

Preventing childhood obesity in america

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Preventing Childhood Obesity in America: Everyone Plays a Role

Childhood obesity in America is a growing epidemic. Most would claim they know it is a problem in our country, yet every year there is an increase in the amount of obese children in the United States. The medical, physical, and psychological effects associated with obesity are astounding; nevertheless, processed, high calorie, low nutrient food is widely available and consumed on a regular basis by children. Parents, childcare providers, schools, and the community all need to aid in the cure and prevention of childhood obesity by providing healthy, nutritious food for children and encouraging daily exercise. Childhood obesity rates have risen at alarming rates over the past three decades. Since the 1970s, childhood obesity has more than doubled in America.

According to the Centers for Disease Control and Prevention ([CDC], 2010), obesity increased from 5 to 10.4% between 1976 and 2008 among pre-school children 2-5 years of age. The number of obese children aged 6-11 increased from 6.5 to 19.6% during those years. The estimation for 2010 is that one in every five children in the United States of America is already, or will be, overweight. The result of this has come to the fact that childhood obesity is now the most common prevalent nutritional disorder of children living in the United States.

It is one of the most common disorders seen by pediatricians in this country as well (Obesity Society, 2010). The issue of childhood obesity is complex and not easily remedied. The "toxic environment" we live in right now has contributed to one-fifth of our children having a weight problem (Friedman and Schwartz, 2008, p. 718). Cheap, tasty, nutrient-lacking foods are never

far from reach. Junk food, processed edible items, and calorie dense morsels are sold in every supermarket, convenience store, vending machine, and public place available, including schools. It wasn't until recently that schools became suppliers of nutrient-poor, calorie dense food to children.

Milk and water from the fountain were the only available beverages in schools for decades. In 1970, only 15% of children ages 6-11 drank soda compared to 61% who drank milk. In 2002, the numbers took a turn with 33% of children being soda drinkers and 33% drinking milk. How did this statistic change? Schools started trying to fill the gap between their needs and their budget. Soda was cheaper than milk, so it became a substitution. Meanwhile, vending machines came into the picture (Friedman and Schwartz, 2008). Kids could choose to eat a sandwich and carrots that were packed for them from home, or they could just buy a bag of chips and a soda out of the vending machine.

Obviously, to kids, the sugar and chips would be more appealing than the healthy alternative. Life styles have also changed drastically for children over the past thirty years. With the increased number of broken homes and women in the work force, fast food is an easy dinner fix. Most single working parents, and even many married working parents, would say it is much easier, and generally less expensive, to grab a burger and fries for their kids through a drive through window than it is to cook a nutritious dinner at home. In addition to the buildup of consuming more and more calories on a daily basis due to life style changes, schools have eliminated physical education programs and recess, and now TV and video games baby-

sit children (Friedman and Schwartz, 2008). With the excess of caloric intake in all these unwholesome foods, and the decrease of exercise and movement in children, it's no wonder there is a childhood obesity crisis. So, how can a child be determined as obese? A child's Body Mass Index (BMI) identifies it.

BMI measures weight in relation to height. It is used to determine one's weight status. BMI is the most widely accepted method used to screen for overweight and obese children because it is the easiest way to obtain the height and weight measurements needed to calculate BMI, the measurements are non-invasive for the child, and BMI correlates with body fatness. But, keep in mind; while BMI is an accepted screening tool for the initial assessment of body fat in children and adolescents, it cannot be used to diagnose anything because BMI is not a direct measure of body fat (CDC, 2010). Multiplying their weight in pounds by 703 and then dividing that number by their height in inches determine a child's BMI. This number is then compared to the CDC growth chart that compares other children of the same age and sex. Children who have a BMI at or above the 95th percentile for age and sex are considered obese.

Disturbingly, twenty percent of all children in America are in this percentile (Obesity Society, 2010). The Obesity Society (2010) points out that the numerous negative short term and long-term effects associated with childhood obesity are overwhelming. These include both psychological and physical health effects due to a child being overweight. Potential negative psychological effects obesity may have on a child included depression, poor body image, low self-esteem, and risk for possible eating disorders later in life

such as anorexia, bulimia, or compulsive binge eating. Obese children can also be the target of bullying, teasing, social exclusion, and other negative weight-related issues (Friedman and Schwartz, 2008). Negative health consequences for an obese child can include insulin resistance, type 2 diabetes, hypertension, high LDL cholesterol and triglyceride levels in the blood, low HDL cholesterol levels in the blood, sleep apnea, early puberty, orthopedic problems such as Blount's disease and slipped capital femoral epiphysis, and non-alcoholic steatohepatitis (fatty infiltration and inflammation of the liver). Furthermore, obese children are more likely to be obese as adults; hence they are at increased risk for a number of diseases including stroke, cardiovascular disease, hypertension, diabetes, and some cancers (Obesity Society, 2010).

One study found that approximately 80% of children who were overweight at ages 10–15 years were obese adults at age 25 years. Another study found that 25% of obese adults were overweight as children. If a child is overweight before they are 8 years old, obesity in adulthood is likely to be more severe (CDC, 2010). There are many contributors to childhood obesity. The CDC (2010) states that childhood obesity is the result of an imbalance between the calories a child eats and drinks and the calories a child uses to support normal growth and development, metabolism, and physical activity. In other words, a child becomes obese when he consumes more calories than he uses. The Obesity Society (2010) lists some of these contributing factors as food choices, lack of physical activity, parental obesity, eating patterns, parenting style, and parental feeding and physical activity habits.

A parent can choose a child's food, which can contribute to their child becoming overweight. These choices, which contribute to obesity, include diets higher in calories (including fats and simple sugars), and lower in fruits and vegetables. A child who has obese parents is more likely to be overweight (Obesity Society, 2010). Some of this is inherited and linked to gene mutation; but even children with a genetic risk for becoming overweight will still only become overweight if they eat more calories than they burn. Parents who are overweight may also reflect a household who excessively eats and doesn't get enough physical activity (Obesity Society, 2010). Children look at their parents as role models. If a parent is displaying unhealthy behavior, it can make a child think that kind of lifestyle is accepted and reasonable.

Due to this startling data associated with obese children in the United States, many things need to change. Parents and caregivers should choose what their children eat, (what foods and drinks are in the home, what foods and drinks are served at meals and snacks, what restaurants they go to, etc.); on the other hand, as opposed to food choices, parents should allow their kids to choose whether they eat at all and how much to eat (Obesity Society, 2010). Parents should not force a child to eat when they aren't hungry, nor encourage a child to finish their plate so they can have dessert. This encourages overeating. This will in turn cause a child will think they always need to finish everything that is on their plate, even if that plate contains double their suggested daily caloric intake. The Obesity Society (2010) also states that fruits and vegetables, as compared to high calorie snack foods (often high fat and high sugar), should be readily available in the home;

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parents and childcare providers should serve and eat a variety of foods from each food group.

Small portion sizes should be encouraged, and that if the children are still hungry then more food can always be added when they are done. Meat should be baked, broiled, roasted or grilled instead of breaded and fried; meat substitutes should be incorporated into meals because they contain less calories and fat than meat. Pollan (2009) claims that children should be fed food. They should not be fed high fructose corn syrup, because it is sugar. They should be fed foods that will eventually rot, not over-processed foods that have a decade-long shelf life. They should not be fed preservatives that they can't pronounce, such as ethoxylated diglycerides and ammonium sulfate. Foods that are highly processed are robbed of most of their nutrients, which extends their shelf life.

Processing takes out many healthy nutrients, for instance omega-3 fatty acids (which are crucial for a child's brain development), because they will turn rancid. In turn, children are eating a lot of calories, and missing out on key nutrients that help them grow and learn. There should be a limited use of high calorie, high fat, and high sugar sauces and spreads. Low-fat or nonfat dairy or soy products should be used for milk, yogurt, and ice cream. Sodas and sugary beverages should be completely eliminated from all children's diets and replaced with water, 100% fruit juice, or low fat, nonfat, soy, or another type of milk. If fruit juice is provided, it should be limited to two servings or less a day. Some parents allow their children unlimited

intake of fruit juice because it provides vitamins and minerals (Obesity Society, 2010).

However, children who drink too much fruit juice may be consuming excess calories and sugar. Children may not compensate at meals for the calories they have consumed in sugar-sweetened drinks. Also, liquid forms of energy may be less satisfying than solid foods, which could lead to children drinking more calories than what they would eat (CDC, 2010). Participating in physical activity is important for children because it may have beneficial effects not only on body weight, but also on blood pressure and bone strength. Physically active children are also more likely to remain physically active throughout adolescence and possibly into adulthood. Unfortunately, children may be spending less time doing any physical activity during school than they used to. Daily participation in school physical education among adolescents dropped 14 percentage points over the last 13 years — from 42% in 1991 to 28% in 2003.

In addition, less than one-third of high school students meet current recommended levels of physical activity (CDC, 2010). The Obesity Society (2010) informs us that parents need to support participation in play, sports and other physical activity at school, church or community leagues. Families should be active together by going on bike rides, swimming, or taking a walk together after dinner. The Obesity Society (2010) encourages TV time to be limited with children, and they should avoid eating while watching it. Eating while watching TV can contribute to eating too much and too fast. The foods and drinks that are advertised on TV also influence children. One study found

that and average of over 3 hours per day among children were spent watching TV, movies, videos, and DVDs.

Also, several studies have found a positive association between the time spent viewing television and increased prevalence of obesity in children. This is because media use, especially watching TV in a sedentary position for hours at a time, may take away from time children could spend in physical activities, contribute to increased calorie consumption through snacking and eating meals in front of the TV, influence children to make unhealthy food choices through exposure to food advertisements such as candy and fast food, and lower children's metabolic rate (CDC, 2010). Free play in young children should be encouraged, and environments that allow children to play indoors and outdoors should be provided. Parents and child-care providers should be role model through actions, healthy dietary practices, nutritional snacks, and lifestyle activities. Badgering children, restrictive feeding, labeling foods as " good" or " bad," and using food as a reward is completely unnecessary and can result in harmful behaviors later in life (Obesity Society, 2010). All of these ways of trying to solve the childhood obesity crisis need to be enforced not only by parents, but also childcare providers, schools, and the community. In the home, parent-child relationships and the home environment can affect the behaviors of children.

Kids will most likely develop habits that are similar to their parents'. Another point to consider: on average, 80% of children aged 5 years and younger who have working mothers are in childcare for at least 40 hours a week. These providers share responsibility with parents for children during important

developmental years. Childcare can be a setting in which healthy eating and physical activity habits are learned and developed (CDC, 2010). Schools have a major role in this issue. The majority of young people aged 5-17 years are enrolled in school. Schools provide the perfect setting to teach children healthy eating habits and physical activity behaviors because of the amount of time children spend there (CDC, 2010).

Many schools in the past few decades had cut physical education out of the curriculum and cut recess back to make more time for academic studies. This results in a sedentary day for most students. (Friedman and Schwartz, 2008). Some schools across the country are slowly starting to implement better nutrition and increased physical activity for their students by increasing healthy foods offered, increasing physical education programs, decreasing vending machine advertising to children, and enforcing other general policies (CDC, 2010). In 2005, 37 states considered policy to increase nutrition standards for schools, 19 states considered increasing nutrition education in schools, and 38 states considered increasing physical education programs at schools. Although it was honorable that all of these states considered these policies, only a little less than half actually enacted them (National Conference of State Legislators, 2010). All schools should be required to provide daily physical activity and nutritional lunches to all of their students.

Ways that teachers can involve students in making healthier food choices would be to incorporate it into their curriculum. There are many activities teachers can do to build awareness of health and nutrition to their students. For example, with school age children (ages 6-12) they can teach about the

food pyramid and which foods fit into which food group. They can then have hands-on activities planned to incorporate this new information. After teaching about the food pyramid, teachers can have some menus from some popular restaurants. The teacher can read some options from these menus and ask the students whether or not the options sound healthy. After learning about the food pyramid and discussing some healthy and non-healthy options for eating out, the students can be divided up into groups.

The teacher can talk about a few healthy options that could be on a restaurant menu, and then the students can design their own menu with a few healthy meals with foods from each food group listed on them. The students will need paper and either crayons, markers, or colored pencils for the project. Then the students can present to the class what they have designed as their menu, and talk about why their choices are healthy. It is important for the teacher to evaluate the curriculum in order to get feedback about if the instruction was effective and to see if the children understand the information (Maroz, 2009). To evaluate this curriculum, the teacher would observe the children making their menus and presenting them to the class. By seeing the students listing foods from each food group on their menu, she will know the children understand about healthy and non-healthy foods. The community is an important enforcer of nutrition as well.

If a community doesn't have sidewalks, bike paths, or parks, and can't provide affordable healthy food for its citizens, how can a child be expected to eat healthy and get physical activity (CDC, 2010)? Communities should not allow advertising of food to children. Popular cartoon characters are

often associated with fast food restaurants in their children's meals (Friedman and Schwartz, 2008). Communities should not allow this to happen at these restaurants. It is promoting children to want to eat unhealthy food. In conclusion, the past three decades have changed the way our children eat and play. A meal made at home consisting of a lean protein, vegetable, starch, and glass of milk has been replaced with a triple bacon cheeseburger, super sized sides of fries, and forty ounces of carbonated refined sugar. Going out and playing a game of basketball in the driveway for fun has been replaced with watching a game on high definition TV or playing a video game.

This epidemic has been discovered, and many are completely aware of it and it's consequences. But it will still take a lot of time to break the habits that have been formed over years. It is up to all of us, including parents, childcare providers, schools, and communities, to break the cycle of childhood obesity. We can start with our own children by teaching them healthy living. Eventually, future generations will be able to embrace a life of healthfulness and vitality because of how we behave as role models for our children today. References Childhood Obesity - 2005 Update and Overview of Policy Options. (2010).

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