

NUTRITION CONNECTIONS
PEOPLE, PROGRAMS, and SCIENCE



**FNS NATIONAL NUTRITION
EDUCATION CONFERENCE**

**COLLABORATING
FOR SUCCESS**

**Conference Highlights
and Proceedings**

February 24–26, 2003
Washington, DC



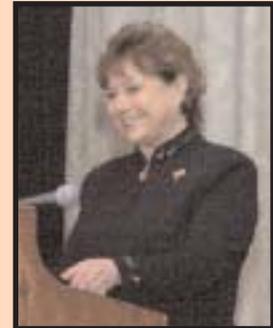
U.S. Department of Agriculture
Food and Nutrition Service

www.fns.usda.gov/nutritionconference



“The human and financial costs of obesity and other nutrition-related diseases is a staggering \$117 billion...but behind this number are real people and real families who have to bear the social, financial, and emotional costs associated with overweight and obesity.”

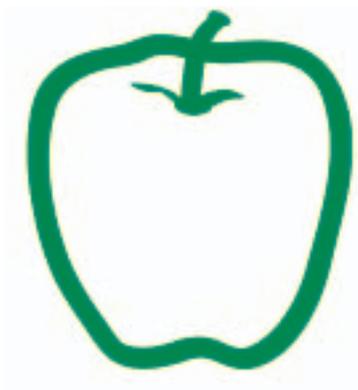
“Studies have shown that most Americans are aware that a poor diet can increase the risk of several diseases...but these studies have also shown that not many Americans change their lifestyle even with these facts being known. So the scope of the challenge is clear: Translating information into not only action, but positive results.”



Ann M. Veneman, Secretary, US Department of Agriculture, Washington, DC, speaking at the FNS National Nutrition Education Conference, February 2003



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“Everyone has a role to play, from parents and educators, to administrators, industry, nutritionists, and health care providers. And the Federal government can help further the process of education, while also demanding that our Federal nutrition programs are effective and accountable.”

Ann M. Veneman, Secretary, US Department of Agriculture, Washington, DC, speaking at the FNS National Nutrition Education Conference, February 2003



About 900 professionals from the Federal nutrition assistance programs attended the first U.S. Department of Agriculture national nutrition education conference, "Nutrition Connections: People, Programs, and Science," held on February 24-26, 2003. This historical conference brought together a diverse group of people from across the country and provided a unique opportunity for them to share nutrition education strategies that make a real difference in the lives of people served by USDA nutrition assistance programs.

We are facing tremendous challenges in addressing the rising rates of overweight, obesity, and other diet-related health concerns in America. Healthy eating, physical activity, and healthy lifestyle choices are factors that can make a difference in the current and future health of all citizens but especially children.

The publication of these proceedings commemorates the expert presentations, information sharing, collaborating, and networking that occurred at the conference. It also reemphasizes USDA's priority of promoting cross-program sharing and working together to achieve common nutrition-related goals. Use this resource to join us as we move forward in partnership to strengthen the health of the Nation's children and families.

Eric M. Bost
Under Secretary
Food, Nutrition, and Consumer Services



The Food and Nutrition Service (FNS) has a long history of providing nutrition assistance to low income children and adults. We also recognize that effective nutrition education combined with the program's food benefits can have an immediate and lasting impact on our target populations, by increasing food security and helping them adopt and maintain healthy eating and lifestyle behaviors.

We can best accomplish this by working together at the Federal, State and local levels. The first FNS national nutrition education conference provided an opportunity for professionals representing all FNS nutrition assistance programs at all levels to:

- Collaborate and coordinate nutrition education efforts,
- Maximize resources, and
- Promote consistent, behavior-focused, science-based nutrition education.

These proceedings provide excellent examples of successful programs and projects that emphasize collaboration and coordination and the application of behavior change and scientifically sound principles. Some of the speeches included also highlight FNS's vision for future nutrition education efforts, focus on areas that need strengthening, and challenge us to overcome barriers to achieving a healthier America.

This conference was an important first step in a multi-step process that we hope will lead to more comprehensive and integrated nutrition education services within and across the Federal nutrition assistance programs. We hope that these proceedings will be a useful tool in this process.

Roberto Salazar
Administrator
Food and Nutrition Service

Collaborating for Success: Integrating Comprehensive Nutrition Education Across FNS Programs

Moderator: Roberto Salazar, Administrator, Food and Nutrition Service, US Department of Agriculture, Alexandria, Virginia

Opening Remarks

Eric M. Bost, Under Secretary, Food, Nutrition, and Consumer Services, US Department of Agriculture, Washington, DC

Good afternoon. This is the first national nutrition education conference for all our FNS Programs and we are pleased and excited that all of you are here. This is an opportunity for us to come together to talk about those major challenges that we face in addressing the issues of obesity and overweight among people in this country. At USDA, we have a very important role to play as do many other Federal agencies, but we cannot address this issue alone. We have to do it in concert with all of you. It would be foolhardy for us to assume that we could address many of the issues, challenges, problems, and concerns that are going to be discussed over the course of the next several days. This conference is an opportunity for all of us to come together and talk about what we can do together to address the issues of encouraging a healthy lifestyle among all Americans.

Part of our hope is that we have an opportunity for us to talk together about some things that you will be able to take away from here and go back and use in your respective communities.

Health-related issues are very important to the President. I have had an opportunity to talk with him about these issues on several occasions and it is something that is also very important to Secretary Veneman, who will be speaking tomorrow. Statistics show that 300,000 people die each year related to being overweight or some obesity-related diseases. Last year in this country, there was a significant increase in Type 2 diabetes among children and significant increases in heart disease, cancer, and diabetes among all of us as a direct result of our eating habits or lack thereof. Also, a billion dollars spent in health-related medical insurance costs as a direct result of this.

But, more importantly, I would like to mention something that I would probably categorize as an epiphany that I had. Since I have been Under Secretary, I have traveled the country and visited many schools. This particular morning, I was preparing to speak to some young kids at an elementary school. I arrived at the school about 10 or 15 minutes earlier



than I was supposed to and was sitting in the car with some of my staff as the kids got off the bus to go into the school. The bus dropped them off no more than 25 yards from the front door of the school. I am sitting there watching the kids get off the bus. Many of the children that got off the bus had to stop and catch their breath before they got to the doorway of the school because they were too overweight.

Folks, we have got to deal with this. That is not good. Over half of the young kids had to stop and catch their breath because they were overweight. This conference provides an opportunity for us to talk about what we can do to turn that around.

So, when you hear all of those statistics and the information that presenters are going to talk about, I want you to put a face on it. I want you to imagine these little kids with these chubby round faces carrying their little book bags who could not walk 25 yards because they were overweight. We need to put a face on it and talk in terms of some very specific actions that together we can take to address these issues.

I talk a lot about children because they are very important but I also want to talk about the responsibility and obligation that parents have and that you have as professionals. We cannot do this alone. We can pass lots of regulations but nothing is going to be different until all professionals, parents, educators, administrators, and physical education people step up to the plate and realize that we have some very important responsibilities in terms of addressing these issues.

Lastly, I always like to talk about this when we talk in terms of nutrition education. If you stopped ten adults, and said to them, "Here is an apple and here is a doughnut; which has more calories and fat?" It is my belief that nine out of ten people know the answer to that question. Am I right? There you go. So, the issue is going beyond nutrition education. The issue is talking in terms of the types of things that we can do to start changing the behavior of adults and children in this country. I am going to tell you – that is so hard.

As Americans, we love to eat. We love choices. We do not like people to tell us what to do and we love a "deal." Do you know that for 10 cents more you can get 50 more ounces of this soda or I will add just two more scoops for 25 more cents. So, we love that deal. The people who are making those elastic pants are making a killing because the way we figure it, you know, I can supersize and all I have to do is go get some more elastic.

It is time for us to realize that we have got to change our ways. We need to look at making some wise decisions and choices and instilling that information in our children given the current medical issues that we are facing. As someone, along with people on the stage and others, who is ultimately responsible for the National School Lunch Program, we are going to try to do that as part of reauthorization. We are going to try to send some suggestions to Congress to address those issues.

But I close with this thought. I have talked about many things and you are going to hear many ideas and suggestions, many people talking and many questions, but I pose this last thought to you. At the end of the day, what is different? At the end of the day, what will you be able to take away from here that is going to be different and result in having a positive outcome in the lives of people who live in this country? At the end of the day, what is different? Thank you all.

Keynote Address: Collaboration-What Counts and Why It Matters

William Potapchuk, MA, President, Community Building Institute, Annandale, Virginia

Good afternoon. I am so delighted to be here. I come here as an unabashed supporter of your work at FNS. Your work is often under appreciated and under recognized in communities. You make critical contributions. Much of my work is in improving the general quality of life in communities and in improving outcomes for children and families. We all know this, but it bears repeating, that healthy kids, good educational outcomes, resilient kids, even economic development cannot happen unless children, families, workers, indeed, everyone has appropriate amounts of nutritious foods. As a community builder, I know the role of food in reweaving the fabric of the community. It would be difficult to recall a successful community building effort in which food did not play a central role.

I am as excited to be with you now as I was when I was first asked to lead the technical assistance team for the Community Nutrition Education Consortia (CNEC), in ten sites around the country. This was one of FNS's first efforts to systematically promote collaboration at the community level and it is where I would draw from as I speak with you today.

In preparing, I also read current materials on FNS and sought to catch up on current activities in the field. The reading not only confirmed but strengthened my conviction that learning how to collaborate more effectively will be absolutely essential to your success, whether it is in community food security efforts, developing strategies to attack obesity, working with schools, working across agencies, engaging clients more effectively or developing strategies to achieve the FNS vision: "To lead America in ending hunger and improving nutrition and health."

The Core of Our Work: Collaborative Strategies

Collaborative strategies will be at the core of your work. Before we jump ahead of ourselves, let's spend a moment focusing on defining collaboration and getting a good picture of it in our minds. Collaboration is the most intense form of partnership between two or more individuals or organizations. This technical definition that is most precise is from Arthur Himmelman: "Collaboration is defined as exchanging information, altering activities, sharing resources"—and this is the critical one—"enhancing the capacity of one another for mutual benefit and to achieve common purpose." Collaboration is the part of a palette of interactive activity that is the most intense. So, we start with networking, just exchanging information, much of what we will be doing here and over the next couple of days.

As part of coordination, we alter activities. At a very simple level, this is something like finding that a neighboring or sister organization is holding an event on the same night that you wish to hold an event and then you alter your timing so that you don't conflict with each other. That is the next level of interaction.

Cooperation is often what passes for collaboration, especially in terms of sharing resources. "I will contribute my outreach worker if you contribute some nutrition education"...and someone else contributes some space and you proceed in a slightly more integrated fashion. That means beginning to pay attention to the capacity, both individually and collectively, of the organizations, individuals, agency and leadership that are brought to bear against the problem. So, what does it mean for a local program to restructure itself in ways that build a more holistic network at the local, State, and Federal levels?

Before we go further, allow me to share my favorite definition of collaboration: "an unnatural act between two un-consenting adults." Why do we find that funny? Because intuitively we know collaboration is hard

and that is a very honest definition at times. We can point to an agency director, a community activist or even a colleague and find it hard to imagine how we might fashion a collaborative working relationship.

More and more individuals and organizations are recognizing the collaboration imperative and shifting that behavior, shifting programs, and shifting attitude to accomplish this goal. It is a significant change. If there is one notion I would like you to walk away with today, it is how fully following the theories, principles and practice of collaboration represents a deep paradigmatic shift in the way we do business. This deep collaboration is hard work. But the good news is, and this is really important, that this work is developmental and benefits accrue at every step of the journey.

I have a friend who observes that if something is really only a small shift, it is "a pair of nickels," not "a paradigm." This is a paradigmatic shift. Deep notions of collaboration speak to systemic issues, policy issues, conceptions of knowledge, our conception of change, and notions of capacity.

The Importance of Social Capital

I want to introduce another topic, which is absolutely central to understanding this work. That concept is social capital. Some of you may know the work of Harvard professor, Robert Putnam, who popularized this term. Social capital refers to the resources imbedded in social relations among persons and organizations that facilitate cooperation and collaboration, the kind of assets that get things done.

Many of you know that the literature on collaboration commonly talks about trust as an elemental factor in successful collaborations. I find social capital to be a richer concept than trust. It includes two additional facets. It recognizes that trust needs to be imbued within a group, whether it is a set of stakeholders sitting around the collaboration table or in a community or neighborhood.

Secondly, social capital speaks to results. I know of many trusting relationships that do not maintain that steadfast attention to getting things done. Judy Innes, a Berkeley urban planner, and Judy Gruber, a Berkeley political scientist, have helped us understand that social capital is part of a triangle with two other forms of capital, intellectual capital and political

capital. Political capital is as the name suggests, the political power, the juice, the "oomph" to gain support, commitment, and resources. Often this is something that can only be built when you have the right people around the table, people who have power, connections, and authority. Intellectual capital is the shared analysis and the knowledge that allows a disparate group of collaborators to have an intelligent conversation about complex issues. It is largely developed through conversation drawing in materials from experts, peers, and other sources of data.

Building Social Capital, Intellectual Capital, and Political Capital

Effective collaboration builds social capital, builds intellectual capital, and builds political capital. When you put these three together, it is that combination that makes collaboration such an effective strategy for change. I would like to illustrate this. I have read about the Obesity Action Network in Georgia, a collaborative effort that started with only four organizations. It has since expanded to include a larger number of members and leveraged a range of positive activities throughout the State.

The network now includes the Georgia chapter of the American Academy of Pediatrics, the Family Health Branch of the Georgia Department of Human Resources, the Centers for Disease Control and Prevention (CDC), the National Association of Pediatric Nurse Associates and Practitioners, the school health nurses, Kaiser Permanente, and others. Imagine for a moment that another State decided to do something similar and its counterparts from all of the organizations I mentioned were sent a meeting invitation. You know the reaction you would receive. A couple of people would come. Some would be interested, but not make time available to attend and others would not even be sure why they received the invitation. What does the Obesity Action Network in Georgia have that their counterparts in other States do not have?

The difference is members of the Obesity Action Network have built social capital. They have built some norms, some trust, and some commitments that allow them to get things done. They have built and are building more intellectual capital and they have built political capital.

Participating organizations are using their resources for a common purpose. The work of making contacts, sharing an idea, moving together jointly, learning about the concerns of other organizations, building commitment, finding a place to start, and gaining early success is hard work. What do you earn when you do that hard work? The literature is replete with the benefits of collaboration and I am sure that you know it from your own

experiences. It can reduce fragmentation and build comprehensiveness, use resources more efficiently, and reshape service delivery. It is often the only strategy that can be used when you are addressing complex social challenges. When done systematically and well, effective collaboration is also a means for rebuilding communities and strengthening our democracy.

I would also like to suggest that there is one more benefit, which is not as widely discussed in the literature, but is very important. For those of us who entered this work because of the desire to help, and I imagine that includes us in this room, we often feel frustrated by limitations that we face daily, whether it be regulations or institutional inertia or funding streams. Yet, we often find we still want what we entered this field for: healthier people, healthier communities, and a better world.

Value of Developing Collaborative Capacity

Collaboration is a vehicle for increasing our sense of what is possible. It enlarges our sense of possibilities and that enthusiasm, that energy, is infectious. These benefits, I believe, make developing collaborative capacity a worthy investment, but as you all know better than I, success in nutrition education usually means positive changes in knowledge and behavior, measured pre and post.

I suggest that the value in collaborative capacity, learning how to measure it and funding it, are essential components of making an institutional commitment to collaboration. It means structuring programs in ways that recognize that the first year or two of the new collaborative effort needs to be focused on building collaborative capacity. Instant success among clients in knowledge and behavior change is not likely and, in some cases, not desirable. This is because it means that new partners are not doing the hard work of reducing suspicions, building trust, doing shared analysis, and mobilizing institutional resources for the long haul.

I know that this work is underway throughout the world of nutrition education, but it is challenging work and I have yet to see a Federal agency that is able to master this challenge. That is one of my principal messages for program administrators: value collaborative capacity, learn how to measure it and fund it. What is the parallel message for those of you on the ground who already go to more meetings than you wish to?

I am sure that many of you have looked at the many manuals on collaboration, as you have embarked on these efforts. There are often a series of steps. Some of them can seem onerous or like "make work." I

would like to suggest the kind of steps that are essential early on and those that can be addressed over time. In Russ Linden's (one of the prime leaders in the reinventing government movement) new book on interorganizational collaboration, he quotes veterans of successful collaborative efforts.

Managing Relationships to Build Effective Collaborative Efforts

One of the most common themes is that building effective collaborative efforts is about managing relationships. This means that first you must cultivate an array of relationships before you can think of managing them. Partnering with school nurses, like the Obesity Action Network, is important, because they are present in those schools. Possibly a key strategy of the nutrition education program is working on relationships with school nurses, their association, and the leadership in that association. Go to their office, take folks out to lunch, attend their meetings, those are some of the ways to build those relationships. While the relationships can start with you, they quickly need to grow into relationships among all of the collaborative partners. Structured information sharing, retreats, and social events can help catalyze relationships among the partners. Those relationship-building steps are absolutely essential early on. They cannot be put on hold while you do other things.

Getting to "A Shared Vision or Purpose and a Good Idea"

Some guidebooks focus on the paper products of collaboration, the vision, the mission. You know this routine: the goals and objectives, the workplan and so on. Recent research by renowned public policy professor, Eugene Bardach, suggests that most successful collaborative efforts have two things in place early on: a shared vision or purpose and a good idea. His research was based upon an empirical analysis of a number of public sector interagency collaborations.

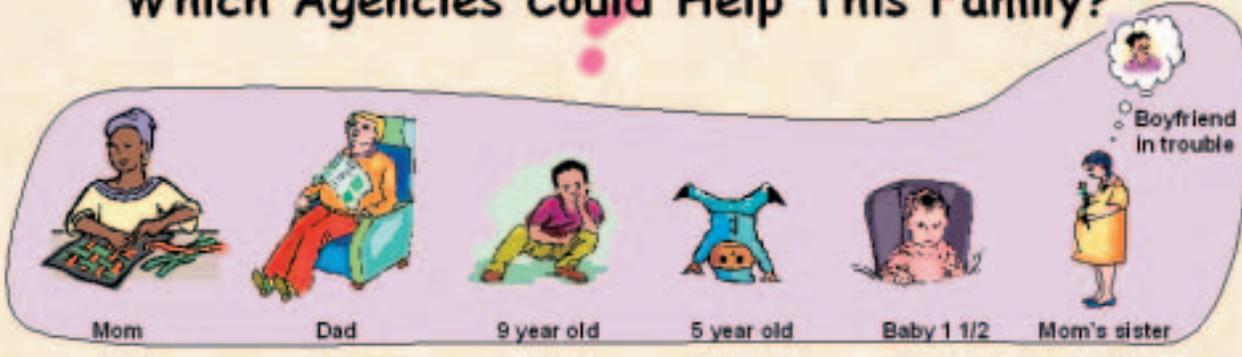
A shared vision or purpose and a good idea. So, how do you find a good idea, one that represents a good analysis of a system? What I would like to do is walk through some slides that you will find difficult to read, but will leave you with a picture. This slide was prepared by Margaret Dunkle of George Washington University and the Los Angeles Children's Planning Council. Across the top and you probably know this array is a set of programs out of education, health and nutrition, social services, children and family services, mental health and probation. We start with asking this question, "Which agencies could help the somewhat typical family?" —

Mom, Dad, the nine year old, the baby, the sister, boyfriend in trouble. Look at this. Mind boggling, isn't it?

AGENCIES - PROGRAMS & SERVICES

Education	Health & Food	Social Services	Child & Family Services	Mental Health & Probation
 <ul style="list-style-type: none"> Public Schools ESEA, Title I School Lunch & Breakfast Head Start IDEA After-School Programs Textbook Funding Tests & Achievement Teacher Issues GED 	 <ul style="list-style-type: none"> Medi-Cal – EPSDT Healthy Families Parent Expansion Child Health & Disability Program Expanded Access Primary Care Trauma Case Funding Co-payments for ER Services Child Lead Poisoning Prevention Program HIV/AIDS Prevention & Education Breast Cancer Screening Food Stamps WIC 	 <ul style="list-style-type: none"> TANF GABI, CAL Learn, CalWORKS, etc. 	 <ul style="list-style-type: none"> Child Care – CCDBG, SSBG, CalWORKS Child Care, etc. After-School Programs – 21st Century Learning Centers, etc. Promoting Safe & Stable Families Child Abuse & Neglect Programs Foster Care – Transition, Independent Living, Housing, etc. Adoption Assistance, Adoption Opportunities 	 <ul style="list-style-type: none"> School-Based MH Services for Medi-Cal Kids Probation Officers in Schools Cardenas-Schiff Legislation Health Care Through Probation Mental Health Evaluations Juvenile Halls

Which Agencies Could Help This Family?



Mom Dad 9 year old 5 year old Baby 1 1/2 Mom's sister

When we think about bureaucracies, working through various stovepipes or silos, here is a small representation of the silos that are faced by the people we serve. Let's go back to Mom for a moment. Mom, as you can see in this slide, receives services from Head Start, Healthy Families, the Promoting Safe and Stable Families Program. She receives breast cancer screenings, food stamps, support and job training.

Example of a Successful Collaborative Program

These are only the large State and Federal programs. She also receives support from her church, a food bank, a local women's program and other support from non-profit and faith-based organizations and the local government. When one is seeking collaborative opportunities, a systems analysis explores complementary services. Let's talk about a specific program for a minute.

First, listen to this program as described by the New Jersey Juvenile Justice Commission:

"This project provides at risk youth with job training through the entrepreneurial experience of owning and operating a business. The primary purpose is to expand the long-term education and employment opportunities for high school youth, through hands on work experience aimed at improving their job and community citizenship skills. The project also strives to develop a core group of successful student entrepreneurs, who will provide a model for the youth in the community, showing that education and employment are viable alternatives to drugs and other destructive behavior."

In other words, this could be any one of dozens of prevention programs for youth, one that at face value may not hold much interest for nutrition educators. Then, listen to a description of the same project by the New Jersey Food Stamp Nutrition Education Program:

"This project helps create access to affordable nutritious food for inner city and limited resource communities. It also provides employment and valuable learning experiences for disadvantaged youth from low-income families. Within the context of this grant, the at-risk youth received nutrition education training and the tools to distribute educational fliers and messages to food stamp recipients in their communities."

It is the Youth Farm Stand Project in New Jersey. It is a wonderful example of how you can take a look at that system and, in this case, see how a variety of programs reach at risk youth. Look for partners and find opportunities to work with programs like the Juvenile Justice Commission, which importantly brought a whole bunch of dollars to the table to begin to put together collaborative efforts that make a difference in settings where you cannot do it alone.

I will now discuss research and collaborative capacity and what it means when it is applied to the complex non-linear process of collaboration. We know intuitively, for example, that Washington, D.C. is quite different from Bakersfield, California, and that a research-based, best practice in Washington, D.C., is likely to be rejected by those folks in California.

Collaboration is not a "one size fits all" process. Collaboration evolves organically out of the local political context, local capacities, and local opportunities.

I would like to close with a quote from a paper by Judy Innes and Judy Gruber. They have done some of the most important work on collaboration on this question of how you build it and sustain it over time. They have reached some very interesting conclusions. They are interesting because when we think of social capital, political capital and so forth, we often think of money, financial capital and we think how money goes away once we spend it.

The quote is: "Social, intellectual, and political capital build on themselves...and one another. Groups that start out in an environment of accumulated social capital find it easy to generate more...and the rich get richer."

When you are able to put together your collaborative efforts, you have built a platform that can only grow. Good luck in your efforts.

Panel: Making Connections-Reaching People Across Programs and Lifespan

CDC Vision and Initiatives

William H. Dietz, MD, PhD, Director, Division of Nutrition and Physical Activity, Centers for Disease Control and Prevention, Atlanta, Georgia

It is a pleasure to be here at this momentous occasion for the USDA. The prevention of chronic diseases, including obesity, is a high priority for Secretary of Health and Human Services Tommy Thompson, who has announced in the 2004 budget that substantial funding will be allocated to our Center to address the problems of diabetes, obesity, and asthma. This is the most significant increase in budget that our Center has ever sustained. It is a reflection of the intense commitment that Secretary Thompson has made to a healthier U.S.

A hundred years ago, the problems in this country were infectious diseases and nutritional deficiency diseases. We have successfully solved the epidemic of diarrheal and infectious diseases in children by a series of policies and environmental changes. For example, water potability, the immunization schedule for children entering school, and the steps to assure the safety of the U.S. food supply have reduced or eliminated most of those diseases. These policy and environmental changes have structured the way we live today.

In addition, we have successfully eliminated many of the nutritional deficiency diseases that characterized the United States a hundred years ago. At the turn of the century, about 85 percent of children in the Northeast had rickets as a result of the coal smoke and the absence of vitamin D fortification of milk.

Pellagra, niacin deficiency, was the leading cause of death in many parts of the South. We have eliminated rickets, nutritionally-related rickets, in most children by fortification of milk with vitamin D. We have eliminated pellagra by fortification of flour with niacin. These are policy-driven changes, which have successfully eliminated nutritional deficiency diseases in much the same way that policies and environmental changes eliminated infectious diseases.

Obesity: The Problem of Today

The problem today is obesity and its associated chronic diseases: cardiovascular disease, diabetes, and cancer. Surgeon General Carmona has stated that this problem threatens our national security, given the limited number of individuals in the country who are eligible for military service, and the impact that obesity has on reducing those numbers.

The challenge for us is to understand this epidemic and how to address it. Then, we can begin to develop policy and environmental changes that will characterize our society for the next hundred years in much the same way that food fortification and the elimination of infectious diseases have made us a healthier society for the last 100 years. The obesity epidemic, in my view, opens the door for a comprehensive nutrition and physical activity program, the likes of which we have never had before. I would like to walk you through our vision of what a comprehensive nutrition and physical activity program looks like.

Vision of a Comprehensive Nutrition and Physical Activity Program

Importance of Surveillance in Understanding Obesity

First, a comprehensive nutrition and physical activity program has to have adequate surveillance. We know that surveillance is a very powerful tool for representing the spread of obesity across the United States. The Behavioral Risk Factor Surveillance System (BRFSS) has transformed the question, "Is there an obesity epidemic?" to "What do we do about it?"

The surveillance that we do collaboratively with WIC is equally important in helping us understand the magnitude of the problem. The data collection

and reporting through the Pediatric Nutrition Surveillance System (PedNSS) and Pregnancy Nutrition Surveillance System (PNSS), exemplify a true collaborative interaction between the USDA and HHS programs. But, it is not enough. Although this tells us the magnitude of the problem, it doesn't tell us what the gaps or barriers are.

It does not tell us whether policies are shifting as we begin to implement them. The first strategy in this regard is to implement more surveys, like the "School Health Policies and Programs Survey." This first CDC survey helps us begin to understand the policies and their application in schools around the country. A second critical gap that we face in the area of surveillance is the lack of data on the prevalence of nutritionally-related diseases in school children. There is a large gap between the end of the pediatric data captured in the WIC program (age 5) and the beginning of the Youth Risk Behavior Surveillance System, which looks at adolescents and high school students. This is a critical need that we have to address.

Science-Based Strategies

The second aspect of a comprehensive program is a science-based strategy. We must develop scientifically-based approaches to address the obesity epidemic successfully. We can begin to implement the following four strategies today to address the epidemic:

Strategy #1: Promotion of Breastfeeding

We are already working collaboratively with the USDA on the promotion of breastfeeding. The WIC program is way out in front of any other program that I know of in the country. We know that breastfeeding reduces the risk of subsequent obesity in infants. We know that WIC is doing a good job of promoting breastfeeding. But, we need to understand the policies that make it difficult for women to either initiate breastfeeding or continue breastfeeding when they return to work.

Strategy #2: Reduce Television Viewing

The reduction of television viewing is another major goal. This strategy is defensible, but not necessarily conclusive. We need to determine the incentives necessary to reduce television viewing in children.

Strategy #3: Increase Physical Activity

The Guide to Community Preventive Services, an evidence-based approach developed by the Task Force on Community Preventive Services of the CDC, has developed evidence-based strategies to promote physical activity. It is time that we begin to implement those in every community.

Strategy #4: Promotion of Consumption of Fruits and Vegetables

The 5-A-Day program, a collaborative effort between the National Cancer Institute, USDA, CDC, and industry partners, is another key theme. The 5-A-Day effort requires that we understand better the opportunities for increasing fruit and vegetable consumption. We need to reduce the number of institutions that stand between the grower and the consumer, offering substantial opportunity for price reduction. We have begun to do this in a series of State visits that Peter Murano, Deputy Administrator, Special Nutrition Programs, FNS, and I made to Texas and Florida. We have begun to understand how to draw growers closer to State programs. Those types of initiatives are central.

Translate Science-Based Programs into Action

The next area that I would like to talk about is the translation of science-based programs into action. The importance of an integrated approach in this effort was demonstrated to Peter and I during our visit to Texas. Our visit to Texas induced changes. It was the first time that the State Commissioner of Agriculture and the State Commissioner of Health had met each other. This, to me, is a ready-made intervention, but we need to go much further than that.

Currently, the CDC funds programs in cardiovascular disease, obesity, diabetes, and cancer. Nutrition and physical activity risk factors are cross-cutting and influence all of those programs. We have spent the last two years working very hard within the CDC to integrate the approaches across divisions.

Importance of Cross-Program Integration, Collaboration, and Partnering

But now the challenge is to link State nutrition and physical activity programs funded by HHS, CDC and the USDA; as well as programs within the Department of Education (which influence the programs and curriculum in schools); the Department of Transportation (which has a significant impact on transportation modalities and, therefore, the availability of physical activity); and even the Department of Defense (which has a very important role in the introduction of fresh fruits and vegetables in schools).

However, if we limit our partnerships to Federal agencies, our activities will be incomplete. We need to actively engage with other partners, like the American Cancer Society, which has made nutrition and physical activity a high priority strategy for reducing the subsequent risk of cancer; the American Heart Association, which has recently concluded the same; and

the American Diabetes Association, which is also focusing now on obesity as a significant risk factor for the subsequent occurrence of diabetes.

Other partners are less obvious. The YMCA, for example, is a willing partner. The YMCA, a natural partner for us, has 18 million members countrywide and half of those members are children under the age of 18. The American Association of Retired Persons (AARP) is very interested in the issue of physical activity and obesity—they need to be one of our partners.

It is also critical that we integrate these programs across settings. Just take the example of a medical setting. Counseling a patient to increase physical activity is not going to be a successful strategy unless that community has the capacity to support physical activity, like the presence of sidewalks. Increased fruit and vegetable consumption is not going to happen in urban areas that lack supermarkets and lack an inexpensive supply of attractive options for people to buy.

If we limit our efforts to one of these settings, we will fail. Collaboration is not an option—it is a necessity.

Partnering With Industry

Business must be part of this equation. In contrast to tobacco, I do not think that demonization of the food industry is going to be a successful tactic. In contrast to the efforts around nutritional deficiency diseases, fortification or a single change is unlikely to have an impact. We must develop more comprehensive approaches and industry must be our partner. They do what they do very well. They provide products that are readily available, inexpensive, and tasty.

How do we make healthier choices fit those same criteria? When a quick service company introduces another helpful product, like the "McLean Burger," we cannot afford for that effort to fail. Millions of women are not going to go back to spending 45 minutes or an hour preparing dinner for their families. Quick service meals are with us and we have to come to terms with this.

The Search for Food-Related Behaviors Linked to Obesity

Despite the fact that there have been major shifts in the food supply, increased reliance on fast food, increased meal skipping, reduction in family meals, increased variety of foods, increased portion size, increased consumption of soft drinks, none of those changes in the food environment

have yet been linked to the issue of obesity. I think it is likely that we will identify those food-related behaviors in the very near future, and a leading candidate is portion size.

Political Will

The final element that we need to work on is the political will. As I indicated at the outset, I think that both Secretary of Agriculture Ann Veneman and Secretary Thompson and this administration have provided the political will. The allocation of \$100 million to this problem, although only a beginning, is a much more substantial increase in our budget than we have ever received.

There are other clear indications that a political will to change the way we do business is emerging. For example, during visits to Oregon, Kansas and Texas, each State either released a strategic plan or described efforts to develop the political base necessary to move these issues forward.

These changes are also happening at the national level with other potential allies that have not been traditional partners in this effort. For example, the American Academy of Pediatrics has announced that childhood obesity is going to become its major focus for the next year. The Robert Wood Johnson Foundation is going to target obesity, although it is not yet clear which population will be their focus. The Institute of Medicine (IOM) is forming a panel on the prevention of childhood obesity. I was delighted to learn about the IOM panel supported by the USDA to review the WIC food package. Those two groups need to interact.

In addition, the IOM formed a panel to review the role of transportation in the promotion of physical activity, another opportunity for childhood obesity prevention. Last year, the American Dietetic Association announced that childhood obesity was its highest priority.

Not only do we have the emergence of the political will at the national level, but it is reflected and amplified by local and State-based coalitions. In turn, effective major partners such as the Robert Wood Johnson Foundation, the American Academy of Pediatrics, and the American Dietetic Association have supplemented State and local projects.

These efforts must continue. We need coordinated and complementary programs. It is clear that this process has already started and the CDC looks forward to continued discussion and support of the USDA programs. Thank you.

Connections Across Cultures and the Life Cycle

Yvonne Bronner, ScD, RD, LD, Professor and Director of School of Public Health, Morgan State University, Baltimore, MD

It is a pleasure and a great opportunity for me to be here today. The first thing I would like to note following Dr. Dietz's presentation is that obesity is an equal opportunity problem. One of the things that we find is that it is everywhere. So, it gives us a great opportunity to come together and to rally ourselves around something that affects all of us.

I will address the issue of nutrition education connections across cultures and the life cycle. My training is in maternal and child health and the life cycle has been a very important concept for me. As we participate in the whole nutrition education/obesity challenge, the life cycle is looming great, along with the family as the focus for change.

I was very encouraged to see the logo on which the father is portrayed. I have had a real interest in the promotion of the father's role in family health for a number of years.

First, I will share with you my experience with a cardiovascular disease enhanced dissemination and utilization project in Baltimore. These are fondly called EDUC's. We are trying to see how empowering information can be. Second, I will describe how nutrition education in an urban setting must consider culture and how it benefits from considering the life cycle and intergenerational linkages.

Baltimore City Cardiovascular Disease EDUC Project

So, what is the Baltimore City Cardiovascular Disease Enhanced Dissemination and Utilization Centers (EDUC) project? It is a community-based participatory project to enhance the dissemination and utilization of National Heart, Lung, and Blood Institute (NHLBI) cardiovascular disease education materials and messages for at-risk populations.

While it is not very different from most of what all of us do, it is the first and only EDUC that is administered through a public housing authority project. Right away you can see that we have a wonderful opportunity to help because we are in the midst of people who really need this project, and the education and information provided, the most.

This EDUC is also a partnership. Our partnership has four components. We are working with:

- 1) Housing Authority of Baltimore—They are the fiduciary for this project. They receive the funds and then disperse them.
- 2) Morgan State University—has two components that are working on the project:
 - a. Public Health Program, with responsibility for developing the conceptual and theoretical models and monitoring the intervention,
 - b. Engineering—with responsibility for evaluation and developing the program model. We hope that as a result of this project, we will be able to spread across the United States through the Housing and Urban Development (HUD). We are using engineering technology and system theory to develop the model for this project.
- 3) Baltimore City Housing and Urban Development (HUD)—responsible for developing the implementation and community health worker model.
- 4) Parks and Recreation Department—responsible for partnering to develop the physical activity (PA) component.

Our partnerships are very rich in the components that we think will be necessary to make this work.

Planning Process Towards Development of a Successful Community-Based Participatory Project

The EDUC is community-based and participatory. The first thing we did was to use an 18-month planning period to get to know the community and for the community to get to know us. Sometimes we send out letters of agreement when sending a grant proposal and we want them to sign quickly because the FedEx man is waiting out there in the hallway.

Well, this didn't happen that way. We started out 18 months before the proposal was to be submitted and we did some relationship building. In the African American community, in particular, we do business by relationship. So, it is very important for us to get to know each other.

Next, we conducted some qualitative research to know what the people wanted. Another component of work that is not successful is giving people our theoretically-based opinions on what needs to happen. What happens is that it stays in theory, not in practice.

Lastly, we asked the residents to review the materials that NHLBI produced over recent years to see how relevant they were. Did they really communicate to them? Were they the kinds of materials that they would find useful? We found that the materials that NHLBI has produced were not necessarily relevant.

Value of Using the Community Health Worker Model

Now we are going back to the drawing table. We are using a community health worker model. We wanted to be able to engage people who were close to the environment: who knew what it meant to have to walk down sidewalks with broken glass, that did not exist in spots, with boarded-up housing, and in areas where you had to pass several liquor stores en route, where there had just been a killing the night before, and there may have been a pending drug deal going down on the corner.

We wanted people who understood this. So, we are engaging community health workers to help us get this work done. Now, I am going to ask Dr. Dietz if he would be kind enough to consider helping us out here because we have 60,000 people in our housing authority and we were funded for two community health workers—Two—T-w-o.

The community health worker is very important because they are people who live among the target population. They learn from the people, work with the people, start with what the people know, build on what the people have, and teach by showing; learn by doing.

This is a model that we think has the potential for helping us understand what the problem is. We are training the community health workers at the local community college and have received college credit for the training.

This was very important because we are about the business of building careers for people and helping them move forward. We are also engaging our youth. We are forming youth corps and will be training them on the cardiovascular disease messages because these messages cross generations.

We are engaging the residents in committees and health clubs. We are going to have a health fair and involve the media in this fair. We will do screenings and have fitness/exercise, smoking cessation, and cooking classes. We want to involve our local politicians as well as advocacy groups from throughout the Housing Authority. We do not want there to be a single person who is not aware of this very important activity.

Lessons Learned Regarding Culture

The next two or three points are so important. They are lessons that I am continuing to learn as I work with this population. The first lesson involves aspects of culture to consider when you are working in urban settings. I thought I knew a lot about culture in urban settings. I grew up in a very poor neighborhood and felt like I would just be able to go right in there and "hang."

The truth is that I was not able to go in there and hang, if you will. There were several reasons why. I will talk about cultural attitudes, beliefs, and practices that are on the side of the residents and those that are on the side of the project team because it is a two-way street.

We are all noticing that ethnicity is changing rapidly within the United States. If you have been listening to the news and hearing the reports on the census, you know that we are seeing some shifts. This means a couple of things. First, your clients are likely to be very different. When we go into the urban setting, we are not just seeing African Americans. We are seeing many different cultures.

Staff who work with clients are not the same either. We are trying to get African Americans, Hispanics, Native Americans, et cetera, as staff. We have to get to know each other. It is not all just about the nutrition education; we have to get along.

Second, it has to do with the length of time we have been working together. You bring these people together and then you expect them to be able to speak Spanish overnight and understand all of these foods. It is not going to happen. It takes time. We also have to become sensitive to and aware of all of the different religious practices.

Then, there is the education divide. There are so many assumptions that are made, especially in the African American community. We are not homogenous when it comes to educational level within a Housing Authority. Because of the issues around employability, people who have very high levels of education may be within the Housing Authority, but they cannot find other housing. Thus, you should not make the assumption that everybody you see is uneducated. Then, there is the economic divide, the technology divide, and the personal biases that we all bring to the table. All of these are issues we have to pay attention to on the cultural side.

Issues Related to the Life Cycle

Now, I want to talk about the life cycle side. One of the most important aspects of the problem of obesity is that it is rare that we find an infant or a newborn that is already overweight and obese. Most of them fall within the range of normality, which means that overweight and obesity develops after that point. During the preconceptional period, we can begin to work on the issue of not just folic acid, but obesity and food habits. When working within food assistance programs, it is important that we use the teachable moments during pregnancy, infancy, early childhood and in the family to get our messages across.

We underutilize and undervalue the childhood and adolescent periods. We will see if we can get a youth volunteer corps to help us solve some of these problems in the Housing Authority. We think that a lot of the "standing on the corner" and getting into trouble behavior occurs because we have not engaged our youth in more meaningful activities.

I am hoping that we can begin to pull them in so that they can receive nutrition education and appropriate foods from the many programs that they are eligible for.

Moving to adults, we have several programs intended to bring the family back together. In the studies we conducted over the five years while working at Johns Hopkins University on the male role in family health, we found that while women make many decisions, those decisions are influenced by their significant others. It did not matter whether he was present in the home or absent. He still had an impact on the decisions that were made.

We want to value and applaud the father's role and the male role in family health. We want to celebrate and engage that in our problem solving. We are looking forward to doing this in the Housing Authority project.

Finally, we come to our more mature adults. We had a project in the churches when I was at Hopkins as well. The mature adults we worked with said that they were very interested in learning about food, nutrition, and physical activity because they did not want their grandchildren to fall into the same for health habits and conditions that they had already fallen into.

In closing, what we emphasize is the long view for nutrition education and the value of intergenerational linkages. We know that early dietary and

physical activity habits influence the onset and course of later diseases. We should place great emphasis on starting early and applauding the family throughout the life cycle.

FNS Vision of Integrated, Cross-Program Approaches

**Alberta Frost, Director, Office of Analysis, Nutrition and Evaluation,
Food and Nutrition Service, US Department of Agriculture,
Alexandria, Virginia**

I would like to add my welcome to Roberto's and Eric's earlier. When this meeting was a twinkle in the eye of Judy Wilson about two and a half years ago, we sat around and wondered whether anybody would come if we had a meeting. I can't tell you how thrilled we are to see you all here in Washington. We think this conference is a great idea and we are really happy to welcome you here.

I am going to be speaking about starting to create the long-term integrated nutrition education strategy for the food and nutrition assistance programs. As you know, the major impetus for creating the Food and Nutrition Service (FNS) was to fight hunger and malnutrition by providing food assistance to children in low-income families. Historically, food security has been the focus of FNS programs and the facts suggest that we have been, if not perfectly, certainly remarkably successful.

In the year 2001, almost 90 percent of U.S. households had access to enough food during the entire year. Among the 11 million plus families who did experience food insecurity, children were generally shielded from hunger. We believe that the 15 FNS programs made a substantial contribution to this record.

However, over the last decade or more, a transition in FNS programs has taken place. Our commitment to use the programs to promote both food security and healthy eating grew during this time. The shift occurred in response to a heightened understanding of the role nutrition plays in preventing some diseases and premature deaths and more recently, as you have heard several of the speakers mention today, alarming health trends.

The bottom line is that the physical and mental well-being of low income Americans and children require FNS programs to attend more equally to providing both nutrition assistance and nutrition education. Our commitment to more balance in the program focus is reflected in a number of visible and significant steps. In the agency's strategic plan, which began in the year 2000, the objective of healthier food choices by our program

participants became an explicit part of the broader goal to improve nutrition among children and low-income people.

More concretely, the vitality and the amount of nutrition education taking place under the FNS umbrella have increased substantially. The creation and the positive evaluation of Team Nutrition, the growing number of States that provide food stamp nutrition education, the initiative to revitalize WIC nutrition services and the reenergized WIC breastfeeding campaign, all testify to this shift in program focus.

We have also started the process of creating a long-term integrated nutrition strategy for the FNS programs. There is potential value, we think, in such an approach for all stakeholders. If successful, it could enable us to use our limited resources more efficiently and more effectively. By working across programs and sending consistent messages to all our program participants, we stand a chance of actually changing life style behaviors for the better.

Some of you have participated in our initial consultations about creating an integrated nutrition education plan. We value those contributions and we appreciate your patience as the process continues. Anyone from a State that is working on its own approach to integrating nutrition services can fully appreciate the challenge of just defining what integration means. That is before you even get to the action steps.

Although the details are still evolving, several goals have become clear to us and include:

1. Greater nutrition education focus needs to be given within individual nutrition assistance programs.
2. There must be integration across the programs, that is, a package of nutrition education services that form a coordinated whole.
3. There need to be partnerships and stable State infrastructures to support and lead this coordinated approach.

We would like to see a completed puzzle, where each piece has its own beauty and each nutrition education program makes its own contribution to its participants, but these pieces also should fit together into a larger, more vibrant picture. I would like to elaborate more on each one of these goals.

First, on focusing within the programs: It is no longer enough for administrators and managers to think of and operate FNS programs solely in terms of the food support that they provide. It is essential that the nutrition education community raise the awareness of Federal, State and

local program managers of the fact that FNS programs are intended to, and can, promote both food security and healthy eating.

When I talk about raising this awareness, I am speaking mostly to those who are working in State or local education and social service agencies. In these agencies, there may be a great gulf right now between policy managers who are involved in the main line of the education or social welfare programs and not as involved as we think they should be in the nutrition education and the health aspects of our programs.

Such understanding should be reflected not only through nutrition education for program participants and in outreach efforts, but also in office environments at all levels, especially in those places that program participants visit in order to support and model healthy nutrition behaviors.

There is another dimension to increased focus. I can best describe it as the understanding that no single FNS program can meet all the nutrition education needs of its participants. In truth, our programs are intended to operate together and many participants in one program also receive benefits either occasionally or consistently or could receive them from another program.

Some people participate in one of our programs periodically and in another one regularly. Just as the food program benefits come together to better meet a family's total food needs, so should nutrition education provided in one complement the skills, knowledge and behavior taught in the others. The same information should reach all family members and repeatedly reach them at the important points in the food decision-making process in school, at the store, at the community health center, and other sites where low-income families receive social services.

Both effectiveness and efficiency require careful thinking in ultimately choosing the target audiences of nutrition education, what those audiences are taught, and what is the best setting for the particular intervention. Again, it is important for Federal, State and local decision-makers to thoughtfully consider the available options and be selective. We acknowledge FNS's responsibility for leadership when it comes to identifying such choices in setting priorities. This is particularly challenging, given the universal tendency to view any movement towards standard setting as too prescriptive. Our goal is to provide leadership, but we don't intend to provide a cookie cutter.

The second goal or area of focus is integration and I would like to speak of two aspects that merit some mention. The first is the need to make sure that the nutrition education provided is science-based. The application of science should cover all aspects of nutrition education, including an assessment of target audience needs, accurate information delivery, and the honest determination of the impact of the education that is being delivered.

This is not necessarily requiring new research, but does imply familiarity with the current body of knowledge and keeping track of already developed interventions, which ones are successful and which ones could apply to me. The States have a responsibility and an important leadership role to encourage initiatives that are based on sound and current science and to follow-up with appropriate oversight.

Integration also means that Federal, State and local stakeholders share responsibility for effectively communicating the implications of science for policy makers who are not nutrition experts. It is easy even for educated people to misinterpret, overlook, or ignore the science of nutrition. Witness the many extremely serious discussions about the relative merits of one popular diet versus another and the virtues of one supplement of the month versus another. We really have a responsibility as a community to educate and keep the current science in front of policy makers who are influential in all of our lives.

The second dimension of integration is perhaps more obvious than that; coordination across and within 15 FNS programs to achieve a seamless whole with respect to any policy area is challenging. Fortunately, getting there involves one step at a time. The journey starts with sharing information and developing relationships.

Later on, strategic planning and decision-making should consider multi-program impact. One of the early questions to address is how to use individual program initiatives in a manner that serves all family members. Nutrition education delivered through FNS programs has tended to focus heavily on children, with more limited attention to parents, other household adults, or childcare providers outside the family.

Given both the influential role that these adults play in children's lives, as well as their own need for healthier diets, we believe that more attention to the adults in children's lives is needed. Parents are still key gatekeepers, especially in terms of foods available in the home. It is their role not only to ensure that healthy food choices are offered, but also to be role models in

their own eating and physical activity behaviors. Our programs can help them be good gatekeepers and role models.

The last point that I would like to discuss is about partnership and infrastructure. Long-term success means building relationships. You have certainly heard that several times today already – an infrastructure that extends the reach of our nutrition education efforts and offers continuity – I think that is very important – continuity over time. This means community connections to leverage resources and tackle activities that are outside the authority or the control of FNS programs.

A few success stories come to mind. One is the nutrition community whose positive impacts on children's nutrition knowledge, attitudes, and behaviors have been rigorously tested. Another example involves the State nutrition education networks that have increased so much in number that there is now a national association of these organizations. The third example is that USDA and DHHS recently signed a multi-agency memorandum of understanding to collaborate on the 5-A-Day campaign. So, we do have successes that we can look at, learn from, and work on.

This conference was planned not only to offer individual networking opportunities but also to initiate some serious cross-program integration of nutrition education within States. Some of you have been asked to participate in the "connecting for success" conference track that begins immediately after this session. During the next few days we hope that your State group will discuss and choose at least one nutrition education goal to pursue together after the conference in a coordinated way across FNS programs.

We have facilitated this first step by creating a master agenda of alternative goals that are part of the agency's priority initiatives for this fiscal year. They are also part of the broader Federal initiative, Healthy People 2010, as well as the President's HealthierUS effort. Choosing your goal from the menu offered does not require a State to give up or change priorities among the current components of its program specific nutrition education plans.

In fact, the individual options are broad enough to cover many existing activities. The purpose is to find the facets of nutrition education that can be addressed across all the programs. This experience will provide valuable information to both States and FNS as we seek increased integration.

It is likely that many of you will be engaged in this effort in a variety of ways over the next several months and years. Consider it an important expedition

with a powerful incentive. Together we can reach millions of program participants where they live, where they work and learn and make a significant contribution to creating healthy productive lives.

Thank you very much for coming and thank you for the work that I know you all are about to undertake during this conference and after you leave. Thanks.

Motivational Interviewing 101

Moderator: Lissa Ong, Nutritionist, WRO, Food and Nutrition Service, San Francisco, CA

Gary S. Rose, PhD, Clinical Instructor, Harvard University Medical School, Steering Committee, Motivational Interviewing Network of Trainers, Cambridge, Massachusetts

I am a clinical psychologist hailing from Boston and, among other things, I have taught and trained many health care professionals in motivational interviewing (MI). We did a three-hour workshop this morning, so I get to hear myself say the same things over again only twice as fast. You all get to hear it for the first time. I will provide a smorgasbord on motivational interviewing. I will touch on some of the more important concepts and ideas and introduce a few tools that may be helpful in getting the ball rolling should you want to use this method.

Motivational interviewing is a style of talking to people about change that started in this country as an alternative to confrontational ways of talking to people about their alcohol and drug problems. It developed in Europe as a style of talking to people about health behavior change in a more general sense, and it has gone through a number of iterations. Now, much work is being done on using this as a consultation model, a way of teaching and supervision, and a way of trying to increase motivation of caregivers, people who are working with folks who have illness or foster parents. The web site to access any information that I talk about is www.motivationalinterview.org; tapes are available there as well. I will introduce a couple of concepts that are important in order to understand this model. Then, we will go through what we call the "pyramid model of steps" to do an MI-consistent intervention and I will show a few videos.

The Righting Reflex

First, I am going to talk about the righting reflex. It is one of the basic ways that motivational interviewing is different than traditional ways of doing health care consultation. One of the ways it is different from traditional ways of talking to people about change is in how we approach the nature of a problem. Traditional health care consultation is an advocacy model. The clinician takes it as his or her responsibility to try and persuade, advocate, and directly suggest to the patient that they change.



Motivational interviewing is a self-advocacy model. In other words, fundamental to this model is the concept that we want to create a situation in the consultation room where the client or patient is given the opportunity to begin to talk about, think about, entertain, and hypothesize about making change. We want them to convince us that it is a good idea to change versus us trying to convince them that it's a good idea to change.

The Decisional Matrix

To talk about this, I need to introduce the decisional matrix. The matrix is this 2 x 2 table that does a very nice job of allowing us to map out all sides of an issue, whatever it might be.



Respect Ambivalence

	STAYING THE SAME: SMOKING	CHANGING: SMOKE-FREE
	BENEFITS OF: Taste, smoke in throat, buzz "Best friend" Fills time Boredom Friends/family smoke Stress break Relaxes Coping: Anxiety, depression Weight mgmnt. Great with coffee	Feel healthier More energy Lose fear of future Independence/ Control Self-respect Self-esteem Good example for kids Doing the right thing LLP: <u>Live Long & Prosper</u>
COSTS OF:	\$\$ Inconvenient Pariah yellow fingers, teeth, skin bad breath cough, colds, no stamina Lost friends/ dates Grandson's asthma Nicotine fits	Withdrawal \$\$ of Tx Weight gain Headaches Lost identity "Who am I?" Lost friends Peer rejection No coping strategies Boredom No Alt. Pleasures Fear of failure



Gary S. Rose, Ph.D. grosephd@erols.com

This is about smoking, but you could use this matrix with eating, job change, etc. It allows us to look at all sides of the issue and it does a very good job of putting in words and on paper what we mean by ambivalence. Essential to motivational interviewing is the concept of ambivalence, and ambivalence is normal, it's almost always there. The only time you don't have ambivalence is when somebody does not at all want to change, and somebody is in what we call the pre-contemplative gain stage in the Prochaska & DiClemente model. Otherwise, there is ambivalence. Using this matrix, you can take anybody you are working with and complete a matrix based on the target behavior.

Built into this matrix are two different kinds of concepts, ideas, or conversations. First, built into the matrix is what we call change talk oriented focus or conversation.



Change Talk

	MAINTAINING MY CURRENT:	CHANGING MY CURRENT:
BENEFITS OF:		<i>Change Talk</i>
COSTS OF:	<i>Change Talk</i>	



If you are talking to somebody or listening to them talk to you about the cons, the costs of continuing to smoke, the costs of eating whatever I want, or the benefits of perhaps giving up smoking, giving up drinking, adopting a healthier lifestyle; if we're having a conversation with these two topics, where one or the other are the focus, then we're talking or listening to somebody talk about change. It's forward moving and the focus is on change. "I can't breath as well as I used to, my pants don't fit anymore, I'd be so much more active if I lost weight, if I stopped smoking." You see the cons of staying the same, pros of change, and the change focus. That's one conversation built into the matrix—one side of the issue.

The other side of the issue that is built into this matrix is a conversation, a focus, on staying the same—on the *status quo*.



Status Quo Talk

	MAINTAINING MY CURRENT:	CHANGING MY CURRENT:
BENEFITS OF:	<i>Status Quo Talk</i>	
COSTS OF:		<i>Status Quo Talk</i>



If we are listening to somebody tell us what they enjoy about being able to rush out at lunch time and grab a sub sandwich or go to a fast food restaurant, or they are telling us that smoking is relaxing, or that drinking takes the edge off, they are talking about status quo. They are talking about the benefits of staying the same, and about what we call status quo talk. If somebody is talking to us or we are talking to them about the costs of treatment, the impact of withdrawal early in smoking, and the costs of shopping in the fruit and vegetable store and, then, they are moaning and groaning about those kinds of things and are talking about staying the same, they are talking about status quo. So, we can listen or talk to people about change or we can listen or talk to them about staying the same. We can talk about change or we can talk about "squat." Both of these conversations are built into this matrix.

Examples of the Righting Reflex

Now, think of a health care provider who is right out of medical school or graduate school training. I like to use a physician as an example because they have the most personal debt when they get out of school and they have the biggest reason to feel like they are doing a good job, because they could have taken all that money and invested it in a bunch of pizza stores and made a fortune. Imagine this health care provider having a conversation with a man who has just had a heart attack and continues to smoke.

Which of the four topics in this matrix is our physician or health care provider most likely to start in trying to do his or her best job of persuading the patient to change? Pros of staying the same, cons of staying the same, pros of change, cons of change? Which of our four topics? Costs of staying the same? One or the other of the change talk topics is what our practitioner is most likely to begin with. How might that conversation go? "Mr. Smith, did you know that at three days after you stop smoking, your lungs are going to start to clear. Four weeks after smoking, the color comes back in your cheeks. Six years after smoking, you'll be as healthy as any other 97-year-old man. Don't you want to do it?" Kind and gentle change talk.

When this gentleman comes back three months later reeking of cigarette smoke, how do you think the conversation will go? It is still change talk, but it's less kind and less gentle. And, the finger always comes out, right? "What is it going to take? Here's a picture of your heart. I want you to take this pen and put an X through the parts of that muscle that you don't think you

need, because you are going to have another heart attack, sir." That's how it goes—change talk. It's called the righting reflex—the urge to try and directly persuade the person to change by taking up the argument for change.

Sometimes this works. It works when the person is almost ready to do what you want them to do. Most of the time it doesn't work, and this is the source of a lot of distress among health care providers—"Why don't people listen to me?" Do you want to know why? Ask yourself. How do I handle ambivalence? Most people are ambivalent, they have some mixed feelings about making health behavior changes. As we see with the smoker, there are always some good reasons to behave badly and to continue high-risk behavior. The good reasons may be idiosyncratic, "Smoking relaxes me," maybe very short term, "I love the taste," but they are there. So, if you are ambivalent and are in a conversation with somebody in which they are supporting one side of your mixed feelings—anybody ever have that happen? It happens all the time.

What happens? Where do you go with your feelings, with the things that you think about and talk about? What happens? You bounce to the other side. For example, think of two guys out having a drink or having some coffee on a Friday night. One of them is moaning, groaning, and whining about his 27 year old son who failed college a hundred times, is in bed all day long, doesn't do anything at all, a no-good-nik kind of kid; he goes on and on and on. He takes a breath and his friend pops into the conversation in a nice supportive way and says something like, "I've known you since that kid was born; he was the ugliest baby I have ever seen in my life. I wish that they had swapped him in the nursery and it's gone downhill from there." How is our first guy likely to respond to that? "He's not that bad, he treats his mother like a queen, takes out the garbage, and he is going to make a great rock and roll star one of these days." He flips to the other side. That is what happens often in health care. The harder we argue for change, the more the clients and patients think and talk about it, and, if they have the courage, argue back for staying the same. The harder they argue for change, the more they stay the same—this results in the righting reflex, and the taking sides trap.

"You'd be better off if you stop smoking." "Smoking relaxes me." "You can do it." "No, I can't." "Oh, just a little patch, a little this." "Do you know what the patch costs buddy?" "When was the last time you looked at your health insurance?" In that way, we get into the wrestling match called the righting reflex. We are going to show you a very brief video that demonstrates this; as you are watching, ask yourself who's arguing for change and who's arguing for staying the same.

Who's arguing for change and who's arguing for staying the same? The doctor talks about many of the costs of staying the same such as: "Smoking will kill you, it's the worst thing for you, half a bottle of wine is not moderate drinking, and fried foods will kill you." He is giving a lot of change talk, the cons of staying the same. He's also giving us a tad bit of the kinder gentler change talk such as: "We're going to set you up to live a long and prosperous life, feeling good now, more so tomorrow." We see the doctor arguing for change—how does the very human patient respond? What does he say? "I feel fine, smoking relaxes me, it's been pretty darn stressful around here with all these heart attacks, you know. I've cut back, I've tried to quit and that doesn't work." He is giving us the pros of staying the same, but also the cons of change. "Cold turkey quitting doesn't work for me. What about the side effects? I've got a whole handful of those." "No pain, no gain," is what the doctor says. Here we see the wrestling match of the righting reflex. I argue that you ought to change for very good reasons, you counter with the other side of the argument.

Relapse Triggers

Why do we want to know this status quo stuff? "Smoking relaxes me, I like the taste of a hamburger, I'm afraid of withdrawal." Why do we want to know the benefits of continuing to stay the same? What will be of value to us down the road in working with someone? Well, these are the relapse triggers. At the moment in time when someone feels very anxious, they're going to start smoking again or start doing stress eating—these are the relapse triggers. In the "benefits of staying the same" quadrant are all the relapse triggers that a person is telling us; it shows what function this high-risk behavior plays in their life. The relapse triggers are there.

One of the many reasons that we want to know about the relapse triggers is that, as it is written in the Bible, "Thou must giveth if thou taketh away." Be very careful when you ask people to give up things that they find positively reinforcing. Because if there's no substitute and there is nothing else to take its place, they are going to be in a position of very unstable change. People have to have another way to get the same buzz and to cope, before they are going to be able to manage and maintain change. In motivational interviewing, we try very hard to avoid the righting reflex and there are a number of ways we do that.

Listen, Listen, Listen...Listen

For the sake of time, all I need to say is that we try to listen, listen, listen, listen, listen, and listen more to all sides of the issue. We try to use as an

operating principle that, unless and until I can fill out all of these four quadrants of the matrix for my client, I don't really understand sufficiently what's going on for them. But, avoid the righting reflex. Try to figure out a way to learn from your client what they like, or what they find reinforcing, what they find enjoyable, about their high-risk behaviors, and also what they find difficult, cumbersome, or confusing about coming over to the right side.

We try to always allow the client to voice the argument for change, and that is because we know from research that what people say predicts behavior change. The best predictor of whether I am going to do something or not is if I tell you I'm going to do it. The only thing we can do within a consultation session (unless we're going to walk the person out the door, take them home, cook them a meal, slap them silly if they have a cigarette, and run them around the block) is use words to manipulate and change the words they say to us. We say things and then they say things back.

Bill Miller, one of the originators of motivational interviewing says that the best way to teach motivational interviewing is to teach this one simple principle. Go to your office and say a bunch of things to your next client or patient. If they come back and respond with change talk; for example, "I ought to change, I want to change, I'm concerned, I can do it," keep saying what you're doing; or, if they come back with status quo talk, "I don't want to change, the thing I'm doing now is kind of helpful in my life;" then change what you are doing. Very simply, we need to figure out a way to invite people to begin to talk to us, to self-advocate for change, rather than our doing the advocacy.

Point number one: we don't need no stinking righting reflex. MI is a model based on dancing rather than wrestling with people. We saw a beautiful wrestling match here. But, the moment that you are wrestling, struggling, arguing, and going point to point to point with a client, you are not doing motivational interviewing, and we go even further in saying that you have limitations as to how effective you can be as a health behavior change person.

Respect Natural Change

Point number two: respect natural change. Most people change on their own without ever accessing health care or self-help resources. There are incredibly powerful natural change forces in the environment, a lot having to do with people's cycling through different periods in their life. For

example, most people, who as late adolescents or early adults have had a drinking problem, mature out of it as soon as they pick up a career, get married, have a child, etc. Respect natural change, and this harkens back to the stages of change model. That model really started as a way of understanding how people change on their own, because the first smokers that Prochaska & DiClemente talked to were self-changers.

What we know about natural change is that people start thinking about change before they ever make a behavior change. Thinking about change occurs before behaving. What we know about successful changers is that the difference between a successful and unsuccessful change attempt, for example quitting smoking, is not about somebody doing something differently, but rather about thinking about the situation differently. If you ask smokers or drinkers who stop or anybody who's made a big change, "What was different about this time; you tried it 12 other times, this time did you do the patch, did you do something else different? What happened?" What they say is, "I thought about it differently. The look on my kid's face when I lit up that cigar in the garage—that mixed look of excitement and intense fear scared me and I said to myself, 'I can't smoke anymore.' And that was it. I read the brochures. I didn't do anything differently; somehow I thought about it differently."

What we need to do when we talk to people about change, and try to motivate them or get them to motivate themselves to make some changes, and stick with the changes, is to help them think differently about the situation rather than educate them on how to behave differently. Most people know what they need to do; behavior change is more about motivation than it is about education.

What happens with all this thinking and contemplation that people go through that seems to be determinative of success? What happens is that people begin to make a link between things that really matter to them; called core values, goals, beliefs; and health behavior change. The moment that somebody makes the connection that the way I'm leading my life today gets in the way of me achieving the goals that really matter or gets in the way of me becoming the person I want to be. That's a moment in time when we get some significant motivation to change and you can often see some very quick health behavior change.

The challenge in adopting this approach to talking to people about health behavior change is to begin to think about the fact that health behavior, and being healthy, is hardly ever at the top of anybody's list in terms of goals. Did anybody wake up today, this morning, and say, "What will make this day

an absolute success is if I do everything possible to stay as healthy as I possibly can?" No—the only time, in general, when people define healthiness as an end in and of itself is when their keister is on fire, when they are really sick or are undergoing some acute treatment, or they have just had a heart attack. Then, for those little windows of time, health is the goal in and of itself. This is why it is so wonderful to work with people who have just gotten out of treatment, just had a heart attack, just had something awful happen, because they listen, right? Anybody work with people, in disease management or rehab? It is a wonderful job because for that moment in time people's ears are perked up—they really, really want to listen. People who work with pregnant women and high-risk pregnancies often say, "I have the most motivated bunch of patients in the world, because for that little period of time, that window, people are really focused." For most of the rest of us, being healthy is not an end goal in and of itself. It is a means to an end.

What I mean is that for most of us, we value our health. Why? Because we want to live long, there are certain things we want to achieve that require being healthy. It is a means to an end. In motivational interviewing, we believe that a very effective way to engage somebody in a conversation about health change is to first start by not even talking about health but rather getting to know the person in a bigger more general sense. What matters to you? How do you see yourself fitting into the world? How do you connect with the people around you? What are your goals, short-term versus long-term? If you are working with somebody who has an end stage disease, you will be working on very short-term goals.

Once we know all that, and appreciating natural change, we try to back-door into health risk reduction. "If you are going to be alive four more months, more than likely, what you want to do in that time is to spend as much time as possible with your grandchildren. The nausea and fatigue from the dialysis get in the way of that. Would you be interested in having a conversation with me about things that you can do to make the dialysis go more smoothly with less fatigue?" "Sure." Then, we have our health care conversation. Is the health care conversation based on the fact that this person wants to do whatever she can to have as smooth a dialysis as possible? No. It's based on the fact that this person would like to not be fatigued so that she can get up and visit her grandchild after the treatment. Do you get the difference? Think of health behavior as a means to an end for most of us. This is the way that people think and is the basis for natural change.

Avoid the righting reflex, respect natural change, and accept the fact that for most of us health is not an end goal but a means to an end. Now, we will get into a little more practical information.

Pyramid Model of Health Behavior Change

This is the "pyramid model of health behavior change."



We put it together a number of years ago as a way to telegraph some of the principles or points of motivational interviewing. You build from the bottom of the pyramid. The first step in doing effective health behavior change is that you have to build rapport. Without rapport, we are not going anywhere. How do you build rapport? Somehow you demonstrate to the person, usually through listening, listening, listening, and more listening, that I'm interested in all sides of the issue. Decisional matrix pros and cons of change is a good rapport builder. Build rapport—the foundation is talk.

Once we build rapport and we have a decent working relationship with the individual, the next step, and part of building rapport is setting an agenda. There are many things that people can talk about, especially people with chronic illnesses. For example, somebody with diabetes has six or seven different things that they can change to get healthy. Where they start does not really matter. Most people have different things they can do to reduce their health risks and put smiles on our faces. Part of the foundation is building rapport and setting an agenda. You can ask, "What would you like to talk about Mr. Johnson?"

Assess Readiness

Then, the next step in our model is to assess readiness. We need to have a quick way of getting a sense of just how ready somebody is to change and

where to go next with them. From Prochaska and DiClemente, we know that what somebody needs from us at different points along the readiness journey varies and we can really blow things by jumping ahead of their readiness or holding them back.

Once we have completed that step, we move into a more directive part of this model which is where we need to provide the information, advice, discuss diagnostics, educate people, talk about treatment options, give them feedback, etc.—what we call more traditional health education. Our goal here is to provide expert information without falling into what we call the "expert trap."

The pinnacle of the model is to negotiate health behavior change with somebody. From the motivational interviewing perspective, we believe that no matter where someone is on this journey of readiness; whether they're just beginning to think about change, stepping up to the plate, or taking action; we can leave them with a prescription for change. We will go through this model now.

Avoid the Expert Trap

The expert trap occurs when "the expert" thinks, "I'm the boss and you're not. If you'll just listen to me things will go well. I'm going to ask you 500 close-ended questions, preferably without making any eye contact. Then, I'm going to throw some diagnostic label on you and, then, I'll tell you what you need to do about it. As long as you listen to me, you'll get better, live long, and prosper. I'm big, you're little." That is an example of the expert trap. The expert trap is a great model for acute medicine. If I come into the hospital in a coma, I want my doctor to be as expert as she can be. As I'm getting wheeled in for brain surgery, I do not, I repeat, I do not want my surgeon to say, "Dr. Rose, we can cut you this way or we can cut you this way, which would you prefer?" I want my provider to be as expert as he or she can be, and I hope that they get paid lots and lots of money, at least while they are doing my surgery.

There are problems with this model when it comes to health behavior change. Some are obvious and some a little less obvious. First, there is no communication going backwards and forwards—we don't know what suits this person and how they go about making changes. Second, there is a real problem when we have the patient or client being so small, powerless, and passive because we are asking people to change exercise habits, dietary habits, cooking habits, recreational habits, and so on. What are we asking them to do? Take charge of their lives, and give up behaviors that are

over-learned and integral to the rest of their life. We are asking them not only to change for today, but to make that change for the rest of their lives. Hardly anybody says, "Well, as long as you stop smoking for a year, then you can pick up a stogie once in a while." It doesn't happen that way. We are asking people to step up to the plate to persist and do something that is very, very hard to do, especially if you are feeling kind of passive. Avoid the expert trap.

Dual Expertise

What we prefer instead is something much more collaborative which we call a model based on dual expertise. This means that whenever we have a consultation, there are two experts in the room. One is the health care provider and the other is the patient or client. The client is an expert in self-change; that is, how I go about making difficult decisions and, once I've made the decision, who I ask for help, what works for me—that kind of thing.

In the video we just saw, who is running the show? The patient, yes, patient-centered consultation, the patient is running the show. The basic rule of good consultation is "Let your client drive things." In health care, somehow we have avoided that. When patients are running the show, with conversation back and forth, and a little more focus on the patient—this is an example of something we call "elicit provider." In this example, the doctor is doing very good listening. What did you observe? A lot of active listening and reflection, and simple little content reflections—that is, what did the guy say, repeat it back, what we call small summaries. When he asks questions they were big wide open questions. How did you feel? What do you think? And so on. All of these types of questions let the client run the conversation for the sake of learning more about his needs. This is dual expertise.

Many topics were brought up. They talked about exercise, diet, alcohol, and smoking. You had a sense that this man was at different stages or points of readiness relative to the topic at hand. Right? There were some things he was already doing, some things he absolutely didn't want to do, and some things he was thinking about. What was he already doing? Aerobic exercise—he was already walking. He was also probably taking his meds and coming to his doctor visits. What did he absolutely not want to do? He did not want to follow any rigid diets. What else didn't he want to do? You're not going to make me do any of that upper body strengthening stuff are you now? What was he in the middle of thinking about and almost ready to change? His alcohol—with the alcohol, he was saying, "I'm going to go home and talk to my wife and think about whether alcohol is a problem or not."

Also, he was just about ready to make small changes to his eating behavior. So, he's all over the place.

Let's say that Monday morning comes, and it is real foggy, this guy stumbles in the wrong door at the community health center and ends up in the office of Bruno, the exercise physiologist. Bruno puts him on the equipment, has him up and down and up and down and up and down and up and down. The session ends, Bruno goes off to the carrot juice bar and is talking to the other exercise physiologist. What is he going to say about our gentleman? "He wasn't motivated, he just doesn't get it." He's going to dis the poor old man.

Imagine that the fog lifts and he walks in the other door and ends up in an aerobics class. He takes off his slacks, puts on his spandex, and he starts doing his thing in the aerobics class. What is the aerobics teacher going to say about him at the end of the session? "He's got it together; he's doing whatever he wants to do." He ends up in the office of a nutritionist who's 14 minutes away from retirement, and the nutritionist pulls out a dusty old food pyramid and a rigid sheet, and waves a finger. What is the nutritionist going to say about this man as he or she packs up the stuff? "Ah, this one's a goner."

If we spend a little time listening, listening, and listening to find out what the person is most ready to change, we are going to catch them behaving well. What is the benefit of catching somebody at their most ready? They buy in, they will change, and we get to have a big smile on our face because it is a nice success. They have developed the beginnings of an effective healthy relationship with us and they are more likely to come back and talk about something else. That is what we mean by agenda setting.

With dual expertise, two people are working together—with me listening to you, letting you run the show, and spending time sorting through all the different things we can talk about today, and there's always more than one thing. For example, one thing I like to talk to all my patients about is weight. When it comes to weight, there are a couple of ways you can go. Some people prefer changing what they eat, other people like starting with doing some exercise. I ask, "Where would you like to go?" We give people two options, we have some agenda setting going on, and it gets better from there. This is what we are looking for in terms of collaboration. A relationship built on rapport and working together with you being a little more equal than me and you telling me where we ought to go.

Building Rapport Quickly

Words that you can use to build rapport very, very quickly include, for example:

- "Let's put our heads together..."
- "Let's review the options and figure out what's best for you."
- "It'll take both of us to figure this one out."
- "You're in the driver's seat..."

You can build rapport by using a sentence. You can start with: "Why don't you come in, let's talk and put our heads together and figure out what's best for your children?" We have now established some rapport that says I'm not going to tell you what to do, we're going to work together. The next step, whether it is done over time or in a brief intervention, is to get a little measure of how ready that person is to make some changes. This will tell us what they need from us and also hopefully tell us what to talk about next.

Importance Confidence Scaling Technique

In motivational interviewing, we do something called the importance confidence scaling technique. We ask questions that are on these two slides.

MI Importance/Confidence

1. How **important** is it for you right now to change?
On a scale of 0 to 10, what number would you give yourself?

0 10
not at all extremely
important important

A. Why are you at **x** and not at **0**?

B. What would need to happen for you to raise your score a couple of points?



Importance/Confidence

2. If you did decide to change, how **confident** are you that you could do it?

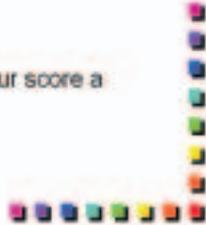
0 10

not at all extremely
confident confident

A. Why are you at **x** and not at **0**?

B. What would need to happen for you to raise your score a couple of points?

C. How can I help you get there?



We are trying to get people to rate how important it is to make a change right now, and also how confident they are that if they decided today to do it, they would be able to do it. Where do the concepts of importance and confidence come from? We need to look back at the stages of change and at things that people are struggling with. Early on in the stages of change or the journey to readiness, people are really struggling with importance. Why should I do it? Why should I be bothered? Why should I be worried? Why should I? The issue early on is that people are thinking about change and struggling with importance.

Once they have decided that they ought to make this change, whether it's a health behavior or lifestyle change, they begin to struggle, or at least address, a very different issue, which is confidence. How can I do it? Why should I do it? How can I do it? We try to measure these directly. We ask the questions and we not only try to get some information, but also set the stage for self-advocacy, i.e., for the client to convince us that they ought to change. How might this go?

I'm going to try to role play both sides of this. "Mr. Jones, if it's okay with you (ask permission first), I'd like to ask you a few questions so I can better understand where you're at in terms of doing something about your weight." You can say it a little more eloquently than that. "First of all, on a scale of zero to ten, can you give me a number that reflects just how important it is for you right now to do something about your weight?" "Seven." "It's a seven out of ten—it's pretty important. Why is it a seven and not a zero? Why is it important?" Why is it so important, inviting you to convince me. "Well, you know, I have gained 25 pounds in the last three years and it's kind of consistent weight gain. I'm hitting 50 and I know it's harder to do and I just

keep buying bigger and bigger clothes. I'm starting to feel this kind of pain in my chest when I'm working outside and I had it checked out. Thank goodness, it's not any heart illness, but I'm starting to get worried about it." Summarize it. "So, it's a seven instead of a zero because you've had some consistent weight gain, you're concerned that at your age it's going to get harder and harder to lose weight, and you're starting to feel some kind of symptoms." "What would have to happen to raise that seven up, just a little bit, to maybe an eight? What would have to happen to make it just a little more important to do something about your weight?" "Well, if I really started to look bad, that would do it. If I went out and somebody called me granddad, that would do it. If I had to start shopping in the husky section, that would do it." And so on and so forth. What did we learn about this person? Appearance! Vanity! Vanity is where the motivation is rather than health. Health is an issue, but vanity is the gold standard.

"Ok, Mr. Jones, let me ask you another question if it's ok." "Sure." "If today were the day that you decided to do something about your weight, how confident are you that you could start to do something and succeed? Zero to ten." "Probably a three." Not very confident. "Why is it a three and not a zero?" "Well, I lost weight before." "What would have to happen to raise that three up a little bit to about a five?" "Well, if I could ever stop drinking that might do it, because that's what puts the weight on. But, I tried to do that and I can't do it, and if you had my wife you'd drink, too." I rate this importance eight and confidence two. Generally speaking, we would say, "Where do you go next?" Raise importance or build confidence? Importance is probably high enough at eight that you can leave it alone, but we have to do something about this confidence, i.e., we have to do something about his drinking.

The importance confidence technique tells us very quickly where this person is on our readiness journey, in terms of the size of the numbers. Secondly, do we need to work on building importance or raising confidence? We generally suggest building importance first. Thirdly, what on earth should we talk to him about next? What makes sense in his life, what has meaning in his life, relative to weight loss? This next video shows something called looking forward, which is another way of asking "What would have to happen to raise your importance score?" Ask yourself, if I were to have another conversation with this individual who is a smoker, the goal of which would be to raise her sense of importance of change ("Why should I stop smoking?"), what would I talk about?

What would you talk about next? Where's the beef? Where's the motivation? What would have to happen to raise her importance score up a bit? What's

the thing that's of most concern to her about her smoking? She says coughing and following the same path as her father, but the money, folks, is on the phlegm, on that little hairy green bugger there in the handkerchief. Having a constructive conversation about phlegm is where you would want to go with her. Now what textbook do you know that says that on the second visit with a smoker, talk about phlegm? It's not there; they talk about lungs and other things, the lungs are an issue but the phlegm is it. What does phlegm mean to her? Everybody has to come up with an answer and then say the same thing at the same time. What does phlegm mean to her? Embarrassment. What does phlegm mean? Unladylike. It's the gold standard, the meaning has to do with her sense of her self as a woman in public. She says, "It might be Okay for a man to do that, but as a woman, I couldn't possibly do that."

So, finding something about self-concept, social appearance, femininity, that kind of thing was important. What she is telling us in two minutes is that if you were to talk to me about how smoking is affecting my femininity and my sense of myself as a woman in public, then I might be willing to consider doing something about my smoking. We want to then have a conversation with her that results in her seeing that she's far enough down the phlegm road to give up smoking, right? That she's lost enough of what matters to give up smoking.

So, how do you do this? Do you use an educational piece talking about the next step is phlegm or...? It all depends on where she's at in terms of readiness. Let's say she was about an eight, she seemed real ready. Then, you could have conversations that were very direct, and you could be a little confrontational. If you could have a heart-to-heart direct conversation about this, what might you talk about in terms of the effects of smoking on her appearance to help her self-confront? You could bring in a mirror and say look in the mirror and describe yourself. If you did that with somebody who walked in the door who said, "Oh, man, I'm just looking for a brochure about smoking because maybe one of these days I'd like to see if my Uncle Fred will stop smoking." and you said, "Look in the mirror..." they're going to run out and light a cigarette. But, if you knew you had some rapport and readiness you might have her look in the mirror, and bring in some photographs of herself three years ago. Then, you can talk about what you observe—premature aging, wrinkles, ashen color, talking like this, all those effects of smoking on appearance for the purpose of helping her say to herself enough is enough. This woman is only about a six in terms of readiness and willingness to do something about her smoking. How could you get this same agenda on the table in a way that doesn't blow her out the window?

You want to establish homework for somebody who is less ready to change and more resistant. You could say, "On your way to work, look around and observe smoking women. Make some notes for yourself and, next time, talk to me about what you observed. The woman might say "Oh, man, they all look awful, wrinkled, old." Maybe she was just about a one in terms of readiness and you still wanted to get the same conversation on the table, and not blow her out the door. How might you do it? On your way home today go to the video store, rent a bunch of classic videos from the 1940's. Go home and watch them. Come on back and let's talk about them.

What is she going to come back with? What is she going to observe in those old 1940's movies when it comes to cigarettes? A lot of women smoking all the time. What is she going to observe about those women? They look sultry, beautiful, and as healthy as can be. We get the flip side of the same conversation going. These women look very healthy, very young, and very youthful. Why might you want to have that kind of conversation? Because if we meet her where she is at, then we are getting the conversation about the connection between smoking, femininity, and physical appearance on the table in a way that doesn't jump ahead of her. What might the next conversation be with her after she comes in and says that one of the famous actresses from the 1940's who smoked in the movies looks so wonderful in the movies, but then she forgot how she looked before when she started looking like a 90-year-old woman when she was 60. She's going to start to see through it very quickly. She might say, "There's no smoke coming out of those cigarettes; they can't really be smoking cigarettes." And on and on, and we move her up the road.

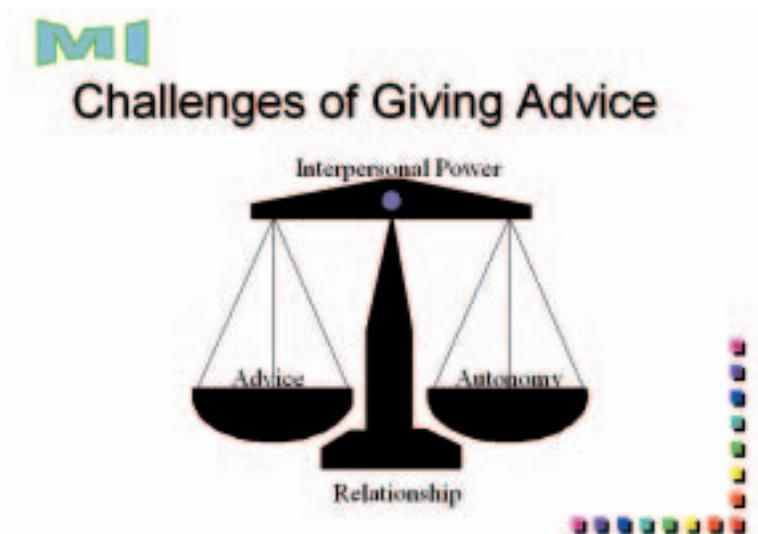
The point is that we are having a conversation with somebody about something that has a lot of meaning to them. We are more likely to increase her willingness and desire to change because she wants to rather than because we think it's a good idea. Now, where does the education and advice come in? It comes in along the way and how we introduce it sets the stage. The idea here is that the importance confidence technique is a simple way to get some quick information about somebody's readiness to change and where to go next.

We have moved through these steps in our model: Build rapport, avoid the righting reflex, let the person decide what we are going to talk about, and find a general idea of their readiness to change. Now, we move into the more active part of this model, whether it's within one brief session or across time: Provide information, advice, feedback, education, discuss treatment options, and so on. What we don't want to do, and this happens all the time, is get to this point, having spent lots of time building rapport,

avoiding being confrontational, doing all the right things, and then fall right into the expert trap. "Okay, now I get to tell him what to do," and then suddenly all the good work is for naught and we have a struggle that can happen when the righting reflex occurs.

Balance of Power in Relationships

The power balance is very, very important in these relationships. This set of scales attests to an important observation.



Balance of power in a relationship like this is very tenuous. The moment that we start to become the expert and give advice and information and take charge, most clients or patients start to feel their power, autonomy, and decision making whittle away – then we start to see the balance of power shift. It's called reactance; threaten to take something away from somebody and they get very grumpy about it. Threaten to take away somebody's power by asserting your authority and they start to feel very grumpy and we get a lot of rebelliousness. We need to give advice and information, discuss treatment, express concerns and caution while also maintaining the relationship. We have two tasks—give expert advice and maintaining rapport. If you blow rapport, what happens to all the expert advice that you are giving? It falls on deaf ears. Maintain rapport as you give advice.

The Concept of "Ask Permission First"

A very simple concept that we see as the first step in keeping the balance of avoiding the expert trap is "Ask permission first." It's like the knock on the door that primary care physicians and nurses do before barging in on you. There was a time when that did not occur. At some point during the last 20

years in medical education, somebody decided that the knock on the door was a very economical way to do what. Why did they do it? It is a very quick way to show respect. It also gives you a chance to get your hands out of their drawers, but the real reason is that it shows respect. Asking permission before giving advice is what we do in the health behavior field that does the same thing. Do you mind if I ask you a few questions? Mind if I talk to you about your weight? Do you mind if I talk to you about some dietary changes you can make? Do you mind if I talk to you about exercise? Mind if I express some concerns I have about your plan to have 6,000 calories before lunch? If it's okay with you, I'd like to ask you some questions. You can come up with your own words.

What does that do? The first thing that it does is that you get a weird look back from your patient, because half the time they'll look at you like you're stupid. What it does is buys you a nice big wide berth of freedom to take charge and become expert. They have bought into it. I guarantee that if you ask permission first, and this is based on what I and many others have found, then it allows you to talk in an expert way and not lose the patient. Just ask permission first—a very, very simple idea.

Avoid Provider-Centered Advice Giving and Give Patient-Centered Advice

Second goal: Avoid provider-centered advice giving and give patient-centered advice instead. Most of the world does client-centered consultation. Health care providers have somehow missed the boat on this. If you think about it, traditional health care advice giving is provider-centered. It starts with what the provider has decided you need to know. Think about the last time you went into a dental hygienist or a dentist or think about the last time your physician talked to you about making some change that you weren't all that hot to change. They typically have decided ahead of time what we need to know. This may or may not be what you need to know. It's provider-centered advice giving—in England they call it chunk, check, chunk, where you give a chunk of information, then you take a breath and check in with the person, "Any questions?", and then you give them another chunk. You may be lucky and have chunked them in the right way, but if you've given them information that they don't need or they already have, you have lost an opportunity.

Elicit, Provide, Elicit

What we try to do in MI is client-centered advice giving, otherwise known as elicit, provide, elicit, ask, tell, ask. Before starting to give information, ask

permission first such as, "Would it be okay with you if we talked about the effects of a high fat diet on diabetes?" "Sure, I'm here anyway, my cab doesn't come for an hour." "What questions do you have about the effects of fat on sugar? What have you tried? What thoughts do you have? What concerns do you have?" You are eliciting from the person first the things that they need to know and setting the context of the conversation. Then, we provide them the information by answering their questions. Then, we elicit back from them their reactions, "What do you think? What do you want to do? Where do we go from here?" Elicit, provide, elicit.

Elicit, provide, elicit: "What do you know? What do you need to know? What are your concerns? What are your thoughts? What have you tried in the past?" Then, provide, provide, provide. Finally, check back in. Elicit first. Educate second.

Tips on Advice Giving

Here are a couple of thoughts about providing information and advice giving. This comes in handy when you are supervising, too. Words matter. In giving advice, you want to avoid the expert trap and try to avoid at all costs the "I" and the "Y" words--these are dirty words when it comes to information exchange: "I think/you should." The moment those words are uttered, nine out of ten clients or patients say to themselves, "Who does he think he is" or something like that and the conversation ends. Use neutral language. I always suggest that people find alternative language that fits and say it over and over. "Research shows..." and "doctors suggest..." are two options. The third person tense is much more neutral, avoids power struggles, and gives people choices. Try to use neutral language and conditional words.

For example, instead of "you ought, you should, why don't you do this," use more neutral and conditional language such as "you might consider, you might think, perhaps you could do this, why not think about that." These words leave the power and control in the person's hands. The moment that they feel like power is being stripped away, they're less likely to listen. So, avoid the "I" and "Y" words in providing advice.

Watch the doses of advice. If you are listening to a counselor's conversation with a patient, how do you know when they have overdosed the patient on information? What do you hear and more importantly, what don't you hear? You may hear a dialogue at the beginning, but when the person's been overdosed, they get quiet. The provider continues to chatter. It's a great

indicator that you have gone beyond, that you have overdosed the client. For example, my 11-year-old son went to a go-cart racing school about two months ago, and they had about 15 to 20 kids from the age of 10 to 16 in the room. Before they got them on the racetrack, an expert gets up and talks about racecar driving. Great guy, he had all sorts of information. For the first 15 minutes of the conversation, every single kid in the room was making eye contact, right up front and center with the guy, with the instructor. At minute 15, the 10-year-olds started fidgeting. At minute 30, every single head in the room was on the table, the guy talked another 15 minutes before he figured it out. He overdosed these kids on information. Watch the dosing of information—smaller doses are very helpful. It's very clear—clients will be communicating, but the minute they stop talking with you, you've lost them.

Reflection Breaks

How do you avoid overdosing? How do you maintain rapport? How do you keep the rapport going? Find opportunities for reflection breaks. What's a reflection break? A reflection break is any opportunity that the client or patient gives you to throw in a simple short summary of what they've just said, what we also call a content reflection. Any time a patient says something back to you in the conversation, that's any opportunity to throw in a reflection. For example, yada yada yada, I'm saying all these meaningful things to you that are really important, la ta da ta da, about how you can change your life, yada yada yada. "So, you're saying to me that if I start eating pickles on Wednesday afternoon that would really help me with my salt intake." What's the reflection break opportunity there? If you were to say a short little summary to repeat back to that person what they said to you, what would you say? "So, you're saying that if every other Wednesday I ate pickles at lunchtime that would help me with my weight?" The short summary would be, "You're thinking about the benefits of eating pickles."

That is what I am talking about in terms of a reflection break. Look for reflection breaks; opportunities to just throw a small little content reflection, a small little summary into the conversation when you are giving advice. These breaks are very helpful in keeping the client engaged. It's helpful in using about 10 to 15 words to communicate to the client that even though I'm doing most of the talking here, I'm still listening to you. It's very helpful to keep the information exchange a dialogue rather than it turning into a monologue. Find opportunities to put little reflections in to give you a break in the advice giving. Anybody who provides advice, education, or information for a living benefits from this concept.

Providing Information in an MI Consistent Way

These are some of the details about how to provide information in an MI consistent way. When it comes to negotiating change, think about offering small positive steps. Do not jump ahead of people's readiness to change. Remember that people think about change before they begin to behave differently. "Thinking about" goals are legitimate for those early in the journey. Also, offer folks a menu of options. What are the benefits of offering people a menu of options for change, things they can do, rather than giving them one option? Choice is great. If I've chosen something, I am more likely to commit to it and stick with it. This makes sense and the research shows that choice is important. It's also a wonderful way to avoid a struggle.

Provide a Menu of Options

Thirdly, the benefits of having more than one option include the following: If the poor patient comes back having failed, and you have given them one option, they're screwed and you are in trouble. If the person has come back having failed and there were many options, you just go back to the list. "There are all different ways to get from here to there, and between you and me and our two heads, we are going to come up with one way that will work. It may not be the first way, but it will be the last way." Provide a menu of options. Again, using elicit, provide, elicit, ask, tell, ask, to maintain the patient-centered nature of the relationship.

Basic Principles of Motivational Interviewing

Before we finish, I will talk about something very briefly that I used to talk about at the beginning of lectures and found had no meaning to folks. The basic principles of motivational interviewing:

- Express empathy,
- Roll with resistance,
- Develop a discrepancy, and
- Support self-efficacy.

Good listening is fundamental. If you can't listen, listen, listen, and understand all sides of the issue, the pros and the cons, the status quo talk and the change talk, it's going to be very hard to move forward with two heads together to push some of these big changes that we're asking people to make. Ambivalence is normal, it is always there. Understand it, get it out

on the table, create a situation where people are comfortable talking about the things that they are afraid to talk to us about, like "I might really still enjoy French fries even though I know they're killing me."

Roll with resistance, dance rather than wrestle, ask permission first, and avoid arguing. The moment that you are arguing with a client from an MI point of view, you have blown it. Argument is a cue to the clinician to step back and think of another way to make the same point. Avoid jumping ahead and avoid giving people advice they haven't asked for. Develop a discrepancy, the why of change. When a client understands and can articulate that how they are leading their life and treating their body is getting in the way of them becoming the person they want to be and achieving the goals that they want—that is the source of intrinsic motivation.

Finally, regarding the how of change, support self-efficacy. People need to feel like there is something that they can do to be effective, to stick with it, otherwise they check out. Let them drive the goal setting, the agenda setting, offer them options, empower them through in different ways, in terms of collaboration and so on, and we have the basis for this model.

Selected Citations on Motivational Interviewing

A couple of the best sources for information about motivational interviewing are listed on the following page.

One is Miller and Rollnick's "Motivational Interviewing," 2nd Edition, which came out a year ago now. The other book is the Rollnick, Butler, Mason book "Health Behavior Change: A Practitioner's Guide," a nice simple paperback that you can read while watching television. Other resources are at motivationalinterview.org, the web site for the network of MI trainers group that I'm part of. Please send me an email if you have any questions or thoughts, I will definitely respond. My email is: grosephd@erols.com.

Thank you very much.



MI: Selected Citations

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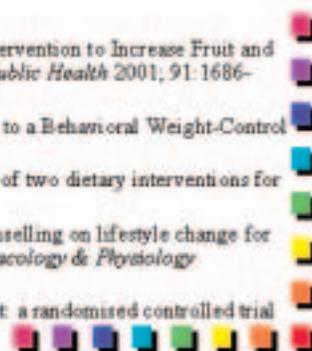
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FNS Programs: Building Bridges For Healthy Eating and Lifestyles

Moderator: Eric M. Bost, Under Secretary, Food, Nutrition, and Consumer Services, US Department of Agriculture, Washington, DC

HealthierUS: A National Priority

Ann M. Veneman, Secretary, US Department of Agriculture, Washington, DC

Thank you very much. Good morning, and thank you, Eric Bost, for that very kind introduction. Every time he introduces me, he talks about his mother.

I don't know what that has to say about our relationship, but—

But, seriously, Eric Bost is doing a phenomenal job in our department. We have a tremendous team at USDA. I'm very proud of every one of them, but Eric Bost has come into this job, having had a very, very important experience in the State of Texas and some other places as well and just hit the ground running and has dealt with a whole array of issues.

So thank you so much for the tremendous job you're doing, Eric.

It is a pleasure for me to be with you today and for those of you who have traveled from around the country to be at this conference, welcome to Washington. I heard this morning on the news that we're going to welcome you, if you stay long enough, with yet another snowstorm of maybe even six inches. It's the winter where the snow never ends.

In many senses, this is an historic occasion because it is the first time that nutrition educators, managers and others who work in all of the Federal nutrition assistance programs have come together from all across the country, from all levels of Government at one meeting, and I can see that so many have come today that there must be a tremendous amount of interest. And I heard in the hallway, as I was walking in, what a great conference this has been so far.



We have the opportunity to share experiences, to share strategies that work, and most of all to formulate plans for the future. I want to thank not only Under Secretary Bost, but particularly the staff for all of the work that they've put into to convene this conference, a conference that we hope will advance a healthier America.

I'm delighted to have the opportunity today to share President Bush's vision for a nation where we all work together to provide the tools and connect people with the nutrition assistance they need to support healthier lifestyles. The President wants us to work to ensure that all who are eligible receive the help that they need. He's given clear direction, and it is the course of compassion.

Studies have shown that most Americans are aware that a poor diet can increase the risk of several diseases, including diabetes, cancer and heart disease, but these studies have also shown that not that many Americans change their lifestyles even with these facts being known.

So the scope of the challenge is clear: Translating information into not only action, but positive results. Our common purpose is to improve the health of all Americans, and this can best be accomplished through existing partnerships and the new ones that will be forged during this important conference.

These partnerships form the foundation on which meaningful change is supported, and they are one of the tools and resources that bring about the change. Part of our challenge is establishing an integrated education network and framework, something that crosses all of the programs and efforts and which breaks down the walls that separate those silos in which we sometimes tend to operate.

Everyone has a role to play, from parents and educators, to administrators, industry, nutritionists, and health care providers. And the Federal government can help further the process of education, while also demanding that our Federal nutrition programs are effective and accountable.

As I'm sure you're all aware, the child nutrition programs are due for reauthorization this year. Reauthorization of these programs, which include school meals, WIC, summer feeding programs and other related programs, gives us an opportunity to address vital issues dealing with the nutritional health of our children.

Today, I'd like to share with you some of the principles the administration has established to guide our efforts, as we begin the reauthorization of these critical nutrition programs.

Our goals are to, first, ensure all eligible children have access to program benefits. This includes streamlining the program administration to minimize administrative burdens and increasing meal reimbursements to provide support for quality program meals.

Second, support healthy school environments. This includes potential for providing financial incentives to schools that promote good nutrition, including serving meals that meet the dietary guidelines, offering healthy choice alternatives, and providing nutrition education.

And, third, ensure the program integrity. This includes a variety of efforts, including addressing the issue of over certification, increasing resources to evaluate the impact of program changes on children and schools, and providing adequate program oversight because we have to do this right.

We need to know that we're getting the results that we seek and the outcomes that we expect, but please be clear that the commitment to ensuring program integrity is balanced with our commitment to access for eligible children and minimizing administrative burdens for those who operate the program.

And so access to healthy, nutritious meals, support for nutrition education and commitment to accountability, clearly, these are goals and principles shared by all of us who are committed to the health and well being of our children. And while taking action in some cases will entail costs, inaction, when it comes to good health and nutrition, ultimately will be even more costly for us all.

There are many opportunities for us to realize these principles. Today, I am pleased to announce that the administration is prepared to lead this effort by providing financial incentives to schools that support a healthy school environment. It will be up to individual schools, still a local decision, but if schools support healthy alternatives for students, that choice could result in additional funds.

Healthy eating, physical activity, and a balanced diet are important messages to instill in our children and in consumers, in general.

Over the next few months, we will be working with Congress and our partners to strengthen and improve our child nutrition programs, and we will unveil more specific details about proposed changes to WIC and child nutrition programs in the future.

Joining together as partners today, can help yield positive results tomorrow. The Federal government cannot, and should not, fight this battle alone. You, too, have an important role to play, both in your professional capacities and as leaders in your own communities. Your leadership is needed to engage parents and local communities, industry, and business, and to harness the power of Federal, state and local efforts.

This is a conference to talk about partnerships and collaborations. One such effort we want to look at, and further explore, has been a pilot project to provide fruit and vegetable snacks in schools in several areas of our country. These schools that are participating in the pilot are already reporting positive feedback and results in promoting these healthy snack alternatives. Innovative approaches like this can work, and they should be the focus of our efforts because the stakes are high.

Today, health experts are using words like "crisis" and "epidemic" to describe the problem of obesity in America, especially as it relates to our children. Child obesity in the United States has tripled since 1980. Today, 6 out of every 10 Americans are overweight or obese, and, sadly, those numbers are increasing.

As Under Secretary Bost indicated in his opening remarks yesterday, these are major risk factors for chronic diseases such as diabetes, cardiovascular disease, and sometimes with types of cancer.

The human and financial costs of obesity and other nutrition-related diseases is a staggering \$117 billion. \$117 billion every year. That's more than the combined budgets of the States of California and Connecticut. But behind this number are real people and real families who have to bear the social, financial, and emotional costs associated with overweight and obesity.

Last June, President Bush launched the HealthierUS Initiative, a health and fitness challenge to bring all resources, Federal and local, public and private, to help improve personal fitness and health. Simple and modest

changes in nutrition, physical activity, and behavior can have a profound influence on the quality of life. The HealthierUS Initiative is based on four pillars:

First, preventative screening. As many of you know, I understand firsthand the importance of these screenings. It was a routine screening last year that detected my breast cancer at a very early stage and led to treatment. I cannot stress how much a routine screening can tell about your current health status and provide the opportunity to make meaningful changes in your health and in your life.

Second, making healthy choices. Avoiding tobacco and drugs and the abuse of alcohol are smart and sensible choices for everyone.

Third, being physically active every day.

And, fourth, eating a nutritious diet.

If we all make simple adjustments to our diet and avoid excessively large portions, this will make a significant difference in our health. In addition, eating five to nine servings of fruits and vegetables a day helps lower the risk of developing life-threatening diseases. These are understandable, reasonable, and simple recommendations that, if followed, can make a real difference.

Participation in this initiative is at the heart of our plans during the next year and involves many mission areas in the Department of Agriculture. Many of those agencies are represented here at this conference. We are also active partners with colleagues in the Departments of Education, Health and Human Services, Interior, and Defense, to name a few. Together, we are taking action on a number of significant areas. We're working to expand school-based efforts to help children develop healthy eating habits, and we're helping to promote life styles that are healthy through sound nutrition, physical activity, and recreation in America's great outdoors.

We have several programs that support the HealthierUS, including a historic action-based MOU among USDA, the Department of Education, and the Department of Health and Human Services that coordinates and supports nutrition education and physical activity in our nation's schools.

We have an evaluation of our fruit and vegetable pilot program, which I mentioned earlier, that will help us see how we can move forward and support these kinds of successful, innovative projects. We have stepped up our efforts to support the national 5-A-Day campaign, and we're working through our Forest Service to promote recreational opportunities on national forests to enhance physical fitness.

Additionally, President Bush's budget for fiscal year 2004 supports our nutrition and health message with an estimated \$528 million in proposed funding for nutrition education as a part of the WIC, Child Nutrition, and Food Stamp programs.

The President continues to show unwavering support for the WIC program because it works.

His budget request includes a record \$4.8 billion in funding to serve low-income, nutritionally-at-risk participants. To enhance WIC's capacity to foster better nutrition and life styles, we've proposed \$20 million for a breastfeeding peer counseling program to target nutrition education and information aimed at convincing women to begin breast feeding and also increasing the length of time a woman breastfeeds her baby.

We have also requested a \$990 million increase in the Food Stamp program for a total of \$25.8 billion.

Finally, the administration's commitment to the nutritional safety net is made even clearer when you look at the historical support for the Temporary Emergency Food Assistance program. For example, in the last three years of this—in the first three years of this administration, three fiscal years—we're in the third one; haven't been here quite three years yet—USDA has contributed over \$1 billion dollars to TEFAP commodities. In comparison, the three years prior to this administration totaled just over about \$660 million. It is a priority of the Bush administration to ensure that every eligible person who wishes to participate has access to our nutrition programs.

Today, I am also pleased to announce two important new nutrition education resources that reinforce the combination of our nutritious meals with physical activity for a healthier life style. These resources were developed by USDA for use by people like you, a partnership that allows us to work together to serve people in need and to meet our mutual goals.

Our new Eat Smart, Play Hard website is user-friendly and provides direct access to tools and resources that will help you reach kids and their caregivers.

The campaign focuses on four basic themes: the importance of breakfast, healthy snacks, physical activity, and achieving a healthy balance between what you eat and what you do. The initiative's website is on the USDA Web page at www.usda.gov, and it takes advantage of the Power Panther, who's our "spokes-character" for the campaign. If you haven't met him, you soon will. The Panther helps to illustrate nutrition and physical activity messages to children in a way that they can understand.

Another program is called "Nibbles for Health." Nibbles for Health are ready-to-use communication tools designed to build skills and help parents of pre-school-aged children understand and master nutrition and fitness concepts. It is ideal for parents, and the program makes suggestions and recommendations that the whole family can follow. In addition to information we will provide on the Web, there is a leader's guide that will be used by staff at child-care facilities to encourage and support parents in making better health choices for their children.

In closing, I would like to remind you of a call the President made to all of us in January. In his State of the Union Address, President Bush called upon us to apply the compassion of America to the deepest problems of America. Addressing hunger for our neediest individuals and showing people the way to live healthier lives is compassion at its very essence.

To those of you who envision sound nutrition as the bridge to a better world, we are grateful for your commitment and for joining us in this historic opportunity to change people's lives in meaningful ways.

I want to thank you again for inviting me to be here with you today. I wish you a very successful conference; one that will develop a framework for partnership and one that will establish plans for action. Please know that we truly appreciate your work, we appreciate your dedication, and we appreciate the opportunity to work with you toward our mutual goals.

Thank you very much.

A Fit and Healthy Nation: Strategies to Get America Moving

CDR Penelope Royall, PT, MSW, Acting Executive Director, The President's Council on Physical Fitness and Sports, Washington, DC

Good morning, everyone. On behalf of the 20 members of the President's Council on Physical Fitness and Sports, I thank the Food and Nutrition Service for including us on this very esteemed panel. I bring you greetings from my bosses, I have three bosses: the Surgeon General of the United States, the Secretary of Health and Human Services, and the President of the United States. All three of these men are living examples of what fitness can do for you. They are all enthusiastic exercisers; they move every day. If they have time to do it, I have time to do it.

HealthierUS Program

Secretary Thompson is leading an interdepartmental task force that is part of the President's program HealthierUS. That interdepartmental task force is looking across the entire Federal government, at all of our programs that have to do with fitness, nutrition, and health. We have already sent one report to the White House cataloguing all of these programs. Our next report is going to be the one that makes recommendations. We are choosing the programs that we want to put forth and really get behind and push, to help America be healthier.

President Bush is so committed to being healthy and fit that he began HealthierUS. HealthierUS is his way of saying to the American people "pay attention, pay attention." There are four pillars that uphold a HealthierUS. They are:

- 1) Be physically active every day.
- 2) Eat a nutritious diet.
- 3) Get preventive screenings.
- 4) Make healthy lifestyle choices and avoid risky behaviors.

"Marrying" Physical Activity and Good Nutrition

As a physical therapist and a clinical social worker, I think of my profession as a marriage of the body and the mind. And I'm going to propose another marriage to you today. I'm going to propose a marriage between physical

activity and good nutrition. Just as you cannot separate the body from the mind, you cannot separate physical activity and fuel, the proper fuel, when you are talking about good health. They are a "couple."

The marriage that I propose is of the utmost necessity in the troubling world we face today. Our nation is fighting a war. We are fighting two wars as a matter of fact: a war against tyranny and terrorism, and a war against the diseases of a sedentary lifestyle. And friends, the diseases of a sedentary lifestyle are already killing Americans. These diseases are killing your friends and mine, your neighbors and mine, your family and mine. This war is not always on the front pages like that other war. Although it's not headline news it is a major threat to the well being of our nation. It is as deadly as anthrax. It is as lethal as smallpox, and it is as dangerous as a dirty bomb.

This war is costing America more than the lives of its citizens, it's costing a lot of money: about \$117 billion dollars for obesity-related diseases and \$132 billion dollars for diabetes (as of 2003). You all know the grim statistics, I'm not going to stand up here and give you a bunch of numbers right now. You know the morbidity and mortality statistics. However, there is good news, there is very good news. For most of us, most of the time these diseases are preventable, and they are preventable without making major changes in our lives. We know that sound nutrition and daily physical activity decreases the possibility that any of us will suffer from the diseases of a sedentary lifestyle.

If the government took the billions of dollars that I just mentioned, the government still could not buy you a healthier life. We could not buy a healthier nation. A healthier nation depends on you and me. We need to change the culture of America. I like to remind people that in 1964 the Surgeon General's report on smoking came out, 1964, it's almost been 40 years. I don't know if I'm going to make it 40 years, so I want this to take place sooner. We are not going to wait 40 years to get America moving, we're going to get America moving today.

Back to my proposal of marriage. Here is my proposal: as the Food and Nutrition Service modifies their Food Guide Pyramid, I propose that they marry the Pyramid with physical activity, by setting that pyramid on a base of physical activity. All of you know the Pyramid, right? You've seen it hundreds of times. Imagine the Pyramid now sitting on a base of physical activity to support it, the ground underneath it. You exercise, you eat right, they go together.

Tool for All to Use: the "President's Challenge"

The President's Council on Physical Fitness and Sports has a tool for you to use now. As the 20 Council members and I travel around this great nation to spread the President's vision of a HealthierUS, we want to give you that tool. So on behalf of the President's Council on Physical Fitness and Sports, I challenge you to take the President's challenge. Do it for yourself, do it for those you love. Do it for your nation. I believe that a healthy America is a better prepared America, for whatever comes to our nation. If we're fit and healthy we're ready.

Some of you may remember taking a fitness test when you were in school and earning this patch. Right? Today, the President's challenge is much more than a fitness test in school. The new President's challenge is a tool to help all Americans, young and old, to become active and stay active for a lifetime. For the first time since the President's Council began in 1956, Americans, adult Americans, can become role models, join their children, and participate in the President's challenge awards. You need to move 30 minutes a day, five days a week, for six weeks, and you too can earn a President's challenge award.

You either log your activity in the paper folder for this award or go to the Council website and create your own lock box. Then, you can go in every day and log the activity you've done. Then, after six weeks, you can submit the information, and we will send you an award. You just have to do what your body was made to do—move it, move it. Every activity counts. When you are beginning, every activity counts: walking, climbing steps, raking leaves, mopping the floor, and some fun things like running, biking, playing sports, even counting steps. I have my pedometer, do you? When you are beginning, you do not even have to take 30 minutes. You can accumulate 30 minutes over the day. Log it in. Do it for six weeks. Earn your Presidential patch. Challenge your co-workers, challenge your family members. This is an award for all Americans from age five to forever. All of the information that I have talked about so far is available in paper and on the web site at: www.fitness.gov.

At the moment, health and fitness experts are working with web developers to create an interactive website that we will launch later this spring. Soon, Americans of all ages can bank points—you earn your award after six weeks and then take those points and put them on our web site and bank them. Before you know it, you have become a Presidential champion. We are even going to have a bronze, silver, and gold medal. All of these tools are for the

purpose of getting America moving and keeping America moving. When the time comes we really would appreciate your support in promoting the President's challenge as an effective motivational tool for your constituents. If you don't know how to work the web, get up, run outside, grab a kid.

Presidential Active Lifestyle Award and CDC's "5-A-Day" Program

One of our recommendations to the HealthierUS report is to combine the Presidential Active Lifestyle Award with CDC's 5-A-Day program. Again, that is the marriage I'm talking about. We're going to marry the CDC's nutrition program, 5-A-Day, and the President's challenge. We're going to get America fed and moving.

I ask all of you to spread the word. There is something that you can do today. The greatest thing is, guess what? It's free, it's totally free. You don't have to pay. I ask all of you to join with the President's Council on Physical Fitness and Sports. Again, do it for yourself, do it for those you love, and do it for this great country. That couch that you are sitting on, that couch isn't going anywhere, are you? I challenge you, get up, get out, get fit. Thank you very much.

Building Healthy Communities: One Step at a Time

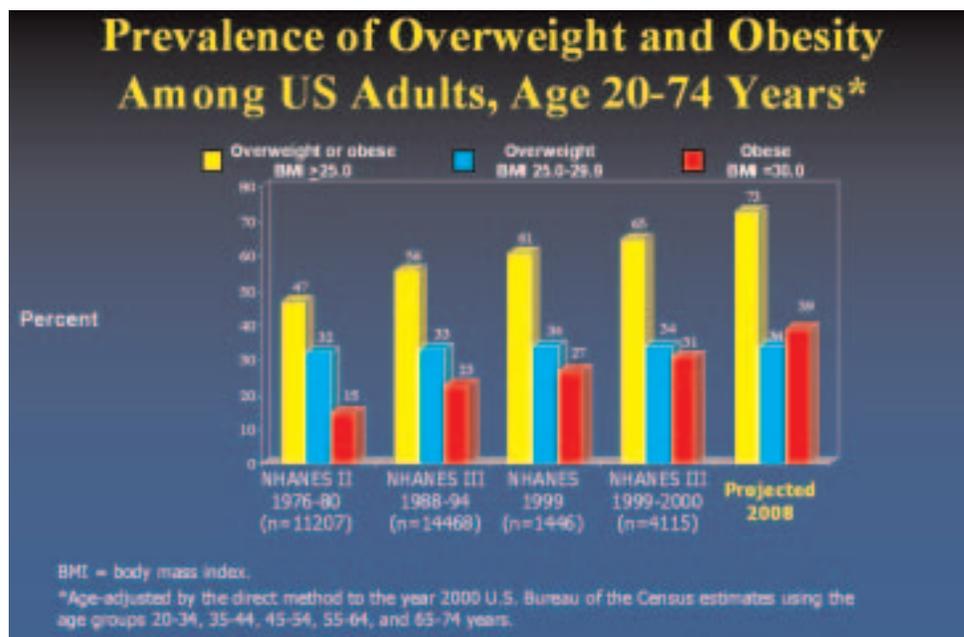
**James O. Hill, PhD, Director, Center for Human Nutrition,
Professor of Medicine and Pediatrics, University of Colorado,
Denver, Colorado**

Although the title of my talk is "Building Healthier Communities: One Step at a Time," my real purpose is to work you into an absolute frenzy in the next 15 minutes — do you know why? It's time to do something, right now in 2003, it's time to quit talking about obesity and do something. I believe that the sun, the moon, and the stars are lined up right now for us to help Americans do something. I've talked with many of you in the audience and know that you feel the same way I do — it's time to get going.

Obesity Prevalence Rates and Projections

Here are the obesity prevalence rates: right now 31 percent of the adult population is obese and about 65 percent of the population is either overweight or obese. We have examined trends of weight gain in the population and if these continue, by 2008, we are going to have 39 percent

obese and three quarters of the people will be overweight or obese. That is intolerable, we can't allow that to happen; we have to start doing something right now to change this.



Let me quickly talk about how we got here. This is not an epidemic of bad genes. Genes are important, but we have an obesity problem because of the environment we live in – the environment is a total mismatch for our genes. Our genes say "eat" when food is available, "rest" when you don't have to work. But, food is always available and you never have to work, that is why we have so much obesity. You can look at all of the things in the environment that are causing obesity. Large portions – what is it about Americans who can't resist getting twice as much as they need just because it's only 39 cents more? So, if the environment is causing us to become obese, what do we do about it?

Social and Environmental Change to Reduce Obesity

In the long term, we need to think about social change. This is a social issue – obesity is tied up in the way we live. I defy you to look out in society at someone who is not contributing to obesity. The food industry is contributing to obesity, and so are TVs, cars, parents who are poor role models, teachers who have no time for physical activity, you could go on and on. What we need is to change society, but, you will probably say, "That's too hard." But we have done it before – we have changed society with smoking, seat belts, and recycling. If the American public decides that they want to do something about this problem, they are going to roll up their sleeves and do it no matter how hard. So, we need to look at how we can

facilitate social change. But, the numbers I showed you before suggest that we do not have much time to do this, we don't have 40 years to make this happen. In 40 years, we will have lost the chance to prevent obesity. So, in the short term, we need to push back against the environment. How can we push back against the environment to avoid gaining weight?

In order to deal with obesity, we must deal with the environment, certainly the environment is pushing people to eat more and exercise less, but you also have to deal with the individual. So it's not just individual choice, it's not just environment, it's a combination of working with food and physical activity decisions that individuals make and working to modify the environment to support and sustain those choices.

Goals for Addressing Obesity Epidemic

First, we need specific goals for addressing the obesity epidemic. If you look at the "Healthy People 2010" weight goal, it is to reduce adult obesity to 15 percent—"I don't think so." At this time, the obesity rate is heading for 39 percent in 2008. My dream goal would be to keep it from getting to 39 percent. "Healthy People 2010" recommends reducing childhood obesity to five percent—"I don't think so." How is this going to happen? How are we going to get there?

If you look at the current diet and physical activity recommendations, they are pretty general:

- Eat according to the Food Guide Pyramid,
- Eat five servings per day of fruits and vegetables,
- Get 30 to 60 minutes of physical activity.

They are telling people to eat less and exercise more. We have to give people a better and more specific message. We must think about: "What is the specific behavioral goal that will help people to start dealing with the issue of obesity?"

The first step has to be to stop the weight gain. The average American is gaining one to two pounds a year, 10 to 20 pounds a decade. That is how we developed this problem and why the problem is getting worse. So, our first goal has to be stop the madness, stop the weight gain.

How To Stop Weight Gain in the U.S.

How is this going to happen? We looked at some of the large data sets that are collected every year, from the Coronary Artery Risk Development in

Young Adults (CARDIA) Study and the National Health and Nutrition Examination Survey (NHANES). The average adult is gaining 1.8 to 2 pounds, this is over the past eight years — we used this statistic to project what's going to happen in 2008 unless we do something. One question we then asked is "What would it take to prevent that 1.8 to 2 pounds of weight gain a year?", and we call this the "energy gap." By modifying energy balance by only 100 calories a day, we could prevent weight gain in 90 percent of the population. Any combination of eating less and exercising more than 100 calories a day could prevent weight gain in most people. One hundred calories is nothing in people that are eating 2,000 to 3,000 calories. So, you leave a couple of bites on your plate at dinner and you walk an extra 2,000 steps and you are there — you have done enough to prevent weight gain.

We published an article in "Science" earlier this year in which we argue that it is time to test whether we can produce small behavior changes that can be sustained and have an impact over time. So, we are throwing out this number of 100 calories a day as the "energy gap." If we could manage this, we could stop weight gain in 90 percent of the population. Now think about that. That would be an enormous accomplishment in simply stopping weight gain.

We have not been effective at producing and sustaining large lifestyle changes. Every January, health club membership goes through the roof, then by about March, it is back down to where it was. So, we can get people to make lifestyle changes, but these are temporary. We have not been very effective at getting people to make and sustain lifestyle changes. Thus, I suggest that it is time to seriously test an alternative hypothesis. Can we produce and sustain small changes of 100 kilocalories per day in diet and physical activity? Will this slow or prevent weight gain? I believe that it will but we need to test this.

"America on the Move"

Now I want to tell you about a program that we have developed to accomplish this, called "America on the Move." We believe that this program can be the grassroots initiative that can inspire people to address the obesity epidemic and at least stop the weight gain. It is run by a national non-profit organization, the "Partnership to Promote Healthy Eating and Active Living." We are going to launch "America on the Move" nationally in July 2003. It is based on a pilot project that we have been conducting in Colorado. By the way, Colorado is the leanest State, which is why I was

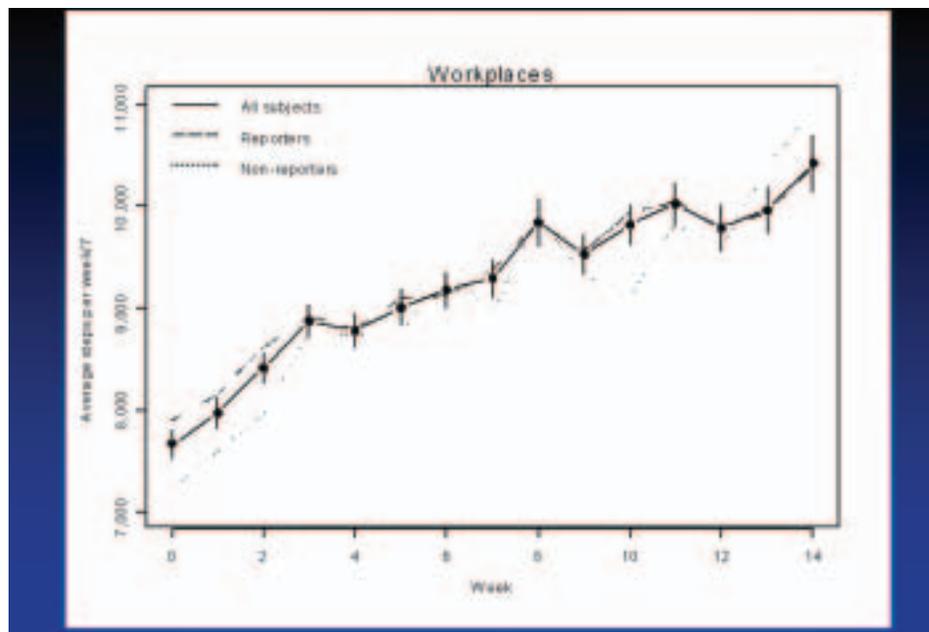
asked to speak I guess. "Colorado on the Move," a pilot project for "America on the Move," has been underway for 18 months. We use inexpensive step counters or pedometers to increase physical activity. This is a big part of our program because we believe that dealing with obesity has to involve an increase in physical activity. There is no way that people can maintain their weight given how sedentary our society is today. There is no diet on earth that will allow our population to maintain a healthy weight with no physical activity. That is the way the body works. Our body's physiology did not develop to work best when we are sedentary.

You have to increase physical activity, and improve nutrition as well. Sure, you also have to help people make small changes in how much they eat, because most of us eat more food that we really need or want, but our program started with increasing physical activity. The step counters are an easy way to increase physical activity. We have developed "America on the Move" programs for schools, work sites, and communities. This program can be sustained by focusing on communities. "America on the Move" is a program that can be implemented community by community. We are currently developing "America on the Move" programs for families and for health care providers.

"America on the Move" will inspire people to make two simple behavior changes: 1) to increase steps by 100 calories a day, or 2,000 steps, and 2) to take away 100 calories on the intake side. This program works because it's fun and simple. We have a long list of simple ways to reduce energy intake by 100 calories per day on our website <http://www.americanonthemove.org>. If you get in your 2,000 steps and you do one of these behaviors, you are done for the day.

"Colorado on the Move"

Our pilot project for "America on the Move" was conducted in Colorado. We started by evaluating our ability to use step counters to increase physical activity. The physical activity goal of "Colorado on the Move" was to have people wear step counters and measure their baseline steps. This is important—we don't like the "10,000" step number. There is nothing wrong with "10,000," but, if you are at "2,000," "10,000" seems insurmountable. So, we gave people step counters and had them wear them for a week to get their own baseline, and then asked them to increase by 2,000 steps each day (2,000 steps is about 15 minutes, or about 1 mile, or about 100 calories). In work sites, this slide shows how people increased the number of steps over 14 weeks using step counters.



We saw the same thing in communities. One of the communities we worked with in Denver was the Metro Denver Black Church Initiative. They started out at a lower baseline, but, it was very easy for them to achieve a 2,000 step per day increase in steps. Now, obviously we have to show the sustainability of this program and whether over time, it can prevent weight gain.

On October 3, 2002, Governor Bill Owens, Governor of Colorado, launched this as the first State-wide obesity prevention program in the country. It has now been endorsed by both the House and Senate in Colorado. We estimate that in Colorado, and Colorado is a small State in population, we estimate that 100,000 people are participating in this program. This estimate is based on step counter sales through our program.

Why Focus on the Physical Activity Side?

There is a reason to start with physical activity. You have to make some dietary changes but it is imperative that people increase physical activity. The body is built to work best when it has higher levels of physical activity, and getting off the couch and walking 2,000 steps is the first step towards taking control of your weight. When this program is launched in July, we hope that it will be a grassroots initiative that will inspire Americans to take control of their weight. I hope that you will help us by starting these programs in your own community, work site, and school system.

I think that Americans are tired of being told to make big lifestyle changes, and that there is a sense of hopelessness. We need a program to inspire

Americans to make small changes and to take control of their weight—I think that people want to be part of something big. We hope that "America on the Move" will be big. We can best sustain this through the community. This will work best when the whole community takes on the idea of small behavior changes. You tie it back to incentives for people's lives. If we want people to make and sustain these changes, there has to be something in it for them.

Will This Program Work?

As a nation, I do not think that we have tried this idea of getting people to make small sustainable changes that can have a big impact over time. We have not tried a program that involves all sectors—government, private industry, academia, the media. The final message here is: will it work? We are testing it. In Colorado, it is working in the short term, but, we want other people to test it. My real message to you is that you cannot do nothing. If not this, what? It's time to quit talking about obesity and start doing something. We put a program on the table that we think can help people start to take control of their weight and we are going to launch it in soon. It is not the sole solution to the obesity epidemic, but it is a way to get people to start taking control of their weight. We hope that everybody in this room will help us and get out and start getting people healthier. Thank you.

Raising Healthy Children in the Current Environment: The Challenge Facing Parents

Marlene Schwartz, PhD, Co-Director, Yale Center of Eating and Weight Disorders, Yale University, New Haven, Connecticut

Good morning. We have heard a lot about the activity side of the equation in terms of combating the problem of obesity. Today, I will discuss the food side of the equation; specifically, about how children eat and what parents can do. I will review the research on how children develop their food preferences and how these preferences interact with today's environmental influences. Then, I will look at this issue from the parent's perspective and focus on what parents can do.

Early Food Preferences

Some research shows that children are born with innate food preferences. First they prefer sweet tastes and dislike bitter and sour tastes. Infants quickly learn to prefer the flavors of salt and fat. Historically, this made

sense—from an evolutionary perspective, the problem was more often famine than overeating. So, it makes sense that we are "hard-wired" to prefer calorie-dense foods. But now the trouble is that we have these ancient genes in a modern environment.

Challenge #1: Competing Messages for Parents

The first challenge that faces us as parents is that we know that the Food Guide Pyramid recommends that we limit the sweets in our children's diets. Yet, there is the phenomenon of "If you are good, you can have a cookie." Every parent also knows that sweets are a powerful reinforcer of behavior. Parents need to be told that they have to give up a very powerful tool for modifying their children's behavior. That's a tough lesson to learn. Advertisers know that food is a powerful way that parents and children relate. Advertisements portray the message that food is love and it is a way to express love and caring for your children. One such advertisement illustrates the dilemma that many parents feel. It says that you are the "fairly good" mother when you give your children something that their hearts desire, or the "wicked bad" mother when you deny them. There are these conflicting messages in which parents are told that giving sweets or treats to children is a way of showing that you love them and of having fun. Yet, from a health perspective it is not a good idea.

Challenge #2: Competing Messages for Kids

A second challenge that parents face in their efforts to teach their children about nutrition is the work of the food industry trying to sell their products. The food industry is huge and introduces thousands of products each year, and the rate at which new products are introduced is increasing quickly. The number of new products introduced to the market increased from 5,500 in 1985 to 17,000 new products in 1995. We need to look at how healthy these new products are and if advertisers are marketing them directly to children.

One study found that the average child sees 10,000 food advertisements per year and that 95 percent of these are for candy, fast food, soft drinks, and sugared cereals. As a mother of three small children, I try to educate my girls about good nutrition. But I have figured out that if I told them during three meals a day, 365 days a year: "It is really important to eat well, have lots of fruits and vegetables, not eat too many sweets," and even if I had famous pop singers and well known cartoon characters that my children love to back me up, I could not compete. I deliver about 1,095

messages and the media delivers 9,500. While we want to emphasize that parents are responsible for teaching their children and for feeding them well, we also have to appreciate what parents are up against.

Challenge #3: Self-Regulation Versus Restricted Access

Another challenge that parents face is whether to allow their children to self-regulate or try to restrict access to unhealthy foods? Some research shows that children can self-regulate their intake, but only under certain circumstances. Parents often feel, "If I just leave my children alone and don't interfere, they will eat when they're hungry, stop when they're full and make healthy choices." But that isn't really true. The studies showing that kids can self-regulate over time, were designed so that the foods available were mostly healthy foods. The children had access to a very healthy diet with the occasional dessert, the occasional treat with no high calorie beverages available, and large portions were not served. This is not the environment in which most children live.

We also know that people eat more when served larger portions despite their hunger levels. When this research was done with children, they found that if you give a child a large portion of macaroni and cheese versus a smaller one, the child with more on his/her plate will eat more. The problem with this scenario is the phenomenon of "super sizing" our meals, which is contributing to people eating more food than usual.

Regarding the question of whether or not to restrict foods, other research has found that children develop preferences for foods that are visible but restricted. The worst case scenario is having a child in an environment in which they constantly see appealing foods that they are not allowed to have. Every time I go to the grocery store, video store, drug store, almost any store, what is there? There is a huge candy counter! My six year old sits at eye level with 45 different types of candy in the checkout line. She asks if she can have some candy and I refuse. This is an instance in which an "attractive" food is visible but restricted.

Challenge #4: Using Food as a Reward

Children learn to prefer food when it is used as a reward. A major doughnut company has apparently heard of this research and has developed a program in which the teachers can reward children for doing homework with a coupon for two free doughnuts. We need to pay attention to these types of programs and have a much more critical eye as to how they influence children.

Environmental Influences: Meal Location

Some good news—as a parent, I was very happy to read the report that meals eaten at home are more nutritious than meals eaten elsewhere. So, parents are doing a pretty good job when they are feeding their children at home. But, on the other hand, you have to be careful when eating out. Kids' meals, in particular, need more attention. These meals are specifically marketed to children with toys and movie characters. These have a very, very strong appeal to kids.

A study we did at Yale, inspired mostly by my frustration with "kids' meals" options, examined the kids' meal menu items at the top five fast food restaurants and the top five family style restaurants. We found absolutely no fresh fruit or fresh vegetables at all on any of the menus. French fries were the only available vegetable. The meals had higher than recommended levels of calories and fat and the portion sizes were large. The family style restaurants were actually worse than the fast food restaurants. The food that they were serving was the same (e.g., chicken nuggets/French fries), but the portions were so much larger that they were providing a less healthy option than the fast food restaurants.

Environmental Influences: Familiarity of Foods

Children will choose foods that are familiar. This can work both ways. This means that it is important that children not be exposed to too much "unhealthy food." This is also encouraging because it means that the more that you expose children to healthy foods, the more they will learn to prefer them. Children can learn to like new foods, but it takes up to ten exposures to a new food for children to develop a preference. That is a very important public health message to communicate to parents—many parents will try a food once or twice, and when their child rejects it, they decide "He/she doesn't like that food so I am not going to try it again." Parents need to learn that it takes up to ten exposures, and to be persistent and not give up.

Environmental Influences: Availability of Foods

People also eat foods that are most easily available. Again, this can go both ways. When the unhealthy foods are easily available (such as soda or candy machines in schools), people are more likely to eat them. But if the unhealthy foods are less available, for example, if soda and candy are not served in schools, then people are not going to eat them as often.

What Parents Can Do

Parents can keep healthy foods readily available and serve them frequently. Don't be discouraged by initial rejection. I've tried this strategy at home. If I ask my kids if they would like a piece of fresh fruit, they often answer "no." But, if I take the orange, peel it, and put it down in front of them, they often will start to eat it. So, parents need to learn that there's a lot to be said for just having the food available for the child and then letting the child choose to eat it.

Another challenge relevant for parents of overweight children is the difficult dilemma of having a child with a health problem and the social stigma of obesity. It is very important for parents to emphasize to their children that they are encouraging them to eat healthy foods and exercise because of their health, not because of how they look or because they want to make changes in how they look.

Summary

To summarize, there are many challenges facing parents. Changing eating and exercise habits is more difficult than some other behavioral changes because there are so many tiny decisions you make each day. Unlike stopping smoking or drinking alcohol where you choose not to do one thing, changing food choices and activity levels requires constant decision-making.

The societal stigma of obesity is different than other medical conditions. Parents often feel guilty or blamed for their child's weight. Parents need help to make changes so they do not get caught up in feeling guilty and blamed. With other child health issues, such as using car seats or choking hazards, there are laws and public messages that are consistent with what parents need to do in order to keep their children safe. When it comes to food, society is working against parents. There are many pressures and forces that expose children to unhealthy foods. The parents are fighting against those forces rather than being in a situation where the parent and society are working together.

Many people have already drawn the parallel with smoking. When I feel discouraged, I look back on the changes in the marketing of cigarettes to children. We have made big changes in our society about how we market products to children and we can definitely do it again.

My final message is for us all to "think outside the box." Thank you.

Adapting Global Strategies for a Domestic Crisis

William Clay, Chief, Nutrition Programmes Service, Food and Nutrition Division, Food and Agriculture Organization of the United Nations, Rome, Italy

I am pleased to be with you and to have this opportunity to talk about adapting global strategies for a domestic crisis.

First, allow me to explain what FAO is and does. The Food and Agriculture Organization is a specialized agency of the United Nations System which actually pre-dates the existence of the United Nations itself. We were founded in 1943 by 44 very far-sighted governments who recognized that putting the world back together after the trauma of the Second World War would require feeding people and helping them to get back on track with agriculture and food supplies. So, FAO was established with the mandate of raising levels of nutrition and the standard of living around the world; these are still our main goals today.

Nature of the Global Obesity Problem

Let's talk now about the focus of this symposium—primarily problems of obesity and chronic diseases. We do not have very good numbers on the extent of the global obesity problem, but estimates run between 200 and 300 million people globally. These numbers are steadily increasing as more people around the world are able to secure greater access to food and consume more dietary energy than they expend. The U.S. has long been a world leader in many areas, and it has the dubious distinction of being the world's leader in obesity as well with well over 1/3 of the population being considered obese. However, many parts of the the world are quickly catching up. In Europe, in the past ten years the prevalence of obesity has increased between 10 and 40 percent in almost all of the countries within the European Union. While obesity in Asia is still fairly low in many countries, in some of the more affluent Asian countries, obesity ranges from 2–6 percent. However, these the rates are increasing.

In most of Sub Saharan Africa, the obesity rate is very, very low. For example: in Mali, it is one percent obesity, and in Zimbabwe, six percent. In South Africa, six percent of the males and 32 percent of the females are obese at the present time. This pattern is not uncommon, women tend to be heavier in many countries. In Latin America, we are starting to see some increases. In Brazil, six percent of males and 12 percent of females are

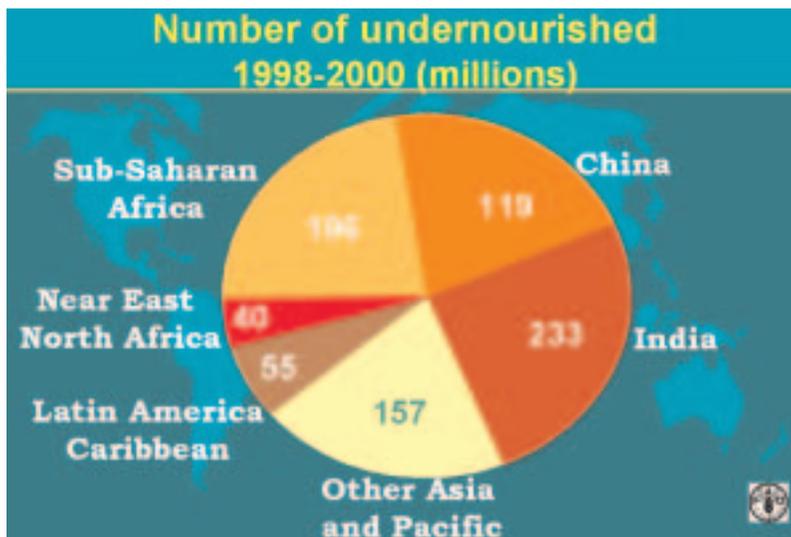
obese. In Mexico, 24 percent of the women are obese at present. In the Near East, we're starting to move into high rates of obesity. In Kuwait, 32 percent of the males, 41 percent of the females are obese.

This points to one of the key problems in trying to prevent obesity and to do something about it once it exists. Society has to find opportunities to change. In Middle Eastern countries, especially where there are very defined gender roles, it will be difficult to get women out of the house and into the gym. We have to find some other ways to help these women increase their physical activity.

In developing countries, the present obesity rate tends to be low but it is on the rise. Obesity is more prevalent in urban than rural populations, and, in many countries, it coexists with problems of undernutrition.

Problem of Undernutrition

As serious as obesity is throughout most of the world, there are other nutrition-related problems that still dominate in most countries. For example, problems of undernutrition, which we deal with most in our work, currently affect approximately 800 million people around the world. These people virtually never get enough food to eat to meet their daily energy needs. That is four times the number of people who are obese. This is a breakdown of where we find the undernourished around the world.



Undernutrition is concentrated in South Asia, India, Pakistan, Bangladesh, and in China. It's coming down, but very, very slowly. Other problems that

we see include:

- 30 million children born annually with impaired growth due to poor fetal nutrition;
- 182 million children under 5 who are stunted; this is 33 percent of the kids throughout the developing world;
- 27 percent of all children under 5 throughout the world are under weight;
- Extensive problems with micronutrient deficiencies;
- 3.5 billion people are either anemic or at high risk of anemia, with some level of iron deficiency being the greatest problem;
- Two billion people at risk of iodine deficiency; and
- 200 million children under five are affected by Vitamin A deficiencies.

These numbers are staggering; what do these numbers mean for individuals, communities, and societies? The loss of human potential that comes along with these figures is unacceptable. In order to make progress in development, we have to become very serious about trying to take care of the problems of undernutrition around the world.

What's the reason for such wide-spread undernutrition? Poverty. We have about 1.3 billion people around the world that live on less than one dollar a day. That's one dollar for food, shelter, clothing, health care, transportation, education, anything and everything. We have two to three billion people who live on less than two dollars a day. That is where we have to begin our fight. It is a fight that has to be won if we also want to make progress in the fight against obesity. We are seeing that the poorest are somewhat protected against obesity, but as soon as populations begin to move into middle income levels, obesity levels rise dramatically. We must work within households to assure that they have the resources, food available, incomes, knowledge, the time and opportunity to put their knowledge to use, and motivation so that they can decide to make changes that will improve the welfare of themselves and their family.

The FAO Approach to Nutrition Education

Nutrition education is a key component of addressing the problems of undernutrition and obesity. The FAO approach to nutrition education focuses on promoting lifelong healthy eating patterns and lifestyles. Our programs address specific problems in local areas. The solutions developed have to be relevant in terms of available food supplies, resources, and cultural approaches. We need to look at the whole diet in relation to

physical activity and other lifestyle factors. We also need to focus on foods and appropriate, safe diets, rather than just individual nutrients.

There are four basic principles that underlie the dietary guidance promoted by FAO:

- A wide range of dietary intakes can be consistent with good health (and, therefore, there is no single global diet or dietary pattern that needs to fit everyone);
- There are no good or bad foods, per se;
- There are good and bad diets, but they must be judged according to individual requirements and lifestyle factors (including physical activity levels); and
- Dietary intakes are primarily a matter of choice (except in those situations where one's access to food is constrained).

Based on these principles, we developed a global nutrition education package entitled "Get the Best from Your Food." This package has four simple messages that need to be adapted, expanded and utilized in an appropriate cultural context in local areas. The four messages are:

Enjoy a variety of foods. Enjoyment is key. If nutrition education is seen to be a list of "dos and don'ts" that takes away from the appreciation of food, it will be very hard to get people to learn about and heed the messages. We need to stress that eating and sharing food are important aspects of social interactions and that food serves purposes other than just meeting nutrient requirements. That is, people choose foods for more than their nutrient content, and if we want to have a chance of moderating eating behaviors, an attractive alternative must be presented. Eating properly should not be a chore, we need to ensure that people recognize it as a pleasant and worthwhile activity.

Eat to meet your needs. People need to learn this concept well—neither too little, nor too much. Variety, balance and moderation are still the keys to a healthful diet, and the challenge of nutrition education is to help people understand what their nutritional needs are and how those needs can be met from available foods.

Protect the quality and safety of your food — from the source of the food supply to the household level. The problems that can arise from eating unsafe foods are as bad as those that come from not eating enough food or from eating too much. For example, water and food borne dysentery and diarrhea contribute to high levels of morbidity throughout the developing world and are primary killers of children.

Keep active and stay fit. Enough said. Physical activity is a key to good health: a good diet alone will not be successful in assuring long-term nutritional well-being.

Remember that there are no bad foods, just bad diets and lifestyles. We need to look at total diets. Virtually all foods can be part of a healthful diet, if they are eaten in moderation and combined properly with other dietary components.

What Next?

So, what do we need to do to combat the problems of obesity and chronic diseases? What are we faced with? What are the problems? How have we failed? What has gone wrong with what we have been doing? One of the biggest problems that we have is that we are dealing with a really tough audience. The European Food Studies Institute, in Ireland, carries out a range of studies looking at the attitudes of consumers. They survey people by asking if they agree or disagree with various statements. One statement was: "I do not need to make any changes to the food I eat as it is already healthy." What percent of Europeans do you think would say, "Yes, I agree with that"? Seventy one percent of the Europeans surveyed think that they are doing everything just fine now. However, that is clearly not the case.

We also have a problem that we often use the wrong messenger to get these stories out. We are the professionals, right? We think that if we give somebody advice, they ought to pay attention to us. Again data from Europe shows that people are getting their information about diet and health from magazines, radio and television and newspapers. Nutrition educators and health professionals are fourth down on the list. Consumers get information from food packages, advertising, and supermarkets as well. There are many opportunities to get messages out, but, if we just rely on our professional connections to get this done, we are going to fail.

Sometimes the wrong message is given. For example, a dietary guideline for India, is: "Use sugar, fat, and oil sparingly." This is in a country in which a significant proportion of the adult population has a chronic energy deficit. So, your messages have to be tailored to the local situation. The other problem is making the messages fit the audience's capacity to respond. Often guidelines come through that talk about not exceeding 30 percent energy from fat, or don't exceed 10 percent energy from sugar. Many of these guidelines are meaningless. For example, how many of you—arguably the most knowledgeable collection of nutritionists in the U.S.—can tell me what proportion of your intake yesterday came from fat? Of course

you can't, and if you can't nobody can. These then are irrelevant guidelines for individuals. Finally, another problem is that dietary guidance is often removed from lifestyle and physical activity. One size guidance does not fit all consumers.

Successful Programs Around the World

Dietary approaches

Encouraging and enabling consumers to change dietary and lifestyle habits is not easy, but there are some encouraging examples from around the world. At least 20 – some countries are promoting "5-A-Day" type programs to promote fruit and vegetable consumption with some very good success stories. For example, the "5-A-Day" program in New Zealand teaches children (and adults) to use their five fingers to remind themselves of the minimum number of servings required daily, and to use the size of their hand (that is a handful) to determine the size of a serving. In effect, this means that for a small child, a small handful equals a serving; for an adult with a bigger hand, a larger serving is required. The program managers use a multimedia promotion approach which includes work with supermarkets, mass advertising, radio, buses, etc. to get messages out. They have shown that 81 percent of all New Zealanders are aware of the message, and 90 percent of those that have children 15 years or younger are aware of it. In addition, about 46 percent of all New Zealanders are now eating five or more servings of fruit and vegetables a day which is up from 31 percent in 1995. These types of broad-based programs can have an effect, and have been shown to be effective in such countries as Denmark, Germany and the United Kingdom. They can make a difference.

Promoting Physical Activity

However, progress in combatting obesity cannot be sustained by focussing on diet alone. Physical activity levels must also be addressed. In fact, a very common shortcoming of many anti-overweight/anti-obesity campaigns is that they focus on restricting dietary intakes but fail to address issues of an individual's lifestyle and physical activity levels.

There are, however, several successful examples from around the world of programs to promote physical activity. In Singapore, the "Trim and Fit" program has reduced obesity among teenagers. Australia's Physical Activity Campaign has led to a marked awareness among the population of the need to adequate physical activity. Similar programs in the Netherlands, Switzerland, Finland, England and Brazil have also shown promise.

My message is that progress can be made in turning the tide of obesity and chronic diseases. However, the key to success is in reaching out to other stakeholders and in building effective partnerships. There is a need for governments to work together with industry, community leaders, faith-based groups, special interest groups, schools, non-governmental organizations to develop manageable, affordable and doable programs. You will have to get everybody involved in the community to come together. This will take time and effort, but it can be done. And if we don't start acting now, many of these problems are going to overwhelm us.

I appreciated being with you this morning. Thank you very much.

Topic: Turning the Corner: Nutrition and Fitness for Native Americans

Moderator: Colleen Bray, MS, RD, Food Stamp Program, Mountain Plains Regional Office, Food and Nutrition Service, USDA, Denver, Colorado

New Avenues for Nutrition Education in the Native American Community

Melinda Newport, MS, RD, LD, Director of Nutrition Services, Chickasaw Nation, Ada, Oklahoma

The Chickasaw Nation operates a variety of social, economic, cultural, and health programs with Tribal, Federal, and State funding throughout a 13-county area in south central Oklahoma. This area includes a population of approximately 25,000 Native Americans and 250,000 non-Native Americans.

Nutrition Services for The Chickasaw Nation includes a broad spectrum of community and clinical nutrition activities. Programs include the WIC Program, Food Distribution Program (FDP), Farmers' Market Nutrition Programs (WIC and Senior) and the Food and Nutrition Services for our hospital and clinics. We are most fortunate to have a well qualified staff to serve our clients across these programs, including: 6 registered dietitians, 1 Lactation Consultant, 4 Nutrition Assistants (with BS degrees), 8 WIC Paraprofessionals, 10 Certified Breastfeeding Educators and 3 Breastfeeding Peer Counselors.

Our Food Distribution Program is administered primarily through 3 Nutrition Centers that include grocery stores for selection of commodity foods. This setting allows us to serve our clients with dignity and respect in an attractive and comfortable setting. A 2000 USDA Pyramid of Excellence Award was received for this particular concept. We serve approximately 4,500 people per month in the FDP program. In recent years, the Food Distribution Program has added fresh produce to the selections for our participants.



We encourage our clients to take as much of their fruit and vegetable allocation in the fresh form, compared to canned, as they desire. Now, I will discuss some of the types of activities that we do in our store. When people have special health concerns, we help them make their selections among the commodity foods in a way that will optimize their nutrition. Commodity foods through the years have taken a bad rap for being the cause of obesity in the Native American community. Based on what we have heard during this conference, it is certainly more complex than that. I find that the food package for the Food Distribution Program has grown leaps and bounds in terms of the availability of nutritious foods, and certainly we want to teach folks how to use those in a healthy way.

We have cooking classes for FDP and WIC clients, and anybody else that wants to attend. These classes are very popular, enjoyed by all, and we have a lot of fun in them. We advertise the class schedules and folks sign up to attend. They have enjoyed the hands-on opportunity to learn how to prepare specific foods. At our grocery store, we promote the consumption of 5 fruits and/or vegetables a day (5-A-Day) to encourage people to utilize the fresh fruits and vegetables available. The fresh fruits and vegetables are in our reach-in coolers in our newest grocery store. We also encourage people to identify ways to prepare food and recipes that expand the types of foods that they are accustomed to eating, and give them an opportunity to try new things.

Another technique that I like to use in the commodity food program is to promote commodity foods as "fast food," giving a different image to "fast food" than just foods from fast food establishments. We identify all the "fast foods" that can be eaten without any preparation. These foods include nuts, cheese, fresh fruit or other food items that can be opened and offered as a snack for a child or family, without any significant cooking or preparation.

Nutrition Messages

We also take the opportunity in the grocery store to put nutrition messages on our shelves next to appropriate food items. For example, we have a sign promoting the consumption of plenty of fiber, and the sign is located near oats and similar high-fiber products. We promote healthy messages with signs next to various foods in different locations in the store. Some messages also cover food safety topics. We take every opportunity we can to convey these messages.

Recipe Books and Nutrition Calendars

We prepare recipe books every two years or so. They seem to be extremely popular. We have also developed nutrition calendars. Our region has had a nutrition calendar the last few years, and then the National WIC Association also puts out a nutrition calendar that is broadly used, and can be either in a pocket calendar form or a full page.

At the Grocery Store

At the grocery store, we are able to intercept at any point in their shopping experience and ask them "Is there anything I can help you find?" or "Is there anything we can help you learn to prepare?" I think that the FDPIR participants also tend to take only what they need, rather than feeling obliged to take everything that is available to them.

The voucher system has changed over time. In the past we would say, "Mark off the voucher what you don't want." I think that they felt like that may impact their future benefits, and so they were hesitant to ever mark anything off. Now we tell them, "Get what you need today. If you want to come back later in the month, you can." In addition, we developed scanning software that is finally being implemented after much testing. Now we just scan the UPC codes on the food and the participants get their groceries with a tape receipt. We can also run a tape of what they are still eligible for, in case they come back later in the month for the remainder. I think that the system has allowed clients to feel honored and receptive in all of their experiences with this food program.

Partnering

Regarding partnering, I wanted to mention a few of the groups that we have partnered with for nutrition education services outside of our own resources. They include Extension, EFNEP, and our own Head Start program. We also integrate our efforts with a Chickasaw wellness program, the university within the Chickasaw Nation, Oklahoma State University, and other nutrition programs. We also include the food and nutrition services of our hospital cafeteria. We take these same nutrition messages and display them with the foods being sold in the hospital. We sometimes give out complimentary water or sell fruit very inexpensively in our cafeteria to encourage increased consumption. It is not profit-making, rather it is just another opportunity to send a message to clients.

Our inpatient service also has a hotel-style room service menu for clients to select whatever they want to eat for every single meal. That menu can also be used as a tool for patient counseling related to the patient's diet restriction.

As you know, we have a very high prevalence of Type II diabetes in our community, including a lot of children. We screen clients very carefully to recognize children at risk for diabetes, and we hold special classes for those families. This is just an example of one of our services. The WIC program is another one of the large programs we administer. We have 7 clinics across our 13 counties and we serve about 3,000 clients. There are many opportunities for nutrition education classes.

Breastfeeding Promotion

Breastfeeding promotion is a priority. We put significant resources into this subject. We have many staff who are very zealous about promoting breastfeeding and supporting moms in any way that we can. We have peer counselors spread across the Chickasaw Nation so they will be convenient to moms any time they need them. We have a lactation consultant and offer breastfeeding support classes. We provide supplies for moms such as bras, pads, and pumps, and anything that we can to prolong the duration of breastfeeding.

We are putting in a "warm line" for breastfeeding moms to call any time they need some help or have questions or challenges. This encourages them to stay in touch, rather than give up during that moment of crisis. We also have breastfeeding lounges in as many of our facilities as we are able, to promote breastfeeding to employees and our clients. The lounge is a place where a mom can go when she is waiting and wants to feed the baby and where employees can go to pump breastmilk at any time they want to. We provide an electric pump in the rooms. It is good PR to have some of our employees utilizing that opportunity often.

Nutrition classes overlap quite a bit, whether it is for WIC or food distribution programs. A nutrition education class may be held in the food demonstration kitchen. We grab clients that are available and offer them an opportunity to participate in the class.

Farmers Market Nutrition Programs

Our Farmers Market Nutrition programs are probably the most fun and unique programs that we have had the pleasure of implementing in recent years. It is a win-win all the way around. We started our WIC Farmers Market Nutrition Program (FMNP) about seven or eight years ago. It provides food coupons to all the clients that are over six months of age. This is a very enjoyable program for the farmers and the participants.

Once the farmers figured out that they were going to get paid with checks, that they got their money immediately, and they didn't have to fill out a bunch of forms, they decided that this program was okay. They have been just great to work with.

Regarding the Senior Farmers Market Program, we receive money to give our clients coupons or checks for fruits and vegetables to be purchased only at the farmers market. The growers sign a contract with us just like the grocery store would with WIC, the products have to be grown in Oklahoma, and the clients can get the fruits and vegetables throughout the growing season. Our seniors get about \$100 to use in each growing season; other clients get \$20.

The WIC Farmers Market Program requires a 30 percent match, and the Senior Farmers Market Program provides only food money. The State agency has to be willing to administer the program. But, since we already established the Farmers Market Program, we do everything the same with the Senior Farmers Market Program. It is such a win-win. If you could ever promote the idea to any organization that is willing to match, you get more good PR out of this program than anything I have ever done. These are all Federal programs. From the tribes, there is a 30 percent match for the Farmers Market Program, and then we just run the Senior Farmers Market Program with the same folks that run the other programs.

We do food demonstrations at the markets to teach people how to use fruits and vegetables. The Chickasaw Nation also has a garden program, where we teach youth how to grow, sell, and prepare a wide variety of fruits and vegetables. The farmers market creates a great deal of community spirit. The growers enjoy teaching the clients how to prepare foods and use some of their products that they are not accustomed to preparing and consuming, so the program creates a lot of good will.

Consistent Cross-Program Nutrition Messages

The primary thing that I feel very strongly about is that we have targeted nutrition messages that are consistent across all of our programs. There is a great advantage when we integrate these programs and collaborate. For example, we want to say the same thing in WIC, as we are saying in FDP, in the outpatient clinic, and in the hospital room. In this way, we are sending the same message and not confusing people.

Commodities

There are so many commodity foods. There are over 80 commodities and with the amount of storage available, we try to promote messages such as try more variety, eat more fruits and vegetables, come any time, and commodity foods are more convenient. That way we draw them into the stores, because they have so much more flexibility than they do at the tailgate sites. The foods can be provided in many different ways; there are still some more potential sites. I would have to take a deep breath before I put commodity foods in a smoke shop, but you take what you can get. You start with a building that used to be a garage, a service garage, which we used for our first store, and then renovate it into a store.

Thank you very much.

Work Out Low Fat (W.O.L.F.) Curriculum

Betty Jo Graveen, FDPIR Director, Lac du Flambeau Band of Chippewa, Lac du Flambeau, Wisconsin

Rebecca Hanson, Family and Consumer Science & Health Teacher, Lac du Flambeau School District, Lac du Flambeau Band of Chippewa, Lac du Flambeau, Wisconsin

MS. GRAVEEN: Welcome. We are from a small reservation in Northern Wisconsin. The Lac du Flambeau Reservation is not quite as large as other reservations in Wisconsin. The Reservation is 12 square miles, and there are approximately 4,000 enrolled members with about 2,500 living on the Reservation. It is a real tourist trap in the summertime. I have been with the Food Distribution Program since the 1980's. Since that time the program

has come a long way in improving the nutritional quality of the foods provided. All of the commodity foods have commercial labels, and this is working out very well. There is a fresh produce program, which has expanded dramatically over this past year and there are frozen foods available.

The work is done in collaboration with the Great Lakes Intertribal Council, a consortium of 11 tribes in the State of Wisconsin, and the public school system. I play a dual role—as I am also the President of our local School Board. Hearing the nutrition concerns brought up by parents of school children prompted me to run for the School Board. I am the only female, along with four men, on the School Board. There was not much concern about nutrition in the past. Being involved with the school as a board member, it came to my attention that the school foods program did not meet my standard. The school was serving high fat foods such as hot dogs, sausages, and whole milk and also items that made little sense like sugary cold cereal when it was 20 degrees below zero.

The School Board took an active role in searching out a method of improving the nutritional quality of the foods served. Thanks to USDA, we became a Team Nutrition school and started the Work Out Low Fat (W.O.L.F.) curriculum three years ago. Our school system has 550 students. The school houses the Head Start program, and there is also pre-kindergarten for the four-year-olds. I would like to introduce Rebecca Hanson, the school's Family and Consumer Science and Health Teacher to tell you about the WOLF Curriculum.

MS. HANSON: Good morning. I am the Family Consumer Science and Health Teacher at Lac du Flambeau Public School. I teach 5th through 8th grade. I have been in nutrition and health education for over 18 years. Initially my career started out in northern Illinois in Public Health as a WIC Nutritionist, and then I became the WIC Coordinator. Eventually, as breastfeeding became an issue, I took over the position as Breastfeeding Education Coordinator. I became an International Board Certified Lactation Consultant and worked as a Lactation Consultant during my final years in Illinois. Working in public health was a very hectic job with long hours and a lot of traveling. My husband also worked as a professional for several years and we were getting tired and decided to slow down. We moved our family to the beautiful northern Wisconsin area, thinking of having a more peaceful life. I decided that I wanted to go into education in public schools,

because I would only have to work nine months out of the year and have three months off. As many people do, I had mistakenly thought that teaching would be a less hectic job. Along with taking a huge pay cut, teachers have a lot of work to do over the summer when they finally have some time away from students. In the end, the decision to move up north and become a public school teacher really worked out. It is a beautiful and peaceful place. When I went to interview at Lac de Flambeau, I felt very welcome and comfortable in what they wanted me to do.

I began working at the school in 1998. At that time, teachers were directed to eat in the cafeteria with the students and be positive role models. Well, after nine months I gained ten pounds eating the school lunch program food. Over the next year, I gained another 15 pounds because I did not traditionally eat that way. After gaining the 25 pounds, I stopped eating the school food and became concerned about the school lunch program. I started to take a closer look at it to see what was going on, and I changed the "Foods" classes into "Foods and Nutrition" classes. Before I started teaching at the school, the Life Skills course offered was the traditional Home Economics class—making high fat and sugary foods like white sauces, macaroni and cheese, cookies, and cakes. I totally changed the class curriculum to a health and nutrition focus, incorporating the 5-A-Day Campaign, diabetes and heart disease (low fat, sugar, salt & soy foods), international foods, food supply, and helped the students gain a more global and nutritional understanding of food.

My concerns grew and grew and grew, and then in spring of 2000, Betty approached me and said that USDA would like to work with the school to improve the nutrition environment. I was so grateful to have the support of USDA and the Department of Public Instruction (Wisconsin's version of the Department of Education). Many people were called to the table that spring. The list of participants is long, with many, many agencies, some people who are here at this conference, family resource groups, the local clinic staff who were providing the Prenatal and WIC Programs, all the Maternal Child Health Programs, Food Distribution, and all the programs involving nutrition-related health issues.

As the stakeholders sat down that spring and brainstormed ideas, diabetes and obesity came into the picture. The team ended up having four, three-hour initial meetings, with a total of over 12 hours of brainstorming and trying to pull our thoughts together. USDA provided a kit that helped us get

organized. At these initial meetings we identified team members and performed an assessment. With many different people including the Director of the clinic, the Superintendent, the School Board President, and many others we did the assessment and worked toward discovering what we needed to do using the kit provided by USDA. This kit also provided a tool to develop an action plan.

At the beginning of the following school year, key members of the team introduced the action plan to the teachers at their inservice. It was decided that teachers needed to do the assessment and provide their ideas too. Thirty teachers filled out the survey, which gave us even more insight and more people involved in helping us figure out what we needed to do. Then, we came up with a revised action plan of very specific ideas, and started to summarize what would be workable. Being a teacher, I have no time. I am overextended and know that my colleagues are, too. So the team needed to make it something that was simple and would work easily for everyone.

USDA introduced the team to the Work Out Low Fat (W.O.L.F.) curriculum. It covers first, second, third, and fourth grades. For each grade level, there are a series of 18 lessons, which have all been completed. Teachers are given a box with the lessons and most of the supplies. For example, if the students are going to make a healthy low-fat snack, then the lesson plan lists any additional needed supplies (food). The teacher can duplicate a copy of the list and send it to the cafeteria to get the food needed. The planning was all taken care of, so it was easy. The curriculum is based on Native American themes.

The other main issue was marketing it to teachers given their time constraints. Teachers are overwhelmed with work that they have to do in a short period of time. The teachers were nervous about having more demands on their time. So, not only is the W.O.L.F. curriculum ready to go it is fun, which makes the teacher look really cool to their students. During W.O.L.F. lessons, students make food and get to play games (exercise). The W.O.L.F. program does not just cover foods; it also includes physical activity. Students do aerobics and fun things. In addition to the 18 lessons and resources for the teachers, there is a box for each teacher's classroom that contains T-shirts, pencils, stickers, and letters to send home on a weekly basis to the student's family. There is also homework, such as a cartoon that the child will take home to color and then have signed. When children bring the work back to school, they can put a sticker on their card. As they

finish homework assignments over the 18 lessons, there are drawings for prizes and other motivators. The messages are all health-based. There are characters and stories that involve the Native American culture, such as the turtle, crane, and other characters.

Before we were able to bring the curriculum into the school, we had elders review it to make sure it was appropriate for us to be talking about. The elders determined if we needed to bring in others to tell the stories, work with the timing, and different cultural issues like that. It is a very good curriculum. It is easy, fun, and the kids and teachers like it—it has been very popular so far. Another benefit of W.O.L.F. is that many people can help teach nutrition education because there are professionally prepared lessons so they can feel comfortable talking about a subject they may not be too familiar with. At the school we have a variety of people teach the 18 lessons — the Health teacher, the Physical Education teacher, the home-room teacher, and Extension staff conduct some lessons too. So, it is a coordinated and collaborative effort.

The W.O.L.F. curriculum package is available for purchase. At this speaking, the program is for 1st through 4th grades. Our binders are kept in the school's resource library, so they are accessible for all staff. It has been a great start and I hope that it will continue. Our team and Physical Education teachers are hoping to get pedometers to promote physical activity among students and staff.

MS. GRAVEEN: One of the problems that we had was the limited available staff time.

MS. HANSON: There was great resistance. Change is extremely difficult, especially when staff are stressed because of the demands on their time. To accept these additional burdens and time commitments—it was a scary undertaking for them.

MS. GRAVEEN: Of course the rumor mill among teachers was that they would end up being forced to take all the candy away from the children at Halloween and Christmas. Fortunately, we overcame that fear among the staff and children's families, assuring them that celebrations would continue as an important part of school life.

Breastmilk Does a Body Good

Suzan Murphy, RD, MPH, CDE, IBCLC, Breastfeeding Program Coordinator, Phoenix Indian Medical Center, Phoenix, Arizona



I want to thank you for the honor of being here. It is truly a privilege to come and share the information that we have about the benefits of breastfeeding.

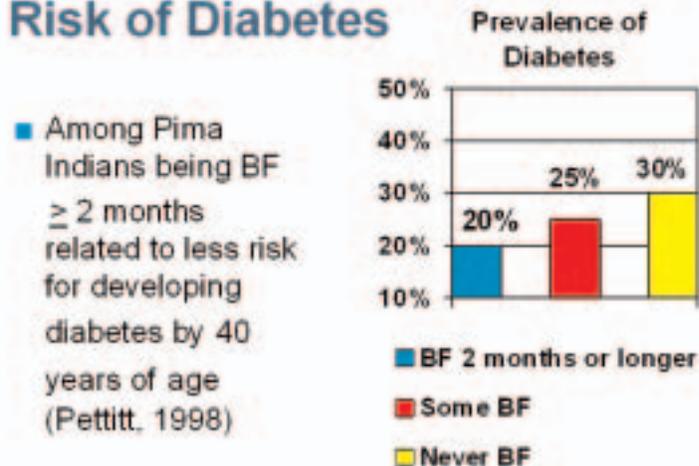
I work at the Phoenix Indian Medical Center, which is a referral hospital in Phoenix, Arizona. We take care of the Phoenix service unit, which includes Arizona, parts of Nevada, a little tiny corner of Nevada, a little bit of Colorado and a little bit of New Mexico. A number of tribes are represented. I am part of the Diabetes Center of Excellence. I work with a wonderful woman who is Hopi. She belongs to the tobacco rabbit clan, she speaks Spanish, and she is very nice, too. That always helps.

Often, people will ask, "Of all the things to pick, why did you pick breastfeeding with diabetes? What is the connection?" About five years ago, the National Institutes of Health (NIH) looked at research that they had accumulated over the years to try to figure out why some of the people on the Gila River Reservation, which is composed of Pimas, have the highest diabetes rate in the entire world. Eighty percent, that is four out of five people, will have it by the time they are 55.

What Dr. Pettit found was that if a mother breastfed her child, by the time the child was 40 years old, the prevalence of diabetes was 20 percent. If the child had been breastfed and bottle-fed, then the prevalence was 25 percent. It goes up to 30 percent if the child was not breastfed, which really caught our attention. Looking at breastfeeding in the population was one more tool to use to deal with diabetes. At the same time, we found that a

man named Von Kreis had done some research in Bavaria, Germany, with 10,000 kids. He found that if the children in the study had ever been breastfed, then the prevalence of obesity and overweight was less than if they had never been breastfed. What was even more interesting is that the risk of obesity was reduced as the amount of time for breastfeeding increased. Cool, huh? Nice little stair step effect.

Breastfeeding (BF) Reduces Risk of Diabetes



In our little corner of the world, we thought, if they can do it, we can do it. So, we looked at our WIC data. As you all know, WIC is the superstar program for gathering accurate heights and weights. We found in our population at the Indian hospital that if a child had been breastfed for six months, then their prevalence for obesity and overweight was 23 percent by age three to four. If the child had been formula-fed, their rate goes up considerably. Scary, huh?

You may ask, "What did we do with all this information?" We developed a hypothesis using the public health planning model that used breastfeeding as a way to reduce diabetes. When we started asking questions, we found that the baseline for breastfeeding prevalence was below the Healthy People 2010 goal, which is not an unusual thing, unfortunately.

With focus groups, we found that the interest in breastfeeding was very high, not just among patients, but also among staff. I was surprised that there were not any naysayers. In fact, the only message we received consistently in all the focus groups (pediatrics, the clinic, the floor, women's

clinic, prenatal classes, patients, and anyone we asked who was willing to sit down and have a bagel and share their thoughts) were comments about what helped and what hindered breastfeeding. The strong message that came across, besides the support was: "Please do not hassle our moms." Don't make them feel guilty. Give them the choice, and then let them proceed as they know best. That has been a very valuable piece of information for us.

We also discovered that we needed multiple levels of intervention. One size was not going to fit all. We also discovered that we needed support to begin and maintain breastfeeding. This isn't news to you, right? We knew it too, but they had to put it down on paper and make it real. So, we ended up having a fulltime lactation consultant and, in July, added a breastfeeding consultant.

We have a 24-hour hotline support phone, which actually is just a little tiny cell phone. It is the 1-877 number that is on all the printed things, and I answer it as long as I am awake. We provide staff education, patient and family education, outreach, and follow-up. Surveillance means that we find out what the mom was doing at birth in terms of feeding choice, and also what they are doing at eight weeks. Our goal is to increase both. We use RPMS, which some of you are familiar with. It is a computerized IHS system, and we modified the diabetes case management registry system to begin keeping track. We are now keeping track, and it is so much easier.

Regarding our outcomes, we are really excited about and proud of the fact that the percentage of mothers and infants who are still breastfeeding at eight weeks has gone up 12 percent in two and a half years. Also, the rate at which mothers quit breastfeeding has gone down. The number of breastfeeding hotline calls has increased over time. Often, people call me and say, "How do you do hotlines?" You just answer the phone. Usually the questions are very simple, like, "I've got a head cold—can I take Tylenol while I am breastfeeding? What can I use?" Occasionally, the questions get a little trickier, but most of the time moms have questions when they need reassurance.

We started out with 60 phone calls a month; we are now into the 175 per month range. Twenty percent of the calls occur outside normal business hours, and those calls are almost always very quick calls, moms who just have a question and they want an answer, so it is not hard to pick the phone up.

In terms of diabetes risk reduction, we have had an increase of 12 percent in breastfeeding. What that converts to in terms of Dr. Pettit's study is a five percent relative risk reduction for this age cohort. In other words, there will hopefully be five percent less diabetes in the people we are seeing now, whether breastfeeding or otherwise, by the time they grow to be 40 years old. Other studies have been done that support Dr. Pettit and Dr. Von Kreis' research in Scotland, Germany, and the United States, to suggest that the longer people breastfeed, and the longer babies are breastfed, the less risk they have of obesity as they get older. There was a study done in Manitoba that concurred with the Gila River Pima study that we used to show reduced risk of diabetes. Their sample was much smaller.

Where to now? We are going to keep bugging our moms, be available to them, keep spreading the word, and keep educating staff. We will try to find out why moms quit breastfeeding and what interferes with breastfeeding. The next stage is to start asking questions when we call our moms at eight weeks.

Our role is to share what we know. Living in Arizona, we don't always find out what is happening on the East Coast. The web site, <http://www.4woman.gov>, is an awesome resource for all sorts of good stuff. They have a "warm line" as well that you can use.

We worked with NIH to put together the "Close to the Heart" project. We produced calendars and a 12-minute video that talks about breastfeeding. They are really beautiful, we are so proud.

PATHWAYS: Nutrition Education and Exercise: A Path to Good Living

**Jean Anliker, PhD, RD, LDN, Research Associate Professor,
Department of Nutrition, Amherst, Massachusetts**

Presentation not available. For information on the Pathways study and program, see this website: <http://hsc.unm.edu/pathways/index.htm>

Topic: Family, Food and Fitness: What's Culture Got To Do With It!

Moderator: Judy F. Wilson, RD, MSPH, Director, Nutrition Services Staff, Office of Analysis, Nutrition and Evaluation, Food and Nutrition Service, USDA, Alexandria, Virginia

Cultural and Racial Variance in Obesity and Overweight: 2000 NHANES Data

Cynthia Ogden, PhD, Epidemiologist, National Center for Health Statistics, Centers for Disease Control and Prevention (CDC), DHHS, Hyattsville, Maryland

Good afternoon. I am happy to be here. I am going to talk about the current national prevalence of overweight and obesity. I will look particularly at differences in subgroups in the population. You may have many questions about differences in different subgroups that I may not be able to answer because we do not have as much data from 1999-2000 yet. Hopefully, in the next couple of years when we have more data, we can do an even more detailed subgroup analysis. I will discuss the data so that you can make judgments yourself when you see prevalences and estimates from the data set. I will talk about definitions of overweight and obesity because they are very important and are different for children and adults.

NHANES is the National Health and Nutrition Examination Survey. It is a series of surveys. I will discuss particularly the NHANES III, which was undertaken from 1988 to 1994 and then NHANES-1999-2000. The NHANES are conducted by the National Center for Health Statistics, which is part of CDC. They are a series of cross-sectional, nationally representative examination surveys of the civilian, non-institutionalized population. This is an examination survey, so especially when we are talking about overweight and obesity, this survey is a great resource.

When you talk about self-reported weight and height, people tend to underreport their weight and height. You are going to get different estimates of obesity and overweight when you look at self-reported versus examination data.

NHANES is a stratified, multistage probability sample. In 1999, NHANES became continuous. Before, it was a periodic survey. About 5,000 sample



people (or "SPs" in the lingo) are surveyed per year. You need two years for adequate sample sizes to do analyses, so I will show you results from 1999 and 2000 data. More data from 1999 - 2000 will be available in the next couple of months.

NHANES oversampled non-Hispanic blacks, Mexican-Americans and adolescents in the 1999 - 2000 survey. The different surveys have oversampled different groups at different times. Examinations are conducted in mobile examination centers. The exam includes standardized measurements of height and weight and recumbent length for children less than four. Anthropometry is just one of many topics in the NHANES survey. These mobile examination centers actually drive around the country. It is a pretty impressive survey.

So, what are obesity and overweight? They are a little bit different. Obesity is a measure of adiposity, but it is often impractical to measure it directly using skin-fold thickness, MRI, C-T scans, DEXA, or BIA (Body Image Assessment). So, often, we use overweight, which is the excess of weight for height to be a proxy for obesity. It is easy to obtain and it is very highly correlated to obesity.

There are various indices. The one that is most often used is body mass index (BMI) or weight over height squared in metric units. This is widely used to define overweight and obesity in adults. The criteria for excess weight for height is related to health risks, and this is determined from different studies. The BMI definition in adults is 25 for overweight and 30 for obesity. It is also recommended for use in childhood.

But, in childhood it is a little bit different. The definition of overweight is not based on some sort of health risk the way it is in adults. There are a variety of issues that have to be taken into account, including that BMI varies with age and sex. It is unclear what risk-related criteria to use because there is a long span between adverse outcome and childhood. You have small samples on cardiovascular risks in youth, and a predictive value in childhood varies with heaviness and age, in terms of predicting adult overweight or obesity. In childhood, we have a statistical definition that is based on percentiles in a reference population.

The definition of overweight for adults is a body mass index between 25 and 30, obesity is between 30 and 40, and extreme obesity is over 40. For children, we use the 2000 CDC growth charts. You could use different

definitions. This is the most common definition that is used. For two to 19 year olds, we talk about overweight as being a body mass index for age greater than the 95th percentile. That would be a sex-specific percentile. You don't talk about overweight and obesity; you use the terms overweight and at risk for overweight in children, so at risk would be between the 85th and 95th percentiles.

For younger children, we do not have a body mass index chart to use, so usually the weight for length chart is used, and overweight is greater than or equal to the 95th percentile. But, most of the discussion about overweight and obesity focuses on kids two years and above and then adults. To reiterate again, the definitions for adults are based on a health outcome, whereas the definition in childhood is statistical. That is an important distinction to make.

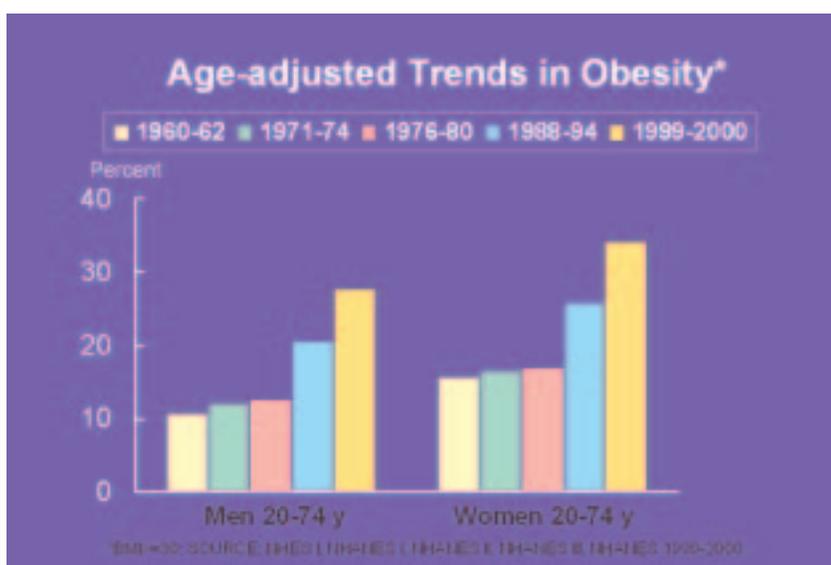
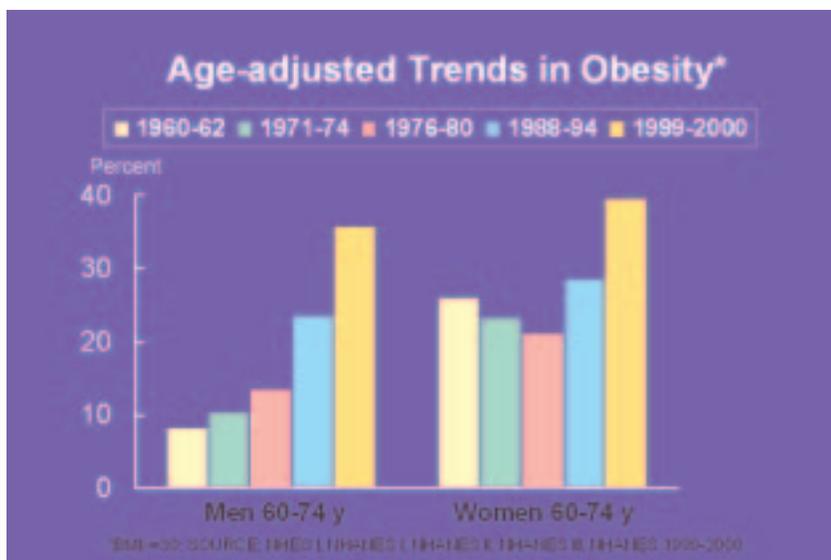
Let's look at some results. These results were the most recently published. You can get all of these results in two Journal of the American Medical Association (JAMA) articles that were published last October. The adult paper is available free on the Internet. You have to subscribe to get the paper on kids.

Some statistics on obesity and overweight statistics from NHANES, 1999-2000 include:

- Among adults 20+ years:
 - 31% are obese (about 59 million people)
 - 64% are overweight or obese (about 123 million people)
- Among children, 6-19 years:
 - 15% are overweight (about 9 million children).

We can look at some trends from the different NHANES surveys from the early 1960s to the most recent, 1999-2000 for adults. You can see the tremendous increase. It was about an eight percent increase between NHANES III and NHANES 1999-2000. It is about the same increase that we saw between NHANES II and NHANES III.

For men it is about 28 percent and for women it is about 34 percent. This is obesity. We are not talking overweight.

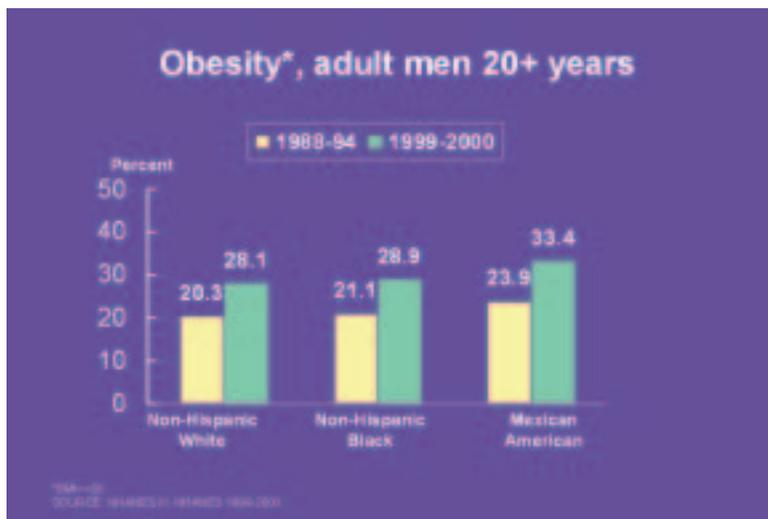
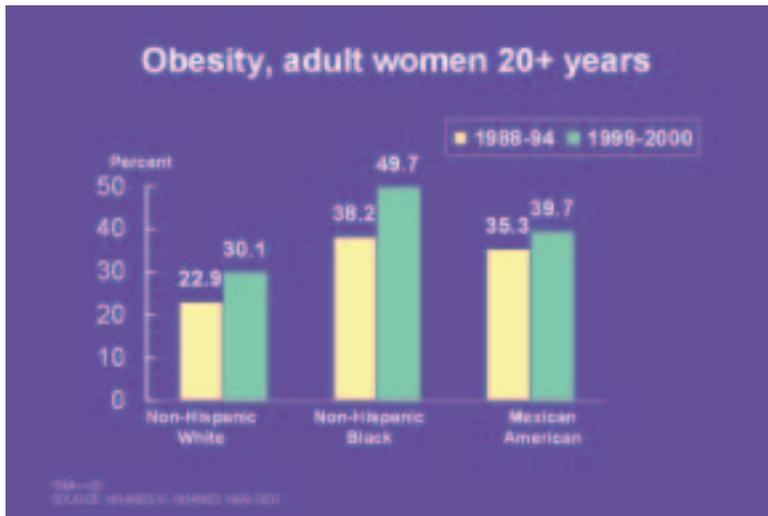


I wanted to show you the trends in obesity particularly for people in their 60s, because the trend there has been very high. The increase there has been one of the highest of all the different subgroups that we looked at.

You can see for men, in the early 1960s the prevalence was much lower than women, but men are catching up. The increase has been over ten percent between NHANES III and NHANES 1999-2000 for people in their 60s.

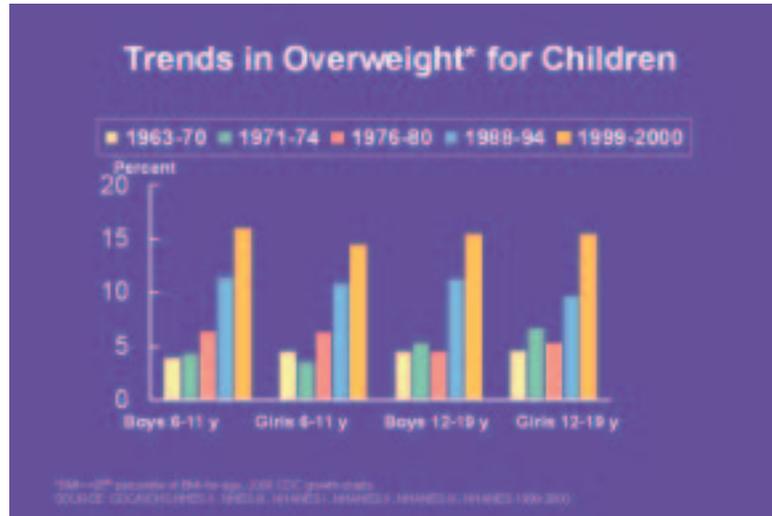
If we look at obesity by race-ethnicity, there are only three race-ethnic groups we can look at in NHANES because of the sample size.

We look at non-Hispanic white, non-Hispanic black, and Mexican-Americans. For adult men 20 years and above, you can see that in all groups, there has been an increase, but there is no variation by race-ethnic group among men. This is different than among women. Among women, you see again an increase in all groups. Again, the bottom line here is that obesity and overweight have increased in all groups, but there is a difference by race-ethnicity in adult women, which you don't see among adult men.



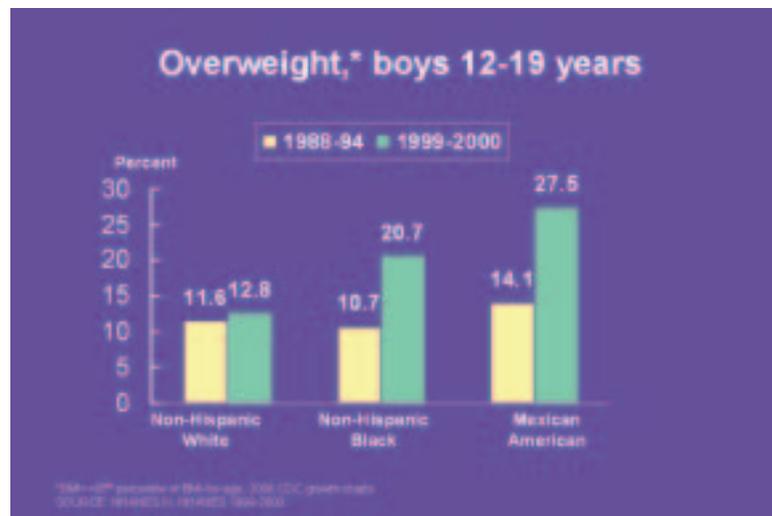
Now, almost 50 percent of African-American women are obese, compared to 30 percent of white women and 40 percent of Mexican-American women.

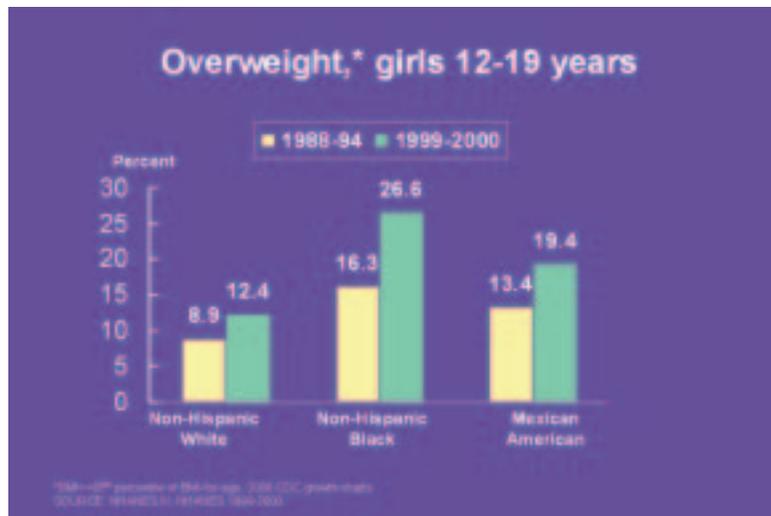
If we look at trends in overweight for children, you see a similar pattern as we see in adults. It has gone from about five to ten to 15 percent, about tripled in the last two decades—a very similar pattern as with adults. You see the same thing for school age versus teens.



The slide below looks at race-ethnic difference in teens. Among boys, you saw no difference in NHANES III between the different race-ethnic groups, but now in NHANES 1999–2000, we do. It is a significant difference. Now, over 27 percent of Mexican-American teen boys are overweight.

For girls, the difference between the race-ethnic groups is larger than it was in NHANES III. For non-Hispanic black girls, almost 27 percent are overweight. I did a run looking at the percent of African-American girls, teens, that were obese using the adult definition, and it was about ten to 15 percent. So, it was pretty high using the adult definition of obesity.





I want to examine data from NHANES III looking at differences in overweight in kids and at risk for overweight by poverty level, looking at 130 percent, 131 to 300 and over 300 percent of poverty. I have a strong bias here, because I think people often assume that it is only poor people that are overweight and obese. That is just not true or at least the NHANES data do not indicate that that is the case. It is a problem for everyone.

Results from a paper published by Alaimo in 2001 indicate that for girls, the only significant difference by income was among white girls eight to 16 years old. For all the other groups, the differences were not statistically significant by income. The same was true for boys.

I can't just talk about this tremendous increase in overweight without mentioning why there has been an increase. Of course, it is related to calories and physical activity. Some data, including NHANES data, suggest that at least on the median, calorie consumption is not up that much. We know that we are very inactive, 25 to 40 percent are inactive during leisure time, depending on what surveys you look at. Of course, it is a very complex issue, related to our lifestyles, the environment and genes, but there are underlying factors such as larger food portions, eating out, computers, and crime. But, data is lacking to be able to say for sure what has caused this problem. It is many different things for different groups.

In summary, overweight and obesity are increasing among all groups, but the biggest increases between NHANES III and NHANES 1999–2000 were among the 60 to 69 year olds (13 percent increase); black women (11 percent increase); black teens (about a ten percent increase); and Mexican-American teen males (about a 13 percent increase).

We see differences by race-ethnicity, especially among adult women, where African-American women have a much higher prevalence than do other women. There are no race/ethnic differences among men. We see differences by income among children, but only among white teens.

Family, Culture, Ethnicity: Influence on Eating and Activity in African-American Communities

Yvonne Bronner, ScD, RD, LD, Professor and Director, School of Public Health, Morgan State University, Baltimore, Maryland

Thank you. We will be talking about the influence of family, culture, and ethnicity on eating and activity in African-American communities.

I want to tell you about a book called "Food Counts in the African-American Community." Several years ago, in the mid-90s, I discovered that there was not very much information in an interesting format available for the African-American community. Some of you may have experienced the fact that when you say you are going to write a nutrition book, people sort of "go to sleep." We wanted to get away from that concept. The book is designed to use images, activities, and situations that would be in the African-American community. We said, "Let's focus on food versus diet." We also looked at nutrition and physical activity throughout the life cycle. I'm going to share with you some of the points that we used.

Focusing on Food Instead of Diet

Why not focus on diet? Clearly, diet has a bad connotation. Diet is time-limiting. Diets are complicated and maybe confusing, and there are too many diet choices. When we ask folks in the African-American community about diets, there was this "glassing over," so, we felt like maybe we needed to move away from that.

We need to move to the concept of talking about food. Why talk about food and what are some issues that you can talk about when you talk about food? Number one, food is very simple. You can start with very small children. You can tell them apple, orange, pear, whatever—it is tangible, it is right there. You can put your hands on it, you can smell it, you can feel it, et cetera. If we spend some time, it can become interesting.

The other interesting thing about food is that it provides a learning experience for many of us. If you go back in your thinking over the last ten years and ask yourself, "How much have I learned about foods from other cultures?" Most of us would say that we have learned quite a bit. Our grocery stores now have many of these foods on the shelf. So, there is always the learning experience.

It is a wonderful teaching experience as well, as we are working with our children, families, friends, et cetera. I am in the process of learning and teaching a lot about food.

Many of us now are being creative and going gourmet in many of the things that we cook. We are using spices we haven't used before, and foods that we may not have used before. When we do that, food can be fun.

We used the Continuing Survey of Food Intakes for Individuals (CSFII), from USDA, not the NCHS database, as a source of information for this book. One of the things that we learned, quite astonishing to me, was that in the African-American community, high income and education did not necessarily lead to good nutrition practices.

If you are familiar with the 50 years of change that we experienced with cardiovascular disease among Caucasians, it was because the message of high fat got out and people changed their diet and exercise patterns. We also had drugs, and I will not discount the influence of the pharmaceuticals, but cardiovascular disease dropped by 50 percent. To some extent, that dramatic change was attributed to dietary changes. But, we have not been able to see that kind of change in the African-American community, and we learned that from examination of the CSFII data.

What factors influence the amount of food that you need? Gender, activity, age, and level of fitness. We know that we are "eating ourselves to death," but how can we learn to eat less with so many incentives to eat around us all the time?

The Serving Size Issue

What can we do about the whole business of serving size in the settings in which we work? Let's see if you have any innovative ideas about serving size and how you have been successful helping people lower their serving sizes.

PARTICIPANT: In the program that we run, one of the things that we try to do is increase variety. We find that when there is more variety, there is less over consumption of any one particular type of food.

DR. BRONNER: That is very interesting. So, it is less consumption of one type, but do people still tend to eat a lot? I said "serving size;" I guess that I meant the whole dinner.

PARTICIPANT: You mean the whole plate. I would say "no." My experience with people that we work with, including elementary students, is that they eat less when there is more variety.

ANOTHER PARTICIPANT: I am in the WIC program, and we use a measuring cup with clients so that they can see what reality is.

DR. BRONNER: Many of us could benefit from that. We need to pay attention to how we might communicate this message of serving size. As Dr. Ogden pointed out, our real problem right now is to stop the increases in obesity. Most of us recognize that losing weight is as big a problem as stopping weight gain. If eating more than we need is one of our problems, then we are going to have to come to grips with the issue of serving size.

Perception of Body Image

How can we help our clients to perceive a healthy size, that is, a body size, as being a desirable size? We have been doing work at Morgan and Johns Hopkins on the perception of body image. Several studies that have been done on African-American women have found that they tend to be more comfortable with a body size, a perception of body image, that may not be related to a healthy body image.

How can we begin to help folks change their perception of what is healthy in line with what actually is healthy?

PARTICIPANT: In the Boston Public Schools, we have stopped talking about weight and pounds, less perception of the body, and more about what is healthy. There is a cultural difference between white Americans, African-Americans, and Latino Americans. I have found that it may not do any good to talk about aesthetic practices or weight, but instead we should focus more on health issues.

DR. BRONNER: Absolutely. We are not out to destroy people's positive self-image. The truth of the matter is that there are some relationships between weight and disease. So, we are going to move over to the health issue and not focus so much on the body size, and what is "pretty." We are not as concerned about how one looks as we are about health outcomes.

Most of us who work in this field recognize that this is probably not an issue that we are going to resolve right away. One of my students is doing a dissertation on the subject of perception of body size and health outcomes, and we may learn something in the next few years from her work that will help move us forward.

Nutrition Issues During Pregnancy, Breastfeeding, Infancy, and Early Childhood

Folic acid was in vogue at the time that the book was written. We have foods that are fortified now, and hopefully we are having less risk in this area. But, it allowed us to use the preconceptual period as the time for us to begin to get our messages out. WIC folks and others who work in the area of early lifecycle nutrition know that pregnancy is a teachable moment. Further, learning about weight gain and the degree to which weight gain during pregnancy may be a factor in the onset of obesity is a very interesting point.

A study from Cornell has demonstrated that if you gain weight during pregnancy and fail to lose that weight in the inter-pregnancy interval, several pregnancies might then lead you to move from a healthy weight to overweight. So, weight gain during pregnancy maybe a factor in overweight and obesity.

The whole issue of breastfeeding and overfeeding in infancy is being considered as well. I believe that one of the most important periods in the life cycle for us to use as a preventive measure against obesity is during the toddler stage. During that stage, food habits are being developed, and often it is the stage when parents just give up. They throw their hands up, because it is very difficult to work with toddlers.

Several books have asked us to place appropriate food before the toddler and allow him or her to make decisions about satiety. I think that these do have some meaning for us. We need to teach children about foods and the appreciation of foods. Then, when they move into childhood, when appreciation for food and eating habits are beginning to develop, they may not be led toward overeating, overweight and obesity.

Our children are kept in the infantile state much too long, and need to become involved in food. They need to develop food shopping and preparation skills. Of course, we would have to have these skills ourselves in order to pass them along. Many of our young people are just like we are—they start in the morning and they don't stop until late at night. Saturday is no different. It is almost as if we are afraid to give them a moment when they are not programmed.

In that regard, it is very difficult for any of us to sit together for the home meal. An important thing to strive toward is resetting the dinner table, so that we can have at least one time, two times, three times during the week when we can actually have role models of eating well.

Weight gain should be monitored at all ages and curbed, if necessary. This is a very important stage for us to get on top of. Dr. Ogden gave us some very shocking statistics about our adolescents. Most of us used to think that once you passed your 30's, that was when your weight gain was going to set in. It is shocking that we are having these young people, adolescents, children, who are not only overweight, but they are also putting themselves at risk for developing diabetes, hypertension, and the other chronic diseases that could be prevented.

Nutrition Issues Related to Adults

What issues impact on nutrition and obesity in adults?

- We are engaged in advanced training.
- Jobs—our jobs cause us to go into a sedentary state. One of the things that I talk about in our program is that we often don't think of life stages in terms of their ability to add to our obesity status. Think about the fact that if you were active as an adolescent, and then you go to college, you tend to become a little less active. Then, when you get a job, you become very much more inactive, in most cases. You become sedentary. If you don't think about that and you keep eating the same way, just that in itself is going to cause you to gain weight. You have to think about the lifestages and what those mean for the development of overweight/obesity.

- Family formation—we just talked about pregnancy. With pregnancy, you gain weight, and don't lose the weight—what is going to happen? You get pregnant a second time.
- If you are not aware of the time drain of childcare and employment and if you do not program yourself for physical activity, obesity can result. You have to think consciously about lifestyle changes to prevent weight gain.
- Poor food acquisition—you start running more, you eat worse, you get food from fast food places, instead of planning meals.
- Limited food knowledge—many of our colleagues who are not in the field of nutrition do not have the knowledge to make good decisions around food. So, it is our responsibility to pass that on, not just to our program people, but to people that we interact with in general.

With our older group, this life stage involves decreased energy need, decreased activity, and illness states that might place them at risk.

I don't know about you and your communities, but in my community, the old folks are the ones out walking. They are the ones who are retired, they have time, they have their warm-ups on and their weights in hand, and they are out there moving. Maybe, we can take a hint from them, let them do some babysitting, and let us get out there and do some walking. Then, when we go to work, they can still walk. Our older people are moving around a lot more, and they want to live healthy and live long.

Know Your Numbers

Regarding the diseases that we all know about, do we know our numbers and insist on our families knowing their numbers? For example, know your numbers for total cholesterol, HDL (> 35), LDL (<130), and for blood pressure (120/80). They made a very significant change in the measures for high blood pressure in the late 1990s. It used to be that we only thought of high blood pressure as 140 over 90, but now there are six different categories. This means that they are asking us to think about blood pressure at an ever-earlier stage, so that we don't allow it to get high. I think that is very good in terms of prevention.

In terms of obesity, we know the factors that lead to it. Regarding osteoporosis and cancer and all of the chronic diseases that we are looking to prevent—how are we going to prevent those? When you go to work, you are going to now take the steps—you are going to park far away, all the things we know. Regarding leisure time physical activities, we can get up earlier or stay up later, but get it done.

We now heard today about the HealthierUS Initiative, that we can join. I think it is very exciting to join in with this national movement to get involved.

Thank you very much.

Promoting Healthy Eating and Healthy Living: A Response from the Nonprofit Community

Fabiola Gaines, RD, Nutrition Consultant, Hebni Nutrition Consultants, Inc., Orlando, Florida

I want to thank Judy Wilson so much for having this Florida girl come to some cold weather. It has been a long time since I felt this cold! I am one of the co-founders of Hebni Nutrition Consultants. We are a 501c3 nutrition practice in Orlando.

The way we came up with our name is out of Webster's Dictionary. We wanted to be ethnic, but we didn't want to have our names spelled E-b-o-n-y. This is the Egyptian way you spell H-e-b-n-i so you pronounce it as Ebony. My partners are Roniece Weaver and Eldaretha Carson.

When we were in the process of founding our nutrition practice, we wanted to make Orlando, Florida, lose weight. We were going to make millions of dollars. I can see myself in a 10,000-square-foot home right now. But, we went to a health fair in our community, and when we were there, only ten black people came through. There were probably 75 health professionals at this health fair, and we realized that this is not working. Passing out pieces of paper in the population does not work.

At my dining room table one night, we decided that we were going to come up with a program that will attract women, because as we know, women make all of the decisions in the household, from the money to what we eat. We came up with a program called "Sisters, Take Charge of Your Health." Roniece and I have been blessed to be co-authors of three books: "Slim Down, Sister," "The New Soul Food Cookbook for People with Diabetes," and our newest book that came out last week for the American Diabetes Association, is "Month of Meals: Soul Food Selections." We have been truly blessed with being able to provide our community with information that addresses the needs of our community.

Programs and Workshops

Through our nonprofit, we have a program called "Sisters, Take Charge of Your Health." Along with that, we addressed the teen population. I have to tell you a story about this program. We were told that the women are not going to come, "They don't come to our programs, what makes you think they are going to come to yours?" So, we told the American Heart Association and the American Cancer Society, that we had the "FUBU," "For Us By Us," concept, and we are going to show you just how to do it. We started nine years ago with 200 women, and this past April 2002, we had 2,000 women. We do have the interest because we have used a culturally sound method.

Some of our workshops are called "Slim Down, Sister," "How to Get the Junk Out of Your Trunk," and "My Pressure Is UP"— we have a cardiologist do that work for us. We are very specific with our professionals. We tell the doctors: "We will give you a whole page to brag about yourself, and all our participants can read, the majority of them. When you get in front of our audience, no three syllable words and no boring slides." We are right up front with them, because we want our participants to be able to take the information home and use it with their families. For our teens, we have workshops like "I'm All That," where we talk about self-image; "Work Out, Little Sister," where we bring in exercise. We have an aerobic teacher that works them out real well.

We have all of our nutrition components worked into all of our workshops. How do you work health and wellness into financial fitness? We do. If the questions aren't answered in the workshop, we have a table in our exhibit area that is called, "Ask the dietitian," where we rotate dietitians in to answer questions from our participants.

We also have a program called "Seniors, Take Charge of Your Health." That stems from our sisters, because our senior citizens were so slow about registering, they couldn't make our program. So, we designed a specific workshop just for them. We also provide individual counseling, HIV education, and anti-smoking counseling.

Soul Food Pyramid

We developed the "Soul Food Pyramid" about six years ago. When we were in our community trying to educate our population, we didn't have anything

to work with, because the Food Guide Pyramid didn't tell us where chitterlings fall. Where do chitterlings go on the Food Guide Pyramid? So, we developed our own. On our pyramid, you will see chitterlings, ham hocks, and pig feet. We had to take pictures of a chitterling, because you can't draw it. Those were brought up as a meat, but we are trying to tell Southerners and African-Americans that those foods are fat. That was the difference between our pyramid and the Food Guide Pyramid that we are all familiar with. We added some other vegetables and other foods that you don't find on the Food Guide Pyramid. We have a low literacy version of the pyramid. We also developed a Soul Food Pyramid for kids that is about three years old.

Providing HIV Education

In terms of the interest in the programs and the demographics of the women that attend our program: seven percent of them are African-American and 65 percent are over the age of 40. When we did our workshop in 2002 on HIV education, no one wanted to go to that workshop. We had about 25 to 30 women in that workshop, because we wanted to address HIV in the African-American population. So, guess what we did? We changed the name: "Sexual Healing, How to Make Love for a Lifetime." We had 350 women in that workshop. Just to show you what words can do.

We found that even in our population, we have problems with certain issues, but it is important that those issues be addressed. We felt that it was real important that we concentrate one of our workshops on HIV education. The women showed up and there was standing room only—it was real powerful.

It is important that when you have a group of people in one room at one time, you try to educate them as much as possible. Dr. Bronner talked about serving sizes. We do a faith-based wellness program in Orlando, a 12-week wellness program, that encompasses weight loss, diabetes, heart disease, all of the chronic diseases. In talking about all of those diseases, we know that diet plays an important role.

Educating About Portion Control

We are committed to educating African-Americans on portion control. We have some tools that we use. One of them is called a spoodle. The

restaurant industry has been very instrumental in portion control for years. This is a device we get from a restaurant equipment supply store. You can stir in a pot with it and can also measure with it. A lot of times we aren't going to pick up a measuring cup, but we all have those big silver spoons in our houses, don't we? We give our classes using a spoodle with a four-ounce serving, and it seems to work. We go through a detailed education program to teach them how to use this device.

We also developed a pie chart that seems to be working very well for us. I am going to put a piece of white paper behind it. We put it on a transparency. This is an inside circle of a plate. Our classmates tell us: this is not a circle of a plate, because we always eat on the white edges of our plates when we talk about eating and portion control. So, we have to take a real plate and show them that this is the inside circle of a plate. We tell them to eat within the lines. When you deal with African-Americans, we are real visual, and this tends to get the point across that if I eat outside these lines, my portion sizes are too large. This has been working very well.

Wonderful Results in Health Outcomes

With our wellness series, our theory was that through nutrition education, we can change outcomes, that is, lipid levels and hemoglobin A1Cs. So, we test for hemoglobin A1C, and total cholesterol, HDL, and LDL initially, along with the weight and BMI of all our participants. We also do it at the end of the 12 weeks. We have found some wonderful statistics and data that we have lowered weights, hemoglobin A1Cs, and total lipids, after just 12 weeks of education. So, it can be done.

I want to emphasize: Don't forget about the poor grassroots nonprofits in your community, because we are out there chipping at a mountain, and nobody sees us. When we try to collaborate with universities and other big organizations, they look at us and smirk, until we show them the results that we are getting and the numbers of African-Americans that we are reaching through our programs. If you don't remember anything else I have said today, remember that not all seeds of knowledge fall into a fertile environment to produce change. Of those that do, some will take years to germinate. Be patient and provide counseling in a culturally appropriate environment to promote positive health behavior.

This is what we believe at Hebni—we have seen it work and we know that it works. We want you to continue to support us as you have. Look into your communities and find little nonprofits like us, and help us continue the effort to educate my people. Thank you very much.

Father's Breastfeeding Support Initiative

Yvonne Bronner, ScD, RD, LD, Professor and Director, School of Public Health, Morgan State University, Baltimore, Maryland

This last presentation today in this session is the one that is dear to me. That is, the Father's Breastfeeding Support Initiative that I have worked on since about 1995. This has yielded a set of materials that has been widely distributed in the WIC program.

Let me tell you about it. One of the things that I noticed in working with WIC was that I did not see very many positive male images in the WIC clinics, and that bothered me a lot. We did not have any males engaged in our breastfeeding promotion. So, my goal then was to increase father's support of breastfeeding.

I am going to share with you how that project got started and how men can be informed about breastfeeding. We have to understand the male perspective regarding breastfeeding. At first, everybody would just fall out laughing. But, it turned out that men wanted to know a lot more about breastfeeding once we got started. I will be discussing specific things that fathers can do to support breastfeeding and strategies for encouraging father involvement in breastfeeding success.

Use of Qualitative Methodology

We used qualitative methodology to collect our information. We had focus groups with the WIC staff. If you are going to implement a program, you should have the people who are going to implement it be on board with the issues to be discussed. So, we started with the staff. We had a focus group of partners of WIC clients, with WIC clients plus their partners, both married and unmarried, because those were different issues, and finally WIC clients in general. We wanted to know the women's perspective, as well.

Examination of African History for Positive Male Role

Since the male role in America right now is so fragmented and, from the media perspective, very undervalued, we started with a literature review

that went all the way back to Africa. We wanted to see if we could find a place in time when the male role was valued. So, we started way back in African history and found that there were very positive male role images back then, with the middle passage, and the issues that followed during slavery, the split-up of the family, and then the reuniting of families. As a matter of fact, one of the primary drives following emancipation was the attempt to find family members and get married.

Modern Male Role Images

Then, we moved forward in our search for male role images. Many of you are familiar with Blankenhorn's book on the evolution of fatherhood roles in the United States. We referenced that book to cover a lot of issues of concern. That brought us up to the current perceptions of African-American males around the whole issue of fatherhood. Blankenhorn found that fatherhood is a scripted role, versus motherhood, which is a role that is much clearer to people. Because that role is scripted and sociologically based, it is also very dynamic. It has changed a lot over time.

If we look from 1988 forward, you will find that there were several scripts that we bought into. If you go back even further than that, most of us grew up with the "old father" script, and that script portrayed the father as a disciplinarian and a person who worked, earned the bacon, brought it home, et cetera. But, that father was not very often emotionally involved in the home setting.

Then, there is the "sperm father," the one that just simply donates to the birth and then is gone after that. There is the "deadbeat dad"—the one that is often commercialized; this father takes away more from the home setting than he contributes. There is the "visiting father"—the one who comes and goes, but the children do not see him as a real presence within the home.

There is the "new father." This was a role that was very interesting to me, because this new father is one that has finally got it right in some people's opinion. This is a father who 50-50 or 100-100 percent is in there doing the things that the old father's perspective would have been maternal tasks. They cook, clean, take care of the kids, and take them to the doctor. To some extent, that fatherhood role is one that was popularized in the popular literature in the late 1990s and early 21st century.

Then, there is the "good family man." This was a role that Blankenhorn set forth, as a "necessary father." He is not perfect, he doesn't do all of these

things that we were just talking about necessarily, but he is good enough. For him, the key word is not a verb at all, but a gender-specific noun. This was the last model in the Blankenhorn book. For any of you who are interested in learning more about this evolutionary process, I recommend that book.

In our research, we found that it was very important for us to understand the male perspective. One of the things about fathers, relative to infants, is that they are jealous of their infants because of the affection that infants receive from their mothers. Often this is the first schism that happens in the relationship, unless mothers are astute. Little babies are the cutest things, but they know how to take control of the situation. Before you know it, they have everybody marching around in the house to their orders.

Mothers need to think a bit more creatively, that is, to hopefully recognize that these children come into the world and they are not going to spend their entire lives at your home. At some point, they are going to leave. We need to keep the parental relationship tight so that it will last for the lifetime. So, we need to not give in to all of the little whimpers that the baby makes.

Father's Role During Prenatal and Breastfeeding Periods

The next thing we learned from fathers is that the prenatal period should be used and assessed to help couples anticipate this problem. We need to be up front with the power of the baby, and encourage couples to begin to think, "How can I guard against this, what are some things that we are going to do as a couple to not let the baby come between us?" We talked a lot about that within this research.

Why should fathers be more involved in breastfeeding issues? One of the reasons is obvious—to increase their commitment. The more they know, the more they feel that their input is valued; the more they are going to do. Another reason is to decrease the workload for the mother. Often, there are other siblings and there is the work to be done—a man around could take care of some of this work. We heard somebody earlier today talking about some things that people could do for physical activity. There would be mopping the floor, getting the groceries, ironing, and washing. These are some things that a father could actually do. If he is involved, the father is a role model.

What should fathers do to support breastfeeding? Since we have to script this role, the men said, you have to tell us what we need to do. The father's support for breastfeeding is a role that needs to be scripted, since it is not often seen in many communities. Fathers said that they did not know what they needed to do, and so many women said, "We are happy to let you know what we think you need to do."

The first thing that fathers needed to do was to learn as much as they possibly could about breastfeeding. We hope that you will take advantage of our materials, which are available from the WIC program at USDA. They describe how breastfeeding works in very graphic terms, and also talk about how fathers can be involved.

Breastfeeding Supportive Activities for Fathers

Examples of supportive activities for fathers include: take care of other siblings so that the mother can rest, clean the house, and reassure the mother about her decision to breastfeed. If you work with women, you know that they say they are going to breastfeed; but even in the hospital, they are brought bottles. Then, the advertising folks give them more bottles. They also give them coupons for milk, and pretty soon that decision is undermined. So, having a father at home supporting that decision is very important.

Successful breastfeeding should be a family affair, with mothers and fathers working together—that was the outcome that we came to. Another thing that came out of the WIC survey were the perceptions that some of the women had about males in the WIC environment and from their own personal experience. Think about the men in your lives, how has it been with fathers, brothers, husbands, mates, friends, and relationships in the workplace. Sometimes, these have not been positive. Women told us several stories that made it difficult for them to embrace the male role, especially within the WIC clinic.

Ask yourself what are my perceptions of the male role in family health promotion? What are my expectations for male participation in family health promotion? These questions are important for each of us to ask ourselves, because they make a real difference in how we interact with the men in our lives.

Strategies to Increase Father's Support of Breastfeeding in the WIC Program

For WIC, what strategies might work? First of all, we are trying to use our materials to develop some staff training that might be appropriate, so that we can open up the whole conversation around male involvement. We need to have some environmental enhancements, such as having appropriate pictures around. We need to invite men to become a part of things, that is, programmatic inclusion.

Most of the WIC clinics that I am familiar with do not have male staff. We need to change that picture. Reward fathers for their efforts. Then, if we get some males into the environment as volunteers or employees, we should make sure that their efforts are rewarded. Recruit, train, and hire more male staff. These are things that WIC can do to move forward. I hope that many of you will take advantage of these materials and use them, to increase the male role in family health in general.

Thank you.

African-American 5-A-Day Campaign: Putting Churches in the Forefront

**Valarie Scruggs, Communications Specialist, California
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Thank you. I wanted to tell you a little bit about what we started to do in developing the African-American 5-A-Day Campaign. We wanted to take a look at what we knew about the health disparities affecting African-Americans. We knew that African-Americans are disproportionately affected by heart disease, cancer, diabetes, stroke, and obesity. In California, nearly 70 percent of African-American men and women are overweight or obese.

We also asked, "What are African-Americans doing to get their five a day?" Since we know that eating at least five servings of fruits and vegetables and being active significantly reduces the risk for chronic diseases. Our California dietary practices survey from 1999 showed that African-Americans were getting just 3.2 servings a day. Only one-third of African-American women and nearly half of African-American men eat two or fewer servings of fruits and vegetables, compared to one-third of both white men, women and even the State as a whole. They eat more fruits and vegetables.

We noticed that African-American women are doing a little bit better at eating their fruits and vegetables than African-American men, but not doing as well in exercising. If we can get the men to teach the women to exercise more and the women to get the men to eat more, we will be able to make some real changes in the community.

Campaign's Key Intervention Behaviors

With this knowledge, we set out to develop a campaign that had three key intervention behaviors:

1. To increase fruit and vegetable consumption to at least five servings a day,
2. To increase physical activity to at least 30 minutes for adults and 60 minutes for children, and
3. To increase participation in food assistance programs, especially the Food Stamp program, and to help low income families to ensure food security, while promoting healthy eating.

In order to do this, we sought advice from the community to help identify effective methods for reaching out to the African-American community. We looked at developing an advisory group of concerned California residents, community leaders, ministers and registered dietitians, nurses, doctors, and advocates.

In November 1998, our African-American Task Force, which is now our African-American 5-A-Day Advisory Council, was formed. This group was established to help us address the poor dietary habits that are reducing the quality of life for African-Americans, and to actively spread the 5-A-Day message.

Barriers to Consumption of Fruits and Vegetables

We looked at the most common barriers cited as to why African-Americans are not consuming more fruits and vegetables. "They are not in the habit" is the number-one reason why African-Americans were not eating more fruits and vegetables. We also found that they said that these foods were hard to get at work and that there was lack of access to quality fruits and vegetables in their community. This translated into low income communities not having many grocery stores where they could get quality fruits and vegetables, and the lack of farmers markets in their areas, as well as lack of preparation time.

Components of the African-American 5-A-Day Campaign

With this in mind, the African-American 5-A-Day Campaign now works to reach African-Americans where they eat, shop, spend time with their families, and work. And we added worship to that list because churches and our faith-based organizations were identified as the number-one channel for outreaching to the African-American community. We also work with retail and grocery stores, media, and community festivals. All of those activities are supported by our faith outreach projects. These channels were supported by community responses through surveys. These were the areas where they wanted to receive education on nutrition.

Historically, the church is the strongest institution within the African-American community. The benefits of working with faith-based organizations show that there is a history, a broad range of services offered through churches, and that they have an infrastructure to help administer programs. They have a high level of community trust, social support that is inherited in faith settings, and an ability to reach large numbers of people over a consistent amount of time. In terms of the mixed levels of social classes, it helped us to train community leaders with various skills and levels—that will leave a sustainable effect in that community.

Currently, the California Nutrition Network funds 15 faith-based programs to expand the health ministries to include nutrition and physical activity. Their projects implement community assessments, they implement the American Cancer Society's Body and Soul program, and they conduct evaluations using standardized measures.

With our programs, church policy has changed, so that churches are able to offer healthier food options after church events and in community events. Our faith projects integrate nutrition and physical activity into their Bible studies and into the vacation Bible schools. They have been able to work with their community members to offer healthy cooking classes and food demonstrations. We found that you could tell people to eat healthier and that healthy food can taste good. But, unless they were going to eat that food in a place where they could taste it and see that it tasted good, and was prepared by someone who they trusted as a cook, they weren't going to try it.

We also work with community health and fitness fairs, and many of our churches are offering gospel aerobics groups, praise dance, and walking clubs. There is a youth gospel aerobics team at Loveland Church in Rialto. What is special about this group is that not only does it teach the youth to be healthier themselves, but it has allowed them to perform for their other auxiliaries, senior groups, youth groups, so that they can encourage others to be healthy.

Our marketing and media work group wanted to create some artwork that would show African-Americans engaging in the behaviors that we promote. They have an image showing an African-American family in a park, with fruits and vegetables and physical activity images in the background: some bicyclists, a silhouette of a church to give our faith connection, and a farmers market. This poster was tested with the community. Some of the things that the people liked about the poster were the colors and the family orientation. They identified with the spirit that was in the picture. People who were shown this poster were asked, "If given this art work, what would you do with it?" The top three things that they said they would do was:

- Frame it and put it in their house,
- Share it with friends, and
- Put it on their refrigerator for the recipe cards.

So, it was a picture that had legs, and was well received within the community. It has become our signature piece.

Based on our success with our Latino 5-A-Day Campaign, we created an African-American game wheel. This game wheel has culturally appropriate fruits and vegetables on it and the most common physical activities. It has been a piece that has attracted people, they see themselves in it, and it has been utilized well within our community.

Another tool that we created is our "Passport to Million Dollar Health Game." It is used with our community festivals. It helps to drive traffic to our booths and connect African-Americans with additional services within our communities. We have partnered with one of our retailers that helps us do food demonstrations for healthier versions of smothered greens that are lower in sodium and lower in fat. We have done other recipes such as peach parfaits, peach cobblers, chicken vegetable creole. It gives them a way to partner with other agencies that might be helpful, such as the American Cancer Society and the Black Nurses Association.

Training

Our advisory groups strongly encouraged us to provide training and to build the capacity of our faith projects. So, we provided them with additional media spokesperson training and policy advocacy training. We also provided training on working with churches to get them to be aware of their community and how to voice the needs of those communities, changing church policies, working through their associations, being a core church that also filters information to other churches in their community, and doing effective festival booths. Our regional California network trainings have focused on evaluation techniques, administration of their programs, and our annual social marketing conference. It helps them to pull all of those pieces together for an effective campaign.

Media Activities

Our faith projects are also supported by media activities, such as print media, ad placements, radio remotes, and television commercials. The Beat 100.3 FM radio station, a contemporary radio station, partnered with one of our churches to come out and give them information. We have also done public service announcements with 1190 The Light, which is a gospel radio station in Northern California. They have been very supportive.

As a result of surveys that showed that grocery stores were the number-one place where people wanted to be reminded of fruits and vegetables and taught how to select appropriate fruits and vegetables, we worked with our retail 5-A-Day Campaign to help our faith projects establish partnerships with our local retailers to display point of sale signage and to conduct food demonstrations and radio remotes.

Festivals

Our festivals that are held throughout the State included activities such as our 5-A-Day game wheel, our food demonstrations, physical activity demonstrations, and promotional materials. The East Oakland Faith Deliverance Center conducted a festival, and the community voted on what color background the prize wheel would have. This Center has created a farmers market that they offer weekly. They started out monthly, and it was so successful that they were able to move to bi-weekly, and they kept going, so now they are up to doing it weekly. We have had a lot of churches hold effective festivals in their parking lots.

Challenges

Challenges that we have had with the program are lack of senior pastor involvement for some churches. So, we have been trying to work with our churches to help them ensure that they get buy-in from their spiritual pastor. With large numbers of African-Americans attending, the churches have been very effective working with their congregations. Other challenges include limited ability to reach males and limited resources. Both are tied together, and the fact that our target audience was originally low-income women. We are still working to find additional resources to reach out to the family.

Key Ingredients for Success

The key ingredients for success that we found in all of our successful churches include their having a clear designation of authority for the project, designated physical space, and structure for program activities. They have a healthy volunteer support base, a calendar for meetings and community events, and an effective information dissemination network within the church and within the community.

Future Direction

Regarding our future direction, we are going to continue to investigate and develop new channels such as work sites, schools and medical services, to expand our set of culturally appropriate marketing and educational tools, and to develop appropriate resources to fully fund and extend the African-American 5-A-Day Campaign statewide.

If you would like any more information, please feel free to visit our website at www.ca5aday.com. If you would like any of the tools and products or samples of those, you can call our 1-888-EAT-FIVE number.

Thank you.