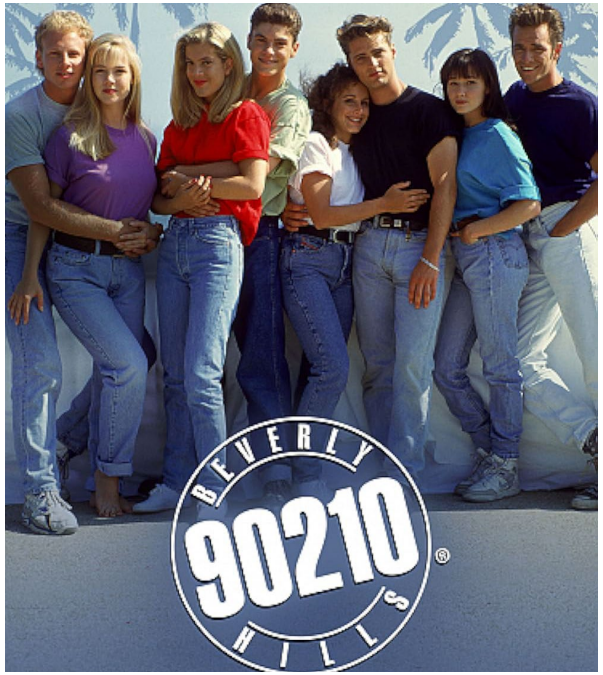
30 Years of the Food Forum: Reflecting on Progress, Envisioning the Road Ahead: Food and Nutrition Security and Equity

Angela Odoms-Young, PhD
The Nancy Schlegel Meinig
Associate Professor of Maternal and Child Nutrition
Director of the Food and Nutrition Education in Communities Program (FNEC) and NYS EFNEP
Division of Nutritional Sciences
Cornell University


BEVERLY
90210
HILLS


TIME
President-elect
Bill Clinton


SUNS
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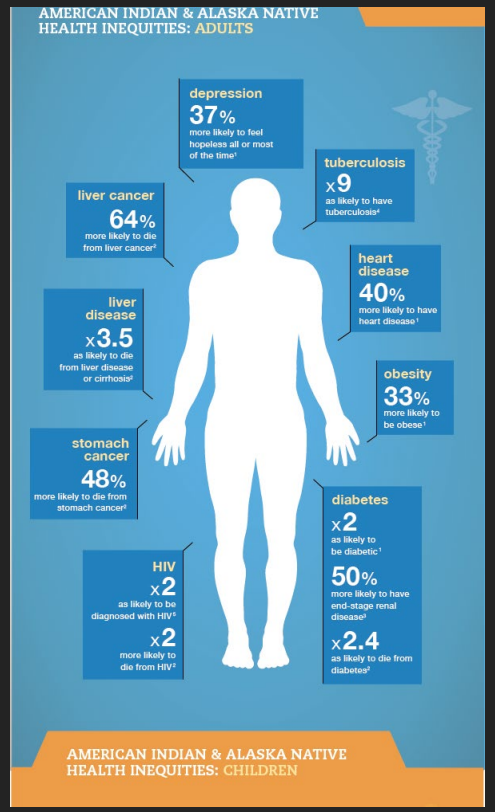
MADE IN
1993
LIMITED EDITION

Overview

- What are equity trends in the field of nutrition and health?
- What are considerations for the future and next steps?



Despite technological advances and some overall population decline, the high burden of chronic disease remains.

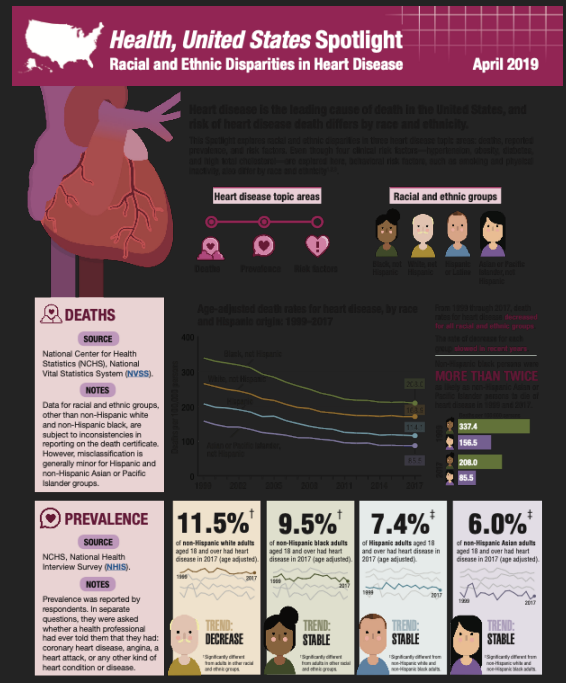
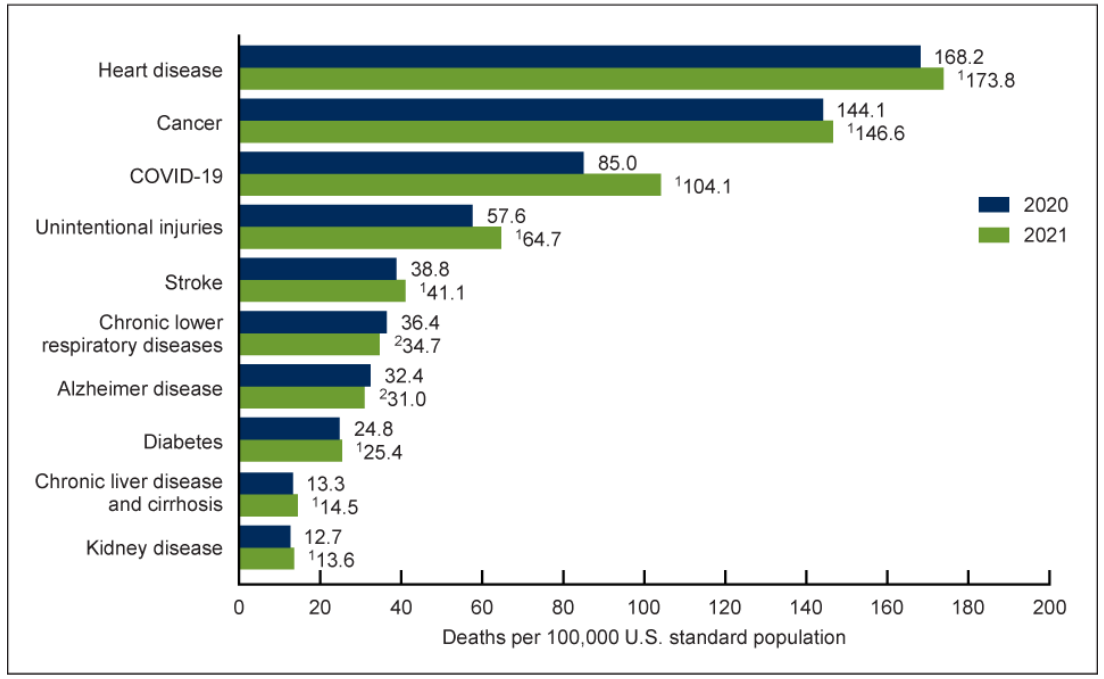


Figure 4. Age-adjusted death rate for the 10 leading causes of death in 2021: United States, 2020 and 2021



[1]Statistically significant increase from 2020 to 2021 ($p < 0.05$).
[2]Statistically significant decrease from 2020 to 2021 ($p < 0.05$).
NOTES: A total of 3,464,231 resident deaths were registered in the United States in 2021. The 10 leading causes of death accounted for 74.5% of all U.S. deaths in 2021. Causes of death are ranked according to number of deaths. Rankings for 2020 data are not shown. Data table for Figure 4 includes the number of deaths for leading causes and the percentage of total deaths. Access data table for Figure 4 at: https://www.cdc.gov/nchs/data/databriefs/db456-tables.pdf#4.
SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality.

In 2019, 53.8% of adults aged 18–34 years had at least one chronic condition, and 22.3% had more than one condition. Prevalence of any as well as specific chronic conditions varied by population subgroup

Suggested citation for this article: Watson KB, Carlson SA, Loustalot F, et al. Chronic Conditions Among Adults Aged 18–34 Years — United States, 2019. MMWR Morb Mortal Wkly Rep 2022;71:964–970. DOI: http://dx.doi.org/10.15585/mmwr.mm7130a3.

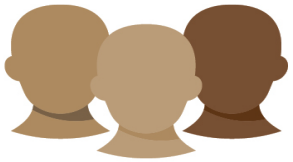
Many U.S subgroups continue to experience higher rates of diet-related morbidity and mortality than the general population (e.g. cardiovascular disease) across the life course

These disparities have persisted for decades

Which U.S. Population Groups Experience Cancer Health Disparities?

According to the National Cancer Institute, cancer health disparities in the United States are adverse differences in cancer measures such as number of new cases, number of deaths, cancer-related health complications, survivorship and quality of life after cancer treatment, screening rates, and stage at diagnosis that exist among certain population groups including:

Individuals belonging to different ancestry, race, or ethnicity



Individuals of low socioeconomic status

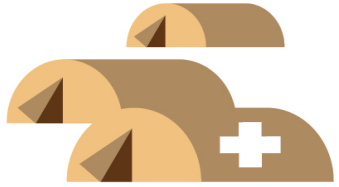
Individuals who lack or have limited health insurance coverage

Residents in certain U.S. geographic locations, such as rural areas, or territories, such as Puerto Rico and Guam

Members of the sexual and gender minority communities

LGBTQ+

Certain immigrants, refugees, or asylum seekers



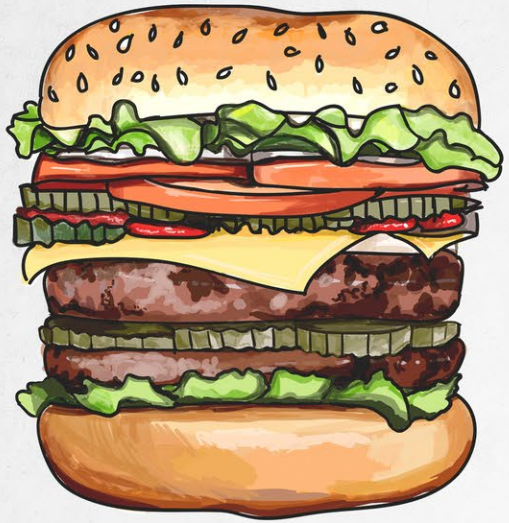
Individuals with disabilities

Adolescents and young adults

Elderly

It is important to note that some populations may carry even a higher burden of cancer because they simultaneously fall into more than one of these categories.

erican Association for Cancer Research® (AACR) Cancer Disparities Progress Report 2022



DOWN HOME HEALTHY COOKIN'

RECIPES AND HEALTHY COOKING TIPS

National Institutes of Health

National Cancer Institute

Platillos Latinos

¡Sabrosos y Saludables!

Delicious Heart Healthy Latino Recipes

U.S. Department of Health and Human Services
National Institutes of Health
National Heart, Lung, and Blood Institute

SISTERS TOGETHER

Program Guide

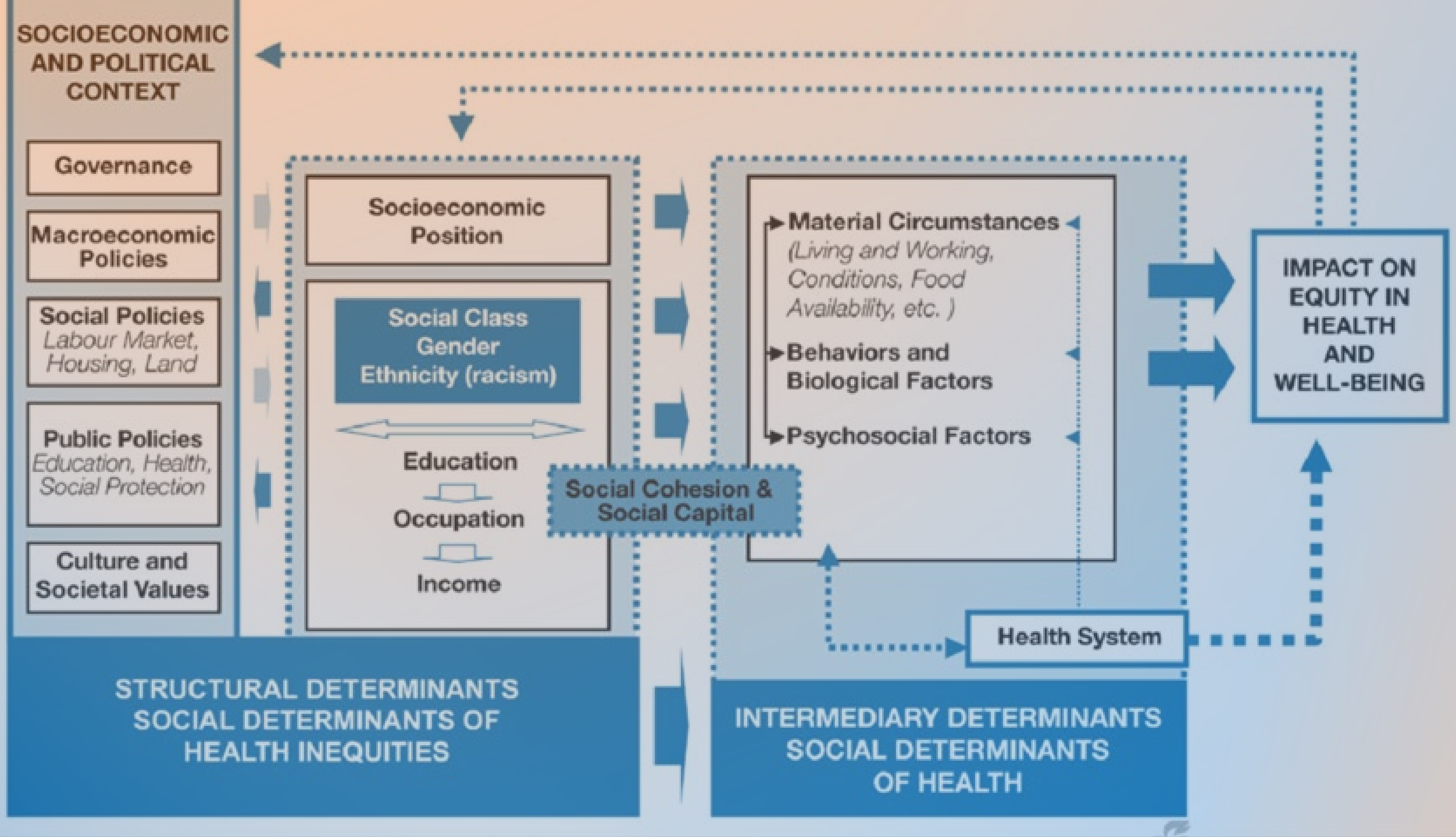
Move More, Eat Better

Your community take steps toward better health

SISTERS together
MOVE MORE EAT BETTER

NIH National Institute of Diabetes and Digestive and Kidney Diseases

WIN Weight-control Information Network


SOCIOECONOMIC AND POLITICAL CONTEXT
Governance
Macroeconomic Policies
Social Policies
Labour Market, Housing, Land
Public Policies
Education, Health, Social Protection
Culture and Societal Values
Socioeconomic Position
Social Class
Gender
Ethnicity (racism)
Education
Occupation
Income
Social Cohesion & Social Capital
Material Circumstances
(Living and Working, Conditions, Food Availability, etc.)
Behaviors and Biological Factors
Psychosocial Factors
Health System
IMPACT ON EQUITY IN HEALTH AND WELL-BEING
STRUCTURAL DETERMINANTS SOCIAL DETERMINANTS OF HEALTH INEQUITIES
INTERMEDIARY DETERMINANTS SOCIAL DETERMINANTS OF HEALTH

Identifying Racism in the Drivers of Food Insecurity

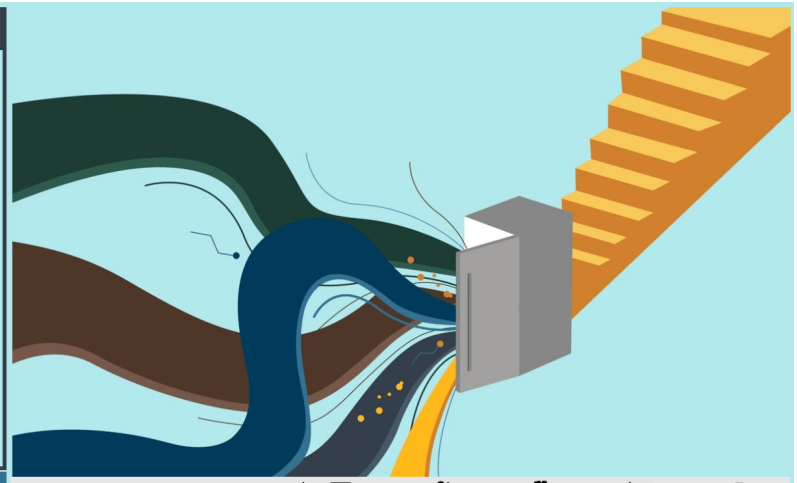
Introduction

Food insecurity exists in every county in the United States - as does systemic racism in its root causes.

Individuals experience food insecurity within the context of their community and broader environment. Associations between household characteristics and increased risk of food insecurity often reflect underlying inequalities, such as longstanding economic and social disadvantage resulting from systemic racism.

Food insecurity is an economic condition, meaning it is driven primarily by lack of money and other critical resources. This tool outlines five drivers that have been directly linked to food insecurity.

Click on one of the variables below to learn more.



Disability
Homeownership
Median Income
Poverty
Unemployment
Food Insecurity
About Data & Credits

National Food Insecurity Rates by Race or Ethnicity (2019)

		Disability	Homeownership	Median Income	Poverty	Unemployment
Asian	6%	7%	60%	$88,204	11%	4%
Black	22%	14%	42%	$41,935	23%	10%
Latino	18%	9%	47%	$51,811	20%	6%
Native American	27%	17%	54%	$43,825	25%	10%
Pacific Islander	21%	11%	41%	$63,613	18%	7%
White, non-Hispanic	9%	14%	72%	$68,785	10%	4%

Source: https://www.tableau.com/foundation/data-equity/economic-power/feeding-america-racism-food-insecurity

Differences in Cardiovascular Risk Factors by Race and Ethnicity, Adjusting for Social Determinants of Health, During 1999-2008 and 2009-2018

Cardiovascular risk factors	NHANES 1999-2008 No. of participants	Age- and sex-adjusted difference	Age-, sex-, and SDOH-adjusted difference[b]	NHANES 2009-2018 No. of participants	Age- and sex-adjusted difference	Age-, sex-, and SDOH-adjusted difference[b]
Mean body mass index[c]						
Black – White	4253/10 407	2.1 (1.8 to 2.4)	2.0 (1.7 to 2.4)	5124/9826	2.0 (1.7 to 2.4)	1.8 (1.5 to 2.1)
Hispanic – White	5280/10 407	0.7 (0.3 to 1.1)	0.9 (0.5 to 1.2)	5677/9826	1.2 (0.9 to 1.5)	1.2 (0.8 to 1.5)
Mean systolic blood pressure, mm Hg						
Black – White	3516/9100	5.5 (4.7 to 6.4)	4.6 (3.8 to 5.5)	4831/9409	6.4 (5.6 to 7.2)	5.3 (4.5 to 6.1)
Hispanic – White	4585/9100	1.7 (0.7 to 2.7)	0.2 (-0.8 to 1.2)	5375/9409	1.7 (1.0 to 2.4)	0.2 (-0.5 to 0.9)
Mean hemoglobin A_{1c}, %						
Black – White	3991/10 295	0.4 (0.3 to 0.4)	0.3 (0.3 to 0.4)	4801/9663	0.4 (0.3 to 0.4)	0.3 (0.3 to 0.4)
Hispanic – White	5207/10 295	0.3 (0.2 to 0.3)	0.2 (0.2 to 0.3)	5535/9663	0.3 (0.3 to 0.4)	0.3 (0.2 to 0.3)
Mean total cholesterol, mg/dL						
Black – White	3933/10 194	-5.6 (-7.3 to -3.9)	-4.4 (-6.3 to -2.5)	4694/9571	-5.9 (-7.8 to -4.1)	-4.3 (-6.0 to -2.5)
Hispanic – White	5167/10 194	0.1 (-1.7 to 1.9)	0.4 (-1.5 to 2.3)	5493/9571	0.5 (-1.8 to 2.8)	1.3 (-1.1 to 3.6)
Prevalence of current cigarette smoking, %						
Black – White	4388/10 697	-0.5 (-2.9 to 1.8)	-8.0 (-10.0 to -5.9)	5183/9973	3.8 (1.7 to 6.0)	-4.0 (-5.9 to -2.1)
Hispanic – White	5412/10 697	-6.1 (-9.1 to -3.1)	-17.5 (-20.6 to -14.4)	5740/9973	-6.1 (-8.3 to -3.9)	-16.6 (-18.9 to -14.3)
Mean 10-y risk of atherosclerotic cardiovascular disease, %[d]						
Black – White	2855/7633	1.4 (1.0 to 1.7)	-0.3 (-0.6 to 0.1)	3905/7828	2.0 (1.7 to 2.4)	0.7 (0.3 to 1.0)
Hispanic – White	4054/7633	0.8 (0.3 to 1.3)	-1.3 (-1.9 to -0.7)	4752/7828	0.7 (0.3 to 1.0)	-0.7 (-1.1 to -0.4)

Abbreviation: NHANES, National Health and Nutrition Examination Survey.

SI conversion factor: To convert total cholesterol to millimoles per liter, multiply by 0.0259.

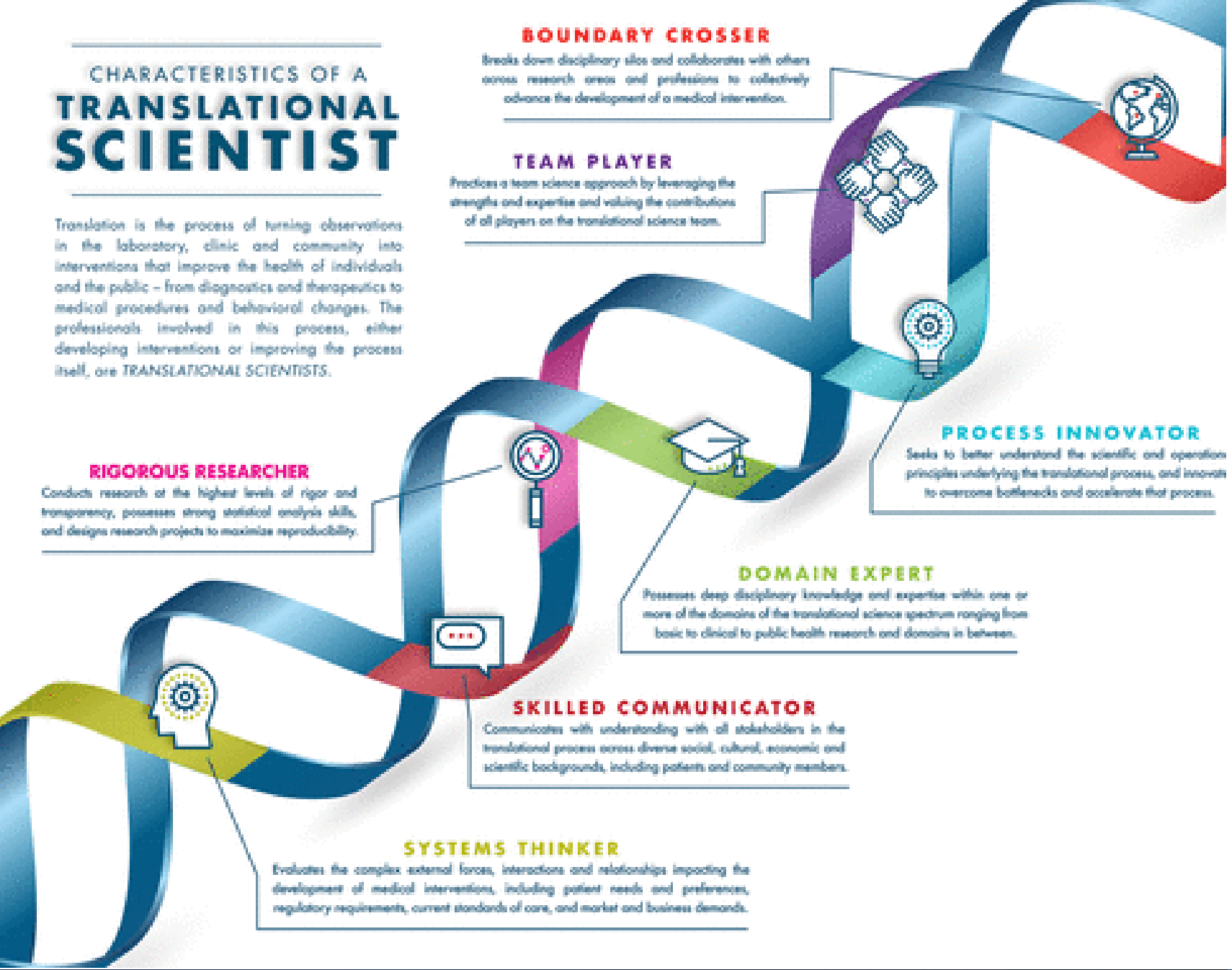
[a] Racial and ethnic differences in cardiovascular risk factors were defined as mean values in Black participants minus mean values in White participants or mean values in Hispanic participants minus mean values in White participants. NHANES participants with complete data for cardiovascular risk factors were included in the analysis. Absolute values on which this table is based can be found in eTable 5 in the Supplement. Additional data on obesity, hypertension, diabetes, high total cholesterol, and self-reported history of cardiovascular disease can be found in eTable 6 and eTable 7 in the Supplement.

[b] Social determinants of health (SDOH) included education (less than high school, high school graduate, some college, or college graduate or higher), family income-to-poverty ratio, home ownership, employment (employed, student, retired, or unemployed), health insurance (private, government, or none), and regular access to health care facility.

[c] Calculated as weight in kilograms divided by height in meters squared.

[d] The 10-year risk of atherosclerotic cardiovascular disease was calculated using the Pooled Cohort Equations among individuals without a self-reported history of cardiovascular disease. The probability of developing atherosclerotic cardiovascular disease over 10 years ranged from 0% to 100%.

Source: He J, Zhu Z, Bundy JD, Dorans KS, Chen J, Hamm LL. Trends in Cardiovascular Risk Factors in US Adults by Race and Ethnicity and Socioeconomic Status, 1999-2018. *JAMA.* 2021;326(13):1286–1298. doi:10.1001/jama.2021.15187



Team and Implementation Science

- The National Institute of Health's concept of team science is a means of addressing complex clinical problems by applying conceptual and methodological approaches from multiple disciplines and health professions.
- Implementation Science is the scientific study of methods to promote the systematic uptake of research findings and other evidence-based practice into routine practice and, hence, to improve the quality and effectiveness of health services and policies.
- Both can serve as a bridge between discovery and implementation and help incorporate social and structural factors

Source: Little MM, St Hill CA, Ware KB, Swanoski MT, Chapman SA, Lutfiyya MN, Cerra FB. Team science as interprofessional collaborative research practice: a systematic review of the science of team science literature. J Investig Med. 2017 Jan;65(1):15-22. [1]Gilliland CT, White J, Gee B, Kreeftmeijer-Vegter R, Bietrix F, Ussi AE, et al. The fundamental characteristics of a translational scientist. ACS Pharmacol Transl Sci. 2019;2(3):213–6. Eccles, M., and B. Mittman. "Welcome to implementation science. 2006." *Implementation Science* 1, no. 1 (2012).

Types of Interventions

Structural

Aim

Change economic, legal, political, or social environmental factors that shape public health outcomes

Example

- Decriminalise sex work
- Community empowerment, such as enhancing skills to mobilise or engage in legal advocacy
- Sensitivity training for law enforcement

Behavioral

Aim

Support changes in human behavior to influence health outcomes

Example

- Peer education on strategies to improve condom use with clients and partners
- Self-efficacy building workshops to increase treatment adherence

Biomedical

Aim

Provide clinical or medical approach to health outcomes

Example

- PrEP program for sex workers
- STI treatment services
- Post-violence response medical care and reporting support

Source: Integrated Interventions to Address Sex Workers' Needs and Realities: Academic and Community Insights on Incorporating Structural, Behavioural, and Biomedical Approaches. In S. M. Goldenberg (Eds.) et. al., *Sex Work, Health, and Human Rights: Global Inequities, Challenges, and Opportunities for Action*. (pp. 231–253). Springer.

Brown, A. F., Ma, G. X., Miranda, J., Eng, E., Castille, D., Brockie, T., Jones, P., Airhihenbuwa, C. O., Farhat, T., Zhu, L., & Trinh-Shevrin, C. (2019). Structural Interventions to Reduce and Eliminate Health Disparities. *American journal of public health*, *109*(S1), S72–S78.

Reflecting on Progress… **Using a Lens of ‘Sankofa’**

The word Sankofa comes from the Akan people of Ghana.

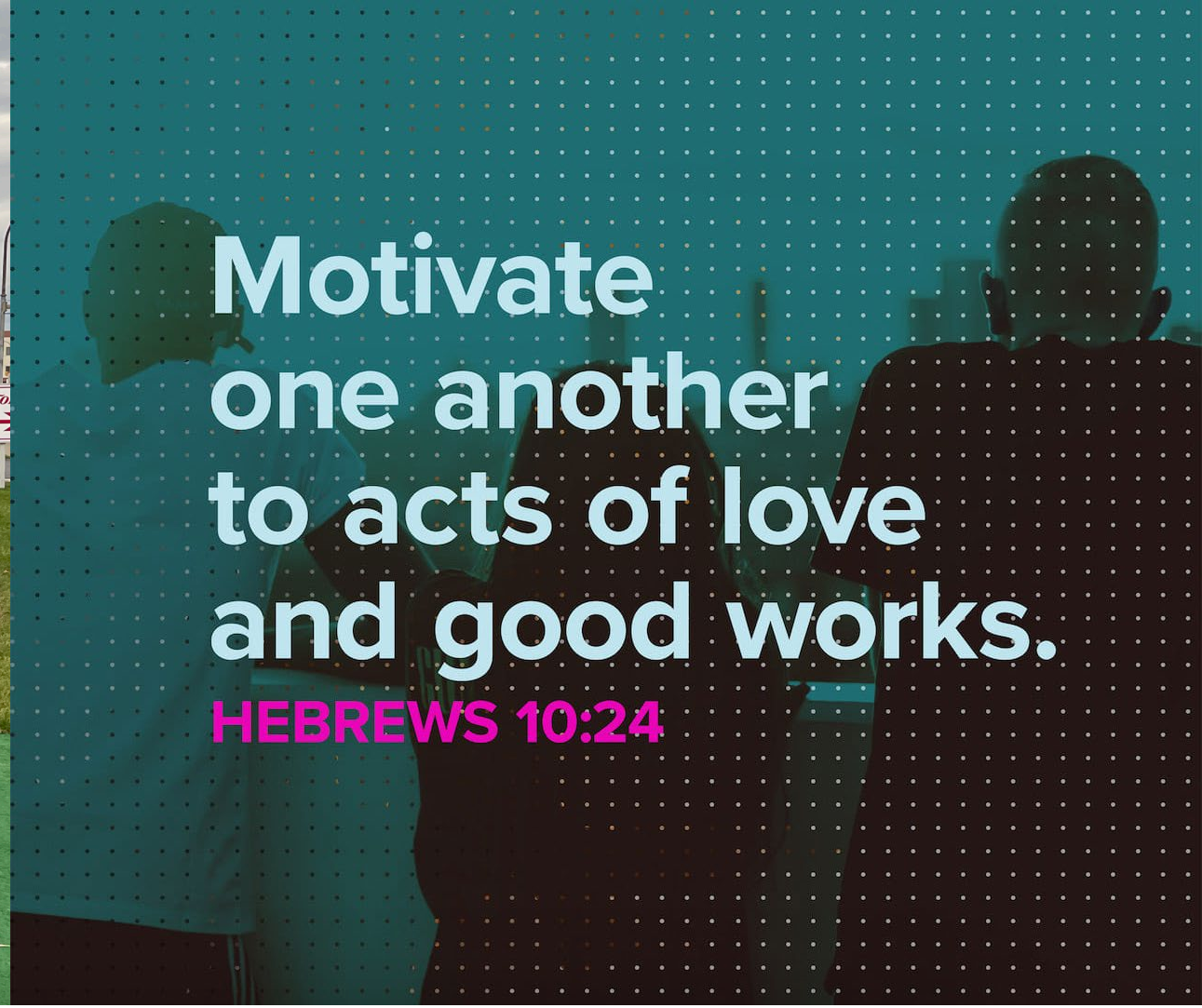
It has been embraced as a symbol of Pan-Africanism and African Diaspora

Se wo were fi na wosankofa a yenkyi” (translated from the Akan language to mean “it is not taboo to go back and fetch what you forgot”).

The power of Sankofa centers around this: to know history and your heritage is to know your current self, the world around you, and how to better both.

Taking from the past what is good and bringing it into the present in order to make positive progress through the benevolent use of knowledge.


As we look toward the future we reflect and honor the ten precious lives lost on May 14, 2022.
With the help of their families, the community, and Tops associates, a permanent memorial will be built on this sacred space so that we never forget.
It is our hope that this space will serve as a place of honor, solace and reflection for all who visit. May it inspire us to strive for a better world where we celebrate diversity and the richness that comes from different perspectives and experiences.
LANDON ST
JEFFERSON AVE
1. 9/11 Memorial Survivor Tree Seedling
Gifted Callery Pear Tree
2. Decorative Lighting
3. Custom Art Installation
With Community Collaboration, to be Installed at Later Date
4. Concrete Pathway
5. Granite Benches
6. (10) Artistic Bollards
Representing the 10 Precious Lives Lost
7. Standard Bollards
TOPS
STOP
FOREVER IN OUR HEARTS
Celestine Cheaney
Roberta Drury
Andre Mackneil
Katherine Massey
Margus Morrison
Heyward Patterson
Aaron Salter, Jr.
Geraldine Talley


Motivate one another to acts of love and good works.
HEBREWS 10:24

Thank you!