Combating Childhood Obesity

Materials


“Chapter XXII – Toys and Other Incentives with Restaurant Food,” The County of Santa Clara, CA.

“Creating a Healthy Food Zone Around Schools,” ChangeLab Solutions and National Policy & Legal Analysis Network to Prevent Childhood Obesity, October 2009.


“Planning and Health Resource Guide for Designing and Building Healthy Neighborhoods,” National Center for Environmental Health, Division of Emergency and Environmental Health Services, Center for Disease Control.

Bidisha Nath, “Health in Your Hands,” City of New Haven, CT.

Speakers

**Laurie Capitelli** was elected in 2004 and serves as the Berkeley Councilmember for District 5. As a member of the Executive Committee for Berkeley’s Measure D, he worked for two years to help pass the nation’s first Sugar-Sweetened Beverage Tax.

**Ian McLaughlin** is a senior staff attorney and program director with ChangeLab Solutions, working both on tobacco control and childhood obesity issues. Ian’s practice focuses on creating healthy retail environments, parks and recreation, public financing (taxes and fees), and code enforcement issues, and he provides training and legal technical assistance in all of these areas. Ian sits on the Park, Recreation and Open Space Commission for the City of Walnut Creek, California, and also serves as a municipal administrative hearing officer for the City of Petaluma, California, conducting hearings and deciding a variety of code enforcement matters. Prior to joining ChangeLab Solutions, Ian practiced municipal law with a private law firm, Meyers, Nave, Riback, Silver & Wilson, and served as City Attorney for the City of Clearlake, California, and Assistant City Attorney for the City of Healdsburg. He has also served as legislative counsel to the Hawaii State Senate and the National Legislature of the Republic of Palau. Ian graduated from UC Berkeley School of Law.

**Dr. Martha N. Okafor** is the City of New Haven’s Community Services Administrator. Okafor is also a faculty at Yale University teaching Population Health to the doctoral students at Yale School of Nursing. Prior to joining the city of New Haven, Okafor directed the Division of Behavioral Health in the Satcher Health Leadership Institute [SHLI] at Morehouse School of Medicine [MSM], in Atlanta, Georgia. She is an Assistant Professor in the Department of Community Health and Preventive Medicine at MSM. Dr. Okafor is the Principal Investigator of three funded research projects by the National Institute on Health [NIH] through the National Institute of Minority Health and Health Disparities [NIMHD]. She directs the behavioral health initiatives aimed at reducing and ultimately eliminating disparities in health. She served as one of the 35 invited visionary leaders from across the nation to help develop the rationale and national performance metrics underlying the current Office of Minority Health’s National Partnership for Action [NPA] to End Health Disparities. Prior to her joining academia, Dr. Okafor was the second in command at the Georgia State agencies for Public Health, Child Welfare and Family Economic Support. Prior to this appointment, she served as the director of Family Health Division in Connecticut State Department of Public Health and in senior leadership roles in Strategic Planning and Medicaid – Managed Care divisions of Connecticut State Departments of Social Services. Dr. Okafor received her Ph.D. at the University of Connecticut, in Anthropology: Medical Anthropology, Health Care and Social Science. Her research interests center on policies and health equity. She is published author in scientific peer-reviewed journals nationally and internationally and co-authored a text book chapter with Dr. David Satcher, the 16th U.S. Surgeon General on ‘Social Determinant of Mental Health.

**Mayor Acquanetta Warren** was sworn in as Fontana’s first female and first African-American Mayor in December, 2010, and was re-elected in 2014. She was appointed to the Fontana City Council as a City Council Member on December 17, 2002, and was re-elected in 2004 and 2008. Mayor Warren’s term will expire in 2018.
Top Takeaways

After increasing steadily for decades, the national childhood obesity rate has leveled off. This policy brief examines reports from across the country to learn more about where progress is being made to address childhood obesity.

**Recent reports show declining rates of childhood obesity in some school districts, cities, counties, and states.**

**Many of these places have made comprehensive changes in schools and communities to help children grow up at a healthy weight.**

**Progress in reducing racial, ethnic, and socioeconomic disparities in obesity rates has been more limited.**
HEALTH POLICY SNAPSHOT

Key Facts

Since 2003–2004, the obesity rate among U.S. youth ages 2 to 19 has held steady at 17%.

Among children ages 2 to 5, the obesity rate decreased from 13.9% in 2003–2004 to 8.9% in 2011–2014.

The national obesity rate was 14.7% among white youth, 19.5% among black youth, and 21.9% among Hispanic youth in 2011–2014.

In 2011–2014, 20.2% of Asian American youth were overweight. Among Asian ethnic groups, Chinese youth (11.8%) had the lowest prevalence of overweight; Filipinos (29.5%) and Southeast Asians (27.3%) had the highest rates.

States and Communities Take Action

Places where childhood obesity rates have been reduced have implemented a wide range of strategies to make healthy foods and beverages available in schools and communities and have integrated physical activity into daily life. Each community has taken a unique approach and no single strategy is directly linked with declining rates, but the collective effect of their far-reaching changes may be helping to support healthier choices and behaviors among kids and families.

New York City requires childcare centers to offer healthier foods, improve nutrition education, increase physical activity, and limit screen time. A Mississippi law sets specific requirements for physical education, health education, and wellness policies in schools, as well as nutrition standards for school meals, snacks, and drinks. Lincoln, Nebraska, started a
“Rethink Your Drink” public service campaign and encouraged employers to stock, promote, and competitively price healthy beverage options. Other communities have created incentives to bring supermarkets to underserved areas, expanded use of Supplemental Nutrition Assistance Program benefits at farmers’ markets, highlighted healthier options on local restaurant menus, and developed walking and biking trails connecting homes to schools, parks, and businesses.

Collaboration among diverse partners is a common theme for many of the places reporting declining obesity rates. In Cherokee County, South Carolina, the school district, local government agencies, faith-based organizations, hospitals, and other health care providers are working together to host healthy field day events, build school gardens, and offer free courses that teach families how to shop for and prepare affordable, healthy meals. Kaiser Permanente has partnered with the city of Whittier, the Safe Routes to School National Partnership, the National Parent Teacher Association, and many local organizations to offer a variety of community programs that help children throughout Southern California eat healthier and be more active.

Lincoln, Nebraska, started a “Rethink Your Drink” public service campaign and encouraged employers to stock, promote, and competitively price healthy beverage options.
Inequities Persist

Childhood obesity disproportionately affects communities of color, and in communities with high levels of poverty, families often lack access to healthy foods and beverages and safe places to be physically active. There has been limited progress to reduce childhood obesity rates among these populations, but some places have seen modest success.

For example, the widespread progress in reducing obesity among preschool children reported by the Centers for Disease Control and Prevention marks the first time in decades that rates have dropped among young children from low-income families. Between 2008 and 2011, 18 states and one U.S. territory measured declines in obesity rates among children ages 2 to 4 who were enrolled in federal health and nutrition programs, like the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Colorado recently reported a 7.4 percent relative decline in rates of overweight and obesity among preschoolers participating in the state’s WIC program, from 22.9 percent in 2012 to 21.2 percent in 2015.

In 2012, Philadelphia reported significant reductions in obesity rates among youth from low-income families and among African-American males and Hispanic females, making the city the only place to see such progress within ethnic/racial groups traditionally at greatest risk. However, data released in 2015 show the obesity rates among Hispanic females in Philadelphia may be going back up. Additionally, while obesity rates among youth overall in several locations have declined, those declines have been most pronounced among whites and higher-income students, an indicator that disparities are getting worse.

Building a Culture of Health

More efforts are needed to implement broad, far-reaching changes that support healthy eating and regular physical activity, especially among underserved communities and populations. The experiences and lessons learned from places reporting progress can help other communities identify and pursue a mix of policy and environmental approaches that may work best for them. Building an inclusive Culture of Health in this country, in which every person has the equal opportunity to live the healthiest life they can, will require: making health a shared value, fostering cross-sector collaboration, creating healthier communities, and integrating health services and systems.
The Agenda

In order to spread progress to every community, our nation must place a higher priority on increasing investments in policies and programs that give all children the opportunity to grow up at a healthy weight. Some recommendations include:

- The federal government, states, and localities should continue to prioritize and fund efforts to increase access to affordable healthy foods and beverages among low-income families.

- Every community should build and support sidewalks, bike lanes, parks, playgrounds, and safer road crossings to make it easier and safer for children and adults to be active.

- Child care and other early childhood education facilities should provide healthy food and beverages and ample physical activity opportunities for our youngest children.

- School districts, with support from local, state, and federal governments, should provide regular physical education and physical activity opportunities to help children and adolescents be active for at least 60 minutes each day.

- The U.S. Department of Agriculture (USDA) should continue to provide training and technical assistance to help school administrators and staff achieve and continue to meet the healthier school meals and snacks standards.

- As the USDA updates its guidelines for local school wellness policies, it should use the Smart Snack standards—at a minimum—for school marketing to maintain consistency with the school food sales environment, facilitate implementation, and help reduce confusion.

- Schools and communities should sign shared-use agreements to provide access to school recreational facilities outside of school hours.
### Table 1. National and Statewide Declines in Childhood Obesity Rates

<table>
<thead>
<tr>
<th>Place</th>
<th>Ages</th>
<th>Time 1</th>
<th>Obesity or Obesity and Overweight Rate at Time 1</th>
<th>Time 2</th>
<th>Rate at Time 2</th>
<th>Relative Percent Decline</th>
<th>Absolute Percent Decline</th>
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<tbody>
<tr>
<td>National</td>
<td>Ages 2–5</td>
<td>2003–04</td>
<td>13.9%</td>
<td>2011–14</td>
<td>8.9%</td>
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<td>State or Territory</td>
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<tr>
<td>California</td>
<td>Grades 5, 7, 9</td>
<td>2005</td>
<td>38.4%</td>
<td>2010</td>
<td>38%</td>
<td>-1.1%</td>
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<tr>
<td>California</td>
<td>Ages 2–4, from low-income families</td>
<td>2008</td>
<td>17.3%</td>
<td>2011</td>
<td>16.8%</td>
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<td>Colorado</td>
<td>Ages 2–4, enrolled in Colorado WIC</td>
<td>2012</td>
<td>22.9%</td>
<td>2015</td>
<td>21.2%</td>
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<td>Florida</td>
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<td>-7.1%</td>
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<td>Georgia</td>
<td>Ages 2–4, from low-income families</td>
<td>2008</td>
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<td>2011</td>
<td>13.2%</td>
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<td>Idaho</td>
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<td>2008</td>
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<td>2011</td>
<td>11.5%</td>
<td>-6.5%</td>
<td>-0.8%</td>
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<td>Iowa</td>
<td>Ages 2–4, from low-income families</td>
<td>2008</td>
<td>15.1%</td>
<td>2011</td>
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<td>-4.6%</td>
<td>-0.7%</td>
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<td>Kansas</td>
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<td>2011</td>
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<td>Maryland</td>
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<td>2008</td>
<td>15.7%</td>
<td>2011</td>
<td>15.3%</td>
<td>-2.5%</td>
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<td>Massachusetts</td>
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<td>New Hampshire</td>
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<td>17.9%</td>
<td>2011</td>
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<td>New Mexico</td>
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<td>2015</td>
<td>34.4%</td>
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<td>New Mexico</td>
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<td>2010</td>
<td>30.3%</td>
<td>2015</td>
<td>25.6%</td>
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<td>Tennessee</td>
<td>Grades K, 2, 4, 6, 8, High School</td>
<td>2007–08 school year</td>
<td>41.1%</td>
<td>2012–13 school year</td>
<td>38.5%</td>
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<td>U.S. Virgin Islands</td>
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<td>2008</td>
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CITIES SPEAK
HEALTH AND WELLNESS

5 Things Mayors Can Do to Create Healthier Communities

Posted on January 5 by Alyia Gaskins

NLC’s new report, Addressing Health Disparities in Cities: Lessons from the Field, provides lessons learned and examples of actions that mayors and other city leaders are taking to intentionally address childhood obesity-related health disparities.

Baton Rouge, Louisiana Mayor-President Melvin L. “Kip” Holden and a young Baton Rouge resident ride bikes together at a Healthy Baton Rouge event.

Today’s cities are facing many challenges — aging infrastructure, income inequality and health disparities — all of which threaten the economic vitality and resiliency of cities.

Health disparities — differences in incidence, prevalence or burden of disease between population groups — are chief among cities’ challenges because they prevent children and families from reaching their full potential and fully contributing to society.

If you were to ask a group of mayors why they ran for office, a likely response is that they wanted to make their community a better place to live. Health disparities threaten their ability to accomplish this goal.

Consider the health and economic consequences of childhood obesity. One in three children in the U.S. is overweight or obese. And low-income children and children of color tend to experience higher rates of obesity compared to their peers:

- Low-income young people ages 2 to 19 years old, regardless of race or ethnicity, are 1.7 times more likely to be severely obese than their peers;
- Among young people ages 2-19, the obesity rate for white youth is 14.7 percent, compared to 19.5 percent for black youth and 21.9 percent for Hispanic youth;
- Between ages 6 to 11, 23.8 percent of black children are obese compared with 13.1 percent of whites; and
- Between ages 2 to 5, the obesity rate among Hispanic children is 16.7 percent. For white children, it is just 3.5 percent.

The U.S. population is becoming more racially diverse, with more than half of the nation’s children projected to be part of a minority racial or ethnic group by 2020. If low-income youth and youth of color are more likely to suffer poorer health outcomes that prevent them from reaching their full potential, what are the implications for the future workforce and for the overall social and economic health of American’s cities and towns?

And what can city leaders do to reduce these health disparities?

Last year, NLC created the Learning Collaborative on Health Disparities to explore this question. Local leaders from seven cities were invited to share their perspectives about the challenges and opportunities associated with local efforts to address childhood obesity-related health disparities. The seven cities are:
Every day, mayors in these and other cities across the country make decisions in areas such as transportation, public safety, housing and economic development that directly or indirectly impact the ability of children and families to make healthy choices. As such, mayors are uniquely positioned to lead and drive change to reduce health disparities.

The Learning Collaborative identified five actions that mayors can take to address childhood obesity-related health disparities. These actions have implications for childhood obesity prevention efforts as well as broader efforts to promote a culture of health and equity in health.

1. **Speak Boldly about Race, Racism and Health** — Mayors can speak candidly about how historical patterns of racism, segregation and discrimination have resulted in the unequal distribution of social, economic and environmental resources by race and income across neighborhoods. Bold leadership, including an investment in professional development and training, can empower mayors and other city leaders to confront individual, institutional and structural racism as well as bias in policies, practices and systems.

2. **Listen to the Stories of Residents** — Mayors can bridge the divide between government and community by actively listening to and engaging with residents, especially those experiencing the poorest health outcomes. Residents’ stories about the conditions in their neighborhoods can provide important insights about the barriers to healthy living that many low-income residents face. Mayors can incorporate this information into policy development and implementation.

3. **Focus on Health Equity** — Mayors can convene a broad array of city leaders, community partners and residents to create a shared vision, cross-sector commitment and goals for building a healthier city that incorporate strategies to address inequities. A strong commitment to health equity from the mayor can ensure there is an intentional focus on improving the underlying social, economic and environmental conditions that shape communities.

4. **Connect Health to Other City Priorities** — Mayors can use their bully pulpit to elevate the connections between health and other city priorities such as economic development and public safety. This messaging can help city departments outside of the local health department better understand how the core functions of their department directly and indirectly impact health, as well as specific actions they can take to advance health equity.

5. **Engage the Business Community** — Mayors can enlist the support of local business leaders to develop public–private partnerships to promote public health and address the underlying causes of health disparities, such as poverty and education, which directly impacts a city’s ability to attract and maintain a healthy, educated workforce that businesses need to thrive.

Mayors can lead the way in eliminating health disparities. They can connect children and families to the social, economic and environmental resources they need to thrive, such as quality education, jobs, healthy foods and safe spaces for physical activity. The time to act is now.

*About the Author:* Alyia Gaskins is a Senior Associate for Health and Community Wellness at NLC’s Institute for Youth, Education, and Families. Follow Alyia on Twitter at [@a_gaskins412](https://twitter.com/a_gaskins412).
City Spotlight

LINCOLN, NEBRASKA
Leveraging the Power of the Purse to Advance Health Equity

The city of Lincoln is home to 133 miles of trails and more than 125 parks and green spaces on over 6,000 acres of public land. Lincoln’s trail system consistently ranks among the best in the country. Numerous partnerships exist throughout the community to promote and encourage active living through bike lanes, bike racks on public/city buses, public pools, recreation centers, city golf courses, dog parks, skateboarding parks, signage and public awareness campaigns, and neighborhood and community events.

In the 1970s, the U.S. Department of State designated Lincoln as a refugee-friendly city because of its size, nationally recognized educational institutions and economy. Refugees from over 40 countries have settled in Lincoln and surrounding Lancaster County. This explosive growth has brought new cultures, traditions and opportunities, as well as health challenges.

Large numbers of foreign-born or minority residents are concentrated in specific neighborhoods throughout the city. Many of these neighborhoods are among the poorest in the city and are considered Medically Underserved Areas (MUA), areas with too few primary care providers, high infant mortality and high poverty rates.

“Lincoln is a vibrant community with many strengths and assets. Yet, we know that health disparities and inequality exist here. Recently, the Community Health Endowment of Lincoln (CHE) undertook a community mapping project to better understand the role of ‘place’ in a person’s health and well-being,” explained Lore Seibel, president and CEO of CHE.

This mapping project highlighted some of the challenges that children and families who live in Lincoln’s low-income neighborhoods face in maintaining a healthy lifestyle.

These challenges — poverty, crime, and limited access to health care services — influence the ability of families to make healthy lifestyle choices and places them at a greater risk of chronic diseases such as childhood obesity. For example:

- In 1980, Lincoln had 18 census tracts
with at least 10 percent of residents living in poverty. By 2013, there were 42 census tracts with at least 10 percent of residents living in poverty.

- Self-reported data sources such as the 2009-2013 American Community Survey estimate there are approximately 43,000 non-White residents in Lancaster County, with 31 percent living below the poverty level.

- According to recently published surveys, between 26 and 35 percent of residents living in an MUA reported needing an interpreter to obtain health care, depending on the type of service sought (e.g., medical, dental, mental health).

- Although crime in Lincoln is at its lowest level since 1970, cases of child abuse/neglect, domestic violence, protection orders and residential burglary are concentrated in the city’s poorest neighborhoods.

- The average life expectancy for babies born to mothers in Lincoln varies dramatically across the city. Babies born to mothers living in southeast Lincoln have a life expectancy of nearly 30 years longer than babies born in central Lincoln.

**Taking Action**

In 2008, Mayor Chris Beutler launched the Taking Charge initiative, an outcome-based budgeting process. Eight outcome areas including safety and security, economic opportunity, accountable government and healthy and productive people were identified through a community survey process. Across the outcome areas, there are multiple goals and performance measures for city departments designed to foster interagency collaboration and reduce barriers that prevent residents from achieving optimal health.

Performance measures hold departments accountable for supporting active transportation and physical activity, which studies show can help reduce childhood obesity. All city departments serve on a Complete Streets Advisory group that is charged with implementing Mayor Beutler’s 2013 Executive Order that established a policy for the development of complete streets. City departments such as health, planning, public works, parks, and urban development review the design, planning, construction, reconstruction or rehabilitation of public and private streets and development projects.

The Antelope Valley Project is another example of interagency collaboration to improve health and mobility options for residents. The project includes transportation improvements and revitalization efforts intended to increase the vitality of existing businesses and residences, promote economic development and job creation. This project also increases recreation and trail opportunities for children and families in this currently underserved area.

The city is leveraging these robust partnerships within city government and throughout the community to promote health. In 2011, Lincoln signed up to participate in the First Lady’s Let’s Move! Cities, Towns and Counties (LMCTC) initiative, which has enabled the city to address
the policy and environmental factors that contribute to childhood obesity.

To support these efforts, the city’s 5-4-3-2-1 GO!® Coalition, which includes representatives from schools, afterschool providers, and cultural and faith-based organizations, has integrated the countdown message in over 60 community-based youth and family serving organizations.

Lincoln has also developed a Local Foodshed Working Group to conduct a community food assessment to inform programs and policies to increase healthy eating among low-income communities. In addition, the group runs the Let’s Grow: Get Out and Garden campaign to encourage residents to grow and eat more fruits and vegetables, exercise and connect with their community.

**Impact**

As a result of these efforts and others:

- Since March 2014, 7.5 miles of sidewalks have been repaired or replaced, 250 sidewalk curb ramps have been repaired or installed, and Capital Improvement Program funds ($300,000 over six years) have been secured for the Pedestrian and Bicycle Capital Program.

- Over 50 percent of all Lancaster County children and parents surveyed reported recognizing the 5-4-3-2-1 GO!® message and have tried to make lifestyle changes based on the message.

- Little Voices for Healthy Choices, a national initiative for Early Head Start, has trained 45 Lincoln child care centers in the Nutrition and Physical Self-Assessment for Child Care (NAP SACC) intervention and 20 centers with the 5-4-3-2-1 Go!® message, reaching over 4,000 children.

- In 2012, the League of American Bicyclists recognized the city as a bronze-level bicycle friendly community.

- In 2012 and 2014, Lincoln received the highest well-being score out of 189 U.S. metropolitan areas by the Gallup-Healthways Well-Being Index.

- Lincoln became the first city in Nebraska to be named a Playful City USA in 2014.

- The city saw a reduction in childhood obesity rates among kindergarten through eighth grade students in Lincoln Public Schools, from 17.2 percent in 2010 to 15.4 percent in 2014.

**Advancing an Intentional Focus on Eliminating Health Disparities**

Despite the city’s progress, American Indian, Black, Hispanic children, and children of two or more races remain more likely to be obese than their White peers. As the city and county become more diverse, closing these gaps is critical.

The Lincoln-Lancaster Health Department (LLCHD) is exploring ways to leverage the infrastructure created by Mayor Beutler’s Taking Charge initiative to better address health disparities.

Although outcome-based budgeting has facilitated tremendous opportunities for cross-sector collaboration, the complex ways in which the policies, programs and practices impact health and equity are often unfamiliar to city leaders, staff and their partners.
Health department epidemiologists, in collaboration with GIS specialists, are using an array of data visualization tools, such as maps and dashboards, to analyze data on education, housing, unemployment, crime, and air quality as well as city services and response times to raise awareness among other city departments about the health and equity impacts of their work.

The health department hopes that this visual approach and framing can facilitate more strategic collaborations to intentionally address the underlying causes of health disparities and to establish indicators measuring the health and equity impact of these collaborations.

Next Steps

A new performance management initiative is underway. Leveraging this momentum and robust cross-sector partnerships, the health department intends to:

- **Elevate the Importance of Health and Equity**: The health department is exploring how to use the Taking Charge initiative’s infrastructure to better inform city departments on how the core functions of municipal government impact community health and how health disparities threaten the success of investments in other city priorities, such as economic development and public safety. Additionally, they hope to identify new opportunities to apply a health and equity-related focus to long-range planning.

- **Develop Strategic Linkages with Other City Departments**: The health department intends to meet with the city planning director to explore the connections between city planning and health, and discuss opportunities to include health and health equity language in the next update of LPlan, the city’s comprehensive plan.

- **Measure Health Impact**: The health department is researching evidence-based strategies for evaluating the health impacts of existing policies across city departments, and the feasibility of including health and equity language in future city plans.

“Lincoln is strong and growing and I plan to continue focusing on the economy, transportation infrastructure, government efficiency and accountability, public health and safety, and the environment. This will help ensure our community’s health and vitality into the future.”

- Mayor Chris Beutler
  Lincoln, Nebraska

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Why Adopt an Obesity Prevention Resolution?

Passing a local resolution is one way for communities to promote obesity prevention policies. Today more than two-thirds of adults in the United States are overweight or obese,¹ and among children and adolescents, 16.3 percent are obese and 31.9 percent are obese or overweight.² Obese children are likely to become obese adults: in fact, an obese older teenager has up to an 80 percent chance of becoming an obese adult.³,⁴

The health consequences of this trend are dire. If the obesity epidemic continues unchecked, experts warn that excess weight could reduce average life expectancy by five years or more over the next several decades.⁵
Many social and environmental factors influence individual behaviors and contribute to the recent rise in obesity rates. Longer work hours and commute times mean that more parents are relying on fast food restaurants to feed their families, while at the same time, restaurant portions have dramatically increased in the last three decades. Unhealthy junk foods are easily accessible from vending machines in most schools, while fast food and chain restaurants saturate many neighborhoods. A lack of grocery stores, sidewalks, bike lanes, trails, and mixed-use development (integrating residential and commercial uses) also makes active living and healthy eating more difficult and higher obesity rates more likely in many communities.

Although obesity affects everyone, Black, Latino, American Indian and Alaska Native, Pacific Islander, and lower-income communities are disproportionately affected. Studies show that low-income areas with a high proportion of Blacks or Latinos have fewer supermarkets per capita than higher income neighborhoods. Likewise, predominantly Black, Latino, or lower-income neighborhoods often lack access to quality recreational facilities, including parks and playgrounds, or have facilities that are in poor condition and are perceived as unsafe.

It is harder to make healthier choices in an “obesogenic” environment that encourages sedentary lifestyles and unhealthy eating. The good news is that local governments can have a significant impact on the environmental factors that contribute to obesity, and in fact, many state and local governments have made noteworthy efforts to do so.

A local resolution is one way for communities to begin implementing obesity prevention policies.

What is a resolution?

Local governments create binding laws within their borders by passing ordinances. A resolution, on the other hand, does not create binding law, though it is a policy tool that can be used to accomplish many different objectives. Because resolutions are more informal than ordinances, they are often procedurally easier to enact.

Local governments use resolutions to set internal city policy, direct internal operations, make a statement of support or opposition to a particular issue, or encourage other branches of government (such as Congress or the Executive Branch) to take certain action. For example, Chicago recently passed a “Green City” resolution encouraging the consumption of local, plant-based foods and the expansion of farmers’ markets, community supported agriculture, and community gardens.

The advantage of a local obesity prevention resolution is that it gives local lawmakers a relatively easy opportunity to demonstrate their support for obesity prevention policies. Once the local legislature passes the resolution, advocates then have a tool to hold local lawmakers accountable to their stated commitment.

The disadvantage of an obesity prevention resolution is that there is little recourse for the failure to comply. A resolution is merely a policy intention—it is not a mandate that could be enforced through litigation, for example.

NPLAN’s Model Local Obesity Prevention Resolution

By addressing multiple factors that contribute to high obesity rates, NPLAN’s Model Obesity Prevention Resolution is designed to be comprehensive. Although the resolution is primarily drafted for cities and other local municipalities, it can easily be adopted for county or state governments as well.

The model resolution begins with a series of “findings”—facts giving rise to the reasons for implementing the resolution, in this case demonstrating that obesity is a pressing health concern for the locality. NPLAN has provided some data in the findings section, but local governments can and should add or subtract from these findings as appropriate for their particular community.

The core of the model resolution is divided into ten subcategories: (1) the built environment, (2) access to healthy food, (3) obesity disparities, (4) schools, (5) parks and recreation, (6) community and day care centers, (7) the food and beverage industry, (8) city and county hospitals, (9) employee wellness, and (10) implementation. The resolution focuses on internal government policy but encourages action by outside parties as well.

1. The Built Environment

The built environment section directs all local government personnel involved in the design and development of the city to prioritize physical activity and access to healthy foods, including developing “complete streets” (enabling safe access for all users, including pedestrians, bicyclists, and people with disabilities) and new grocery stores in underserved communities. This section directs built environment professionals such as city planners to examine current planning and zoning codes and policies, and report to the legislative body with recommended revisions that could increase opportunities for physical activity and access to
Why Adopt an Obesity Prevention Resolution?

2. Access to Healthy Food

Focusing on farmers’ markets and community gardens, this section directs the appropriate municipal agency to conduct an audit to determine if the local government owns land that could be made available for community gardening. Here, the city commits to reviewing existing laws or policies that might present unnecessary barriers to community gardens or farmers’ markets. This section also encourages landowners to make their fallow land available to the community for gardening, and encourages food retailers to accept EBT (electronic benefit transfer) cards and WIC vouchers (Special Supplemental Nutrition Program for Women, Infants, and Children) so that low-income families receiving government benefits can access healthy food from a variety of sources as well.

3. Obesity Disparities

While obesity affects all Americans, Blacks, Latino, American Indian and Alaska Native, Pacific Islander, and lower-income people are more likely to be obese. This section of the model resolution creates a local task force on obesity disparities to examine where the disparities exist within the locality and what factors contribute to or cause them. The model resolution charges the task force with drafting a report to recommend legislative action.

4. Schools

School districts are creatures of the state, and municipal governments have little power to dictate what schools can and cannot do. But local governments can work with schools to facilitate healthier school environments. In this section of the resolution, the municipality pledges to work with local school districts to implement joint use agreements and to support school gardens, safe routes to schools, and farm-to-school programs, as well as to collaborate with schools to site new schools within walking and bicycling distance of the neighborhoods where students live.

5. Parks and Recreation

This section addresses the role the local parks and recreation department can play in creating healthier environments. Here, the resolution directs the department to review existing vending machine contracts and, upon renewing those contracts, eliminate most unhealthy snacks or sugar-sweetened beverages. Further, to promote local parks and other physical activity resources, this section directs the department to develop a guide for the public with a description of all local parks and activities, and to make this resource available on the local government website, in parks and recreation offices, and in community centers.

6. Community and Day Care Centers

Many families participate in programs through community centers, and children are especially likely to spend regular time at day care centers and after school programs. This section encourages community and day care centers, afterschool programs, and youth-centered organizations to serve healthy, balanced foods instead of unhealthy junk foods, and to promote healthy eating and active living through their program activities.

7. Food and Beverage Industry

This section urges local restaurants to offer (and clearly identify) healthy meal options on their menus so that consumers can make healthier choices.
8. City and County Hospitals

To help hospitals model healthy living for the communities they serve, this section urges local government-run hospitals to adopt healthy vending policies and revise cafeteria menus to be consistent with current USDA Dietary Guidelines for Americans. Moreover, recognizing that breastfeeding can help prevent obesity as well, this section urges hospitals to adopt practices to support new mothers in breastfeeding their infants.

9. Employee Wellness

It is important for work environments to support healthy lifestyles, not only to improve individual health outcomes, but also to save employers money lost from obesity-related illness. The employee wellness section of the resolution directs the city’s human resources department to work with management, employees, and union representatives to implement an employee wellness policy. This section also encourages private employers to follow suit.

10. Implementation

The last section of the model resolution builds in a mechanism for some accountability. Under this section, the departments or agencies identified will report to the legislative body with a summary of what they have done to realize the resolution’s goals and objectives. This section also directs the department heads to provide the legislative body with any additional recommendations for further action. NPLAN encourages local governments adopting the resolution to make this section as specific as possible to ensure compliance.

Visit www.nplan.org to download NPLAN’s Model Local Obesity Resolution.

The National Policy & Legal Analysis Network to Prevent Childhood Obesity (NPLAN) is a project of ChangeLab Solutions. ChangeLab Solutions is a nonprofit organization that provides legal information on matters relating to public health. The legal information in this document does not constitute legal advice or legal representation. For legal advice, readers should consult a lawyer in their state.

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6 See “F as in Fat” supra note 1, at 18; Center for Science in the Public Interest. Anyone’s Guess: The Need for Nutrition Labeling at Fast Food and Other Chain Restaurants. 2003, p. 11.
13 For a summary of recent state and local legislative and policy efforts to address obesity, see “F as in Fat: How Obesity Policies are Failing in America 2009” supra note 6, at 31-51.
14 5 McQuillin Mun. Corp. § 15:2 (3rd. ed.).
15 Id.
17 Ogden, Halpren, Pleis, et al., supra note 10.

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The New York Times

The Opinion Pages | OP-ED CONTRIBUTOR
Taxing Sugar to Fund a City

By MARK BITTMAN
MAY 25, 2016

Credit: Walter Green

OVER the last decade or so, taxes on sugar-sweetened beverages have been proposed in a handful of American cities; they’ve failed all but once. Sometimes, this has been through a lack of governmental support — in 2009, David Paterson, then governor of New York, quickly gave up on his proposal for a tax — but mostly their advocates’ efforts have been overwhelmed by injections of cash from soda manufacturers and distributors.

Things changed 18 months ago, when a penny-per-ounce excise tax on soda and its relatives (heavily sweetened tea, sugar-added juices and so-called energy drinks) was approved by a 3-to-1 margin by voters in Berkeley, Calif. Conventional wisdom (and the soda industry) immediately labeled Berkeley a wacky anomaly. But in fact that East Bay university town is a harbinger: It was the first, or among the first, to voluntarily and intentionally desegregate schools, make sidewalks wheelchair accessible, establish a municipal recycling program and limit fast-food packaging and indoor smoking. Each of these was radical in its time, and all are now common — as I believe soda taxes will be five years from now.

The Berkeley tax “works”: Prices have gone up, and some stores have stopped selling taxed beverages altogether, although it’s too soon to tell whether consumption has declined or how much money has been generated. So the door has been opened, and this year four cities in Northern California — San Francisco, Oakland, Albany and Richmond — are considering a soda tax, along with Illinois and Boulder, Colo. Britain plans to establish a national soda tax in 2018; and India, Indonesia and other countries are debating one. And no consideration of this subject can omit Mexico, which established a national tax on soda and junk food in January 2014. In that laboratory of 120 million people, sales of sugary beverages have indeed declined, while those of bottled water have increased.

This year’s biggest news in this arena could come from Philadelphia, the country’s fifth biggest city, where a tax as high as three cents per ounce may be voted out of committee as early as Wednesday, and come to full vote in the City Council in a few weeks. The plan, part of Mayor Jim Kenney’s budget package, is especially interesting for four reasons. One, no public referendum is needed, as the council approves the budget. Two, its passage in the spring may
pave the way for other cities to get a tax on their ballots this November. Three, even die-hard soda tax advocates usually recommend two-cents-per-ounce as an acceptable level; three cents is wildly optimistic (and, indeed, may be seen as an opening bid with an opportunity for compromise).

Finally, in what is by some measures the country’s poorest big city, the tax is being billed as an anti-poverty initiative. Until now, every proposed soda tax has been sold first as a health measure; income from the tax has been secondary — destined for the general fund in Berkeley and, in Mexico, for establishing safe, free drinking water.

Mayor Kenney’s plan is different. The tax is being pitched as one that will pay for services for the city’s needy, and especially children — community schools, universal prekindergarten (which has overwhelming support), parks, recreation centers, libraries — rather than as one that will discourage people from consuming a damaging product. The health effects, of course, are equally beneficial, but Mayor Kenney and his allies maintain that there is simply no better way to raise this much-needed funding (an estimated $95 million annually) than to tax sugar-sweetened beverages.

“We are going to a source where there is substantial profit,” Mayor Kenney said to me in a phone interview last week, “and one that has the ability to take that hit and not skip a beat. They sell more of their product in poor communities than elsewhere, and for generations none of that profit was passed on to those communities. There is no downside to this other than that the three major soda companies may make a little less money.”

The soda producers and distributors, as well as the Teamsters members who deliver the product, argue that the tax is a job killer, and may spend as much as $10 million to make that case. There’s zero evidence to substantiate that claim; people who don’t buy soda will most likely buy other beverages, in most cases produced by the same companies.

There are those — including the Democratic presidential candidate Bernie Sanders — who oppose soda taxes as a regressive tax on the poor. But it is poor people who are disproportionately targeted in the marketing of sugary foods, and poor people who most suffer the health consequences of consuming them. Furthermore, as Philadelphia’s plan demonstrates, this tax will benefit low-income residents in two ways: It will increase their services and decrease their likelihood of developing chronic disease. Nothing regressive about that.

The logic of taxing sugar-sweetened beverages has been clear for a decade; every delay in doing so means dooming another percentage of our children to the increased threat of diabetes and other diseases. As Philadelphia and other cities consider this move, the federal government should follow their lead.

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BEST PRACTICES IN DESIGNING LOCAL TAXES ON SUGARY DRINKS

ChangeLab Solutions and Healthy Food America
March 2016
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*Best Practices in Designing Local Taxes on Sugary Drinks* was written by Ian McLaughlin, staff attorney of ChangeLab Solutions, and Jim Krieger, MD, MPH, executive director of Healthy Food America, with additional contributions by Susan Mottet, JD, and was edited by David Goldberg, MS. The document benefitted immeasurably from input and discussion among these noted experts in the arena of sugary drinks taxes:

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- Harold Goldstein, DrPH, Executive Director, California Center for Public Health Advocacy
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INTRODUCTION
Action for Healthy Food, Healthy Food America and ChangeLab Solutions collaborated to produce this analysis to identify best practices for designing taxes on sugary drinks as a strategy to improve public health. Our intent is to help communities develop tax legislation that will be both effective and workable for their constituencies. While this analysis focuses primarily on local taxes, much of the discussion is relevant for the development of state taxes.

A critical first step when considering a local tax is to review state law to determine what kinds of taxes are authorized for local governments in your state. Whereas states have broad authority to impose almost any type of tax, local governments can only impose taxes that have been specifically authorized by the state legislature or state constitution. Some states grant relatively broad authority for some local taxes (such as business license taxes, which are allowed in every municipality in California), whereas other states require specific state enabling legislation for each local tax. Therefore, it is essential that any local jurisdiction considering a tax consult with a local municipal tax expert to ascertain the available tax options.

When crafting a tax law, there are numerous policy considerations that will affect the scope and breadth of the tax, and also the disposition of the proceeds. This document discusses these critical policy considerations, including the effect of adopting different provisions; legal, administrative, and political considerations; and other factors.

These policy considerations were reviewed and discussed by a panel of public health, legal, and advocacy professionals with expertise in various aspects of sugary drink taxes. When possible, we sought consensus recommendations from the panel, although consensus was not always attained. The input from the panel of experts is woven throughout the discussion in this document, and areas where there was consensus are noted.

It is important to note that this is not a political strategy document, and that “best practices” are so labeled from the perspective of public health policy. Nonetheless, we make note of some relevant political and administrative considerations.

WHAT TYPE OF TAX TO EMPLOY?
The specific type of tax a local government should pursue will depend almost entirely on what has been authorized in its state. Assuming there is authority to impose a tax, there is a fundamental decision whether to pursue an excise tax or a sales tax. An excise tax is imposed on businesses for the privilege of conducting commercial activity such as distributing or selling sugary drinks. A sales tax is imposed on consumers, calculated as a percentage of the retail sales price, and collected by retailers at the time of sale.

The consensus in the literature on sugary drink taxes is that an excise tax is preferred as it is more likely to achieve the desired result of reduced consumption.\(^1\) Excise taxes can result in an increase in the shelf price of the taxed item if businesses decide to pass the tax through to consumers in the retail shelf price of the product.
It may be possible in some states to require that the tax be passed through to the consumer, but this approach raises questions of how it can be practically enforced, and more importantly, whether it is legal. Answering these questions requires an analysis of state law by legal counsel. For example, it is possible that a court would interpret an excise tax with a pass-through provision to operate functionally as a sales tax; if local sales taxes are preempted in your state, the court could invalidate the tax.

Sales taxes, which are charged to consumers as a percentage of the sales price of taxable items, have a number of drawbacks and are not a strong strategy for reducing consumption and conveying a message about the product’s health risks. First, a sales tax is always imposed on consumers and does not result in a higher shelf price for the taxed goods. In addition, in some states there is a cap on the total sales tax amount and many jurisdictions are at that cap, so additional sales taxes would not be feasible. Sales tax caps may also limit the size of the tax, thus eliminating the possibility of imposing a tax large enough to meaningfully change consumption.

Despite these disadvantages, in communities where a local excise tax is not feasible (due to pre-emption or other reasons), a sales tax may be the only viable option. If that is the case, in theory a sales tax could be set high enough to reduce sugary drink consumption (i.e., at least 20 percent of the price of an item) and coupled with a requirement that the shelf price reflect the after-tax price, or that the retailer post signs on the shelves to alert consumers that the beverage will be taxed at that higher rate at the register. It should be noted that these features are rarely, if ever, included in sales taxes.

One advantage of sales taxes is that most states have administrative mechanisms already in place for the collection of sales taxes, which could ease administration of a local sales tax. For an excise tax, the government will likely need to create new procedures and mechanisms to collect the tax.

Finally, because sales taxes are fairly common, it may be politically easier to impose or increase a sales tax than to impose an excise tax.

**BEST PRACTICE RECOMMENDATION:**

An excise tax imposed on businesses selling sugary drinks is the best type of sugary drink tax and is preferable to a sales tax. If an excise tax is not feasible, a sales tax is preferable to no tax if the tax rate is sufficient to raise the price by 20 percent, and if a meaningful amount of the proceeds is dedicated to health initiatives such as chronic disease prevention. However, we recognize that there is no one-size-fits-all approach. Advocates should craft the tax in the context of local circumstances and preferences.
DEFINING BEVERAGES SUBJECT TO THE TAX

A key early step in writing the tax legislation is defining the "sugar-sweetened beverages" subject to the tax, consistent with the evidence of the effects of the beverages on metabolism and health. The baseline definition that has commonly been used as a starting point is all nonalcoholic beverages with any added caloric sweetener, and necessary exemptions are carved out from there. Medically necessary beverages and infant formula are typically exempt from all tax proposals.

A tax law typically is permitted to include exemptions, even when they may seem somewhat arbitrary, so long as it includes specific findings to support the exemption. However, even when exemptions are legal, the perception that the list of taxed products is arbitrary can present political challenges.

From a public health policy perspective, our expert panel advocates for a graduated tax based on the amount of added sugars contained in the container or serving (e.g. 2 cents per teaspoon). Using this approach makes it less important to completely exempt low-sugar beverages, as those beverages would be taxed at a lower rate than high-sugar beverages. It also provides an incentive for sugary drink producers to offer lower-sugar products. However, this approach may not be legally feasible, depending on the state’s tax laws. Moreover, it also is likely to be more difficult to administer, which is an important consideration. If the tax is imposed on fruit drinks and flavored milks – which may have both naturally occurring and added sugars – it will be very difficult for a tax department to determine how much sugar is subject to the tax. (That job could be made easier if and when added sugars are included on the Nutrition Facts Panel.) If 100 percent fruit juices and flavored milks are exempt, all of the taxed beverages will contain added sugars and in many, nearly all of the “total sugar” on the label will be added sugars, so this approach would be feasible even if the Nutrition Facts Panel is not amended to include “added sugars.”

Taxing each ounce of product – rather than each unit of added sugar – is an all-or-nothing approach that makes some of the exemptions in the definition more important. (See the “tax base” discussion below.) Some volume-based proposals have set a sugar threshold and would only impose the tax on beverages with added sugar content that exceeds that amount. Setting a threshold in a volume-based tax could provide an incentive for the industry to produce lower-sugar beverages, because beverages below the threshold would not be taxed at all. Where to set the threshold is a health policy question in its own right. An expert panel convened in 2013 by the Robert Wood Johnson Foundation to establish recommendations for healthier beverages suggests that for adults and adolescents, beverages should contain no more than 40 calories per container. Since one gram of sugar contains 4 calories, the threshold under this recommendation would be no more than 10 grams, or approximately 2.5 teaspoons, of sugar per container.
Flavored milks, 100 percent fruit juices, and low calorie/sugar beverages (including zero calorie beverages with non-nutritive sweeteners) often have been exempted. Research regarding the metabolic and health effects of flavored milks and 100 percent fruit juices is evolving. While many experts believe that their health effects are not significantly different from other sugary drinks, the current evidence is mixed, and recommendations and guidelines from expert groups and professional associations vary. It is therefore up to each jurisdiction to make its own judgment of the current evidence and its own determination whether to include these types of beverages.

There is also consensus among those who have run tax campaigns that it is important to “keep it simple.” To some members of our expert panel, this means that beverages that are widely perceived as “healthy,” such as milk and juice, should be exempt.

Finally, alcoholic beverages, which are subject to existing excise taxes in comprehensive regulatory regimes in most states, are typically exempt from sugary drink tax proposals.

**Syrups and Powders**

The second definitional issue is whether, and how, to tax powders and syrups used to make sugary drinks. There is consensus to impose the tax on syrups used in soda fountains to make sugary drinks. Be aware, however, that this means that restaurants with self-serve fountain soda would have to decide whether and how to charge different prices for sugary and sugar-free beverages.

There is no consensus whether to tax syrups and powders used by a business to make other sugary drinks, such as Italian soda or flavored coffee drink. Although the expert panel generally agreed that it makes sense from a public health perspective to tax them, it may be difficult to ascertain the quantity of drinks made from these types of syrups and powders absent a specific formula or manufacturer’s instructions. Also, as with juices and milks, the public may not perceive these types of drinks in the same way as soda. Because there is no consensus on this specific issue, consultation with tax policy design experts is recommended.

Panel members advised against imposing the tax on syrups and powders that are intended for use within the home, such as Tang powder. From a public health perspective it makes sense to include these types of syrups and powders, but doing so may prompt more political resistance to the tax.

**BEST PRACTICE RECOMMENDATION:**

At a minimum, a strong tax should include caloric sodas, sports drinks, fruit drinks, energy drinks, sweetened teas and coffees, as well as syrups and powders used by businesses to make such beverages. If pursuing a volume-based tax, a jurisdiction needs to decide whether to exempt beverages below a minimum sugar content. Regardless of type of tax, a jurisdiction needs to consider whether to include 100 percent juices and flavored milks.
DEFINING THE TAX BASE

The tax base is the measure upon which the tax liability (the amount to be paid) is calculated.

Volume: Tax per ounce

Most recent tax legislation has proposed to levy the tax on each ounce of beverage sold, regardless of amount of sugar. While simple to calculate, this approach taxes beverages with very high amounts of sugar at the same rate as low-sugar beverages (at least those above a threshold sugar content, if one is included.)

Sugar content: Tax per gram or teaspoon of [added] sugar

An alternative is to base the tax on the amount of sugar by levying the tax on each gram (or teaspoon) of added sugar. The expert panel generally agreed that this approach makes more sense from a public health policy perspective. It is important to understand state law prior to pursuing this approach, as it may not be legally feasible for local governments in some jurisdictions.

A tax based on sugar content is slightly more difficult to administer than a per-ounce tax but from a public health standpoint is more rational – the more sugar a beverage contains, the higher the tax for that beverage. It also may contribute to public awareness that sugar is an underlying health concern, and it may provide an incentive for industry to produce and market lower-sugar products. A tax based on sugar content may be useful in raising the issue of sugar and health more broadly, but also could make it more difficult to make the case for taxing sugary drinks and not other products with sugar. As the general public understands the amount of sugar in a teaspoon more readily than in a gram, basing the tax rate on sugar content measured by teaspoons, rather than grams, is preferable.

As discussed above (in the section “Defining Beverages Subject to the Tax”), a tax based on amount of sugar becomes more complicated when a beverage contains both added sugars and naturally occurring sugars, as in flavored milk, which contains lactose naturally. In that case officials could simply ask marketers to provide the amount of added sugars their products contain, and in the event of noncompliance either estimate the taxable content or tax the full amount of sugar. However, this is only a concern if flavored milk products and fruit drinks are included, and could be obviated should the FDA require added sugars to be noted on the Nutrition Facts Panel.

BEST PRACTICE RECOMMENDATION:

Although a per-ounce tax on volume is easy to understand and administer, there is consensus that a tax based on the amount of sugar in a beverage is more rational from a public health standpoint and therefore preferable. However, a jurisdiction considering this approach should note that a tax based on sugar content is slightly more difficult to administer than a volume-based tax, and local jurisdictions must analyze the legal feasibility of this approach under state law. Other political considerations – such as whether lawmakers or voters understand or support one tax base more than another – may also apply to this decision. See Tables 1 A and B for a comparison of methods for defining the tax base using 1 and 2 cents.
**TAX RATE**

Discussions about the proper tax rate typically focus on two issues: the amount of revenue to be raised, and whether and to what degree the rate is sufficient to reduce consumption.

By using the tax base, tax rate, and sales data, the potential revenue is relatively simple to calculate, though this information may not be readily available. One should also take into consideration that a well-designed sugary drink tax will likely suppress consumption and will thereby reduce revenue from the tax over time. The Rudd Center for Food Policy and Obesity has developed an online tax calculator that can help calculate the amount of revenue that would be raised by a tax in your jurisdiction.⁴

The issue of what level of tax will produce a sufficient reduction in consumption is much more difficult to analyze. Most experts agree that the price of a sugary drink must increase by at least 20 percent to meaningfully affect consumption patterns and health outcomes.⁵ When taxing by volume, a tax rate of two cents per ounce will result in a roughly 20 percent increase in the purchase price, if all of the tax is passed on to consumers in the shelf price. In many jurisdictions, polling shows equal support for rates of one- and two-cents-per-ounce.

When the tax is based on sugar content, a half-cent per gram (or 2.5 cents per teaspoon) yields about a 20 percent tax rate, based on the price and sugar content of popular sugary drink products. The best way to get a sense of how a per-gram tax may affect prices is to visit local retailers and get a sampling of prices for popular drinks. By looking at their sugar content you can get a sense of how certain per-gram or per-teaspoon rates may affect price. In Table 1B, you can see that, though the two products are comparable in price, a tax on amount of sugar raises the price for a 20-oz. Coca-Cola more than for a 20-oz. Vitaminwater, which has half the sugar. Although Red Bull and Coke have the same sugar content and Red Bull has twice the sugar of Vitaminwater, a 20 oz. Red Bull has the smallest percent price increase because the drink is significantly more expensive than Coke and Vitaminwater.

Note that most of the literature and modeling that discusses a potential reduction in consumption focuses on the potential effect of a specific percent price increase for the beverages subject to the tax. The actual increase in price produced by a given tax rate depends on the proportion of the tax that is passed through and the base price of the drink. Regardless of what type of tax is imposed, it is not yet clear how much the sales price might increase because of uncertainty in the exact proportion of pass-through.⁶ Economists suggest that the larger the jurisdiction, the more likely the full amount of tax will be passed on to the consumer.
As noted above, the tax law could conceivably mandate that the tax be “passed through” to businesses further down the distribution chain and ultimately to consumers. Even with mandatory pass-through language, the beverage industry retains control over the base costs and wholesale prices of the beverages, and could lower those to blunt the effects of the tax. Therefore, absent adoption of an actual minimum price law (which sets a statutory minimum price for retail sales of sugary drinks), a jurisdiction setting a tax rate must acknowledge this uncertainty.

There is also consensus that the tax rate should be automatically adjusted for inflation.

**Table 1: Comparison of Methods for Defining the Tax Base Using 1 and 2 Cents**
The tables below are included for illustration purposes only. Prices and preferences for different types of beverages vary across the US and will impact revenue generation and the percent by which prices increase. Price data were collected in January 2016 from a Safeway grocery store in Seattle, WA and may not represent prices across the US.

<table>
<thead>
<tr>
<th>A. Tax on Volume (ounces of beverage)</th>
<th>Price</th>
<th>1 cent per oz. tax price increase</th>
<th>2 cent per oz. tax price increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coca-Cola 12 oz 39g sugar</td>
<td>$ 1.17</td>
<td>$ 0.12 10%</td>
<td>$ 0.24 21%</td>
</tr>
<tr>
<td>Coca-Cola 2L/72oz 234g sugar</td>
<td>$ 1.99</td>
<td>$ 0.72 36%</td>
<td>$ 1.44 72%</td>
</tr>
<tr>
<td>Mountain Dew 20 oz 77g sugar</td>
<td>$ 1.89</td>
<td>$ 0.20 11%</td>
<td>$ 0.40 21%</td>
</tr>
<tr>
<td>Coca-Cola 20 oz 65g sugar</td>
<td>$ 1.89</td>
<td>$ 0.20 11%</td>
<td>$ 0.40 21%</td>
</tr>
<tr>
<td>Red Bull 20 oz 65g sugar</td>
<td>$ 4.29</td>
<td>$ 0.20 5%</td>
<td>$ 0.40 9%</td>
</tr>
<tr>
<td>VitaminWater 20 oz 32g sugar</td>
<td>$ 1.39</td>
<td>$ 0.20 14%</td>
<td>$ 0.40 29%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Tax on Amount of Sugar (grams)</th>
<th>Price</th>
<th>1 cent per teaspoon tax price increase</th>
<th>2 cent per teaspoon tax price increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coca-Cola 12 oz 39g / 9 tsp sugar</td>
<td>$ 1.17</td>
<td>$ 0.09 8%</td>
<td>$ 0.18 15%</td>
</tr>
<tr>
<td>Coca-Cola 2L/72oz 234g / 56 tsp sugar</td>
<td>$ 1.99</td>
<td>$ 0.56 28%</td>
<td>$ 1.12 56%</td>
</tr>
<tr>
<td>Mountain Dew 20 oz 77g / 18 tsp sugar</td>
<td>$ 1.89</td>
<td>$ 0.18 10%</td>
<td>$ 0.36 19%</td>
</tr>
<tr>
<td>Coca-Cola 20 oz 65g / 16 tsp sugar</td>
<td>$ 1.89</td>
<td>$ 0.16 8%</td>
<td>$ 0.32 17%</td>
</tr>
<tr>
<td>Red Bull 20 oz 65g / 16 tsp sugar</td>
<td>$ 4.29</td>
<td>$ 0.16 4%</td>
<td>$ 0.32 7%</td>
</tr>
<tr>
<td>VitaminWater 20 oz 32g / 8 tsp sugar</td>
<td>$ 1.39</td>
<td>$ 0.08 6%</td>
<td>$ 0.16 12%</td>
</tr>
</tbody>
</table>

* In Berkeley, the sugary drink tax was on average passed through at 69%. If the tax is not passed through at 100%, a higher tax rate may be necessary to raise the price of products sufficiently to have an impact on consumption. For example, at 69% pass through, a two-cent-per-ounce tax on a 20 oz. Coke would only increase the price by 15%, somewhat less than desired.

**BEST PRACTICE RECOMMENDATION:**
While there is no ideal, uniform “best” rate, a tax that equals 20 percent of the price of the beverage is the appropriate starting point.
WHAT BUSINESSES ARE REQUIRED TO PAY THE TAX?
Assuming an excise tax is proposed, another decision is whether to impose the tax on wholesalers/distributors or on retailers. (Sales taxes are paid by consumers.) There are both policy and legal considerations in deciding this issue and input from local legal counsel is advised.

Applying the tax to wholesalers/distributors is potentially simpler to administer because there are fewer (generally larger) taxpayers. These larger businesses are better equipped to compute and pay the tax they owe. From a political standpoint, it may be easier to explain the tax as being “on the industry” rather than on local mom-and-pop businesses. However, there are several potential issues that arise with a tax on wholesalers/distributors. One potential disadvantage is that it may be difficult to identify all the wholesalers and distributors, particularly common carriers such as a trucking company with no affiliation with the soda industry. At the same time, some distribution occurs within a single company, such as store brand sodas transferred from a company-owned warehouse to a retail outlet within a large chain. The taxable event should be defined broadly enough to capture these intracompany transfers. Finally, some retailers travel to neighboring cities or counties to purchase their stock and therefore would not be a defined wholesaler or distributor in those instances. In such cases, the retailer could be made liable for the tax, to ensure that all eligible beverages are taxed.

For local jurisdictions, imposing the tax on retail businesses rather than distributors forecloses any legal argument that the payors are not subject to the city or county levies. Most retail businesses are also already required to obtain a general business license and they can therefore be more readily identified. (Many wholesalers/distributors also obtain business licenses, but not all of them.) However, applying a tax to retailers could be politically more difficult as it is a tax on local, often small businesses, and may also be more difficult to collect because there are more taxpayers (i.e., more retailers than distributors). Some retailers may also find it difficult to implement and remit the tax. Further, if levied at the retail level, it is more difficult to ensure that the shelf price reflects the tax.

BEST PRACTICE RECOMMENDATION:
There is consensus that wherever possible, the tax should be imposed on wholesalers/distributors. These businesses must be carefully defined to ensure that only those with a presence in the jurisdiction are taxed, and that the tax is on distribution rather than transportation. Moreover, the tax ordinance should include language to capture products that are distributed internally, or that are purchased by retailers from outside the jurisdiction.

EXEMPTION FOR SMALL BUSINESSES
In California it is not uncommon to exempt very small businesses (below a certain level of annual gross sales, typically $100,000) from business license taxes. While supporters may find it politically advantageous to include such an exemption, the impact on the efficacy of the sugary drinks tax will be a local political and policy calculation.
EARMARKING TAX PROCEEDS
Another key policy decision – with legal considerations as well – is whether to earmark the revenue, and for what purposes. One approach has been to dedicate the proceeds in the law to support activities and programs aimed at improving population health. Various proposals have directed revenue toward chronic disease/obesity prevention, public health funding in general, and increased access to individual health insurance (e.g. Medicaid). Earmarking can also direct tax proceeds to the communities that disproportionately bear the burden of conditions such as diabetes and obesity that are associated with overconsumption of sugary beverages. Our experts agree that a meaningful amount of the tax revenue should support prevention of chronic disease and/or obesity. However, political considerations in the context of a specific tax initiative may require negotiations and compromises on the dedication target(s) or even whether revenues should be dedicated at all (versus contributing to the General Fund).

Dedication is the most certain mechanism to ensure that health initiatives are funded, but may limit flexibility for addressing changing priorities over time. Dedication may also pose legal and political problems in certain jurisdictions. An alternative strategy is to create a panel of experts to provide input on the process of allocating proceeds. If the tax proceeds are not earmarked, such a panel can make recommendations to the legislative body about how to spend the funds. Even if the tax proceeds are earmarked, a panel of experts can provide recommendations about how funds are used and disbursed, and serve as a point of accountability to assure that the entities that receive funds are using them as intended.

While there is consensus that a significant portion, if not all, of the tax proceeds should be directed to vulnerable populations, there is no consensus on the specific entities or programs that should receive the proceeds. This is a decision best made in the specific context of a jurisdiction designing the tax. Note: In California there are different and more onerous procedural requirements for imposing taxes with the proceeds earmarked. This may be the case in other states.

BEST PRACTICE RECOMMENDATION:
There is consensus that tax proceeds should be earmarked for public health policies and programs that address the health conditions caused by sugary drinks and directed to communities that disproportionately suffer from sugar-related chronic disease, but no consensus about the exact type of programs and whether the tax is not worth pursuing without earmarking. We recommend dedication or including alternative mechanisms to direct all or at least a meaningful amount of the revenues to health initiatives. However, we recognize that there is no one-size-fits-all approach. Advocates should craft the tax in the context of local circumstances and preferences.
FOOTNOTES

1. The term “excise tax” encompasses many different types of taxes – gross receipts tax, business license tax, business and occupations tax, business privilege tax, and fees (e.g. the language used in California: business license fee, health impact fee) – to name a few. Although lacking a precise and universal definition, a common element of most excise taxes is that they are usually imposed on businesses for the privilege of operating the business or for the privilege of selling a specific product.

2. Note that at the time of this publication, the FDA has already begun a rulemaking process to include “added sugars” on the Nutrition Facts Panel.
http://www.fda.gov/Food/GuidanceRegulation/GuidanceDocumentsRegulatoryInformation/LabelingNutrition/ucm385663.htm

3. See “Recommendations for Healthier Beverages,” available at:

4. Available at: http://uconnruddcenter.org/revenue-calculator-for-sugar-sweetened-beverage-taxes


7. Also, in some states, such as California, local jurisdictions cannot impose taxes on transportation businesses, so the tax proposal must be structured so as not to impose the tax on transportation, but rather on distribution.
Retailers in Berkeley, Calif., are passing about 70 percent of the extra cost from the 1-cent-per-ounce tax on to consumers, a study finds.

Public health advocates have argued that one of the best ways to fight obesity would be to tax the sugary drinks that science has implicated as a big part of the problem.

While many states and cities have tried to find ways to tax sodas and other sugar-sweetened beverages, only Berkeley, Calif., has succeeded. A grass-roots coalition, funded in part by Bloomberg Philanthropies, managed to get 76 percent of voters to support a soda tax, which passed in November 2014 and was the first of its kind in the U.S.

Now, researchers say the tax seems to be working in one important way: From May through June — the first three months of its implementation — soda prices in Berkeley increased seven-tenths of a cent per ounce more than in other cities, the researchers at the University of California, Berkeley found. That means that retailers are passing about 70 percent of the extra cost from the 1-cent-per-ounce tax on to consumers who buy soda. For all the sugary beverages, they're passing on just under half of the tax on average.

That's the way excise taxes are supposed to work — they make it more likely that consumers will see and feel the extra cost for a specific product. But the researchers say their findings, which appeared Wednesday in the American Journal of Public Health, provide the first evidence that that's actually happening.
According to the researchers, the fact that consumers will now have to confront the tax with their own pocketbooks represents a "meaningful step" toward reducing consumption of sugar-sweetened beverages. At the same time, they admit they don't yet know if it's having any of the desired impact on health. (They acknowledge other limitations to their study, including an inability to assess whether retailers were shifting added costs from the soda tax on to other products.)

If Mexico, which passed its own nationwide soda tax in 2014, is any example, Berkeley's tax could very well affect consumer behavior. A preliminary study by the Mexican National Institute of Public Health and the Carolina Population Center at the University of North Carolina, Chapel Hill found that purchases of sugary beverages in Mexico dropped 6 percent on average in 2014, compared with pretax trends.

Soda taxes on the whole, though, remain highly contentious, both politically and economically, in the U.S. The beverage industry has consistently maintained that taxes won't help solve public health issues like obesity. And as author and nutrition scholar Marion Nestle writes in her latest book, *Soda Politics: Taking On Big Soda (And Winning)*, the American Beverage Association spent $114 million between 2009 and 2014 to fight soda taxes.
Consumers deserve to know how sugary drinks affect their health. Requiring beverage companies to put this simple and accurate statement on cans, bottles, and dispensers of sugary drinks and on menus and ads that promote them, will alert consumers to health risks, and may discourage parents from buying sugary drinks for their kids.

Why Sugary Drink Warning Labels?

- Scientific evidence has clearly established that sugary drinks harm health, contributing to our alarming rates of diabetes, obesity, heart and liver diseases, and tooth decay.
- Sugary drinks have no nutritional value but are the #1 source of added sugars in our diet, representing almost half (46%) of all added sugars we consume.
- Sugary drinks are especially harmful because sugar delivered in liquid form bypasses the body’s defense against consuming too many calories: sugary drinks don’t make you feel full.
- Warning labels inform parents. In a recent study, parents who saw warning labels were less likely to choose sugary drinks for their children.
- Beverage companies spend close to a billion dollars every year to convince us, and especially our children, to drink these beverages. But they don’t warn us of the risks.

What Can Warning Labels Do?

- Provide consumers with clear and accurate information about how sugary drinks are associated with increased risk of obesity, diabetes, heart, and liver diseases, and tooth decay.
- Promote further public discussion about sugary drinks and policy actions to reduce their availability, affordability and appeal.

Sugary drinks include soda, fruit-flavored drinks, flavored water, sports and energy drinks, and sweetened coffee and teas.
Additional Considerations

• Local and state governments can put carefully worded laws into place that require warning labels.

• Warning label policies should specify exact language that is likely to withstand legal challenge.

• Warnings can be placed on sugary drink containers, outdoor advertising, menus and vending machines.

• At this time, local laws have focused on placing warnings on advertising only, because legal analysis suggests this reduces vulnerability to lawsuit.

• The size of the warning label is typically determined by the size of the container, advertisement, or menu.

• Specific beverages may be declared exempt, such as 100% fruit or vegetable juices, infant formula, or any beverage whose principal ingredient is milk.

Momentum Is Growing for Warning Label Policies

• Warning label legislation has been filed in California, Hawaii, New York, Oregon, Vermont and Washington, as well as in San Francisco and Baltimore.

• Public opinion polls consistently show substantial support for warning labels.

San Francisco in 2015 became the first U.S. jurisdiction to pass a warning label bill. It requires labels on outdoor advertising. The American Beverage Association (ABA) immediately sued to block implementation. However, a federal District Judge dismissed industry arguments and concluded the City’s mandated warning is factual and accurate; moreover, warning that sugary drinks contribute to tooth decay, obesity and diabetes is reasonably related to the City’s interest in public health and safety. While industry has appealed, it is unlikely to win.

For More Information

This fact sheet was produced by Healthy Food America, which works to reduce the unacceptable level of added sugars in the American diet, by promoting policy and changing industry practice. For more information, visit www.healthyfoodamerica.org or email us at info@hfamerica.org.

Visit ChangeLab Solutions for a model warning label policy.
San Francisco’s first-in-the-nation law requiring display ads for sugary drinks to carry warnings of increased risks of obesity, diabetes and tooth decay can take effect in July as scheduled, a federal judge ruled Tuesday in rejecting a challenge by the beverage industry.

“The warning required by the city ordinance is factual and accurate,” and is a “legitimate action to protect public health and safety,” said U.S. District Judge Edward Chen, who turned aside industry arguments that the advertising message is misleading and violates free speech.

The American Beverage Association, the California Retailers Association and the California State Outdoor Advertising Association sought the injunction against the requirement.

The ordinance, passed unanimously by the Board of Supervisors last year and due to take effect July 25, requires publicly displayed advertising for sugar-sweetened beverages to display a warning label that takes up 20 percent of their advertising space, attributing the message to the city. It doesn’t apply to ads in newspapers, magazines, television, menus or product labels.

Beverage industry lawyers argued that the city was unfairly singling out their products and implying that they were more dangerous than high-calorie foods like cheeseburgers or pizzas, which carry no warnings. They contended the labeling would chill freedom of expression, and they submitted declarations by PepsiCo and other soda companies saying they would stop advertising in San Francisco if the ordinance took effect.

But Chen said the city is not preventing the companies from speaking, but simply requiring them to disclose accurate information about their products. He said there was ample scientific evidence that sugar-sweetened beverages are “a significant source of calories” that contribute to health problems.

Chen said the city also provided evidence that African Americans, Latinos and low-income people were “particularly affected by added sugars in their diets” and also had high rates of obesity and related chronic diseases.

Advertisers’ claims that they would pull out of San Francisco are of “questionable credibility,” Chen said. Like tobacco companies, which continue to make profits despite
having to place government-mandated warnings on their packages, beverage companies will still reap financial benefits from advertising, he said. He also noted that pharmaceutical firms still broadcast advertising despite warnings about side effects that take up almost as much time as the ad messages.

In November, San Francisco voters are likely to consider a penny-per-ounce tax on sugared drinks.

Tuesday’s ruling is one of the first legal setbacks for the beverage industry, which has sued successfully over restrictions on beverage sizes and sales, said Dr. John Maa, a board member of the American Heart Association of the Greater Bay Area and a supporter of the ordinance.

“We believe there will be a wave of similar legislation across the country, and we believe this will improve the health of America,” Maa said.

Supervisor Scott Wiener, who carried the ordinance, praised the ruling and said the warnings “will provide the clear information people need to make informed decisions about what they are choosing to drink.”

The American Beverage Association said it was disappointed by the ruling. San Francisco is “unfairly discriminating against one particular category of products, based on one ingredient found in many other products,” the association said.

*Bob Egelko is a San Francisco Chronicle staff writer.*

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CHAPTER XXII. - TOYS AND OTHER INCENTIVES WITH RESTAURANT FOOD

Sec. A18-350. - Findings and intent.

The Board of Supervisors of the County of Santa Clara does hereby find the following:

(a) Childhood obesity and overweight are widespread in the County of Santa Clara. Nearly one in four 7th, 9th, and 11th graders in the County was either obese (10.4%) or overweight (14.3%) in 2007-2008, while one in three toddlers ages 2—5 years old in the Santa Clara County Child Health and Disability Prevention Program (CHDP) was either obese (17.2%) or overweight (16.2%) in 2007.

(b) Obesity, overweight, and unhealthy eating habits pose a serious risk to the health and welfare of children and adolescents. Children and adolescents who are obese or overweight have an increased risk of being obese or overweight as adults, increasing their chances of experiencing chronic health conditions later in life. During childhood and adolescence, obese and overweight individuals are already more likely than their peers to exhibit risk factors for heart disease (including elevated cholesterol levels, triglyceride levels, and blood pressure); risk factors for cancer; and impaired glucose tolerance, a precursor for development of Type 2 diabetes. In recent years, Type 2 diabetes in children and adolescents has risen dramatically in conjunction with increases in obesity and overweight. The Institute of Medicine has stated that the prevalence of obesity among children is so great that it may reduce the life expectancy of the current generation of children and diminish the overall quality of their lives.

(c) Childhood obesity and overweight have serious economic costs. Nationally, the annual costs of providing inpatient treatment to children diagnosed with obesity increased from $125.9 million in 2001 to $237.6 million in 2005. In addition to inpatient treatment, an estimated $14.1 billion is spent nationally in prescription drug, emergency room, and outpatient visit expenses each year as a result of childhood obesity and overweight. As children and adolescents in the County become adults, their high rates of obesity and overweight are likely to contribute to the already high economic costs of healthcare ($420 million in 2006) and loss of productivity ($496 million in 2006) associated with adult obesity in the County.

(d) The food that children and adolescents consume at restaurants has a significant impact on their risk of developing obesity, overweight, or other related health risks. Families increasingly dine in restaurants on a regular basis, with 133 million Americans purchasing food at restaurants every day. The food and beverages that restaurants typically serve to children and adolescents often fail to meet accepted nutritional recommendations. Research shows that consumption of fast food, sugar-sweetened beverages, and other restaurant offerings by children and adolescents is frequently associated with overeating, poor nutrition, and weight gain.

(e) Restaurants encourage children and adolescents to choose specific menu items by linking them with free toys and other incentive items. The Federal Trade Commission (FTC) estimated that ten restaurant chains surveyed spent $360 million in 2006 to acquire toys distributed with children's meals, and that toys accounted for the fast food industry's second highest category of child-directed promotional expenditures, after television advertising. The FTC reported that in 2006 fast food restaurants sold more than 1.2 billion meals with toys to children under 12, accounting for 20% of all child traffic.

(f) Research analyzing children's meals at major restaurant chains found that many exceed the recommended caloric limits for children and that 10 of the 12 high-calorie meals in the study came with toys.

(g) Toys, games, trading cards, admission tickets, and other items given out by restaurants tend to be particularly appealing to children and adolescents. Digital incentives like computer games and online media similarly appeal to youth.
Targeting children and adolescents for particular purchases has an effect on what they eat. Research shows that parents frequently make purchases based on requests made by children, particularly for items that are geared toward children. Additionally, children and adolescents ages 4—17 years have increasing discretionary income that is frequently spent on restaurant food. The Institute of Medicine concluded that advertising affects not only the food and beverage preferences of children ages 2—12 years, but also the requests they make and what they eat.

The FTC recommends that companies adopt nutrition-based standards for food and beverages targeted at children. However, as of March 2010, 35 of 45 major national restaurant chains surveyed had no policies or extremely vague policies on this issue, and the remaining 10 restaurant chains were found to have key weaknesses in their policies or the nutritional criteria used.

The intent of this chapter is to improve the health of children and adolescents in the County by setting healthy nutritional standards for children's meals accompanied by toys or other incentive items. These standards will support families seeking healthy eating choices for their children by permitting restaurants to offer toys and other incentive items only in conjunction with foods meeting specified nutritional criteria. This chapter imposes no requirement for the labeling of food or beverages.

Sec. A18-351. - Definitions.

For the purposes of this chapter, the following definitions shall apply:

(a) **Restaurant** is as defined in Section B11-53(x) of Division B11 of the County Ordinance Code.

(b) **Incentive item** means (1) any toy, game, trading card, admission ticket or other consumer product, whether physical or digital, but not including "Single Use Articles" as defined in California Health and Safety Code Section 113914 as of January 1, 2009, or (2) any coupon, voucher, ticket, token, code, or password redeemable for or granting digital or other access to an item listed in (b)(1).

(c) **Single food item** means the complete contents of any food offered for individual sale by a restaurant, not including beverages.

(d) **Meal** means any combination of single food items and/or beverages offered together for a single price.

Sec. A18-352. - Incentive items with restaurant food.

(a) **Single food items and meals.** A restaurant may not provide an incentive item linked to the purchase of a single food item or meal if it includes any of the following:

(1) **Excessive calories.** More than two hundred (200) calories for a single food item, or more than four hundred eighty-five (485) calories for a meal;

(2) **Excessive sodium.** More than 480 mg of sodium for a single food item, or more than six hundred (600) mg of sodium for a meal;

(3) **Excessive fat.** More than thirty-five percent (35%) of total calories from fat, except for fat contained in nuts, seeds, peanut butter or other nut butters, or an individually served or packaged egg, or individually served or packaged low-fat or reduced fat cheese;

(4) **Excessive saturated fat.** More than ten percent (10%) of total calories from saturated fats, except for saturated fat contained in nuts, seeds, peanut butter or other nut butters, an individually served or packaged egg, or individually served or packaged low-fat or reduced fat cheese;
(5) Trans fat. More than 0.5 grams of trans fat;
(6) Excessive sugars. More than ten percent (10%) of calories from added caloric sweeteners; or
(7) A beverage that fails to meet the criteria below.

(b) Beverages. A restaurant may not provide an incentive item linked to the purchase of a beverage if it includes any of the following:

(1) Excessive calories. More than one hundred twenty (120) calories;
(2) Excessive fat. More than thirty-five percent (35%) of total calories from fat;
(3) Excessive sugars. More than ten percent (10%) of calories from added caloric sweeteners;
(4) Added non-nutritive sweeteners; or
(5) Caffeine.

(Ord. No. NS-300.820, 5-11-10)

Sec. A18-353. - Enforcement.

(a) Civil enforcement. The County is hereby authorized to bring a legal action or claim:

(1) To enjoin any violation of this chapter;
(2) To collect any past due fine, charge, or penalty provided for under this section, or under Division A37 of the Santa Clara County Ordinance Code, resulting from a violation of this chapter; or
(3) To recover attorneys' fees and/or costs incurred in bringing any legal action pursuant to this section.

(b) Administrative enforcement.

(1) Each violation of this chapter shall be subject to an administrative fine of $250.00 for the first violation and $500.00 for the second violation.

   The County reserves the right to impose fines for additional violations, not to exceed $1,000.00.

(2) Each violation of this chapter shall be subject to regulatory fees, not included in the administrative fine, not to exceed the amount reasonably necessary to recover the cost incurred by the County in the enforcement of the provisions of this chapter.

(3) The imposition, enforcement, collection, and administrative review of administrative fines and regulatory fees provided for in this chapter shall be governed by Division A37 of the Santa Clara County Ordinance Code.

(c) Fines, charges, or penalties collected as a result of a violation of this chapter, and which are not used to cover the costs of enforcement, shall be deposited into a separate account within the Public Health Department for obesity prevention and education.

(Ord. No. NS-300.820, 5-11-10)

Sec. A18-354. - Statutory construction and severability.

This chapter shall be construed so as not to conflict with federal or state laws, rules or regulations. Nothing in this chapter authorizes any County agency to impose any duties or obligations in conflict with limitations on municipal authority established by federal or state law at the time such agency action is taken.

In the event that a court or agency of competent jurisdiction holds that federal or state law, rule, or regulation invalidates any clause, sentence, paragraph, or section of this chapter or the application thereof
to any person or circumstances, it is the intent of the Board of Supervisors that the court or agency sever such clause, sentence, paragraph, or section so that the remainder of this chapter remains in effect.

(Ord. No. NS-300.820, 5-11-10)

Sec. A18-355. - Effective date.

(a) This chapter shall become operable ninety (90) days after this ordinance receives final approval from the Board of Supervisors, unless:

   (1) The Board of Supervisors decides to adopt an alternative approach proposed to it during that ninety-day-time period that meets all of the requirements of this ordinance.

(Ord. No. NS-300.820, 5-11-10)
Many schools are surrounded by fast food restaurants, which provide students with easy access to unhealthy foods and undermine schools’ efforts to offer nutritious meals. Prohibiting fast food restaurants from locating near schools is one strategy to help reduce childhood obesity and support schools striving to improve students’ health. NPLAN has developed a model ordinance that creates a “healthy food zone” by restricting fast food restaurants near schools or other areas children are likely to frequent.

Why would a community enact a “healthy food zone” ordinance?
Childhood obesity is epidemic in the United States. Over the last 25 years obesity rates in children and teens have tripled.1 Today 16.3 percent of children and adolescents ages 2 to 19 are obese, and 31.9 percent are obese or overweight.2,3,4 Recent studies show that if this trend continues, today’s young people may be the first generation in American history to live sicker and die younger than their parents’ generation.5 At least one study has shown that students with fast food restaurants within a half-mile of their school are more likely to be overweight than students whose schools are not near fast food restaurants.6
Creating a Healthy Food Zone Around Schools

What does this model ordinance accomplish?
NPLAN’s Model Healthy Food Zone Ordinance prohibits new fast food restaurants from locating within a certain distance from any school or other designated location children are likely to frequent, such as parks, playgrounds, or youth centers.

What constitutes “fast food” under the model ordinance?
NPLAN’s ordinance defines fast food as food that is (1) made in advance, (2) prepared for quick consumption, (3) ordered or served over a counter or at a drive-through window, and (4) paid for before consumption.

Is it legal to regulate fast food restaurants in this way?
Yes. NPLAN’s model ordinance is an example of how zoning regulations can be used to limit children’s access to fast food restaurants. State law authorizes local governments to use zoning and other land use measures to regulate a community’s growth and development. Local governments have considerable discretion when enacting zoning regulations, and as long as there is a reasonable basis – such as protecting the community’s health – a court is likely to uphold the regulation. Courts have long upheld zoning laws that prohibit adult businesses and liquor stores from locating near schools,

What about fast food restaurants that already exist?
NPLAN’s Model Healthy Food Zone Ordinance is designed for communities that want to prevent new fast food restaurants from moving into areas near schools. It is ideal for communities planning new schools or trying to prohibit new fast food restaurants from setting up near existing schools. The ordinance does not remove fast food restaurants that are already in operation, which is a much more difficult and costly process. Because land use planning and zoning regulations are primarily tools to shape a community over time, they do not result in overnight changes to the landscape.

Does the ordinance restrict other types of food establishments?
The Model Healthy Food Zone Ordinance focuses on fast food restaurants, but it includes an option to prohibit mobile vendors (who sell food from portable vehicles like carts and trucks) near schools. Communities that choose this option may want to exempt mobile vendors selling healthy foods, such as fresh fruits and vegetables. The ordinance does not include convenience stores within the healthy food zones; in many communities, particularly lower-income neighborhoods, these stores are the only places where groceries are sold. Advocates may want to work with store owners and local residents to get more healthy foods on convenience store shelves.

NPLAN’s Model Healthy Food Zone Ordinance supports schools’ efforts to make healthy foods available to children before, during, and after the school day. Through zoning, this ordinance allows communities to prevent new fast food restaurants from locating within a certain distance from schools, limiting children’s access to the kinds of foods most likely to contribute to childhood obesity.

Visit www.nplan.org to download NPLAN’s Model Healthy Food Zone Ordinance and Findings.

2 Government agencies, foundations, and researchers often use different terms to describe obesity in children and adolescents. The Robert Wood Johnson Foundation uses the term obese for children and adolescents who have a body mass index (BMI) at or above the 95th percentile for their gender and age, and the term overweight for children and adolescents with a BMI at or above the 85th percentile but below the 95th. The Institute of Medicine also uses the term obese to describe children and adolescents at or above the 95th percentile but uses the term at risk for obesity to describe those with BMI at or above the 85th percentile but below the 95th.
7 See, e.g., Function Junction v. Daytona Beach, 705 F.Supp.544 (M.D. Fla. 1988) (upholding municipal ordinance outlawing adult theaters within 400 feet of schools, churches and parks); Mom N Pop, Inc. v. Charlotte, 979 F. Supp. 372 (W.D.N.C. 1997)(denying defendants motion for preliminary injunction and finding that City of Charlotte’s ordinance prohibiting adult establishments from locating within 1500 feet of any residential district, school, church, child care center, park, or playground was designed to serve a substantial government interest in curbing blight and protecting the integrity of schools, churches, and areas frequented by children.); Augusta-Richmond County v. Lee, 277 Ga. 483, 592 S.E.2d 71 (2004) (upholding denial of liquor license, on basis that there were already several stores in the area and that the proposed store was close to several schools and churches); & Taste Me Concepts v. New York City, 307 A.2d 237, 762 N.Y.S.2d 390 (2003) (holding that denial of liquor license was not arbitrary and capricious when petitioner’s establishment was within 200 feet of a church in violation of local law.)
8 For example, the Healthy Corner Stores Network promotes efforts to bring healthier foods into corner stores located in low-income and underserved communities. See www.healthycornerstores.org for more information.

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INTRODUCTION

Over the last two decades childhood obesity has risen at an alarming rate in the United States. In 1999, 13 percent of children ages six to 11 and 14 percent of adolescents ages 12 to 19 were overweight. This prevalence has nearly tripled. Now, the number of overweight children in the nation exceeds 12 million.

Evidence shows that children who enter adulthood obese are unlikely to shed the burden. And they also have a higher risk of premature death and disability in adulthood.

Sedentary behavior is partly to blame. Forty-three percent of adolescents watch more than two hours of television each day, according to a federal report. But excessive screen time — whether it’s the TV or computer— is only one obstacle that limits children’s ability to obtain the one hour of daily exercise recommended by the U.S. Surgeon General.

The built environment surrounding a child’s neighborhood and school can also help or hinder physical activity. Research shows that children who live closer to parks and recreational facilities are more active than those who live further away. And active living, along with eating nutritious foods, plays a key role in maintaining a healthy weight.

An important 10-year longitudinal study of more than 3,000 children living in southern California found that those who lived closer to parkland and recreational programs have much lower Body Mass Index (BMI) at 18 years of age than comparable children who lived further away.
More than half the children in the study had no recreational programs within 550 yards of their home — the equivalent of five city blocks. Nearly one-third had no such programs within three miles of their home and 20 percent lacked programs within six miles.

This policy brief summarizes new research that suggests increasing proximity to parks and recreational programs is part of the solution to reducing childhood obesity in Los Angeles and elsewhere in the United States.

**Figure 1. Portions of the Los Angeles study area showing the varied distributions of parks**

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**Methods Summary**

In a 10-year longitudinal study, researchers examined the influence of urban parks and recreational resources and their impact on childhood obesity in a cohort of 3,173 children from 12 communities taking part in the Southern California Children’s Health Study. Participants were enrolled beginning in 1993 to determine whether chronic respiratory effects are a consequence of air pollution.

Trained technicians measured the height and weight of all children when they joined the study, then again annually for eight years, to calculate BMI. Participants also completed written questionnaires each year on demographics, physical activity and household characteristics.

Researchers inventoried built environment measures including park space within a little more than a quarter mile of each child’s home and school. They linked this information to their BMI and individual questionnaire.

Next, they measured the number of active recreational programs targeted to those 18 years of age and under within three-mile and six-mile buffers of children’s homes. They restricted their measurement to include age-appropriate recreational courses offered by municipalities or non-profit organizations located at city-owned or city-sponsored sites.
Scientists also predicted BMI trajectories for children ages nine to 19. Predicted values were compared to each participant’s actual measurements to assess whether the lack of parkland and recreational programs contributed to BMI growth.

All statistical models controlled for race, ethnicity, gender and community of residence. In addition, researchers took into account many other risk factors that could affect weight gain such as asthma, smoking, second hand smoke and household income. They also controlled for aspects of the built environment that might influence their results, such as proximity to fast food.

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**Key Research Findings**

- Parkland and recreational programs significantly reduce the risk of overweight and obesity as measured by BMI attained at age 18. Recreational programming affected the children’s BMI much more than parkland.

- More than half of children in the study had no recreational programs within 550 yards of their home.

- Researchers estimated that if all children in the study had matching recreational programs near their homes, up to 9.5 percent would move from overweight to normal and approximately 2 percent would move from obese to overweight – a noteworthy result for children’s health.

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**What Can Policy-makers Do?**

The scientific findings summarized in this brief are clear: proximity to parks and recreational programs is a factor in reducing childhood obesity. Local expenditures vary on parks and recreation in California from less than $1 per capita in the poorest communities to almost $600 per capita in those most affluent. A critical obesity intervention strategy, therefore, is not only to increase funding from local, state and federal programs, but to spread that funding more evenly to all neighborhoods.

Current federal law provides for such opportunities. For instance, the Land and Water Conservation Fund Act of 1965 (P.L. 88-578) provides matching grants to enable federal, state and local governments to purchase land and open spaces primarily for the purposes of providing recreation opportunities. Over nearly half a century, Congress has appropriated more than $9 billion for the purchase of seven million acres of land by the National Forest System, which is the largest provider of outdoor recreation sites in the country.

Policy-makers can take additional steps to shape policies designed to reduce obesity and promote active living, such as:

- Creating age-appropriate recreational programs in “park poor” neighborhoods that are close to children’s homes;

- Encouraging recreation programs at existing public and non-profit facilities as well as at neighborhood schools — a significantly lower cost option than building new facilities;

- Expanding parks by converting vacant spaces in built-up communities into mini parks, or pocket parks;
- Including public space as a requirement for new building development plans;
- Investing in parkways, street trees and other forms of green cover that promote walking, running and biking outdoors;
- Supporting traffic calming measures such as speed bumps and stanchions to encourage walkable neighborhoods; and
- Investing in crossing guard programs to make it easier for children to commute on foot or by bike to parks and recreation facilities.

Acknowledgements

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Sources

2 http://www.surgeongeneral.gov/obesityprevention/index.html
13 http://www.fs.fed.us/land/staff/LWCF/about.shtml
Over the past several years, shared use has emerged as a promising strategy for creating opportunities for physical activity, particularly in places where recreational space is scarce. Too many cities and towns lack the resources residents need to be active, and finding safe, accessible, and affordable spaces to exercise and play is more challenging than it ought to be. Further, because recreational space is not equitably distributed, not everyone has the same opportunities to be active. Low-income communities and communities of color are far less likely to have access to places to be active, and these communities are also less likely to have sufficient resources to create new recreational spaces. Shared use can play a role in helping to address this inequity and the resulting health disparities.

This fact sheet provides public health advocates and shared use practitioners with an introduction to shared use as a strategy for reducing race- and income-based disparities in recreational access. It also highlights three considerations – safety, maintenance, and transportation – that may be of particular concern to low-income communities and communities of color as they assess different shared use arrangements.
What is Shared Use?
Shared use – also called joint use or community use – occurs when government entities, or sometimes private organizations, agree to open or broaden access to their facilities or other recreational spaces for community use.

The Many Forms of Shared Use
Though shared use has traditionally involved opening up school playgrounds and fields for community use, it can take many different forms. Successful shared use arrangements have occurred in a diverse range of settings, involved a variety of partners (or no partners at all), and pursued unique goals. Here are a few examples of possible arrangements:

- An agreement between a city and a utility district to allow a community group to plant a community garden on utility district land
- A government agency acting alone to open its office buildings during the winter months to give residents a place to walk
- A community organization hosting free Zumba classes in local schools and churches
- A hospital developing a public walking trail on its property

Shared use is often set up through a formal written agreement between the property owner and the party looking to gain access to the property. However, shared use can be, and often is, more than that; community use of facilities policies, open use policies, and even informal arrangements can create successful shared use partnerships. The key is not to get hung up on the mechanism through which shared use might occur. What is most important is that shared use is a worthwhile strategy, and it can be tailored to the specific needs of a community.
Moving Beyond Access: Safety, Maintenance, & Transportation

Creating meaningful and equitable access to recreational space is about more than simply opening the gates to a schoolyard. Aside from making a space physically accessible — an important first step — there are three elements of access that are often particularly relevant to low-income communities and communities of color: safety, maintenance, and transportation.

SAFETY

Communities with scarce resources and communities of color often identify safety as one of the biggest barriers to the use of existing recreational facilities. The perception that public spaces are unsafe — in addition to actual crime or violence — can prevent residents from accessing those spaces for physical activity. Residents may not feel safe traveling to a local park or playground, and insufficient lighting, secluded paths and areas, and the presence of homelessness and drug use can further deter people from using parks and other recreational spaces. Facilities that are accessible but poorly maintained may also seem unfit for use. While the perception that recreational spaces are unsafe can limit physical activity opportunities for all residents, safety concerns tend to disproportionately limit the activity of women, children, and the elderly.

At minimal cost, recreational spaces can be modified to promote safety through the principles of Crime Prevention Through Environmental Design (CPTED). For example, to reduce safety concerns among residents, shared use sites should have adequate lighting, ample sightlines (allowing users to see and be seen by other users), and allow informal monitoring of behavior. While some communities may want security or law enforcement present in recreational spaces, it is critical that any efforts to increase police presence remain sensitive to community concerns about inequitable policing and police violence.

Residents in many low-income communities and communities of color may feel the recreational spaces available to them are unsafe. But a well-used public space can in fact reduce violent crime, and be a social and community resource. Parks, trails, and other common recreational spaces can help create and enhance family and community ties by increasing interaction, decreasing isolation and crime, and encouraging volunteerism. Social interaction through physical activity and recreation can also help residents foster relationships and connect with people of different neighborhoods, classes, and races.
MAINTENANCE

Maintenance and upkeep of recreational facilities can be challenging in under-resourced areas. Often the public entity that owns the land – the school district, city, or county, for instance – is hesitant to divert limited funds to the upkeep of existing facilities. But poorly maintained facilities can discourage people from being physically active. Inadequate or deteriorating facilities may be less appealing, and improper maintenance can pose safety and liability concerns.32

For example, residents may be less likely to use a playground if the equipment is broken or if the blacktop is significantly cracked. Likewise, they may be more likely to get injured due to inadequate maintenance of the space and its structures. Although addressing inequities in public funding should be a central part of any long-term campaign to reduce disparities in recreational access, shared use agreements and other mechanisms for creating successful shared use partnerships can be part of a solution in the short-term.11 For instance, a nonprofit organization, like a Boys and Girls Club, could offer to cover a portion of the maintenance costs for school athletic fields, and/or assume some level of responsibility in the event of an injury, in exchange for the school district allowing the Boys and Girls Club priority use of the fields during certain times.

TRANSPORTATION

Transportation barriers can limit access to recreational spaces. When selecting a shared use site, it is important to consider whether the recreational space is accessible by foot, bike, and public transit.34,35 Streets in low-income neighborhoods are far less likely to have sidewalks and pedestrian-friendly infrastructure than high-income areas, limiting residents’ ability to walk or bike to the site.36,37 These considerations are particularly salient in neighborhoods where residents are concerned about safety and violence – even if the recreational space is safe and welcoming for people of all ages and genders, the routes residents travel to get to that space must also be safe and convenient. In rural areas where resources are geographically dispersed, it is crucial to understand the transportation patterns of the community. Shared use efforts should be targeted to locations that are widely accessible to the community, as determined through a robust community engagement process.

Safety, maintenance, and transportation are three primary concerns associated with creating meaningful access to recreational space in low-income communities and communities of color. While a number of other concerns may arise in the process of implementing a shared use arrangement – liability, insurance, scheduling, and staffing, for example – ChangeLab Solutions has published a number of resources, including a shared use toolkit, a checklist for developing a shared use agreement, and a comprehensive webpage, dedicated to helping communities address these concerns.

Overcoming the Liability Barrier

Many parties interested in shared use are fearful of liability and cite it as a reason not to open up their facilities. Sometimes this fear is a real hurdle, complicating potential shared use opportunities. Other times it is merely a perception of fear that can be overcome with the right tools. For example, by using prudent risk management strategies, such as regularly inspecting and maintaining property, carrying the proper insurance, and distributing legal risk through shared use agreements, parties can often overcome any liability concerns that potentially stand in the way of a successful shared use partnership.33 ChangeLab Solutions has published a primer on liability to help shared use partners overcome this barrier.
Keeping an Equity Focus

ENGAGE THE COMMUNITY

Before opening facilities for shared use, the parties involved must evaluate community interest. Meaningful community engagement will ensure that shared use efforts target locations, facilities, and programming that residents prioritize. Flexibility is also key – shared use is not the right strategy for every community. A community may already have access to sufficient recreational facilities, or maybe residents feel other issues are more pressing. Even when shared use is a community priority, advocates must be sensitive to concerns about community identity and stability. Investment in recreational areas and parks can increase local property values, and in turn increase property tax revenues for local governments, but such economic benefits may raise valid concerns about displacement and gentrification. Accordingly, one of the goals of a robust community engagement process should be to ensure that whatever recreational opportunities are created sufficiently meet and respect the needs of existing residents.

For more information on community engagement in the context of shared use, see the Centers for Disease Control and Prevention’s Practitioner’s Guide for Advancing Health Equity. It provides advice for public health practitioners on how to involve community members in health initiatives, including shared use, and includes a set of “questions for reflection” to help develop a community engagement approach. Additionally, Salud America!’s research review, Using Shared Use Agreements and Street-Scale Improvements to Support Physical Activity among Latino Youths, includes examples of communities where thoughtful engagement and stakeholder cooperation resulted in successful shared use arrangements in communities of color.

MAKE USE OF DATA

Individuals and groups interested in promoting shared use should keep an up-to-date inventory of communities that have the greatest need for recreational space in order to target shared use efforts in these areas. They should also compile a list of spaces and facilities that may be appropriate for shared use. With their specialized resources and expertise, local health and planning departments may be uniquely suited to undertake or support these efforts. Data and maps on potential shared use sites can help proponents of shared use work with communities to ensure that the sites are accessible in the most holistic sense possible.

For example, successful data collection and inventory efforts may be conducted by interviewing school administrators, conducting telephone surveys, and/or analyzing existing data to gather information and identify community needs. One successful effort to collect and analyze data on potential shared use sites was undertaken by the Honolulu County Department of Parks and Recreation, which hired an independent agency to assess the shared use potential of each of the county’s high schools.
THINK UPSTREAM

It is important to acknowledge that shared use does not address all of the systemic inequalities that pervade our political and social systems. That is to say, shared use is not a substitute for adequate funding to develop or upgrade recreational facilities in low-income communities and communities of color. A successful shared use arrangement is not a comprehensive solution to address the significant disparities in access to recreational space; to present it as such could reduce political urgency around these disparities. Rather, shared use should be one part of a much larger strategy to increase recreational access, pursued in concert with other strategies aimed at reducing health inequities.

Advocates for social and racial justice must continue to look at the root causes of health disparities. In the shared use context, one way to have a greater impact would be to address inequities in funding for recreational facilities. For a framework on how to work toward equity in recreational funding, research from the Los Angeles metropolitan region may serve as a case study. In addition, ChangeLab Solutions authored a Complete Parks Playbook that includes a chapter on community-based strategies for financing the development of parks and recreational facilities.

The Benefits of Equity-Focused Shared Use

- Shared use makes use of existing resources to increase opportunities for physical activity at low cost, which can be especially beneficial in communities with few opportunities for physical activity and scant resources.
- Shared use can revitalize existing, underused recreational spaces by opening them up for community use.
- Shared use sites can be a community resource, where residents can socialize, feel a sense of community ownership, and create an environment that is welcoming and safe for everyone.
- Well-used recreational space can place more eyes on the street, which discourages criminal activity.
- The presence of recreational space can increase the value of neighboring properties.
- Spending time outdoors and living near a recreational space can have psychological and physiological benefits, including reduced stress and lowered blood pressure.
Conclusion

Shared use can, and should, be used as a tool for advancing health equity, as it can be an effective strategy for reducing race- and income-based health disparities. But when promoting shared use in under-resourced communities, context matters. Lack of physical activity is rarely the only or primary concern for community members that do not have adequate access to recreational space. Poverty, poor educational outcomes, environmental pollution, and crime are often more immediate concerns than access to spaces for exercise and play. However, when public health advocates thoughtfully engage with community members to develop shared use sites with facilities and programming that meet community needs, shared use can have broad and lasting benefits.

ChangeLab Solutions is a nonprofit organization that provides legal information on matters relating to public health. The legal information in this document does not constitute legal advice or legal representation. For legal advice, readers should consult a lawyer in their state.

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Introduction

The way we design and build our neighborhoods can affect our physical and mental health. In this time of rising obesity rates, traffic congestion, long work hours, high stress levels, and fewer opportunities to be physically active, finding creative ways to address these issues is important. We must also consider the changing weather patterns and the possible impact on our way of life. All these factors stress the importance of designing and building healthy and vibrant communities that promote health.

To learn more about healthy community design, watch the Centers for Disease Control and Prevention’s (CDC), 15-minute video Building Healthy Communities at [http://www.cdc.gov/healthyplaces/cdc_healthy_community_design_webserver/video_h.htm](http://www.cdc.gov/healthyplaces/cdc_healthy_community_design_webserver/video_h.htm). You may also find helpful CDC’s Healthy Community Design fact sheet available at [http://www.cdc.gov/healthyplaces/factsheets/healthy_community_design_factsheet_final.pdf](http://www.cdc.gov/healthyplaces/factsheets/healthy_community_design_factsheet_final.pdf).

About the Resource Guide

This resource guide provides links to guides, checklists, audit tools, Web sites, and pamphlets that can help planners, local officials, and local citizens create vibrant neighborhoods where the healthy choice is the easy choice. The guide is structured to complement CDC’s Healthy Community Design Checklist ([http://www.cdc.gov/healthyplaces/factsheets/healthy_community_checklist.pdf](http://www.cdc.gov/healthyplaces/factsheets/healthy_community_checklist.pdf)), including resources for each of the Checklist’s seven categories. The resource guide is a small sample of the many excellent resources available that address healthy community design.

Comprehensive Guides

- **NYC’s Active Design Guidelines**
  
  NYC Dept. of Health and Mental Hygiene Built Environment and Physical Activity Program worked in partnership with the American Institute of Architects and other city departments including the Departments of Transportation, Design and Construction, and City Planning to develop NYC’s Active Design Guidelines ([www.nyc.gov/adg](http://www.nyc.gov/adg)).

- **Healthy, Active & Vibrant Community Toolkit**
  
  The toolkit is a resource to provide key community decision-makers with innovative ideas, policy suggestions and healthy community and living resources for improving the health of their communities.


- **Leadership for Healthy Communities Action Strategies Toolkit**
  
  The toolkit addresses the childhood obesity epidemic in the U.S., especially the increased risk faced by racial and ethnic minorities. Comprehensive strategies on how the built environment influences active living and healthy eating are provided.


- **New South Wales Department of Health Healthy Urban Development Checklist**
  
  The checklist, developed by the Government of New South Wales, Australia, provides evaluation questions that include housing, public open space, and social cohesion, to measure the health impacts of various development plans and policies.


- **Health Impact Assessment: A Guide for Practice**
  
  The guide is for local officials and others to conduct Health Impact Assessments in their communities, laying out the basic steps and strategies used in the process.

Guidelines by Category (See CDC’s Healthy Community Design Checklist)

(cluster icon) I want more options to help me get outside and be more active

Providing features such as parks, bike trails, rec centers, and outdoor plazas that give people a place to be active encourages outdoor physical activity. Ensuring that sidewalks are in good repair and streets are safe for people who walk and bike are important, too. The following guides offer strategies for creating features that encourage people to spending more time outside and living active lives.

(cluster icon) Active Neighborhood Checklist

This do-it-yourself checklist addresses street-level features of neighborhood environments relating to physical activity.

http://activelivingresearch.org/files/Protocol_ActiveNeighborhoodChecklist.v2.pdf

(cluster icon) Community Park Audit Guideline and Tool

This guide allows users to audit neighborhood parks for design criteria related to physical activity. The tool itself is


Tool: http://activelivingresearch.org/files/CPAT_AuditTool_0.pdf

(cluster icon) Wisconsin Active Community Environments Resource Kit to Prevent Obesity and Related Chronic Diseases

This guide offers advice on creating an active-friendly environment where it is easy to be physically active on a routine basis. The guide also includes an Active Community Environments checklist for assessing communities (p.31-42) and a sample resident survey (p. 42-48).

http://www.reducingobesity.org/docs/toolkits/Active%20Community%20Environment%20Tool%20Kit.pdf
I want to have healthier and more affordable food choices

Just hearing about the benefits of a balanced diet persuades some people to change their eating habits and lifestyles. For others, eating a healthy diet may be more difficult because healthy food options are not readily available, easily accessible, or affordable near their homes. These guides offer tools and strategies to help increase access to healthy foods through the promotion of “farm to fork” campaigns, farmers markets, community gardens, urban agriculture, the equitable placement of grocery retailers, and healthy corner stores.

APA Policy Guide on Community and Regional Food Planning

This American Planning Association (APA) policy guide offers seven general policy recommendations regarding urban and regional food planning, with specific roles for planners.


Food Access Policy and Planning Guide

This guidebook offers advice and provides examples of model language for policies that address issues of healthy retail, farmers markets, urban agriculture, restaurants, and transportation. It also includes a quick reference “Food Access Menu” with key steps to follow (pp. 10-11).


Community Food Security Assessment Toolkit

The U.S. Department of Agriculture toolkit offers guidance on conducting community food security assessments to ensure that all residents have access to enough food for an active, healthy life. The toolkit includes tools for assembling community assessment teams, conducting focus groups and surveys and collecting the necessary data for the assessment.

http://www.ers.usda.gov/media/327699/efan02013_1_.pdf

Improving Access to Healthy Food: A Community Planning Tool

The tool offers strategies on developing a healthy food action plan, implementing it, and evaluating its effects.

http://publichealth.columbus.gov/uploadedFiles/Public_Health/Content_Editors/Planning_and_Performance/Cardiovascular_Health/Improving_Access_to_Healthy_Foods.pdf

Good Food Checklist

The checklist provides steps people can take to promote a healthier food environment in their community.

http://www.iatp.org/files/143_2_102827.pdf
I want to get around in my community more easily without a car

Walking, biking and other active modes of transport are great ways to fit exercise into busy daily routines. They also allow us to get outdoors, interact more with our neighbors, and help reduce traffic emissions. These resources offer advice on how to make neighborhoods safer for people who walk, bike, and take public transit.

**Bikeability Checklist**
This checklist provides an easy-to-conduct audit that scores a neighborhood’s bikeability based on a number of design features.


**Walkability Checklist**
Similar to the Bikeability Checklist, this tool evaluates a neighborhood’s design for walking and produces a walkability score.


**LA County Model Design Manual for Living Streets**
The manual, developed by Los Angeles County, provides principles of good street design as well as concept drawings that promote active, living streets. The manual focuses on issues related to walking and bike access, traffic calming, intersection design, and land use along streets.

[http://modelstreetdesignmanual.com/training.html](http://modelstreetdesignmanual.com/training.html)

**Great Corridors, Great Communities**
The guide highlights eight successful corridor planning projects that considered multiple forms of transportation. Detailed case studies illustrate the tools used to make the projects a success.


**Creating a Road Map for Producing & Implementing a Bicycle Master Plan**
The guide provides steps and strategies for the initial planning, development and implementation of a bike master plan.

[http://www.bikewalk.org/assets/BMP_RoadMap.pdf](http://www.bikewalk.org/assets/BMP_RoadMap.pdf)
I want to feel safer in my community

Feeling safe in our surroundings plays a big role in the state of our mental health, social interaction and our physical activity levels. The following tools and guides offer ways to evaluate a locale for crime or danger, and offer strategies for creating safer places to live.

**CPTED Resource Guideline**

The guide explains CPTED (Crime Prevention Through Environmental Design), offers tips on how to apply CPTED in various situations, provides templates to follow and links to other resources, including those tailored to specific safety problems.


**National Crime Prevention Council of Singapore CPTED Guidebook**

This guidebook, which draws from several U.S. CPTED manuals, provides guidance on safety design measures by specific location type such as schools, downtowns, and shopping districts. It also includes a checklist of Yes/No questions to assess a location’s safety.


**City of Edmonton Safety Audit Guide**

Created by the Safer Cities Initiative Office in Edmonton, Canada, the guide provides a checklist of safety audit questions; and detailed advice on how to organize, conduct, and follow-up on a safety audit. The guide also offers tips on conducting large, joint, and transit safety audits.

http://www.edmonton.ca/for_residents/PDF/SCACSafetyAuditGuide.pdf

**LISC/CSI Safety Audit Checklist**

This safety audit checklist from the Local Initiatives Support Coalition (LISC), offers a quick-reference tool to conduct safety audits for any location.

I want to have more chances to get to know my neighbors

A friendly neighborhood is a healthy neighborhood. We need to feel comfortable walking around and talking with our neighbors. This allows us to build a sense of safety and trust and helps create a neighborhood that is relaxing, enjoyable, friendly and welcoming. Public places, such as parks and plazas, are great places for neighbors to interact.

Good Neighboring Resource Guides

The one-page Good Neighboring guide offers simple tips on how to create a friendly and welcoming environment through social activities and fostering neighbor interaction.

http://nrc-neighbor.org/resourceguide2

The Good Neighboring pamphlet gives 8 strategies for becoming better neighbors such as “welcoming a new neighbor,” “motivating people,” and “creating partnerships with a local business.” (http://nrc-neighbor.org/publications).

(http://www.ci.longmont.co.us/cnr/neighboorhood/documents/book.pdf)

The Community Toolbox

This chapter of the toolbox explains the importance of creating neighborhood action activities that bring neighbors in contact with one another, or helps them appreciate their neighborhood more; and offers strategies and tips on when and how to promote neighborhood action. Links to additional resources with more in-depth guidance are also provided.

http://ctb.ku.edu/en/tablecontents/sub_section_main_1327.aspx

How to Form a Neighborhood Association

This general guide, written by Sacramento County, California, gives pointers on how to form and run a neighborhood association. A by-law template is provided.

http://www.msa2.saccounty.net/dns/Documents/HOW%20TO%20ESTABLISH%20A%20NEIGHBORHOOD%20ASSOCIATION%20webcopy%20040709.pdf
I want my community to be a good place for all people to live regardless of age, abilities, or income.

People from every age, ability, income, and ethnic group deserve a healthy place to live, work, and play. These guides give advice on meeting the needs of diverse communities, and making sure everyone has fair and equal access to the resources needed to lead healthy, stable and fulfilling lives.

**AARP Livable Communities Guide**

The evaluation guide offers advice on how to evaluate the livability of communities for adults over age 50. The guide is broken down into sections including transportation, health services, safety and security, housing, and provides recommendations for each section as well as survey questions to guide evaluation.

[http://assets.aarp.org/rgcenter/il/d18311_communities.pdf](http://assets.aarp.org/rgcenter/il/d18311_communities.pdf)

**Policylink Community Engagement and Participation Checklist**

This evaluation tool allows residents to rate their community in five main categories relating to citizen participation and involvement. Links are provided on certain questions to offer further resources.

[http://www.policylink.org/atf/cf/%7B97c6d565-bb43-406d-a6d5-eca3bbf35af0%7D/COMMUNITY%20ENGAGEMENT%20CHECKLIST.PDF](http://www.policylink.org/atf/cf/%7B97c6d565-bb43-406d-a6d5-eca3bbf35af0%7D/COMMUNITY%20ENGAGEMENT%20CHECKLIST.PDF)

**Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health**

This Centers for Disease Control and Prevention (CDC) workbook was created to encourage and support the development of new and the expansion of existing, initiatives and partnerships to address the social determinants of health inequities. It provides a number of case study examples and lays out the steps for developing initiatives to address the causes of health inequality on a local level.


**Best Practices for Stakeholder Participation in Health Impact Assessment**

This resource guide gives best practices for involving citizens and other interested parties in Health Impact Assessments.

I want to live in a clean environment

A healthy neighborhood has clean air to breathe and clean water to drink. The health of our natural environment and resources can affect our own health. Protecting the natural environment helps make it more resilient to pollution, natural disasters and human disease.

A Citizen’s Guide to LEED for Neighborhood Development

This citizen’s guide helps residents evaluate the impact of development in their neighborhoods. It is based upon the LEED for Neighborhood Development (LEED-ND) criteria and offers an evaluation checklist for residents.


LEED-ND and Healthy Neighborhoods: An Expert Panel Review

This CDC guide specifies which LEED-ND rating system standards could provide several health benefits.


Household Carbon Footprint Calculator

This online tool allows individuals to calculate their current carbon footprint based on the lifestyle choices they make. It also shows how changing certain behaviors can lead to possible reductions in carbon footprint. This allows all of us to see the role we can play in making sure we have a clean and healthy environment in which to live, work, and play.

http://www.epa.gov/climatechange/ghgemissions/ind-calculator.html

2011 Enterprise Green Communities Criteria

This checklist can help evaluate the environmental impacts of new and existing developments. It focuses on community-wide impacts but also on construction materials and energy efficiency. A number of recommendations and resource links are provided.

http://www.enterprisecommunity.com/servlet/servlet.FileDownload?file=00Pa000000FxwvNEAR
GOAL I CASE STUDY: FONTANA, CALIFORNIA

The city of Fontana, California, population 203,000, has earned a gold medal for its work on Goal I: Start Early, Start Smart of Let’s Move! Cities, Towns and Counties (LMCTC), a key part of First Lady Michelle Obama’s Let’s Move! initiative. As part of their efforts, Fontana partnered with community organizations to promote health among Fontana’s youngest residents by providing professional development trainings that incorporate healthy practices to early care and education (ECE) providers in their city.

LMCTC Goal I: Start Early, Start Smart

To provide children with a healthier start, local elected officials commit to helping early care and education program providers incorporate best practices for nutrition, physical activity and screen time into their programs.

Early Care and Education in Fontana

The majority of early care and education centers in Fontana are privately-run, including in-home daycares, franchise daycare centers and church-based child care programs. In addition to private ECE providers, Fontana has a Head Start Program, as well as city-run programs for three- to five-year-olds at community centers.

Prior to participating in LMCTC, the city government had very little interaction with the city’s private ECE providers and did not hold professional development trainings. To establish relationships with ECE providers, the city identified individuals to contact using a county database of licensed child care providers in Fontana. The city of Fontana has used their work with LMCTC Goal I: Start Early, Start Smart as an opportunity to reach out to and build relationships with ECE providers, as well as to connect them to a range of community organizations and provide professional development opportunities.

Community Collaboration and Promotion

The Fontana Community Services Department, which runs Healthy Fontana (a city-led initiative focused on improving the health and well-being of its residents), works with a number of community partners to promote and hold their professional development training for local ECE providers. These partners include the local Women, Infants, and Children (WIC) clinic, the Dairy Council of California, and the San Bernardino County Human Services’ Transitional Assistance Department (TAD), as well as local health providers and educators. These partners provide support by presenting at the annual professional development training and by promoting the training to their clients.

In addition to collaborating with community organizations, Fontana works with local ECE providers to obtain their input in preparation for the yearly training. This collaboration helps city staff tailor the training to best suit the schedules and needs of providers. To receive their input, Fontana surveys the network of ECE providers that the city has built since joining LMCTC. The survey includes questions to see how knowledgeable ECE providers are about Let’s Move! Child Care, and whether ECE providers are aware that city-led professional training is available. Let’s Move! Child Care is the component of the Let’s Move! initiative that focuses on early care and education providers and helps them make positive changes in their programs to help children develop healthy habits.

Fontana extensively promotes their annual Let’s Move! Child Care professional development training. To get ECE providers to attend the training, staff from the Fontana Community Services
Department consistently reach out to ECE providers in the months and weeks leading up to the training, sending emails, letters and even visiting to the providers to talk about the training and the benefits of attending.

**Professional Development Training**

The annual training educates providers about the five goals of *Let's Move! Child Care*. The training, which lasts approximately an hour and a half, is held in the evening after most child care centers have closed, because that is when most Fontana ECE providers and their staff are available to attend.

The training opens with a light dinner and time for ECE providers to connect with local organizations and businesses. Organizations such as *Kids Come First*, a community health center, talk with ECE providers about the work they do and the programming they can offer families, particularly low-income families. Businesses, including Costco and local supermarkets, donate food for the training and share promotional materials about healthy products they sell that may be of interest to ECE providers. Prior to Fontana’s implementation of LMCTC Goal I, there was no opportunity for city-facilitated interaction between ECE providers and the greater health and business community.

Following dinner and the exposition, community partners present on each of the five goal areas of *Let’s Move! Child Care*. For example, a representative from the Dairy Council of California presents on the health benefits associated with limiting children’s consumption of juice and other sugary drinks in connection to *LM Child Care Goal II: Providing Healthy Beverages*. Similarly, a representative from WIC talks about the importance of supporting mothers who choose to breastfeed their children and strategies for accommodating breastfed babies in line with *LM Child Care Goal V: Support Breastfeeding*.

In addition to learning about the five LM Child Care goal areas, ECE providers have the chance to learn a new activity that they can share with the children they work with. As a break during the training, someone leads the ECE providers through a sample physical activity. One year, a presenter had the providers moving throughout the room, even crawling on the floor at times, mimicking the transition a caterpillar goes through to become a butterfly. If they choose to, providers can incorporate the activity into their own programming.

**Promoting Let’s Move! Child Care**

Outside of the annual training, the City of Fontana promotes *Let’s Move! Child Care* in a variety of ways. One way is advertising *Let’s Move! Child Care* and the five goal areas with a commercial on Fontana’s **local access television channel**. Another is the distribution of press releases through the mayor’s office about *Let’s Move! Child Care*. Fontana also promotes *Let’s Move! Child Care* on the [Let’s Move!](#) page of the city’s website. To encourage ECE providers to sign up for *Let’s Move! Child Care*, Fontana offers registered providers public recognition at a yearly Fontana Parks and Community Services Event, which city residents are invited to attend.

**Lessons Learned**

The biggest challenge that Fontana has encountered in their implementation of LMCTC Goal I: Start Early, Start Smart has been recruiting ECE providers to participate in the annual professional development training. Many ECE providers have limited resources and cannot afford to pay their staff to attend the training, especially because attendees are not eligible to receive continuing education units (CEUs) for the city-run training. To address this challenge, Fontana Community Services staff try to come up with creative incentives for ECE providers. These incentives have included free dinner for attendees, guest presenters from partner organizations who are knowledgeable about their topic area in the context of the Fontana community and the chance to interact with community organizations whose work is relevant to ECE providers.

Fontana city staff say that LMCTC Goal I is a good opportunity to connect with private ECE providers, a network that many cities, towns and counties often have little or no interaction with. In addition, taking advantage of the opportunity to educate ECE providers about strategies for promoting nutrition and physical activity is a great way to make a lasting, positive impact on a community’s youngest members.
Health In Your Hands

Program Manager: Bidisha Nath, MD, MPH
Community Services Administration (CSA)
City of New Haven
Childhood Obesity Statistics in New Haven and in CT

- Overweight and obesity is rapidly rising among children across the nation. In New Haven as well, childhood obesity has posed a major public health challenge for the region. Overweight and obese children are more likely to be overweight or obese as adults. For the first time ever, today’s generation of obese children are projected to have shorter life expectancies than their parents – because of obesity related complications. We must intervene with children as early as possible to reverse these trends.

- As illustrated, in 2011, nearly 40% of New Haven’s preschool students were overweight or obese; Nearly 50% of elementary and middle school students were also overweight or obese.

- In addition, 34% of residents in New Haven’s low income neighborhoods report food insecurity (– ie., do not have enough food or money to buy food) compared to rest of the city (10%) and statewide (22%). 52% of Hispanic and Latino residents are food insecure;

- Based on research evidence, childhood obesity is best addressed by focusing interventions on improving nutrition and healthy diets and promoting physical activity. CARE, Yale’s survey of New Haven’s six low income neighborhoods reveal that only 14% of residents in meet the recommendation of 5 servings or more of fruits and vegetables per day. 61% of people reported drinking sugary beverages (soda, iced tea, sports drinks, etc), for 5 or more times per week.
March, 2015, City of New Haven won the first place in the Childhood Obesity Prevention Grant Award (in the medium city category). A one year grant money of $120,000 was awarded to City of New Haven by US Conference of Mayors (USCM) and American Beverage Association (AMA) to develop a childhood obesity program to address the issue. With that funding, Community Services Administration (CSA), City of New Haven in collaboration with several other community partners including Yale University, launched a one-year community based initiative called Health In Your Hands (HIYH).

**Program Vision:** The primary goal of the program is to address the issue of childhood obesity, through – promoting healthy eating and increased physical activity, improving the access to fresh healthy food, and raising an overall awareness about culture of healthy living.

**Program Objective:** The objective of Health in Your Hands was to reduce childhood obesity in the city of New Haven by 20% by 2018.

**Target Neighborhood & Why:** Health in Your Hands focused on two of the most vulnerable neighborhoods in the City of New Haven: Fair Haven and the Hill. Residents in these neighborhoods are impacted by poor social determinants of health (including high unemployment, inadequate housing, and homelessness) and, subsequently, the highest burden of poor health outcomes. Both Fair Haven and the Hill are considered medically underserved communities and since the early 1960s have been supported by Federally Qualified Community Health Centers—Fair Haven Community Health Center and Cornell Scott-Hill Health Center.

**Target Population & Approach:**
We believe that like any child health issue, the problem of childhood obesity cannot be effectively addressed by targeting exclusively the kids. We made a two-generation approach by targeting the child and their parent as well as involving the caregivers in the child’s life. With that approach in mind, Health in Your Hands targeted all children in K-12 schools and their parents and extended family (grandparents) living in these two neighborhoods. In addition, the project also engaged providers of early childhood education and care, schools, community based after-school care providers, and community-based health providers. These children generally come from low-income families, as defined by federal standards for school-lunch program and family services programs.
Unique Features of the Program Model

• The program model follows an evidence-based participatory model that encourages participation of the community members (in form of focus groups) to make sure program interventions are designed around the community’s unique needs.

• The program incorporates the socio-ecological model [SEM] to ensure participation at all levels – starting with the child, then their family and other caregivers, moving onto the community organizations like schools, childcare providers – such an approach allows harnessing of efforts from all sectors of the society – ensuring a collective impact.

• Being responsive to community needs: We conducted focus groups in an effort to involve community in designing the program in an CBPR (Community based participatory research) approach. During our focus groups and listening tours,, residents told us what would work for them and what will not.
  • Eg: they said they did not see themselves going into gym for exercise, but would like have more fun if it was dancing – some liked line dancing, others liked hiphop.
  • They said just learning how to cook healthy is not enough, they need to learn recipes that are culturally relevant; also to make sure that they actually practiced cooking those recipes the program gave them free produce at the end of the cooking class to take home and re-create those recipes.

• To make sure access is not a barrier, the programs were brought to the local schools/library/churches.

• To make sure the program reached the high risk families, families were refer

• To leverage off of existing resources and avoid loss from duplication of efforts - the program encourages participants to take part in ongoing health and wellness events in the society – and thus lists events in the neighborhood organized by other sponsors on the monthly calendar for HIYH side by side its own direct services.

• To bolster sustainability efforts, the program has built into its model a train-the trainer component, identifying residents to become community chefs to teach healthy cooking or become trained as dance instructors to teach classes in the community. Part of the program’s funding will go into funding future stipend for these community trainers. This strategy aims to build capacity within the community and helps build confidence and leadership within the community.

• To nurture a sense of cohesive community, the program organizes community events like community walks with the Mayor and community festivals – so that people feel a sense of belonging and take pride in contributing towards making their neighborhood a healthier place to live.
Program Strategies & Services

The basic goal for HIYH program is to empower residents of two of the most vulnerable neighborhoods in Hill and Fair Haven about how to address the issue of childhood obesity through family involvement focusing on physical activity and nutrition education in a way that is relevant to their everyday lives.

This project has the following main components:

1. **Teaching healthy Eating & how to Cook Healthy** Cooking Classes and Workshops (In collaboration with *Cooking Matters, CT*)—teaching nutrition education and how to make healthier food choices; how to cook culturally relevant food in a healthier way; how to accurately read nutrition labels on food items while purchase and buy healthier food items; teach smart shopping tips on how to shop healthy and still remain within budget.

2. **Addressing Food Insecurity** : Health In Your Hands in collaboration with CitySeed and Cornell Scott Hill Health Center, brings in farmer’s market and mobile markets to the identified food desert areas of the city, thereby improves access to fresh fruits and vegetables through farmer’s market, doubling benefits for SNAP recipients.

3. **Promoting Urban Agriculture – as form of exercise and growing your own produce**: City partnered with New Haven Farms, a local nonprofit organization committed to utilizing green space for neighborhood food production, nutrition education, and food security. Participants were invited to own a small plot, where they were given resources for gardening to help them grow their own vegetables. At the end participants can enjoy those produce and learn how to cook healthy recipes with them.

4. **Promoting physical activity in non-traditional format (through dancing)**: The City contracted local family oriented exercise programs with the aim to promote increased physical activity and a more active lifestyle among the children and their families in the community through Zumba/fitness dance classes.

5. **Building community leadership** for sustainability and building capacity: training community residents to become Community Chef and Community Zumba instructors to promote healthy habits within the neighborhood at grassroots level. The program also trained Community Ambassadors as champions of healthy living to raise awareness at grassroots level. The program will pay small stipend to these champions to conduct classes in the community, help them schedule and host classes and also buy the resources needed to conduct those classes. (The program plans to buy two cooking kits, on commercial grill to be utilized for community festival promoting community cohesion, music system to support the free dance/fitness classes.

6. **Monthly calendar** – listing our services and other local free events promoting healthy living. Thousands of calendars printed each month for distribution widely within the target communities.
Health In Your Hands - Program Evaluation & Impact

Evaluation Conducted by CARE (Community Allied Research & Education), Yale University
Impact on the Community

• Launched in July, 2015 Health in Your Hands implemented numerous activities, reaching nearly 1500 people in 12 months: 123 activities were offered through partnerships with Cooking Matters, New Haven Farms, and local exercise instructors. Activities took place in the Fair Haven and Hill neighborhoods and reached a total of 1415 participants – 990 in Fair Haven and 425 in the Hill. Fair Haven hosted 57 activities and the Hill hosted 58 activities.

• **Tangible health benefits:** Health in Your Hands programs led several participants to lose weight. One participant noted that she was able to get off of her blood pressure medication.
  • 2015 New Haven Farms participants had an average weight loss of 3 lbs.

• **Behavior change:** Participants changed eating and exercise behaviors as a result of the initiative.
  • 75% of New Haven Farms participants reported a change in healthy eating habits.
  • Cooking Matters participants report substantive changes in cooking and exercise habits, as indicated by qualitative data collected in focus groups.

• **Benefits of program extended to families at home:** Participants applied the lessons they learned in the cooking and exercise classes in their homes, which provided an opportunity for their families to engage in healthier habits.
Important feedback from Community about the program – post program Focus Group outcome

• Many participants expressed that cost was a major barrier to healthy eating and exercise. Participants praised the program’s economic accessibility, with many saying that they participated in a Health in Your Hands program because its activities were free.

• Participants also chose the program for its convenient location. Some participants noted that they were specifically looking for an exercise program in their neighborhood, and they enjoyed being able to walk from home or work to the program site.

• The programs took a family approach, integrating both adults and children and addressing their nutrition and exercise needs. Participants noted that having their children involved in the program was a family bonding experience that brought them closer together, and that they saw benefits to having children and young adults prepare food alongside them.

• For the majority of participants, the time of the program was also convenient; they noted that they were able to go to class directly from work. Spanish-speaking participants said that they appreciated and were better able to take part in the programs because the instructors spoke some Spanish. Being able to present exercise instructions and recipes in Spanish helped participants to feel more included. (Spanish speaking participant quoted through an interpreter.)

• Many participants explained that the programs had a positive influence on their families as well, often encouraging them to cook at home more often, try new recipes, and make small changes, such as substituting whole wheat pasta for white pasta.

• In addition to the health benefits of these programs, participants also appreciated the social aspect of the programs. They found that the programs were an excellent way to socialize and make friends.

• Some participants explained that a major motivation for participating was the group setting, and they might not have otherwise participated in a similar program or made healthier changes. The social aspect of the program also lent itself to a supportive environment where participants felt encouraged by their peers. Some participants noted that they had not felt this way when they had previously gone to gyms. The classes provided a low-pressure environment where they felt that they could work at their own pace.

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Our Cooking Classes – in partnership with Cooking Matters, CT

The program aimed to help participants acquire the knowledge and skills needed to shop strategically, choose healthier foods, and prepare balanced meals on a limited budget. Using an evidence-based curriculum, Cooking Matters, CT provided school- and neighborhood-based nutrition education program and training in healthy cooking to our participants. The program consisted of six-week courses as well as one-time cooking workshops. The program helped promote local and healthy food, recruited and trained individuals from these neighborhoods to serve as Community Chefs who were trained to teach nutrition, cooking, and food resource management skills to maximize nutritional value and minimize cost. Their grocery store tours, included teaching participants how to read nutrition labels, comparing unit prices, finding whole grain foods, and identifying three ways to purchase produce. It also included the $10 challenge, an activity where participants use the skills they had just learned to buy a healthy meal for a family of four for under $10.

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<thead>
<tr>
<th>Neighborhood</th>
<th># Activities</th>
<th># Participants</th>
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<tr>
<td>The Hill</td>
<td>41</td>
<td>548</td>
</tr>
<tr>
<td>TOTAL</td>
<td>81</td>
<td>1,322</td>
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Community Feedback on HIYH’s Cooking Courses

**Adult Feedback:**
- Adults noted that the course taught them how to cook healthier foods and how healthy foods can also taste good. They learned that it does not take much effort to prepare a delicious meal with healthy ingredients.
- Many found that they were more conscious of nutrition labels and sugar and carbohydrate intake following the course. Participants also appreciated the time spent with their families. One participant explained that it gave her something special to do with her son. Another participant explained that the course had a positive impact on their family as well.
- Participants were also encouraged by the youth in the class and their high involvement and engagement. Participants enjoyed learning about food labels and nutritional values and discovering new recipes and ways to prepare food.
- “It can be easier and faster to prepare foods than I’d thought. Before, I’d just eat raw, plain fruits and veggies. Now I know with just a little more effort and preparation, I am much happier and satisfied with the result.”

**Student Feedback:**
- The majority of students felt that participating in the course had taught them to eat healthier, cook using different ingredients, and learn about nutrition. Students felt that they learned creative ways to make healthy food that tastes good, and they actively look for healthy choices now. One student reported that she helps more in the kitchen than she used to, and another said that he helped his mother now when she cooks.
- “It has showed me how to be able to cook really matters and that I should also be making healthy food choices when preparing a meal.”
Key Findings from 2015 Farm-based Wellness Program
In collaboration with New Haven Farms

Farm-based Wellness Program is a partnership between New Haven Farms Fair Haven Community Health Center and Cornell Scott-Hill Health Center. Medical providers from both institutions refer adult patients who have at least two diet-related chronic disease risk factors and who live within 200% of the 2010 federal poverty level. During the 16-20 weeks of the summer growing season, these referred patients and members of their families come to the farm to for weekly 2-hour, bilingual Spanish/English cooking demonstrations, nutrition classes, and gardening seminars. Participants and their families take home a share of fresh vegetables and fruits each week, along with sets of recipes. Youth who attend the weekly Farm-Based Wellness Program receive simultaneous age-appropriate gardening, cooking, and nutrition education. Forty-eight people participated in the 2015 program.

People who had participated in New Haven Farms’ programs felt that the programs had positively shaped their knowledge of fruits and vegetables. Participants found that their involvement with New Haven Farms helped them make better food shopping choices.

- 75% of all participants reported changes in eating habits, with 90% of high attendance participants reporting changes in eating habits.
- 75% of all participants reported eating new vegetables and 79% reported a willingness to buy new vegetables in the closing survey.
- Among participants who completed the program (n=31), high attendance participants had an average weight loss of 3 lbs. from the baseline to closing survey compared to a 3 lbs. increase in low attendance participants (high/low attendance as defined by New Haven Farms).
- Male participants had an average weight loss of 4 lbs. compared to female participants with an average weight loss of 0.73 lbs.
- Participants older than 50 reported greater changes in eating habits, new vegetables eaten and willingness to buy new vegetables compared to participants under 50 years old.
- Participants who were referred from the Fair Haven Community Health Center Diabetes Prevention Program (DPP) reported greater changes in eating habits, new vegetables eaten and willingness to buy new vegetables compared to non-DPP participants.
- The mean fruit and vegetable intake per day decreased by 0.57 servings.
New Haven Farms created three additional programs to augment Health in Your Hands. These components included:

1. **The Green Thumb Challenge**: New Haven Farms organized this friendly neighborhood challenge to celebrate and support community members growing their own food. It included four celebrations in Fair Haven and the Hill neighborhoods. Activities included cooking demonstrations, shared meals, gardening and composting tips, and prizes for these family-friendly, fun events. A total of 62 residents participated, with 36 in Fair Haven and 26 in the Hill.

2. **Community Health Ambassadors Program**: This component provided a leadership development opportunity for past New Haven Farms participants. Ambassadors share personal stories with referred patients and providers, mentor new participants, and lead community-based groups through the off-season. These leaders cultivate a culture of health in their neighborhoods. Five Ambassadors were trained in the Hill during 2015-16.

3. **Thomas Chapel Church Garden**: New Haven Farms assisted Thomas Chapel Church in the Hill to develop a community garden. The partnerships that are a result of creating this garden allowed New Haven Farms to deepen their engagement in the Hill neighborhood. Specifically, the garden offered New Haven Farms and Cornell Scott-Hill Health Center a way to work together on a common project, and develop greater trust for moving forward. This partnership has led to considerable expansion of the church garden this year by collaborating with the New Haven Land Trust to support and extend its growing capacity. This work has attracted additional funding through a CARE mini-grant of $1500.
Exercise/Fitness Classes under HIYH

Our Exercise classes were implemented through partnerships with the New Haven’s Parks and Recreation Department, Community Policing Youth Activities, the Mayor’s Walking Program, Yale University Urban Resources Initiative’s Greenspace program, local dance instructor organizations Dance Haven, Alisa’s House of Salsa and Cornell Scott’s Hill Health Center. Exercise classes used either live instructors for dance classes or workout DVDs.

Dance Haven Dance/Exercise Classes
Between November 2015 and April 2016, 39 dance classes were completed with a total of 493 participants. Thirteen Latin dance classes were completed in Fair Haven (N=126 participants) at John Martinez School and 26 hip-hop classes were completed in the Hill (N=367) at Hill Central Middle School and Clinton Avenue School. The majority of participants in the dance classes were under 18 years of age.

Collaboration With Cornell Scott Hill Health Center
Five types of workout classes were offered in Fair Haven and the Hill: Line dancing, George Forman boxing, Leslie Sansone: Walk Away the Pounds, Shaun T: T25, and Zumba. Classes were held at Wilson Public Library and led by a wellness educator from the Cornell Scott Hill Health Center. Approximately 1020 participants took part in exercise classes between July 2015 and June 2016 in collaboration with.
Our Partners

• **Administrative Lead:** Community Services Administration, City of New Haven
• **Funders:**
  • United States Conference of Mayors
  • American Beverage Association
• **Community Partners:**
  • New Haven Health Department, City of New Haven
  • New Haven Public School
  • Parks and Recreation, City of New Haven
  • Cooking Matters, CT
  • New Haven Farms
  • CitySeed
  • Cornell Scott Hill Health Center
  • Fair Haven Health Center
  • CARE, Yale
  • URI
  • NH Food Policy Council
  • New Haven Public Library
  • Dance Haven, LLC
  • Alisa’s House of Salsa