

Rural Obesity

*Strategies to Support Rural Counties
in Building Capacity*



NACO National Association of Counties
The Voice of America's Counties

Rural Obesity

Strategies to Support Rural Counties in Building Capacity

Produced by the Community
Services Division of NACo's
County Services Department

January 2008



About NACo – The Voice of America's Counties

The National Association of Counties (NACo) is the only national organization that represents county governments in the United States. Founded in 1935, NACo provides essential services to the nation's 3,066 counties. NACo advances issues with a unified voice before the federal government, improves the public's understanding of county government, assists counties in finding and sharing innovative solutions through education and research, and provides value-added services to save counties and taxpayers money. For more information about NACo, visit www.naco.org.

NACo's Health Care programs are designed to help counties find solutions to the health challenges they face in their communities, including increasing access to care, expansion of rural health systems, and advancing programs and policies to prevent childhood obesity.

For more information on NACo's Health Care programs, please contact:

Lesley Buchan
Program Director
Community Services Division
☎ 202.942.4261
✉ lbuchan@naco.org

or

Christina Rowland
Senior Associate
Community Services Division
☎ 202.942.4267
✉ crowland@naco.org

To order copies of this publication or other Health Care publications, please contact:

Casey Dillon
Program Assistant
Community Services Division
☎ 202.942.4243
✉ cdillon@naco.org

Primarily written by Casey Dillon, Community Services Program Assistant, Christina Rowland, Community Services Senior Associate. Edited by Lesley Buchan, Community Services Program Director.

Support for this publication was provided by the Robert Wood Johnson Foundation as part of its Leadership for Healthy Communities national program.

Acknowledgements

NACo wishes to thank the following individuals for their time and contribution to the development of this publication:

- Commissioner Peggy Beltrone, Chair of the NACo Rural Obesity Initiative
- Members of the Rural Action Caucus and other county leaders who participated in the Rural Obesity Initiative.

Table of Contents

Executive Summary	3	Opportunities to Leverage the Unique Features of Rural Communities to Maximize Investments	6
Background: The NACo Rural Obesity Initiative	3	Recommendations for the Philanthropic Community	6
Obesity in Rural Communities	4	Empowering Rural Communities to Prevent Childhood Obesity	8
The Funding and Capacity Gap in Rural Communities	5	Appendix A	10
Necessity of Targeted Best Practices and Research for Rural Communities	6	Appendix B	10

Executive Summary

As governments and institutions across our nation work to reverse the growing childhood obesity epidemic, there is an emphasis on reaching children at greatest risk—African-American, Latino, Native American, Asian American and Pacific Islander children living in low-income communities. Recent research shows that children and adults living in rural communities* may also have an increased risk for obesity and require focused prevention efforts as well.

Rural typically has been synonymous with robust health. Today, however, many rural Americans are struggling with overweight or obesity. Research recently published in *Obesity* and *The Journal of Rural Health* reinforces what rural community leaders already know—that children living in rural areas should be recognized as a high-risk population for childhood obesity, who warrant additional attention and assistance. According to the studies, 16.5 percent of rural children and 20.4 percent of rural adults are obese, compared with 14.4 percent of urban children and 17.8 percent of urban adults.^{1,2} The studies also show that in addition to being at increased risk for obesity and overweight, rural children are also at increased risk of poverty, are less likely to have health insurance, are less likely to have accessed preventive care in the past year, and have lower levels of physical activity.³ Overall, children living in rural areas are about 25 percent more likely to be overweight or obese than children living in metropolitan areas.⁴ This represents a change from the past when children from metropolitan areas were at greater risk for being overweight than rural children.

Rural county officials are working to address obesity, the related health consequences and the unique challenges that their residents encounter. However, rural communities at times may lack the same funding, technical assistance and resources that may be available to their urban counterparts.

To raise awareness of this disparity and share insight from local elected leaders on the nature of obesity in rural communities, the National Association of Counties (NACo) planned and conducted the Rural Obesity Initiative. This project received funding from Leadership for Healthy Communities, a national program of the Robert Wood Johnson Foundation. It was a three part initiative that included an opinion survey, two meetings with focus groups at NACo's Western Interstate Regional and Annual Conferences, and individual feedback from rural county elected leaders.

This publication describes the Rural Obesity Initiative and the lessons learned from this project. It includes the following sections:

1. Background on the NACo initiative;
2. A description of the unique nature of obesity in rural America and the challenges of implementing commonly promoted best policies and practices in these areas;

* Note: For the purpose of this publication, we define “rural” based on the US Office of Management and Budget definition as any counties outside the boundaries of metro areas

3. A rationale for increasing funding commitments for obesity prevention in rural America and the benefits of funding smaller communities;
4. Recommendations on how the philanthropic community can support rural communities' efforts to develop successful obesity prevention policies and programs;
5. A brief conclusion to summarize the key points of the publication; and
6. An appendix which includes the methodology and results of the NACo Rural Obesity Survey.

Background: The NACo Rural Obesity Initiative

For a number of years county officials have expressed a need for technical and philanthropic resources specific to rural communities. This topic became central to a discussion on rural obesity among the leaders of NACo's Rural Action Caucus during their retreat in Gallatin County (Bozeman), Montana in January 2007. Caucus members heard presentations from the Montana Physical Activity and Nutrition Department about the unique struggles rural communities face in the area of obesity prevention. Caucus members encouraged NACo to draw attention to the lack of resources available to support rural communities' efforts to address obesity. As a result, NACo began to make special focus on rural obesity and then referred to it as the Rural Obesity Initiative.

The initiative was formally introduced at NACo's Legislative Conference in March 2007 and county officials were encouraged to participate. The goals of the Rural Obesity Initiative were to gain a better understanding of the unique face of obesity in rural America and to draw attention to the need to fund obesity prevention work in rural America. The initiative was chaired by Commissioner Peggy Beltrone of Cascade County, Montana.

The Rural Obesity Initiative was carried out in three steps. The first step was the NACo Rural Obesity Survey⁵, an opinion survey designed to gain feedback from rural county leaders on the primary challenges and opportunities around obesity in their communities. NACo received nearly two hundred responses.

The second step involved hosting two meetings with rural county leaders at NACo's Western Interstate Regional Conference (WIR) and at NACo's Annual Conference and Exposition. At the WIR meeting survey results were vetted and participants discussed factors leading to childhood obesity and the resources needed to improve children's health in their communities. At the annual meeting, presentations from a panel of experts highlighted the importance of addressing obesity in rural America and on a national level. Following the presentations, participants reviewed a draft list of recommendations prepared by NACo on how the philanthropic community could best assist rural communities in addressing childhood obesity.

The third phase of the initiative involved collecting individual feedback from rural county leaders and refining the initial draft of NACo's recommendations. The recommendations were shared in August 2007 by Commissioner Beltrone at Senate Finance Committee Chair Max Baucus's meeting with the Council

of Foundations.

The NACo Rural Obesity Initiative began with an interest in obesity in all rural populations, but shifted its focus specifically to childhood obesity. It is important that any obesity initiative target the whole family, as many studies have indicated a strong correlation between the health of a parent and the health of their child.⁶ And although obesity affects people of all ages, rates have increased most quickly among children over the past three decades.⁷ Overweight and obese children are at higher risk for a host of serious illnesses, including heart disease, stroke, asthma and certain types of cancer. And these children already are being diagnosed with health problems that previously were considered to be “adult” illnesses, such as type 2 diabetes and high blood pressure. Preventing obesity during childhood is critical because habits that last into adulthood frequently are formed during youth. If we don’t act now, we are in danger of raising the first generation of children that will live sicker and die younger than the generation before them.

Obesity in Rural Communities

The findings of the NACo Rural Obesity Initiative demonstrate the obesity challenge in rural America. These challenges are similar to those confronted by more urban communities which include the struggle against the effects of marketing of unhealthy foods to children; the over-abundance of and easy access to calorie-dense foods, and the overall trend of less active lifestyles. Rural obesity is, however, markedly different in a number of important ways. There are unique factors contributing to increasing rates of obesity among rural children and adults including: poor access to health care; population diversity; food insecurity and food deserts; economic transitions; low-population density; and few opportunities for physical activity.

Poor Access to Health Care

Rural Americans face barriers to accessing health care not found in more urban communities. Not only is the proportion of uninsured persons higher in rural areas, but rural residents are also more likely to report fair or poor health than their urban counterparts, and are more often diagnosed with chronic conditions.⁸ Despite an apparent greater need for health services, rural counties face severe physician shortages—60 percent of rural white Americans and 75 percent of rural minority Americans live in designated Health Provider Shortage Areas.⁹ Barriers to accessing health care make it difficult to implement early obesity screening and intervention programs, and also limit the opportunity for comprehensive chronic disease care management and nutrition education.

Population Diversity

Rural areas are also seeing new and increasing population diversity. According to the U.S. Department of Agriculture (USDA), as of February 2007, racial and ethnic minorities make up 18.3 percent of non-metro residents, compared with 14.1 percent in 1990.¹⁰ These changing demographics create new pressures on local health and social services working to prevent obesity, including a need for culturally and linguistically appropriate programs and services. It also creates changes in demand for services, as minorities are disproportionately affected by obesity and

obesity-related chronic illnesses.¹¹ According to the National Health and Nutrition Examination Survey 1999-2000, 23.6 percent of non-Hispanic black and 23.4 percent of Mexican American adolescents were overweight, compared with 12.7 percent of non-Hispanic white adolescents.¹² Studies have shown that obesity is also significantly more prevalent among rural minority adults compared to rural white adults.¹³

Food Insecurity and Food Deserts

Another issue affecting obesity in some rural areas is a growing percentage of residents classified as “food insecure”.¹⁴ Food insecurity is defined as limited or uncertain access to nutritionally adequate and safe foods,¹⁵ and is linked with higher obesity rates.¹⁶ Respondents to the NACo Rural Obesity survey report frequent and increasing utilization of emergency food resources, suggesting that more rural citizens are relying on their neighbors and governments to supplement their meals as food insecurity increases.¹⁷

Growing food insecurity in rural areas may be attributable in part to changes in retail grocery store placement patterns, especially the growth of grocery “supercenters” in rural areas. Over the past 10 years, the average distance rural populations must travel to have access to quality, affordable groceries has increased, in most cases requiring access to a car and lengthy commutes,¹⁸ creating what has been termed a “food desert”. Rural consumers residing in these food deserts often must rely on convenience retailers, who offer a smaller variety of products and limited access to fresh fruits and vegetables. Food insecurity and food deserts contribute to the number one challenge cited by respondents to the NACo Rural Obesity survey regarding healthy eating in rural communities: an increasing reliance on processed convenience and fast food.¹⁹

Economic Transitions

Rural communities’ economies and cultures have changed in recent decades in ways that make it difficult to maintain a healthy weight. Compared to their parents’ and grandparents’ generation, which was more likely to engage in labor intensive trades, many of today’s rural residents commute to work, have sedentary jobs and are less active overall.²⁰ Findings from the Rural Obesity Initiative suggest that traditional rural dishes that are high in fat and calories, such as BBQ, steak and potatoes, fried chicken and pies, are still popular. Survey respondents identified the continued preference for these types of hearty meals that were preferred by their rural predecessors as the second most important challenge to reducing obesity.²¹

Low-Population Density

Rural communities, due to their low population density, often have limited communication outlets for sharing health information with citizens. In addition, findings from the Rural Obesity Initiative suggest that rural community members spend a significant amount of time in cars driving between home, work and school—that the distance between these destinations is significant—and that this contributes to obesity. According to the U.S. Bureau of Transportation, in 2004 about 3.3 million Americans traveled 50 miles or more one way to get to work, with 40 percent of these commutes originating in rural areas.²² Furthermore, recent studies have found that low-population density is posi-

tively associated with both obesity and vehicle miles traveled among urban and suburban population samples, suggesting the same may be true for rural communities.^{23, 24, 25}

Few Opportunities for Physical Activity

Recent studies have found that rural children have higher rates of physical inactivity than their urban counterparts.²⁶ The same research finds that rural children spend more time watching television and using the computer. The NACo Rural Obesity Survey supports these findings, the challenge that the greatest number of respondents felt contributed to reduced physical activity levels among residents was the rise of TV/technology.²⁷ Findings from the Rural Obesity Initiative also suggest that a decline in physical activity in schools, lack of recreation facilities and parental concerns about letting children play outside unsupervised may contribute to lower physical activity levels among rural children. In addition, several characteristics common to the built environment in many rural areas including: limited access to parks; fewer sidewalks; lack of public transportation; and limited physical education classes may be barriers to active living.²⁸

The Funding and Capacity Gap in Rural Communities

Like their urban and suburban peers, rural leaders are working to address obesity with the resources at their disposal. Greater philanthropic support could enhance the implementation of policies and programs that rural communities need in order to address the alarming increase in childhood obesity. There are, however, some specific challenges and barriers that rural communities often face in competing for grant resources which include: access to financial resources; local government staff size; and number of community stakeholders.

Access to Financial Resources

Rural communities, particularly in certain regions of the Untied States, have limited local financial resources to draw upon. This is in part due to rural poverty. According to the U.S. Census Bureau, in 2006, 15.2 percent of rural Americans were living below the federal poverty level (compared with 11.8 percent of persons living inside metropolitan statistical areas).²⁹ Furthermore, the Rural Policy Research Institute, using data from the USDA Economic Research Service, has identified 386 counties that have consistently had poverty rates of 20 percent or higher in every decennial census between 1970 and 2000,³⁰ meaning that over 12 percent of all the nation's counties are persistently poor. The majority of these persistently poor counties are in the rural south, a region that has some of America's highest obesity rates.³¹

When communities face poverty, their local governments have tight budgets with little leeway to support preventative health programs. Local charitable giving is also likely to be inadequate. In addition, local governments with limited financial resources may not invest as much as their peers can in up-to-date technological resources, presenting a potential barrier to researching and applying for online grants.

Also contributing to the lack of financial resources available to devote to obesity prevention in rural communities is limited

philanthropic giving in certain regions of the country. The Big Sky Institute, an interdisciplinary research center based in Helena, Montana, has conducted research that suggests an association between rural status and low in-state foundation assets as well as low philanthropic per-capita giving. It has named ten "Divide States," the ten states with the lowest total foundation assets.³² All of these are predominantly rural and include: Alaska, North Dakota, Montana, Vermont, South Dakota, Mississippi, Maine, West Virginia, Wyoming and New Hampshire. Of these ten, nine also have the lowest total per-capita foundation giving (Wyoming being the exception).³³ In these states, and other rural regions where philanthropic infrastructure may be relatively lacking, local governments and non-profits have fewer foundations to work with as they apply for grants and other types of assistance to support their obesity prevention efforts.

Local Government Staff Size

Low-population density is inherent to the definition of rural. For rural counties this means fewer citizens within jurisdiction boundaries to serve, and also often comparatively less tax revenue. For both of these reasons, rural counties typically have small staffs that work in an integrated manner to handle county responsibilities. As such, the staff person in charge of finding and applying for grant applications is likely to have additional and competing job responsibilities. This situation can result in rural local governments not applying for as many assistance opportunities as they might otherwise, and also in having less time to invest in the preparation of applications.

Number of Community Stakeholders

Low-population density also contributes to another barrier that rural local governments face when applying for foundation assistance: a smaller pool of stakeholders and health experts to enlist as partners. Smaller population sizes typically support fewer community organizations. Also, one of the most important partners in any government health effort, medical professionals, are less likely to be located in rural areas. According to the National Rural Health Association, only about ten percent of physicians practice in rural America despite the fact that nearly one-fifth of the population lives in these areas.³⁴ Low numbers of partner community stakeholders can make rural local governments' grant applications look inferior relative to applications with long lists of community partners.

In light of the growing awareness that rural populations are at greater risk for both childhood and adult obesity, the need to address the funding and capacity gap in rural America is critical. Rural communities, particularly those in poor regions of the country and in regions with low in-state funding capacity are especially vulnerable.

Necessity of Targeted Best Practices and Research for Rural Communities

Much of the research and evaluation on obesity prevention efforts has focused on solutions that work best in urban and suburban communities. Unfortunately, the unique characteristics of rural obesity can mean that best practices for active living and healthy eating that work well in urban and suburban communities may be difficult to implement or are not as effective in rural ar-

eas. Many rural communities are spread out over large distances, making sidewalk implementation, mixed-use development, and public transportation prohibitively expensive on a community-wide basis. For example, one of the nation's most promoted active living best practices, walking to school, can be difficult to implement in many rural areas because of how these communities are laid out. After-school programs, another approach promoted as a best practice in urban and suburban areas, can prove challenging in rural areas. According to the U.S. Department of Education, children attending rural schools have the lowest median per-student funding for after-school programs, and lower financial resources in general than their urban counterparts.³⁵ The distance and time it takes residents to travel from their homes to schools and other facilities may also challenge the success of after-hours community programs.

Keeping these challenges in mind, preliminary discussions with rural county leaders suggest the following type of initiatives may be more suitable for rural communities: employee wellness programs; collaborating with regional agricultural producers to bring more fresh foods into schools and communities; neighborhood supervised play programs; outdoor recreation initiatives and community gardens. However, additional research is needed to determine which strategies and policies will be most effective in reversing current childhood obesity trends in rural communities.

Opportunities to Leverage the Unique Features of Rural Communities to Maximize Investments

Despite the challenges that rural communities face there are a number of characteristics endemic to rural communities that could be leveraged to support and enhance philanthropic investments. Below are several examples:

- Rural local governments are frequently more integrated and centralized than urban and suburban governments so cross-department work and planning may be easier to coordinate.
- For children, the majority of food (outside of school meals) is eaten in homes and/or with parents. Given the proper resources parents can have a significant and positive impact on their children's diets.
- Rural communities are often surrounded by public lands that offer a multitude of outdoor recreation opportunities. Currently, rural leaders and active citizens are leading efforts to ensure safe access to "natural treadmills."
- Many rural communities could take advantage of their proximity to local farmers in order to establish a partnership to make fresh fruits and vegetables easily available and affordable to the community.
- Because of their concentrated scale, rural communities make excellent, low-cost test areas and learning laboratories for pilot projects and interventions.

- Local rural leaders, whether they are supervisors, judges, commissioners, or county and parish elected leaders, interact frequently with their constituents and can provide valuable feedback to the philanthropic community on what is needed on the ground.

Recommendations for the Philanthropic Community

During their participation in the Rural Obesity Initiative, rural county leaders offered recommendations about the approach and action steps that the philanthropic community should consider if they want to support rural local governments in implementing successful childhood obesity prevention policies and programs. These recommendations include:

Make Accommodations for Capacity Challenges in Rural Communities

Rural governments often face barriers that prevent them from having the access that urban and suburban governments have to philanthropic resources. They tend to have fewer staff, smaller budgets, less on-site expertise, fewer community partners and sometimes inferior internet connections that make online applications an arduous task. Programs and grant applications may need to be specifically tailored to accommodate the capacity of smaller, rural communities. This may involve making adjustments in criteria regarding target populations, resource availability and stakeholder support, and exploring alternative ways to publicize proposals.

Recognize the Diversity and Specialized Needs of Each Type of Rural Community

Rural communities vary drastically in population size, resources and culture. Many of NACo's rural county leaders have found that solutions that work well for rural communities in the urban fringe often are not feasible in communities where total population size is in the low thousands. Similarly, rural communities vary greatly depending on geography and other variables including whether they are located in a wealthier state or a poorer one, or whether the bulk of their population is year round or seasonal.

The Carsey Institute recognizes three distinct types of rural communities, each of which require special consideration in developing and planning programs to address obesity³⁶:

- Amenity-rich areas, which are growing as seasonal destination hotspots with rich natural amenities or proximity to large cities.
- Declining resource-dependent areas, which can no longer rely on agriculture, timber, mining or related manufacturing industries to support a solid working middle class.
- Chronically poor communities, where decades of resource extraction and underinvestment have left a legacy of poverty, poor education and broken civic institutions.

This suggests that one size fits all approaches to investing in rural communities will not be effective. The funding community will be most successful in assisting rural communities to reverse

the obesity epidemic if they recognize the variances inherent to the term rural.

Support Initiatives that Increase Access to Healthy Foods

Research and findings from the Rural Obesity Initiative show that access to affordable, healthy foods is a significant challenge in rural communities' efforts to prevent obesity. Philanthropic organizations can help overcome the healthy food access challenge by supporting initiatives that work to reduce food deserts and food insecurity in rural communities.

Invest in Affordable, Community-Supported Agriculture

Often in scarce supply in urban and suburban communities, most rural regions have land under agricultural cultivation or have the ability to create new farms and gardens. Philanthropic investments could help facilitate collaborations between rural farmers and communities in the form of farmers' markets, farm-to-institution programs and low-income food basket programs. Such programs would improve local residents' access to fresh, healthy produce and offer educational opportunities about healthy foods and food processing.³⁷

Educate and Include the Whole Family in Childhood Obesity Prevention Programs

While NACo's rural county leaders believe that obesity prevention efforts should focus primarily on children, they emphasized the importance educating parents and providing them with the tools they need to make sure their children have the opportunity to be healthy. Children in rural America eat the majority of their food at home or with parents, and parents are responsible for providing the majority of their children's meal choices outside of school. Parents need to be equipped with a solid understanding of balanced diet so that when they go to the grocery store they can make informed choices in order to create a healthy food environment at home.

Encourage Local Governments and Businesses to Consider Employee Wellness Programs

Just as school administrators can implement policies to create healthier environments where children have access to nutritious foods and opportunities for more physical activity during the school day, businesses can offer programs that make it easier for their employees to make healthy choices during the work day. They can also help foster a culture which encourages parents to be role models for their children and equips them with the knowledge and tools to help raise fit, healthy children. Though wellness programs with a specific obesity prevention component hold much potential for rural communities, only about a fourth of Rural Obesity Survey county respondents said they offer such programs to county employees.³⁸ Small employers, who employ 60 percent of rural workers, and rural county governments often lack the technical or financial capacity to institute employee wellness programs without outside assistance and could greatly benefit from philanthropic support.³⁹

Support Programs Targeted to Rural Immigrants

NACo's Rural Obesity Survey and other sources show that rural communities are becoming increasingly diverse. In most communities, Latinos represent the majority of new minority residents.⁴⁰ Latinos are also one of the populations most vulnerable to obesity. By supporting programs in rural communities that are specifically geared to help new immigrant parents and children eat a balanced diet and stay fit, the philanthropic community can take the lead in supporting healthy lifestyles right from the moment new at-risk residents enter rural communities.

Improving Access to Health Care with a Focus on Obesity Reduction

Findings from the NACo Rural Obesity Initiative suggest that inadequate access to health care in rural areas presents an important challenge in obesity prevention efforts. Rural residents are more likely to be uninsured than urban residents, face severe primary and specialty provider shortages, and are almost 50 percent less likely to receive regular preventive healthcare than urban residents. Interaction with health care providers serves as an important potential point of intervention for obesity programs, especially in early screening and intervention, chronic disease case management, and nutrition education. Philanthropic assistance in improving access to medical and preventive care should be an important aspect of any rural obesity initiative.

Help Rural Leaders Conduct Community Assessments

During conversations with rural county leaders, NACo learned that rural leaders feel uncertain about how to take the first steps to prevent childhood obesity in their communities. They said it would be tremendously helpful to have childhood obesity experts come and work with rural leaders to assess their communities on a case by case basis. Assessment experts could help each rural community identify their particular challenges and opportunities and share relevant case studies and research in order to help local leaders develop tailored, high-impact solutions to prevent childhood obesity in their community.

Establish a State Level Coordinator Position in the County State Associations

Overwhelmingly, NACo's rural leaders expressed a need for regional leadership and support in their efforts to prevent childhood obesity. Because of limited staff, financial and technological resources, rural communities are often unaware of relevant programs that are active in similar communities, miss announcements about financial and technical assistance opportunities, and often do not receive the latest research to inform or shape their efforts. Having a designated person at the state level who understands the unique challenges and assets of the area and is knowledgeable about local case studies, research and funding opportunities would be a significant help to rural local governments trying to implement successful childhood obesity prevention policies and programs.

Support Strong Multi-Stakeholder Collaborations

NACo urges the philanthropic community to support multi-stakeholder collaborations. Because obesity has proven to be a deeply-rooted challenge; it requires strong, coordinated efforts to reverse. When stakeholders work together, their obesity policies

and programs have the capacity to reach more people, are strengthened because of the additional resources, and are more likely to be successful in the long run. Although some rural communities have smaller pools of community stakeholders, the NACo Rural Obesity Initiative identified several key groups particularly important in rural areas: the U.S. Department of Agriculture Extension, schools, 4-H groups, public health departments, public land agencies, youth sports teams, faith-based organizations, community centers, pediatricians and parks and recreation.

Empowering Rural Communities to Prevent Childhood Obesity

NACo has learned a great deal from the Rural Obesity Initiative about the challenges rural county officials face as they promote healthy eating and active living in their communities. More importantly, NACo has learned that rural communities have just as much at stake and just as much to offer as urban and suburban communities in the national effort to reverse childhood obesity. While it is important to leverage and apply promising practices from across the country, rural country leaders can offer practical, on-the-ground suggestions about how to tailor successful interventions and messages that will resonate with the immediate needs of local families and children.

NACo will use the insights and findings from Rural Obesity Initiative to conduct further research into promising program and practice models that already exist in rural counties. NACo also hopes that this publication will raise awareness and provide valuable information on the growing trend of adult obesity and childhood obesity in rural America. Rural communities are struggling with obesity and grappling with the limited resources to fight it. More attention and investment from the philanthropic community and others is needed and would greatly benefit rural families and children.

NACo hopes that the recommendations offered by rural county leaders provide a candid and compelling picture of the type of assistance that rural communities need from the philanthropic community and other key stakeholders in order to prevent childhood obesity and increase healthy eating and opportunities for physical activity in their communities.

Country leaders were generous with their time and insights, and NACo hopes that their valuable observations and recommendations will motivate more national, regional, and local efforts to investigate and support the unique needs of rural communities so they can be an effective partner in the national effort to reverse childhood obesity.



Endnotes

- 1 Patterson, Moore, Probst and Shinogle. “Obesity and Physical Inactivity in Rural America.” *Journal of Rural Health*. Spring 2004. Volume 20. Pages 151-159.
- 2 Liu, J; Bennett, KJ; Harun, N; Zheng, X; Probst, JC; Pate, RR. *Overweight and Physical Inactivity among Rural Children Aged 10-17: A National and State Portrait*. South Carolina Rural Health Research Center, May 2007.
- 3 Lutfiyya, Lipsky, Wisdom-Behounek and Inpanbutr-Martinkus. “Is rural residency a risk factor for overweight and obesity for U.S. Children?” *Obesity*. Sep 2007. Volume 15. Pages 2348-2356.
- 4 Lutfiyya, Lipsky, Wisdom-Behounek and Inpanbutr-Martinkus., 2007
- 5 Note: See Appendix A for Rural Obesity Survey methodology and Appendix B for results.
- 6 Rosenbaum, S; Treviño, RP. *Parental Health Insurance Coverage as Child Health Policy: Evidence from the Literature*. The George Washington University School of Public Health and Health Services, June 2007.
- 7 Levi, J; Gadola, E; and Segal, LM. *F as in Fat: How Obesity Policies are Failing in America* 2007. Trust for America’s Health.
- 8 Ziller, EC et al. *Health Insurance in Rural America*. The Kaiser Commission on Medicaid and the Uninsured, September 2003.
- 9 HRSA Office of Rural Health Policy <http://ruralhealth.hrsa.gov/pub/MinoritiesinRuralAm.htm>
- 10 USDA Rural Population and Migration www.ers.usda.gov/Briefing/Population/Diversity.htm
- 11 Ziller, EC et al., 2003.
- 12 Ogden, CL; Flegal, KM; Carroll, MD; Johnson, CL. *Prevalence and Trends in Overweight Among US Children and Adolescents, 1999-2000*. *JAMA*. 2002;288:1728-1732.
- 13 Patterson et al., 2004
- 14 USDA Household Food Security in the United States, 2000 and 2006
- 15 Olson, C.M., “Nutrition and health outcomes associated with food insecurity and hunger,” *Journal of Nutrition*, 129 (1999): 521S-524S.
- 16 Basiotis, P.P. and M. Lino, “Food insufficiency and prevalence of overweight among adult women,” *Family Economics and Nutrition Review*, 15 (2003): 55-57.
- 17 See Appendix B, survey question 17 and 18.
- 18 Hinrichs, CC and Lyson, TA. *Remaking the North American Food System: Strategies for Sustainability*. University of Nebraska Press, 2008.
- 19 See Appendix B, survey question 3.
- 20 Patterson et al. 2004
- 21 See Appendix B, survey question 3.
- 22 US Department of Transportation, Bureau of Transportation Statistics. www.bts.gov/press_releases/2004/bts010_04/html/bts010_04.html
- 23 Lopez-Zetina, Lee, Friis. The link between obesity and the built environment. Evidence from an ecological analysis of obesity and vehicle miles of travel in California. *Health and Place*. 2006. Vol. 12. pp 656-664.
- 24 Holtzclaw et al. *Location Efficiency: Neighborhood and Socioeconomic characteristics Determine Auto Ownership and Use – Studies in Chicago, Los Angeles and San Francisco*. *Transportation Planning and Technology*. 2002. Vol 25, pp1-27.
- 25 Ewing et al. Relationship Between *Urban Sprawl and Physical Activity, Obesity and Morbidity*. *The Science of Health Promotion*. 2003. Vol 18. No. 1. pp 47-57
- 26 Lutfiyya et al. 2007
- 27 See Appendix B, survey question 4
- 28 Lutfiyya et al., 2007
- 29 U.S. Census Bureau. *Income, Poverty and Health Insurance Coverage in the United States: 2006*. Table 3. People and Families in Poverty by Selected Characteristics.
- 30 Rural Policy Research Institute. www.rprconline.org/
- 31 Centers for Disease Control and Prevention. www.cdc.gov/nccdphp/dnpa/obesity/trend/maps/
- 32 Big Sky Institute. www.bigskyinstitute.org/
- 33 Schechtman. “*The Philanthropic Divide*.” *Foundation News and Commentary*. July/August 2002. Pages 32-33.
- 34 National Rural Health Association. www.nrharural.org/about/sub/different.html
- 35 Naftzger, N; Kaufman, S; Margolin, J; Ali, A. *21st Century Community Learning Centers Analytic Support for Evaluation and Program Monitoring: An Overview of the 21st CCLC Program: 2004–05*. Submitted to the US Department of Education, July 2006
- 36 The Carsey Institute, *Rural America in the 21st Century: Perspectives from the Field*, 2007
- 37 Note: For additional information see “*Counties and Local Food Systems*.” NACo, 2007.
- 38 See Appendix B, survey question 10.
- 39 McDaniel, K. *Small Business in Rural America*. Center for the Study of Rural America, Federal Reserve Bank of Kansas City, May 2001.
- 40 USDA Economic Research Center www.ers.usda.gov/publications/EIB8/eib8.pdf

Appendix A

Methodology, NACo Rural Obesity Survey

In the spring of 2007 the National Association of Counties (NACo) distributed the Rural Obesity Survey via e-mail to 700 counties with populations of 50,000 or less. Representatives from 29 rural counties were also encouraged to fill out the survey at NACo's Legislative Conference in March and 25 rural county representatives were encouraged to fill out the survey at NACo's Western Interstate Regional Conference in May. A reminder e-mail was sent out to the original e-mail group in April. One hundred and ninety seven responses were received, for a response rate of 26.1 percent.

Appendix B

NACo Rural Obesity Survey Results (2007)

1. I) Since 2000 has your county's population

- (97) Increased
- (43) Decreased
- (48) Stayed about the same

II) During that time, which of the below-mentioned characteristics are true for your county's population?

Please check all that apply

- (120) Greater diversity
- (19) Less diversity
- (69) Higher mean income
- (61) Lower mean income
- (76) More constituents living in town/city centers
- (36) Fewer constituents living in town/city centers
- (39) More young people
- (92) Fewer young people
- (5) None of the above

2. In the next ten years, do you expect the population of your county to

- (118) Increase
- (28) Decrease
- (42) Stay about the same

3. Please prioritize the importance that the following challenges have in promoting and/or maintaining obesity in your county.

Challenges	Most Important	Important	Somewhat Important	Not Important
Challenges in the local Economy	28	75	60	7
Access to health care	52	93	25	5
Poverty	51	84	37	4
Meth/ drug use	35	73	47	10
Availability of grocery stores	11	54	64	28
Fewer home cooked meals/ more fast food	92	67	23	0
Lack of recreational facilities, parks and trails	30	61	60	16
Cultural shifts are promoting unhealthy lifestyles	31	76	56	11
Availability of grocery stores	11	54	64	28
Access to fresh fruits and vegetables	31	66	50	23
Lack of sidewalks/ safe pedestrian routes	26	60	51	23
Climate not conducive to year round activity	34	57	57	18

4. I) In your opinion, in the past 10 years has the physical activity level of county residents

- (16) Increased
- (55) Decreased
- (23) Stayed about the same

II) If residents’ physical activity has decreased, please indicate to what extent the following factors contributed to the decline.

Factors	Very Much	Somewhat	Not Important
Rise of TV/ Technology	100	24	1
Changes in the local economy/ longer workdays	27	67	28
Loss of farming community	30	76	19
Change in community culture/ values	29	76	16
Resident turn over	9	61	49
Decline in physical education in schools	55	56	14
Aging population	62	56	8
Fewer facilities/ recreation areas for physical activity	43	42	35
Increased community safety concerns	14	60	46
Other	5		

5. In your opinion, how easy or difficult is it for constituents to access quality affordable health care in your county?

- (12) Very easy
- (62) Easy
- (73) Somewhat difficult
- (35) Difficult
- (6) Quality affordable health care is not available

6. Does your county consider health issues such as the need for increased physical activity and access to healthy foods when developing its comprehensive plan?

- (128) Yes
- (42) No

7. In your estimation, what percentage of county residents lives within a 20 minute drive of access to fresh affordable food?

- (38) All
- (62) More than 75%
- (53) 75%-50%
- (25) 50% and 25%
- (9) Less than 25%

8. During the past ten years, has this access to fresh affordable food

- (67) Increased
- (28) Decreased
- (92) Stayed about the same

9. I) Does your county offer a specific nutrition education program on obesity?

- (102) Yes
- (86) No

II) If yes, who is providing the education? Check all that apply.

- (57) Schools
- (9) Libraries
- (14) YMCA/YWCA
- (2) PTA/PTO
- (10) Boy Scouts/Girl Scouts
- (8) Youth sports teams
- (73) Health department
- (32) 4-H
- (13) Faith based organizations
- (73) Cooperative extension

10. I) Does your county offer county employees a wellness program?

- (94) Yes
- (90) No

II) If yes, does the wellness program have a specific obesity prevention component?

- (52) Yes
- (62) No

11.I) Does your county have public places where people can be active at no cost such as parks, wilderness recreation areas and trails?

- (178) Yes
- (10) No

II) If yes, how would you characterize constituents' usage levels of these public places?

- (7) Excellent
- (60) Good
- (84) Fair
- (28) Poor
- (0) Nonexistent

12. I) One of the traditional ways that children have burned calories is by playing outside. Do you believe your constituents have significant concerns or fears about letting their children play outside unsupervised?

- (71) Yes
- (117) No

II) If residents' physical activity has decreased, please indicate to what extent the following factors contributed to the decline.

Factors	Very Much	Somewhat	Not Important
Traffic speed/ safety concerns	30	48	6
News stories about endangered children	44	37	4
Fear of pollution/ hazardous environment	3	24	56
Children will get lost	11	47	25
Dangers posed by other children/ gangs	14	40	29
Climate not safe for outdoor play year round	11	40	31
Other	7		

13. Please rank the amount of influence the following stakeholders have in increasing youth physical activity and health education in your county. Rank from 5 (highest) to 1 (lowest). *NOTE: Numbers shown are the average of received response rankings. Some stakeholders may have received more responses than others.

- (4.10) Youth sport teams
- (3.89) PE in schools
- (3.25) 4-H
- (2.95) Boy Scouts/Girl Scouts
- (2.93) Public land agencies/Parks department
- (2.86) Outdoor recreation groups
- (2.75) Cooperative Extension
- (2.50) Community health center
- (2.21) Private Sector
- (2.18) PTA/PTO
- (2.15) Faith based organizations
- (2.12) YMCA/YWCA
- (1.85) Community development agency
- (1.40) State transportation agency

14. Please indicate the extent to which the county has established partnerships with the below stakeholders to increase youth physical activity and health education.

Stakeholders	Partnership Established and Effective	Partnership Established	Partnership Established but Struggling	No Partnership Established	Stakeholder is working independent of county
4-H	36	44	12	48	34
Boy Scouts/ Girl Scouts	4	12	9	67	80
Youth sport teams	25	31	9	46	64
PE in schools	12	33	16	46	67
Outdoor rec. groups	16	21	13	63	57
PTA/ PTO	0	6	7	81	67
YMCA/ YWCA	6	17	3	70	60
Faith based orgs	1	9	10	72	75
State transportation agency	9	24	11	72	48
Community development agency	12	30	12	66	45
Community health center	20	40	13	55	35
Public land agencies	14	21	10	72	43
Private sector	7	22	22	62	47
Cooperative Extension	48	43	15	34	26
Other	4				

15. Please rank the influence of the following stakeholders in increasing access to healthy food in your county. Rank from 5 (highest) to 1 (lowest).

*NOTE: Numbers shown are the average of received response rankings. Some stakeholders may have received more responses than others.

- (3.70) Grocers
- (3.23) Farmers market associations
- (3.05) Cooperative extension
- (2.87) Emergency food support programs
- (2.86) Farmers
- (2.74) Restaurant owners
- (2.53) Community health center
- (2.30) Citizen groups/advocates

- (2.12) Private sector/Business community
- (2.07) Community garden associations
- (1.98) Faith based organizations
- (1.93) Community development agency
- (1.86) Local food council/advisory body
- (1.63) PTA/PTO

16. Please indicate the extent to which the county has established partnerships with the below stakeholders to increase access to healthy food.

Stakeholders	Partnership Established and Effective	Partnership Established	Partnership Established but Struggling	No Partnership Established	Stakeholder is working independent of county
Farmers market associations	15	20	7	66	56
Community garden associations	7	11	8	83	46
Emergency food support programs	30	53	12	32	38
Restaurant owners	2	11	12	32	38
Grocers	4	14	10	67	71
Local food council/ advisory body	8	9	9	80	46
Farmers	3	14	8	77	62
Citizen groups/ advocates	4	11	9	81	54
Community development agency	9	21	8	73	44
Community health center	13	25	8	63	41
Private sector/ business community	3	14	8	70	661
Cooperative extension	38	53	11	33	28
PTA/ PTO	0	5	4	85	60
Faith based organizations	3	13	11	71	61
Other	1				

17. I) Which of the following food assistance and support programs are available in your county?

- (177) School Lunch
- (177) Food Stamps
- (174) WIC
- (165) School Breakfast
- (161) Food banks
- (137) Faith based assistance
- (117) Child and Adult Care
- (58) Summer Food Service

II) If these programs are available, how would you describe the level to which county residents utilize them.

Program	Frequently Utilized	Occasionally Utilized	Rarely Utilized	Not Available
Food banks	127	35	3	11
Faith based assistance	70	75	12	11
School lunch	171	6	3	0
School breakfast	148	17	3	10
Summer food service	34	26	5	73
Child and adult care	90	34	7	25
WIC	158	19	0	3
Food stamps	160	21	0	0

18. In your opinion, in the past 10 years has the number of county residents taking part in food assistance or support programs increased, decreased or stayed about the same?

- (106) Increased
- (15) Decreased
- (36) Stayed about the same

19. Besides financial assistance, what types of resources would be most beneficial to you in helping to combat obesity (particularly among youths) and developing county resources that make it easy for residents to be physically active and eat healthy?

- (109) Sample policies and programs
- (122) Increased training/education
- (114) Best practices/case studies from communities like mine
- (50) Facilitated connection with peers
- (84) Facilitated connection with school officials
- (76) Access to leading experts, funders, and community groups
- (75) Research statistics that prove the link between academic performance and fitness
- (81) Assistance on incorporating active living into land use planning



*25 Massachusetts Avenue, NW / Suite 500 / Washington, DC 20001
202.393.6226 / fax 202.393.2630 / www.naco.org*