POVERTY AND HUNGER

Shrinking Budgets and Expanding Bodies: Battling Obesity When the Economic Belt is Tight

KELLIE O’DARE WILSON and DIANE L. SCOTT
Department of Social Work, The University of West Florida, Pensacola, FL, USA

Although Americans reduced spending on food during the Great Recession, the prevalence of overweight and obesity continued to increase. This article uses socioeconomic life course models to organize the issues surrounding obesity, striving to illustrate how community, social, and intergenerational factors, compounded over the course of a lifetime, increase risk, particularly among poor, minority, and otherwise under resourced communities. Conceptualizing obesity within life course models informs policy recommendations, practice, and guides future research. Social workers are called to respond with collaborative approaches to create accessible and affordable community food environments where the default option is the healthy, preferred choice.

KEYWORDS barriers to healthy food, community food environment, food insecurity, life course models, obesity, obesity stigma

The Great Recession, lasting from December 2007 through June 2009, was the longest and most severe economic crisis since the Great Depression of the 1930s and negatively impacted the economic well-being and security of many US families, with an estimated 70% of Americans enduring considerable financial effects (Danziger, 2013; Hurd & Rohwedder, 2010; National Bureau of Economic Research, 2010). Precipitated by a significant collapse in housing values and large declines in the stock market, unprecedented numbers of
American families suffered unemployment (up to 16% of all workers experienced a job loss during this time), declines in wealth, reduced incomes, and increased poverty, as well as a general loss of optimism regarding their financial futures (Danziger, 2013; Hurd & Rohwedder, 2010).

Although the ranks of the new poor, the near poor, and others eligible for social service programs escalated, public revenue sources experienced unprecedented declines leading to a retrenchment of social welfare and safety net programs. In particular, states and localities bore a disproportionate burden of programmatic cuts due to significant tax revenue losses from the housing market crash (Gordon, 2012). And similarly, in states constitutionally required to pass a balanced budget, many reduced social service program funding and shifted costs to localities (National Conference Association of State Legislatures, 2014). Estimates indicate caseloads for safety net programs, such as the Supplemental Nutrition Assistance Program (SNAP or food stamps), unemployment benefits, Medicaid, and Social Security rose from $276 million in 2007 to $310 million in 2010 (Moffitt, 2013). Although the federal government responded by spending $2.1 trillion on safety net programs for those impacted by the recession, this spending caused federal budget deficits to climb as high as $1.5 trillion per year, fostering prolonged economic stagnation (Grusky, Western, & Wimer, 2011; Moffitt, 2013). As a result, the economy, communities, and American families, have yet to fully recover from the Great Recession.

As the economic burdens received national attention, many Americans also endured an overall decline in well-being, as well as significant and lingering social, mental, and physical health effects from the Great Recession. Research has demonstrated financial hardships, like those caused by the Great Recession, are associated with increases in poor physical health and chronic disease (Suhrcke & Stuckler, 2012). This article discusses overweight and obesity as a manifestation of poor physical health exacerbated by the Great Recession. This article uses socioeconomic life course models to organize the issues surrounding obesity, striving to illustrate how community, social, and intergenerational factors, compounded over the course of a lifetime, increase risk. In addition, conceptualizing overweight and obesity within life course models can inform policy recommendations, social work practice, and guide future research in the area.

**SIGNIFICANCE FOR SOCIAL WORK**

Although social workers have responded to issues of food insecurity, eating disorders, and chronic hunger, historically, overweight and obesity have not been considered fundamental to social work's mission. However, obesity disproportionately affects vulnerable populations, including ethnic minorities and the poor. Just as social workers respond on an individual basis to food insecurity, they should address community and environmental issues to
Shrinking Budgets and Expanding Bodies

 assure populations have equal access to healthy food and safe environments for physical activity. Furthermore, this issue is germane for social work because persons of obese status are subjected to stigma, discrimination, and negative stereotyping, and are generally viewed more negatively than those who are not of obese status (Larkin & Pines, 1979; O’Dare, 2011). Often stereotyped as lazy, unintelligent, unhappy, slovenly, less capable, weak-willed, or even mentally ill, persons of obese status may be subject to ridicule and inappropriate and offensive cruel humor such as fat jokes and fat shaming (Council on Size and Weight Discrimination, 2010; Larkin & Pines, 1979).

Obesity is not considered a protected disability, and codified antidiscrimination laws are absent at most levels. In fact, even “protection against obesity discrimination under the Americans with Disabilities Act (ADA) is extremely limited” (Maranto & Stenoien, 2000, p. 9). Obese women, in particular, are highly stigmatized and devalued in the United States, and are more likely to be accepting of and internalize negative stereotypes (Puhl, Andreyeva, & Brownell, 2008; Puhl & Brownell, 2001, 2003; Schwartz & Puhl, 2010)

In addition to individual consequences, overweight and obesity pose both direct and indirect costs to society and have a significant impact on the US health care system. Direct and indirect costs can include lost workplace productivity, increased disability claims, and high healthcare spending (Berke & Morden, 2000; Centers for Disease Control, 2012; O’Dare, 2011). Although the direct costs associated with obesity are difficult to measure, estimates for 2008 reflect between $148.9 to $210 billion (up from $75 billion in 2003), or 10% of health care spending, a large portion of which was borne by publically funded health care programs such as Medicaid and Medicare. For example, the average Medicaid costs for a child with obesity-related conditions was $6,730, compared to the costs including non-obese children at $2,446 (Centers for Disease Control, 2012; Finkelstein, Fiebelkorn, & Wang, 2004; Gostin, 2005; Robert Wood Johnson Foundation, 2013; Tsai, Williamson, & Glick, 2011).

LIFE COURSE MODELS

The socioeconomic life course model shares important elements with social work’s person-in-environment perspective as it situates an individual within a wider ecological framework to capture determinants of health risk. Conceptually, the socioeconomic life course encompasses all facets of the human condition, including an individual’s journey from childhood to adulthood, through formal institutions such as the education system and labor market, and informal intuitions, such as culture and the family (Graham, Francis, Inskip, & Harman, 2006). The concept of the socioeconomic life course provides a key framework to begin contextualizing overweight
and obesity, and can help us understand how powerful influences from childhood through adulthood affect an adult’s individual health outcomes.

The life course model considers the long-term effects of social and physical exposures, such as poverty, unemployment, malnutrition, poor housing, and parental education levels, as they occur during gestation, childhood, adolescence, young adulthood, and later adult life. The model pays particular attention to patterned exposures throughout the lifetime, and even across generations, that may result in increased disease risk (Kuh, Ben-Shlomo, Lynch, Hallqvist, & Power, 2003; Naess & Claussen, 2002). For example, African Americans and Latinos may experience social, economic, or political exclusion from an early age resulting in health deterioration rendering a higher obesity risk. In addition, obesity appears to be multigenerational, further beckoning the need for a life course approach in prevention (Doherty & Harkaway, 1990). Exposure to a major economic crisis, such as the Great Recession, exacerbates poverty and unemployment which influences risk for obesity across the life course.

DECLINES IN WELL-BEING, INCREASES IN OVERWEIGHT AND OBESITY

The financial hardships inflicted during a recession are associated with increased food insecurity, malnutrition, reduced physical activity and nutritional quality, and result in continued spikes in overweight and obesity. Families struggling to make ends meet reported less time for self-care activities overall, in particular healthy eating and exercising, and were more likely to overeat unhealthy food products during the recession (Zhang, Lamichhane, & Wang, 2014). Studies also report real food expenditure (food expenditures relative to the consumer price index) declined, households bought fewer calories overall, switched to cheaper calorie sources, and more calorie-dense types of food products (Griffith, O’Connell, & Smith, 2013). For example, between 2006 and 2007 the number of children experiencing a significant reduction in calories doubled, to the highest rates since 1998 (US Department of Agriculture, 2009). The number of poor mothers who reported skipping meals to protect their children from hunger increased during this time as well. “Record levels of participation in food assistance programs and increased demand at emergency kitchens and food pantries make clear that more families than ever before are struggling to get enough to eat in the aftermath of the recession” (Center for American Progress, 2010, p. 1). Despite Americans tightening their belts by spending less on food, decreasing the overall number of calories eaten at both home and in restaurants, and experiencing the pangs of hunger, the prevalence of overweight and
obesity continued to increase during this time (Centers for Disease Control [CDC], 2014; Todd & Morrison, 2014).1

In addition to affecting the quantity and quality of Americans food, the recession negatively impacted physical activity opportunities for many families as well. Although regular physical activity has been shown to reduce risk for obesity, opportunities may be considered a forgivable luxury during tough financial times (Estabrooks, Lee, & Gyurcsik, 2003). Families may not have discretionary income for gym memberships or registration fees required for activities. Lack of physical proximity to safe parks and green spaces may also prohibit physical activity, and poor neighborhoods are often particularly lacking in safe recreational resources (Moore, Diez Roux, Evenson, McGinn, & Brines, 2008). Living in neighborhoods directly impacted by the Great Recession was associated with reductions in physical activity and increased obesity risk. For example, people in areas with a higher density of foreclosed homes were less likely to be physically active, and living within 100 meters of a foreclosed home was associated with a higher risk for obesity (Arcaya et al., 2013).

COMMUNITY-LEVEL RISK PROLIFERATION

Constrained budgets resulting from recessionary economic times have compressed the food purchasing ability of many families, and a wealth of research has indicated the strong link between limited financial resources and risk for obesity (Cassady, Jetter, & Culp, 2007; Kaufman, 1998; Larson, Story, & Nelson, 2009; O’Dare, 2011; Zhang et al., 2014). Many families continue to experience restricted financial and proximal access to the foods that nearly all experts assert as integral to a healthy diet: fresh vegetables and fruits, high quality protein, fats, and nonrefined grains (Ludwig & Pollack, 2009). Barriers to access can include limited proximity of grocers offering healthful food choices, inundation of more convenient, yet less healthful options, as well as a perceived cost-prohibitive nature of health foods. Healthy food consumption patterns, as well as obesity, are both inversely correlated to the travel distance from home to a grocer (Rose & Richards, 2004; Rundle et al., 2009). Residents of these food deserts, or areas farther than 10 miles from a supermarket, discount supercenter, or wholesale club, must rely primarily on fast food restaurants, convenience or corner stores, or even gas stations for a majority of caloric intake (Blanchard & Lyson, 2002; Larson et al., 2009). If families cannot access grocery retailers due to limited transportation, access, or financial resources, they are forced to choose from lower quality foods offered at substantially higher prices (Blanchard & Lyson, 2002; Larson et al., 2009). If families cannot access grocery retailers due to limited transportation, access, or financial resources, they are forced to choose from lower quality foods offered at substantially higher prices (Blanchard & Lyson, 2002; Larson et al., 2009).

1While some studies have shown positive effects in dietary quality during recessional times, more research is needed to determine the relevance of these effects on poor and minority families (Andreyeva, Long, & Brownell, 2010).
Studies continue to demonstrate that greater proximal access to a chain grocer is related to a reduced risk for obesity; conversely, greater access to convenience stores and fast food outlets is related to increased risk for obesity. In fact, the highest levels of obesity are located in census tracts with limited access to grocers and increased access to convenience stores (Jetter & Cassady, 2006; Larson et al., 2009; Rose & Richards, 2004). In addition, residents of these communities also experience cycles of food deprivation and overeating, high levels of stress, higher marketing of obesity-promoting products, and limited access to health care, all of which contribute to increased obesity risk (Block, He, Zaslavsky, Ding, & Ayanian, 2009; Bruening, MacLehose, Loth, Story, & Neumark-Sztainer, 2012; Dammann & Smith, 2009; Freeman & Corey, 1993; Kumanyika & Grier, 2006).

Social workers must work to combat a culture of obesity emerging in these poor neighborhoods—a culture perpetuating the notion that becoming overweight and obese is a typical, unavoidable summation of life course experiences for the poor. This expectation leads to both internalized and externalized beliefs that obesity is a natural consequence of poverty, and is yet another affliction easily disregarded among vulnerable and oppressed populations.

Although the relationship between low fruit and vegetable consumption and obesity is well established in the literature, proximity and cost can be highly prohibitive for fresh fruits and vegetables in particular (He et al., 2004; Rose & Richards, 2004). Studies demonstrate that low fruit and vegetable consumption is one of the top 10 mortality risk factors worldwide, and poor families struggle with having to replace calories from fresh fruits and vegetables with less healthful alternatives (Epstein et al., 2001; He et al., 2004). More accessible highly processed junk foods, filled with calories, refined grains, and sugars are a cheap and easy way to fill up. Sadly, low-income families would need to allot 43%–70% of their food budget on fresh fruit and vegetables alone to meet published USDA Dietary Guidelines (Cassady et al., 2007; O’Dare, 2011). Projects like Portraits of Hunger have highlighted the experience of those living in food deserts and struggling with obesity since childhood: “You can’t find fresh fruits and vegetables in this neighborhood. I ate a lot of instant noodles and drank a lot of Hawaiian Punch from the corner stores up here” (Lubrano, 2010, para. 8). Changing food preferences, dietary habits, and the individual choices within volitional control are only small pieces of the obesity puzzle. The availability of healthy foods in neighborhoods directly influences behaviors. “One of our biggest misconceptions is that it’s poor people’s fault. . . . The poor, without access to healthy foods, are making the best possible choices under difficult circumstances” (Lubrano, 2010, para. 16).
POLICY RESPONSES

Since the Great Recession, despite a lack of fiscal resources, the US. has seen an outpouring of policy initiatives aimed at combatting obesity at the local, state, and federal levels. In 2010, the White House established its Task Force on Obesity. The CDC, the USDA, and National Conference of State Legislatures have all created programs and resources for states and localities desiring to implement obesity prevention efforts (National Institute for Health Care Management, 2010). In addition, higher education, not-for-profit, private, and independent sectors have contributed research and resources for obesity prevention and reduction efforts. However, lack of time since implementation, limited funding, and no clear understanding of how individual and environmental factors interact to cause obesity make evaluation of programs difficult.

NATIONAL PREVENTION STRATEGY

After the official end of the Great Recession, Congress passed the 2010 Patient Protection and Affordable Care Act, commonly known as the Affordable Care Act or Obamacare. This historic health legislation was intended to increase health care coverage for the uninsured, improve the quality of health care, and reduce health care costs to individuals and government (National Conference of State Legislatures, 2014). The Affordable Care Act created the National Prevention Council under the US Surgeon General’s Office to codify the critical role of preventative efforts in improving health. In 2011, the National Prevention Council published the National Prevention Strategy (NPS); a comprehensive guide to intended to “improve the health and quality of life for individuals, families, and communities by moving the nation from a focus on sickness and disease to one based on prevention and wellness” (US Surgeon General, 2011, p. 7). The landmark NPS provides comprehensive approaches intended to reduce the leading preventable causes of death and major illness. The seven national priorities include: “tobacco free living, preventing drug abuse and excessive alcohol use, healthy eating, active living, injury and violence free living, reproductive and sexual health, and mental and emotional well-being” (US Surgeon General, 2011, p. 7). NPS reports this is the first national, comprehensive preventative strategy of its kind and builds on evidence suggesting the strongest predictors of health and well-being, such as social, economic, and environmental factors, “occur primarily outside of health care settings” (US Surgeon General, 2011, p. 3). NPS also acknowledges the existence of significant health disparities linked with social, economic, and environmental disadvantage, and emphasizes that a collaborative effort across a wide range of partners, including governments, businesses, health care settings, insurers,
K. O’Dare Wilson and D. L. Scott

schools and universities, community, not-for-profit and faith based organizations, as well as individuals and families, is imperative for the success of NPS (US Surgeon General, 2011).

The federal-level acknowledgement of healthy eating and active living as top priorities, identifying prevention and wellness as a national focus, and recognizing the existence of significant social, economic and environmental barriers to prevention and wellness, are tremendous positive steps toward reducing overweight and obesity and align well with models of strength-based social work practice. The six healthy eating recommendations include (a) increase access to healthy and affordable foods in communities; (b) implement organizational and programmatic nutrition standards and policies; (c) improve nutritional quality of the food supply; (d) help people recognize and make healthy food and beverage choices; (e) support policies and programs that promote breastfeeding; and (f) enhance food safety. The indicators (or measures of progress) associated with the healthy eating recommendations are (a) proportion of adults, children, and adolescents who are obese; (b) average daily sodium consumption in the population; (c) average number of infections caused by salmonella species transmitted commonly through food; and (d) proportion of infants who are breastfed exclusively through 6 months (US Surgeon General, 2011, p. 57). The five active living priorities include (a) encourage community design and development that supports physical activity; (b) promote and strengthen school and early learning policies and programs that increase physical activity; (c) facilitate access to safe, accessible, and affordable places for physical activity; (d) support workplace policies and programs that increase physical activity; and (e) assess physical activity levels and provide education, counseling, and referrals. The indicators associated with the active living recommendations are (a) proportion of adults who meet physical activity guidelines for aerobic physical activity, (b) proportion of adolescents who meet physical activity guidelines for aerobic physical activity, (c) proportion of the nation’s public and private schools that provide access to their physical activity spaces and facilities for all persons outside of normal school hours, and (d) proportion of commuters who use active transportation (i.e., walk, bicycle, and public transit) to travel to work (US Surgeon General, 2011, p. 57). Table 1 provides the recommendations and key indicators for healthy eating and active living priorities.

LINKING RECOMMENDATIONS TO LIFE COURSE CONSIDERATIONS

The recommendations for healthy eating and active living are evidence based and include social and environmental factors, however, their comprehensive nature may be difficult to operationalize, particularly in light of continued economic and structural barriers. For example, the recommendation to
**TABLE 1** Healthy Living Priorities, Indicators, and Recommendations

<table>
<thead>
<tr>
<th>Priority</th>
<th>Indicator</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Eating</td>
<td>• Proportion of adults, children, and adolescents who are obese</td>
<td>• Increase access to healthy and affordable foods in communities</td>
</tr>
<tr>
<td></td>
<td>• Average daily sodium consumption in the population</td>
<td>• Implement organizational and programmatic nutrition standards</td>
</tr>
<tr>
<td></td>
<td>• Average number of infections caused by salmonella species transmitted</td>
<td>• Improve nutritional quality of the food supply</td>
</tr>
<tr>
<td></td>
<td>commonly through food</td>
<td>• Help people recognize and make healthy food and beverage choices</td>
</tr>
<tr>
<td></td>
<td>• Proportion of infants who are breastfed exclusively through 6 months</td>
<td>• Support policies and programs that promote breastfeeding</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Enhance food safety</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Encourage community design and development that supports physical activity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Promote and strengthen school and early learning policies and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>programs that increase physical activity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Facilitate access to safe, accessible, and affordable places for</td>
</tr>
<tr>
<td></td>
<td></td>
<td>physical activity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Support workplace policies and programs that increase physical</td>
</tr>
<tr>
<td></td>
<td></td>
<td>activity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Assess physical activity levels and provide education, counseling,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>and referrals</td>
</tr>
<tr>
<td>Active living</td>
<td>• Proportion of adults who meet physical activity guidelines for aerobic</td>
<td>• Provide information, tools, and expertise to help</td>
</tr>
<tr>
<td></td>
<td>physical activity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Proportion of adolescents who meet physical activity guidelines</td>
<td></td>
</tr>
<tr>
<td></td>
<td>for aerobic physical activity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Proportion of the nation’s public and private schools that provide</td>
<td></td>
</tr>
<tr>
<td></td>
<td>access to their physical activity spaces and facilities for all persons</td>
<td></td>
</tr>
<tr>
<td></td>
<td>outside of normal school hours</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Proportion of commuters who use active transportation (i.e. walk,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>bicycle, and public transit) to travel to work</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Recommendations are aligned to the Priorities, not directly to the Indicators. Table 1. Source: U.S. Surgeon General (2011), The Priorities.

“increase access to healthy and affordable foods in communities” is excellent, but it does not provide an appropriate and relevant definition of “healthy and affordable,” as these terms could have different meanings among different communities. Nor does it provide local and community partners with specific actions for implementation, and it does not discuss the economic and structural barriers underresourced communities continue to face. Minority and poor communities often face challenges related to lack of political clout, and are frequently underrepresented in decisions about limited resources. In addition, because many state and local partners continue to reel from budget cuts, funds are scarce to implement new interventions, especially at the macro level.

NPS does provide an *Actions* section where it lists actions the federal government will take related to the recommendations. Unfortunately, the actions are also extremely broad and little information is provided about the progress of the actions or research on effectiveness. For example, one of the actions includes: “Provide information, tools, and expertise to help
Americans understand and apply the Dietary Guidelines for Americans” (US Surgeon General, 2011, p. 35). A 2014 NPS status update highlights one program intended to carry out this action, the USDA’s Super Tracker, a free web-based tool intended to help users choose foods that comply with USDA guidelines and track physical activity (US Surgeon General, 2014). However, use of such a tool assumes access to and comfort using the Internet, proximal and financial availability of the recommended healthy food choices, and safe places for physical activity, which are all well documented barriers in poor and under resourced communities (O’Dare, 2011). In addition, aside from published anecdotal testimonials, limited scientific information is available to ascertain if the Super Tracker is significantly changing dietary behaviors.

In addition to challenges with NPS recommendations, it is difficult to link progress on the healthy eating and physical activity indicators directly back to the recommendations. For example, although the key indicators for healthy eating include proxy measures of obesity, sodium consumption, food borne infection, and breastfeeding prevalence, none of those measures specifically evaluates whether or not individuals actually obtained better access, either proximally or financially, to healthier foods in their communities. Measuring changes in the food environment, such as distance to grocers who offer affordable, healthy items and density of fast food outlets would be a more accurate measure of improvements to access.

IMPLICATIONS FOR PRACTICE AND RESEARCH

“Obesity is common, serious, and costly” (Centers for Disease Control, 2014, p. 1). Given that overweight and obesity disproportionately affects poor, minority, and under resourced communities and that differential access to healthful, nutritious foods and safe places for physical activity are issues of social justice, social workers are called to respond (National Association of Social Workers, 2008; O’Dare, 2011). Social workers working directly with individuals, families, and groups should include questions regarding level of access to healthy foods and physical activity opportunities to clients as a part of standard bio-psychosocial instruments. In doing so, social workers can help shift the focus from individual behavior to the available resources and changes needed in the macro environment. Social workers should become aware of local and community resources, aside from the traditional nutrition assistance programs, where clients may access services related to healthy eating and physical activity. For example, social workers can provide information and referrals to community gardens offering fresh fruits and vegetables in addition to referrals to food pantries typically able to only stock non-perishables. Social workers can assist clients who are able with evidence-based information on how to shop for and
prepare healthier meals, while respecting and affirming cultural contexts and financial constraints. Social workers can spearhead the establishment of fairly-priced and accessible farmers markets, community gardens, or community sponsored agriculture agreements in local areas, or volunteer with existing agencies that engage in these activities. Social workers can advocate for grant programs to enable local and community providers to develop and implement highly operationalized and evidence based interventions that include detailed evaluation plans to ascertain effectiveness.

Social work researchers interested in obesity prevention and reduction should explore the yet largely misunderstood connections between biological, behavioral, and environmental factors that contribute to obesity, as well as take an active role in designing and implementing evaluation plans to assess the impact of a myriad untested policy initiatives in the area. Research should attempt to build upon recent successes in reducing obesity within certain populations, while acknowledging and identifying the limitations of these successes. For example, although some recent studies have shown a decrease in obesity rates among preschoolers, these findings must be interpreted with caution, as they include methodological limitations and do not include obesity reductions for all groups, including ethnic minorities and severely obese children (Ogden, Carroll, Kit, & Flegal, 2014; Skinner & Skelton, 2014; Visscher, Heitmann, Rissanen, Lahti-Koski, & Lissner, 2015).

Rather than focusing solely on individual’s behavior, reducing the incidence and prevalence of obesity ultimately requires a multilevel, interdisciplinary, and collaborative approach to create food environments in communities where the default option is the healthy, preferred choice.

REFERENCES


Shrinking Budgets and Expanding Bodies


