Childhood Obesity
Our Children in Crisis
By
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Childhood Obesity

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Acknowledgments

First and foremost, I give all praise to my Lord and Savior JESUS CHRIST. He has truly sustained me my entire life.

My mother Mary, who is my rock and my inspiration; She is the cause of all that is great in my life. She taught me perseverance, hard work and most of all the power of faith.

To my sister Traci, you have pulled me off many a ledge. You listened to me scream, cry, curse, mumble, groan and complain. You gave me encouragement and a kick whenever it was needed. You never let me quit.

To my children, Chantal and Isaac, you are my guiding light. I’m supposed to lead and teach you, but you have taught me, love; patience, and self-control. Being your mother has brought me unspeakable joy and I thank you for allowing me to take time away from you to pursue this dream.

To My Pastor and First Lady Jackson, thank you for allowing GOD to use you. I have followed your unfailing faith and your guidance. I couldn’t have done this without you.

From the bottom of my heart; Thank you all.
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Abstract

Childhood obesity has reached epidemic proportions in our country and is causing sickness and disease in our children. Childhood obesity can lead to diabetes and has been linked to certain types of cancer.

In the Antelope Valley, the percent of children in grades 5, 7 & 9 who are overweight is 18.1% from a population of 305,400. The Los Angeles county average is 21% in a population of 9,862,049.

Although, obesity affects children from all demographics and income levels For the Hispanic and African-American, economically disadvantaged children, the numbers are even more staggering.

First Lady Michelle has started the “Let’s Move” campaign, to address the issue and get schools and communities involved in the challenge. The message behind the Let’s Move campaign is that when people are more active they burn more calories. She has challenged chefs in individual communities to collaborate with school cafeterias to develop a menu that is nutritious and tasteful. She also encourages parents to make sure their children eat healthy and exercise.

The focus of this paper will be best practices in the treatment and prevention of obesity in children.
Chapter One

Introduction

According to the Center for Disease Control (CDC) child-
hood obesity has reached epidemic proportions in our country.
Seventeen percent or twelve million children and adolescents
age 2-19 are obese. (2012)

According to the United State Department of Health and
Human Services, (HHS) childhood obesity is one of the greatest
public health, social, and economic challenges of the twenty-
first century.(2012) Obesity is a nationwide problem but it
disproportionately affects low income children. According to
the Children’s Defense Fund, almost forty-five percent of
overweight or obese children age 10-17 are poor.

Obesity is costly to state taxpayers who fund about
half of obesity-attributable U.S. medical expenses through
Medicare and Medicaid. The medical care costs, for the treat-
ment of obesity and obesity related illnesses, in the United
States are colossal. In 2008, these costs totaled about $147
billion (Finkelstein, 2009). Today the costs are $190.2 bil-
lion per year. (2012 U.S. World Reports) According to the CDC,
the costs assoc-
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-iated with obesity are significant and increasing. Annual hospital costs related to obesity among children and adolescents increased, rising from $35 million to $127 million (CDC, 2008). The medical costs for a child treated for obesity are approximately three times higher than those for the average insured child (IOM, 2007 website). Today, about one in three American children and teens is overweight or obese; nearly triple the rate in 1963. The percentage of children age six to eleven in the United States, who were obese increased from seven percent in 1980 to nearly twenty percent in 2008. Similarly, the percentage of adolescents aged twelve to nineteen who were obese increased from five percent to eighteen percent over the same period.

With good reason, childhood obesity is now the No.1 health concern among parents in the United States, topping drug abuse and smoking. Excess weight at young ages has been linked to higher and earlier death rates in adulthood. Perhaps one of the most sobering statements regarding the severity of the childhood obesity epidemic came from former Surgeon General Richard Carmona, who characterized the threat as follows:

Because of the increasing rates of obesity, unhealthy eating habits and physical inactivity, we may see the first generation that will be less healthy and have a shorter
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life expectancy than their parents. (2012 aha.org)

Overweight and obesity may be the result of “caloric im-
balance”—too few calories expended for the amount of calories
consumed—and are affected by various genetic, behavioral, and
environmental factors. Childhood obesity has both immediate
and long-term effects on health and well-being.

Immediate health effects:

According to the Center for Disease Control, an immediate
health effects is that obese youth are more likely to have
risk factors for cardiovascular disease, such as high chole-
sterol or high blood pressure. In a population-based sample of
five to seventeen year-olds, seventy percent of obese youth
had at least one risk factor for cardiovascular disease. Obese
adolescents are more likely to have prediabetes, a condition
in which blood glucose levels indicate a high risk for devel-
opment of diabetes. Children and adolescents who are obese are
at greater risk for bone and joint problems, sleep apnea, and
social and psychological problems such as stigmatization and
poor self-esteem.
Long-term health effects:

The long-term health effects are, children and adolescents who are obese are likely to be obese as adults and are therefore, more at risk for adult health problems such as heart disease, type 2 diabetes, stroke, several types of cancer, and osteoarthritis. One study showed that children who became obese as early as age 2 were more likely to be obese as adults. Overweight and obesity are associated with increased risk for many types of cancer, including cancer of the breast, colon, endometrium, esophagus, kidney, pancreas, gall bladder, thyroid, ovary, cervix, and prostate, as well as multiple myeloma and Hodgkin’s lymphoma. (2012 Center for Disease Control)

Statement of the Problem:

According to the World Health Organization (WHO), childhood obesity is not just a national problem, it is a global problem that primarily affects middle and low-income nations. (2012) In America, childhood obesity primarily affects middle and low income families. The families with the least amount of money have the highest incidence of obesity. According the World Health Organization (WHO), Childhood obesity is preventable. In order to prevent this epidemic from continuing it will take collaboration between parents, schools and the leg-
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islature. These three entities working together is the focus of The “Let’s Move” Campaign.

The Let’s Move Campaign was launched by First Lady Michelle Obama on Feb. 09, 2010. This program is dedicated to solving the childhood obesity epidemic within a generation. (2012 let’s move.gov) “Let’s Move“ is a national campaign that advocates, schools, parents and local governments partnering together to find ways to improve nutrition for children and to encourage them to be more active. Since its inception, Let’s Move has been adopted in numerous states and cities around the country, including California communities of Palmdale but not neighboring Lancaster.

Purpose of the Study

The focus of this paper will be on how best practice programs on the treatment and prevention of childhood obesity compare to the “Let’s Move” Campaign by Michelle Obama. This process shall include analyzing strategies and key components of obesity programs in California and around the country. Analyzing the key components and strategies of the “Let’s Move” campaign and finally assessing what implications this may have for current programs in the Antelope Valley; and keys steps community leaders, parents and stakeholders can take to establish a program in the local region.
Importance of the Study

In the Antelope Valley, Los Angeles County, and in the rest of the country, childhood obesity rates have leveled off in recent years. However, According to The Department of Public Health (DPH) the numbers are still dangerously high. When complete, this study can be used by current programs in the Antelope Valley, to assess existing program policies and possibly establish new guidelines. Key stakeholders in the City of Lancaster may use it to decide, if instituting the “Let’s Move” campaign in their school districts is viable. This paper can also be used by community leaders, in unincorporated areas of the Antelope Valley for guidelines when establishing new programs.
Chapter Two

Review of Literature

The focus of this chapter will be on the, Let’s Move Campaign’s design and how it compares to other local and national programs. Most of the programs in operation today are modeled after a study conducted in Bogalusa, Louisiana in 1973. According to the American Association of Pediatric Medicine, (AAP) this study revolutionized the way Pediatricians and Public Health agencies looked at and treated overweight and obese children. (2009, AAP website).

**Louisiana-Bogalusa Study**

The Bogalusa Study is a comprehensive study of childhood obesity that was conducted over a period of 30 years; following program participants from childhood thru adulthood. The Study compiled data from 1973-1994, and routine school screenings provided 2008 -2009 data. Trends in mean BMI, mean gender-specific BMI-for-age z scores, prevalence of overweight/obesity (BMI _ 85th percentile), and prevalence of obesity (BMI _ 95th percentile) according to age, race, and gender were examined.

**RESULTS:** Since 1973-1974, the proportion of children and adolescents
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aged 5 to 17 years who are overweight (overweight plus obese) has more than tripled, from 14.2% to 48.4% in 2008 –2009. Similarly, the proportion of obese children and adolescents has increased more than fivefold from 5.6% in 1973–1974 to 30.8% in 2008 –2009. The prevalence of overweight or obesity, and secular changes, were similar among black and white boys and girls.

CONCLUSIONS: In semirural Bogalusa, the childhood obesity epidemic had not plateaued, and nearly half of the children are now overweight or obese (Pediatrics 2010;) This study has been used by national pediatric schools and is one of the most comprehensive of our times. It shows how heart disease and liver cancer start in childhood without showing any symptoms and can continue if not treated.

As a result, of this study some of the most successful programs, that treat obese children start in preschool.

Treatment vs. Prevention

Some programs focus on treatment of obesity, some focus on prevention and some programs incorporate both. When dealing with the issue of childhood obesity, it is important to understand the difference between treatment of obesity and prevention.
Treatment

The GAO and WHO both agree that any treatment programs for childhood obesity must include supportive environments that encourage physical activity and teach the benefits of a healthy diet. Such programs should reinforce behavioral intervention and must prioritize the inclusion of vulnerable groups. Programs should include collaboration between parents and schools.

Prevention

In prevention of childhood obesity, the targeted outcome is healthful weight gain, building muscle, strengthening the heart and other vital organs, rather than focusing on weight loss only.

This writer evaluated programs in the state of California, Programs in other states, and local programs to assimilate a comprehensive list of similarities, differences and best practices.

California Programs

Project Lean

The State of California, instituted the Project (LEAN) Leaders Encouraging Activity and Nutrition, in 1987. The program originally started in the Bay Area and its focus was to promote low fat eating. Since its inception this program has grown to include working with key community organizations,
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school stakeholders, and nutrition leaders to affect policy changes in schools. (2012 LEAN website) These changes included support for Senate bills 12 and 965, which set standards for the sale of sugary drinks in public schools.

The Fit Kids Program

The Fit Kids program is a free afterschool program that promotes physical activity. It gets children involved in structured physical education and organized sports. It is located on the campus of several public schools in the Northern California area. The Fit Kids program, is a traveling program that meets one hour a week for eight weeks. The program emphasizes exercises that increase physical strength, stamina, and endurance. This program is a prevention program.

Other State Programs

Chicago-CLOCC

The Consortium to Lower Obesity in Chicago Children, (CLOCC), is a nationally recognized childhood obesity prevention program. The program promotes healthy eating and a healthy lifestyle in the Chicago area. (2012 CLOCC.org) the program focuses on low-income neighborhoods where the prevalence of obesity is the highest. CLOCC, is a broad-based program that partners with local, grassroots obesity prevention and treatment, organizations to assist them with program implementation, guidelines and evaluation.
Healthy Kids Healthy Communities

Healthy Kids Healthy Communities is a national prevention program that is helping organizations and communities around the country reshape their environments in order to prevent childhood obesity. (2012 Healthy Kids website)

This program places and emphasis on providing funding in communities with children who are highest risk for obesity on the basis of race/ethnicity, income and/or geographic location. (2012 Healthy Kids)

Obesity, not only effects a child’s physical health, it can affect their mental health as well. Constant struggles to lose weight can have a negative effect on a child’s self-esteem, and self-image. It can also, affect their ability to form positive attachments with peers. (2012 Weight of a Nation)

Detractors

With all the evidence, that childhood obesity is a national epidemic, there are still prominent stakeholders, that contend, childhood obesity is not a worldwide epidemic

Arguments Against

Detractors for the “Let’s Move” campaign, state, this is another way for the government to infringe on our personal lives and choices. They state that obesity has not reached the epidemic proportions as claimed. Detractors state, children
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are the same today as they were in the ’70’s and that the change has come because the Body Mass Index (BMI) that measures obesity has been lowered, so more people are now falling into the overweight/obese categories.

**Body Mass Index**

BMI is calculated by using weight and height. BMI does not measure body fat directly, but it is an indicator of body fatness. BMI for children is determined by measuring age and sex on the CDC-Growth Charts.”(2012 Center for Disease Control)

According to Anna Kirkland, Prof. of Women’s Studies at the University of Michigan, Obesity is a case of personal responsibility. It comes down to food having a social hierarchy. “There is a highly specific and evolved set of social rules governing the hierarchy of foods. A baguette is not junk food, but sliced white bread is; the sugar in honey and fruits is healthy while white granular sugar is junk.” When looked at from this point of view, Obesity is then reduced to a problem of the less than socially responsible or acceptable population.(The poor folk)

There is also the argument that obesity is hereditary or that people are genetically predisposed. The biggest flaw in
these arguments is that they don’t consider the actual data. The numbers show an increasing trend in the numbers of new cases of obesity as reported by the Centers for Disease Control (CDC) and the American Academy of Pediatrics (AAP). The AAP reports that less than 1% of cases of childhood obesity are linked to genetics or hormonal imbalances.

Basic Freedoms

One of the most pervasive arguments against the “Let’s Move” Campaign or any programs that are sanctioned by the federal government, is the one that states, these programs are an infringement on basic freedoms. When Agriculture Secretary Tom Vilsack said that Americans will “adjust” their tastes to the food the government says is best for people to eat.” (2011 CNS News.com); he set off a firestorm of criticism, from political figures, and key stakeholders who felt that Mr. Vilsack, was trampling on individual rights and freedoms. When Tom Vilsack made those remarks he was speaking to members from the National Restaurant Association, and it was in response to a question regarding ways to reduce food waste.

However, When statements like the one above are made, (then taken out of context) they tend to prove the “Nanny State” theory.
The Nanny State

The Nanny State, is the belief that the United States has too many rules and regulations, too many laws that are meant to control and regulate everyone’s life. The Nanny state believes that the federal government has gone overboard. Although, the laws may have good intentions they do nothing more than limit the individual freedoms on which this country was based. These rights are defined and upheld in the Constitution of the United States and in the Declaration of Independence. Does the Government have the right to ban the sale of large sodas or sugary drinks? Or to limit the number of fast food restaurants within a certain radius? Or to ban the giving away of happy meal toys unless the meal meets certain nutritional standards.(2010, Baerltin, Reuters)? To take away a preschoolers lunch she brought from home because it didn’t meet the nutritional guidelines set forth by The US Dept. of Agriculture? (USDA) (2012, Carolina Journal). Incidentally they gave the preschooler chicken nuggets to replace the turkey and cheese sandwich she brought from home.

These types of laws make it virtually impossible to defend the need for stronger guidelines in the fight against childhood obesity. There is a fine line between advocacy and antagonism.
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Childhood obesity is a national problem and it will take a concerted effort on the part of our leaders as well as parents and schools in order to curb this growing epidemic. The Let’s Move campaign calls for this type of collaboration.

Health Belief Model

When examining any program that seeks to treat or prevent childhood obesity, the role of personal responsibility can not be ruled out.

In 1966 Irwin Rosenstock, developed the Health Belief Model, this model was originally designed to predict behavioral response to treatment in chronically ill patients. In recent years, the study has been updated to predict more general health behaviors.

The Health Belief Model is one of the most widely used conceptual frameworks for understanding health behavior. (2011RECAPP)

It has been used to promote greater condom use, seat belt use, health screenings and most recently in the prevention of obesity.

Core Assumptions and Statements

The HBM is based on the understanding that a person will take a health-related action if that person feels that a negative
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health condition (i.e., obesity) can be avoided, has a positive expectation that by taking a recommended action, he/she will avoid a negative health condition, (if he/she exercises and eats right they can avoid being obese) or if he/she believes that he/she can successfully take a recommended health action (i.e., he/she can eat right and exercise with confidence). (2012, Health communication)

<table>
<thead>
<tr>
<th>Concept</th>
<th>Definition</th>
<th>Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceived Susceptibility</td>
<td>One’s opinion of chances of getting a condition</td>
<td>Define population(s) at risk, risk levels; personalize risk based on a person’s features or behavior; heighten perceived susceptibility if too low.</td>
</tr>
<tr>
<td>Perceived Severity</td>
<td>One’s opinion of how serious a condition and its consequences are</td>
<td>Specify consequences of the risk and the condition</td>
</tr>
<tr>
<td>Perceived Benefits</td>
<td>One’s belief in the efficacy of the advised action to reduce risk or seriousness of impact</td>
<td>Define action to take; how, where, when; clarify the positive effects to be expected.</td>
</tr>
<tr>
<td>Perceived Barriers</td>
<td>One’s opinion of the tangible and psychological costs of the advised action</td>
<td>Identify and reduce barriers through reassurance, incentives, assistance.</td>
</tr>
<tr>
<td>Cues to Action</td>
<td>Strategies to activate &quot;readiness&quot;</td>
<td>Provide how-to information, promote awareness, reminders.</td>
</tr>
<tr>
<td>Self-Efficacy</td>
<td>Confidence in one’s</td>
<td>Provide training, guidance</td>
</tr>
</tbody>
</table>
ability to take action in performing action.
Chapter Three
Methods

Research Design

Using a non-experimental quantitative design, this paper will provide information on key strategies used by successful programs in the prevention and treatment of childhood obesity.

Method

The method used in this study is policy research using textual analysis. Policy research also called social scientific research For the most part such research attempts to apply social scientific findings to the solution of problems. Policy research may be descriptive, analytical, or deal with causal processes and explanations; it may evaluate a new or existing policy program, describe examples of best practice. (Marshall 1998) This researcher is evaluating best practices for the treatment and prevention of childhood obesity.

Sample Frame

A review of textual materials was conducted to identify the features of best practice or successful programs. Due to time constraints, this paper will focus primarily on programs that treat obesity in middle and elementary students.

Most of the materials used were restricted to scholarly journals, research publications and studies from government websites. Much of the information gathered was on childhood
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obesity affecting the poorest individuals. Other articles had information on the rates of obesity in other countries, the history and causes of childhood obesity, the role parents play and the importance of parental involvement. Material was also gathered from the NASBE, The Alliance for a Healthier Generation and The Clinton Foundation. This material was used to show what politicians and state legislatures have done. Articles on the “Nanny State” were also used to show stakeholders reactions to proposed government interventions.

Sample Size

This researcher gathered as much information as possible to ensure sufficient information on the subject. The majority of the information available discussed, middle school children and teenagers, because, according to The Dept. of Public Health, teenage obese children are more likely to grow up to be obese adults. The information gathered by this researcher was dealing with younger children up to middle school and included very few studies for teenagers. The sample size was concluded when the materials presented started showing the same information and saturation occurred.

Data Collection

Several of the documents came from CDC, WHO, GAO, State of California Websites, The American Academy of Pediatrics and the Dept. of Public Health. Keywords used were “childhood
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obesity”, “physical education in schools”, “obesity rates in other countries” “prevention of obesity in children” and “Let’s Move.” Jstor and the Online Stein Library was used to find articles on childhood obesity, and to check peer-reviewed articles in pdf. format. The Internet was also used to access the WHO, CDC and AAP websites, and to access newspaper articles on the subject. This researcher also accessed the four part documentary, Weight of a Nation,(2012) sponsored by the CDC and the Dept. of Public Health.

Textual Analysis

Textual Analysis is a data gathering process, whereby researchers analyze texts, documentaries, online sources, that develop and detect patterns around a given subject., develop explanations, and test hypothesis. this writer used textual analysis to detect patterns.(2003 McKee, Allan)

Institutional Review Board (IRB) Process

The research design did not include human subjects. There were no interviews experiments, surveys, or focus groups conducted to complete this study. The form, “Is My Project human Subjects Research ?” was submitted to the first reader, Dr. B.J. Moore, on July 11, 2012. This project was reviewed and ascertained to be not human subjects research.
Limitations

The major limitation to this study was time constraints. Due to the vast quantity of available data and the differing viewpoints, it prohibited the researcher from being able to analyze all available data. Another limitation to this study was the available information for middle schools and teenagers. The effects of obesity on younger children are just now being investigated, so information dealing primarily with that target group was more difficult to find. One of the biggest limitations on this study came when comparing national and global levels of obesity. The Center for Disease Control and the World Health Organization, have different criteria for rating obesity. The CDC defines obese as having a body mass index in the 95th percentile while the WHO defines obesity as having a body mass index in the 50th percentile. Many of the children considered obese by the World Health Organizations standards would not be considered obese by the Center for Disease Control.
Chapter 4 Results

Criteria for Success

In order for a program to be considered successful, it had to meet certain criteria. First, due to the current economic climate and the research showing that obesity seems to overwhelmingly effect the poorest population, cost was a definite factor in determining a program’s success. In order for a program to be considered it had to be either free, have a sliding payment scale or accept medical or Medicaid for payment.

Secondly, programs had to be easily accessible for participants. Transportation can be a major issue for many low-income people, or working parents. If the children are unable to access the program, how can they utilize it? Many of the programs we examined, were held at local schools and offered as after-school programs or they offered transportation to program participants.

Thirdly, outcome was measured. The programs which had a twenty percent success rating or higher and met all of the above criteria were considered successful. In the chart below, several programs are outlined, to show
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the most successful programs and the similar practices they utilized.

Many of the programs were broad-based, with certain guidelines or policies recommended for the treatment and/or prevention of childhood obesity. One such program was the “Let’s Move program.

Broad-Based Programs

The “Let’s Move” program, The California “Project Lean” (Leaders Encouraging Activity and Nutrition) and The Chicago “CLOCC” (Consortium to Lower Obesity in Chicago Children) are broad-based programs. Broad-Based means, they support community programs that promote healthier, more active lifestyles for children and families. These programs push community involvement and they offer tools and resources to organizations looking to treat or prevent childhood obesity at local levels.

Elements of Successful Programs—(Best Practices)

The most successful program all dealt with treatment and prevention and they implemented certain similar guidelines. For the purposes’ of this paper, these guidelines will be referred to as “Best Practices.”
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Physical Exercise

According to the California Superintendent of Public Instruction, physical education is an instructional priority for California schools. Education Code section 51210 requires 200 minutes of physical education every ten school days for students in grades one to six. (2012 California Dept. of Education) However, a recent article in the New York Times, (2012, Baker, Yee) states that many schools in California don’t have P.E teachers or facilities, making it difficult to reach the twenty minute a day requirement. Rainy days present even more difficulty.

According to the Surgeon General, 43% of adolescents watch two or more hours of television daily. Lack of physical activity outside of school may be due to increased violence in urban areas, making it unsafe to ride bikes or play in neighborhoods. The decrease in physical activity can be traced across ethnic lines, with African American and Mexican American children being the least active and living in the most economically depressed neighborhoods. Lack of consistent physical education classes in schools and lack of exercise outside of schools is why Physical Education is a key component of our Best Practices Programs.
Parental Involvement

The most successful programs also required parents to be involved. Parents have to make conscious decisions about what foods they consume and allow their children to consume. Parents have an ultimate responsibility to mirror the eating habits and physical activity habits they want to see in their children. Parents that are overweight have a 25% chance of having an overweight child. (2012 AAP) The programs that were most successful in treatment and prevention, involved the participation from the entire family rather than just the obese child.

Behavior Modification

Although behavior modification has been used to treat obesity in adults for some time, it is relatively new as a treatment for obesity in children. According to Dr. Gary Foster of Temple University, behavioral treatment is based on principles of classical conditioning. Overweight and obesity in children and adults is the result of more than just overeating and lack of exercise. Certain genetic factors may predispose some individuals to being overweight or obese. (2011 Foster, Gary, Makris, Angela, Bailer, Brooke) In such instances, behavior modification can help those individuals develop certain skills to achieve a healthier weight.
Behavioral treatment has three basic parts. First, it is goal directed—it specifies clear concise goals that can be easily measured; For example, increasing physical activity from five minutes a day to ten minutes a day. Second, it is process oriented, it identifies the process necessary for change and assists people in finding solutions to increase their chances of changing. For instance in the above example, the participant would list possible deterrents to increasing their physical activity to ten minutes a day. Third small changes are recommended rather than large changes that may be difficult to support or maintain. The participant would just increase the activity to ten minutes a day instead of thirty minutes a day. When instituting the behavior modification plan it is important that the entire family is involved in the goal setting process. When parents are involved with their children to set the goals it increases the chances for success.

School Involvement

The last component of the successful programs, was the involvement of local schools, one key aspect of most of the programs is that most of them were instituted on school campuses.

In a study following 6th thru 12th graders found that healthful or unhealthful patterns that had started by 6th grade re-
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mained constant thru high school. This shows the importance of teaching healthy eating habits early. Also, since two of the three recommended daily meals is eaten at school five out of seven days schools have a responsibility to positively influence diet. (2009 Schauss). In economically depressed neighborhoods, the likelihood that the most nutritious meals, sometimes the only meals children get are served at school. Different states have passed legislation regulating the types of items available in vending machines, revamping school menus. The Healthy Hunger – Free Kids act of 2010 authorizes funding for federal school meal and child nutrition programs and increases access to healthy food.(2010HHFKA)

Success in any program depends largely on the participants’ motivation to succeed. Utilizing the Health Belief Model might increase the success rate.
Chapter 5 Conclusions

Recommendations

This writer started out researching the “Let’s Move” Campaign, to see how it related to other “Best Practice” Programs. The “Let’s Move” Campaign is a recipe, if you will, with all the ingredients necessary for a successful obesity prevention and/or treatment program. It is flexible enough to allow individual communities to implement in the way that would be most productive. Upon researching other programs it was discovered that the principle ingredients in the “Let’s Move” Campaign were synonymous with the aspects of other treatment and prevention programs. The fact that the Let’s Move Campaign starts with schools is an additional selling point as there is much work that schools can do to join in the fight against childhood obesity. The reduction of sugary snacks and the removal of vending machines are definitely a step in the right direction but there is still much to be done. In the treatment and prevention of
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childhood obesity there is no one set in stone policy that will end this epidemic. It will take the collaboration from different entities to be successful. As with any great recipe, you start with the basic ingredients and add your own flavor to make a successful dish.

The City of Lancaster and other outlying cities might consider implementing physical exercise and some behavior modification to their Cares afterschool programs. The implementation of Saturday activities at the local parks for families, such as dodge ball, tug of war etc. could be a positive way to encourage exercise. Nutrition and cooking classes can be offered at the neighborhood houses in Palmdale and Lancaster.

Any of these recommendations can go a long way in the treatment and prevention of childhood obesity.
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Sarah M. Lee PhD1,*, Charlene R. Burgeson MA2, Janet E. Fulton PhD3, Christine G. Spain MA (28 SEP 2007) Article first published online: DOI: 10.1111/j.1746-

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http://www.temple.edu/medicine/faculty


Date: 11 July 2012

To: Peggy Whyte, PPA Student

cc: Paul Newberry, IRB Chair
    B. J. Moore, Public Policy and Administration

From: Steve Suter, Research Ethics Review Coordinator

Subject: Protocol 12-90: Not Human Subjects Research

Thank you for bringing your protocol, "Childhood Obesity: Our Children in Crisis", to the attention of the IRB/HSR. On the form, "Is My Project Human Subjects Research?", received on July 11th, 2012, you indicated the following:

I want to interview, survey, systematically observe, or collect other data from human subjects, for example, students in the educational setting. NO

I want to access data about specific persons that have already been collected by others [such as test scores or demographic information]. Those data can be linked to specific persons [regardless of whether I will link data and persons in my research or reveal anyone’s identities]. NO

Given this, your proposed project will not constitute human subjects research. Therefore, it does not fall within the purview of the CSUB IRB/HSR. Good luck with your project.

If you have any questions, or there are any changes that might bring these activities within the purview of the IRB/HSR, please notify me immediately at 654-2373. Thank you.

Steve Suter, University Research Ethics Review Coordinator