National Indian Health Board

March 26, 2010

Secretary Kathleen Sebelius
U. S. Department of Health and Human Services

Secretary Thomas J. Vilsack
U. S. Department of Agriculture

Secretary Arne Duncan
U. S. Department of Education

The National Indian Health Board (NIHB), representing 564 Federally-recognized Tribes, is pleased to present our comments and recommendations to the Task Force on Childhood Obesity. Our comments are specific to Federal Register notice March 16, 2010, Docket ID USDA-2010-0001, on behalf of all youth and communities members of Tribes nationwide.

In June 2009, the NIHB launched the **Obesity Prevention Strategies for Native Youth Initiative. T**hrough the analysis of the *Overweight/Obesity Programs in Indian Country Survey* disseminated by NIHB, and the outcome of the 2009 Obesity Prevention Strategies for Native Youth meeting hosted by NIHB, we have developed the attached recommendations for the Task Force. NIHB is confident that these recommendations speak to the issues and concerns of Indian County and will, if executed, ensure that American Indian and Alaska Native youth are positively affected by the policies and programs set forth by this Task Force.

NIHB remains firmly committed to supporting the health of American Indians and Alaska Natives through innovative health policy and program initiatives. Urged by Tribal Leaders and Tribal Organizations, NIHB is leading the effort in Indian Country to reverse the devastating impacts of the childhood obesity epidemic. As evidenced in the 2009 *Obesity Prevalence Among Low-Income, Preschool-Aged Children- United States, 1998-2008* report issued by the Centers for Disease Control and Prevention (CDC), **31.2% of AI/AN four year olds are currently obese;** a rate higher than *any other racial or ethnic group studied* and almost *double the rate* of white four year olds.

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The Red Feather of Hope and Healing

On behalf of the 564 Tribes we serve, I wish to thank the Task Force on Childhood Obesity for your commitment to reverse childhood obesity trends for our People.

In Partnership and Health,

Reno Keoni Franklin
Chairman

Stacy A. Bohlen
Executive Director

CC: Jodi Gillette, Associate Director
White House Office of Public Engagement,
Deputy Associate Director
Office of Intergovernmental Affairs

Enclosures: 2

National Indian Health Board response to Federal Register Notice
National Indian Health Board childhood obesity survey

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Matters to Be Considered: Information is being sought on the categories of information that follow. When submitting comments, interested parties are asked to restate the question and to provide any additional information deemed pertinent to their comment.

Four Objectives:
(A) Ensuring access to healthy, affordable food;
(B) Increasing physical activity in schools and communities;
(C) Providing healthier food in schools; and
(D) Empowering parents with information and tools to make good choices for themselves and their families.

1. For each of the four objectives described above, what key topics should be addressed in the report?

Over-arching comments:

- Make specific accommodation for American Indian Tribes and Alaska Native Villages to fully engage in this process and make measurable improvements in the childhood obesity epidemic plaguing American Indian and Alaska Native children.

- One method of ensuring appropriate input would be to engage in a consultation process with American Indian Tribes and Alaska Native Villages. As well, engaging with regional and national Indian organizations with expertise in health promotion, disease prevention and programs at the Tribal level also would be highly beneficial throughout this program.

- The National Indian Health Board strongly recommend that the National Task Force on Childhood Obesity focuses on the epidemiology and data collection capacity of the Tribes and work to ensure that Tribes are supported to gather and provide accurate and consistent data.

- The National Indian Health Board strongly recommends the appointment of the Director of the Indian Health Service to serve on the National Task Force on Childhood Obesity.

- Ensure that policies are flexible and adaptable to community-specific needs. It is clearly visible in the vision for this initiative that the federal government, alone, cannot fix this problem. However, through national leadership and focusing attention on this epidemic, it *can* empower families, Tribes, states and local governments to act. The programs and grants should be flexible and responsive to the unique needs of different communities and this can be achieved through stake-holder investment at each level instructing and guiding the programs.

- Determine how cross-agency policy development and funding mechanisms will be implemented. We must approach childhood obesity from multiple perspectives, but how will agency silos impact the usefulness of local efforts? Many programs exist across the Federal government (e.g. Women, Infants and Children's (WIC) program, school breakfast and lunch programs, etc.) that are designed to promote the health of children, yet we still find ourselves faced with the obesity epidemic. The report should develop innovative solutions to determine how tribal, state and local governments as well as organizations access the programs and funding across agencies, in addition to developing policies across agencies.

Specific Response to the Four Stated Objectives:
(A) Ensuring access to healthy, affordable food;

American Indian and Alaska Native Communities are often located in the most remote and rural areas of the United States, and are often the most impoverished communities in the Country making access to affordable and healthy foods a unique challenge in Indian Country. This results in extremely high costs of fresh fruits and vegetables in Tribal communities, if these items are even available, which effectively makes access nonexistent. (For example, in the hub-village of Bethel, Alaska, a head of lettuce can cost $8.00.)

- Eligibility for the school nutrition program at schools in Tribal communities with the goal of ensuring that school programs provide high quality, healthy foods to American Indian and Alaska Native children;
- Align the United States Department of Agriculture commodities program to ensure that the commodities provided to American Indian and Alaska Native communities fresh fruits and vegetables and high quality lean meats and dairy products that will give American Indians a true opportunity to incorporate healthy foods into their daily lives;
- Create policy and provide economic incentives for the creation of Tribal grocery stores, farmer's markets and other accessible market places to ensure access nutritious food.
- Create subsidy mechanisms for American Indian and Alaska Native families to be able to afford purchasing fresh fruits and vegetables. This includes streamlining eligibility processes so that if a family qualifies for one program, they meet the criteria for all

programs. Today, the administrative burden on eligible families makes full participation unlikely. Streamlining these processes would empower families to access better choices.

(B) Increasing physical activity in schools and communities;
In many Tribal communities, the ability to engage in physical activity at the community and school levels is often predicated on the built environment and/or, or lack thereof, and the presence, or lack thereof, of wellness/fitness facilities. Tribal communities that have had the opportunity to create sidewalks and walking trails, fitness facilities, playgrounds, for example, have a better chance to engage in wellness activities. These proven models should be built upon in the quest to address "built environment" needs of other Tribal communities.

Policy to improve funding for the built environment, including funding to provide safe spaces for children to be active and play, need to be developed. This includes traditional spaces such as parks and playgrounds, but also should include bike lanes, skate parks, sports fields and equipment to *use* the built environment, such as the purchase of bicycles, kayaks and shoes. For example, Nike has developed shoes specifically designed for Native American feet. The goal is to encourage physical activity such as walking. Finding a way to "get shoes on feet," would be a good step toward empowering Native kids' wellness.

(C) Providing healthier food in schools;
We encourage policy creation and attendant funding to ensure that all schools located in Tribal communities, both Bureau of Indian Education schools and others, provide nutritious meals for breakfast and lunch.

Work toward encouraging Memoranda of Understanding between the community, Tribe and schools to work together on creating, supporting and implementing policies that achieve solid nutrition offerings in schools.

National Indian Health Board also strongly recommends that time be committed for play and physical activity during and after school. This includes programs that embrace all children attending the school, not only those participating in school-sponsored sports teams. In order to achieve this goal, Native children will also need assistance with acquiring appropriate equipment (shoes, for example) to participate.

(D) Empowering parents with information and tools to make good choices for themselves and their families.
Engage community members and local or national Indian organizations to create culturally appropriate social marketing campaigns to increase youth self esteem, nutrition information and to publicize new opportunities and activities geared toward healthy Native children. This should include the input of children, including those residing in communities most affected by childhood obesity.

Develop family-based trainings with Tribal and community-member input to support family-based change and empowerment.

2. For each of the four objectives, what are the most important actions that Federal, State, Tribal and local governments can take?

First of all, changing the question to include Tribes is the first step toward finding the right answer. The National Indian Health Board strongly recommends that the construct of the discussion includes Tribes wherever Federal, State or Local governments are addressed or discussed.

Ensure that there is funding for all programs and policies distributed directly to Tribes and not through State or other levels of government.

Among NIHB's Recommendations, please address the following;

- Ensure Tribes are included in policy development and as direct recipients in the distribution of Federal funds.
- Ensure Tribal schools that do not function under state regulation are included in physical activity opportunities and policies.
- In instances where funding for this project is directed through the States, place accountability measures on States to ensure that State-appropriated funding is dispersed to Tribal schools and governments to support nutritious food programs and the overall programmatic objectives.
- Ensure American Indian and Alaska Native messaging is used for all Federal, Tribal State and local social marketing campaigns.

3. Which Federal government actions aimed at combating childhood obesity are especially in need of cross-agency coordination?

All four objectives each require cross-agency coordination. For American Indians and Alaska Natives (AI/ANs), cross-agency coordination is critical. The Bureau of Indian Affairs and the Indian Health Service should be part of a coordinated effort by other Federal agencies regarding the AI/AN population; however, Federal Trusts responsibility extends to all federal agencies (including the United States Departments of Agriculture and Transportation) and should be integrated into commitments to address this issue. In addition to cross-agency coordination, Tribal consultation must occur so that the efforts of the Federal government can be a responsive, coordinated, effective and well-informed partner with the Tribes.

Enhancing data collection and epidemiology capacity at the Tribal and Tribal Epi-Center level is critical to the success of this project, and will remain so throughout. Effectiveness of outcomes measures will not be possible without supporting data collection from the beginning of this process and throughout the program.

4. For each of the four objectives, what are the most important actions that private, nonprofit, and other nongovernmental actors can take?

There is significant opportunity for private, nonprofit and other nongovernmental actors to engage with Indian Country to fight childhood obesity. There remains a lack of investment in Indian Country from the private sector. The lack of grocery stores is a good example. Partnerships between Tribes, Villages and private-sector entities, such as the Boys and Girls Clubs of America, continue to be mutually valuable and community-enhancing. Like all partnerships, mutual respect and willingness to learn about each other is central to the success of the partnership. Private, nonprofit and other entities offer countless services, funding opportunities and programs throughout the Nation and the world, yet, they often overlook Indian Country – where need and opportunity abound right here in the United States. American Indian and Alaska Native Communities would welcome the opportunity to engage with private entities and mutually determine how each can be of service to achieve the goals of the project.

Additionally, private, nonprofit and other nongovernmental actors will have the responsibility of leveraging the investments of the Federal government. The issue of childhood obesity, as acknowledged by the government, cannot be solved *by* the Federal government. It will require a community approach, of which the private nonprofit sectors role will be to build upon the resources and investments of the Federal government.

NIHB reserves the opportunity to comment on this further in the near future.

5. For each of the four objectives, what strategies will ensure that efforts taken by all of the entities mentioned above reach across geographic areas and to diverse racial, ethnic, socioeconomic, and geographic groups, including children who are at highest risk of obesity and children with disabilities?

AI/AN youth are the most susceptible to childhood obesity. This is evidenced by the fact that 31.2 percent of American Indian and Alaska Native four-year olds are currently obese. In addition, American Indian and Alaska Native children are presenting with Type II Diabetes as young as age four, with the Tohono O'odham Nation now reporting the highest levels of obesity, including for children, in the United States. Obesity increased across all racial and ethnic groups between 1998-2003, with the exception of Asian/Pacific Islander children. However, during 2003-2008 obesity remained stable among all groups except American Indian/Alaska Native children, from whom the rates continued to increase (Centers for Disease Control and Prevention).

These children are often located in some of the most rural, remote and impoverished communities in America. This fact leads to the comment often made that the #1 disease from which Indian Country suffers is anonymity: this must stop now and it must stop with our children. Their story must be told and is every bit as important and significant as the story of childhood obesity across America.

In addition, please consult with Tribes and make funding directly available to Tribes. This cannot be emphasized enough. It is important that Tribal members are made aware of programs and

funding opportunities so that they may translate this information to their communities. Regional and national Tribal organizations dedicated to the improvement of American Indian and Alaska Native health can be instrumental throughout this process.

6. What goals should we set within each objective to ensure that we meet our overall goal of solving the problem of childhood obesity in this Nation in a generation?

Within each objective the Task Force should ensure Tribal involvement, working with Tribes and Tribal organizations to gain insight and knowledge about our communities, people, programs and needs. This goal will help the Task Force understand the needs and opportunities presented for these highly at-risk communities and in turn help to appropriately and effectively address the issue of childhood obesity.

Responding to a problem as serious as childhood obesity over the span of a generation means that short-term goals will be an important part of achieving the longer-term results; however, they will not achieve the goal. Long-term, data driven goals such as whether more fresh fruits and vegetables are being provided, whether physical education and nutrition education are being improved are important, but cannot be analyzed over the course of one, two or three grant cycles. The report should determine how to set short term goals that are based upon the desired outcome of the applicant within a specific time frame (i.e. increased fresh food marketing in local school district over two, five, ten and twenty years, for example).

7. What concrete, specific actionable recommendations or guidelines would help parents reduce the risk that their child will become overweight or obese and how can their effectiveness be measured?

Guidelines should be set in Tribal schools that ensure nutritious foods be offered and limit the amount of soda and calorie dense snacks accessible during the school day. These guidelines can be measured by the number of nutritious foods purchased by students. Recommendations can be made to improve the accessibility and safety of local parks and recreation centers for youth. These recommendations can be measured by the change in use of these parks/centers (e.g. increase or decrease in youth use). An increase in number of nutritious foods purchased and number of youth utilizing parks and centers will yield effectiveness in reducing the risk of overweight/obesity.

The Task Force should consider programs, education or funding for parents that address teachable behaviors to children. For example, consumption of alcohol can lead to a less healthy diet. Alcoholism is rampant in the AI/AN community and the behavior of the parents, including diet, can be taught to children. By providing information to adults, the diet available to children, as well as the influence of unhealthy habits, can be diminished.

8. What are the key benchmarks by which we should measure progress toward achieving those goals?

- Degree to which specific accommodation was achieved for American Indian Tribes and Alaska Native Villages to fully engage in this process and make measurable improvements in the childhood obesity epidemic plaguing American Indian and Alaska Native children.

- Degree to which the Task Force achieved engaging in a consultation process with American Indian Tribes and Alaska Native Villages. As well, the degree to which regional and national Indian organizations with expertise in health promotion, disease prevention and programs at the Tribal level also would be highly beneficial throughout this program were engaged.

- Degree to which the Task Force enhanced epidemiology and data collection capacity of the Tribes and work to ensure that Tribes are supported to gather and provide accurate and consistent data.

- The appointment of the Director of the Indian Health Service to serve on the National Task Force on Childhood Obesity.

- The degree to which the Task Force ensured that policies are flexible and adaptable to Tribal community-specific needs.

- Degree to which cross-agency policy development and funding mechanisms were implemented to ensure the Federal Trust responsibility was evidenced across Agencies in efforts to assist and empower American Indians and Alaska Natives in this effort.

- Demonstrated commitment to making funding directly available to the Tribes.

- In instances where funding flows to Tribes through the State, County or Local Government entity, the degree to which those entities were held accountable for their engagement with the Tribes.

9. What important factors should be considered that do not easily fit under one of the four objectives?

- Contextualizing the concept of historical trauma suffered by American Indians and Alaska Natives will be a powerful component of adult education in this effort. Research has proven that many of the disease processes from which we suffer are related to historical trauma, and this is certainly true for the obesity epidemic our children are experiencing.
- Specific to AI/AN culture, traditional foods should be addressed in access to healthy foods as well as increasing PA (farming, gathering, hunting).

- The Task Force must address the psychological determinants of obesity/overweight such as low self esteem and depression, as well as the behavioral issues of substance abuse. Both play a critical role in the lifestyle of AI/AN youth and access to mental health providers needs to be addressed.
- Prenatal care.
- Liquid intake: Research has shown that many calories that contribute to weight gain are linked to liquid (i.e. soda) consumption. Consumption of fewer sugar drinks and more water consumption as well as other healthy liquids should be encouraged. However, many tribes live in areas where there could be unclean or short water supplies, the report should explore how liquids contribute to weight gain and propose policy solutions to address how to increase healthy liquid consumption.

10. What are the key unanswered research questions that need to be answered with regard to solving childhood obesity and how should the Federal Government, academia, and other research organizations target their scarce resources on these areas of research?

There is extremely limited research focused on AI/AN youth and childhood obesity. Research is needed to effectively measure the determinants and contributing factors, as well as evaluations of current prevention programs. There are currently Tribal EpiCenters which, with moderate, focused and additional funding, could provide the research and statistics on AI/AN childhood obesity. Federal Government should look to Tribal colleges to produce research on this topic area as well.

11. In areas or communities that currently have a high incidence of childhood obesity, what is the best explanation of why particular children do not become obese?

We do not believe there is on explanation to why particular children do not become obese. Genetics and prenatal care play a role in obesity at a young age. A household that is supportive of the promotion of physical activity and healthy eating provides a "preventative environment" for childhood obesity; however, if the child also attends a school that does not reinforce the same values and provide the same healthy opportunities, the child may still become obese.

12. Specifically with regard to objective 1 (empowering parents): How can Federal, State, and local governments, the private sector, and community organizations best communicate information to help parents make healthy choices about food and physical activity?

First of all, please re-frame the question to include TRIBAL in the question, along with Federal, State and local governments.

Engage Tribal community members and parents in the development of educational materials. These entities need to provide culturally appropriate educational material to the parents of the AI/AN communities and have them disseminated by trusted AI/AN community members.

13. Specifically with regard to objective 2 (healthier food in schools): What are the most promising steps that can be pursued by the Federal, State, and local governments, schools, communities, the private sector, and parents to ensure that children are eating healthy food in schools and child care settings?

First of all, please re-frame the question to include TRIBAL in the question, along with Federal, State and local governments.

POLICY, funding and youth involvement! Policy needs to be set forth that ensures healthy foods are accessible in the school and child care settings and that unhealthy foods are not readily available. In order for the youth to adapt to the changes in policy, the youth need to be involved in the selection of "new" foods to be added to the menu. When children are involved in the selection process they will take more ownership over the change.

14. Specifically with regard to objective 3 (access to healthy, affordable food): What are the biggest challenges to enhancing access to healthy and affordable food in communities across America, and what are the most promising strategies to overcome these challenges?

Indian Communities are often the most rural, remote and impoverished in America. In Indian Country many people shop at corner stores and local markets with limited offerings of fresh fruits and vegetables. Large grocery stores and farmer's markets are often non-existent. In addition, many people receive government supplemented food through commodity programs. Policy should be set forth to ensure that healthy commodity foods are provided to those AI/AN families utilizing the service, and to ensure that healthy foods are accessible at reasonable rates at existing venues. In addition, establishing grocery stores, farmer's markets and other quality food resources is recommended. Assistance with the establishment of community gardens would also be positive.

15. Specifically with regard to objective 4 (physical activity): What steps can be taken to improve quality physical education and expand opportunities for physical activity during the school day, in local communities and neighborhoods, and in outdoor activities and other recreational settings?

Policy regarding the built environment needs to be addressed, developed and implemented. Physical activity needs to be included in the school day through physical education as well as incorporation into other coursework. Policy should be in place to ensure students engage in a minimum of one hour of activity throughout the school day. Built environment should be addressed by providing safe areas to be active (i.e. parks, sidewalks, recreation centers). Issues specific to AI/AN communities (e.g. "res dogs") need to be addressed. Access to sports equipment, such as shoes and clothing, is an essential need in Indian Country.

16. What other input should the Task Force consider in writing the report?

NIHB will comment further as this process continues.

National Indian Health Board

The Overweight/Obesity Programs in Indian Country Survey
Preliminary Results
January 21, 2010

On October 1, 2009, the NIHB disseminated the "Overweight/Obesity Programs in Indian Country Survey" through the NIHB listserv and colleagues at the Indian Health Service. The nine question survey was opened online via Survey Monkey for a month and closed on November 1, 2009. The survey yielded a total of 87 responses from Tribal Programs.

Of the 87 responses, the majority were from three states: Oklahoma (15), Montana (14) and Arizona (10). The majority of the respondents listed a program staff size of 1 to 5 members (74%) and were currently implementing programs (86.6%). The numbers of direct tribal beneficiaries reached by these programs varied greatly with 32% reaching 26-50 beneficiaries, 24% having 51-100 beneficiaries, and 24% having 100 or more direct beneficiaries. Most programs were supported through federal funds (63.5%), funded directly by the Tribe (20%), while 25% of respondents did not list a funding source.

The survey also inquired about the format and target audiences of the Tribal programs. Half of the programs were community based (49.4%), followed by individually-based (26.4%) and family based programs (24%). Most interventions involved beneficiaries on a weekly basis (33.3%), while 16% featured daily activities,. The majority of the programs (96.5%) targeted both males and females. One third of the programs focused on all ages (33.3%), while 23% focused on 4-12 year olds, 13.8% focused on 13-17 year olds, and 13.8% focused on 25-64 year olds. The majority of the programs stated goals of increased physical activity (93.1%) and increased consumption of nutritional foods (89.7%). 82.8% of the program reported that they had completed or planned to complete an evaluation of the program. Almost all of the respondents (97.7%) said they were available to be contacted for follow-up by NIHB for additional program information.

For more information about the Overweight/Obesity Programs in Indian Country Survey please contact Erica Doxzen, NIHB Public Health Programs Assistant, at edoxzen@nihb.org or (202) 507-4070.

Below please find the results of the survey, broken down by question.

Tribal Participation by State

State	Number of Surveys
Oklahoma	15
Montana	14
Arizona	10
New Mexico	8
Alaska	6
California	5
Michigan	5
South Dakota	5
Idaho	2
Nebraska	2
Oregon	2
Washington	2
Wisconsin	2
Kansas	1
Massachusetts	1
North Dakota	1
Nevada	1
Wyoming	1

How many staff was required to facilitate the program?

1-5	57	74%
6-10	14	18.2%
11+	6	7.8%

Is the program current or past?

Current Programs	71	86.6%
Past Programs	11	13.4%

How many individuals participated in the program?

26-50	25	32%
51-100	18	24%
101+	18	24%
1-25	15	20%

How was your program funded?

Federal	54	63.5%
Other	21	24.7%
Tribal	17	20%
State	5	5.9%
Non-profit	4	4.7%

What is/was the format of the Obesity Program?

Community based	43	49.4%
Individually based	23	26.4%
School based	21	24.1%
Family based	20	23%
Clinic/hospital based	19	21.8%
Workplace based	8	9.2%
Other	7	8%

What is/was the frequency of the program?

Weekly	29	33.3%
Other	27	31%
Daily	14	16.1%
Monthly	12	13.8%
One event	5	5.7%

Who is/was the target population of your program based on gender?

Both	84%	96.5%
Female	3	3.4%
Male	0	0

Who is/was the target population of your program based on age?

All ages	29	33.3%
4-12	20	23%
13-17	12	13.8%
25-64	12	13.8%
18-24	6	6.9%
0-3	4	4.6%
Prenatal	2	2.3%
65+	2	2.3%

What was the goal(s) of the program? (Select all that apply)

Increased physical activity	81	93.1%
Increase consumption of nutritious foods	78	89.7%
Create policy change	15	17.2%
Change current environment	11	12.6%

Have you evaluated or do you plan to evaluate your program?

Yes	72	82.8%
No	15	17.2%

Can the National Indian Health Board contact you for more information?

Yes	85	97.7%
No	2	2.3%