

The RURAL MONITOR

A Publication of the Rural Assistance Center

New Features

Starting with this issue, the Rural Monitor will feature a column by Wayne Myers, M.D. on the current state of health care in this country, with a particular focus on rural areas.

Myers, a pediatrician, founded the University of Kentucky Center for Rural Health in 1990 and served as its director for seven years. The center works with other agencies to train rural people in health professions and, under Myers' direction, became one of two recipients of a 1997 award for primary care education from the Pew Health Professions Commission. Myers served as director of the Office of Rural Health Policy in the Department of Health and Human Services' Health Resources and Services Administration from 1998-2000 after more than two decades of leading or consulting for rural health projects in the United States and abroad. He is

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Obesity: Combating a Rural Epidemic

By Thomas D. Rowley

Like most people in the United States these days, rural Americans are eating more and getting bigger.

In fact, rural data in the CDC publication, *Health, United States, 2001*, shows a higher incidence of obesity among nonmetropolitan men and women than in their metro counterparts in nearly every region of the country.

While it's tempting to think that rural residents—by virtue of their rural lifestyle—are somehow immune to the dangers of growing larger and unhealthier, the opposite is true.

Michael Meit, Director of the University of Pittsburgh's Center for Rural Health Practice thinks that obesity is a nationwide epidemic. "I just think that we in rural areas are a little further along," Meit said. "We're the proverbial canary in the coalmine. The rural populations are getting more and more obese and facing the health care challenges that come along with that." Meit said that this obesity is going to put more of a

strain on rural health care systems and that it will lead to more illness and more uncompensated care.



Oct 2nd, 2003: A fifth grade class in Lewistown, Montana participates in a Walk to School Day—to encourage kids and parents to walk instead of drive.

"That's a recipe for disaster," he said.

According to researchers Tom Tai-Seale and Coleman Chandler in *Rural Healthy People 2010*, while rural areas traditionally had lower rates of overweight and obese people because of the physical demands of farming and other occupations, such is no longer the case. They cite several studies showing that obesity and being overweight are more common among rural residents—children, adolescents, and adults—than their urban counterparts.

(continued on next page)

In *Bridging the Health Divide: The Rural Public Health Agenda*, by the Center for Rural Health Practice, Jeff Oxendine and Emily Elman at the Pacific Public Health Training Center cite research that shows both men and women in rural areas have higher rates of self-reported obesity than men and women in other areas.

They note that rural residents are also more likely to describe their overall health status as fair/poor than urban residents and that chronic illnesses are more prevalent in rural areas. (Rural dwellers—adults and adolescents—are also more likely to smoke and rural adults are more likely to drink.)

The statistics are part of a larger national concern.

Not only are we eating too much, we're eating the wrong things. According to the CDC, only 25 percent of U.S. adults eat the recommended five or more servings of fruit and vegetables every day. Fewer kids (less than 20 percent) eat five a day, while more than 60 percent eat too much fat. Even more troubling is the fact that the obesity epidemic threatens our infants and toddlers. According to Susan Pac of baby-food maker Gerber in a presentation at the U.S. Department of Agriculture's 2004 Agricultural Outlook conference, by the tender age of 15 months the most commonly consumed vegetable is that staple of American diets, the French fry.

Nor are we exercising. The CDC reports that despite the proven benefits of physical activity, fewer than 40 percent of American adults get enough physical activity to provide health benefits. More than a

Overweight or Obese?

Overweight and obesity can be defined in a number of ways. And whether a particular person is overweight or obese may vary according to the definitions used. Body mass index (BMI) is a popular method used to determine whether someone is at a healthy weight, overweight or obese. BMI is calculated by dividing a person's weight (in kilograms) by his or her height (in meters squared). BMI is more highly correlated than any other indicator of height and weight with body fat.

BMI of:

- 19 to 24.9 is considered the healthy weight range
- 25 to 29.9 is considered overweight
- 30 and higher is considered obese

The CDC maintains a BMI calculator for adults at <http://www.cdc.gov/nccdphp/dnpa/bmi/calc-bmi.htm>

Sources: Rural Healthy People 2010 and the Centers for Disease Control and Prevention.

quarter of them are not active at all in their leisure time. Sadly, lack of exercise is also rampant among children. Daily participation in high school physical education classes dropped from 42 percent in 1991 to 29 percent in 1999. As a result, more than one-third of kids in grades nine through 12 "do not regularly engage in vigorous physical activity." Unset-

ting as all that is, the damage to our health and economy caused by our expanding national waistline is even more alarming.

- Obesity increases the likelihood of type 2 diabetes, cardiovascular disease, gallbladder disease, sleep apnea, osteoarthritis and various types of cancer.
- The cost of obesity in dollars is approximately \$120 billion a year.
- The cost in lives approaches 400,000 a year.

While tobacco use is still the leading cause of preventable death in the United States, a recent article by CDC researchers in the *Journal of the American Medical Association* shows that obesity is catching up and, if trends continue, will pass tobacco next year, causing more than 500,000 deaths each year.

Slimming Down

Fortunately, efforts are underway to alert Americans—rural and urban—to the need to slim down and get healthy, and to help them get busy and do it. According to Kristine Sande, the Rural Assistance Center's Project Coordinator, the concept of wellness is starting to resonate with rural communities, especially in terms of controlling the incidence of obesity and chronic conditions related to it such as diabetes and cardiovascular disease.

"I've seen this trend while reviewing grants at the Federal and State levels, in the calls that we get here at RAC and when the Center for Rural Health staff visited 13 rural



A grandmother and granddaughter take part in a WIN promotional video that encourages physical activity.

communities around North Dakota this fall,” said Sande. “I think that this is a topic where there are all kinds of ways that different groups can work together to promote healthy living.”

Based on what she’s seen and heard in the field, Sande listed several ways communities can help promote wellness. Her list is by no means comprehensive:

- Schools can promote healthy living by teaching proper nutrition; emphasizing the importance of physical activity through physical education; holding contests that challenge kids to walk; serving healthy choices for lunch; and limiting the availability of candy and soda.
- Hospitals and clinics can offer classes on controlling diabetes and can expand their cardio/pulmonary rehabilitation areas into workout facilities available to the community at large.
- County extension offices can provide healthy-cooking demonstrations and nutrition classes.
- Churches can offer support groups for weight management, organize walking clubs and make church facilities available for exercise classes.
- Local public health departments can provide fitness screenings for community members.
- Community organizations can start a wellness center or community garden. For example, Sande said, there is a community gardener in North Dakota who also works for the local diabetes prevention program. The gardener invites local Native American youth to help in the gardens, providing them with physical activity and making it more likely that the kids will eat healthy food because they helped raise it.

“I really think there is tremendous opportunity in most communities for folks to come together around this issue,” Sande said.

WINning the Rockies

Dr. Sylvia Moore, Professor and Director of Medical Education and Public Health at the University of Wyoming would likely agree with Sande, pointing to a unique program called “WIN the Rockies.”

The program targets rural areas because small rural communities have a better chance of making things happen, Moore said.

With efforts in Wyoming, Montana, and Idaho, WIN the

Rockies—now in its final stages—has two goals: first, to enhance the well-being of people by improving their attitudes and behaviors related to food, physical activity and body image; second, to help build the capacity of communities to foster and sustain these changes. Ultimately, the project seeks to reverse the rising tide of obesity in the three states. The underlying philosophy is that people are responsible for their own health and communities can create environments that foster good health and provide health options. The idea was to take a holistic look at the problem of obesity.

“We wanted to look at health as opposed to weight, look at healthy and pleasurable eating and at body sizes,” Moore said. “We wanted to help people accept who they are, instead of going after an advertising ideal. And we wanted to put a community focus on it, rather than doing individual intervention.”

Begun in 2001, the program selected six small rural communities—two in each state. Three received help while three acted as comparison communities to help measure the success of the interventions. The program has three components: pre- and post-intervention surveys in the six communities, efforts aimed at 50 adults in each community, and efforts aimed at fifth grade classes in each community. The efforts varied according to what participants in each community wanted to do—e.g., walking programs, classes in healthy eating, physical activity, and body awareness and appreciation. Each, however,

was designed to meet one or more of the following principles:

- Accept and value all body sizes and shapes and recognize that everyone can reduce their risk of poor health by adopting a healthy lifestyle.
- Enjoy physical activity every day.
- Take both pleasure and control in eating.

In addition, communities received assistance in building walking paths, purchasing milk machines for schools, obtaining gym equipment and other improvements to help promote wellness. Project organizers even brought in experts from the famous Cooper Institute in Dallas, Texas—founded by cardiovascular surgeon Kenneth Cooper to advance the understanding of the relationship between living habits and health—to help set up community fitness programs. It also brought in a sculptor to show how beautiful the human body is—in all shapes and sizes—using body cast sculptures.

Efforts in the demonstrator communities have concluded, and comparator communities are now receiving the educational materials and some assistance in creating programs. In addition, results are being evaluated and showing some mixed success. The incidence of being overweight in all six communities (even the comparators) went down, but rates of obesity stayed the same, as people with the most weight to lose have not been able to do so. At this point, project organizers have no real explanation as to why that is the case.

As for lessons learned, Moore says they found a common thread. There is a work ethic that keeps rural people from exercising unless it has a productive purpose.

“People are having a hard time shifting to activity for activity’s sake,” Moore says.

Combating Diabetes in Ho-Chunk Nation

Type 2 diabetes runs high among members of the Ho-Chunk Nation in rural Wisconsin, even among the youth. Within the tribe’s six- to 18-year-old population, obesity—a major risk factor for the disease—occurs at five times the national rate.

To help reduce those numbers and the risk of diabetes, the Ho-Chunk Nation Youth Fitness Program in Jackson County, Wisconsin, provides at-risk youth with nutrition counseling and exercise training.

On the nutrition front, a pediatric nutritionist performs in-home family assessments and teaches meal-planning skills. The project focuses on providing low-fat cooking tips, food substitutes and advice on eating out.

The exercise portion of the program includes games, weight training and cardiovascular exercise for older children along with balance, coordination, agility and strength work for younger children. Exercise classes also teach about the effects of exercise on the body.

To help motivate the kids, they get t-shirts, water bottles and field trips. Participation is also encouraged through articles in local newspapers.

The program is a collaboration

Why Is Rural Fatter?

According to *Rural Healthy People 2010*, “there is evidence that rural life presents special challenges to maintaining a healthy weight.” Researchers Tom Tai-Seale and Coleman Chandler list several cultural and structural limitations in rural areas that hamper both diet and exercise.

- Higher dietary fat and calorie consumption, and lower frequency of exercise
- More television watching
- Lack of nutritional education
- Lack of access to nutritionists
- Lack of physical education classes in schools and recreational facilities in general

Finally, there is demography.

According to Tai-Seale and Coleman, “A fair portion of the disproportionate prevalence of obesity in rural areas is caused by the distinctive demographic composition of rural communities. Rural residents are on average older, less educated and have a lower income than urban residents; and those who are older, less educated and have a lower income have greater obesity.”

Source: “Nutrition and Overweight Concerns in Rural Areas: A Literature Review,” Rural Healthy People 2010.

between the Ho-Chunk Nation Department of Health, the Ho-Chunk Nation Youth Services

Program, the University of Wisconsin-Madison Pediatric Fitness Clinic and three rural school districts.

For its innovative efforts, the program received an award from the Pan American Health Organization as part of the 2002 national celebration of World Health Day.

Helping Workers with HealthWorks

In McKean County, Pennsylvania, employers, health care providers and insurers are coming together to promote wellness. The program, known as HealthWorks, is the brainchild of Zippo Manufacturing, Highmark Blue Cross/Blue Shield, and Bradford Regional Medical Center. Its aim—once up and running—is to improve the health of employees and lower their health care costs. So far, 18 employers from the region have signed on to participate.

In May, leaders and representatives of the employers will meet to design specific activities such as a 10,000 steps program in which participants receive pedometers and are encouraged to walk 10,000 steps each day.

In addition to the activities themselves, research will be conducted on the effectiveness of the effort. The Center for Rural Health Practice will evaluate the hypothesis that employers hold such sway over people in rural areas that they can really be powerful change agents when it comes to health, as can churches and community groups.

Indeed, some of the most promising programs are community-wide initiatives, the Center's Michael Meit said. And because rural communities are smaller and tend to have closer social networks, they may be in a better position than urban areas to engage in such initiatives.

"While the challenges are greater, I think it's easier to implement programs in rural areas," says Meit. "I think obesity is [becoming] the number one health issue in this country. Unfortunately, rural seems to be disproportionately affected. We need to get out in front of this thing. We need to be the leader. There's no reason we shouldn't be the leader."

Continued from textbox, page 1

the past president of the National Rural Health Association and currently serves on its Board of Trustees.

In this issue, his "Going (for) Broke" looks at the future of the Medicare Trust Fund.

In addition, starting with the next (Summer) issue of the Monitor, Tom Corbett will write a column on human service issues.

Corbett has emeritus status at the University of Wisconsin-Madison and remains an active affiliate with the Institute for Research on Poverty where, until recently, he served as Associate Director. He has long studied trends in welfare reform and social programs that affect the well-being of vulnerable families. Over the years, he has worked on welfare reform issues at all levels of government, including a year as senior policy advisor at the U.S. Department of Health and Human Services. He continues to work with a number of states through networks of senior state welfare officials in the Midwest and West Coasts and on issues of program and systems integration to deliver better services to challenged families.

GET CONNECTED

For more information on the people and sources described in the previous article, see the following web sites:

Health, United States, 2001 With Urban and Rural Health Chartbook
<http://www.cdc.gov/nchs/products/pubs/pubd/hus/2010/2010.htm#hus01>

Rural Healthy People 2010
<http://www.srph.tamushsc.edu/rhp2010/>

WIN the Rockies
<http://uwadmnweb.uwyo.edu/WinTheRockies/>

The University of Pittsburgh Center for Rural Health Practice
<http://www.upb.pitt.edu/crhp>



Look What's Coming

by Wayne Myers, M.D.

Going (for) Broke

The Medicare Trustees recently announced that the Medicare Trust fund will go broke in the year 2019 instead of 2026 as previously projected. This announcement got a lot more attention than it deserved. Suppose your mechanic told you that your old Ford will need a new engine at a half million miles. HA! That old Ford will be history long before 500,000 miles. And our current way of organizing and paying for health care will be history before 2019.

Of all the money that changes hands in this country, 15 percent goes for health care. Health care has been taking larger and larger bites of our economy for the last 75 years. In 1930 it took about three and a half percent. By 1970 it had doubled to seven percent. We tried regulating the building of expensive hospital beds and gadgets (1974) and putting controls on payments to doctors and hospitals (1984) to rein in costs. Despite these efforts the health bite doubled again in only 25 years, hitting 14 percent in the mid 'nineties.

Health spending growth slowed for a few years as we tried various new business approaches to paying medical bills. But by the year 2000 patients, employers, hospitals and clinicians were fed up. The brakes began to slip. Health care costs are again growing twice as fast as the economy. If this expansion continues as it has ever since the Great Depression, we'll be spending a quarter of our total economy on health care by the time the Medicare Trust Fund goes bust. This won't happen. Our

current approach to organizing and paying for care will break down long before 2019. It is already breaking down. The main payers for health care are employers and government. Health benefits are front and center in labor relations today as we saw in the West Coast grocery workers' strike. Large national companies are renegeing on retirement benefit agreements. Most employers are shifting part of the costs of premiums to employees. Some are quietly saying that they will no longer be able to provide health insurance to their workers by the end of the decade. Similarly, States are finding they can't pay their Medicaid bills. And there is the 15 percent of Americans with no health insurance at all. Medicare looks to be the best funded of the lot.

This cost crescendo is one symptom of the way our health care is organized, or, more accurately, not organized. There is another even more important effect. Our disorganized health care kills a lot of people. For example, mistakes in the care of hospital inpatients kill more people than car wrecks. We can identify several aspects of our health care that simultaneously waste money and kill people. The Institute of Medicine of the National Academy of Sciences has estimated the health cost of medical mistakes and outlined ways to prevent them. The good news is that several of the things we need to do to save lives would also save lots of wasted money. We can have safer care while getting costs under control.

Our health care organization is extremely fragmented. Patients have to cross multiple boundaries between

independent organizations in any major episode of care. When patients cross organizational boundaries, work is duplicated, records are lost, errors creep in and patients get hurt. The death of the girl killed by her heart-lung transplant at Duke a few months ago is an example. The organ blood type got lost moving among hospitals. The costs of duplicate management and record-keeping run into the hundreds of billions of dollars. This fragmentation makes it impossible to develop the kind of error detection systems in use by other industries, such as the airlines.

In the next issue of *The Rural Monitor* we'll look at the Institute of Medicine findings and recommendations. We'll see how small town health care can act on some of these recommendations right now while large systems founder. Rural health care can develop the models to lead the country out of this mess.

Wayne Myers, a pediatrician, founded the University of Kentucky Center for Rural Health and served as its director. He also served as director of the Office of Rural Health Policy in the Department of Health and Human Services' Health Resources and Services Administration. He is a past president of the National Rural Health Association and currently serves on its Board of Trustees.

Around the Country

by Erica Hauck

Pennsylvania

Northwest Pennsylvania Rural AIDS Alliance

Although AIDS is most often associated with inner-city populations, thousands of rural residents are newly diagnosed with HIV every year.

Due to their location, rural HIV patients face barriers that HIV patients in urban areas do not: long commutes to receive health care, difficulty finding a doctor who specializes in the treatment of HIV and AIDS, and the greater sense of stigma and denial of the problem among rural populations.

HIV-positive people in rural Pennsylvania, however, are finding help in overcoming these barriers through the Northwest Pennsylvania Rural AIDS Alliance.

The Alliance, funded primarily through the federal Ryan White Care Act, takes a comprehensive team approach to delivering services to about 200 HIV-positive people in its 10,000 square-mile area, most of them from poor populations. That approach simultaneously addresses the multiple needs and barriers faced by its underserved clientele, focusing not only on access to medical care, but also on other social services needed by its clients. Some of the services provided include referrals to area physicians who specialize in HIV and AIDS care; a traveling clinic that offers early intervention medical services; assessment of eligibility for public programs like Medicaid; mental health counseling; temporary financial assistance with utility bills; provision of food from local

food banks; dental and visual medical care; strategies for adhering to drug regimens and counseling; and overall service management.

According to Alliance Coordinator Jeff Curtis, the major strength of the Alliance lies in its team-based approach to providing comprehensive, “seamless service” to its clients. The organization consists of 16 full-time employees and several contracted professionals who provide clients with a multitude of services under one umbrella. It also has formed partnerships with other organizations in the area to provide social services to its clients and help raise awareness of the issue.

“In rural areas, people often believe it’s not here, it’s not us,” said Curtis. “It’s true that urban areas got it first. But it’s spreading.”

For more information, contact Jeff Curtis, Project Coordinator, at (814) 764-6066, or jcurtis@clarion.edu.

Virginia

Virginia to Create Rural Agency

The State of Virginia is in the process of creating a permanent focal point for rural concerns.

The new Center for Rural Virginia will serve three primary purposes: conducting analysis and research on topics of relevance to rural areas; providing a forum for rural advocacy; and offering technical assistance to rural communities to help them form partnerships and conduct strategic planning. Virginia will join other States—including North Carolina, Pennsylvania, Texas, Georgia and Arkansas—which have cre-

ated State-level agencies for rural concerns.

The Center was established by House bill 1213, which has been passed by both chambers of the General Assembly and is expected to soon be signed into law by the governor. Its creation follows the recommendation of the Rural Virginia Prosperity Commission.

The Commission was created by the State’s General Assembly in January 2000 to study the strengths, needs and priorities of rural areas. It was comprised of State House and Senate members and private citizens and staffed by faculty at Virginia Tech and the Cooper Center for Public Service at the University of Virginia-Danville. After holding six regional public meetings throughout the State and consulting with numerous groups and agencies interested in rural issues, the Commission presented its final report, with a comprehensive set of recommendations meant to be enacted as a package. Many of the recommendations, such as improving capital access and broadband capabilities in rural areas, already have resulted in legislation.

Perhaps the most important result of the recommendations is the creation of the Center for Rural Virginia. Like the Commission that established it, the Center will be composed of private and public sector partners.

However, the Center will be responsible for leveraging outside funds for its operations. The Virginia Senate is expected to approve an appropriation for the Center of about \$150,000 a year, but most of its operating funds will come from private

funds or State and Federal grants.

Randy Arno, a faculty member at the Cooper Center, and a primary agent in the establishment and work of the Commission, said “The Center (for Rural Virginia) will serve as a platform from which to identify and launch programs for rural Virginia, and a means through which to protect rural resources.”

For more information, contact Randy Arno of the Cooper Center for Public Affairs at (434) 489-1535 or Dr. Wayne Purcell of Virginia Tech at (540) 231-7725.

Call for Input

Something newsworthy going on in your part of rural America? Send a one-paragraph summary to the editor at: editor@raconline.org.

Spotlight on Rural Research

by Thomas D. Rowley

A Hungry Irony

Ironically for a nation of overeaters, many in this country have too little to eat—or at least too little of the right kind of food.

According to *The Food Assistance Landscape*, March 2004 by the U.S. Department of Agriculture, 11 percent of U.S. households were “food insecure,” meaning that the households were uncertain of having, or unable to acquire, enough food for all household members because they did not have enough money or other resources for food. Worse, 3.5 percent (3.8 million) of households were food insecure to the point of one or more members going hungry at least some time during the year because they could not afford to eat. On average, food insecure households with hunger experienced the condition for a few days each month in eight or nine months of the year.

To help combat food insecurity and hunger, USDA administers 15 domestic food assistance programs. The goals of the programs are to: provide needy persons with access to a more nutritious diet; improve the eating habits of the Nation’s children; and help farmers by providing an outlet for distribution of food purchased under farmer assistance programs.

In all, approximately one in five Americans participates annually in at least one of the 15 programs. That figure, however, may soon increase due to the soft economy and high unemployment rates. In fact, expendi-

tures for the programs already increased 9.4 percent in fiscal year 2003, to a record high \$41.6 billion. Five of the 15 programs accounted for 94 percent of total expenditures:

- **The Food Stamp Program** is the largest food assistance program, accounting for 57 percent (\$23.7 billion) of spending. The program provides monthly benefits for eligible participants to purchase approved food items at authorized food stores. Participation in the program averaged about 21.3 million people per month; the average participant received \$83.91.
- **The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)** helps safeguard the health of low-income pregnant, breastfeeding and postpartum women, and infants and children up to age five who are at nutritional risk. The program provides a package of supplemental foods, nutrition education and health care referrals. During fiscal 2003, spending for WIC totaled \$4.5 billion. Monthly participation averaged 7.6 million, with children (ages one to four) comprising 50 percent of the total. USDA reports that nearly half of all children (47 percent) born in the United States today are born into families receiving WIC.
- **The National School Lunch Program** provides nutritious low-cost or free lunches to schoolchildren by providing schools with cash and commodities. Any child at a participating school may enroll in the program. Children of families with incomes at or below 130 per-

cent of poverty receive free meals, those of families between 131 and 185 percent of poverty receive reduced-price meals, and those of families with incomes over 185 percent of poverty pay full price, though the meal is subsidized by USDA to a certain degree. Spending for the program in fiscal 2003 was \$7.2 billion, with an average of 28.3 million children participating in the program each day.

- **The School Breakfast Program** provides low-cost breakfasts to schoolchildren, with low-income children receiving free or reduced-price meals under the same eligibility requirements as the lunch program. In 2003, some 8.4 million children participated in the program each school day. Spending for the program was \$1.6 billion.
- **The Child and Adult Care Food Program** subsidizes healthy meals and snacks in participating child care centers and homes and adult day care facilities. Total spending for this program was \$1.9 billion, with a total of 1.8 billion meals served.

Obesity Strikes Even the Needy

In still more irony, even people in need of assistance battle the bulge. Indeed, many low-income people lack the resources to afford or access a healthier, more nutritious diet—relying instead on relatively “cheaper” foods higher in fat, salt and sugar and lower in nutritional content. As evidence of this ironic twist, conversations with providers at rural health

facilities serving the poor reveal a high incidence of obesity, hypertension and diabetes among their patients.

In deep east Texas, Dr. Duane Tisdale sees poor, uninsured immigrants from Mexico at a mobile clinic run by the St. Paul Children's Foundation and the Northeast Texas Public Health District. In addition to their chronic poverty, most of the patients are struggling with chronic diseases—many of them related to diet and physical inactivity.

“People come from another culture and try to adapt to our culture and our diet and they don't adapt well,” Tisdale said. “We see a lot of degenerative diseases related to lifestyle—things like diabetes and hypertension.”

The Food Assistance Landscape, March 2004 is available at <http://www.ers.usda.gov/publications/fanrr28-4/fanrr28-4.pdf>.

For more information on food security and food assistance in general, see <http://www.ers.usda.gov/Briefing/FoodNutritionAssistance/>.



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The Rural Assistance Center
PO Box 9037
Grand Forks, ND 58202
800-270-1898
Fax: 800-270-1913