

by addressing the environmental and social conditions that influence children, youth, and families where they live, work, and play. Enhancing access to affordable locally grown foods and safe space for physical activity and play are being used as organizing tools to support community development, address health disparities, and link the health, food system, physical activity, and built environment constituencies at the local, state, and national levels.

The work builds on lessons from the foundation's previous and current investments in health, community collaborations, play and recreation, and food systems and rural development. Early investments in farmers markets, community gardens, edible school gardens, and other community owned enterprises for production and distribution of locally grown foods and local community health partnerships have informed the approach. The initiative is led by Health and Food Systems and Rural Development Program areas within the foundation.

During the first phase of the initiative a select number of community collaboratives will receive grants to support a two year planning process to build their collective capacity to implement systems change.

The community collaboratives are developing action plans with a focus on environmental change and policy strategies (including organizational practices and public policies) that support healthy eating and physically activity. The initiative will also include program support for technical

assistance, communication research to inform advocacy efforts, the engagement of youth as key change agents, and an extensive evaluation effort. Based on results of the planning phase, funds will be allocated to implement and sustain the change efforts. In order to support community efforts, the Food and Fitness Initiative will be catalyzing networks at state and national levels to inform policy and leverage learning for broader national impact.

## CHALLENGES AND OPPORTUNITIES

*Funders interested in policy approaches to reversing the obesity epidemic face both challenges and opportunities. These include selecting and prioritizing strategies, fostering effective coalitions both within the health sector and beyond, and making realistic plans for evaluating efforts, monitoring progress, and communicating lessons learned. Funders must also be comfortable working in an environment where obesity is often seen as an individual concern, evidence on effective strategies is not fully developed, and consensus on best practices is still emerging. Recommendations from the IOM and others offer a useful starting point, but there are challenges in translating broad recommendations into practical and politically feasible policy changes.*

Changing policies is not easy, and as the IOM indicated, the investments to date have not matched the scale of the problem. According to a recent survey of the nation's state chronic disease directors, the most significant barriers to progress in preventing obesity are:

- insufficient funds to support serious and sustained efforts;
- lack of political prioritization;
- not enough translation of research to support practical, on-the-ground application of science into policies and programs; and
- the need to establish other ways to measure success and behavior change in addition to weight loss and BMI (Trust for America's Health 2006).

Another challenge is combating perceptions that obesity is only an individual concern. A 2004 survey by The Henry J. Kaiser Family Foundation asked how much responsibility different groups have in

addressing the problem of obesity. The survey found that higher percentages say that parents (88 percent) and individuals themselves (84 percent) have a lot of responsibility in addressing obesity, compared to doctors or other health care providers (54 percent), the food industry (42 percent), schools (38 percent), or the government (26 percent) (San Jose Mercury News and The Henry J. Kaiser Family Foundation 2004).

Funders can be leaders in changing the debate about who is responsible for obesity, and can play a critical role in the adoption of local, state, and federal policies that lead to healthier lifestyles. The work of several foundations has also demonstrated the power of locally generated data and advocacy on issues ranging from soft drink pouring contracts and availability of sodas in school, to advertising to kids, and the availability of fresh food in urban areas.

In addition to the many examples of work in schools, health care settings, community design, and food systems

noted above, funders can also foster development of networks or coalitions that bring together multiple sectors including education, sustainable agriculture, public health, transportation, parks and recreation, development, and urban planning. By supporting data collection, convening, and offering organizational support for coalitions, foundations can provide a neutral meeting ground, motivation, and support for sustained action.

Funders can also support research and evaluation to advance understanding of which strategies are effective and their impact on both BMI and other critical measures such as school

performance, health care costs, food availability and security, and environmental health. Areas requiring support include methods development as well as efforts to synthesize what is known, disseminate what is learned in practical and usable ways, and promote adoption of evidence-based practices. There is also a pressing need to better understand how poverty, race, and ethnicity affect families' food and activity choices. Sharing results with others in the field of health philanthropy and beyond will help us build the evidence base and learn about what strategies are most effective in reversing the obesity epidemic.



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# ABOUT GIH

With a mission to help grantmakers improve the health of all people, Grantmakers In Health (GIH) seeks to build the knowledge and skills of health funders, strengthen organizational effectiveness, and connect grantmakers with peers and potential partners. We help funders learn about contemporary health issues, the implications of changes in the health sector and health policy, and how grantmakers can make a difference. We generate and disseminate information through meetings, publications, and on-line; provide training and technical assistance; offer strategic advice on programmatic and operational issues; and conduct studies of the field. As the professional home for health grantmakers, GIH looks at health issues through a philanthropic lens and takes on operational issues in ways that are meaningful to those in the health field.

## Expertise on Health Issues

GIH's Resource Center on Health Philanthropy maintains descriptive data about foundations and corporate giving programs that fund in health and information on their grants and initiatives. Drawing on their expertise

in health and philanthropy, GIH staff advise grantmakers on key health issues and synthesizes lessons learned from their work. The Resource Center database, which contains information on thousands of grants and initiatives, is available on-line on a password-protected basis to GIH Funding Partners (health grantmaking organizations that provide annual financial support to the organization).

## Advice on Foundation Operations

GIH focuses on operational issues confronting both new and established foundations through the work of its Support Center for Health Foundations. The Support Center offers an annual two-day meeting, The Art & Science of Health Grantmaking, with introductory and advanced courses on board development, grantmaking, evaluation, communications, and finance and investments. It also provides sessions focusing on operational issues at the GIH annual meeting, individualized technical assistance, and a frequently asked questions (FAQ) feature on the GIH Web site.

## Connecting Health Funders

GIH creates opportunities to connect colleagues, experts, and practitioners to one another through its Annual Meeting on Health Philanthropy, the Fall Forum (which focuses on policy issues), and day-long Issue Dialogues, as well as several audioconference series for grantmakers working on issues such as access to care, obesity, public policy, racial and ethnic health disparities, and health care quality.

## Fostering Partnerships

Grantmakers recognize both the value of collaboration and the challenges of working effectively with colleagues. Although successful collaborations cannot be forced, GIH works to facilitate those relationships where we see mutual interest. We bring together national funders with those working at the state and local levels, link with other affinity groups within philanthropy, and connect grantmakers to organizations that can help further their goals.

To bridge the worlds of health philanthropy and health policy, we help grantmakers understand the

importance of public policy to their work and the roles they can play in informing and shaping policy. We also work to help policymakers become more aware of the contributions made by health philanthropy. When there is synergy, we work to strengthen collaborative relationships between philanthropy and government.

## Educating and Informing the Field

GIH publications inform funders through both in-depth reports and quick reads. Issue Briefs delve into a single health topic, providing the most recent data and sketching out roles funders can and do play. The GIH Bulletin, published 22 times each year, keeps funders up to date on new grants, studies, and people. GIH's Web site, [www.gih.org](http://www.gih.org), is a one-stop information resource for health grantmakers and those interested in the field. The site includes all of GIH's publications, the Resource Center database (available only to GIH Funding Partners), and the Support Center's FAQs. Key health issue pages provide grantmakers with quick access to new studies, GIH publications, information on audioconferences, and the work of their peers.



## DIVERSITY STATEMENT

GIH is committed to promoting diversity and cultural competency in its programming, personnel and employment practices, and governance. It views diversity as a fundamental element of social justice and integral to its mission of helping grantmakers improve the health of all people. Diverse voices and viewpoints deepen our understanding of differences in health outcomes and health care

delivery, and strengthen our ability to fashion just solutions. GIH uses the term, diversity, broadly to encompass differences in the attributes of both individuals (such as race, ethnicity, age, gender, sexual orientation, physical ability, religion, and socioeconomic status) and organizations (foundations and giving programs of differing sizes, missions, geographic locations, and approaches to grantmaking).





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