NW BULLETIN
Family and Child Health

◆ http://depts.washington.edu/nwbfch/ ◆ Volume 18 ◆ Number 1 ◆ Winter 2004

Child and Adolescent Obesity

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Introduction

Obesity and overweight are implicated in a disturbing array of health problems among the youngest and most vulnerable members of our society—children and adolescents. The ill effects of overweight on physical and mental health may persist into adulthood unless a healthier environment is created that supports and sustains healthy lifestyles.

A new vocabulary is emerging to better frame the problem of overweight among children and adolescents. The Centers for Disease Control and Prevention recommends that health care professionals (and others) use the term **"overweight"** rather than "obese" for children who are overweight or at risk for overweight. This policy acknowledges that children are still growing and that the assessment of overweight in young children differs somewhat from the assessment of obesity in adults. Some authors in the articles that follow use the terms interchangeably.

The *Northwest Bulletin* sought the perspectives of three professionals to add dimension to our editorial section. These contributors—an advocate, a legislator, and a pediatrician—present their views on creating healthier environments for children.

Food insecurity—defined as the limited availability of nutritionally adequate and safe foods—has long been associated with underweight in developing countries. In the United States, researchers are finding an association between food insecurity and obesity. In this issue, Shelley Curtis explores the relationships between poverty, food insecurity, overweight, race, and ethnicity; and how these relationships impact children. Pediatrician Benjamin Danielson takes a hard look at the obesity epidemic among those most severely affected—ethnic minorities—and suggests innovative community approaches to preventing overweight in children.

Reports from the Northwest states show that all—Alaska, Idaho, Oregon, and Washington—are developing nutrition and physical activity programs and guidelines for healthier communities. The reports describe creative programs that engage many sectors of the community from schools to nonprofit organizations. Legislative strategies are a key component of many statewide initiatives.

Childhood overweight is multifactorial in both its roots and solutions. Our hope is that the information and interdisciplinary perspectives described here will stimulate dialogue, new partnerships, and actions that will build healthier communities for children.

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For 18 years the *Northwest Bulletin* has been dedicated to bringing you timely information on the health of children and families. To help us to continue to meet your needs, please complete our survey at:
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Northwest BULLETIN: Family and Child Health is published biannually for the Northwest Region by a consortium of organizations including the Maternal and Child Health Program, University of Washington (UW) School of Public Health and Community Medicine; and the Healthy Mothers, Healthy Babies Coalition of Washington State. Support is provided from the Public Health Seattle-King County; the Washington State Chapter of the March of Dimes; the Bureau of Parent-Child Health Services; State of Washington Department of Health; and the state health departments of Alaska, Idaho, Oregon, and Washington. It is produced under MCH Grant #6T76MC00011, with additional grants and in-kind contributions.

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Please send correspondence to Janet Epstein at *jepstein@nwlink.com.*

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Editorial Board Transitions

The *Northwest Bulletin* editorial board extends many thanks and best wishes to departing members who have been an integral part of our work for several years. **Helen Stroebel**, Idaho representative, is shifting her professional focus to other public health issues. **Talibah Chiku** has moved on to other endeavors as well, while serving as the editorial board representative from the Regional Primary Care Association in Seattle. And **Rachel Hien** of the Washington State Chapter of the March of Dimes is embarking upon a new challenge, having enrolled in the School for International Education in Brattleboro, Vermont. Lastly, **Janna Bardi**, CHILD Profile Manager for the Washington State Department of Health, is completing a lengthy stint on the editorial board.

We extend a hearty welcome to **Traci Berreth**, the incoming representative from Idaho. After managing Idaho's immunization program, Traci now serves as the MCH Special Projects Coordinator with the Idaho Department of Health and Welfare.

Cherish Hart, Program Services Director for the Washington Sate Chapter of the March of Dimes, is also joining us, bringing expertise in teen alcohol and drug prevention, and adult literacy.

New editorial board member **Stephanie Birch** is the MCH Title V and CSHCN Director for the state of Alaska, overseeing maternal, child, and family health programs.

No stranger to the editorial board—having served as an alternate—**Ruth Francis Williams** is now the sole representative from the Washington State Department of Health. Ruth is the Health Promotion Coordinator for the CHILD Profile program.

Many thanks to the editors of this issue of Northwest Bulletin. Cynthia Shurtleff is a long-time member of our Editorial Board and founding president of the Healthy Mothers, Healthy Babies Coalition of Washington. Donna Oberg—our guest editor—is a nutrition consultant with Public Health–Seattle & King County, recognized for her expertise in public health nutrition.
Also, a special thanks to MPH student Alisen Peterson for her assistance with this issue.

Child and Adolescent Overweight: A Call to Action

by Janet Epstein

In hearings on nutrition, physical activity and school-related legislation in the 2004 legislative session in Olympia, Washington, pediatrician Amy Belko[1] relayed some stunning facts during her testimony to legislative committees. In the first three months of 2004, two of her pediatric patients had been admitted to the hospital for joint replacements, and one for gallbladder surgery. The cause of these problems normally associated with the elderly? Obesity.

This experience—no doubt shared by Belko's colleagues in communities throughout the nation—evokes a disheartening snapshot of today's epidemic of childhood obesity.

The short- and long-term health consequences of overweight during childhood are becoming familiar: lifelong obesity, early onset of type 2 diabetes, and psychological problems. This article reviews these consequences and their risk factors, as well as environmental influences that are contributing to this serious problem.

Lifelong Obesity
It's been estimated that 70% to 80% of all obese adolescents will remain obese as adults, increasing the risk of heart disease, diabetes, stroke, gallbladder disease, some forms of cancer, and osteoarthritis.

Orthopedic Problems
Overweight produces increased stress on weight-bearing joints in children, whose joints and limbs are not yet fully developed. This may result in bowing of the legs, pain in the hip joint, and premature wear and tear on the joints, such as that experienced by Dr. Belko's patients.

Diabetes
The incidence of type 2 diabetes in children and adolescents has risen dramatically over a very short time period. According to a review by the American Dietetic Association, less than 4% of childhood diabetes cases in 1990 were type 2; by 2000, that number had increased to approximately 20%. Type 2 diabetes occurs most frequently in 10- to 19- year olds, and among African American and Hispanic youths. Of children with type 2 diabetes, 85% are obese.

According to the Centers for Disease Control and Prevention, a triad of factors—increased obesity, inadequate physical activity, and exposure to diabetes *in utero*—may account for this startling change. Factors common to children and teenagers diagnosed with type 2 diabetes, age range from 10 to 19, include obesity, insulin resistance, and a family history of the illness. Serious potential outcomes of unchecked diabetes include vision loss, heart and kidney disease, and loss of limbs.

[1] *Dr. Belko is a former trustee of the Washington State Chapter of the American Academy of Pediatrics*

Definitions and Policies

Body Mass Index (BMI)
BMI—the ratio of weight in kilograms to the square of height in meters—is commonly used to define overweight and obesity. BMI correlates better with excess adiposity (fat) than any other height and weight indicators.

Centers for Disease Control and Prevention (CDC) Guidelines
CDC growth charts are used to monitor a child's growth in comparison to a nationally representative reference that includes children from all ages, and racial and ethnic groups. Children are classified according to the growth charts as either *at risk for overweight* (BMI-for-age: ≥85th and <95th percentile) or *overweight* (BMI-for-age: ≥ 95th percentile).

Health professionals should use the term overweight instead of obese when talking with parents of infants, young children, or adolescents about weight concerns.

Birth to 2
Use gender-appropriate length-for-age and weight-for-length charts for infants and children up to 2 years.

Children 2-20
To monitor growth over age 2, use the appropriate BMI-for-age and gender growth charts if a child can stand upright and follow directions. Continue measuring length instead of stature when a child is between 24 to 36 months and an accurate stature can not be obtained.

American Academy of Pediatrics (AAP)
The AAP uses the CDC-recommended BMI ranges for children, but refers to "overweight or obese" for children in the ≥95th percentile. In August 2003, the AAP issued extensive prevention-oriented strategies for addressing pediatric overweight.

http://www.cdc.gov/growthcharts for CDC growth charts and related information.
http://aappolicy.aappublications.org/cgi/content/full/pediatrics;112/2/424
for the AAP Policy Statement on the Prevention of Pediatric Overweight and Obesity.

High Blood Pressure/High Cholesterol
Obese children and adolescents are more likely to have elevated blood pressure, a risk factor for coronary artery disease. Overweight children are more than twice as likely to have high cholesterol levels compared to their normal weight peers. As a result, heart problems are more likely to occur earlier in life.

Sleep Apnea
Obstructive sleep apnea has only been recognized in children since the 1970s. Often difficult to diagnose, it is now believed to be relatively common. Obesity is one of many factors thought to underlie the condition that can result in fragmented sleep, difficulty in breathing, and other problems.

While research on the effects of sleep apnea in children is limited, it is thought they may be similar to those experienced by adults. These include daytime fatigue, restlessness, and reduced concentration, poor memory, and reduced learning capacity. Some studies have shown that children with sleep disorders are more likely to have behavioral problems similar to ADHD.

Black children are believed to be at higher risk for obstructive sleep apnea than white children. The peak incidence of the condition occurs in children between 2 and 8 years old.

Mental Health
Overweight children, particularly adolescents, face a tangible risk of damage to self-esteem. In a study conducted by Schwimmer et al, obese children who completed a survey rated their quality of life on par with that of young cancer patients on chemotherapy. Teasing and other types of social discrimination exact a heavy toll. Discrimination can also result in contacts with adults, including some health care professionals.

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Obese children with low self-esteem report increased rates of sadness, anxiety, and loneliness; and may be more likely to smoke and use alcohol. Depression is also more common. In one study, obese Hispanic and white females experienced significant decreases in self-esteem by ages 13 and 14 compared to their normal-weight counterparts. Interestingly, self-esteem of obese African American young women did not show a decline.

Asthma
Pediatric asthma is on the rise and a high percentage of hospital admissions are due to this inflammatory disorder. Unfortunately, obesity places even greater stress on children with asthma since extra adipose tissue coats the chest wall and diaphragm, thereby exacerbating asthma attacks and slowing down recovery from attacks.

There is growing evidence that obesity increases children's vulnerability to lung damage from air pollution. When exposed to the same amount of pollution obese children have a harder time breathing than their normal-weight peers. Since air pollution and obesity both increase inflammation in the airways, excess weight may also be associated with a greater risk of developing asthma.

The impact of obesity on quality of life can be profound, even if a child or adolescent does not suffer major medical complications. Severely overweight youth are more than five times as likely as their healthy peers to have a decreased quality of life. Their ability to move, participate in sports, perform in school, and enjoy good relationships with peers are all likely to be impaired.

Stemming the Tide
The effects of overweight and obesity on child and adolescent health are not to be taken lightly, hence the aggressive efforts by government agencies, non-governmental organizations, professional associations, child advocates, and clinicians.

The litany of health risks to overweight youth is discouraging, but health educators, school officials, advocates, and other professionals should remember that even a modest loss of weight can greatly improve a child's health.

Kyle Unland, Manager of the Nutrition and Physical Activity Section at the Washington State Department of Health, likens the obesity epidemic to a tsunami. "We're dealing with an epidemic, but also a tidal wave of awareness and media attention."

The door for securing resources and implementing system change is ajar, providing an opening to secure resources to address this problem in a time of relative scarcity. When this tidal wave hits the shore, the window of opportunity to enact needed policy changes may ebb away. So now is the time for concerned individuals and groups to act in order to avoid being overwhelmed by this epidemic.

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Janet Epstein, MA, MSW is the managing editor of Northwest Bulletin. Trained in social policy/management and international public health, Janet has worked in health communications for numerous dot.coms and for local, national, and international organizations and publications. Her focus has been maternal and child health, health services, and medico-legal issues. She also manages a chronic disease program for the City of Seattle.

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Next issue: Immunization

Did you know?

- The prevalence of overweight in young people aged 6 to 19 has tripled since the 1960s. Fifteen percent in this age group are at risk of becoming overweight.
- Over 10% of preschool children between 2 and 5 are overweight, an increase of 7% since 1994.
- Mexican-American children between 6 and 11 are more likely to be overweight (24%) than non-Hispanic black children (20%) and non-Hispanic white children (12%).
- 76% of schools from elementary to senior high have vending machines, a school store, or snack bar at which students can buy soft drinks.
- By comparison, only 24% of schools offer 1% or skim milk and just over 17% make fruit or vegetables available through the same venues.
- Many low-income households purchase cheaper, high-calorie foods instead of nutritious foods before they reduce the amount of food purchased. This strategy for dealing with limited funds can contribute to the coexistence of obesity and hunger.

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Editorials

An Advocate's Perspective on Child and Adolescent Obesity

by Shelley Curtis

Childhood obesity—like poverty, racism, and social injustice—is an extremely complex problem. There is no single solution—no magic bullet, no fail-proof cure, no proven remedy. And no single person or system that is solely responsible for the growing epidemic.

Parents and caregivers, childcare programs, schools, after-school programs, federal, state and local governments, the food and beverage industries, nutritionists, physicians, and other health professionals—all play important roles in helping children to eat well and be physically active. Child advocates working in the public policy arena also play a pivotal role in addressing childhood obesity.

There is no single solution—no magic bullet, no fail-proof cure, no proven remedy. And no single person or system that is solely responsible for the growing epidemic.

While individual-based approaches and education are critical, widespread system change is needed to support and guide children through the tangled web of mixed messages, aggressive marketing, and an environment that encourages eating more and moving less.

Public policy is critical in shaping our surroundings and affecting our choices. Child advocates have a responsibility to influence decision makers, the media and the general public to ensure we implement policies to protect our children and improve their well-being. Effective public policy, for example, can limit access to junk food in schools, fund school-based nutrition education, parks and recreational facilities, restrict marketing to children, increase funding for federal food programs, and require breastfeeding-friendly worksites.

While there are a variety of stakeholders in this issue, child advocates must defend the most important bottom line—children's health. Another important role for child advocates is to clearly shape the debate. Much of the focus has been on childhood obesity.

While there is no arguing that this is a serious problem, the underlying issue is actually children's health. Focusing on obesity disregards the fact that underweight and "normal weight" children can still suffer from poor eating habits and lack opportunities to be physically active. It also alienates high-risk groups for whom the messages around childhood obesity may not resonate.

Research shows that children of color are at disproportionate risk for many health problems, including overweight. However, the majority of messages about the causes and associated risks of overweight come from a white, middle-class perspective. Advice to enroll children in soccer camps or to encourage children to play outside instead of watching TV implies that families have the resources to do these things and live in safe neighborhoods. This, unfortunately, is not always the case.

The term itself—obesity—is alienating as well, carrying an unfortunate stigma. The focus needs to be on health through good nutrition and physical activity, not weight. We also need to engage high-risk communities and create messages and strategies that meet the needs of each population. One size does not fit all.

It is critical that advocates continue to support a public health policy approach to improving nutrition. Blaming the victim and targeting the individual will not prevent poor eating habits or increase resources to purchase healthful food among our most vulnerable residents—children, communities of color, and low-income populations. Public health policy that sparks change within the larger system is the only effective way to get long-term, widespread improvements.

Shelley Curtis, MPH, RD, is the Nutrition Outreach and Food Policy Manager at the Seattle-based Children's Alliance. For further information, contact Ms. Curtis at 206-324-0340, x17 or by e-mail at shelley@childrensalliance.org

A Legislator's Perspective on Child and Adolescent Obesity

by Senator Jeanne Kohl-Wells

I can remember when vending machines on school campuses were routinely stocked with fresh fruit and milk. And public schools included daily physical education in the curricula. Unfortunately, children today are not so lucky. They're offered mostly food and drinks that are high in fat, sugar, and calories. They receive less instruction in health, nutrition, and physical education.

I can remember when vending machines on school campuses were routinely stocked with fresh fruit and milk. And public schools included daily physical education in the curricula. Unfortunately, children today are not so lucky.

Over the years, unfunded federal mandates have forced school districts to fund programs with money that could otherwise be used for extracurricular activities and arts and music programs. An increased focus on standardized testing has also led to less health and physical education instruction.

Schools have made up for the funding gap by selling junk foods and sugary sodas to supplement budgets. These foods—called competitive foods—are sold outside of the federal school breakfast and lunch programs. They've become increasingly popular, and now fewer students purchase the school lunches that meet federal dietary standards.

Schools should not be profiting from the sales of products that can contribute to poor health. However, the state legislature must also take the issue seriously

Obesity-related medical expenditures are costing Washington State over $1.3 billion a year. Failing to implement healthy policies now will worsen the long-term medical costs for the next generation. Decisions about what to provide to children in schools should be based on the best interests of children and their education.

But the obesity problem cannot be blamed solely on schools. Many factors have conspired to increase overweight and obesity in youth. For example, public education in Washington State lacks a dedicated revenue stream. An education initiative to address this problem I-884, failed in November 2004.

Senate Bill 5436—recently enacted into law—requires that a model policy be developed by educational stakeholders such as the Washington State School Directors Association (WSSDA), the Office of Superintendent of Public Instruction (OSPI), and the Department of Health by January 2005. The policy will address several areas including access to nutritious foods, developmentally-appropriate exercise, the nutritional content of foods and beverages sold or provided at schools, and health, nutrition, and physical education curricula. Middle school students will be required to have at least 20 minutes daily of aerobic activity in the target heart rate zone.

Local school boards are also required to adopt their own policies by August 1, 2005. Boards may use the model policy or develop one of their own.

There are a growing number of schools around the nation that have replaced unhealthy drinks and snacks with healthier alternatives without financial hardship. Vista High School in San Diego, for example, re-stocked its vending machines with more nutritious foods and 100% fruit juice and water and generated $200,000 more in sales than the previous year. Schools in Philadelphia and Minneapolis have had similar results. In many schools, water is the top selling beverage. And at Venice High School in the Los Angeles Unified School District, monthly beverage sales increased by $1200 after healthy alternatives replaced soft drinks in the vending machines.

Inadequate physical activity among our youth is another serious problem. Twenty-two states currently mandate that schools offer physical education programs as part of the curricula. Only Illinois, however, requires daily physical education through high school. In recognition of the increase in obesity rates nationwide, legislators in 15 states have been working on legislation addressing these issues.

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Besides providing the funding, states must ensure that high standards are met in all aspects of the curriculum. Legislation that strengthens or improves the current standards and curriculum will only benefit the students.

In our society, where too many children choose video games, the Internet, and television over physical activity—and with increasing concern about the obesity epidemic—I believe schools have an obligation to instruct and reinforce the benefits of healthy eating and healthy living.

State legislatures must support that commitment by providing adequate funding for education. We must not force schools to reduce physical education and health requirements in order to fund educational programs. Rather, we need to improve and strengthen school districts' nutrition, health, and physical education curricula.

Sen. Jeanne Kohl-Wells can be reached at 360-786-7670 and by e-mail at: Kohn_je@leg.wa.gov

Sen. Jeanne Kohl-Welles (D-Seattle) has been a member of the Washington State Senate since 1994. From 1992–1994 she served as Majority Whip in the House and is Ranking Member and chair of the Senate Higher Education Committee. She also serves on the Senate Economic Development and Rules Committees. As an advocate for Washington's higher education system, Sen. Kohl-Welles has spearheaded legislation to benefit women, children, and families. In 2004 she introduced Senate Bill 5436, an act relating to the sales of competitive foods and beverages sold on public school campuses. The bill passed unanimously.

A Pediatrician's Perspective on Child and Adolescent Obesity

by Rachel M. Effros, MD

As a general pediatrician, I encounter increasing numbers of children and adolescents who are overweight or at risk of overweight. Presently, approximately 30% of children are either at risk for or suffer from obesity* in the U.S. Like practitioners in every specialty, pediatricians often find this problem to be daunting and difficult to manage. The magic bullet of "eat less and exercise more" has made few inroads in reducing the prevalence of this problem.

As pediatricians, we can effect change by working on obesity directly with our patients, while simultaneously working with our communities to foster healthy weight.

**The terms obese and overweight are used interchangeably in this article.*

Clearly, obesity is multifactorial, so finding one solution that helps every person is impossible. Furthermore, the medical problems associated with obesity in children may occur 10 or 20 years in the future, so convincing families that obesity has serious health consequences like diabetes and hypertension can be difficult.

First, it's important for both the provider and the family to recognize when the child is overweight. I often find that parents are unaware of or in denial of the problem. As pediatricians we routinely plot height and weight and we need to include body mass index (BMI) as another measure of obesity. The CDC defines BMI $> 85\%$ as at risk for overweight and $\geq 95\%$ as overweight. It seems that the earlier and the more severe the obesity, the greater the risk that obesity will persist into adulthood.

First, it's important for both the provider and the family to recognize when the child is overweight. I often find that parents are unaware of or in denial of the problem.

I then discuss the complications of obesity. In the younger child, poor self-esteem from teasing by peers may be the most immediate complication of obesity. Later in childhood and adolescence, hypertension, insulin resistance, and hyperlipidemia are some of the more common morbidities clearly related to obesity.

In addition, obesity is a risk factor for conditions like obstructive/restrictive pulmonary disease, hepatic/gall bladder disease, and musculoskeletal problems such as slipped capital femoral epiphysis. In this condition, the thighbone is separated at the upper growing end of the bone. This can cause knee and hip pain, walking problems, and an increased likelihood of osteoarthritis in adulthood if not diagnosed and treated—often through surgery—early on.

I next address the dietary changes needed to treat obesity. Because children are still growing, I sometimes show families that if weight is simply maintained, the child can "grow into their weight".

I also stress to parents that this is not simply the child's problem—it is a family problem. If the whole family is not willing to make changes in lifestyle and diet, how can I expect the child to change? I try to solicit the child for what foods he or she thinks are healthy. When I speak of eating healthier, I avoid using the phrase "going on a diet." I try to find areas of the family's diet that could be improved, such as sugary drinks or fast food intake. For families that are unable to recall unhealthy eating habits, a three or four-day diet history can be obtained which may reveal pitfalls in the diet.

I always address physical activity as well. I try to find manageable things kids can do with their parents to get them more active. I don't expect that previously sedentary parents are going to go running every day with their kids, but I suggest after-dinner walks or bike rides. I stress the impact of television and computer time on a child's activity level and suggest that these be limited to no more than one hour per day. I also try to promote physical activity as a means to spend more quality time with their children.

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Screening for complications of obesity should be considered especially when there is a family history of comorbidities. I routinely check blood pressure and consider fasting lipid profiles, fasting insulin/glucose, hemoglobin A1c levels, and comprehensive metabolic panels in obese children.

In our communities, it is important that pediatricians serve as advocates for the health of our patients. We need to work with school districts to make school breakfasts and lunches more healthful and lower calorie. We need to stress the importance of meaningful physical education classes every day for children of all ages. We need to make neighborhoods safer and more pedestrian friendly so that children can walk or ride bikes to school. We need to counter the food advertising on television directed at children.

Clearly as pediatric health care providers, we have an opportunity to impact the development of lifelong lifestyle habits in children. In the future, I hope we can develop screening questionnaires, growth parameters, and even lab tests that can help us identify children at risk for obesity long before their weight gain has accelerated. If we can affect eating and exercise patterns of our very youngest patients, we will ultimately be more successful in achieving healthy weights.

Source: Styne, Dennis, "Childhood and Adolescent Obesity," *Pediatric Clinics of North America*. August 2001: 48 (4).

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After receiving a BA in biology from the University of California, Berkeley, Dr. Effros attended Emory University School of Medicine. She then completed her pediatrics residency at The Children's Hospital in Denver. She has been practicing general pediatrics in Boise, ID since 1999. Dr. Effros is interested in childhood nutrition and is involved with Action for Healthy Kids in Idaho.

Overweight Among the Underserved: Thoughts on the obesity epidemic and minority populations

by Benjamin Danielson, MD

By now we have all been inundated by the myriad stories about our obese society. The overweight trend has been accelerating at an extraordinary pace over the past few decades. The epidemic touches every corner of our nation, every layer of the socioeconomic strata, every ethnicity and culture.

One of the unnerving truths about the obesity challenge is that minorities are more severely affected. Studies have shown that rates of obesity are higher among African Americans than Caucasians, are increasing at more rapid rates among African Americans, and cause more illness in African Americans. Native Americans and Hispanics/Latinos are also disproportionately affected by obesity.

An inner city primary care clinic

As a pediatrician in an inner city primary care clinic in Seattle, I'm intensely aware of and especially concerned by the extent to which this epidemic has affected our youth. The population we serve is largely ethnic minority—about two thirds African American. Our families come from the lowest income brackets, with 80% eligible for Medicaid and free school lunch programs.

Often, these young people are raised in foster homes or by relatives. Many are homeless or move frequently. These realities mean that teens in our clinic are overweight at almost twice the rate of King County teens overall. Moreover, type 2 diabetes—a potential consequence of severe obesity usually associated with older adults—is showing up in the youth who come to us for care.

Heredity, obesity, and other chronic conditions

Genetic factors play an important role in the severity of obesity among minorities. Children of obese African American and Hispanics/Latino mothers are at increased risk of obesity themselves. And children are more likely to develop the worst consequences of obesity if they come from a family whose young-adult members suffer from hypertension, diabetes, kidney disease, or heart disease.

Nearly every family we see in our clinic has multiple family members with these health problems. Obesity exacerbates other chronic conditions. In our clinic, those with the most severe asthma are also overweight. Even mental health problems are aggravated by obesity, often because of the

impact of overweight on self-esteem. But obesity affects behavioral health in more subtle ways. For example obesity can significantly impair sleep, which may worsen or mimic the signs of attention-deficit hyperactivity disorder.

Most of us are aware of the proffered reasons for the rates of obesity in our society. A sedentary lifestyle is one of the prime suspects. 'Tube time' for youth in the form of video games and television has paralyzed untold numbers in front of a glowing screen. Neighborhood design and characteristics are disincentives to physical activity, either because of automobile-oriented suburbs or perceptions that urban communities are unsafe.

If our sedentary ways are a prime suspect, then a partner-in-crime is our unhealthy diet. Fast food is seen as cheaper and more convenient, especially among poorer minorities. Food portions have become enormous. Fast food advertising is ubiquitous and often targets unsuspecting youth.
When faced with challenges like this obesity epidemic, our society tends to respond in extreme fashion. One answer has been an array of fad diets that are impossible to adhere to. Businesses spring up peddling pills or gadgets that feed our desire for a quick fix. These gimmicks are most effective at lightening our bank accounts. Also, serious treatments—such as stomach stapling surgeries—have gained favor.

If our sedentary ways are a prime suspect, then a partner-in-crime is our unhealthy diet. Fast food is seen as cheaper and more convenient, especially among poorer minorities. Food portions have become enormous. Fast food advertising is ubiquitous and often targets unsuspecting youth.

Body image

Our narrow views on desirable body shapes are also part of the picture. Minority cultures can make important contributions to healthier perspectives about body image. Majority culture tends to idolize a very specific shape and look while many minority cultures are more accepting of a range of body shapes and sizes. In the rush to combat obesity it's important that minority cultures not succumb to the narrow imagery our media promote. In fact, the majority culture can learn a broader perspective from minorities.

Demedicalization of the "problem"

Research about overweight treatment is disheartening. The medical profession bemoans the lack of careful research and available studies report that most treatments are ineffective—especially in the long run.

But this isn't the end of the story. Especially daunting health challenges provide opportunities for innovation. In our work at Seattle's Odessa Brown Clinic with overweight minority children, we've scrutinized traditional health care. We're using the epidemic as a vehicle to forge new partnerships with other community organizations, while learning important lessons about our role in various health initiatives. And we've integrated cultural awareness and celebration in treatment strategies. The first, and possibly most important philosophical approach we have adopted is to "de-medicalize" the issue.

A traditional medical approach to lifestyle problems unmasks weaknesses in our health care system. The tendency to commit 'paralysis through analysis' can lead to suboptimal treatment of those acutely in need of care in favor of slow, methodical research. In addition, patients and doctors are engaged in an expensive love affair with high-tech tests.

The tendency to commit 'paralysis through analysis' can lead to suboptimal treatment of those acutely in need of care in favor of slow, methodical research.

Identifying the obesity epidemic as a medical problem is not enough. Medical professionals have not always collaborated well with members of other professions. Obesity is a social problem, an economic problem, a public policy problem, a trans-societal problem. To inspire timely, innovative strategies we must acknowledge the multidimensional nature of this challenge.

Good practical ideas often flow from non-medical community organizations. In addition, the partnerships that are built through this approach can only benefit our communities. We have connected with community advocates with unique resources. It is in the community—not in the medical realm—that successful programs should be located.

Another philosophical strategy is to move our method and discussion away from the narrow focus on obesity and target lifestyle—the root of this challenge. Successful adoption of

a healthy lifestyle—not adherence to a particular exercise regime or target weight—is a truer measure of success. Another strategy is to stop vilifying food. Food is a vital symbolic representation of family and culture. Everyone has strong ideas of family or culture that relate directly to specific foods or meals. Lifestyle programs must not imply that a food that is fundamental to a person's sense of culture is bad. This is especially true for disenfranchised minorities whose culture is already threatened or marginalized.

Food is a vital symbolic representation of family and culture. Everyone has strong ideas of family or culture that relate directly to specific foods or meals.

Minor adjustments to cooking techniques and smaller portions may be the only dietary changes needed.

The inclusion of the whole family is fundamental to an effective lifestyle program. Isolating a particular family member and expecting them to adhere to a difficult lifestyle program is unreasonable. Overcoming unhealthy habits requires the reinforcement of a whole family joining in the program.

Healthy lifestyle promotion must include political activity. Public schools, for example, are often underfunded and lack adequate supplies for healthy activities. In addition they may not be able to prioritize healthy foods in their lunch programs. The education system needs our active support and political involvement so we can voice our expectations, monitor progress, and direct appropriate resources toward a healthier environment in the school system.

The fine art of listening

In the medical realm, health care providers must elevate the art of listening. Believe it or not, medical training devotes appreciable time in the first years of school to this. However, the real world of health care often wrings that luxury out of the patient encounter as pressure builds to see more patients in less time. The hectic pace is anathema to good listening. Adequate time and good listening skills tend to promote good communication skills. Good communicators are often more effective at helping people become ready for change. This is the first step in embarking on a healthy lifestyle program and is key to maintaining participation.

The ability to listen is central to the development of effective programs for minorities. Barriers and challenges are often quite different than the majority culture may expect. Careful listening to diverse cultures provides important lessons about neighborhood safety, distrust of the health care system, and celebration of family and culture.

Promoting healthy lifestyles and reversing the trend toward worsening obesity-related health problems are daunting tasks. Accomplishing these tasks among more severely affected and disenfranchised minorities adds layers of difficulty. But the challenges also offer enlightening opportunities by rethinking and reshaping our approaches to health care. The lessons of culture, partnership, and listening will help us become a healthier society.

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Food Insecurity and Overweight

by Shelley Curtis

Many people are confused by the notion that food insecurity may be linked to overweight, especially among children. How can a child live in a household with occasionally bare cupboards but still be overweight? "That child doesn't look hungry to me," some might say.

It's a common perception, but one based on misunderstanding. Few are aware of the links between poverty and high-fat, high-calorie foods, or how people may respond when they're worried there won't be enough food for their next meal.

What researchers are finding, though, is that those who are food insecure—defined as a limited or uncertain availability of nutritionally adequate and safe food—use several coping mechanisms that might lead to weight gain over time.

Few are aware of the links between poverty and high-fat, high-calorie foods, or how people may respond when they're worried there won't be enough food for their next meal.

A key to the successful battle against overweight and obesity is to ensure that more nutritious food—and opportunities to be physically active—are readily available, accessible, and affordable. Federal food programs designed to increase resources for food are already in place but are not reaching all who are eligible. School and community-based physical activity programs are often the first thing to go when budgets are cut. Furthermore, the increased emphasis on academic performance challenges schools to squeeze nutrition education and PE into the curriculum.

The relationship between food insecurity and overweight in children

Are food insecure children more likely to be overweight than those who are food secure? While evidence suggests a positive relationship between food insecurity and overweight in *some* adult populations—particularly among food insecure women—the research on children is less clear. Racial and ethnic disparities, however, do exist. For example, Mexican-American boys and non-Hispanic black girls are at increased risk for overweight, *independent* of household income.

An undeniable link exists between poverty and food insecurity and there also appears to be a strong connection between poverty and overweight. But among *children*, household income level is not a reliable predictor of overweight. Although more research is needed on the relationship between food insecurity and overweight in children, the highest rates of both food insecurity and overweight continue to occur among low-income population groups.

Explaining the Paradox

One of the principal reasons behind the co-existence of food insecurity and overweight is the lack of adequate resources for nutritious food on a regular basis. Weight gain among food insecure individuals could occur over time as a result of the following:

- The need to purchase and consume lower-cost foods that are higher in calories and fat to save money, maximize calories, and stave off hunger.
- The need to compromise the nutritional quality and variety of food before limiting the actual amount consumed.
- The adaptive response to periodic food shortages by eating more when food is available—at the beginning of the month for example—eventually resulting in weight gain.
- During periodic food shortages, the body becomes more efficient at storing calories as fat.

Increasing access to healthful food

Thirteen million children in the United States lived in food-insecure households between 2001 and 2002, according to United States Department of Agriculture. Sixteen and a half percent of children nationwide are considered overweight, and almost 32% are at risk of overweight.

What can be done to ensure that children have regular access to nutritious food?

- **Federal food assistance programs.** Federal food assistance programs are the nation's first defense against childhood hunger and can also be a powerful tool in fighting overweight. Increasing participation, enhancing benefits, and improving the nutritional quality of programs such as the Child Nutrition Programs and the Food Stamp Program could go a long way towards reducing the risk of food insecurity and overweight in children.
- **School breakfast and lunch programs.** Children from food insecure households benefit tremendously from participating in the school breakfast and school lunch programs. In fact, research shows that children who participate in the National School Lunch Program have higher intakes of some key nutrients during lunch and over a 24-hour period. And school meal programs must be consistent with the *Dietary Guidelines for Americans* for fat and saturated fat.
  However, there are no reasonable nutrition

standards for food and beverages sold outside the school meal programs in vending machines, student stores, and for fundraising purposes. The almost unlimited availability of junk food and soda on school campuses significantly undermines participation in the school meal programs and may contribute to the over consumption of junk food and soda.

- **Good nutrition—early on.** Providing a foundation of good nutrition in the early years of a child's life is critical. The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) helps low-income pregnant women, new mothers, and young children eat well and stay healthy. Some WIC clients have access to the WIC Farmer's Market Nutrition Program, which provides coupons to purchase fresh produce at local farmer's markets during the summer. WIC also provides nutrition education and helps families stretch their food dollars. However, inadequate funding at the federal, state, and local levels makes the program inaccessible to many eligible families.
- **Healthy eating and activity programs.** Childcare centers and family daycare homes are ideal places to teach and model healthy eating habits and provide healthful, high quality meals and snacks. Adequate funding and support for programs such as Head Start, the Early Childhood Education and Assistance Program (ECEAP), and the Child Care and Adult Food Program ensures that children from low-income households have access to nutritious food, physical activity, and nutrition education.

Exposure to exercise programs for lifelong health.
Children need more opportunities to be physically active. School-based physical education that emphasizes non-competitive, lifelong activity must be adequately funded and staffed. In addition, providing quality, coordinated and comprehensive nutrition education at every grade level would provide children with the opportunity to learn how to eat healthily and be physically active.

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Advertising to kids
Another consideration is the plethora of marketing and advertising of unhealthful products aimed at children. On average, children see 40,000 TV ads a year—the majority for foods and beverages high in calories, fat, and added sugar (such as candy, fast food, sugared-cereals, and soda pop). Research has shown that these ads influence children's preferences for particular types and brands of food and beverages. There is also evidence that watching TV commercials actually has a negative impact on the consumption of fruits and vegetables. Limiting marketing and advertising to children would be a logical place to start.

Food insecurity and the link to overweight cannot be considered in a vacuum. Adequate wages and access to affordable housing, health care, and quality childcare are critical to ensuring families have enough resources to purchase nutritious food on a consistent basis. The western states have some of the highest food insecurity and hunger rates in the country. To prevent food insecurity and overweight, the root causes of poverty must also be addressed.

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Shelley Curtis, MPH, RD, is the Nutrition Outreach and Food Policy Manager at the Seattle-based Children's Alliance. Through the Alliance, Shelley Curtis promotes, supports and expands the reach of federal nutrition programs. She is lead for the Alliance's food and nutrition policy campaign and chair of the Anti-hunger and Nutrition Coalition. Through environmental and policy initiatives—mostly focused on schools—she works to increase children's access to healthful food and beverages.

Ms. Curtis served as a health and nutrition educator in the Peace Corps and as a WIC nutritionist in Boston. She recently received the Mickey Leland Award for Excellence in Leadership from the Congressional Hunger Center.

Food insecurity: Limited or uncertain availability of nutritionally adequate and safe foods; ability to acquire acceptable foods in socially acceptable ways.

Food insecurity with hunger: Uneasy or painful sensation caused by a lack of food. A potential, although not necessary, consequence of food insecurity.

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Birth Outcomes and Weight: A Misunderstood Connection

by Rachel Hien and Cherish Hart

The rising obesity rate in the United States poses a risk to the health of pregnant women and their babies. Pregnancy and childbirth are naturally rife with hazards. Add weight concerns, poor nutrition, overwork, or lack of fitness to the mix, and women are at even greater risk.

More than 40 percent of American women between 15 and 49 are overweight or obese. The majority of overweight or obese girls and adolescents will continue to carry excess weight as adults.

And obesity before pregnancy increases health risks during the entire life cycle. For example, obesity increases risks for infertility, maternal and fetal complications during pregnancy (including congenital malformations), and delivery.

During the postpartum period, obesity may impair lactation performance and—later in life—increase the risk of developing chronic diseases such as cardiovascular disease and type 2 diabetes.

The March of Dimes—focus on nutrition

The March of Dimes has been in the forefront of promoting good nutrition for women of childbearing age. In 2002, the March of Dimes Task Force on Nutrition and Optimal Human Development issued a report called *Nutrition Today Matters Tomorrow* (http://www.marchofdimes.com/printableArticles/681_1926.asp). The report concludes that healthy weight before and during pregnancy improves the likelihood of favorable reproductive outcomes.

Measures that help women achieve a healthy weight include:

- Monitoring body weight and taking corrective actions as needed over the entire reproductive cycle.
- Delaying the first pregnancy to permit full developmental maturation before the start of childbearing.
- Gaining the recommended amount of weight during pregnancy.
- Continuing to be active during pregnancy and the postpartum period, but avoiding activities that produce extreme fatigue.
- Gradually losing weight through diet and physical activity during the postpartum period if overweight or at risk for retention of excessive weight.

Recommendations for health care providers

Increase awareness that healthy weight throughout the life cycle improves the likelihood of good health, including favorable reproductive outcomes.

In preparation for motherhood, help girls, adolescents, and women attain and maintain a healthy weight. Aim to reduce the number of women who start pregnancy with a Body Mass Index (BMI) less than 18.5 or greater than 25.

Where adolescent pregnancy is prevalent—especially among the underweight and overweight—strive to increase the average age at first pregnancy to permit full developmental maturation before the start of childbearing. Assist women to gain a healthy amount of weight during pregnancy. Help women achieve a healthy weight following birth.

Strategies to support these recommendations include the development of policies, guidelines, programs, and materials that promote the importance of healthy weight for favorable reproductive outcomes. In addition, surveillance and evaluation systems should be developed to monitor weight and behavioral changes in diet and physical activity. Health care providers should also be trained in weight management techniques.

For further information on weight and birth outcomes contact: Cherish Hart at 206-624-1373 or by e-mail at chart@marchofdimes.com

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Breastfeeding: A Promising Strategy to Reduce Childhood Overweight

by Alisen Peterson and Lisa DiGiorgio

Idaho, Oregon, and Washington had reason to celebrate during World Breastfeeding Week (August 1–7) since they represented three of only six states in the nation to achieve all of the national *Healthy People 2010 campaign breastfeeding objectives*.

One objective of *Healthy People 2010* is to increase the percentage of first-time mothers who breastfeed to 75% and those that are still breastfeeding at six months to 50%. To support this objective, the U.S. Department of Health and Human Services and the Ad Council recently launched a National Breastfeeding Campaign.

The campaign consists, in part, of public service announcements which describe the consequences of not breastfeeding in the hopes that mothers will be motivated to initiate and maintain breastfeeding to reduce the risk of obesity and respiratory illness and ear infections.

The rates recommended in the *Health People 2010* initiative, however, refer to *any* amount of breastfeeding while the American Academy of Pediatrics (AAP) recommends *exclusive* breastfeeding for the first 6 months of age. Oregon is the one state that has achieved an exclusive breastfeeding rate above 25% at 6 months.

Breastfeeding may be key to reducing the alarming increase in overweight and obese children in the U.S. A growing body of evidence suggests that breastfeeding reduces the risk of unhealthy weight gain in children. A recent study has shown a dose-response protective effect of breast feeding and weight gain—with the greatest benefit in infants who were breastfed six months or more.

How breastfeeding protects against overweight and obesity is unclear but one possible mechanism is greater self-regulation of milk intake by the infant. Also, formula-fed infants consume 66–70% more protein than breastfed infants affecting "metabolic programming" by increasing fat storage and appetite.

Further research should help clarify the association between breastfeeding and reduced risk of childhood overweight by focusing on partial vs.exclusive breastfeeding, genetic, behavioral, economic, and cultural factors. In the meantime, breastfeeding offers a preventive, low-cost, and readily available strategy.

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State Reports

Alaska Report: Planning, policy, and prevention initiatives to combat child and adolescent overweight and obesity

by Erin Peterson

In Alaska, efforts to prevent and control child and adolescent overweight have involved numerous organizations and individuals and have focused primarily on planning and policy change. In June 2003, the State of Alaska Obesity Prevention and Control Program convened a statewide work group to develop a comprehensive plan for addressing obesity. Participants in the planning process met several times between June 2003 and May 2004 to develop obesity prevention and control goals, objectives, and strategies.

Education a priority

Education was identified as an important component of youth program efforts, and specific objectives to raise awareness of the health consequences of childhood overweight were developed. Additional education objectives focused on expanding student participation in school-based nutrition and physical education courses.

The statewide plan also contains program and policy objectives designed to create and maintain community and school environments that are conducive to physical activity and healthy eating. Examples include programs that encourage students and staff to walk or bicycle to school and policies that guide the nutritional content of foods available in schools.

Alignment of statewide and non-profit organization goals

Many of the objectives developed through the statewide planning process parallel policy efforts initiated by organizations within Alaska. The Alaska Action for Healthy Kids State Team—part of the national non-profit organization Action For Healthy Kids—is collecting baseline data related to three "Commitment To Change" goals including:

- Providing age-appropriate and culturally sensitive instruction in health and physical education.
- Adopting policies ensuring that all foods and beverages available on school campuses and at school events are consistent with the USDA *Dietary Guidelines for Americans*.
- Encouraging the use of school facilities for school and community-based programs outside of school hours.

Team members will use the data to direct advocacy efforts around policy initiatives for each goal. During the last legislative session, Alaska Action for Healthy Kids team members actively supported proposed legislation to prohibit some sales of soda and sugared beverages in schools between 8 a.m. and 5 p.m.

Efforts to influence school nutrition policy are also occurring at the local level. From 2002–2004, nine school grantees funded under the USDA Team Nutrition Program developed local school nutrition policies. The policies developed by each grantee differ, ranging from the integration of Alaska Native foods into the nutrition curriculum to increasing the amount and variety of healthy foods available in the school setting. Pending local school board approval, these policies will be implemented in the 2004–2005 school year.

These policy, advocacy, and planning efforts in Alaska are important first steps in preventing and reducing overweight among children and adolescents. Recent data from the Youth Risk Behavior Survey (YRBS) found that 14% of Alaskan high school boys and 8% of Alaskan high school girls are overweight, with BMI values at or above the 95th percentile for their age.

An additional 15% of Alaskan high school boys and 14% of Alaskan high school girls are at risk for becoming overweight, with BMI-for-age values that fall within the 85th to 95th percentiles. When combined, these numbers indicate that there is cause for concern about the weight status of nearly one-third of high school males and more than one-fifth of high school females.

To stem these worrisome statistics, we must continue and expand the educational, programmatic, and policy efforts currently underway in Alaska.

For further information on childhood obesity and overweight initiatives in Alaska, contact Erin Peterson at 907-269-8181 or by e-mail at erin_peterson@health.state.ak.us.

Erin Peterson is the Program Manager of the Obesity Prevention and Control Program with the State of Alaska, Department of Health and Social Services.

Idaho Report: Creating healthier schools for all

by SeAnne Safaii

The state of Idaho is using a multifaceted approach to childhood overweight and obesity. One special focus is school-based programs. We're part of a national campaign—tailored to our state's special needs—and are developing additional activities in local school districts.

Action for Healthy Kids

Action for Healthy Kids (AFHK) is a nationwide initiative, launched in 2002, and dedicated to improving the health and educational performance of children through better nutrition and physical activity in schools. Underlying the program is the assumption that healthy schools produce healthy students—and healthy students are better able to learn and achieve their true potential. Idaho leaders in education, health, and fitness have formed the state's first AFHK team.

Since the national launch of AFHK, the Idaho team has begun targeted efforts to make local schools healthier. Examples include a successful statewide AFHK-I summit in October 2003 and the development of a guide, *Recommendations for Promoting a Healthy School Nutrition Environment*.

Currently the AFHK state team is working to advance its top priority: Educate Idahoans about nutrition and physical activity patterns that improve children's health, well-being, and academic achievement. The AFHK-Idaho team has been awarded funds to implement healthy model schools programs which both promote a healthy school environment and have a negative fiscal impact.

"By bringing together experts from throughout the state AFHK-Idaho team members can assess the condition of our schools and develop action plans to make improvements in nutrition and physical activity," according to the co-chairs of the Idaho team. "Working as part of a national initiative helps to jumpstart efforts to curb the overweight, undernourished and sedentary lifestyles our students face."

Evidence shows the positive relationship between nutrition, physical activity, and the capacity for children to develop and learn. The AFHK state initiatives are working to address these challenges where it counts—in classrooms, playgrounds, lunchrooms and gymnasiums."

A Local Success Story—The Me I Want To Be

Southwest District Health's Division of Nutrition and Health Promotion worked with teachers, staff, and K-2 students at Lincoln and Washington Elementary Schools in Caldwell on a special program designed to address the issue of child obesity.

"The Me I Want To Be" program provided students the opportunity to participate in exercises that promoted the importance of having a positive body image, eating healthy foods, and being physically active.

Israel Espinoza, Principal of Lincoln Elementary endorsed his school's involvement in the program. "Obesity is a problem that is showing up even at the elementary school level. It is imperative that our kids begin to have their consciousness raised when it comes to their wellness."

The project objective is threefold:

- To show children in grades K-2 the connection between eating a variety of food and growing strong and healthy.

- To reinforce self-esteem and sensitivity toward various body sizes and shapes.

- To promote increased exercise by providing ideas for safe and easy activities that are adaptable to any environment.

According to Jeanette Jones, Division Director of Nutrition and Health Promotion Services for Southwest District Health, "Children who learn to love physical activity and fitness, and are taught to eat right at an early age, are almost sure to develop healthy lifestyles."

Nancy Fortner, PE Teacher at Washington Elementary, said that the students especially liked *Power Panther*, who is a "spokes character" that conveys nutrition and physical activity messages in a fun and non-threatening way.

"The students really enjoyed the program and learned what is healthy to eat as well as the importance of exercise," she said.

The health district worked with students and teachers in their classrooms, as well as during their PE periods. The program worked with second graders last fall and with Kindergarten and first graders in April.

Jones praised the teachers and school personnel of both schools. "They were all great to work with, and we appreciate their efforts in making this program so effective."

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SeAnne Safaii coordinates the nutrition education training program and Team Nutrition grants for the Idaho Department of Education. She also co-chairs Action for Healthy Kids in Idaho. Ms. Safaii was trained in clinical dietetics and health education, and is now pursuing a doctorate in adult education. Her publications cover school nutrition and school health programs for, among others, the American School Food Service and the American Dietetic Associations.

Oregon Report: Striving for a healthy active Oregon

by Jennifer Young

"Oregon—Fattest State West of the Rockies and #1 for Hunger in the U.S." This paradoxical dual distinction put Oregon in the headlines and made it clear that a true public health crisis existed in our state.

There's an established link between income, food supply, and obesity, but the obesity epidemic has also crossed income boundaries and taken its toll on some of our youngest residents. In Oregon, one out of every four 8th graders is overweight or at risk of overweight.

The family health programs within the Office of Family Health (OFH)* have been working for two years to improve nutrition and physical activity choices for Oregonians. Our initial goal was to create consistent nutrition and physical activity messages that could be used within each OFH program during client visits or counseling, and that would be repeated in educational materials.

We soon realized that before we could take our messages out to the counties, there was much to be done with our own staff first.

The goal shifted to providing healthy food choices and increased opportunities for physical activity to our state public health staff. Our hope was that this would create a level of enthusiasm for healthy behaviors among employees of the state's health programs and county public health programs. We believe that this integration of consistent nutrition and physical activity messages will eventually improve the health of those who use the public health clinics.

What we've done
We initially created a matrix of all the OFH programs to determine how programs were integrating nutrition and physical activity counseling. We then developed an officewide Nutrition and Physical Activity Plan based on our statewide public health nutrition and physical activity plans. We chose one nutrition objective and one physical activity objective.

1. Increase the daily servings of fruits and vegetables that Oregonians are consuming.
2. Increase the daily physical activity of Oregonians.

We decided to first tackle the nutrition environment of the Portland State Office Building (PSOB) where we work by trying to improve the food quality and the fruit and vegetables provided in the PSOB cafeteria. We conducted a survey of the building cafeteria to understand the preferred meal choices of employees using a Web-based tool, Survey Monkey, with additional comments collected by e-mail. Four hundred people responded to the survey, over half of the building's employees. The café owners were amenable to the survey and are working with us to realize some of the survey recommendations in their food selections and preparation.

To promote physical activity in the 11-story building, we teamed up with the building's Wellness Center and promoted a 10,000 step walking campaign, a stairwell use promotion, and stairwell decorating competition. Also, we asked the building manager to place signs near the elevators directing people to the stairwell.

We have worked to build awareness and educate those in the building by using the display board in the lobby to display nutrition and physical activity information and to promote the building-wide activities.

Getting the message out to counties
In June 2004, we conducted a video conference that was broadcast to Oregon counties. The video presentation covered nutrition, physical activity, and obesity prevention on three levels:

1. Working with the individual
2. Changing the worksite environment
3. Building community partnerships.

We shared our efforts working within the PSOB and asked county participants to focus on one of the three video conference topics. We're hoping to provide small "activity funds" through the Office of Family Health to help counties

**OFH programs include Title V, immunization, oral health, genomics, adolescent health, child health, perinatal health, women's and reproductive health, and WIC.*

get started on obesity prevention efforts.

All of our resources and tools are on a Web site including worksite projects, the videoconference PowerPoint presentation, as well as valuable links on nutrition, physical activity, and obesity prevention for public health professionals and staff.

For more information on Oregon's obesity prevention efforts, go to http://www.dhs.state.or.us/publichealth/ofhs/nutrition/index.cfm or contact Jennifer Young.

Jennifer Young is a nutrition consultant and physical activity coordinator for the Office of Family Health. She can be reached at 503-731-8619 or by e-mail at Jennifer.Young@state.or.us.

Washington State Report:
Tackling childhood obesity through state-wide planning and legislation

by Ruth Abad

Washington State's approach to obesity prevention is described in the *Washington State Nutrition and Physical Activity Plan: Policy and Environmental Approaches.* The plan emphasizes building a strong foundation at the institutional, community, and policy levels to make it easier for people to choose healthy lifestyles.

There are two overarching goals for the plan:

1. Increase the proportion of adults and children whose diets reflect the USDA Dietary Guidelines for Americans http://www.nal.usda.gov/fnic/dga/.
2. Increase the proportion of adults and children who meet physical activity recommendations.

Objectives to improve nutrition include:

- Increase access to health-promoting foods.
- Reduce hunger and food insecurity. (See "Food Insecurity and Overweight".)
- Increase the number of women who breastfeed their infants and toddlers (See "Breastfeeding.").

Objectives to raise physical activity levels include:

- Increase the number of people who have access to free or low cost recreational opportunities for physical activity.
- Increase the proportion of children who meet the recommendations for moderate or vigorous physical activity.
- Increase the number of active community environments.

Partnerships are key

Many individuals, state agencies, organizations, and community groups have joined together to carry out the priority recommendations described in the plan. A few of the many activities that directly affect children and their families are described below.

On the local level, two cities—one in central Washington (Moses Lake) and another in northwest Washington (Mt. Vernon)—used a community participation model to assess needs, identify community leaders, select priorities from the state plan, and develop a Healthy Communities Action Plan.

Moses Lake, population 15,000, is promoting breastfeeding-friendly policies in the workplace, developing a community garden, and a trails project. The priorities for Mount Vernon (population 26,000) include improving access to healthy foods in schools, using urban planning approaches that promote physical activity, and increasing the number of physical activity opportunities available to children in the school setting.

Adopting policies in the schools

School policy on nutrition and physical activity is another avenue for addressing the goals in our state plan. A few of the many initiatives include:

- The Washington Action For Healthy Kids Team whose goal is to reduce the incidence of childhood overweight and obesity by increasing the number of schools that adopt model nutrition and physical activity policies.
- Implement Senate Bill 5436. This bill calls on the Washington State School Directors Association—along with the Washington State Department of Health, Office of the Superintendent of Public Instruction, and the Washington Alliance for Health, Physical Education, Recreation, and Dance—to develop a model school nutrition and physical activity policy by January 2005. Each school district must adopt its own policy by August 2005.
- Organize community forums—coordinated by the Washington State Board of Health and six local communities—to raise awareness of the conse-

quences of children's inactivity and poor nutrition and share strategies for potential adoption by schools. The forums took place in Benton, Franklin, Clark, King, Island, Thurston, and Pierce Counties.

- A pilot survey was conducted in King County—the largest in the state—to assess school district physical activity and nutrition policy.

For a copy of the state plan, go online to http://www.doh.wa.gov/Publicat

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For further information on these activities and other projects related to the Washington State Nutrition and Activity Plan, contact Ruth Abad at 360-236-3708 or by e-mail at ruth.abad@doh.wa.gov.

Ruth Abad is a public health educator with 30 years experience in community health promotion. She serves as a healthy community specialist with the state's Obesity Prevention Program. Her interests are group facilitation, community involvement, and designing effective population-based health promotion projects.

UW Maternal and Child Health Education Opportunities for 2005

The University of Washington offers several pathways to obtain an Masters of Public Health in Maternal and Child Health (MCH). The **Extended MPH Degree Program** (EDP) is available to mid-career public and community health professionals who can not attend school full time. The program can be completed in three years or less and is delivered through a combination of independent study and some required attendance on-campus. The application deadline for this program is **February 15, 2005**. The EDP also offers a one-year **Certificate of Public Health**. Individual MCH courses may also be completed by distance. Application forms and information material are available on the EDP Web site at http://depts.washington.edu/hsedp.

The **MCH Leadership Training Program** offers an in-residence program leading to a **Master of Public Health Degree** through either the Departments of Health Services or Epidemiology. The program requires two years to complete and includes a practicum and thesis. The next application deadline is mid-January 2006.

The MCH Program's core and affiliate faculty are drawn from diverse fields: obstetrics, pediatrics, social work, nutrition, child development, and nursing. Faculty research interests cover a wide range of health policy and epidemiological issues, including perinatal epidemiology; child and adolescent health; children with special health care needs; injury prevention; nutritional risk; behavioral, organization, and social influences on health care utilization; and women's health.

Strong links have also been built between the MCH Program and many public and private health organization in the Northwest. Practicum placements and thesis research can involve working with local and state health departments, area hospitals, private and community health centers, and other regional programs. For more information about the program, check its Web site at http://depts.washington.edu/mchprog/admissions.html.

Resources

American Public Health Association, American Journal of Public Health, 94(9), September 2004.
This issue includes a series of articles on various aspects of obesity/overweight. The editors note that, like tobacco control, multilevel actions on the individual, community, and policy levels are needed. A key goal for organizations and providers is to maximize collaborative efforts in a climate of limited resources.

Action for Healthy Kids
Action for Healthy Kids is a national initiative to improve the health and educational performance of children through improved nutrition and physical activity in schools. Their Web site, updated regularly, contains data profiles on nutrition and physical activity for each state, a report on the relationship between weight, nutrition, activity, and academic performance; and helpful tools and strategies designed by state and national teams.
http://www.actionforhealthykids.org/

American Academy of Pediatrics, "Policy Statement: Prevention of Pediatric Overweight and Obesity," Pediatrics, 112(2) August 2003, p.424-430.
The AAP policy on the subject of pediatric overweight and obesity is outlined in this article which covers definitions, risk factors, early recognition, advocacy, and recommendations.
http://aappolicy.aappublications.org/cgi/content/full/pediatrics;112/2/424

Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.
State-Based Nutrition and Physical Activity Program to Prevent Obesity and Other Chronic Diseases. This comprehensive program funds 28 states (including Oregon and Washington) to increase capacity to develop nutrition and physical activity interventions including reduction of television time and breastfeeding, along with diet and physical activity goals. The Web site also contains obesity and economic data, resources, and recommendations.
http://www.cdc.gov/nccdphp/dnpa/obesity/state_programs/index.htm

Center for Science in the Public Interest (CSPI)
The CSPS Web site contains numerous resources from *Pestering Parents" How Food Companies Market Obesity to Children*—published in 2003 and available in PDF and print—to information on their Nutrition Policy Project.
http://www.cspinet.org/

Bright Futures-Nutrition and Physical Activity Supported by the Health Resources and Services Administration, Maternal and Child Health Bureau, these works offer guidelines to health professionals for promoting physical activity and nutrition in infants, children, and adolescents. Nutrition and activity fact sheets are available in Spanish.
http://www.brightfutures.org

Center for Public Health Nutrition
The Center—based at the University of Washington School of Public Health and Community Medicine—seeks to improve the health and nutrition of residents of Washington state. Some Center activities include supporting community-based research through community grants, educating practitioners and residents about food and nutrition issues, and providing technical assistance to government, community, and advocacy groups.
http://www.depts.washington.edu/uwcphn

Center for Weight and Health, College of Natural Resources, University of California, Berkeley**. "**Pediatric Overweight: A Review of the Literature**,"** June 2001. An extensive overview and analysis of childhood overweight and obesity. Includes information on genetic and environmental factors, diet and physical activity interventions including individual and family, school, and community based interventions, social marketing for health behavior change, and policy and legislative approaches.
http://www.cnr.berkeley.edu/cwh/PDFs/Full_COPI_secure.pdf

Children and Weight: "What Communities Can Do." *Center for Weight and Health,* University of California, Berkley.
A wealth of educational materials, programs, and tools for health professionals, schools and teachers, parents and families, and more. Includes extensive listings and links to programs throughout the country on topics ranging from children with diabetes to body image. Add your program to the list and join an online discussion forum to network about childhood overweight.
http://www.nature.berkeley.edu/cwh/activities/child_weight2.shtml

Coalition for a Healthy and Active America.
This national non-profit organization was formed in 2003 and has active coalitions in 14 states, including Washington. This grassroots coalition seeks to educate children, schools, and communities about the importance of physical activity and nutrition education in reversing the trend of childhood obesity.
Washington State Chapter Contact: Ben Gitenstein; Washington@chaausa.org

Illinois Nutrition Education and Training Program, *Twenty Ways to Raise Funds Without Candy.*
A creative list of ways that schools and students can raise funds while avoiding the common approach of selling unhealthy foods or foods with poor nutritional value. Includes ideas with the added benefits of physical activity and community service.
http://www.kidseatwell.org/flyers/twentywaystoraisefunds.pdf

Institute of Medicine. "Preventing Childhood Obesity: Health in the Balance," September 30, 2004. This nearly 500-page report examines the nature, extent, and consequences of obesity in American children and adolescents focusing on the social, environmental, medical, and dietary factors associated with the increasing prevalence of obesity. Included are a prevention action plan describing short and long-term interventions believed most effective along with recommendations geared toward the many stakeholders concerned with this issue. To order go to:
http://www.nap.edu/catalog/11015.html

Kaiser Family Foundation, "The Role of Media in Childhood Obesity," February 2004.
This issue brief is the first to analyze available research (more than 40 studies) on the role the media plays in childhood obesity. It also

delineates media-related policy options that have been proposed to help address childhood obesity as well as suggestions for how the media can positively influence this epidemic. Readers may be surprised at the finding that media use has not been shown to displace physical activity, though other common assumptions are supported.
http://www.kff.org/entmedia/entmedia022404pkg.cfm?RenderForPrint=1

Morris, Marya, American Planning Association. *Rethinking Community Planning and School Siting to Address the Obesity Epidemic*. Prepared for the NIEHS Conference on Obesity and the Built Environment: Improving Public Health through Community Design. Washington, DC., May 24–26, 2004.
In the last several years, public health policymakers and researchers have turned their attention to the built environment, community design, and transportation options as a new strategy and perspective for addressing the obesity epidemic given the influence of these factors on physical activity. This report by the American Planning Association, funded by the Robert Woods Johnson Foundation, outlines new research and planning paradigms deriving from this interdisciplinary approach to obesity.
http://www.niehs.nih.gov/drcpt/beoconf/postconf/overview/morris.pdf

US Department of Agriculture, Food and Nutrition Information Center-Information Research Services Branch. *Cultural and Ethnic Food and Nutrition Education Materials: A Resource List for Educators*, August 2001.
A compilation of educational and background material for professionals working with a variety of ethnic and cultural groups. Includes health and nutritional information for English and non-English speakers for community, school, and patient educational settings, journal articles on educational interventions, and governmental and education organizations.
http://www.nal.usda.gov/fnic/pubs/bibs/gen/ethnic.html

US Department of Agriculture, Food and Nutrition Information Center. *Childhood Obesity: A Food and Nutrition Resource List for Educators and Researchers,* June 2000.
A useful compendium of resources on childhood obesity aimed at educators and researchers. Includes some Web and consumer-oriented materials and a substantial listing of published articles from 1997–2000 with an emphasis on public health.
http://www.nal.usda.gov/fnic/pubs/bibs/topics/weight/childhoodobesity.html

US Department of Health and Human Services, National Institutes of Health. "Strategic Plan for NIH Obesity Research," August 2004.
This recently published document serves as a guide for coordinating obesity research throughout the NIH. The major themes covered include prevention-oriented research through lifestyle modification, pharmacological, and other medical approaches and research aimed at "breaking the link" between obesity and comorbid conditions. In addition several several related topics such a translational rseearch, educational and outreach efforts, and health disparities are described. From the Web site individuals may order one free print copy or download the entire piece or an executive summary via PDF or text format.
http://www.obesityresearch.nih.gov

WIN in the Rockies-A community based research, intervention, and outreach project to improve health in Idaho, Montana, and Wyoming.
Wellness IN the Rockies (WIN) is a food and nutrition behavior change consortium consisting of the University of Idaho, Montana State University, the University of Wyoming, and several other groups. The focus of this four-year project is to integrate research with an extension/education component that emphasizes collaboration in the planning, implementation, and evaluation of interventions that support behavior change. One particularly interesting research focuss the investigation of attitudinal and behavioral traits connected to food, physical activity, and body image. The Web site also contains a useful list of educational materials and journal articles.
http://www.uwadmnweb.uwyo.edu/WinTheRockies/

Save the Date

January 7–15, 2005, Advanced Health Leadership Forum, School of Public Health UC Berkeley.
The Advanced Health Leadership Forum is a unique certificate-based international health program focusing on key health policy issues. Participants will grapple with policy issues and options that have been converging internationally, learning about both viable and unsuccessful policies. The program also teaches effective policy implementation and health systems change.
http://www.execdev.haas.berkeley.edu/ApplicationFiles/web/WebFrame.cfm?web_id=143

January 9–12, 2005, California Childhood Obesity Conference. Launching a Movement: Linking Our Efforts to Make a Difference, San Diego.
This is the largest conference in the U.S. on pediatric overweigh. It will address issues related to childhood overweight and obesity from a myriad of viewpoints ranging from the health care industry and community-based organizations to schools, parents, and marketing advocates.
Sessions will highlight healthy eating and physical activity strategies and tools appropriate for low-income populations that attendees can adopt in their own communities.
http://www.cce.csus.edu/cts/co/index.htm
(Note: Registration increases after December 8)

January 27–January 30, 2005, American Medical Women's Association (AMWA) Annual Meeting, Washington DC.
AMWA's 89th Annual Meeting will focus on the unique role of women in the workplace, including physicians, residents, and medical students. Attendees will explore issues surrounding the health effects of women in the workplace, personal and work-related safety, and advocacy to support change.
http://www.amwa-doc.org

February 28–March 2, 2005, National Initiative for Children's Healthcare Quality (NICHQ), Transforming Health Care for All Children, San Diego.
NICHQ's 4th annual forum provides opportunities to learn new skills, discover good ideas and practical tools, and network with colleagues. Aimed at health care leaders, clinicians, quality improvement professionals, child and family advocates, and others.
http://www.nichq.org/events/forum/2005/

April 4–April 10, 2005, National Public Health Week
National Town Hall Meetings (webcasts) and Events on Eliminating Health Disparities
Go to http://www.apha.org/nphw/ for more information. For events in Oregon, Washington, Idaho, and Wyoming click on "What's Happening in Your State."

April 5, Washington, DC
Webcast on eliminating ethnic and racial health disparities by moving the nation from statistics to solutions. Ask the Experts: Ethnic and racial disparities in health.

April 6, Memphis
Eliminating rural health disparities—moving from statistics to solutions.

April 7, Chicago
Public response for eliminating health disparities through health literacy.

April 8, New York
Working together to ensure a healthy environment.

April 9, Oakland
California's collaborative approaches to defeating health disparities.

May 12, Health Mothers, Health Babies Coalition of Washington State 2005 Making Connections for Health Luncheon. Bell Harbor International Conference Center, Seattle.

May 21–25
Northwest Regional Primary Care Association 2005 Conference, Anchorage**.**
Registration brochure will be available in February 2005
http://www.nwrpca.org/conf/detail.php?ID=342