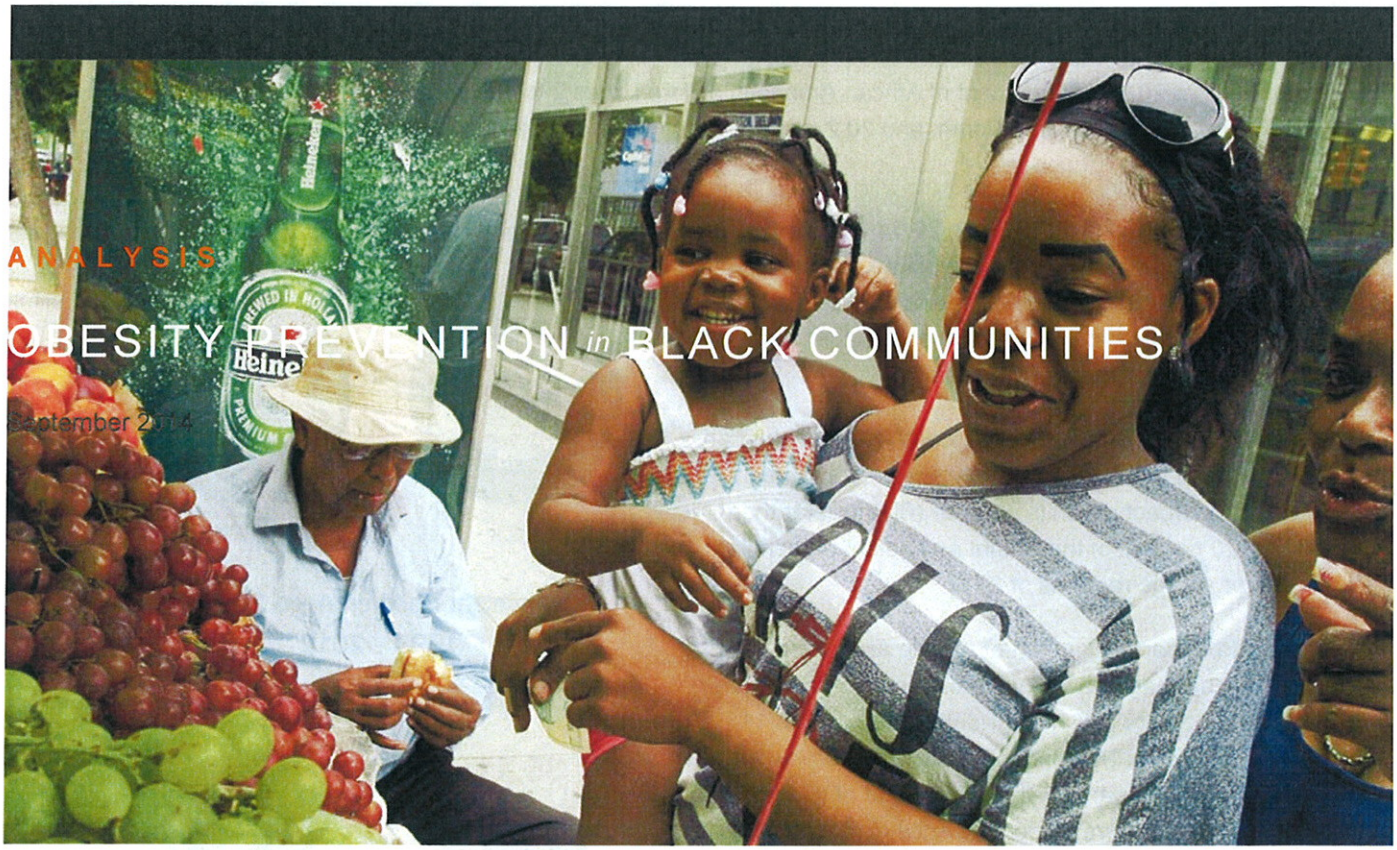
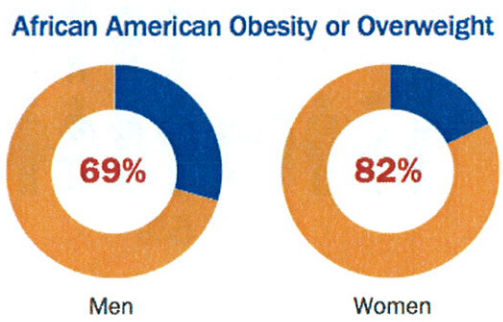


CURRENT STATUS

Inequities in a range of factors — income, stable and affordable housing, access to quality education and others — all influence a person's chance to live a longer, healthier life.[1] These inequities and disparate access to affordable, healthy food or safe places to be physically active, contribute to higher rates of obesity and related illnesses in Black communities.

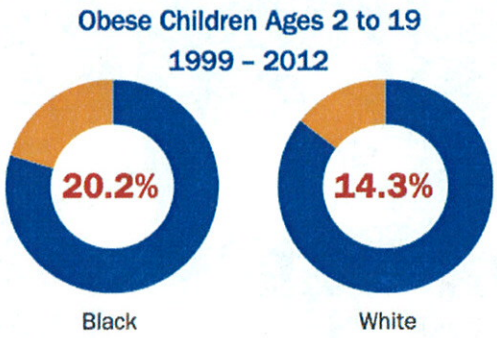
African American adults are nearly 1.5 times as likely to be obese compared with White adults. Approximately 47.8 percent of African Americans are obese (including 37.1 percent of men and 56.6 percent of women) compared with 32.6 percent of Whites (including 32.4 percent of men and 32.8 percent of women).[2] More than 75 percent of African Americans are overweight or obese (including 69 percent of men and 82.0 percent of women) compared with 67.2 percent of Whites (including 71.4 percent of men and 63.2 percent of women).[3]

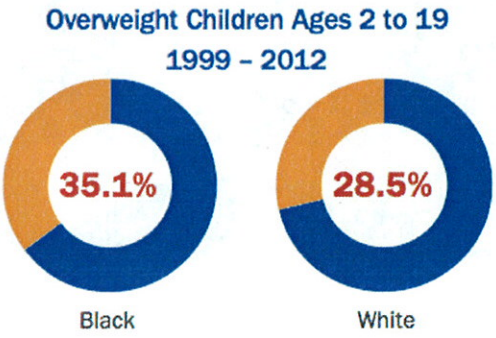


Overweight and obesity rates also tend to be higher among African American children compared with White children, with obesity rates increasing faster at earlier ages and with higher rates of severe obesity.

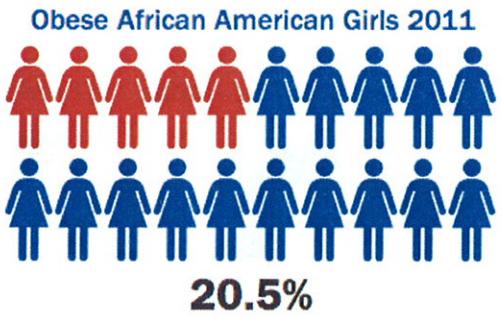
From 1999 to 2012, 35.1 percent of African American children ages 2 to 19 were overweight, compared with 28.5 percent of White children; and 20.2 percent were obese compared with 14.3 percent of White children.[4]

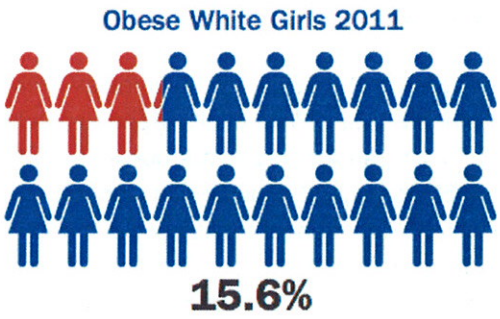
- Nationally, in 2011 to 2012, 20.5 percent of African American girls were obese compared with 15.6 percent of White girls, and 19.9 percent of African American boys were obese compared with 12.6 percent of White boys.[5]
- More than 8 percent of African American children ages 2 to 19 were severely obese, compared with 3.9 percent of White children (BMI greater than 120 percent of the weight and height percentiles for an age rage) as of 2012.[6]
- More than 11 percent of African American children ages 2 to 5 were obese, compared with 3.5 percent of White children. By ages 6 to 11, 23.8 percent of African American children were obese compared with 13.1 percent of Whites.[7] Three-quarters of the difference in rates that arise between African American and White children happens between the third and eighth grades.[8]





Addressing these disparities requires making healthier choices easier in people's daily lives by removing obstacles that make healthy, affordable food less accessible and ensuring communities have more safe and accessible places for people to be physically active.



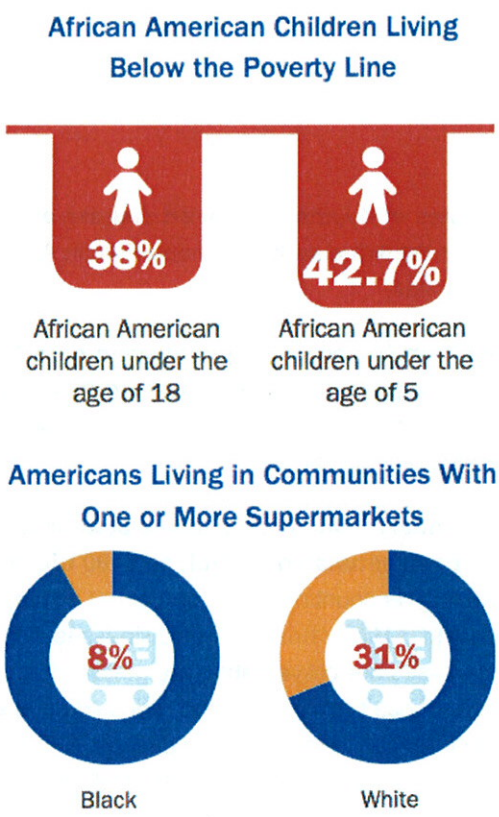


Access to affordable, healthy food

Lower-incomes and poverty correlate strongly with an increase in obesity, since less nutritious, calorie-dense foods are often less expensive than healthier foods.[9] African American families have earned $1 for

every $2 earned by White families for the past 30 years.[10] More than 38 percent of African American children under age 18 and 42.7 percent of children under age 5 live below the poverty line,[11] and more than 12 percent of African American families live in deep poverty (at less than 50 percent of the federal poverty threshold).[12] One in four African American families are food insecure (not having consistent access to adequate food due to lack of money or other resources), compared with 11 percent of White households.[13]

Families in predominantly minority and low-income neighborhoods have limited access to supermarkets and fresh produce. A study of selected communities found that only 8 percent of African American residents lived in areas with one or more supermarkets, compared with 31 percent of White residents.[14] When compared with other neighborhoods, without regard to income, predominantly Black neighborhoods have the most limited access to supermarkets and to the healthier foods such markets sell.[15] According to the 2013 YRBS, 11.3 percent of Black youths did not eat vegetables during the prior week, compared to 4.5 percent of White youths.[16] Black high school students are almost twice as likely to not eat breakfast daily compared with their White peers, which can be a contributing factor to less healthy eating patterns overall, weight gain and poorer performance in school.[17]



Higher exposure to marketing of less nutritious foods

Each day, African American children see twice as many calories advertised in fast food commercials as White children.[18] The products most frequently marketed to African Americans are high-calorie, low-nutrition foods and beverages. Billboards and other forms of outdoor advertisements, which often promote foods of low nutritional value, are 13 times denser in predominantly African American neighborhoods than White neighborhoods.[19]

Limited access to safe places to be physically active

Achieving a healthy energy balance also requires engaging in sufficient amounts of physical activity.[20] As of 2010, African Americans were 70 percent less likely to engage in physical activity than Whites.[21] According to the 2013 YRBS, 21.5 percent of Black youth did not participate in at least one hour of daily physical activity during the prior week, compared with 12.7 percent of White youth.[22]

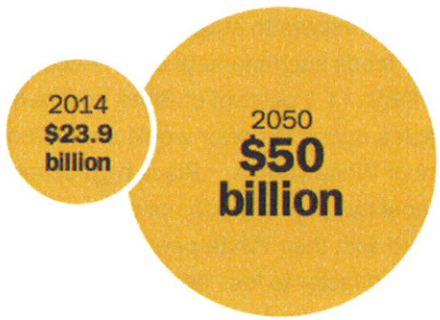
Children in neighborhoods that lack access to parks, playgrounds and recreation centers have a 20

percent to 45 percent greater risk of becoming overweight.[23] National-based studies show that access to public parks, public pools and green space is much lower in neighborhoods largely occupied by African Americans.[24] Safety concerns also further limit outdoor activities among African American children. Sidewalks in African American communities are 38 times more likely to be in poor condition According to a recent study, how African American mothers perceive neighborhood safety, and specifically the threat of violence, strongly influences the amount of daily outdoor play in which their young daughters participate.[25]

WHY INEQUITIES IN OBESITY RATES MATTER

- **The rates of deaths from heart disease and stroke are almost twice as high** among African Americans than Whites.[26]
- **More than 80 percent of people with type 2 diabetes are overweight.** African American adults are twice as likely as White adults to have been diagnosed with diabetes by a physician.[27]
- **The annual medical costs associated with obesity have been estimated as high as $190 billion** (in 2005 dollars) — accounting for 21 percent of all medical spending.[28] High rates of chronic illnesses, which in many cases are preventable, are among the biggest drivers of healthcare costs and reduce worker productivity. A study by the Urban Institute found that the differences in rates among Latinos, African Americans and Whites for a set of preventable diseases (diabetes, heart disease, high blood pressure, renal disease and stroke — many of which are often related to obesity) cost the healthcare system $23.9 billion annually.[29] Based on current trends, by 2050, this is expected to double to $50 billion a year.

Obesity Related Healthcare Costs for Preventable Diseases



- **Eliminating health inequalities — closing the gaps in the health differences by race and ethnicity — could lead to reduced medical expenditures** of $54 billion to $61 billion a year and recover $13 billion annually due to work lost as a result of illness and around $250 billion per year due to premature deaths, according to a study of 2003 to 2006 spending.[30,31]

POLICY RECOMMENDATIONS

- **All public and private investments in community prevention should directly involve local communities** throughout the process, including partnering with Black residents and organizations, as well as understanding the assets and resources within each community, to determine priorities and develop culturally relevant and sustainable solutions.

- **Equity should be a criterion and measure for grants** authorized to address obesity in communities in order to ensure that addressing disparities is a priority goal for a given project or program, and that grantees are held accountable for addressing disparities. For example, at the outset, a program's needs assessments should identify gaps in health outcomes, behaviors and other community features, and evaluation plans should include measures to demonstrate progress toward closing those gaps. Grant requirements must be assessed for feasibility in all communities, to ensure the goals are appropriate and match the existing resources of communities with high percentages of racial and ethnic minorities and low-income populations.

- **Support should be increased at the federal, state and local levels** to address racial and ethnic inequities in obesity.

- **Policies should require that health programs include culturally sensitive communications and language**, and a variety of communication methods and channels — including social media — should be used to most effectively reach communities of color.

- **Strategies and programs need to be developed in conjunction with and led by community leaders and members**, including the implementation of common practices, such as joint-use agreements, to allow community members to use playgrounds and fields when school is not in session and improving zoning rules for increased grocery stores in low-income communities.

- **Increase grant programs encouraging minority business owners to open grocery stores** in low-income communities and ensure that initiatives are sustainable and provide the appropriate support — ranging from financing initiatives to safe, accessible transportation for members of the community — to keep groceries stores open.

- **Standards should be set to limit the amount of advertising of foods and beverages of low nutritional value**, particularly advertising targeting Black children, via television, radio, new digital media (internet, social media, digital apps, mobile phones, tablets, etc.), outdoor ads and point-of-sale product placements. Policies should help encourage increased marketing of healthy foods and beverages to children and families.

EXAMPLES OF STRATEGIES AND CASE STUDIES

- **Nutrition assistance programs can help lower-income families gain access to more affordable food and provide information about healthy eating.** In 2011, more than 3.9 million African American families received SNAP benefits,[32] and, as of 2012, 20 percent of women and children enrolled in the WIC program were African American.[33] Programs such as SNAP-Ed, a partnership between USDA and the states that provides education to help families learn how to eat healthier within a limited budget, and revisions to the WIC food packages that include healthier options, have resulted in increased consumption of more nutritious foods among participants.[34,35]

- **Over the last decade, Philadelphia has implemented a comprehensive strategy to reduce**

obesity rates among children. Between 2006 and 2010, the city experienced nearly a 5 percent reduction in the obesity rates among children in grades K through 12. The biggest declines were reported among kids and teens of color: the obesity rate among African American boys dropped by 7.6 percent. The city created strategies to help improve access to healthy foods and increase physical activity and engaged a wide-range of partners. Efforts included removing all sodas and sugar-sweetened drinks from public school vending machines; implementing a comprehensive, district-wide school wellness policy; banning deep fryers in school kitchens and switching to 1 percent and skim milk; and requiring chain restaurants to post calorie information on menus and menu boards. In addition, they targeted interventions in neighborhoods most in need, such as providing education to public school students whose families were eligible for SNAP and creating new financing methods to attract grocers to open stores in lower-income neighborhoods and supporting safe recreation spaces.

- **The state of Mississippi passed a law in 2012 authorizing local schools boards to allow school property to be used by the public for recreation and sports during nonschool hours.** The NAACP Mississippi State Conference is working to implement shared-use agreements with their partner organizations in majority minority school districts. Their initial efforts have been focused in the Jackson and Indianola school districts. Although the work of the NAACP Mississippi State Conference has been health-focused, they have helped leverage shared-use agreements to help improve health at the same time they help meet other needs within the community. This has spoken directly to the needs of the communities they serve.

- For decades, Tennessee's childhood obesity rates have steadily increased, while equity gaps between Black and White children widen. In Tennessee, 43.9 percent of African American children are obese compared with 21.1 percent of White children.[36] **To address childhood obesity, the NAACP Tennessee State Conference developed an advocacy action plan that expands existing competitive foods guidelines in Jackson-Madison and Haywood County School Districts.** This policy addresses competitive food sales at school activities such as fundraisers and concessions. To gain support for the competitive food sales policy, the NAACP Tennessee State Conference developed partnerships with key stakeholders, including parents and families, faith- and community-based organizations, businesses, and others, and engaged the NAACP youth councils to help with proposed alternative food and non-food options for school fundraisers. Many states, including Tennessee, have existing policies on the built environment, school-based policies and competitive foods. However, many of these policies are not being implemented or expanded. Closing persistent disparities requires advocates and public health professionals to build upon existing policies and hold the responsible entities accountable for implementing them and measuring progress.

ADDITIONAL RESOURCES

NAACP Childhood Obesity Advocacy Manual

Office of Minority Health: U.S. Department of Health and Human Services

Overweight and Obesity Among African American Youth. Leadership for Healthy Communities. Spring 2014.

PUBLIC HEALTH LEADER INTERVIEWS

Maximizing The Impact of Obesity-Prevention Efforts In Black Communities: Key Findings and Strategic Recommendations

May 2014

On behalf of the Trust For America's Health, the Robert Wood Johnson Foundation and the NAACP, Greenberg Quinlan Rosner Research conducted a set of nine one-on-one, in-depth-interviews among public health leaders in Black communities across the country. The participants represent both the public and private sectors and include health professionals, academics and community organizers, among others. The study was designed to evaluate barriers to and pinpoint solutions for reducing obesity in Black communities. All interviews were conducted between April 29 and May 8, 2014.

Black health leaders and activists are deeply aware of the challenges they face in combating the obesity epidemic that disproportionately affects Black communities. They come to the debate with very clear insight into these challenges, from specific barriers at the community level to broader, systemic hurdles that extend state- and nationwide.

These health leaders generally feel that many identified policy approaches to prevent and control obesity offer strong promise, but that there have been a number of hurdles that get in the way of these policies being successfully implemented in Black communities.

They identified three key areas to work on to improve the implementation of policies, including:

- **Addressing socioeconomic and environmental factors**, particularly less access to healthy, affordable foods and a shortage of safe, accessible spaces for physical activity;
- **Providing increased education about healthy choices and how to make these choices more relevant to their daily lives**;

- **Developing partnerships and sustained programs**, including the need to 1) engage leaders to feel and take shared ownership of the long-term success of an initiative; and 2) create models where local, state and national organizations form lasting collaborations, access to ongoing resource and a shared set of priorities and goals.

Addressing socioeconomic and environmental factors to promote healthy, affordable nutrition and access to safe places to be active.

Recommendation: *Focus on making existing policy initiatives more scalable, sustainable and equitable across all neighborhoods and income levels.*

The health leaders interviewed felt there is a lot of attention on making healthier foods more affordable and accessible, and developing safe, accessible places for people to be physically active — but the hurdles to achieving these goals are still very steep.

While the general policy approaches toward obesity prevention and control are viewed favorably, there is a strong sense that the initiatives introduced on the ground level are not scalable or sustainable in their current forms. There is also recognition that the resources invested in these solutions are often short-term grants and are woefully insufficient to match the scope of the problems.

Some key policies the health leaders stressed included:

- Allowing the community to use school facilities for non-school recreational activities before and after school hours.
- Making healthy foods more affordable and available in all neighborhoods.
- Adopting public safety and crime reduction initiatives to give families safe access to recreational facilities and parks.
- Focusing on improving nutrition and increasing activity for young children, such as through efforts or regulations in daycare centers.

They stressed the importance of developing strategies for the range of other factors that impact health — such as accessible, safe, affordable transportation and housing — as a coordinated part of any successful effort to address obesity.

They also quickly point out the need to find improved ways to make these initiatives equitable — across all neighborhoods. There is an acute sense of the different resources available in higher-income versus lower-income neighborhoods — ranging from well-kept green spaces to quality grocery stores. And there is a desire for continued focus on policy changes that help improve resources for everyone, which, they

believe, will help an entire community thrive. For instance, the leaders emphasized that the inability to access healthy food was both a financial and geographical hurdle. Many work with low-income individuals living in food deserts or food "swamps" (where there is a glut of unhealthy fast food options) and if healthy food is available, it is usually not economical.

These leaders also stress the importance of designing or redesigning the physical infrastructure of a neighborhood to incorporate safe, accessible sidewalks, public transportation options, parks and exercise trails.

Accessible, affordable healthy nutrition

> *"We need to increase the opportunity for healthy food. All healthy options are concentrated in one area of my city; availability is different, based on different neighborhoods."*

> *"The access is there, but for people with limited resources, they can't afford it."*

Safe, accessible places to be active

> *"A healthy community should have some place that's safe and welcoming. And the ability for all family members to be outdoors, to exercise openly in a safe environment."*

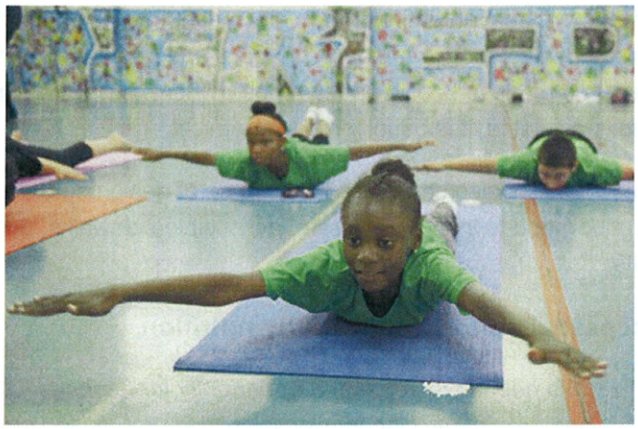
> *"Equitable access to green space. On the more affluent side of my city, there are sidewalks — a lot of them have been redone. There are biking lanes. And then you have other areas; we have three income-based housing projects within a half mile radius, and there's not much green space available there. There is also a city park, but it's been largely neglected."*

Educating about healthy choices and making them more relevant to daily life

> ***Recommendation:*** *Focus on policies and programs that are social, enjoyable and integrated into daily life and routines.*

The health leaders raised concerns that there is not enough information available in many Black communities about why and how to make healthy choices. Specifically, there was concern about the lack of education provided by both schools and the medical community. Giving a community funding to combat obesity is not enough — Black community leaders are quick to point out that change cannot start to take hold unless there is a proper education campaign to accompany these resources.

Another challenge is that conversations about the obesity epidemic often focus on the issue of weight



rather than on health. For example, education about how good nutrition and increased physical activity can reduce risk for or help manage type 2 diabetes, heart disease and stress is lacking. There also is not enough information about ways to manage buying healthy food within a budget.

The participants also emphasized a real need to increase education attainment to combat the greater socioeconomic and environmental factors at play. For instance, the health leaders emphasized the need to increase education to promote good nutrition and increased physical activity to counter the fact that food of lower nutritional value is often more easily available and cheaper, and there is such heavy intensity of marketing junk food in these communities.

The health leaders stressed that some of the most important ingredients to creating successful, long-lasting programs are often not addressed: making them social, enjoyable and integrated into daily life and routines.

For instance, the health leaders in these Black communities place a high premium on the need to teach healthy behaviors in a social atmosphere. As an example, some of the most effective programs they highlighted — or would like to see implemented in their own communities — are healthy cooking classes, and taking advantage of shared-use agreements to start walking clubs, athletic teams and dance classes for both children and adults.

In addition, they emphasized the need to meet people where they are, and make efforts fit into people's needs. Every person, neighborhood, or community has different needs; a "one size fits all" approach to reducing obesity is not sustainable. This goes hand in hand with the social aspect — the programs need to be relevant to the specific community. Many of the participants highlighted cooking classes as an effective way to reach Black communities, not just for the social aspect but also for the usefulness in teaching nutrition and even food budgeting. "This needs to become part of the lifestyle. We need to figure out ways to make Southern cuisine healthier. There has to be a way to retain some of the style and tradition, but with healthier options," said one participant.

Increased education about health and healthy choices

> *"There's very little preventive advice. Most times, people aren't getting any advice on how to get healthy and make small changes, even from their doctor."*

> *"Schools need to educate students about nutrition, so they can make better choices. Parents need to be educated because they did not have the advantage of schools that were providing that sort of information — I think we can all become better advocates for promoting healthy options."*

"It takes commitment from the community to see that this is not fly by night. We need to continue to work with young people to get them to see, early on in life, that if you're healthier, you feel better, you learn better."

Making initiatives social and fun

"There was a man in our community that was working on losing some weight, and so he was getting on the radio, encouraging and challenging parents, students, everybody, to come walk with him. And he wanted a really, really large group of people — they would walk for 30 minutes, and for kids, every time you walked, you got to put your name in for a drawing. That worked really well."

"For kids, [these efforts] would work if you make it fun and social, if you did it around games, activities and sports. Kids want to be part of the group; it's social for them."

Developing Partnerships and Sustainability

Recommendations: *Focus on building lasting programs and community engagement — including buy-in from the outset, shared ownership and goals, coordination with existing assets and efforts and providing programs and services that help connect with the needs and interests of the members of the community — from the outset.*

The health leaders reported feeling that many of the obesity initiatives introduced in their communities do not have built-in goals of sustainability, long-term focus or strategies that engage people within the community to take ownership. They report there is a need to improve the connection between state and national agencies and local communities, including mechanisms to get "buy-in" from individuals within the community, as well as from policymakers and other change agents.

Building sustainable programs in a community requires this buy-in at the outset. National and state groups often have the ability to develop and evaluate particular approaches and provide financial resources, but unless the community has shared ownership and a shared sense that an initiative is a priority or fit for that community, there is little likelihood that the initiative will gain traction or be successful. Local health leaders have a strong interest in partnering with national and state groups because they recognize the expertise and resources those groups provide. Yet local health leaders also are calling for more shared priority-setting and additional support for technical assistance aimed at engaging and training leaders in communities to take ownership of initiatives.

The leaders reported the main procedural barrier to programs comes from a lack of coordination — which could be addressed by ensuring there is a shared vision from the outset and that there is clear, consistent communication across groups. It is also important to learn about the organizations and agencies already

in a neighborhood or community. In many cases, there are groups — such as initiatives by other community- and faith-based organizations or are provided through education or other social service systems — that already exist with shared visions, but there may be limited or no attempts to understand, connect and coordinate with their efforts. The leaders stress the importance of making sure public health officials consult with the communities about existing assets, structures and processes as an essential ingredient when trying to make systemic changes.

The leaders discussed examples of effective programs, which included having a community leader or organization heavily involved in the effort and a sense that the initiative was helping support multiple objectives within a community, such as a shared-use agreement that supports youth sports or walking clubs, which can help foster stronger social and community connections, provide a safe afterschool environment and serve as a crime prevention strategy. The most positive examples of policies and activities focused on making healthy decisions part of a daily routine for both adults and children.

The leaders acknowledge there is often a lot of discussion about community engagement as part of public health initiatives and underscore the importance of having a shared definition of what this means from the community's perspective.

Building Sustainability

"I think what works is when groups and organizations, and even individuals, get community buy-in. That's very important, because when you look at it from the standpoint of implementing programs or policies, then it has to be sustainable — so even if funding runs out, then you've made inroads within the community."

"I think, when you have these parachute programs where they kind of drop in, do work and disappear, that's not effective. But when there's an investment in empowering the community to become the program, and become leaders of the program, that's very effective."

Improving Partnerships and Coordination

"Someone has to step up, take the lead, and say, 'Here's what we'd like to do, would you like to sit at the table with us?'"

"There's sometimes a general lack of engagement between organizations. Organizations become sort of a silo, and I'm thinking it becomes siloed because of funding. Everybody wants to identify funding sources and go out and do the work. But the challenge in that is that even if you're competing against organizations — in some sense — to get the funding, you want to hold on to what you have. And they don't fully engage other organizations in a way where everybody benefits from it."

"I think we need to get the word out in a way that the community understands. And I think, often, the state agencies don't drill it down, or they don't know how to get it to the folks that

need it the most."

"For me, from start to finish, the process has to include community engagement and data engagement. So, every decision that we make along the way, we make it based on community input AND data input. And let both tell us where we need to go."

COMMENTARY

The Next Step in Reducing Obesity in Cities, Towns and Counties: Focusing on Vulnerable Populations

by Leon T. Andrews, Jr., Senior Fellow, National League of Cities

Not too long ago, managing obesity was seen solely as an individual responsibility. However, as obesity rates began their steady climb upward over the last decade or so, local leaders and residents began to understand more fully the risks obesity can pose to their neighborhoods, communities and cities, and the role good government policy and action can have in helping people get and stay healthy.

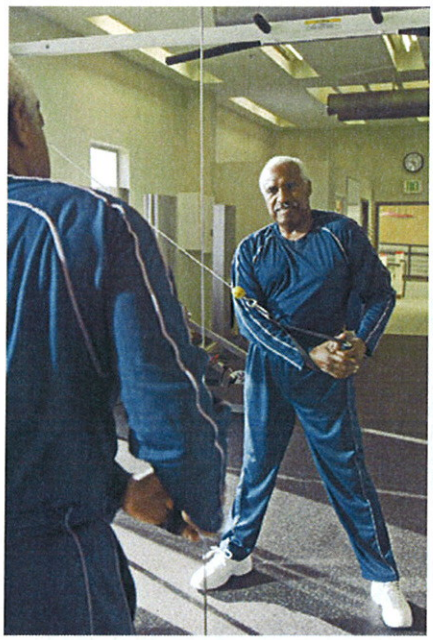
As this shift in public consciousness grew, mayors in cities across the country began to champion public policies that promote healthy eating and active living. These policies are meant to create more walkable, bikeable and transit-accessible neighborhoods, and to encourage better use of and increased connectivity between recreation centers and parks. They have commonly been implemented through shared-use agreements, land use agreements, community gardening initiatives and complete streets and active transportation policies. The most effective policies have been put in place by local leaders that were able to tap into specific community resources.

Clearly, mayors have an important role to play in forming partnerships and using their influence to put policies aimed at reducing obesity in motion. They are uniquely positioned to encourage citywide implementation of policies and programs that promote healthy communities.

Today, policies to increase healthy eating and active living are being implemented all across the country. For instance, in Philadelphia, Mayor Michael Nutter has led a number of policies that have revamped how

the city approaches public health through food financing. The mayor, his staff and partners have forged public-private partnerships and provided incentives resulting in almost 20 retail sites offering fresh fruits and vegetables to low-income neighborhoods in Philadelphia. Elsewhere in Pennsylvania and across the country, we've seen the Fresh Food Financing Initiative become a major model for assisting lower income people gain access to fresh, affordable food.

We've also seen shared-use agreements welcomed wholeheartedly in communities throughout the South. In larger southern cities, complete streets policies have been incredibly important, while in both large and smaller communities mayors have worked to maximize community gardens and farmers markets. In particular, mayors have embraced policies that require farmers markets to accept Women, Infants and Children and Supplemental Nutrition Assistance Program benefits.



For example, in Mississippi, communities have particularly embraced land use protection for community gardens. And Jackson, Miss. is one of a few cities to really look at how their city is oriented and figure out ways to improve walking and biking.

There is similar work going on in Hernando and Tupelo, Miss., Charleston, S.C., Little Rock, Ark., and Baton Rouge, La. Some of these cities don't get mentioned as often as they should, but they are definitely leading the way in making policy changes that result in healthier communities.

At the same time, while the creation and support for these polices are great wins in the battle against obesity, it's unclear whether they are actually reaching and benefiting those in the most vulnerable neighborhoods. Complete streets policies, for example, have helped cities redesign their downtown, but often left other neighborhoods — where more economically disadvantaged people reside — largely untouched.

The next step in the fight against obesity is moving from action to evaluating impact, i.e., making sure that health-promoting policies reach the communities that need them the most. There is far more to be done in this arena — mayors want to know how to target policies to ensure they are reaching their most vulnerable citizens.

Unfortunately, we aren't there yet, but the conversations are happening and the wheels are starting to turn faster. And there is reason for optimism.

One notable example is *Let's Move!* Cities, Towns and Counties (LMCTC), which is focused on several important areas connected to health disparities, including: training early childcare and education providers to promote physical activity and healthy eating; providing healthy foods to school-aged children before, during and after school and/or during the summer; increasing access to healthy foods where cities offer and sell food; and ensuring appropriate city lands are optimized for play.

So far, 425 local elected officials are engaged in LMCTC and moving forward important policy work focused on children and vulnerable populations. Also, there is a strong southern presence — Arkansas,

Mississippi, Alabama and other states, which is particularly important given that region's high obesity rates and poverty levels. These are exactly the places we need to reach to truly stem the tide of obesity.

LMCTC is just one opportunity for mayors to maximize their leadership and use their voice in addressing the health of their community, and, in particular, the health of vulnerable populations. When we talk about moving the needle, this is the logical progression.

NOTES

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