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Recommended Citation

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The Politics of Traditional Foodways in the Arkansas Delta

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Abstract

In response to skyrocketing rates of childhood obesity, state and federal policymakers have developed public school-based programs to fight “America’s pandemic obesity problem.” These programs have focused on promoting “healthy” lifestyles without attempting to explore the cultural or political factors that underlie childhood obesity. One such program was the cornerstone of former Arkansas Governor and Republican presidential contender Mike Huckabee’s Health Arkansas Initiative, Arkansas’ Act 1220 of 2003. The “BMI Initiative” (repealed in 2007) required annual school reporting of Body Mass Index scores. This paper examines BMI Initiative data and the creation of rural foodways—now considered traditionally African American and Southern in the Arkansas Delta—to demonstrate how African American views and behaviors conflict with dominant medical and political definitions of health. Policies that have arisen from public health constructions of obesity allow the politicization of body image for a culturally specific, hegemonic ideal of beauty that ultimately devalues Southern African American women and allows structural inequalities in health care to be effectively ignored.
Rates of obesity in America have reached unprecedented levels with as much as 65 percent of the adult population and 16 percent of children and adolescents now classified as overweight or obese (CDC 2006a). Obesity is pathologized by the medical community and the media and constructed as a primary global risk, effectively relegating obesity-related disease to the status of secondary risk. Not only do state and federal government groups support studies of obesity, but weight loss has become an American obsession. Popular television programs such as *Oprah* and *Dr. Phil* constantly feature discussions about the dangers of fat in American diets and about nutritional supplements and body surgical techniques that seem to offer solutions. Efforts from the $30-billion-a-year diet industry, however, focus not so much on health benefits from weight loss (substantiated mostly through reductions in diabetes) but emphasize improvements in self-confidence and good looks. The federal government provides nutritional guidelines and promotes physical activity, and the aims of public policy have followed suit, creating a rhetoric of individual responsibility in the war on fat. In an attempt to curb what is increasingly referred to as “America’s pandemic obesity problem” (Tillotson 2004), state and federal policymakers are beginning to focus their attention on the role of nutrition education and physical activity in public schools. Public school students in Arkansas, Florida, Tennessee, Illinois, Pennsylvania, Texas, California, Delaware, Missouri, and West Virginia all have some sort of BMI testing (Wickline 2007, 2-B). However, instead of understanding obesity as a behavioral pathology, this paper views overweight as a normal biological and behavioral response to obesogenic conditions, as well as a socially constructed category closely tied to socioeconomic status (SES), environment, and ethnic identity. No matter how well intended, policies that promote a single culturally determined vision of a *healthy* lifestyle will not be sufficient to create effective change in providing for the health and well-being of public school students and their communities.
The terms *overweight* and *obese* refer generally to weights considered unhealthy, at which the likelihood for developing certain diseases and health conditions, such as hypertension, heart problems, failing hips and knees, and diabetes, is increased. While more accurate methods of determining body fat percentage exist, Body Mass Index, calculated from an individual’s height and weight, is the measurement used most often in studies, since it is easy to calculate. An adult with a BMI falling between 25 and 29.9 is considered overweight, while an adult with a BMI of 30 or above is considered obese. The formula for categorizing BMI in children and adolescents differs slightly, placing individuals within specific percentiles referring to the relative position of the child’s BMI number among children of the same gender and age. A child is considered “at risk for overweight” with a BMI falling between the 85th and 95th percentile, and “overweight” with a BMI equal to or greater than the 95th percentile (CDC 2006b). BMI statistics can be alarming, but it may not be the weight Americans sustain that causes long-term health problems as much as Americans’ lack of exercise and balanced eating. Diet plans are largely unsustainable, and yo-yo dieting apparently causes increased rates of mortality.

With an overweight/obese rate of 63.1 percent, Arkansas ranks as the sixth fattenest state in the nation (Levi, Segal, and Juliano 2006). In 2003, Arkansas became the first state to require all of its K-12 public school students to have an annual BMI assessment (Act 1220). The bill also set forth general rules regarding nutrition and physical activity aimed at providing “students with the skills, opportunities and encouragement to adopt healthy lifestyles.” Among the key provisions of Act 1220 were the following requirements: “annually report each student’s BMI to his or her parents and provide families with information about the importance of nutrition and physical activity, bar student access to food and beverage vending machines in
elementary schools, and disclose food and beverage contract agreements, including revenues and expenditures.” In addition, a Child Health Advisory Committee was created and, based upon the committee’s recommendations, schools were subsequently also required, among other provisions, to “improve access to healthy foods in cafeterias, limit access to competitive foods (such as vended snacks and beverages) and ensure that products offered meet strict nutrition standards” (Act 1220 of 2003).

Headed by the Arkansas Center for Health Improvement, the Body Mass Index Initiative has resulted in a BMI database for approximately 97 percent of Arkansas’ public school students. According to the nationally published results of the third-year study, “analysis of the BMI assessments reveals that the progression of the childhood obesity epidemic in Arkansas has been halted” (ACHI 2006b). This conclusion, however, seemed premature to the members of the 2007 General Assembly that replaced the Huckabee initiative with Act 201. This new act will require BMI measurements to be taken less frequently and will make it clear to parents that they have the right to refuse to have their children tested. Between 2003 and 2006, the overall BMI of Arkansas schoolchildren dropped from 38.1 percent to 37.5 percent—a decrease of only 0.6 percent. The largest drop in BMI, from 38.0 percent to 37.5 percent occurred from 2005 to 2006 (ACHI 2006b). By 2007, data seemed to indicate that the weight of children was either leveling off or increasing slightly. Furthermore, 80,000 Arkansas public school children were not tested, either because they refused to participate in the study or were absent from school when measurements were made. In year one of the study, 10 percent of those whose BMI could not be measured were listed as “child refused to be measured”; in years two and three, this reason accounted for 17 percent and 19 percent, respectively, of those who could not be measured. “Parent refused” was listed as between 21
percent and 24 percent during the three years of the study. An Arkansas Delta school nurse was quoted as saying that those who opted out were “usually the ones that need it” (Peacock 2006). Figures reported for the 2006-2007 school year showed that more than 50 percent of the students in four school districts (Bearden, Palestine-Wheatley, the KIPP Delta College Prepatory School in Helena-West Helena, and Strong-Huttig) were overweight (Wickline 2007, B-1). All of these school districts are in eastern Arkansas.

Upon closer examination of year-to-year data, it appears that the only groups that made (slight) progress were Caucasian males and females and Hispanic females. The two groups with the highest overweight/obese percentages, Hispanic males and African American females, saw little change. The percentage of Hispanic males classified as overweight/obese actually rose from 50 percent to 51 percent from 2004 to 2005, and then dropped back to 50 percent by 2006, while the percentage of African American females classified as overweight/obese remained at a relatively constant rate of 44 percent throughout all three years of the study. By the twelfth grade, all groups except African American females reached approximately the same population percentage of individuals classified as overweight/obese. All male subgroups’ rates leveled off at 36 percent to 40 percent; Hispanic and Caucasian female rates declined to almost exactly 30 percent, while African American female rates jumped to approximately 45 percent (ACHI 2006a). Arkansas State Surgeon General Joe Thompson acknowledged that the rate of valid assessments had declined from 85 percent in 2005-2006 to 77 percent in 2006-2007 (Wickline 2007, B1).

With an overweight/obese population of approximately 64 percent concentrated mainly in the rural South, African American women nationwide are at a much higher risk for obesity than any other subgroup (Baturka, Hornsby, and Schorling 2000; Peralta...
2003). Statistically, all of the following populations are most at risk for becoming overweight or obese: African Americans, females, those of low socio-economic status, residents of areas of ethnic segregation, residents of the rural South, and those with low levels of education (CDC 2006b; Chang 2006). According to the BMI Initiative data, rates of childhood obesity are highest in the Arkansas Delta where 25 percent of children are obese, compared with 16 percent nationwide (ACHSI 2006a). The Delta, with current and historical conditions marked by exploitation of human and agricultural resources, economic depression, and ethnic segregation, also has high rates of high blood pressure, diabetes, stroke, cancer, and heart disease. Low birth weights, high infant mortality rates, and infrequent medical care add to the region’s poor health profile. Convenience stores outnumber supermarkets, and fruits and vegetables are relatively expensive. Delta diets are long on carbohydrates and sugars, short on vegetable, fruit, and dairy products, and fried potatoes make up one-third of all vegetables eaten (Champagne et al. 2004). Considering these risk factors, the Arkansas Delta can, in fact, serve as a microcosm for examining public health policy and the ways in which the numerous causes of obesity intersect to create unhealthy environments.

The portion of the Mississippi Alluvial Plain known as the Arkansas Delta encompasses ten million acres of land and is characterized by rich soils, plantation agriculture, ethnic and social stratification, and the most extreme and persistent poverty in the United States. The area’s extensive waterways, while nourishing the soils, have also caused periodic flooding and swamp-related diseases. Droughts and boll weevils, enervating heat, deadly pests, pellagra, dysentery, malaria, typhoid, diarrhea, and hookworm combine to cause the Delta to be considered the least healthy section of America. The Delta remains fairly isolated today, which has also led to the region’s “subcultural
persistence in mass society” (Reed 1972). Today, the Delta’s historic natural abundance is practically no more; the swamps and age-old aquifers have been drained, runoff from agricultural chemicals pollute the streams, and the once-lush forests have been clear-cut (Gatewood 1993). Such environmental devastation has long been linked to poor public health. Large-scale cultivation in the Delta relied on slave labor, and later, on black and white tenant farmers. To this day the region retains a significant portion of the state’s African American population.

Historically, cotton is the main crop of the Delta, and as food selection for slaves was linked to the agricultural objectives of planters (Cobb 1992; Semmes 1996), widespread cultivation of a non-food, nutrient-intensive crop such as cotton had devastating and lasting effects on nutrition and health in the Delta. The cheapest and most easily preserved foods were pork and corn meal; thus, these became the core staples of the Delta diet. The plantation owners’ leftovers, which provided slave rations, usually consisted of three to four pounds of fat pork and a peck of corn meal. Diets were later supplemented with rice and wheat products, but the availability of these products was limited. Pork, considered by doctors of the time to be high energy and thus suited to slaves and laborers, was ubiquitous, and every part of the animal was used—down to the feet and intestines. Methods of preservation were not uniform, but the meat was generally preserved with large quantities of salt, which significantly degraded its nutritional value. Other methods of preservation included smoking and pickling, and many slaves never consumed fresh meat. Certain types of poultry, mostly chickens, were also present, but were usually reserved for Sundays and special occasions, if they weren’t sold. This limited availability (combined also, perhaps, with the preeminent symbolism of the chicken in West African culture) contributed to the view of chicken as a prestige food (Carney 1998; Semmes 1996).
In their own small garden plots, slaves grew turnips, sweet potatoes, cowpeas (black-eyed peas), cabbage, collards, pumpkins, okra, onions, and squash. Slaves also fished and hunted; the game most often caught included rabbit, opossum, and raccoon. Most of these foods, however, did not contribute significantly to diet, as they were usually sold or used by the plantation owners. Hunger and instances of nutritional disease are highest when vegetable consumption is lowest, and the vegetables that did make it on to the tables of slave families were cooked for hours with fat pork or bacon, greatly diminishing the nutritive content. *Potlikker*, the liquid left over from boiling vegetables and pork, retained some of the vitamins of the vegetables and was eaten with cornbread. The methods of cooking all available foods consisted of boiling or frying, most likely because the only utensils readily available were large cooking pots (Whitehead 1984; Semmes 1996).

The diets of African Americans did not improve after the Civil War. Freed slaves were landless and penniless and forced to work under a sharecropper system that was slavery in everything but name. Cotton was still king and still in competition with food production, and after years of harsh cultivation, soil qualities began to diminish, compounding the lack of dietary diversity. The diet of sharecroppers through the 1930s was almost identical to that of slave culture, and throughout the South, rural tenant farming families who owned no land and little more than the clothes on their backs, depended on landowners for meal, coffee, lard, flour, molasses, pork (often fatback), and the ever ubiquitous snuff and tobacco. When landowners had a store or commissary, prices were grossly inflated and credit charges were exorbitant. Corn remained the staple gain, eaten as hominy, roasting ears, or cornbread. Landowners typically supplied sharecroppers with a cabin and a garden plot, which provided some seasonal corn, Irish potatoes, collards, turnips, okra, peas, and...
beans. The combination of inadequate diet, heavy work, and excessive use of tobacco was often devastating.

In theory, landowners were not tied to working on a cotton farm and could diversify their diets by growing food. However, many land-owning farmers depended upon the sale of homegrown fruits and vegetables to buy staples. In Georgia during the 1920s and 1930s, vegetables probably made up “less than one-tenth of the food consumed by the mass of rural families” (Semmes 1996). These foodways still form the basis for the diets of many African Americans and Southerners and will prove very difficult to change, because, as Clovis Semmes (1996, 53) writes:

> Maladaptation to antibiosis is the dysfunctional way in which people may adjust to the constraints of exploitation in order to survive. Poor dietary habits that derive from adaptation to limited, inadequate, and nutritionally imbalanced food sources are examples. Adaptive responses are initially circumstantial and conditional but can become dysfunctional cultural habits. In the context of cultural hegemony, dysfunctional cultural habits are very hard to alter because they are frequently reinforced by the system of exploitation and subsequently have become tied to the identity of the group, whose members now view such habits as traditional.

While agricultural mechanization was hailed as an advance that would contribute significantly to public health (Levenstein 2003), it had the opposite effect in the Delta. Sharecropping all but disappeared, and the drastic reduction in cotton acreage due to federal legislation cut day labor employment as well (Cobb 1992). Food shortages increased in times of drought, and the New Deal relief programs increased the breakdown of home-production and dependence on store-bought foods. Younger generations who were lucky
enough to be employed in federal programs like the WPA had far less time for and interest in gardening, while older generations still placed prestige on self-sufficient food production (Bennett, Smith, and Passin 1942). The diets of Delta people, in the past and today, were rich in carbohydrates and salt, and low in fresh, leafy vegetables. The change from a subsistence to cash economy meant that canned meats were substituted for wild game and fish and candy bars replaced home-canned fruits. Homegrown vegetables, wild greens, fish, and game such as squirrel, opossum, raccoon, and frogs became stigmatized (Bennett, Smith, and Passin 1942). This shift in foodways mirrored the mechanization of agriculture, further degradation of soil composition and a changing definition of success—from the possession of land to the possession of cash. Welfare payments, and the movement from commodities (ironically, surpluses given away to benefit the agriculture industry by driving up prices—still effectively the leftovers of plantation owners) to food stamps in the late 1960s, sealed the dependence on purchased (and less nutritious) foods (Levenstein 2003). In fact, this transition from agricultural surplus to food stamps is credited with causing conditions of starvation in the Delta by the 1960s. Participants in the federal food stamp program were required to purchase a month’s supply of food stamps all at once, and most people who needed the stamps were not able to come up with sufficient funds to buy them. This crisis marks the first time in which poor black people in the Delta were the focus of national public health debate.

Following the Senate antipoverty committee’s 1967 hearing in Jackson, Mississippi, Senator Robert Kennedy made a visit to the state’s cotton-producing area where “thousands of black farm workers and sharecroppers” had been displaced by the push toward mechanization and crop-reduction. Although Representative Samuel Resnick of New York had visited the Delta nearly two years before
and tried to call attention to “the desperation point of starving Negroes,” it was Kennedy’s well-publicized day-trip in the squalor of these communities that transformed black hunger into “a politically sexy issue” (Levenstein 2003). Soon after, numerous media organizations began publishing reports of desperate poverty and starvation, located mainly in the rural South, and the anti-hunger movement grew. While the media attention to conditions in the Delta did further the cause of separating food policy from the farm lobby and agricultural surplus, the health of the people of the Delta was ultimately manipulated only for political gain. Despite calls for increased aid and easing of food stamp requirements, President Johnson feared the implications that the enactment of such measures might have for Kennedy’s presidential aspirations. House Agriculture Committee member Robert Poage of Texas was quoted as saying that he was “not going to help some deadbeat” and that “in the Book that most all of us accept it says somewhere, by the sweat of thy brow shalt thou eat bread.” Sentiments such as these, which construct individuals as autonomous actors independent of social conditions, echo arguments that have long been made against social welfare programs. Even those politicians who professed loyalty to the anti-hunger cause were often revealed to be simply manipulating it for political gain. Despite President Nixon’s 1969 vow to expand the food stamp program and “put an end to hunger in America for all time,” he later was revealed to have stated in a meeting that very day, “Use all the rhetoric you need, as long as it doesn’t cost money” (Levenstein 1973, 154).

Shortly after this statement, Nixon’s social policy advisor Daniel Patrick Moynihan predicted events to come when he wrote of the need to examine “the remnant of pre-industrial problems, such as hunger and malnutrition, the onset of post-industrial problems, such as overeating, and the industrial era problems such as the toxic effects of prepared foods” (Levenstein 1973, 154). It was Moynihan’s
last suggestion that was to effectively end large-scale public attention to rural black hunger for a time and plant the seeds of the dominant political ideologies at work in the current obesity debate. Despite the intense national attention to black people’s health through the 1960s, little good was accomplished in the Arkansas Delta, and the same social and political rhetoric is being replayed in the current obesity debate.

From the 1960s, declining death rates among African Americans from contagious disease paralleled an increasing death rate from degenerative and obesity-related diseases such as diabetes, cancer, and cardiovascular diseases (Semmes 1996). Modern foodways in the Delta reflect a tendency toward food behavior developed from the food insecurity of the antebellum South, combined with an increased dependence on the food available through social assistance programs. Foods available through social assistance, including foods available as part of the free and reduced public school lunch program, exhibit many of the same basic qualities as those available in the antebellum Delta. Those foods that are cheapest per calorie are those that are highest in fat and calories; healthier foods, such as fruits and vegetables, can increase a food budget by as much as 5,000 percent per calorie (Ulrich 2005). Public institutions, such as the historically poor and low-performing public schools of the Delta, and families facing financial troubles must stretch food budgets as far as possible. In fact, national public school lunches are still funded in part by agricultural surpluses—more leftovers (Sobo 1997).

As children, all humans learn to think of food as “given or withheld at the discretion of a donor,” implying its possible uses as a means of control; government food assistance programs become a natural outgrowth of the power differentials among donors (the food and agriculture industries), the dominant cultural and socio-political ideology, and the hungry (Fitchen 1997). During the 1970s,
middle-class fears over food safety and the use of pesticides eclipsed the issues of poverty and hunger within the media and public policy, creating ideals of clean food that resonate today in the nutrition, whole foods, and organic movement. Concurrently, public views turned against food assistance programs while participants were condemned for buying *pleasure or junk* foods instead of *necessities*. Reliance on high-fat, processed foods with little nutritive content can lead to obesity combined with malnourishment. For the first time, it was pointed out that low-income black women tended to weigh more than white women, the paradox of malnourished overweight was misunderstood, and the hunger lobby was seen as advocating “handouts for undeserving blacks.” The growing middle-class concern over *pure* foods stigmatized those who were dependent upon lower-priced, high-calorie, processed *impure* foods, thus poor health was rationalized as the fault of the uneducated lower class due to the inability to “resist temptation and postpone gratification” (Levenstein 2003). A strong time preference fueled by urgent present need is often mistaken for a strong leisure preference and the indulgence of instant gratification over future needs (Douglas and Isherwood 1996).

While the mass media carry messages associating a slender body with health, attractiveness, and status, fast-food establishments are more prevalent in ethnically segregated, predominantly low-income black neighborhoods, and fast-food and snack advertisements are shown significantly more often during programming directed specifically toward African American children (Block, Scribner, and DeSalvo 2004, 10; Fitchen 1997; Morland et al. 2002, 1; Outley and Taddese 2006). These advertisements reflect an American preference for convenience foods, and consumption of heavily advertised, and thus high-status, foods can be interpreted as a way in which those of low socioeconomic status express membership within the larger...
society despite poverty. Not only do these foods carry connotations of status, they also, being cheaper per calorie, satisfy hunger for longer periods of time than do fruits and vegetables. Many parents express having trouble in denying hungry children access to these high status foods, particularly if they are unable to provide other, more expensive, commodities. Parents, who as children experienced hunger, do not want their own children to feel similarly deprived, and are, thus, more likely to indulge a child’s requests for specific foods. Hunger is not simply a physical phenomenon, and high-status food consumption not only expresses group membership, it also stems feelings of psychological deprivation. The wealthy, however, can purchase these junk foods and healthier foods, as well. The poor can only afford to purchase one, and the increased psychological and physical satiety gained from higher-calorie, higher-status advertised foods often outweighs the higher nutritional content of more expensive foods (Fitchen 1997).

The increased dependence upon high-calorie, low-nutritive content foods carries implications specifically for mothers. Women of any socioeconomic status are likely to place nutritional needs of children above their own; however, the nutritional status of poor women is significantly compromised by this practice (Fitchen 1997; Whitehead 1984). Poor mothers have higher incidences of obesity and malnutrition than their higher-SES counterparts, and indeed, the other members of their own families (Roe and Eickwort 1973). Surveys indicate that although many rural Southern African American women are aware of the healthy lifestyle changes that are necessary in avoiding being classified as overweight, they are unable to make such changes. Long work hours, tight budgets, and minimal access to parks and recreational facilities (characteristic of ethnically segregated African American communities) all prevent changes in diet and physical activity, despite public education that stresses the
benefits of such changes (Chang 2006; Baturka, Hornsby, and Schorling 2000). For many in such positions, there are more pressing matters than weight loss. In fact, for parents of low socioeconomic status, the weight of their children ranks among the least of their worries (Backett-Milburn et al. 2006). This could only compound the tendency for children of working parents with low SES to have fewer restrictions on and supervision of food habits. A state of perpetual financial inadequacy affects the structure of mealtimes, and in such conditions, parents allow children to decide when and what to eat (Fitchen 1997).

African American attitudes toward body image are frequently suggested as contributing to obesity. African American women are under less social pressure to be thin (Hawkins 2005). Particularly in rural areas, there is greater pressure to remain slightly overweight and to display self-acceptance, even in cases where women express personal dissatisfaction with body image, possibly illustrating the tension between African American ideals of a healthy body and white hegemonic ideals of a healthy body (Baturka, Hornsby, and Schorling 2000). African American women and girls are subjected to conflicting ideals of the body every day. Some black women express preferring a small-to-medium size body but identify a larger body as signifying better health (Liburd et al. 1999). Food insecurity has been shown to be positively linked specifically to overweight females (and not to overweight men) (Townsend et al. 2001), and the history of economic insecurity for African Americans in the Delta must certainly have created widespread food insecurity. One African American father in the Arkansas Delta refused to have his daughter take part in the BMI measurement saying, “Sissy’s no different from anyone else in the family.” African American respondents in a recent study published in *The Journal of General Internal Medicine* mentioned the importance of maintaining a perceived *healthy* weight in
case of illness as a reason not to lose weight (Baturka, Hornsby, and Schorling 2000).

Extensive networks of friends and kin with whom families could trade and borrow from were of utmost importance in the days of the Delta’s early colonization and remain important throughout the South today, particularly among those of low SES. (Fitchen 1997; Hughes 1997; Payne 1993; Whitehead 1984). Children of poor families are often specifically encouraged to share with others (Fitchen 1997). The importance of extensive kin networks relates to a positive view of higher weight in West African immigrant rural communities: “because kin share wealth, no one gets rich; because kin feed each other, no one becomes thin” (Sobo 1997). Health, prosperity, generosity, and connection are symbolized by plumpness, whereas a thin body implies a mean, hoarding, socially-subversive nature (Hughes 1997; Sobo 1997). An extensive support network reinforces physical and psychological health in periods of economic insecurity, and a healthy, plump physique is indicative of a caring and cared-for status. Contrary to the idea that an overweight body is a body out of control, for African American women it can be a way of affirming control over identity and a symbol of resistance against hegemonic white ideals of health and beauty.

While not as well publicized as many reports on the dangers of obesity, growing quantitative evidence supports an African American view of health as well. Overweight may, in fact, not be as deadly as the popular media claim. An influential study by the Centers for Disease Control and Prevention was shown to have incorrectly attributed thousands of deaths per year to obesity (McKay 2004). In a follow-up study published in JAMA, those who were classified by BMI as slightly overweight, but not obese, actually displayed a lower risk of death than those whose weight was classified as falling within the normal range (Flegal et al. 2005). A study published in the same
issue of *JAMA* found that the risk factors for cardiovascular disease decreased “considerably over the past 40 years in all BMI groups.” Rates of diabetes, the disease most often associated with overweight in the African American population, rose among all BMI classifications, not just overweight and obese (Gregg et al. 2005). Nagourney (2006) found that those who are overweight may fare better when critically ill. The fact remains, though, that African Americans of low SES in the rural South have life expectancies well below those of other subgroups in America. Arkansas ranks forty-third in overall life expectancy, and two of the Delta’s counties, Crittenden and Phillips, made the top twenty list of the lowest life expectancies in the nation (Associated Press, September 12, 2006).

Ideas of health and foodways that are identified as belonging to Southern rural African Americans were developed during extended periods of food insecurity and are now operating in obesogenic environments of economic insecurity. Instead of focusing on the concept of an obesogenic environment, it may be more accurate to propose something more encompassing—an environment that is detrimental to total health, and not just weight. However, public policy continues to target weight and body image in order to benefit public health. Concepts of health influence the symbolism of the body, and “often ideas about the body and its health are ideological supports for conditions, such as class and gender inequalities” (Sobo 1997).

Nixon would be proud of Mike Huckabee’s short-lived BMI Initiative—full of rhetoric and not a dime of funding for the implementation of public school health programs. Former Governor Huckabee’s personal weight loss and his subsequent crusade against childhood obesity buy him quite a lot of national airtime. As a 2008 presidential hopeful, the social conservative didn’t need to be a born-again Christian to create a platform of national interest; all he had to do was to be born again, 105 pounds lighter, and write a best-selling
book about it (Peacock 2004). Huckabee, however, had considerable resources at hand in helping him to attain his weight goal, including a personal physician and even a bass boat (offered as incentive by his supportive wife).

The BMI Initiative in Arkansas mirrored the national obesity debate, as well as previous sociopolitical attention given to black health and black bodies in the South. Huckabee’s rhetoric of improving the lives of Arkansas children carries bipartisan appeal, as does the stigma from overweight. Those on the conservative right can get behind this notion of “preventative healthcare” that curbing obesity supposedly accomplishes. Those African American children of low SES who are overweight are portrayed as ticking time bombs for draining publicly funded health care, a claim that sounds suspiciously like the criticisms of food assistance programs in the 1960s, as well as the worn-out arguments against social welfare programs in general. Those on the liberal left can get behind a constructed image of the obese as ignorant greedy consumers compromising the environment (even causing global warming) and eating up all kinds of resources to the detriment of the global community (Kolata 2006). It is worth noting that the initiative to repeal Huckabee’s BMI initiative came from a member of the General Assembly from Rogers, Arkansas—the Ozarks, where the rate of obesity among public school children is lowest and concern over the negative effects of subjecting children to BMI measurements seems to be greatest.

The definition of fat or obese varies over time and space, and measures such as BMI are far less based in science than in the minds of a culture obsessed with weight loss and a slender body that signals social status, prosperity, beauty, and health (Kulick and Meneley 2005). Notions about health influence symbolism made through the body and the current framing of public health in terms of obesity devalue African American concepts of health and the body. Within
economic structures defined by free market trade, theories of purity, in this case, food purity, are constructed as “techniques of selective exclusion.” These categories of purity then serve as tests governing fairness in competition for status among individuals. Thus the white-middle-class emphasis on clean foods, which began in the late 1960s and 1970s, constructed the value judgment of *overweight* as indicative of an uneducated lower-class preference for *unclean* food sources, wherein overweight people are “judged as wanting in moral and intellectual stamina,” having failed these tests of worth (Douglas and Isherwood 1996). The choices as they are framed by public policy and the media force the maxim “eat different, look different” in order to validate a specific culturally defined ideal. By focusing on obesity as the primary risk, instead of on the actual diseases that public policy is supposedly trying to prevent—wherein those targeted by policies must devalue their own cultural systems in order to be seen as taking responsibility for their own health—politicians and the media are not forced to truly examine the inequalities over which individuals have little power. Those inequalities do create not just an obesogenic environment, but an environment that compromises overall health. Although programs modeled on Arkansas’ BMI Initiative are expanding nationally, we must ask whether or not these programs are ultimately exploiting the poor for political and social gain under the guise of humanitarian aims. Policymakers must ask themselves what it means to successfully implement health and nutritional policy, and they must also “answer for whom they do not invite to their table” (Douglas and Isherwood 1996). The Arkansas experience indicates that programs may do little in the final analysis to alleviate inequalities in dietary health.
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