Scaling Up: Innovative Citywide Collaboration to Improve Community Health in New Haven, CT
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The Community Alliance for Research & Engagement (CARE) at the Yale School of Public Health was established in 2007 to identify solutions to health challenges in New Haven through community action research. We have developed unique collaborations between Yale and the New Haven community, including neighborhood and non-profit associations, hospitals and health centers, city government and public schools, business community as well as faith, arts and cultural institutions. Herein we describe our community-university initiatives to track health, organize for action and strengthen coalitions – and our successes in improving population health.

Tracking Health: New Haven Community Health Needs and Assets
New Haven is a diverse, mid-size city that experiences substantial socioeconomic and health inequities. The population is predominantly racial/ethnic minority subgroups: 35% Black/African American and 27% Hispanic/Latino. Median household income is well below national and statewide averages. Among the 20 neighborhoods that comprise New Haven, six experience the highest levels of morbidity and premature mortality as well as the highest rates of food insecurity, poor housing, violence and crime. In 2012, we documented that obesity prevalence (43%) was 2.5 times higher than nearby towns. Consequently, we note disparities in disease. For example, age-adjusted mortality for diabetes ranges from 51 per 100,000 in the wealthiest suburbs to 80 per 100,000 in New Haven. More striking are disparities within the city, where the mortality rate is only 48 per 100,000 in our high-income neighborhoods and is 87 per 100,000 in our low-income neighborhoods.

CARE has been closely involved in collaborative coalitions investing resources to improve health in New Haven. One of CARE's biggest contributions has been conducting community health assessments in 2009, 2012 and 2015. Using a neighborhood-stratified, population-based randomized design in our six lowest income neighborhoods, the purpose is to understand and document health status, behavior, and perceptions of social and built environments. Recognizing the importance of this work and motivated by requirements of the Affordable Care Act, Yale-New Haven Hospital (fifth largest US hospital system) partnered with CARE to support the 2012 and 2015 surveys. At each timepoint, 20 community residents were hired and trained to conduct interviews, with 1,200-1,300 collected triennially in <10 weeks (70% response rate), and with preliminary results released shortly thereafter. CARE is committed to rapidly disseminating data back to the community — with the intention of helping communities utilize these data to create change. In addition to releasing written reports and social media, community forums were organized in each neighborhood, where staff — including community surveyors — participated and presented data directly back to residents. Action planning focused on interpreting results, generating ideas for interventions, and integrating city and neighborhood efforts. Data also are shared with elected officials and other city leadership; we work continuously with the health department, other municipal entities and various health coalitions across the city and state.

Organizing for Action
Since CARE's initial health assessment in 2009, we have worked within the six neighborhoods — organizing with residents to make their neighborhoods healthier places in which to live and work. Communities most at-risk for obesity, diabetes and other chronic diseases also experience structural barriers within the built environment that prevent people from engaging in healthy behaviors — unsafe streets for walking/biking; lack of access to affordable, healthy foods; limited recreational resources, etc. CARE uses its data to inform, develop and build community support for neighborhood-focused, resident-led chronic disease prevention. CARE hired a team of community organizers to work with these neighborhoods to strengthen local capacity, ownership and sustainability around health. Most importantly, CARE is guided by community organizing principles to train and mobilize residents around health-related issues important to their neighborhoods. Organizers guide groups to identify health priorities, access resources, implement activities and track results. Neighborhood groups meet monthly with up to 60 residents engaged per neighborhood. Collectively, we have:
• Supported the start-up of eight community and school gardens.
• Increased access to farmers’ markets by supporting expansion, implementing mobile markets and working with CT Food Bank’s mobile pantry to reach residents where food insecurity is most severe.
• Implemented traffic calming measures to improve access to parks and recreation facilities through a collaborating between residents and the New Haven Transportation Department.
• Developed marked walking trails and maps in our lowest resource neighborhoods.
• Contributed to work addressing community violence through increased social cohesion.

CARE also has supported traditional public health projects targeting individual behavioral change, including the YMCA’s Diabetes Prevention Program, cooking classes, walking groups, organized sports and exercise.

**Strengthening Citywide Coalitions**

CARE works closely with the Partnership for a Healthier New Haven, a coalition co-led by the New Haven Community Services Administration (which oversees the Health Department) and Yale-New Haven Hospital. Recognizing the potential power of the city’s robust networks – including health service, research and policy organizations – the Partnership convened stakeholders in 2010 to systematically assess and strategize to improve health. CARE engages with municipal leaders and others to develop a local approach to utilize survey findings to inform strategic planning and to develop a community health improvement plan.

The New Haven Food Policy Council (directed by CARE’s Alycia Santilli), a city commission that advises the Mayor, develops strategies to effectively address food access, hunger, obesity and food-related diseases, community and economic development, urban agriculture, nutrition and food education. In 2013, the Food Policy Council’s *Food Action Plan* was adopted by the Board of Alders to establish formal food policy goals/priorities for the City. The Council successfully secured funding for a citywide Food System Director and expanded the reach of New Haven Public School’s Summer Meals Program to feed hungry children by 25%.

**Improved Population Health**

This work – coupled with other health initiatives implemented across New Haven – is resulting in improved population health in New Haven’s low-income neighborhoods. Preliminary data from December 2015 document improvements in several health-related indicators. Most notably, there was a 7% reduction in obesity, decreasing from 43% in 2012 to 40% in 2015. Food insecurity decreased, from 41% in 2012 to 32% in 2015. Forty-three percent of residents reported improvements in their neighborhood over the past three years that make it easier to lead a healthy lifestyle. Residents also feel safer: in 2012, 33% felt unsafe walking in their neighborhood during the day, and 67% felt unsafe walking at night; these rates dropped to 15% and 53%, respectively. We also note improvements in healthcare: 95% of respondents have health insurance, up from 88% in 2012. In turn, residents report improved access in 2015: 87% have a primary care physician; 84% did not delay seeking care due to cost; 81% could purchase needed medicines. However, we are still lagging in terms of healthy diet and physical activity. Only 14% of residents meet minimal fruit/vegetable consumption guidelines (≥5/day) and only 54% of residents meet physical activity recommendations (≥150 minutes/week). Innovative collaborations are still needed to address community health among our most vulnerable populations. Through the first part of 2016, as in other years, we will be disseminating our results directly back to the community at neighborhood meetings and will host a community forum in the spring. We will collaborate directly with residents to utilize these data to improve health in our community.

CARE’s community organizing approach to health and its contributions to local coalitions, combined with rigorous survey methodology, is a unique and effective way to catalyze and sustain engagement, especially in low-resource neighborhoods. This approach can be a model for other collaborative, community-level obesity and chronic disease prevention efforts.

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Redstone Center Symposium Abstract
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Obesity and Chronic Disease Prevention in Boston Chinatown: Collaborative efforts between Tufts University Public Health and Community Agency Partners

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BACKGROUND: This abstract reflects on-going collaborative academic-community work designed to improve healthy weight across the lifespan in Boston Chinatown. The Tufts University School of Medicine (TUSM) Department of Public Health and Community Medicine (PHCM) research group represents a multidisciplinary team that has been working together over the past five to ten years on community-engaged obesity prevention. In 2011, the PHPD investigators, Tufts Medical Center (MC) and other Tufts Schools, along with leaders in service organizations in the Boston Chinatown community created an academic/community partnership, ADAPT (Addressing Disparities in Asian Populations through Translational Research), to develop the capacity for community-based participatory research efforts and health improvement in Boston Chinatown. With Tufts PHCM and MC sitting in the heart of Chinatown, this coalition sought to address disparities and improve community–academic affiliations. As a testament to the shared trust, respect, and vision of the partnership, ADAPT successfully submitted a disparities center grant application to NIH in 2015 to implement two health improvement interventions: a multi-generational diabetes prevention project, and a lung cancer prevention project. Chinatown is a dense neighborhood in Boston, with low median income, high poverty rates, low educational attainment and low English proficiency. The population in Chinatown has increased by nearly 40% between 2000 and 2010, yet the Chinese community in Chinatown is shrinking due to gentrification and a dearth of affordable housing.

SIGNIFICANCE: Prevention of excess weight gain is particularly crucial for diabetes prevention for Asians, and, due to their large and increasing numbers, Chinese Americans. The prevalence of diabetes is expected to double in the next 20 years, with some of the largest increases occurring in Chinese populations. Asian Americans are 30% more likely to have type 2 diabetes than their white counterparts, even though they have lower prevalence of overweight and obesity. Importantly, despite their lower BMI, Asians (and Chinese, in particular) have increased risk for diabetes at lower adiposity thresholds than other groups. This elevated risk reflects that Chinese individuals have a higher percentage body fat than whites with the same BMI, the result of genetic, metabolic, or epigenetic factors and differences in body fat distribution associated with insulin resistance. All of these factors may be exacerbated by chronic stress related to immigration. By CDC standards, rates of obesity in the Asian community have increased substantially, as they are exposed to much the same obesogenic environment as their non-Asian counterparts. Obesity prevention efforts among Chinese across the lifespan are important, with each generation presenting unique challenges and opportunities for prevention efforts.

ACADEMIC/COMMUNITY COLLABORATIONS: The following healthy eating and active living projects illustrate collaborative efforts to foster community and academic capacity, improve health outcomes, and reduce health disparities in Boston Chinatown.

Healthy eating and physical activity among young children: Healthy Chinatown. In partnership with Boston Chinatown Neighborhood Center, Tufts PHCM researchers conducted a survey of parents of children in Boston Chinatown’s child care centers (n=198), a focus group with child-care providers, and identified opportunities to promote healthy living. The survey documented high rates of overweight and obesity (35%), low levels of daily outdoor play (55%), and relatively high levels of daily screen time (65%). Family feeding practices associated with obesity were prominent. More than half of respondents opted to complete the survey in Chinese, suggesting a need for Chinese language educational materials and support. The focus group confirmed perceived cultural and family feeding practices as impeding healthy diet and activity as well as environmental barriers to physical activity. As a result of this assessment, area child-care providers met regularly to prioritize needs and mobilize actions. Due to their efforts, healthy eating and physical activity-related staff development and trainings were provided at child-care centers, at least one playground was renovated by the city, and several center-based play areas were opened to community use.
**Health of Boston Chinatown needs assessment survey.** In collaboration with one of the community-based organizations, Boston Chinatown Neighborhood Center, a community-based random sample survey (Chinatown Survey), funded through a grant from Tufts University, collected broad information on health and resource utilization among adult Chinatown residents. Adults in this survey were mean age 63, 91% were born in China, and 53% received WIC or food stamp benefits in the 12 months prior to the survey. While dietary patterns appeared to be quite good, with high daily fruit (81%) and vegetables (96%) consumption, only 64% percent meet or exceed the national Physical Activity Guidelines. Notably, 20% report a doctor told them that they have diabetes, far higher than estimates for Americans of Chinese descent reported in other studies. Table 1 shows the high rates of overweight and obesity based on the US/WHO standards (for non-Asians) and the Asian cut-offs recommended in the 2004 WHO Consultation. The results of this survey have only recently become available: the data helped shape the recent NIH center grant application, and were shared in a community forum.

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<th>Table 1: Overweight and Obesity in a representative sample of Chinese adults in Chinatown</th>
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<td><strong>Non-Asian definitions</strong></td>
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<td><strong>BMI 25 and 30</strong></td>
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<td><strong>Asian cut-offs points</strong></td>
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**BabySteps** This pilot intervention study with Tufts Dental School demonstrated the feasibility of the first dental visit as the venue for a brief obesity prevention intervention with parents of Chinese children ages 6 to 36 months. Parents completed a short dietary assessment to determine current behaviors. With assistance from dental providers in a coaching role, parents then set a single behavior change goal. Customized guidance delivered in a brief counseling session comprised synergistic messages for early dietary practices and caries prevention. Messages printed on refrigerator magnets reinforced the goal in the home environment. Results indicated parents were eager to make changes for the health of their baby. As a result of this project, we established our ability to work effectively with families of young children living in Chinatown, and identified behaviors for intervention and methods for engaging care providers and parents. ADAPT partners, (including Action for Boston Community Development, which manages Head Start centers) have been eager to adapt the BabySteps protocol to child-care settings and we have co-developed research protocols that have been circulated for funding.

**Housing and health: One Greenway project.** PHPD faculty are currently collaborating with the Asian Community Development Corporation (ACDC) to examine the impact of stable, affordable housing on health outcomes, including nutrition and physical activity. ACDC is the leading regional developer and preserver of affordable housing in Chinatown. This research project will compare healthy eating and active living-related measures between residents who were randomly awarded affordable housing units in a new Chinatown development compared with waiting-listed residents. The results will help shape community development and built environment efforts in Chinatown to promote healthy weight and health equity.

**Chronic disease management among elders:** PHPD faculty are currently collaborating with the Greater Boston Chinese Golden Age Center to develop a sustainable program for diabetes self-management. The Greater Boston Chinese Golden Age Center provides a comprehensive network of culturally sensitive and linguistically appropriate programs and services to accommodate the needs of the Chinese-speaking elders so that they can maintain their independence and wellness at home.

**DISCUSSION:** The academic / community partnerships between the Tufts community and the Chinatown community have facilitated the first steps in community health improvement: community engagement, needs assessment, and program planning. The coalition has only undertaken modest intervention efforts to promote healthy weight in Boston Chinatown, but their successful collaboration to date foreshadow the potential for capacity development, health improvement and the reduction of disparities.
The Alberta Policy Coalition for Chronic Disease Prevention (APCCP): An Innovative Community-University Partnership to Address Obesity and Chronic Diseases through Policy

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For a decade, the POWER (Promoting Optimal Weights through Ecological Research) and PLACE (Policy Location and Access in Community Environments) research programs of the University of Alberta School of Public Health (UofA SPH) have been working collaboratively with practitioners, policy-makers and community organizations to enhance capacity to develop population-based interventions for the promotion of healthy weights and prevention of chronic diseases. Interventions began with community environmental-level interventions (1,2). The strength of the community-level focus of the intervention was in providing an opportunity for community participation in setting the direction of prevention activities by capturing the knowledge, experience, and expertise of community members. Community partnerships influenced local citizens (e.g. community gardens) and broad-level action influencing entire communities (e.g. coalition for active transportation). In all communities, the need to address broader policy issues – whether the need for adequate income support to promote food security, or the need to develop policies to create a built environment supportive of active transportation – were acknowledged as boundaries placed on community-level social change.

The Alberta Policy Coalition for Chronic Disease Prevention (APCCP) [http://www.abpolicycoalitionforprevention.ca/about-us.html] was created in 2009 to:
- Increase the capacity of policy makers and decision-makers in Alberta to use policy as a strategy for chronic disease prevention.
- Provide leadership in the development, implementation and evaluation of policy-related activities for chronic disease prevention.
- Facilitate practitioners, policy-makers, researchers and community organizations from various sectors working together to enhance public acceptance of policy-related activities.

The APCCP consists of 17 organizational members who represent a broad range of practitioners, policy-makers, researchers and community organizations who have come together to coordinate efforts, generate evidence, and advocate for policy change in order to reduce chronic diseases in Alberta. Since 2011, funding for the coalition is primarily provided by the Heart and Stroke Foundation, a member organization of the APCCP. The APCCP builds on models used successfully in tobacco control to extend the policy scope to other behavioral risk factors, including unhealthy diet and physical inactivity, and to the social environment as a means of preventing disease. Our premise is that investment in macro-level environmental changes via policy development will create opportunities for healthy living among the general population that will lead to improved population level risk profiles.

The APCCP concentrates its efforts primarily on policies which affect schools, workplaces, communities and municipalities. To begin, we examined policy influencer’s “appetite” for policy change for obesity prevention (3). Using this knowledge as a justification for interventions relevant to policy advocacy, we have published consensus statements on marketing of foods and beverages to children (4), built environment influences on obesity (5), and taxation of sugar sweetened beverages (6). We have also developed interventions to address policy implementation (healthy food environments in recreation centres) (7), and developed methods to assess food environments (8). The combination of innovative interventions and research methods have moved the field of environmental and policy intervention for obesity prevention
significantly ahead. While health outcome indicators with community level interventions showed minimal change, our objectives have focused on creating public health capacity and environmental conditions supportive of changes rather than health outcome change directly.


A win-win-win: Increasing children’s physical activity and healthy eating during the school day through university, local public health, and school partnerships

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While childhood obesity rates are holding steady nationally\(^1\), Colorado is one of only three states showing an increase in childhood obesity\(^2,3\) with higher overweight rates among rural versus urban children (28.8% vs. 20.5%)\(^4,5\). Public schools are important settings for promoting healthy behaviors and reversing obesity trends\(^7\) and this is particularly true in rural settings because of the higher prevalence of poverty\(^8\), lower population density\(^9\), fewer opportunities for physical activity\(^10\), and greater distances to reach organized activity opportunities\(^11\). Recess and physical education (PE) are sometimes the sole opportunities for rural children to engage in physical activity\(^12\). While there is an extensive menu of effective practices known to increase student opportunities for physical activity and healthy eating in schools\(^13\), most of Colorado’s rural schools have not yet implemented those practices or recommendations\(^14\). For example, one study demonstrated that recess before lunch increased students’ consumption of healthy foods\(^15\); yet 15 years later, only 46% of rural Colorado schools were offering recess before lunch\(^14\).

Innovative approaches are needed across the state and especially in rural communities to increase opportunities for daily physical activity and healthy eating in schools. In 2005, the Colorado School of Public Health’s Rocky Mountain Prevention Research Center (RMPRC) created and tested a strategic planning process called “Assess. Identify. Make it Happen.” (AIM). Based on Intervention Mapping\(^16\), AIM was tested in rural, elementary schools using a pair-randomized control trial and was shown to be an effective method for implementing evidence-based school environment, policy, and practice changes associated with increased physical activity and healthy eating\(^17\). In AIM, schools assemble a task force comprised of 5-8 adults and are guided by a trained facilitator through a 7 meeting process over a 12 month period in which school assess the presence or absence of evidence-based environment and policy features, identify at least 4 evidence-based changes to implement, and make it happen through careful action planning and implementation. In its 11 years, AIM has led to the implementation of over 300 evidence-based environment and policy features in 51 K-12 schools and 17 preschools. Examples of changes include playground markings for games; portable playground equipment such as balls and hula hoops; new playgrounds designed to maximize activity; classroom activity breaks; increasing time for physical education; adding more fruit and vegetable options in the lunchroom; implementing policies requiring healthy snacks; and installing water fountains.
In 2014, the RMPRC joined forces with local public health departments and rural elementary schools to speed up the process of translating evidence-based practices into rural school settings. In 2015, the RMPRC expanded its partnership to include local public health departments and preschools in urban settings. With funding from several sources, the RMPRC recruits schools to participate in this partnership, then trains and certifies local public health department staff to facilitate schools in AIM. The RMPRC provides ongoing technical assistance to public health department staff including a web site (aimschools.net) in which both AIM facilitators and schools can access best practices and resources to help schools make changes. The website has a private page for local public health departments to get resources such as video tutorials on facilitating each of the 7 AIM meetings. Our partnerships bring together the university’s expertise in evidence-based practice, public health departments’ understanding of the childhood obesity problem in their local context, and school members who are affected by the health issue, understand what is culturally relevant, what has been tried before, and what is likely to be successful.

The research focus of AIM has shifted from establishing effectiveness to studying the conditions under which local public health departments can successfully partner with schools to implement evidence-based practices. In this dissemination and implementation science framework, we collect data about local public health departments’ organizational capacity to take on AIM; effects of doing the work on their daily operations; amount and type of technical assistance provided by the university; and the extent to which schools benefit from the process.

This partnership is considered to be a “win-win-win” because it moves all three entities forward on a commonly held goal to reduce childhood obesity and it moves each partner forward on its distinct organization-specific goal. For example, the partnership offers the university an opportunity to make strides in dissemination and implementation research while it provides much needed financial resources for local public health departments to take action on their local public health plan, a requirement of the Colorado Public Health Improvement Act. Finally, the partnership addresses schools’ primary goal: to ensure academic achievement for every student. AIM improves students’ academic success by increasing opportunities for healthy eating and physical activity.

We will discuss the important facilitating roles of our Clinical and Translational Science Award, the Colorado Health Foundation, and the work our founding dean and other long-standing faculty did to build bridges to these communities. We will explore ways in which our school can continue to support these community collaborations, such as working with university officials to expand the promotion and tenure process to place greater understanding and value on public health practice.
References


The Healthy Hawaii Initiative: A multilevel statewide project to address obesity  
Redstone Symposium: March 1, 2016  

Jay Maddock, Ph.D.  
Professor and Dean  

School of Public Health  
Texas A&M University  

Obesity, poor nutrition and inadequate physical activity have become major public health problems across every state in the nation. Schools and programs of public health can play an important role in addressing this epidemic by partnering with health departments and communities to create innovative solutions. In this talk, Maddock will discuss his grassroots approach in Hawaii by working with the state departments of health and education as well as county governments to address obesity.

From 2000-2015, Dean Maddock led the evaluation team of the Healthy Hawaii Initiative, an innovative partnership between the Hawaii Department of Health, the Department of Education and the University of Hawaii funded by the Tobacco Settlement Special Fund. Based on the social ecological model, the initiative included social marketing, school-based interventions, health professional interventions, and community-based policy and environmental change. Major outcomes during the initiative included Complete Streets policies in all counties, a robust safe routes to school program funded by a new surcharge on moving violations, a model schools program and statewide schools wellness guidelines, the development of a statewide obesity taskforce and the creation of the state's first public health institute. The latest win was $13 million grant award from the US Department of Transportation to the County of Kauai for complete multimodal transportation improvements in the town of Lihue. The partnership with the University provided a science and evidence base to the initiative. Over the course of the project, more than 50 peer-reviewed publications were produced many with Department of Health authors. The contract also included funding for three graduate assistants per year resulting in the training of over 25 students. Many of these students are now employed by the state including the state physical activity coordinator and two University of Hawaii faculty members.
Abstract: Policies for the prevention of obesity in Mexico: the role of the School of Public Health

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Director General of the National Institute of Public Health (INSP)

Mexico’s obesity prevalence is one of the highest in the world. The National Public Health Institute-School of Public Health of Mexico (INSP-SPHM) has supported the Mexican Government in developing evidence-based obesity prevention policies. Several of these were implemented by the Ministry of Health in the 2006-2102 administration, including recommendations on beverage intake and a multi-faceted National Agreement for Healthy Nutrition (ANSA) which led to banning sodas and unhealthy food in schools. A main challenge of the ANSA was lack of harmonization between industry interests and public health objectives and lack of effective accountability and monitoring mechanisms to assess implementation across government sectors. An evaluation of the school regulations showed progress but also important implementation challenges which has resulted in partial success. An obesity prevention strategy of the current administration, which was based largely on a position document by the National Academy of Mexico and INSP-SPHM includes regulation of food marketing to children, implementation of a front-of-pack labeling system and nutrition and physical activity promotion. Estimations of own and cross price elasticity of the demand for SSB and modeling effects of different tax levels on weight loss and diabetes prevention by the INSP-SPHM were used in the process for approval of taxes to SSB and junk food by the congress. Civil society organizations have embraced the prevention of obesity as their goal and have used evidence from INSP-SPHM to position obesity prevention in the public debate and the government agenda, and have been key in the approval of initiatives such as taxing SSB. The tax and the new prevention strategy were evaluated by INSP-SPHM and the Population Center at the University of North Carolina. have estimated changes in household purchases of beverages over 2014, after the SSB tax implementation. The data comes from a commercial panel of consumers that contains information on purchases of beverages from households living in 53 cities with at least 50,000 residents. A difference in difference model using fixed effects was implemented. A counterfactual-comparison group was created which represents the expected purchases if the tax had not been implemented. Adjustments were made for the pre-existing downward trend of taxed beverages since 2012 and for macromeconomic variables that can affect purchases (salary and unemployment). A 6 percent average decline in purchases of taxed beverages over 2014 compared to pre-tax trends was observed and the difference accelerated over 2014 reaching 12% by December 2014. Also, a 4 percent increase in purchases of untaxed beverages over 2014, mainly driven by water was found. All socioeconomic groups reduced purchases of taxed beverages, but reductions were higher among lower socio-economic households, averaging a 9% decline over 2014 compared to pre-tax trends. We conclude that the tax did work in terms of reducing the purchases of unhealthy beverages, with potential positive effects on health. The use of the tax revenues for obesity prevention could increase effects even further.

The Mexican experience in fighting obesity, the role of INSP-SPHM, the challenges and lessons learned will be discussed.