Taking Research to Action through Neighborhood Walkability Assessments

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Background:
Walking is our oldest and most basic form of transportation - one that is essential not only to our  
individual health, but also to the overall livability of our cities. Modernization for many cities has meant  
replacing walking with motorized travel as a primary form of transportation. Louisville is a leading site  
for Healthy Kids, Healthy Communities (HKHC), a national program of the Robert Wood Johnson  
Foundation (RWJF) whose primary goal is to implement healthy eating and active living policy- and  
environmental-change initiatives that support healthier communities for children and families.

In Louisville, the HKHC initiative is focused in 12 lower income neighborhoods and is a part of the  
Mayor’s Healthy Hometown Movement (MHHM), which began in 2004. Led by the Louisville Metro  
Department of Public Health and Wellness (LMPHW), MHHM unites diverse community partners from  
business, schools, government, academia, neighborhood groups and non-profit organizations to  
coordinate activities that will increase physical activity and healthy eating to improve the health of  
Louisville Metro residents.

Active living is a major focus of MHHM through its Step Up, Louisville committee. MHHM partners from  
Planning & Design Services, the Department of Public Health & Wellness, Public Works and Assets  
and the University of Louisville have worked together to create, validate and implement Louisville’s  
walkability assessment tool. During this four year process the goal has been to increase walkability in  
Louisville neighborhoods through a participatory process including city officials, trained volunteers and  
neighborhood residents, with an emphasis on youth engagement. Residents play a key role in  
reviewing the final walkability assessment reports, which they present to local policy makers such as  
Metro Council members and other city officials in order to address neighborhood improvements.

Objectives:
As part of HKHC, the objectives of the walkability assessments are to:

1. By November 7th, 2010, assess walking conditions in HKHC neighborhoods, including  
streetscapes, sidewalks, lighting, vacant lots, and abandoned houses.
2. By November 18, 2010, present walkability assessment reports to policy makers.
3. By December 17th, 2010, complete improvements in at least two of the 12 neighborhoods  
through the use of the walkability assessment process.

Methods:
Due to the complexity of previously used walkability assessment tools, MHHM partners created a more  
user-friendly tool and a process that empowers residents to take action towards policy and  
environmental changes in their neighborhoods.
The assessment process involves 15-20 participants who are trained onsite or at a volunteer training. The group facilitator first defines the importance of a walkable neighborhood with a brief presentation. Next, the participants are provided a well defined walking route and check list of potential walkability assets and issues such as amenities, sidewalk problems or obstructions, and safety issues. After the walk, the participants reflect on their experience and prioritize potential improvements. Assessments are collected, analyzed and a report is created for participants to review and use as a communication tool with policy makers and city officials.

Results:
MHHM partners have created a powerful and easy to use walkability assessment tool, which has been used in nine neighborhoods to date. Early results include funds appropriated for sidewalk and streetscape improvements in two of the twelve HKHC neighborhoods, taking this research approach to action. Step Up Louisville has also begun evaluating the effectiveness and usability of the tool through focus groups and post assessment surveys. Those results will be available in Fall 2010.

Conclusions:
Community engagement has been a challenge throughout the assessment process. Well-organized neighborhood associations contribute to a more successful event and better recruitment of neighborhood residents. Residents also want to see action come from the assessment process. Many neighborhood residents feel they have done too many assessments with little results.

In other cities where walking audits or assessments are done, most tend to look at suburban areas, with a lot of focus on hard infrastructure needs. In Louisville’s HKHC designated neighborhoods where greater health inequities tend to exist, many of the greater barriers to physical activity and safe walking conditions focus on meta-infrastructure needs such as property maintenance, vacant property, lack of destinations, and safety issues. Louisville has been able to take assessment data gathered and use it as a communication tool for real action, such as infrastructure improvements. The greatest discovery during this process is realizing the walkability assessment is a gateway tool to engage all involved (residents and officials alike) in the big picture items that serve as barriers to walkability.

Support:
Support for current walkability assessments comes from Healthy Kids, Healthy Communities, a national program of the Robert Wood Johnson Foundation. The first assessment was completed as part of Active Living by Design, another national program of RWJF. The assessments are also included in Louisville’s Pedestrian Master Plan in order to sustain the efforts past the grant period.
APA Healin’: Partnering to Promote Active Living among Asian Pacific American in New York City

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Presenter: Matthew Ryder, Asian Americans for Equality

Background:
Cardiovascular disease is the leading cause of death for Asian Pacific Americans (APA). Behavioral risk factors associated with this disease can be linked specifically to physical inactivity and nutrition. Asian Pacific Partners for Empowerment, Advocacy and Leadership (APPEAL) began the National Asian American and Pacific Islander Network to Eliminate Health Disparities (NAPNEHD) in October 2009 with the goal to eliminate health disparities in APA communities by focusing on environmental and policy change. As part of NAPNEHD, NYC-based Asian Pacific Americans Healthy Eating and Active Living In our Neighborhoods (APA HEALIN’), utilizes advocacy, empowerment and leadership development approaches. The purpose of this presentation is to describe the process of collaboration development in regards to building an empowering learning community, enhancing organizational capacity, and documenting challenges and successes.

Objectives:
APA HEALIN’ aims to address healthy food and active living disparities in APA communities in NYC.

Specific objectives for year one of the collaboration are to:

1. Create a learning community that facilitates information sharing and collaboration throughout the NAPNEHD Network and the APA community;
2. Enhance capacity of the local APA HEALIN’ affiliates to reduce health disparities through policy change;
3. Document and disseminate the progress and performance of APA HEALIN’.

Methods:

Partners
APA HEALIN’ 5 organizational partners serve the following diverse communities: Nepali, South Asian, and Filipino communities in Queens; Southeast Asian communities in Chinatown and the Bronx; as well as the pan-Asian community throughout New York City. Additionally, Dr. Kevin Nadal, assistant professor at John Jay College and grantee of the RWJF Active Living Research Program, provides essential research expertise and technical assistance services to the group.

Activities
APA HEALIN’ activities were developed in response to the collaboration’s objectives. First, to “create a learning community” and “enhance capacity,” members of the collaboration participate in monthly meetings and a collaboration listserv that provide a forum for members to review and discuss current
issues in active living policy and present ideas and findings from their individual research and observations. To track progress and technical assistance needs, qualitative and quantitative data, in the form of meeting minutes, number of shared resources, and number of activities resulting from information shared via meetings and the listserv, are compiled. Second, members of the collaboration participate in local and national conferences, workshops and trainings to familiarize the organizations with both mainstream and community-level active living policy. To document knowledge and skills of the partner organizations, debriefing summaries are compiled. Third, members of the collaboration will enhance their staff’s, volunteers’, and community members’ capacity to conduct community assessments using Photovoice and community mapping methods. The assessment documented nutrition and active living knowledge, attitudes and behaviors of community members and access to healthy foods and safe environments to play and exercise. To document knowledge and skill development, staff/facilitators of the community assessment completed a process evaluation survey. Those engaged in the community assessment also determined effective modes (i.e. exhibits, forums) to disseminate findings to engage community stakeholders and influence policy makers, thereby translating research into practice and policy to promote active living.

**Outcome Measures**

In addition to measuring the extent of the activities, strategies were developed to measure progress in completing the project objectives. The objective to “create a learning community” will be measured through individual interviews with organization staff in order to examine how activities have impacted information sharing and collaboration. The objective to “enhance capacity” will be evaluated through an organizational capacity assessment survey to measure organizational readiness to do policy advocacy. The objective to “document and disseminate progress” will be measured by creating a list of documents/products and activities carried out by APA HEALIN’ member organizations.

**Results:**

The first round of organizational capacity assessments were conducted in June 2010. Preliminary findings show technical assistance is needed in these areas:

1. Increase knowledge/resources to gain funding for food justice and active living policy work;
2. Increase capacity/opportunities to conduct and review community-level research;
3. Develop opportunities for partners to advocate for policies that improve the food and built environment in the community; and
4. Increase capacity to monitor and evaluate advocacy activities.

Activities will be ongoing and complete results will be presented.

**Conclusions:**

Partnerships such as APA HEALIN’ can be a valuable tool to bridge the gap between mainstream food justice/active living movements and communities with high levels of limited English proficiency and lower incomes. Collaborations are critical to bringing diverse stakeholders together to advocate for policies that consider the particular socio-cultural and linguistic needs of underserved Asian American communities. This process evaluation is crucial to identify promising practices that are relevant to the people who are most affected, and recognize opportunities for replication in similar communities across the nation.

**Support:**

The NAPHEHD Network is funded by the Centers for Disease Control and Prevention as part of the national program, Racial and Ethnic Approaches to Community Health Across the U.S. (REACH U.S.)
Policy Approaches to Children’s Health (PATCH:) A Community-Based Participatory Research Partnership

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Background:
In 2006, a Community Health Improvement Partnership (CHIP) implemented a community health development process model to engage citizens in rural Jefferson County, Oregon around locally identified health concerns. Through an iterative process childhood obesity emerged as a priority health issue. In 2007, a research component was added. The Mountain View CHIP and its Community-based Participatory Research Partnership (CBPR) have secured resources, conducted research, and proposed policy suggestions for the local school board.

Objectives:
PATCH objectives were threefold. We examined the school district policy to inform parents of their child/children’s body mass index (BMI); assessed menu labeling in the middle school; and assessed recess before lunch in the elementary school. All three aims sought to understand obesity in this community and approaches for reversing the trends.

Methods:
We used a mixed methods approach to assess our three aims. Focus groups were used to assess views on BMI notification letters with youth and parents. These letters described BMI, plotted the child’s status on standard CDC growth charts, and offered suggestions for community resources. Menu labeling of the food items in middle school cafeteria was assessed by gross-caloric intake per student over a two month time period and was followed by qualitative research. In the first month the menu ran without caloric labels. In the second month the intervention occurred and the same menu was duplicated with caloric labels at the point of purchase. Gross consumption per student served was calculated for each menu item. Further, interviews were conducted with 6th-8th graders regarding their perceptions of menu-labeling on their purchasing and eating decisions. The third aim assessed whether having recess before lunch in grades K-2 improved nutrient consumption and classroom behaviors. We assessed consumption by plate waste study conducted over five discriminate days with all students grade K-2. Approximately half the classrooms across each grade were in the intervention arm and the other half maintained traditional lunch followed by recess schedule. To evaluate classroom and lunch room behaviors we conducted focus groups with teachers, food service staff and playground staff. All quantitative analyses were conducted using STATA 10.0. The plate waste analysis was computed against the National Nutrition Standards set by USDA’s Food and Nutrition Service. Menu labeling was calculated as differences in gross calories consumed per student per day using a t-test. All qualitative analyses were performed using Ethnograph 6.0.

Results:
Focus groups with students revealed that students generally do not mind being weighed and measured; parents generally did not speak to their children about the BMI letter; and the students think it is a good idea to compute BMI despite the fact that most students could not describe BMI or indicate the usefulness of computing BMI.
Parents also thought measuring BMI was a good idea but could not define BMI or explain the usefulness. We also found that Hispanic parents would not feel comfortable calling a non-Hispanic white about their children’s health due to language and the perception of not understanding them. They would prefer to have a Hispanic contact and would recognize a Hispanic name. They felt it was not enough to have someone that spoke Spanish if they were outside of the community they would still lack comfort. In general, parents did not use the suggested resources.

Students who had recess first consumed greater quantities of milk and hence calcium in their diet. No other nutrients were statistically different. Additionally we found that all students exceed recommend fat intake. Teachers and staff identified better behavior and a readiness to get to work when students came from the lunch room rather than the playground.

In our analysis of menu labeling we found that some but not all middle school children did use the labels. Specifically, kids ate more salad bar items and took more skim and 1% milk and less chocolate milk when calories were posted. Most of the youth did not recall how many calories they need in a day despite learning this in health class and the inclusion of a colorful poster on the cafeteria walls that indicate needs based on a 2,000 calorie diet.

Conclusions:
Our findings indicate that BMI is not understood well by students or parents. The research team and school believe that BMI surveillance is important but the letter in current form is not effectively assisting families.

We did see some benefits in our reverse recess arm, namely calcium intake improved, however most of the behavioral changes observed were likely due to reduced volume of children on the playground and in the cafeteria at one time.

Menu-labeling is cited as a tool for reducing childhood obesity in best-practice guidelines and is being more fully implemented across the country in national healthcare reform. We support this practice.

Support:
Northwest Health Foundation
Creating Partnerships for Active Living: Comparing Pedestrian and Bicycle Planning in Rural and Urban Communities

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Background:
Pedestrian and bicycle planning processes can help to create partnerships, programs, policies, and facilities to encourage active living. However, such planning has traditionally been viewed from an urban design perspective, rather than a regional planning perspective that considers the needs of both rural and urban communities.

Objectives:
This transdisciplinary study aims to: 1) explore the prevalence of local pedestrian/bicycle plans in North Carolina (NC) according to geography, regional planning, and sociodemographics; 2) examine variations in plan quality between rural and urban areas, especially with respect to public participation, stakeholder involvement, and implementation elements; 3) assess correlations between plan prevalence and population levels of walking/bicycling to work.

Methods:
Pedestrian and bicycle plans were identified through web searches, a listserv request to NC planners, a library at the NC Department of Transportation, and follow-up telephone contacts. Additional regional planning information was collected from Metropolitan Planning Organizations (MPOs) and Rural Planning Organizations (RPOs). U.S. Census data was collected for each NC municipality (n=543) and merged with qualitative information collected through a content analysis of municipal pedestrian/bicycle plans. Census indicators included median annual household income, median population age, median high school graduation rate, percentage of rural farm land, percentage of land in urban areas, population size, rate of population growth, racial composition, and the percentage of population walking or bicycling to work. Rurality was defined in two ways: 1) areas excluded from Census-defined urbanized areas or urban clusters; 2) areas including rural farm land. All (n=38) pedestrian and combine pedestrian/bicycle plans were scored, using the content analysis, with respect to plan quality (e.g., public participation, fact base, policies and proposals, implementation, and evaluation strategies). Chi-square tests and Fisher's Exact tests were used to assess categorical differences in plan prevalence according to geographic and sociodemographic characteristics. Correlations between these characteristics and plan quality were assessed using nonparametric tests for ordinal data.

Results:
Sixty-three pedestrian, bicycle, or combined pedestrian/bicycle plans were identified in NC at the municipal level, in 57 distinct municipalities; 12 of them in rural areas. Additionally, 12 plans were developed at the regional level, and 4 at the county level. Sixty-two percent of the rural plans were developed in lower-income or lower-education communities.

Despite significantly lower plan prevalence overall, rural areas tended to develop higher quality plans compared to those of urban areas. Specifically, rural areas achieved higher plan quality scores with respect to public participation and implementation elements (p<0.05). Rural areas were more likely to engage diverse partners (e.g., business groups, nonprofits, and the public) in the planning process.
(p<0.05); however, public health professionals, state transportation planners, and law enforcement officials were less involved in rural planning processes than in urban ones. Compared to urban areas, rural plans were more likely to identify persons/organizations that were accountable for implementation (p<0.05).

With respect to regional planning, 47 municipalities were members of the two MPOs that had developed pedestrian and/or bicycle plans; only 5 municipalities were members of the single RPO that had developed a plan. Although urban communities with local plans were also more likely to have regional (MPO-level) pedestrian/bicycle plans (p <0.0001), this relationship was not significant for rural farm land areas located within MPOs, or for RPO members. Correlations between plan prevalence and higher percentages of active commuting were strongest in lower-income rural areas, compared to other areas (p<0.05).

Conclusions:
Pedestrian and bicycle planning may benefit communities directly, by affecting physical activity outcomes, and indirectly, through partnerships that may build community capacity to improve population health. Rural areas, in particular, face unique challenges in coordinating local and regional planning to support walking and bicycling. Public health professionals and transportation planners, by becoming more involved in the planning process at both local and regional levels, can partner with residents and other stakeholders to support active living.

Support:
This work was supported through the North Carolina Physical Activity Policy Research Center (http://www.hpdp.unc.edu/projects/ncpaprC), funded by the Centers for Disease Control and Prevention (CDC) cooperative agreement #U48-DP000059 and an educational grant from the Southern Transportation Center. The UNC Center for Health Promotion and Disease Prevention is a member of the Prevention Research Centers’ Program of CDC. The content is solely the responsibility of the authors and does not necessarily represent the official views of the CDC.
Partnerships for Urban Park Renovation: Strategies to Increase Physical Activity in Parks through Community Knowledge and Participatory Design

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Background:
The Trust for Public Land (TPL) is leading the Parks for People - San Francisco Initiative to rebuild three parks in San Francisco neighborhoods with a high need for safe and accessible outdoor recreational resources. TPL is engaging community members in a participatory design process for each park and will complete the three parks by 2012.

Recognizing the rising concerns of childhood obesity and diabetes and the role that urban parks can have in offering opportunities for physical activity, TPL partnered with RAND Corporation and San Francisco Department of Public Health (SFDPH) to study the health impact of park renovations.

Objectives:
The specific aims of the study are to:

1. Identify park features that contribute to physical activity among youth
2. Evaluate the impact of park renovations on physical activity among youth, using before and after site observation and survey methods
3. Identify factors in the design process and the park’s neighborhood context that contribute to the park renovation’s success or lack of success in increasing physical activity among youth

Methods:
The parks selected for renovation are 0.6, 1.0 and 25 acres in size; all are in diverse, low-income neighborhoods with high populations of children.

TPL used a variety of outreach and workshop tools to gain significant community participation including hiring community liaisons; providing language translation for flyers and meetings; holding a variety of meetings, breakout sessions and focus groups; using graphics and photos, verbal and written surveys; mapping and design exercises. In addition, TPL surveyed park users and local residents about socio-demographic data along with their park use and physical activity habits and preferences.

RAND Corporation provided the System for Observing Parks and Recreation in Communities (SOPARC) research and data collection methodology to evaluate the impact of renovations on park use and physical activity. Using SOPARC, TPL observed use in the three renovation parks and in three comparison parks that correspond to the renovation parks in size and socio-demographics of local populations. RAND analyzed the data results.

SFDPH provided and interpreted local Pedestrian Environmental Quality Index (PEQI) data on streets and traffic, noise and pollution conditions, tree canopy and neighborhood amenities. TPL used the SOPARC and PEQI data results to inform the final park designs.
Results:
Baseline SOPARC data collection observed 1,498 individuals in the parks slated for renovation compared to 4,417 users in comparison parks. People were also less physically active in the renovation parks, with 37% of users engaged in moderate to vigorous physical activity compared to 44% in comparison parks. 34% of park users observed in renovation parks were female; 39% were children and teens.

419 residents and 503 park users completed surveys for the three renovation parks. While patterns of use differed substantially between the parks, between 13% and 41% named the parks as the place they usually exercise. While more than half of respondents said they do not currently exercise at the park, many reported they would consider it if the park had features like free fitness equipment, jogging paths, special programs or classes. In all parks, walking was named the most common form of exercise and most respondents said they walked to get to the park.

Through the community design process, TPL collected qualitative and quantitative data regarding park user and residents’ views on problems with the existing parks, ideas on how to make parks more attractive, and specific design features that would encourage park use and physical activity. Common problems to all three renovation parks were limited visibility, outdated equipment and poor layout. Park users and residents expressed preferences for overall park design and park features such as walking paths, outdoor fitness equipment, basketball courts, lawns, and flexible areas for exercise like Tai Chi and dancing. Preferences varied per park.

Data collected with the PEQI for streets near the parks revealed a lack of basic pedestrian amenities (lighting, seating, complete sidewalks), high traffic volumes, and intersections without physical countermeasures for pedestrians (e.g., crosswalks, signage, traffic calming). Environmental conditions data on noise and air quality informed park areas that would be more suitable for quiet activities or children’s play areas.

Conclusions:
TPL used the community feedback and baseline data from the SOPARC observation, park use surveys and PEQI analysis to create park renovation designs that will support active park use. The designs are unique to each park and include features to promote physical activity, as selected by each community. Each design expands play areas to accommodate children of multiple ages and accommodates the community’s preferred form(s) of active recreation. The designs include pedestrian-friendly entrances and traffic calming where appropriate, as well as increased lines of sight to support safety. Once the parks are constructed, TPL will return to perform follow-up data collection to determine whether the renovations resulted in an increase in physical activity among youth.

Support:
RWJF Active Living Research Program; public and private funding for design and construction.
Can Truck Drivers Maintain Active Living? Multistakeholder Partnerships for Environmental Interventions

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Background:
Employment in the trucking sector has been linked to particularly high morbidity and mortality rates. The trucking milieu places significant strains on truck drivers and creates barriers for active living, which in turn increase risks for obesity-associated morbidities. Despite growing recognition of the importance of environmental determinants in shaping health behaviors, the role of the “transportation environment” (government regulations, trucking operations, corporate policies, and built environment) in elevating truckers’ risk for obesity remains largely unknown. We assume that truckers’ obesity-associated morbidities are predominantly attributable to a “transportation environment” that hinders active living and healthful diets. Although the workplace has been identified as a promising setting for health promotion, such programs in the trucking sector have been few, small-scale, compartmentalized, inefficiently-run, and mostly underfunded.

Objectives:
Grounded in ecosocial theoretical frameworks, this paper: (1) examines how the environmental attributes of trucking worksites influence truckers’ physical and recreational activity (PRA) patterns, and (2) outlines multistakeholder, environmental-level health promotion interventions.

Methods:
We used the “Healthy Trucking Worksites Audit Instrument” (HEATWAI) to collect environmental-level data from 25 trucking worksites near I-85 and I-40 highways in North Carolina. HEATWAI was specifically designed to assess the health-promotive characteristics of trucking worksites and examine how they can influence the PRA and dietary patterns of truckers and others working in the transportation/warehousing sector (k=0.87). Data analysis included descriptive statistics and interrater correlation analysis to establish HEATWAI’s psychometric attributes. The large number of items warranted the establishment of several summary scales: when a scale’s total score represents 90-100% of the maximum possible score, the trucking worksite is deemed fully supportive of active living; for 75-89.9%, mostly supportive; for 50-74.9%, partially supportive; for 35-49.9%, barely supportive; and <35%, not at all supportive.

Results:
(1) Physical/built environment: presence of green space, vegetation and stairwells was recorded and scored 182 from 655 possible points (27.8% active-living support). (2) PRA resources: presence of outdoor walking/running trails and in/outdoor recreational facilities was scored 126/469 possible points (26.9% active-living support). (3) Exercise/fitness facilities: presence of fitness facilities was not expected, however, some existence of dual-purpose space was anticipated due to high volume of truckers passing through truckstops. Zero out of 25 worksites had a room with exercise equipment. In light of these three scales, the Active-Living Index was 20.6%, which indicates that trucking worksites are not-at-all supportive of active living. (4) Active-living-promotive media: bulletin boards, brochures, and fliers with PRA messages were recorded, with a total score of 24/125 possible points (19.2% supportive of active living). (5) Active-living-promotive social environment: zero out of 25 worksites
offered fitness memberships, incentives for PRA participation, or health risk appraisals. The active-living support rating for the social environment was only 8.2%. (6) *Active-living-promotive environment of surrounding communities:* all recorded PRA amenities were scored 46/325 possible points - overall community active-living support was found to be 14.2%. The abysmal performance of trucking worksites vis-à-vis their active-living support is not surprising. Truckers' increases in obesity-associated morbidities cannot be explained merely by genetic/individual factors. The need for worksite health promotion (WHP) programs focusing on improving active-living environments of trucking worksites and on promoting an overall healthier work environment is worthy of attention. The current paradigm entailing mostly an occupational safety approach or small-scale, individually-tailored wellness programs has become obsolete. There is strong evidence that WHP programs can be significantly more effective when they integrate occupational safety with health promotion because they can collectively enhance both the health and safety of working people. In trucking, this holistic approach of multicomponent active-living health promotion would target a wide range of risk factors (including lack of truckstop fitness facilities) at several intertwined levels: truckers’ lifestyles, federal government regulations, trucking-sector operations, corporate policies in trucking worksites, trucking built-environment, as well as the full spectrum of the trucking environment. As per this approach, trucking stakeholders (i.e., union leaders, CEOs of trucking companies and truckstops, health insurance firms) would be co-responsible for a comprehensive and evolving WHP with integrated monitoring and evaluation components. The main thrust of this rationale incorporates the fact that WHP and occupational safety and health provide two parallel pathways for promoting trucker health, which will be significantly strengthened when coordinated and integrated rather than separate and independent.

**Conclusions:**
Findings corroborate anecdotal and empirical evidence supporting that trucking worksites remain active-living deserts contributing significantly to truckers' obesity-associated comorbidities. This paper places the highly-underserved transportation/warehousing sector firmly within the discourse of WHP and occupational health disparities. It calls for comprehensive multistakeholder, multilevel wellness strategies that encompass the plethora of intertwined risk factors linked with individual, organizational, and environmental domains of truckers, other employees and the transportation environment.