

**REPORT
OF THE
BALTIMORE CITY COUNCIL
TASK FORCE
ON
CHILDHOOD OBESITY**



November 30, 2007



BALTIMORE CITY COUNCIL

AGNES WELCH

NINTH DISTRICT

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URBAN AFFAIRS/AGING

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TAXATION AND FINANCE

November 30, 2007



If we could predict that a tropical storm would develop into a Category Five hurricane; and if we had the ability to disrupt it and send it harmlessly out to sea, the lives and dollars saved would be immeasurable. Childhood obesity is that storm. We might very well be at the point of classifying childhood obesity as a Category One and possibly Category Two hurricane. It is this hurricane which the Baltimore City Council Childhood Obesity Task Force addresses in its report.

The methodologies and instruments suggested in the report represent a wholesome, comprehensive and effective action plan. It is that plan which will disrupt the storm and send it harmlessly out to sea. Every plan, no matter how well conceived must be implemented. Legislatively, it is my intent to ask for full review, adoption and implementation of the Task Force's report by the Baltimore City Council, as well as, resolving the appropriate divisions to the State of Maryland.

Unfortunately, there are no accolades laudable enough to address the Task Force participants. The Task Force was not funded in any way, nor were any of the members and participants. Each and every member performed at the highest level and with personal sacrifice.

I thank each participant for contributing their time and effort. Special thanks to Dr. Josephine Ball, DCH.CRT for her leadership, as well as, Dr. Kenneth Stanton. I also thank Jennifer Coates, Director of the Office of Council Service, for serving as support staff to the Task Force. It is their competency, commitment and caring that make this document an effective plan in assuring a healthy future for our children.

Agnes Welch



BALTIMORE CITY COUNCIL TASK FORCE ON CHILDHOOD OBESITY

Executive Summary

According to the United States Department of Health and Human Services, Centers for Disease Control and Prevention, the term obesity represents ranges of weight that are greater than what is generally considered healthy for a given height. The term also identifies ranges of weight that have been shown to increase the likelihood of certain diseases and other health problems.

Competitive foods contribute to obesity. According to the Food Research and Action Center, “competitive foods, refers to foods and beverages which are offered at school, other than meals and snacks served through the federally-reimbursed school lunch, breakfast and after school snack programs. Competitive foods include: extra foods and beverages sold through “a la carte” lines (which offer other food items for sale alongside the federally-reimbursed school meals): snack bars: student stores: vending machines: and fundraisers (where school organizations sell baked goods or candy to raise money).”¹

The prevalence of obesity began a steep upturn in the United States near the end of the 1970s. From a level below fifteen percent (15%) in 1978, prevalence for American adults exceeded thirty percent (30%) by the year 2000. For 2007, the direct medical costs for the U.S. are estimated to be in excess of \$130 million dollars. This ignores indirect costs which are potentially a significant multiple.

From 1980 to 2004, the prevalence of overweight among American children aged 6 to 11, more than doubled and for adolescents it more than tripled. Due to the demographic characteristics of Baltimore, the prevalence of overweight and obesity are undoubtedly higher than the national figures.

Obesity brings with it a host of co-morbidities that are expensive in human terms and in medical costs:

- Overweight young people face a seventy percent (70%) chance of becoming overweight or obese adults, placing them at high risk of heart disease, Type 2 diabetes, stroke, several types of cancer, and osteoarthritis.
- Sixty-one percent (61%) of overweight young people have at least one additional risk factor for heart disease, such as high cholesterol or high blood pressure.
- Children who are overweight are at greater risk for orthopedic problems, sleep apnea, and psychological problems such as stigmatization and low self-esteem.
- Excess weight is suspected as a factor in early onset of puberty, which in turn is linked to greatly increased risk of breast cancer.

¹Food Research & Action Center, Child Nutrition Policy Brief, Competitive Foods in Schools, Washington, D.C., <http://www.frac.org/pdf/cncompfoods.PDF>

It is vitally important to encourage healthy diet and exercise habits in our children. The obvious counterpart is that there is an urgent need to ensure that we assess current practices and limit or remove any factors that are encouraging or facilitating unhealthy diet and exercise choices

The report from the Baltimore City Council Childhood Obesity Task Force (BCCCOTF) acknowledges that there is an urgent need for action in Baltimore. The report considers five priority areas, or access points for intervention: community and the environment; schools; after school program providers; preschools and childcare services, and the healthcare sector. The Task Force presents a wide array of general recommendations and prescribes specific legislative measures.

Notable recommendations of the report include:

- Implementation of the Local Wellness Plan in Baltimore City Public Schools.
- Improving access to fresh produce.
- Discouraging consumption of competitive foods and beverages including, processed snack foods and sodas through the removal of vending machines, educational measures and other controls.
- Encouraging and accommodating wellness programs for caregivers.
- Requiring nutrition training for caregivers.
- Engaging parents in guiding nutrition and exercise choices.
- Creating incentives for innovations and practices that improve fitness and health.
- Promoting and accommodating breastfeeding.
- Developing programs to encourage greater physical activity.
- Requiring appropriate performance measures and follow-up evaluation of programs.

BALTIMORE CITY COUNCIL TASKFORCE ON CHILDHOOD OBESITY

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YMCA Urban Services
National Center for Health Behavioral Change
Parks and People Foundation
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Baltimore City Public Schools
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Bon Secours Foundation
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Saint Agnes Health Care
Parks and People Foundation
University of Baltimore
University of Baltimore
Maryland Beverage Association
Baltimore City Public Schools
University of Maryland

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BALTIMORE CITY COUNCIL TASK FORCE ON CHILDHOOD OBESITY

Introduction

The rate of childhood obesity has more than doubled over the past thirty (30) years. It has tripled for children 6-11 years of age. Childhood obesity has become an epidemic. In response to growing concerns, Baltimore City Councilwoman Agnes Welch introduced City Council Resolution #06-0230R - Organizational Hearing – Baltimore City Council Task Force on Childhood Obesity – A Call to Action (see Appendices).

The Task Force called together key stakeholders in a campaign of partnership to address the critical problem of childhood obesity. The mission is to:

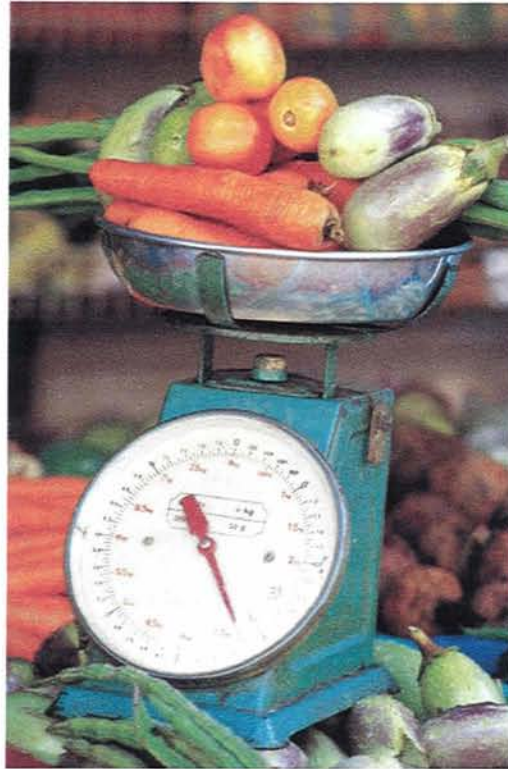
- identify the specific roles that must be undertaken to prevent the onset of childhood obesity;
- to formulate a plan to combat the escalation of the problem among those children at-risk;
- and to devise a medical and behavioral treatment model to treat the diseases caused by this epidemic and to prevent the onset of sickness in the target population.

The Task Force was divided into five (5) subgroups based on the priority areas outlined in the resolution - Community/Environment, Schools, After Schools, Preschool/Childcare and Healthcare. Prevention and intervention efforts were researched, reviewed and discussed. This report represents the Task Force's findings and recommendations.

In no way is this report aimed at blaming schools for childhood obesity. The problem is primarily outside of the school. The school, however, is situated to make a big difference in combating the epidemic.

Many thanks to Councilwoman Agnes Welch for appointing the Task Force to work on such an important initiative.

PRIORITY AREA 1: COMMUNITY/ENVIRONMENT



BALTIMORE CITY COUNCIL TASK FORCE ON CHILDHOOD OBESITY

REPORT: PRIORITY AREA 1 - COMMUNITY/ENVIRONMENT

Goal to improve and sustain access to healthy food and physical activity at the community organizational and environmental levels.

Committee Members

Chair: Jacky Jennings, Ph.D., MPH, School of Medicine,
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Members: Dr. G. Anne Davis, Alpha Kappa Alpha Sorority, Inc.,
Epsilon Omega Chapter

Lena Franklin, OROSW

April Yvonne Garrett, Civic Frame, Inc.

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BALTIMORE CITY COUNCIL TASK FORCE ON CHILDHOOD OBESITY

REPORT: PRIORITY AREA 1 - COMMUNITY/ENVIRONMENT

About the Authors

April Yvonne Garrett, M.A., M.T.S., is the founder and president of Civic Frame, a nonprofit that uses art and intellectual work to encourage civic dialogue, media literacy and critical thinking. She earned a bachelor of art in Islamic Studies at Kenyon College, a master of arts in higher education from Teachers College Columbia University and a master of theological studies in African American Religious History from Harvard Divinity School. She has worked with at-risk adolescent girls in several communities across the country including Atlanta, Baltimore, Boston and New York City.

John Gittlesohn, M.S., Ph.D. – Johns Hopkins Bloomberg School of Public Health, Department of International Health, Johns Hopkins University.

Adrienne McGill, MHS – is the project coordinator for TOPS (Tips on Parenting Study), an overweight prevention study for toddlers. She has a master's degree in Health Science with a concentration on Human Nutrition from Johns Hopkins' Bloomberg School of Public Health.

BALTIMORE CITY COUNCIL TASK FORCE ON CHILDHOOD OBESITY

REPORT: PRIORITY AREA 1 – COMMUNITY/ENVIRONMENT

I. Purpose

Improve and sustain access to healthy food and physical activity at the community organizational and environmental levels.

II. Review of Research/Observations

Advantages of this priority area: Helping low income families to gain access to healthy food options and safe areas for physical activity.

In many low income regions of the United States, including inner city areas and rural regions, healthy options are often hard to find. The dramatic increase in obesity over the past two decades is related to an environment laden with inexpensive, high-fat convenience foods and super-sized portions, as well as a marked decrease in physical activity. These areas usually have limited availability of safe places for engaging in physical activity.

Summary of research

Johns Hopkins University Current and Previous Work in Priority Area 1 Community/Environment - Baltimore Healthy Stores Project (Johns Hopkins Bloomberg School of Public Health):

- The Healthy Stores Project conducts food inventories within communities, including the businesses that sell food to identify areas of need.
- Research has been done to ensure that messages are culturally appropriate. In addition, health communication strategies are used to spread nutrition messages.
- The project works on both the individual and environmental levels to support diet related change.

III. General Recommendations From Priority Area 1 – Community/Environment:

There are two aspects of the Community/Environment that need to be addressed: nutrition (healthy eating) and physical activity.

A. Healthy Eating Recommendations:

1. Improve access to and affordability of healthy foods (especially foods included in the Institute of Medicine's (IOM) Tier One foods recommendations) for low-income populations in Baltimore City. Low-income areas can be identified by previous research conducted at Johns Hopkins Bloomberg School of Public Health.

Access and affordability will be improved by:

- a. expanding the availability of farmers markets to communities currently underserved;
- b. bringing healthy and nutritious produce to communities currently underserved;
- c. city support for community gardens which provide both physical activity and local, fresh produce to communities;
- d. increasing the availability and affordability of healthful foods and beverages at supermarkets, grocery stores, and local markets located within walking distance of the communities they serve;
- e. using health communication and social marketing approaches to develop and deliver effective messages through mass media.

2. Raise community and family awareness and education around healthy and nutritious food choices by:

- a. sponsoring healthy food festivals;
- b. developing workshops on healthy cooking and eating for neighborhood organizations and members of the community;
- c. partnering with higher learning institutions to develop education sessions for neighborhood organizations and members of the community they serve; and
- d. working with public libraries, churches and other community institutions to promote healthy foods.

3. Develop policies that will support healthy eating among Baltimore City residents.

B. Physical Activity Recommendations

1. Improve the walkability of neighborhoods.

2. Improve access and the availability of public transportation.

3. Improve the access and condition of neighborhood parks and recreational facilities, and assess their operations.

4. Promote physical activity through schools, communities and recreation centers by involving parent-teacher associations, student government and neighborhood associations.

5. Enact policies that will support increased physical activity in Baltimore City.

IV. Resolutions

Resolution 1: Create “Health Zones”:

Whereas: schools are an important part of the community and are located in all neighborhoods, regardless of socio-economic status and, therefore, reach a wide range of city residents, especially children.

Whereas: it is imperative to start healthy habits early in life to prevent overweight. Research shows that overweight early in life tracks over time putting those children at greater risk for overweight and obesity in adulthood.

Therefore, Baltimore City should implement a pilot program that will improve the food and physical activity environment of its children by creating and working intensively within “Health Zones” around key schools. Following completion of the initial trial period, the program could be assessed for city-wide expansion.

Suggested details include:

- selecting one school per city council district, selected by the council person for that district;
- selecting elementary or middle schools, in order to have early impact;
- selecting the largest feeder schools of the district (not magnet schools);
- working with school nurses;
- working in a 3-4 block radius around the selected school with supermarkets, corner stores, churches, parks, fast food restaurants to improve the availability of healthy food choices that are economically and culturally acceptable, and provide safe places for children to be physically active; and
- giving a Baltimore City “Best Practices Seal of Approval” to participating grocery stores, restaurants, and businesses.

Resolution 2: Enforce policies to support healthy eating

Whereas: there is general knowledge that high fat, high sugar foods are unhealthy choices.

Whereas: certain types of fat are more harmful to the body than others. These fats include saturated and trans fat.

Therefore, Baltimore City must enact legislation banning the use of trans fats in restaurant and food establishments following the model of New York City and impose a snack tax which would be used to subsidize low-calorie, nutritious food in impoverished areas in Baltimore City.

Resolution 3: Improve walkability

Whereas: thirty (30) minutes of physical activity are recommended to maintain one's current weight and walking is a form of physical activity that is free and available to anyone who is physically able to engage in activity.

Therefore, Baltimore City should commit to providing matching funds to neighborhoods to make walkability improvements which include:

- improving safety from crime and traffic (see Baltimore Plan);
- fixing, maintaining and increasing good street lighting;
- planting trees and improving the aesthetics of the sidewalk environment;
- building bicycle and pedestrian safe and friendly walkways near schools; and
- having neighborhood community organizations identify priorities to empower communities to change their neighborhoods.

Resolution 4: Enforce policies to support physical activity

Whereas: the built environment which includes neighborhood design and urban development affects city residents' access to participating in physical activity.

Therefore, Baltimore City should provide incentives which encourage developers to include mixed use development plans; alter parking zoning laws; and raise community and family awareness and education around the importance of physical activity using mass media campaigns.

V. References/Resources

Resources:

<http://www.healthystores.org/about.html>

References:

<http://www.healthystores.org/about.html>

PRIORITY AREA 2: SCHOOLS



BALTIMORE CITY COUNCIL TASK FORCE ON CHILDHOOD OBESITY

REPORT: PRIORITY AREA 2– SCHOOLS

Goal to improve and sustain access to healthy food and physical activity in the school setting.

Committee Members

Chair: Patricia Brownlee, Med, MHS, M.S.C., Baltimore City Public School System

Members: Joann Bell, RD, Baltimore City Public Schools

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BALTIMORE CITY COUNCIL TASK FORCE ON CHILDHOOD OBESITY

REPORT: PRIORITY AREA 2 - SCHOOLS

About the Authors

Joann Bell is a registered dietitian and is a Staff Specialist with the Baltimore City Public School System.

Patricia Brownlee, M.Ed, M.HS., M.S. – health educator and Coordinator for Health Education for the Baltimore City Public School System (BCPSS); adjunct instructor for Health Sciences Department, Towson University; co-author of the BCPSS Local Wellness Policy; has written, reviewed and revised health education curriculum including nutrition education and other health content for grades K through high school.

Charles B. Colison, MBA, RD, LD/N is a registered and licensed dietitian and is an assistant professor at Baltimore International College.

BALTIMORE CITY COUNCIL TASK FORCE ON CHILDHOOD OBESITY

REPORT: PRIORITY AREA 2 - SCHOOLS

I. Purpose

Improve and sustain access to healthy food and physical activity in the school setting.

II. Review of Research/Observations:

Background: In April, 2003, the American Dietetic Association, the Society for Nutrition Education, and the American School Food Service Association published a position paper on "Nutrition Services: An Essential Component of Comprehensive School Health Programs¹." This reference provides information and resources to develop and support comprehensive school health programs (preschool through grade 12) that include comprehensive and integrated nutrition services with specific note of the role of schools in reversing the trend of childhood obesity prevalent in our communities.

In June 2004, Congress passed the *Child Nutrition and WIC Reauthorization Act*², which mandated that all schools participating in the National School Lunch and/or Breakfast Programs must create a *Local Wellness Policy*. Each school district was charged with setting goals for nutrition education, physical activity, and other school-based initiatives that deal with promoting student health and reducing childhood obesity.

On June 13, 2006, the Baltimore City Public School System (BCPSS) Board of School Commissioners approved the *BCPSS Local Wellness Policy (LWP)*³. A year later, the status of the implementation of the *BCPSS LWP* is unclear.

These references from the *BCPSS LWP*, as well as input from our workgroup, were used to generate and evaluate suggestions for achieving our above referenced goal.

We discovered that numerous recommendations had already been identified and were in place. The remaining recommendations are as follows.

III. General Recommendations From Priority Area 2 - Schools

1. Community volunteers, staff, and students should serve as role models for healthy eating and promoting nutritious foods - Encourage staff, volunteers and students to

model healthy eating by providing opportunities to share nutritious foods through wellness activities at the school site and in the school community. Invite community vendors (food stores, restaurants, etc.) to collaborate with the school staff for “healthy eating events.”

2. Provide at least 50 hours of nutrition education per school year -- BCPSS LWP, Component One I-a, (Page 2) states requirements for “comprehensive school health education” (emphasis added). Insure that health education is scheduled for every student, every year, and in every grade. Hire certified health education teachers to deliver instruction. Hire qualified curriculum and instruction professional staff to provide professional development to teachers of health education. See also #13, below
3. Provide nutrition education programs that focus on changing specific behaviors rather than learning general facts about nutrition. Employ active learning or experimental strategies -- Use research-based, experiential strategies, and evaluated curricula to encourage and support health behavior change from unhealthy to healthy food choices.
4. Involve the child’s family to reinforce classroom nutrition education -- Provide parent workshops on nutritious cooking. Use school site correspondence to remind and reinforce healthy eating activities begun in the school setting and continue in the home and community.
5. Provide well-trained staff to teach nutrition -- Staff currently must be “certified in health” and considered to be “highly qualified” according to *No Child Left Behind* standards. (<http://www.ed.gov/nclb/methods/teachers/hqtflexibility.html>) See also 14, below.
6. Provide nutrition instruction in physical education classes -- Link the growth of healthy bodies with the ingestion of healthy foods for increasingly successful outcomes in physical education and overall fitness tasks.
7. Provide physical fitness messages in school meal program educational and promotional material -- Provide “site of decision” messages regarding improving personal fitness in the cafeteria.
8. Market meals in the classroom related to the core curriculum -- Link the nutrition education provided in the health education classroom with the nutritional value of the food served in the cafeteria.
9. Schedule recess before lunch -- Monitor school scheduling. This is consistent with State recommendations. (See #16)

10. Promote healthy behaviors by using the CDC's self-assessment and planning tool, the *School Health Index (SHI)* -- Provide technical assistance in the use of SHI to assess the successes and gaps in the school site nutrition services and physical education program. <http://apps.nccd.cdc.gov/shi/Default.aspx>

11. Renegotiate vending contract to include more nutritious foods -- The BCPSS School Board has negotiated a vending contract until 2010.

12. Aggressively promote fruits and vegetables choices -- Link the advantages of eating fruits and vegetables with the nutrition education delivered in the health education class and the need for the nutrients supplied in these foods for healthy growth and development.

13. Update *BCPSS LWP* Component One I-a to reflect teaching health education every year to every child in every grade as per:

- a. K-2 – three times per week for 30 minutes each
- b. 3-5 – three times per week for 45 minutes each
- c. 6-8 – one full semester for each grade
- d. 9-12 – two semesters

Monitor the school site scheduling of health education. (See #16). The LWP asks for staff to be assigned this duty in the monitoring and providing technical assistance through the hiring of a Wellness Specialist who would be under the supervision of the Office of Curriculum and Instruction. Link the appropriate delivery of health education and LWP implementation to the success of the School Improvement Plan. (Each school is required to have a SIP by the Maryland State Department of Education.)

14. Provide for health education to be taught by certified, highly qualified health educators; health educators must participate in 6-10 hours of professional development each year -- Recruit certified teachers. Plan, implement, and evaluate a professional development plan for health education teachers that includes an emphasis on nutritional content."

15. Health education curricula for each year must address all of the Center for Disease Control's *Components for Comprehensive Health Education*⁴ -- Review existing curricula in reference to of the Center for Disease Control's *Components for Comprehensive Health Education* making revisions where necessary. Insure that curricula meet *MSDE Voluntary State Curricular Framework* alignment. See # 13.

16. Implement the *BCPSS LWP* -- Provide technical assistance to schools for success implementation of the *BCPSS LWP*. Provide staff for effective and accurate monitoring of the *BCPSS LWP* implementation. See # 13.

IV. Conclusion:

Significant opportunities exist to improve and sustain access to healthy food and physical activity in the school setting as noted in the recommendations and commentary above.

V. Resolutions:

Whereas: Schools are uniquely positioned to provide a consistent environment that is conducive to healthful eating behaviors and physical activity and

Whereas: Government leadership at all levels is able to provide coordinated leadership for the prevention of obesity in children and youth,

Therefore be it resolved that all Baltimore City Public Schools aggressively promote healthy nutrition and physical activity practices as set forth in the recommendations above.

VI. References/Resources: See footnotes, above.

¹ http://www.eatright.org/cps/rde/xchg/ada/hs.xsl/advocacy_1729_ENU_HTML.htm

² <http://www.fns.usda.gov/TN/Healthy/108-265.pdf>

³ http://www.bcps.k12.md.us/About/pdf/Local_Wellness_Policy.pdf and www.baltimorecityschools.org

⁴ http://www.cdc.gov/HealthyYouth/CSHP/comprehensive_ed.htm

PRIORITY AREA 3: AFTER SCHOOL



BALTIMORE CITY COUNCIL TASK FORCE ON CHILDHOOD OBESITY

REPORT: PRIORITY AREA 3 – AFTER SCHOOL

Goal to improve and sustain healthy eating and physical environments in the “after school” setting.

Chair: Leigh Fernald, The Barclay School

Members: Terry Kendall-Briggs, Principal, Frederick Elementary,
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Raegen Lawrence, Chinquapin Middle School

Robin Marcus, Baltimore Freedom Academy, Baltimore
City Public Schools

Dr. Kenneth R. Stanton, Ph.D. University of Baltimore

BALTIMORE CITY COUNCIL TASK FORCE ON CHILDHOOD OBESITY

REPORT: PRIORITY AREA 3 – AFTER SCHOOL

About the Authors

Dr. Kenneth R. Stanton is co-chair of the Task Force. He is an assistant professor of finance at the University of Baltimore, where he chairs the University of Baltimore Obesity Initiative, which is a multidisciplinary group of academics dedicated to addressing the obesity epidemic. He is a contributor to and an editor of the book, *Obesity, Business and Public Policy*. Dr. Stanton is also the lead author of the UB Obesity Report Card, which grades the legislative performance of each state in terms of addressing obesity. The report card has been updated annually and has received heavy national attention in television, print and other media, and it has also had considerable impact on obesity control measures introduced by state governments from coast to coast. He has also provided guidance and support to legislators in various state governments including, Illinois, Maryland, North Carolina and Texas and is now engaged in policy initiatives at the federal level.

Leigh Fernald, The Barclay School, Chairperson

Terry Kendall-Briggs - Bachelor of Science and Master of Education from Coppin State College, Certificate of Advance Studies in Education from Johns Hopkins University. For over 24 years Terry has held positions in education in Maryland and Pennsylvania. Terry has worked in non-public and public school settings as a Special Educator, Curriculum Specialist, Assistant Principal, Dean of Students, and Principal. Terry is presently beginning her second year as Principal of a Title One School within the Baltimore City Public School System

Raegen Lawrence, YMCA Urban Services, Member

BALTIMORE CITY COUNCIL TASK FORCE ON CHILDHOOD OBESITY

REPORT: PRIORITY AREA 3 - AFTER SCHOOLS

I. Purpose

Improve and sustain access to healthy food and physical activity in the after school setting.

II. Review of Research/Observations:

Between 1976 and 2000 the number of obese adult Americans (Body Mass Index (BMI) ≥ 30) grew by 120 percent, or on a prevalence basis, from 14.7 to 30.1 percent. Based on these numbers, the prevalence of obesity could approach 50 percent before 2020 (See Figure 1 in Section VI). The direct medical costs associated with obesity and overweight are currently estimated to be in excess of \$130 billion.¹

In approximately the same time period, 1980 to 2004, the prevalence of overweight among American children aged 6 to 11, more than doubled, increasing from 7% in 1980 to 18.8% in 2004. For adolescents, aged 12 to 19, the prevalence of overweight more than tripled, increasing from 5% to 17.1%.² Due to the demographic characteristics of Baltimore, the prevalence of overweight and obesity are undoubtedly higher than the national figures above.

Even though research indicates a wide variety of underlying factors driving the obesity epidemic³, we know that in its most elementary form, excess body weight results from individuals taking in more calories than are expended. Making matters worse, overweight carries with it greater risk of many serious and costly additional health problems:

- 61% of overweight young people have at least one additional risk factor for heart disease, such as high cholesterol or high blood pressure.⁴
- Children who are overweight are at greater risk for orthopedic problems, sleep apnea, and psychological problems such as stigmatization and low self-esteem.⁵
- Overweight young people face a 70 percent chance of becoming overweight or obese adults, placing them at high risk of heart disease, Type 2 diabetes, stroke, several types of cancer, and osteoarthritis.⁶
- Excess weight is suspected as a factor in early onset of puberty, which in turn is linked to greatly increased risk of breast cancer.⁷

The costs of these health problems are borne disproportionately by publicly funded programs such as Medicare and Medicaid, but private health insurance premiums are also elevated because of the pooling of healthcare expenditures. Health problems related to excess weight can be prevented by improving healthful diet and exercise choices.⁸ Because overweight children are much more likely to become overweight or obese adults, it is vitally important to encourage healthy diet and exercise habits in our children. The obvious counterpart is that there is an urgent need to ensure that we assess current practices and limit or remove any factors that are encouraging or facilitating unhealthy diet and exercise choices. Because of the number of Baltimore children who are involved in after school programs, these programs are an important access point in encouraging healthier habits and that role needs to be taken seriously.

Much of what can be accomplished in after school programs is contingent on what is occurring in the schools themselves. For example, efforts to limit portion sizes of snacks offered through the Free and Reduced Meals (FARM) program in after school venues may be counterproductive in schools where the children receive lunch as early as 9:30 am. Before embarking on any changes to after school programs, immediate steps must be taken to make certain that no Baltimore schools are allowed to operate in this fashion. Inappropriate meal times may be a significant factor in encouraging our children to substitute snacking for eating at standard meal times.

From approximately 1978—the apparent starting point for the obesity epidemic—to 1995, there was an increase in caloric intake of approximately 150 calories for women and 300 calories for men. Over the same period, snacks have increasingly substituted for standard meals. It is likely that similar patterns prevail for children since they are heavily influenced by the examples set by their parents. The increase in intake is important, but it is also important that calorically dense processed snack foods are implicated in overeating. Research indicates that allowing for leisurely meal times is an important factor in recognizing the cues that we are full and preventing overeating.

Although it may be more important to ensure that children are not taking in too many calories, the impact of reduced energy output in the form of exercise is also critical. In after school programs, there must be a concerted effort to encourage greater physical activity.

Background Issues

Thousands of Baltimore City children are currently participating in after school programs and for that reason, it is strongly recommended that after school service providers receive appropriate nutrition and physical education training. The after school setting provides a clear access point for educating not only the children, but also for providing information to parents as a means of encouraging healthier habits within the homes. All snacks offered should consistently include healthy foods, especially fresh fruits and vegetables.

Current snack offerings may be constrained by the lack of storage capabilities for some after school sites. However, the food storage issue is not expected to be a costly problem to solve. As one alternative solution, partnerships with local grocers may be feasible. Businesses have begun to recognize that they have a role in fighting the obesity epidemic and it is in their interest to do so. We acknowledge that there may be many opportunities in which forming alliances with businesses may afford greater gains than taking an adversarial approach.

Beneficial partnerships with restaurants and other business entities should be encouraged but there are also many opportunities for partnerships with non-profits and government agencies that can be more fully exploited. For example, after school programs may be able to utilize nearby parks, recreational centers, or YMCA facilities to increase physical activity options. Similarly, after school programs may not be fully capitalizing on available assistance programs to provide nutritional foods. Federal programs are available and after school providers should be encouraged to make use of them.

III. General Recommendations from Priority Area 3 – After Schools

As an overview, extensive effort must be applied in a broad manner to encourage healthier eating, discourage consumption of unhealthy foods such as processed snacks and sodas, and to increase opportunities for the encouragement of physical activity. A broad based approach would include for example, any feasible actions that improve the safety and “walkability” of the city as a whole. The following recommendations are among the needed measures, but not exhaustive in terms of steps, that can be taken to improve the health of our children.

In order to encourage after school providers to be innovative in developing ideas and programs it is important to publicize and celebrate successes. Recognition for a job well done is a strong motivator. City government officials can influence media and other attention by setting the example and visiting sites that are developing new ideas and demonstrating success.

1. Eliminate the provision of unhealthy foods. In particular, vending machines dispensing soda and processed snack foods from after school sites should be eliminated as soon as possible. Where it is not possible to eliminate the machines completely due to long term contracts or other considerations, after school care providers should aggressively encourage vendors to, at minimum, provide healthier choices in their machines. Research indicates that substituting diet soda for high calorie sugar sweetened soda is insufficient and ill-advised due to the health risks inherent in all sodas.⁹
2. After school staff members serve as mentors and role models. Wellness programs should be established to aid staff in improving their exercise and nutrition choices to better fill their important role.

3. Staff should be trained in nutrition and provided with appropriate guidance in implementing physical activities for the children in their care.
4. Children should be encouraged to be more active through programs offered in after school programs. Activities that engage children in physical activities through the use of computer games, such as Dance Dance Revolution have shown success in trials in West Virginia and other locations. Activities that are enjoyable for the children have greater long term success than activities that are imposed solely to improve fitness.
5. The after school setting should be used to engage parents as well as children. Educational seminars, printed materials and other media approaches can be used to teach parents about nutrition and the importance of exercise.
6. Elected officials should make a personal commitment to publicly recognize the sites that are making noteworthy efforts to control obesity. This may be as simple as visiting sites, and hopefully drawing media attention to the best practice providers.
7. Develop appropriate performance measures for all programs instituted. Accountability and performance measurement rely on being able to collect suitable data. Sensitivity to the privacy and wellbeing of the children is of crucial importance, but it is also critical to evaluate and revise programs in order to ensure success.

V. Conclusion:

After school sites provide an opportunity to influence healthier diet and exercise choices that should be used to a greater extent. Since after school staff members necessarily serve as role models, wellness programs designed to improve staff fitness and health are strongly advised. Staff should also receive nutrition and fitness training to ensure that children in their care receive healthy foods and are encouraged to be physically active. Any programs that are implemented must be evaluated in terms of the contribution to reducing obesity and improving health. Concerns regarding privacy and abuse of data must be addressed, but it is important to direct effort and other resources to programs that have demonstrated positive benefits.

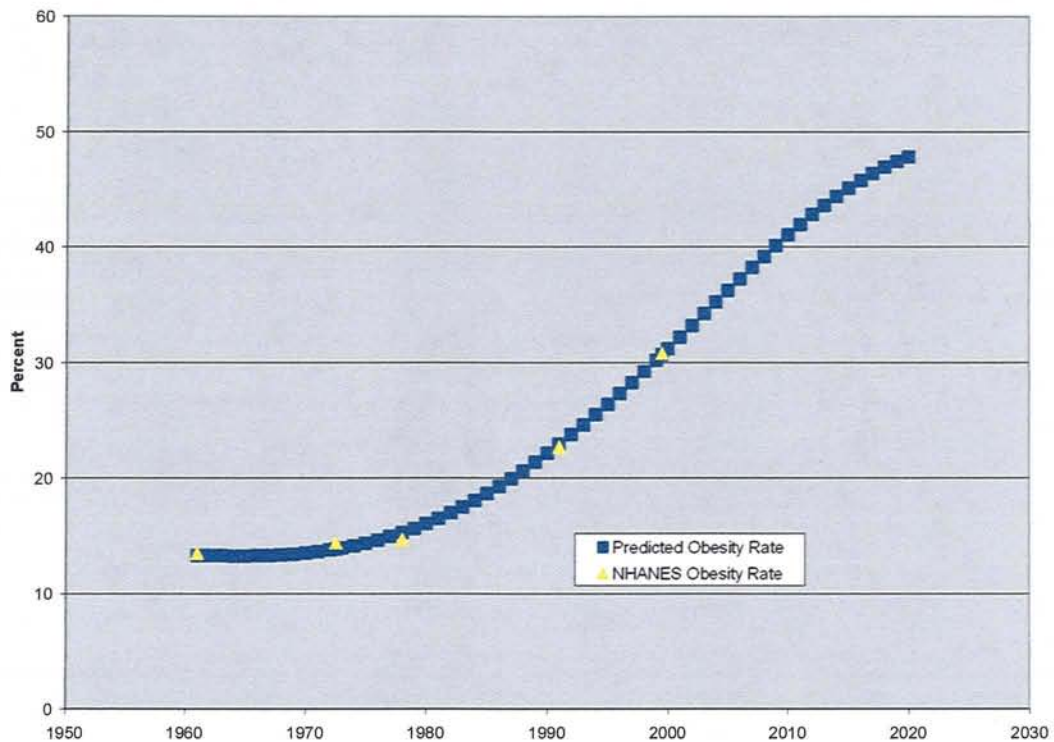
VI. Resolutions:

1. **Eliminate processed snack foods and sodas from after school sites.**
2. **Resolve to provide appropriate fitness and wellness programs for after school care staff.**

3. Staff should be required to complete an appropriate nutrition training program.
4. After school programs should be required to provide suitable programs to encourage physical activity.
5. After school sites should be provided with suitable materials to engage parents in becoming more informed and engaged in the nutrition and physical activities choices of their children.
6. Any proposals must be accompanied by plans for appropriate performance measures and evaluation.

VII. References/Resources:

Figure 1: US Adults: Observed and Projected Obesity Prevalence, 1961-2020



Source: Stanton KR, Acs Z (2005).¹⁰

¹ The dollar amount is based on estimates contained in Stanton KR, Acs Z. The infrastructure of obesity and the obesity epidemic: implications for public policy. *Applied Health Economics and Health Policy*, 2005; 4: 139-46. The \$130 billion estimates is the adjusted for inflation in healthcare costs to reflect 2007 prices. Indirect costs, from lost productivity, additional costs for transportation, investments made by hospitals to deal with heavier patients and other similar factors are not included.

² Ogden CL, Carroll MD, Curtin LR, McDowell MA, Tabak CJ, Flegal KM. Prevalence of Overweight and Obesity in the United States, 1999-2004. *JAMA* 2006;295:1549-1555.

³ Acs ZJ, Cotten A, Stanton KR. The infrastructure of obesity. *Obesity, Business and Public Policy*, Acs ZJ, Lyles CA, Stanton KR, Edward Elgar Publishing, Inc., 2007;135-155.

⁴ Freedman DS, Dietz WH, Srinivasan SR, Berenson GS. The relation of overweight to cardiovascular risk factors among children and adolescents: the Bogalusa Heart Study. *Journal of Pediatrics* 1999;103(6):1175-1182.

⁵ Freedman DS, Dietz WH, Srinivasan SR, Berenson GS. The relation of overweight to cardiovascular risk factors among children and adolescents: the Bogalusa Heart Study. *Journal of Pediatrics* 1999;103(6):1175-1182.

⁶ U.S. Surgeon General. Overweight and Obesity: Health Consequences.

http://www.surgeongeneral.gov/topics/obesity/calltoaction/fact_consequences.htm

⁷ Griffith, D. Early-onset puberty raising health risks for girls. *Chicago Tribune*, September 16, 2007.

⁸ Ogden CL, Carroll MD, Curtin LR, McDowell MA, Tabak CJ, Flegal KM. Prevalence of Overweight and Obesity in the United States, 1999-2004. *JAMA* 2006;295:1549-1555.

⁹ See report of research by Ramachandran Vasan (Boston University School of Medicine, MA) available at <http://www.medscape.com/viewarticle/560344?src=mpnews>

¹⁰ Stanton KR, Acs Z. The infrastructure of obesity and the obesity epidemic: implications for public policy. *Applied Health Economics and Health Policy*, 2005; 4.: 139-46.

**PRIORITY AREA 4:
PRESCHOOL/CHILD CARE
SERVICES**



BALTIMORE CITY COUNCIL TASK FORCE ON CHILDHOOD OBESITY

REPORT: PRIORITY AREA 4– PRESCHOOL/CHILD CARE SERVICES

Goal to improve nutrition and physical activity environments in the preschool and child care services setting.

Chair: Maureen Black, Ph.D., University of Maryland Hospital
for Children

Members: Adreinne MCGill, MHS, School of Medicine, University of
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BALTIMORE CITY COUNCIL TASK FORCE ON CHILDHOOD OBESITY

REPORT: PRIORITY AREA 4 – PRESCHOOL/CHILD CARE SERVICES

About the Authors

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Maureen Black, PhD - a pediatric psychologist and professor in the Department of Pediatrics at the University of Maryland; adjunct professor in the Center Human Nutrition at the Johns Hopkins Bloomberg School of Public Health; has served on the Maryland State WIC Advisory Board for 6 years and conducted the Maryland Infant Feeding Project and the Maryland Food Preference Study with WIC.

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BALTIMORE CITY COUNCIL CHILDHOOD OBESITY TASK FORCE

REPORT FOR PRIORITY AREA 4 - PRESCHOOL/CHILD CARE SERVICES

I. Purpose

Improve nutrition and physical activity environments in the preschool and child care services setting.

Review of Research/Observations

Advantages of this priority area: Helping young children develop healthy dietary habits can have lifelong benefits. Young children who are raised with caregivers who model healthy eating behaviors, such as a diet rich in fruits and vegetables, establish patterns of eating behaviors and food preferences that include fruits and vegetables.

Many young children are at risk for nutritional deficiencies because of their poor dietary intakes and reliance on foods high in fat and sugar, and refined carbohydrates. National surveys have reported excessive caloric intakes during toddlerhood with alarmingly low intake of fruits and vegetables. By elementary school, many children receive over half their beverage intake from sweetened drinks, a pattern that undoubtedly begins during the toddler and preschool years. These poor nutritional patterns (high fat, sugar, and refined carbohydrates; sweetened drinks; and limited fruits and vegetables) increase the likelihood of overweight in children. The early years (birth through age 5) are an ideal time to focus on healthy nutrition and physical activity.

Current Guidelines:

- a. Food choices - food choices and availability of food varies among schools.
- b. Federal programs – [Head Start, Women Infant Children (WIC)] have guidelines provided by USDA.
- c. Day care - Guidelines for nutritious, age-appropriate meals. Snacks and celebrations often include high fat, high sugar options (e.g., cupcakes)
- d. Physical Activity - built in to the school day, structured activity
- e. Amount of attention nutrition education and physical activity received are dependent upon the individual school principals. Wellness policies exist for some schools, but are not universally adhered to.

Summary of research

University of Maryland's Current and Previous Work in Priority Area 4 – Preschool/Child Care Services

- a. Statewide Assessment of WIC food package project - There is a federal mandate to evaluate and revise the current WIC (Women, Infants and Children) supplemental foods package. Each state determines which recommendations from USDA to implement. The University of Maryland in collaboration with The Maryland State

WIC Program is gathering statewide information on the foods that are purchased by families with vouchers provided by WIC.

- b. MIFS (Maryland Infant Feeding Study) data - state-wide cross-sectional study that collected dietary information on feeding practices and dietary intake among 800 infants who received WIC.
- c. TOPS - Toddler Overweight Prevention Study is collaboration with the Anne Arundel County, Maryland WIC Program that evaluates strategies to prevent overweight among toddlers. We are evaluating how an intervention directed toward maternal diet and physical activity and an intervention directed toward parenting toddlers compare with an intervention on child safety (control).

II. General Recommendations from Priority Area 4 – Preschool/Child Care Services:

- a. There are three (3) levels that contribute to toddlers' health state and need to be addressed:
 - i. Parents
 - ii. Schools/ child care settings
 - iii. Government run supplemental food/nutrition programs - ex: WIC, Headstart, Expanded Food and Nutrition Education Program (EFNEP), Maryland Child and Adult Care Food Program (CACFP)
- b. Parents: education, awareness, and access to age-appropriate nutrition, serving sizes, physical activity and general health for themselves and their children. Use media and outlets such as WIC, Head Start, EFNEP and community health clinics to reach parents. Encourage breastfeeding and provide opportunities to support breastfeeding women.
- c. Schools/ child care setting: intervene on the child's level. Improve the food choices and quality (freshness) offered in daycare centers. Make it mandatory to include structured activities into the day and to incorporate nutrition lessons into the current curriculum citywide. Support family events that feature nutrition education and physical activity.
- d. Government run nutrition programs: Increase access to these programs, nutritional quality of the foods distributed and funding for nutrition education within them. There are many programs available that include, but are not limited to WIC, Head Start, EFNEP, and CACFP. Within these types of organizations, providers can use models similar to the one used in the TOPS program to reach parents.
 - The Head Start program provides comprehensive child development services to economically disadvantaged children and families, with a special focus on helping preschoolers develop the early reading and math skills they need to be successful in school. Head Start centers provide meals and snacks that must adhere to the USDA nutritional standards for schools and daycare centers.
 - The Special Supplemental Nutrition Program for Women, Infants, and Children, popularly known as WIC, provides food vouchers, nutrition

counseling, and access to health services to low-income women, infants, and children. WIC provides Federal grants to States for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to the age of five who are found to be at nutritional risk. In addition to providing nutrition education to parents of young children, WIC provides vouchers for specific nutrient-rich foods accepted by most grocery vendors and some farmers markets in Baltimore.

- The Expanded Food and Nutrition Education Program (EFNEP) is designed to serve low-income individuals in developing skills that will improve their family's diet and nutritional well-being. County extension home economists provide on-the-job training and supervise paraprofessionals and community volunteers to use a hands-on approach to teach program participants to select and buy nutritious food, develop new skills in food preparation and learn to better manage their food budgets and related resources such as Food Stamps. EFNEP recruits families and receives referrals from neighborhood and community agencies such as Food Stamps and WIC.

EFNEP also offers youth programs that provide nutrition education at schools and through 4-H EFNEP clubs, day camps, residential camps, community centers, neighborhood groups, and home gardening workshops. In addition to lessons on nutrition, food preparation, and food safety, youth topics may also include fitness, avoidance of substance abuse, and other health-related topics. The hands-on, learn-by-doing approach allows the participants to gain the practical skills necessary to make positive behavior changes. EFNEP works to build participants sense of self-worth and the belief that they have something to offer their families and society.

- The Child Care component of the Maryland Child and Adult Care Food Program (CACFP) is USDA funded and provides reimbursement for nutritious meals served to children aged birth to 12 years who are enrolled in licensed childcare centers. All participating childcare centers must serve meals that meet USDA nutritional standards and may receive assistance for two meals and a snack per child, per day. The program is administered by the Maryland State Department of Education's School and Community Nutrition Programs Branch.

Evaluation Tools: Nutrition/Physical Activity

- Parental participation in government sponsored nutrition programs could be monitored via the agency's existing evaluation tools. For example, the WIC program tracks caretakers attendance at nutrition education classes and monitors WIC children's growth and development by measuring height, weight and risk of anemia every six months.

- Individual participant data collected from government funded nutrition agencies make their program statistics available to the public on an aggregate level by county, city and/or state.

Agencies providing nutritional support to young children and their families in Baltimore could share their de-identified data with the city of Baltimore in a collaborative effort to monitor the health of our youngest residents.

III. **Resolutions:**

Resolution 1: Promote breast feeding

Whereas: the American Academy of Pediatric endorses exclusive breast feeding for the first six months, followed by breast feeding through 12 months and

Whereas: breastfeeding is protective against overweight and

Whereas: breastfeeding has been associated with multiple nutritional, health, and psychological benefits for children and mothers.

Therefore, Baltimore City should encourage employers and health care providers to provide assistance to promote breast feeding. Assistance could include encouragement, education, and support for pregnant and breast feeding women, Family Medical Leave Act to encourage breast feeding, workplace opportunities that are appropriate to pump and store breast milk

Resolution 2: Promote physical activity

Whereas: insufficient physical activity is a contributing factor for developing childhood obesity. Concerns about safety may lead many parents to keep children indoors, limiting their opportunities for active play and vigorous physical activity.

Whereas: preschool children's play has become increasingly more sedentary with the increased use of screen time in the form of television and video viewing. Children's overweight is related to the amount of screen time they acquire each day.

Whereas: healthy preschool children thrive best with at least 120 minutes a day of active play.

Therefore be it resolved that preschools and daycare programs in Baltimore incorporate at least 60 minutes of active play for young children into their daily curriculum. Programs should encourage parents to promote active play with their children at home while reducing children's sedentary time.

Resolution 3: Nutrition / physical activity education for parents

Whereas: toddlers and preschool-aged children are entirely dependent upon their parents and caregivers to provide them with nutritious foods and snacks. Parents and

caregivers must be knowledgeable about basic childhood nutrition and have access to healthy foods that are appropriate for childhood growth and development.

Therefore be it resolved that preschools and daycare programs for preschool aged children in Baltimore provide healthy, developmentally appropriate portions of foods and drinks to children. To the extent possible, preschools and daycare programs for preschool aged children in Baltimore should provide parents and caregivers with information on healthy, developmentally appropriate portions of foods and drinks for children.

Resolution 4: Modify and adopt Wellness Policy

Whereas: there exists institutionalized policies and guidelines for enhancing the health and well-being of Baltimore school children in the Baltimore Education system that could be applied to preschool aged children in daycare facilities.

Therefore be it resolved that preschools and childcare operations in Baltimore implement the Wellness Policy program similar to that which exists in the Baltimore City schools pertaining to nutrition and physical activity, as modified for toddler and preschool-aged children.

IV. References/Resources

Resources:

“Get Fit Kids Program” University of Maryland School of Medicine and Merritt Athletic Clubs and elementary schools (Westside, Bentalou, Frederick)

Head Start Program <http://www2.acf.dhhs.gov/programs/hsb/>

Maryland Child and Adult Care Food Program (CACFP)
<http://www.marylandpublicschools.org/MSDE/programs/schoolnutrition/childcare.htm>

The Expanded Food and Nutrition Education Program (EFNEP)
<http://www.csrees.usda.gov/nea/food/efnep/efnep.html>

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) <http://www.fns.usda.gov/wic/>

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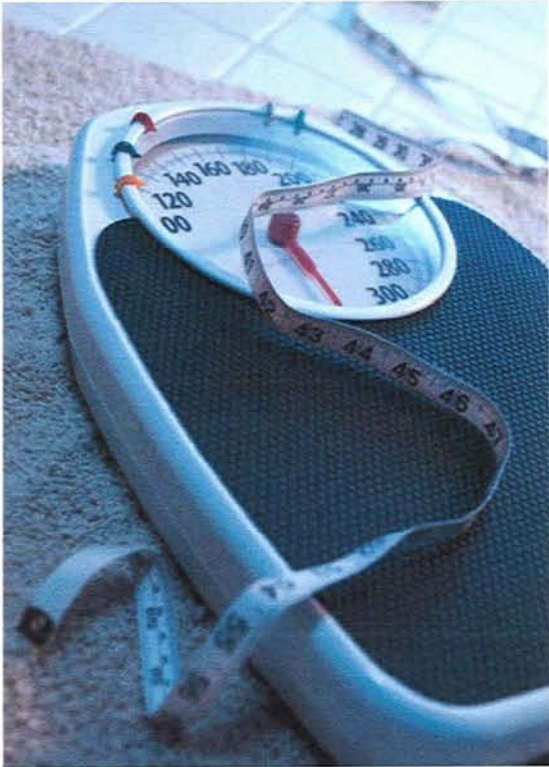
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PRIORITY AREA 5: HEALTHCARE



BALTIMORE CITY COUNCIL TASK FORCE ON CHILDHOOD OBESITY

REPORT: PRIORITY AREA 5 – HEALTHCARE

Goal to improve and sustain access to healthy nutrition and physical activity information and environments in the healthcare setting.

- Chair: Jacky Jennings, Ph.D., MPH, School of Medicine,
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- Members: Dr. G. Anne Davis, Alpha Kappa Alpha Sorority, Inc.,
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- Lena Franklin, OROSW
- April Yvonne Garrett, Civic Frame, Inc.
- Joel Gittelsohn, M.S., Ph.D., Bloomberg School of Public
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- Allen Hicks, Mill Valley Community Coalition
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School of Nursing, Coppin State University
- Mabilia Reyes, Bon Secours Foundation
- David Simpkins, Saint Agnes HealthCare
- Sue Tatterson, University of Baltimore

BALTIMORE CITY COUNCIL TASK FORCE ON CHILDHOOD OBESITY

REPORT: PRIORITY AREA 5 – HEALTHCARE

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BALTIMORE CITY COUNCIL TASK FORCE ON CHILDHOOD OBESITY

REPORT: PRIORITY AREA 5 – HEALTHCARE

I. Purpose:

Improve and sustain access to healthy nutrition and physical activity information and environments in the healthcare setting.

II. Review of Research/Observations:

Healthcare professionals have the advantage of screening and identifying children at-risk of overweight and to provide education to parents during regular office visits.

Summary of research

Overweight carries with it greater risk of many serious and costly additional health problems:

- 61% of overweight young people have at least one additional risk factor for heart disease, such as high cholesterol or high blood pressure.ⁱ
- Children who are overweight are at greater risk for orthopedic problems, sleep apnea, and psychological problems such as stigmatization and low self-esteem.ⁱⁱ
- Overweight young people face a 70 percent chance of becoming overweight or obese adults, placing them at high risk of heart disease, type 2 diabetes, stroke, several types of cancer, and osteoarthritis.ⁱⁱⁱ
- Excess weight is suspected as a factor in early onset of puberty, which in turn is linked to greatly increased risk of breast cancer.^{iv}

The direct medical costs associated with obesity and overweight are currently estimated to be in excess of \$130 billion.^v The costs of these health problems are borne disproportionately by publicly funded programs such as Medicare and Medicaid, but private health insurance premiums are also elevated because of the pooling of healthcare expenditures. Health problems related to excess weight can be prevented by improving healthful diet and exercise choices.^{vi} Because overweight children are much more likely to become overweight or obese adults, it is vitally important to encourage healthy diet and exercise habits in our children.

Bills to require screening, risk analysis or testing of school children for diabetes were enacted in 2003 in California and Illinois, and introduced in New York. Noninvasive screening of school children is aimed at promoting an earlier response to prevent or respond to Type 2 diabetes. Legislation aimed at improving care and diabetes management for children with diabetes in school or daycare settings was introduced

in California, Illinois, Massachusetts, New Jersey, Pennsylvania, Tennessee, Vermont, and Virginia. (3)

Legislation mandating health insurance coverage for obesity reduction treatments and prevention programs for children and adolescents was introduced in 2004 in Hawaii and Maryland. In addition, legislators in Hawaii requested the state auditor's office to assess the social and financial effects of requiring health insurers to cover obesity reduction programs for children and adolescents. (3)

III. Recommendations from Priority Area 5 - Healthcare

There are two (2) main levels of the healthcare systems that can assist with preventing childhood obesity:

- i. Healthcare professionals
- ii. The City Health Department

Healthcare professionals: have access to providing education to parents and children regarding the development of a healthy lifestyle. Autonomy can be encouraged in children for self-regulation of food intake and setting appropriate limits on choices. Health professionals should routinely promote physical activity in school, unstructured play at home, in child-care settings and within the community. All children should be counseled regarding healthy eating and activity, referral to a health educator, nutritionist or weight management program after initial identification of overweight or at-risk of overweight. There must be a coordinated, multi-faceted approach to promote children's health. There must be a responsibility to ensure that preventive and intervention efforts, as well as policy changes, are effective. This collaborative effort offers an opportunity to support each other to improve the well-being of our children.

The City Health Department: Not only does the health department have direct contact with pediatric patients through city-funded clinics, this organization also can promote campaigns related to childhood obesity prevention such as breastfeeding promotion.

IV. Resolutions

Resolution 1: Use of growth charts and screening measures

Whereas: the prevalence of childhood obesity and its co-morbidities has reached epidemic proportions.

Whereas: physicians notoriously fail to plot children's weight-for-length or weight-for-height on growth charts which is often times necessary to recognize overweight or at-risk for overweight.

Therefore, the importance of plotting children's weight-for-length or weight-for-height should be emphasized to all city physicians treating pediatric patients. In addition, all physicians should be required to record weight-for-length or weight-for-height percentiles on their patients' charts. In addition, children deemed at-risk for overweight should be screened for co-morbidities. The city should support bills that provide insurance coverage for obesity treatment and prevention programs for children.

Resolution 2: Education in the healthcare setting

Whereas: changes in the American lifestyle have put the health of our children at-risk. Therefore, be it resolved that it is incumbent upon healthcare professionals and policy makers to provide parents with a consistent and coherent message related to healthy nutrition for children and, be it further resolved that the Baltimore City Health Department lead this effort.

Resolution 3: Promote breastfeeding

Whereas: Research has shown that there is no better food than breast milk for a baby's first year of life. Breastfeeding provides many health, nutritional, economical and emotional benefits to mother and baby. Since a major goal of the Women, Infants and Children (WIC) Program is to improve the nutritional status of infants, WIC mothers are encouraged to breastfeed their infants. WIC has historically promoted breastfeeding to all pregnant women as the optimal infant feeding choice, unless medically contraindicated.

Whereas: The current federal WIC regulations contain provisions to encourage women to breastfeed and to provide appropriate nutritional support for breastfeeding participants.

Therefore, be it resolved that the Baltimore City Health Department adopt a breastfeeding promotion campaign. This campaign can be modeled after the successful campaign WIC has done. The campaign could include billboards, signage on the sides of city buses, posters in the health department, physicians' offices and health clinics and public service announcements (PSAs) via local radio and television stations.

V. References/Resources

Resources:

1. <http://www.fns.usda.gov/wic/Breastfeeding/breastfeedingmainpage.HTM>

2. http://www.cdc.gov/nccdphp/dnpa/obesity/economic_consequences.htm
3. <http://www.ncsl.org/programs/health/childhoodobesity.htm>

References:

Wang G & Dietz WH. Economic Burden of Obesity in Youths Aged 6 to 17 Years: 1979-1999. *PEDIATRICS* Vol. 109 No. 5 May 2002, pp. e81.

ⁱ Freedman DS, Dietz WH, Srinivasan SR, Berenson GS. The relation of overweight to cardiovascular risk factors among children and adolescents: the Bogalusa Heart Study. *Journal of Pediatrics* 1999;103(6):1175-1182.

ⁱⁱ Freedman DS, Dietz WH, Srinivasan SR, Berenson GS. The relation of overweight to cardiovascular risk factors among children and adolescents: the Bogalusa Heart Study. *Journal of Pediatrics* 1999;103(6):1175-1182.

ⁱⁱⁱ U.S. Surgeon General. Overweight and Obesity: Health Consequences.

http://www.surgeongeneral.gov/topics/obesity/calltoaction/fact_consequences.htm

^{iv} Griffith, D. Early-onset puberty raising health risks for girls. *Chicago Tribune*, September 16, 2007.

^v The dollar amount is based on estimates contained in Stanton KR, Acs Z. The infrastructure of obesity and the obesity epidemic: implications for public policy. *Applied Health Economics and Health Policy*, 2005; 4:. 139-46. The \$130 billion estimates is the adjusted for inflation in healthcare costs to reflect 2007 prices. Indirect costs, from lost productivity, additional costs for transportation, investments made by hospitals to deal with heavier patients and other similar factors are not included.

^{vi} Ogden CL, Carroll MD, Curtin LR, McDowell MA, Tabak CJ, Flegal KM. Prevalence of Overweight and Obesity in the United States, 1999-2004. *JAMA* 2006;295:1549-1555.

BALTIMORE CITY COUNCIL TASK FORCE ON CHILDHOOD OBESITY

CONCLUSION

The Baltimore City Council Task Force on Childhood Obesity realizes that numerous policies and recommendations pertaining to childhood obesity have been implemented locally, statewide and nationally. Our major focus, however, was on Baltimore City's pre-school and elementary school children.

A major concern that evolved was inconsistencies, citywide, in implementing policies and recommendations to combat obesity and encourage physical activity. Some schools have no gymnasium and/or playground. Some have little or no structured physical activity. New schools should not be built without a gymnasium and adequate playground.

There was a general consensus that there should be required amounts of time per week for health and nutrition education, including physical activity. A mandated assessment per child, per school must be part of any obesity reduction and physical fitness program. Evaluation of healthy eating and physical activity should be ongoing and rated per child per school.

Designated open-spaces in Baltimore City should be converted into neighborhood gardens. These could be terrific neighborhood projects. Community gardens can be developed on vacant city-owned lots or unused parking lots and can be organized by neighborhood groups, non-profits, or city agencies. City leaders can help identify public spaces for "Farmer's Markets" to operate.

Neighborhood grocers must be encouraged to participate in prevention of childhood obesity. Baltimore City should examine the possibility of subsidizing the cost of fresh fruits and vegetables and/or adding a small tax on soft drinks or snacks. Arkansas has a two cent (\$.02) tax on soft drinks that generates forty (\$40) million dollars per year. Money from subsidizing or tax could be used to promote healthy lifestyles.

Collaboration between Baltimore City government, Baltimore City Public Schools System and the Baltimore City Health Department is most important because their strong positions can provide the necessary steps to reduce childhood obesity. Several neighborhood partnerships are already formed; they should be encouraged to continue and to help others get started. Baltimore City should mandate that recipients for youth programs take steps to promote physical activity and healthy eating. A citywide promotional walking contest, using pedometers could kick-off the program with a prize going to the child with the most steps walked in one day/week/month. After school programs can be helped to get reimbursement from the federal child and adult care food program, if operated by public or non-profits in low-income neighborhoods or serve predominantly low-income children. Baltimore City has many opportunities to take action to alleviate this growing epidemic. The City is also appropriately positioned to

facilitate needed partnerships. A mandated policy is justified and, as a result, cost effective by preventing illness and death.

One of the variables identified as a contributing cause for childhood obesity is access to vending machines in the schools. It is unlikely that schools will welcome removal of vending machines because of revenues produced; however, this should be the goal. Vending machines should not be accessible to children in schools. Convincing principals of the urgency needed to resolve this problem is a must.

The three (3) soft drink firms, Pepsi Cola, Coca-Cola and Cadbury Schweppes, have voluntarily agreed to remove high-calorie beverage from schools in 2009 (with some conditions). The average child is exposed to more than 40,000 television commercials per year. An estimated 80% of targeted advertising falls within fast-food restaurants, cereals, candies and toys. Children view increasing advertisements on television, movies, radio, internet, video games and at school. Evidence states, children are persuaded to request these products.

Benefits of healthy eating and physical activity must be included in the school system's curriculum. Families and communities, as a whole, must be actively engaged as partners. Teachers in the classroom must become creative, especially when it becomes difficult to fit in thirty (30) minutes of consecutive physical activity. The minutes may be broken up with activities such as walking around the classroom or school, classroom or lunch stretches, simple squats, jumping jacks, etc. Principals should acknowledge the most creative teachers. Principals should also encourage physical activity. There must be an emphasis on the need for qualified physical education teachers.

Public recognition can raise awareness and understanding and motivate providers. It can, also, be showcased in local media events with a major boost and initiatives given. Underserved communities should be the focal point for workshops on healthy eating, nutrition label readings, etc. Expansion of "farmer's markets", Arabers, supermarkets, etc. must be encouraged in these areas. Recreation centers could sponsor or promote healthy cooking classes or other prevention sessions.

All of us have a role to play in increasing physical activity and promoting healthy eating for our children. No single intervention will reverse this epidemic. Some strategies stressed in this report include: longer and more frequent physical education classes that require physical activity for at least one-half of the class time. Classes may be three (3) times per week instead of once and should be mandated to total one hundred fifty (150) minutes per week. This can mean a difference of two hundred forty (240) calories per week; reducing sugar-sweetened beverages at home and school; foods served in elementary schools shall provide no more than 35% of calories from total sugars per portion (except for fruits, fruit juices, vegetables and vegetable juices without added sugars): all snack items shall be 200 calories or less per portion and meet a sodium content of 200mg. or less per portion; all foods served shall be caffeine-free with the exception of trace amounts occurring naturally, there must be a decrease of fast foods consumed and advertised; (associated with an additional 120 calories per day); replacing

one hour of TV watching with one hour of slow walking (a difference of 55 calories burned).

Policies are needed at every level to address the epidemic and encourage action which may be unlikely without some prod. Failure to meet the need of getting healthier together strangulates our city and leads to a whole host of negative results. A multi-faceted approach must be coordinated to promote healthy eating and physical activity in our children. Baltimore City has a chance to lead by example if the recommendations and mandates are accepted and passed.

RESOLUTIONS: PHYSICAL ACTIVITY

Whereas, there is no consistency in the amount of minutes for physical activity in the elementary level of the Baltimore City Public School System (BCPS) , and some children are not regularly scheduled for adequate amounts of minutes to combat childhood obesity, and each school determines recess and time allowed for physical activity, the elementary level of BCPS shall mandate 150 minutes per week or 30 minutes per day. These minutes may be broken into small units to accommodate the schedule, but must be accountable for all mandated minutes per day per week. This will meet the national standards and show Baltimore City as a leader.

Whereas, research shows that the school environment plays a vital role in shaping childrens' behavior and in response to growing concerns for childhood obesity; family members and adult volunteers shall be encouraged to become "Athletic Aides." All Athletic Aides shall be subject to background and reference checks. Volunteers shall include: basic childhood physical development, prevention and safety-related to sports injuries, first-aid and CPR.

Whereas, opportunities for physical activity help students to stay alert and attentive in class and

Whereas, physical activity provides opportunities for educational and social benefits:

all elementary schools in the BCPS shall be provided with a playground and equipment available for free play. All recess shall be supervised.

All elementary schools in the BCPS shall have recess, to complement, not substitute, for physical activity classes.

All elementary schools in the BCPS shall develop schedules providing mandated time within every school day.

All elementary schools in the BCPS shall collaborate with agencies/organizations to coordinate or enhance physical activities.

Provided these recommendations are a success, these programs can be expanded into as young as preschool, and up to middle and high school.

The Baltimore City Council Task Force on Childhood Obesity, a multidisciplinary group, reviewed the five (5) priority areas in City Council Resolution #06-0230R and came up with the recommendations in this report.

Coordinated leadership and support must be provided to promote prevention of childhood obesity and ensure regularly scheduled physical activity. Specific roles must be undertaken by all who touch the lives of children and a formulated plan with varied interventions must be devised to combat this epidemic.

RESOLUTION: NUTRITION

Whereas, children spend the majority of their day in school and consume foods and beverages with excess calories, sugars and fats: There shall be consistency in all elementary districts of the BCPS, in meeting the "Local Wellness Policy" requirements to meet nutritional standards. Opportunities for competitive foods shall be limited, and if available, shall consist of fruits, vegetables, non-fat milk, and sugarless drinks. All elementary schools in the BCPS shall collaborate with community organizations, grocery stores and corporations to coordinate and/or enhance nutritional health education (e.g. agreement with neighborhood grocers to sell more fresh fruits, vegetables, milk and less sugary drinks; agreement with property owners to cultivate vacant lots; agreement with community organizations to prep ground and to help with planting gardens).

Whereas, poor eating habits and low physical activity lead to childhood obesity and related health issues: All elementary schools in the BCPS shall show by example by serving foods low in fats with NO trans-fats, low in cholesterol, salt (sodium), and added sugars.

Therefore, be it resolved that all elementary schools in the BCPS shall include nutrition and behavioral change education for parents, caretakers and students. Sessions may include health care professionals, nutritionists, and exercise physiologists and shall be ongoing at regular intervals. At-risk children shall be identified and tracked with additional counseling and referral, or reason for not referring noted.

And be it further resolved, that nutrition shall be a component of the education curriculum mandated in elementary schools in the BCPS. Candy, soda, foods high in fats and/or containing trans-fats shall not be given, rewarded or eaten in BCPS. All trans-fats shall be discontinued from the elementary schools in BCPS. Healthy foods shall be served in elementary schools in the BCPS for breakfast,

lunch, snacks. Sessions for healthy eating and the importance of physical activity shall be ongoing and at regular intervals. Foods high in fats and sugar shall be prohibited for sale in BCPS. Foods and beverages served in elementary schools in the BCPS shall provide no more than 35% of calories from total sugars per portion, except for fruits, fruit juices, vegetables and juices with no added sugar. All snack items in elementary schools in the BCPS shall be caffeine-free with the exception of items with trace amounts occurring naturally and

Be it further resolved that the Baltimore City Council Task Force on Childhood Obesity supports enactment of specific legislation to reverse inequities cited in this report, and

Be it further resolved, that the Task Force encourages and supports efforts for evaluation of consistent healthy eating and physical activity in all elementary schools of the BCPS, and that rating shall be assessed for both student and school, and

Be it further resolved that a report card system be applied to BCPS, grocers, supermarkets
in the school area and made public.

And be it finally resolved that Baltimore City shall be compliant with national guidelines (150 minutes per week) and that physical activity shall not be cancelled for instructional make-up time.

Baltimore City shall support efforts of all the above and coordinate leadership and shall support public and private agencies' collaborative efforts to combat childhood obesity. Baltimore City shall solicit state government for further resources and policies needed to strengthen city policies.

Suggested Ways to Promote Results/Document

1. Press Release
2. Town hall meetings
3. Citywide elementary school essay contest
 - a. I will get healthier by.....
 - b. I will help my family become healthier by.....etc.
4. Participation of the parents of elementary school students
 - a. Healthy recipe contest
 - b. Healthy recipe contest with cooking run-off...etc.
5. Acknowledgement of creative teachers for physical activity sessions.
6. Pilot school (with acknowledgement after six to nine months)

Note: Ms. Sandra Graves, Principal of School #122 has agreed to be a pilot school.

BALTIMORE CITY COUNCIL TASK FORCE ON CHILDHOOD OBESITY

EVALUATION

Recommendations from each Priority Area should be monitored for implementation. In addition, notable improvements to the nutritional and physical well-being of our children would require an assessment of the following:

Nutrition

1. School lunch is not served prior to 10:00 a.m.
 2. Foods and/or beverages are not given as rewards or incentives.
 3. At least 50 minutes are devoted to healthy eating and nutrition per week.
 4. Foods and beverages that are served provide no more than 35% of calories from total sugars/portion except for fruit, fruit or vegetable juices without added sugars.
 5. All snack items are 200 calories or less per portion.
 6. All snack items meet a sodium content of 200 mg or less per portion.
 7. All foods and beverages served are caffeine free with the exception of items with trace amounts occurring naturally.
 8. A qualified nutritionist oversees portion sizes and calories.
 9. Opportunities for competitive foods are limited.
 10. Families are involved in healthy eating education.
-
1. Every child in grades 0-6 have had 150 minutes of physical activity per week.
 2. Physical activity sessions are regularly scheduled per day (physical activity minutes may be broken up, but must total 150 minutes per week).
 3. A physical education teacher oversees curriculum and physical activity.
 4. Creative physical activities are used in the classroom.

APPENDICES

- Appendix 1 City Council Resolution 06-0230R
- Appendix 2 Baltimore City Public School System Local Wellness Policy

**CITY OF BALTIMORE
COUNCIL BILL 06-0230R
(Resolution)**

Introduced by: Councilmembers Welch, Curran, Young, Branch, Kraft, Mitchell, Clarke,
Reisinger, Spector, Rawlings Blake, Harris, President Dixon, Councilmembers Holton,
Conaway

Introduced and adopted: October 30, 2006

A COUNCIL RESOLUTION CONCERNING

**Organizational Hearing – Baltimore City Council Task Force
on Childhood Obesity – A Call to Action**

FOR the purpose of calling together school, preschool, and after-school personnel, health care providers, parents, community groups, faith-based organizations, and other stakeholders in a campaign to address the critical problem of childhood obesity by creating a partnership across sectors with the mission to identify the specific roles that must be undertaken to prevent the onset of childhood obesity, to formulate a plan to combat the escalation of the problem among those children at-risk, and to devise a medical and behavioral treatment model to treat the diseases caused by this epidemic and to prevent the onset of sickness in the target population.

Recitals

In a research brief published in August 2004, the National Institute for Health Care Management (NIHCM) Foundation reported that childhood obesity in the U.S. is threatening child health gains made over the past 3 decades. A study by the Centers for Disease Control and Prevention (CDC) concluded that poor diet and inactivity are close to overtaking cigarette smoking as the leading cause of preventable death and that at this rate the current generation of children will not live as long as their parents.

The prevalence of childhood obesity in the United States, it was reported, is growing rapidly for children of all ages – over 15% of children ages 6-19 were overweight in 2000; for 6-11 year olds, the percentage is double the prevalence in 1980; the impact is even greater for 12-19 year olds with triple the rate; and even more alarming is the increase in overweight among young children 2-5 years old, from 7% 10 years ago to 10% in 2000.

By 2004, the Centers for Disease Control (CDC) reports that overweight among children aged 6-11 had reached 18.8% and for 12-19 year olds, 17.1%, and that an estimated 61% of overweight young people have at least 1 additional risk factor for heart disease, such as high cholesterol or high blood pressure. In addition, children who are overweight are at greater risk for bone and joint problems, sleep apnea, and social and psychological problems such as stigmatization and poor self esteem.

The American Obesity Association reports that many adverse health effects associated with overweight are observed in children and adolescents:

EXPLANATION: Underlining indicates matter added by amendment.
~~Strike out~~ indicates matter deleted by amendment.

Council Bill 06-0230R

- 1 • **Asthma:** Prevalence of overweight is reported to be significantly higher in children and
2 adolescents with moderate to severe asthma compared to a peer group.
- 3 • **Diabetes (Type 2):** The increase of Type 2 diabetes in children and adolescents in a
4 dramatically short time is most significantly impacted by a parallel increase in childhood
5 obesity. Obesity is the most significant factor in the skyrocketing increase in Type 2 in
6 children – from 2-4% of childhood diabetes before 1992, to 16% by 1994.
- 7 • **Hypertension:** Persistently elevated blood pressure levels have been found to occur 9
8 times more frequently among obese children and adolescents (ages 5 to 18) than in non-
9 obese.
- 10 • **Orthopedic Complications:** Among growing youth, bone and cartilage in the process of
11 development are not strong enough to bear excess weight. In young children, excess
12 weight can lead to bowing and overgrowth of leg bones, and increased weight on the
13 growth plate of the hip can cause pain and limit range of motion.
- 14 • **Psychosocial Effects and Stigma:** Adolescent females who are overweight have
15 reported experiences with stigmatization such as direct and intentional weight-related
16 teasing, jokes, and derogatory name calling, as well as less intentional, potentially hurtful
17 comments by peers, family members, employers, and strangers. Overweight children and
18 adolescents also report negative assumptions made about them by others, including being
19 inactive or lazy, being stronger and tougher than others, not having feelings, and being
20 unclean.
- 21 • **Sleep Apnea:** Sleep apnea, the absence of breathing during sleep, occurs in about 7% of
22 children with obesity. Deficits in logical thinking are common in children with obesity
23 and sleep apnea.

24 A study performed by officials from the Johns Hopkins School of Medicine, the Johns
25 Hopkins School of Public Health, and the Baltimore City Health Department, *Social Economic
26 Status and Obesity Among Urban Youth: A Geographic Analysis*, found, in part, that many
27 patients in urban school-based health centers are overweight or at-risk for overweight and that
28 gender, age, and individual level measures of poverty are associated with BMI. Given the
29 number of affected students overall, exploration of the potential role of school-based
30 interventions for obesity prevention and intervention is essential.

31 To address this problem, the Baltimore City Council Task Force on Childhood Obesity is
32 formed, based on a model formed by the Institute of Medicine that was established in 1970
33 under the charter of the National Academy of Sciences to provide independent, objective,
34 evidence-based advice to policy makers, health professionals, the private sector, and the public.
35 The Institute of Medicine, in its role as adviser to the nation to improve health, was charged by
36 Congress, in 2002, with developing a prevention-focused action plan to decrease the number of
37 obese children and youth in the United States.

38 The Institute of Medicine's charge followed the 2001 U.S. Surgeon General's *Call to Action
39 to prevent and Decrease Overweight and Obesity* to stimulate the development of specific
40 agendas and actions targeting this public health problem that, in 2000, was causing 30% of boys
41 and 40% of girls to be at risk of developing Type 2 diabetes and causing obesity-associated
42 annual hospital costs to triple over 2 decades, rising from \$35 million in 1979-1981 to \$127
43 million in 1997-1999. After adjusting for inflation and converting 2004 dollars, the national

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1 healthcare expenditures related to obesity and overweight in adults alone range from \$98 billion
2 to \$129 billion annually.

3 According to the 2005 Institute of Medicine report, *Preventing Childhood Obesity: Health in*
4 *Balance*, an aspiration for local governments is to provide coordinated leadership and support for
5 a collaborative effort of stake holders to increase resources and opportunities:

- 6 • **Schools** should provide a consistent environment that is conducive to healthful eating
7 behaviors and regular physical activity by, in part, (1) developing and implementing
8 nutritional standards for all foods and beverages sold or served in schools; (2) ensuring
9 that all school meals meet the Dietary Guidelines for Americans; (3) ensuring that all
10 children and youth participate in a minimum of 30 minutes of moderate to vigorous
11 physical activity during the school day; (4) enhancing school health curricula; (5)
12 ensuring that schools are as advertising-free as possible; (6) conducting annual
13 assessments of students' weight, height, and body mass index and making that
14 information available to parents; and (7) assessing school policies and practices related to
15 nutrition, physical activity, and obesity prevention.
- 16 • **Industry** should make obesity prevention in children and youth a priority by, in part, (1)
17 developing and promoting products and information that will encourage healthy eating
18 and regular physical activity; and (2) food and beverage industries should develop
19 product and packaging innovations that address total calorie content, energy density,
20 nutrient density, and standard serving sizes to help consumers make healthful choices.
- 21 • **Parents** should (1) promote healthful eating behaviors and regular physical activity for
22 their children; (2) provide healthful food and beverage choices for children by carefully
23 considering nutrient quality and energy density; (3) assist and educate children in making
24 healthful decisions regarding types of foods and beverages to consume, how often, and in
25 what portion size; (4) encourage and support physical activity; (5) limit children's
26 television viewing and other recreational screen time to fewer than 2 hours per day; (6)
27 discuss weight status with their child's health care provider and monitor age and gender
28 specific body mass index (BMI) percentile; and (7) serve as positive role models for the
29 children regarding eating and physical activity behaviors.
- 30 • **Community Programs:** Local governments, public health agencies, schools, and
31 community organizations should collaboratively develop and promote programs that
32 encourage healthful eating behaviors and regular physical activity, particularly for high-
33 risk populations.
- 34 • **Built Environment:** (1) Local governments, private developers, and community groups
35 should expand opportunities for physical activity, including recreational facilities, parks,
36 playgrounds, sidewalks, bike paths, routes for walking or bicycling to school, safe streets
37 and neighborhoods, especially for high-risk populations; (2) communities should
38 prioritize capital improvement projects to increase opportunities for physical activity; and
39 (3) communities should improve the street, sidewalk, and street-crossing safety routes to
40 school, developing programs to encourage walking and bicycling to school and building
41 schools within walking and bicycling distance of the neighborhoods they serve.
- 42 • **Health Care Sector and Providers:** (1) Pediatricians, family physicians, nurses, and
43 other clinicians should engage in the prevention of childhood obesity by routinely
44 tracking BMI, offering counseling and guidance, and providing leadership in their

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1 communities for obesity prevention efforts; and (2) professional organizations should
 2 disseminate evidence-based clinical guidance and establish programs on childhood
 3 obesity prevention and training programs, and certifying entities should require obesity
 4 prevention knowledge and skills in their curricula and examinations.

- 5 • **Government Leadership:** at all levels should provide coordinated leadership for the
 6 prevention of obesity in children and youth. State and local government should (1)
 7 provide coordinated leadership and support for childhood obesity prevention efforts,
 8 particularly those focused on high risk populations, by increasing resources and
 9 strengthening policies that promote opportunities for physical activity and healthful
 10 eating in communities, neighborhood, and schools; and (2) support public health agencies
 11 and community collaborative efforts to promote and evaluate obesity prevention
 12 interventions.

13 In what might serve as an advisory model for the Baltimore City Council Task Force on
 14 Childhood Obesity, San Mateo County, California translated the Institute of Medicine's
 15 guidelines for a childhood obesity initiative into the *Blueprint For Prevention of Childhood*
 16 *Obesity – A Call To Action: A Community Health Improvement Initiative to Eliminate Health*
 17 *Disparities*. The county's action plan incorporates 5 priority areas:

- 18 • **Priority Area 1: Community/Environment** - goal to improve and sustain access to
 19 healthy food and physical activity at the community organizational, and environmental
 20 levels.
- 21 • **Priority Area 2: Schools** - goal to improve and sustain access to healthy food and
 22 physical activity in the school setting.
- 23 • **Priority Area 3: After School** - goal to improve and sustain healthy eating and physical
 24 environments in the "after school" setting.
- 25 • **Priority Area 4: Preschool/Child Care Services** - goal to improve nutrition and physical
 26 activity environments in the preschool and child care services setting.
- 27 • **Priority Area 5: Healthcare** - goal to improve and sustain access to healthy nutrition and
 28 physical activity information and environments in the healthcare setting.

29 In forming this Task Force on Childhood Obesity, the City Council will work to ensure that
 30 our children live healthier, happier, educational childhoods that transition into personally
 31 rewarding, socially meaningful and economically productive adult hoods.

32 **NOW, THEREFORE, BE IT RESOLVED BY THE CITY COUNCIL OF BALTIMORE,** That this
 33 Body is calling together school, preschool, and after-school personnel, health care providers,
 34 parents, community groups, faith-based organizations, and other stakeholders in a campaign to
 35 address the critical problem of childhood obesity by creating a partnership across sectors with
 36 the mission to identify the specific roles that must be undertaken to prevent the onset of
 37 childhood obesity, to formulate a plan to combat the escalation of the problem among those
 38 children at-risk, and to devise a medical and behavioral treatment model to treat the diseases
 39 caused by this epidemic and to prevent the onset of sickness in the target population.

40 **AND BE IT FURTHER RESOLVED,** That membership on the Task Force shall include, but not
 41 be limited to, representatives from:

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- 1 • Baltimore City Health Department
- 2 • Baltimore City Public Schools
- 3 • Baltimore Parent/Teacher Associations and Organizations
- 4 • Community Associations listed in the Planning Department Directory
- 5 • Mayor's Office of Children and Youth
- 6 • Interdenominational Ministerial Alliance
- 7 • NAACP
- 8 • Pepsi Cola, Inc.
- 9 • Baltimore Ravens
- 10 • Baltimore Orioles
- 11 • Johns Hopkins School of Public Health
- 12 • area hospitals
- 13 • area institutions of higher learning
- 14 • the Greater Baltimore Committee
- 15 • the Chamber of Commerce

16 **AND BE IT FURTHER RESOLVED**, That a copy of this Resolution be sent to the Mayor, the
17 Commissioner of Health, the CEO Baltimore City Public School System, Community
18 Associations of the Planning Department Directory, the Executive Director of the Mayor's
19 Office of Children and Youth, the Chair of the Interdenominational Ministerial Alliance, the
20 President of the Baltimore NAACP, the Dean, Johns Hopkins School of Public Health, and the
21 Mayor's Legislative Liaison to the City Council.

*THE BALTIMORE CITY
PUBLIC SCHOOL SYSTEM*

LOCAL WELLNESS POLICY

In compliance with
Section 204 of Public Law 108-265-
June 30, 2004

Child Nutrition and
WIC Reauthorization Act of 2005

Approved by the
BCPSS Board of School Commissioners
on June 13, 2006

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Preamble

Whereas, children need access to healthful foods and opportunities to be physically active in order to grow, learn, and thrive;

Whereas, good health fosters student attendance and educational achievement;

Whereas, obesity rates have doubled in children and tripled in adolescents over the last two decades, and physical inactivity and excessive calorie intake are the predominant causes of obesity;

Whereas, 37% of BCPSS high school students are either overweight or at risk for being overweight;
(Source: *Youth Risk Behavior Survey, 2005*)

Whereas, heart disease, cancer, stroke, and diabetes are responsible for two-thirds of deaths in the United States, and major risk factors for those diseases, including unhealthy eating habits, physical inactivity, and obesity, are often established in childhood;

Whereas 43.3% of BCPSS high school students do not participate in sufficient vigorous physical activity daily and 71.3% of BCPSS high school students do not attend daily physical education classes;
(Source: *Youth Risk Behavior Survey, 2005*)

Whereas, nationally, the items most commonly sold from school vending machines, school stores, and snack bars include low-nutrition foods and beverages, such as soda, sports drinks, imitation fruit juice, chips, candy, cookies, and snack cakes.

Whereas, school districts around the country are facing significant fiscal and scheduling constraints;

Whereas, community participation is essential to the development and implementation of successful school wellness policies; and

Whereas, healthy students learn better:

Thus, the Baltimore City Public School System is committed to providing school environments that promote and protect children's health, well-being, and ability to learn by supporting healthy eating and physical activity. Therefore, the Baltimore City Public School System sets forth the following **Local Wellness Policy**:

- Schools will provide nutrition education in the context of comprehensive school health education to foster lifelong habits of healthy eating and will establish linkages to school meal programs and related community resources.
- Schools will provide structured physical education to foster lifelong habits of physical activity and will establish linkages to health education and school meals programs and related community resources.
- Nutrition and physical education will be delivered by highly qualified teachers.
- All students in grades K-12 will have opportunities, support, and encouragement to be physically active on a regular basis.
- Schools will provide other school-based activities that are designed to promote student and staff wellness.

- Foods and beverages sold or served at school will meet or exceed the nutritional recommendations of the *U. S. Dietary Guidelines for Americans*.
- Qualified child nutrition professionals will provide students with access to a variety of affordable, nutritious, and appealing foods that meet the health and nutrition needs of students; will accommodate the religious, ethnic, and cultural diversity of the student body in meal planning; and will provide a clean, safe, and pleasant setting and adequate time for students to eat.
- To the maximum extent practicable, all schools will participate in available federal school meal programs.
- The BCPSS will engage students, parents, teachers, food service professionals, health professionals, and other interested community members in monitoring and evaluating the implementation of system-wide nutrition standards, nutrition education, and physical education.
- Leadership and coordination for the BCPSS Local Wellness Policy will originate with and be the responsibility of the Departments of Curriculum and Instruction and Food and Nutrition, with advisement from the BCPSS School Health Council.

To implement the **BCPSS Local Wellness Policy**, the following Goals and Action Steps are set forth:

Component One: Nutrition Education Goals

- I. All BCPSS schools will provide students in Pre-K through grade 12 with behavior-focused nutrition education in the curriculum that is interactive and that teaches skills needed to promote healthy eating habits. This will be accomplished by the following Action Steps:
 - a. Schedule comprehensive school health education for a minimum of three 30-minute sessions per week for Pre K-K, three 45-minute sessions per week for grades 1-5 and for a minimum of one full semester in grades 6, 7, and 8 and in high school.
 - b. Deliver nutrition concepts and skills to all students in all grades in the context of the BCPSS comprehensive school health education curriculum that is aligned with the *Maryland State Department of Education (MSDE) Voluntary State Curriculum Framework*.
 - c. Present the integrated nutrition concepts and hands-on skills in other areas of the BCPSS curriculum such as physical education, visual arts, music, mathematics, science, language arts, reading, and social studies.
 - d. With technical assistance provided by the BCPSS Department of Curriculum and Instruction and the Department of Food and Nutrition, utilize a team approach for nutrition education that includes teachers, foodservice staff, guest speakers, field trips, and community partners.
 - e. Utilize the cafeteria as a "learning lab" for school staff and students to apply decision making skills using the nutrition education provided in the classroom.
 - f. Provide "point of decision" posters and serving line tents with nutrition education in the school cafeteria and other places where food may be consumed using materials provided by the BCPSS Department of Curriculum and Instruction and the Department of Food and Nutrition.
 - g. Connect nutrition education in the context of a comprehensive health education program with the MSDE requirement for *Student Service Learning* activities in the school, home, and community. A listing of approved Student Service Learning sites is available through the Department of Curriculum and Instruction.

II. All BCPSS schools will have highly qualified teachers who are adequately prepared and who participate in regular professional development activities to effectively deliver nutrition education in the context of comprehensive school health education. This will be accomplished by the following Action Steps:

- a. Provide professional development opportunities for teachers delivering nutrition education in the context of comprehensive school health education that includes accurate and current nutrition information that combines skills practice in program-specific activities and instructional strategies designed to promote healthy eating habits. System-wide nutrition education professional development opportunities will be provided by the Office of Curriculum and Instruction.
- b. Provide locally funded health education curriculum specialists to coordinate compliance with the Code of Maryland for health education (*13A.04.18.01. 01 Requirements for Comprehensive Health Education Instructional Programs for Grades K-12*) and the Local Wellness Policy.

III. All BCPSS schools will provide nutrition education professional development opportunities for all staff, students, and parents. This will be accomplished by the following Action Steps:

- a. Select a member or members of the School Improvement Team to serve as the Local Wellness Policy Contact(s) and who will plan, implement, and evaluate nutrition activities for staff, students, and parents.
- b. Provide opportunities for whole school professional development for nutrition education on one or more scheduled professional days each school year.
- c. Develop strategies for school faculty and staff to consistently model healthy eating habits that follow the *Dietary Guidelines for Americans*, before, throughout, and after the school day during school sanctioned activities. Technical assistance for this Action Step will be provided by the BCPSS Department of Curriculum and Instruction and the Department of Food and Nutrition

IV. All BCPSS schools will promote the development of partnerships with local, state, national, and private organizations for the support of balanced, skills-based nutrition education taught in the context of a comprehensive school health education program. This will be accomplished by the following Action Steps:

- a. Select a Local Wellness Policy Contact(s) by September 30 of each school year beginning September 2006, who is/are or will be a member(s) of the School Improvement Team.
- b. Assess and evaluate the status of current partnerships to support nutrition education. The Departments of Curriculum and Instruction and Food and Nutrition will provide technical assistance for new partnership development.
- c. Provide a nutrition education resource center to share with families and the community to positively impact healthy food choices. Materials for this resource center will be provided by the BCPSS Department of Curriculum and Instruction and the Department of Food and Nutrition.
- c. Provide current and useable information to families via the school homepage or other method such as adding nutrition information to an existing newsletter or developing a monthly nutrition bulletin that encourages parents/guardians to teach their children about healthy habits, to provide nutritious meals for their families, and, on a regular basis, eat meals with their families. This information will be provided by the BCPSS Department of Curriculum and Instruction and the Department of Food and Nutrition.

V: All BCPSS schools will designate one or more staff member(s) as appropriate, who will, with centralized technical assistance, provide leadership in the school wellness efforts and monitor the annual school-based implementation of the Local Wellness Policy for adherence, improvement, and reporting purposes. This will be accomplished by the following Action Steps:

- a. Assure that the selected staff member(s) has/have opportunities to attend workshops presented by the Department of Curriculum and Instruction and the Department of Food and Nutrition that will provide guidance on the monitoring and reporting process.
- b. Assist with and support the implementation of the Local Wellness Policy reporting process as part of the School Improvement Plan.

Component Two: Physical Education Goals

- I. All BCPSS schools will comply with Code of Maryland (COMAR) regulations as described in *13A.04.13.01 Requirements for Physical Education Instructional Programs for Grades K-12*. This will be accomplished by the following Action Steps:
 - a. Increase and/or maintain centralized support of the COMAR by implementing required policies and procedures as dictated by COMAR certification procedures.
 - b. Hire an additional curriculum specialist to implement and monitor Local Wellness Policy physical education goals.
- II. Highly qualified teachers will provide physical education instruction in all BCPSS schools. This will be accomplished by the following Action Steps:
 - a. Provide all physical education instructors with current training in first aid and cardio-pulmonary recertification. High school physical education instructors will have current *Red Cross Life Guard Water Safety Instructor* certification. All required trainings will be fiscally supported by BCPSS.
 - b. Provide all teachers delivering physical education with professional development opportunities that includes recent teaching trends and best practices in physical education and dance. This will be provided by the Office of Curriculum and Instruction.
- III. All schools will have physical education curriculum aligned to the *Maryland State Department of Education Voluntary State Curriculum Framework (MSDE-VSC)*. This will be accomplished by the following Action Steps:
 - a. Continue to update BCPSS curriculum to align with the *MSDE-VSC*. This will be accomplished by the Office of Curriculum and Instruction.
 - b. Provide professional development on a regular basis to deliver BCPSS physical education curriculum that includes strategies, technology updates, and best practices for implementation. This will be provided by the Office of Curriculum and Instruction.
- IV. Every student in BCPSS will have the opportunity to participate in a comprehensive physical education program. This will be accomplished by the following Action Steps:
 - a. Incorporate fitness content into physical education class to help students develop the knowledge, skills, motivation, and behaviors that will promote and reinforce a lifetime commitment to wellness through a physically active and healthy lifestyle. This will be provided by the Office of Curriculum and Instruction.
 - b. Align all fitness activities with the *MSDE-VSC*. This will be accomplished by the Office of Curriculum and Instruction.
- V. The BCPSS physical education program will meet the needs of the diverse learners through modifications to curriculum according to *Individual Educational Plans*. This will be accomplished by the following Action Steps:

- a. Consider gender, cultural differences, physical and mental abilities of all students when planning physical activity choices.
- b. Provide professional development for physical education instructors will include best practices for curricular modification. This will be provided by the Office of Curriculum and Instruction.

VI. All BCPSS physical education equipment and facilities will be safe, clean, and accessible for all students. This will be accomplished by the following Action Step:

- a. All equipment and facilities will be inspected, updated, and repaired on an on-going basis. This will be accomplished by the site based physical educator, the Department of Curriculum and Instruction, and the Baltimore City Health Department.

Component Three: Other School-Based Wellness Activities

I. All BCPSS schools will create an environment that provides consistent wellness messages and is conducive to healthy eating during other school-based activities. This will be accomplished by the following Action Steps:

- a. As part of on-going after-school programs, provide activities that promote the *American Dietary Guidelines* such as a Culinary Arts Club, a Garden Club, or Healthy Kids Club, whose membership includes school staff, students, parents, family members, and community partners.
- b. Plan and implement parent nutrition workshops to encourage healthy food shopping and planning of family meals. Technical assistance will be provided by the Departments of Curriculum and Instruction and Food and Nutrition.
- c. Establish regular opportunities for staff, students, and families to participate in wellness activities such as aerobics and/or yoga classes, nutritious pot luck lunchtime, and healthy eating tips in a faculty newsletter.
- d. Assure that all summer programs include nutrition education consistent with the Local Wellness Policy.
- e. Plan physical activity events for students not participating in competitive sports.
- f. Access community partners to provide co-curricular and extra-curricular activities such as approved field trips and approved classroom presentations.
- g. Establish and maintain a school garden, where possible, as a comprehensive, cross-curricular teaching tool for faculty, staff and students.

II. Implementation of other wellness activities at the school site will be monitored by school site staff for the purposes of evaluation and reporting. This will be accomplished by the following Action Step:

- a. Wellness activities planned and implemented in adherence to this component will be included in the duties of the selected school site staff member who is monitoring the implementation of the nutrition and physical education activities as described in Component One and Component Two.

Component Four: Nutrition Standards

(This component was approved January 10, 2006 by the Board of School Commissioners)

- I. School meals will meet or exceed USDA nutrition standards by:
 - a. Providing whole grain products, low and fat-free milk, and fresh fruits and vegetables:
 - b. Minimizing trans and saturated fats, sodium, and sugar; and
 - c. Using current nutrition research to improve school foods and meal standards.

II. All foods sold in all schools meet or exceed the nutrition standards approved by the Maryland State Board of Education. These standards apply to ALL snack/ala carte foods sold in cafeteria vending machines, school stores, and concession stands during the school day.

In brief, those standards:

- a. Limit portion sizes to single servings
- b. Limit to specific amounts the fat and sugar content of those foods.
- c. Prohibit the sale of foods of minimal nutrition value (including soda) until the end of the school day.

III. All efforts will be made to maximize meal participation by:

- a. Placing priority on school meals over sales of ala carte and snack foods.
- b. Prohibiting the sale of competitive foods until the end of the last lunch period.
- c. Preparing and presenting healthy foods in ways that will encourage their consumption.
- d. Establishing multiple processes to facilitate immediate, continuous, and specific feedback on school meal preparation, quality, variety, or service.
- e. Working with a standing parent nutrition committee, consisting of members of the Parent Community Advisory Board (PCAB), Special Education Citizens Advisory Committee (SECAC), the Parent Teacher Association (PTA), and other interested persons.

IV. Foods prepared by culinary arts students and sold to other students during the school day may occur to the extent necessary for students to learn preparation techniques for varied foods and to recover food costs. The nutrition standards in Object II should apply to the extent possible and be consistent with the particular food items.

V. Schools will encourage fundraisers that do not negatively impact health, such as the sale of nutritious food items and items other than food. It is recognized that the selling of candy and other foods high in fat or sugar during the school day is detrimental to student health and behavior.

VI. Foods offered during the school day as part of parties/celebrations or as rewards should reinforce healthy eating by taking the consideration that foods high in fat and sugar should be eaten in small portions and in moderation.

VII. Marketing techniques and approaches will be adopted to promote healthy school meals; to expose students to a variety of foods, tastes and diverse cuisines; to connect nutrition education in the classroom and healthy eating in the cafeteria; and to encourage nutritional well-being by the entire school community.

VIII. The Director of Food and Nutrition will report to the Board of School Commissioners by June of each year on:

- a. Steps taken and planned to improve the nutrition, quality, variety, and acceptance of school meals and other foods available in schools.
- b. Evaluations received from the School Improvement Teams and school community regarding adherence to the Local Wellness Policy Nutrition Standards and their recommendations for further improvement.
- c. Annual Climate Survey satisfaction measure of the implementation of the Local Wellness Policy Nutrition Standards.

Component Five: Local Wellness Policy Coordination and Evaluation

I. The Departments of Curriculum and Instruction and Food and Nutrition will provide leadership and coordination for the BCPSS Local Wellness Policy.

II. The *BCPSS School Health Council* (established in 2003) will serve in an advisory capacity to develop, implement, monitor, review and, as necessary, revise school nutrition standards, nutrition education goals, and physical education goals. The *School Health Council* members come from the school system, health department, and community-at-large and represent the following eight school health program components:

- a. Physical Education
- b. Health Education
- c. School Nutrition
- d. School Health Services
- e. Psychological and Counseling Services
- f. School Environment
- g. Parent and Community Involvement
- h. Employee Wellness

III. The *BCPSS Health Education Advisory Board* will make recommendations concerning nutrition education programs. This Board, established in 1985, consists of parents, school administration, community health partners, clergy, law enforcement, judiciary, MSDE, teachers, and students.

IV. The Director of Food and Nutrition and the Director of Curriculum and Instruction will report on *Local Wellness Policy* compliance, progress, and areas for improvement by June of each year.