Policy Recommendations for Obesity Prevention in Early Care and Education Settings

April 25, 2015

Position

The American Heart Association advocates for strong obesity prevention programs in early childhood education settings. One such setting, child care, is an important environment for forming good health habits around children's dietary intake, physical activity, and energy balance, thus combating the childhood obesity epidemic.[1] Child care providers are in a unique position to educate parents about the importance of healthy eating and physical activity, while also supporting a healthy environment for children to learn and grow. The 2012 National Household Education Survey reports that 60% of all U.S. children five years and younger not yet in kindergarten were in some form of non-parental care. Of those children, 56% were in a center-based child care program, making this an ideal setting for obesity interventions.[2] Over one million children are served by the federal Head Start programs every year, including children in every U.S. state and territory.[3] This figure does not include the many children from infancy to age five who are in private and public day care and preschool programs. Furthermore, it has been reported that many children from low-income backgrounds consume 50% to 100% of their Recommended Dietary Allowances (RDA) in a child care setting.[4] Reaching young children and their families is an essential strategy for primary prevention of obesity, cardiovascular disease, and its associated risk factors.

Background

Currently, nearly 17% of children in the United States ages 2-19 are obese and another 15% are overweight.[5] Childhood obesity disproportionately affects racial and ethnic minority populations.[6] Globally, an estimated 43 million preschool aged children are overweight or obese, a 60% increase from 1990.[7] In more recent years, nationally representative data has shown no significant change in obesity among youth, demonstrating obesity prevalence may be stabilizing.[8] This could be due in part to large, broad scale nutrition and physical activity efforts. The Pediatric Nutrition Surveillance System (PedNSS), a child-based public health surveillance system that describes the nutritional status of low-income children, shows that the incidence of obesity in low-income children under five years old has been slightly decreasing since 2009.[9] Continued effort and surveillance is needed to ensure this downward momentum continues.

Despite the importance of addressing obesity prevention in early child care, researchers know relatively little about either the nutritional or physical activity offerings in this setting. Research suggests the meals and snacks served may be lacking in nutritional quality and physical activity levels may be insufficient.[10] With the exception of the federal Head Start program, child care facilities are regulated by state laws and their rules can vary substantially. As a result, few uniform standards apply to foods eaten or physical activity programs administered in this setting. [9] An exception to this are programs that participate in the federal Child and Adult Care Food Program (CACFP). If enrolled in CACFP (which is not required), settings must meet nationally established food-based standards to receive reimbursement.

Obesity in childhood and adolescence increases the risk of obesity in adulthood. Comorbidities associated with excess weight are similar in children as in the adult population.[11] These include problems such as heart disease, type 2 diabetes, stroke, several types of cancer, and osteoarthritis.[12] A recent systematic review showed evidence that demonstrated overweight and obesity in childhood and adolescence is associated with an increased risk of both premature mortality and adult morbidity.[13] Research also shows that overweight five year olds are four times as likely as normal weight children to become obese moving into adolescence.[14] This sets the stage for an unhealthy future for these children considering obesity generally tracks into adulthood.[15] These findings illustrate why it is imperative to intervene in early childhood to prevent obesity and related cardiovascular disease risk factors.

Research has shown that preschool aged children consume too much sodium, saturated fat, and added sugar and have inadequate consumption of fruits, vegetables, and whole grains. Roughly 85% of preschoolers consume a sweetened beverage, dessert, or a sweet or salty snack each day.[16] The American Heart Association recommends a heart healthy diet that emphasizes fruits and vegetables, whole grains, low-fat dairy products, poultry, fish, legumes, non-tropical oils and nuts and limits intake of sodium, sweets, sugar-sweetened beverages and red meat.[17] Assuring that healthy foods are served in age-appropriate portion sizes is extremely important for overall health and effective dietary patterns. Because children's food preferences and practices originate in the first years of life, early dietary interventions may have immediate nutritional benefit and reduce chronic disease risk if these healthful habits are carried into adulthood.[18]

In general, sedentary behaviors are associated with higher body weight.[19] One of the most common sedentary activities preschoolers participate in is screen time, such as viewing computers or television.[20] In addition to reducing screen time, the American Heart Association recommends that children participate in at least 60 minutes of enjoyable, moderate-intensity physical activities every day that are developmentally appropriate and varied.[21] Given that the early years play a vital role in the development of health-related behaviors, early intervention around screen-viewing and physical activity is required to prevent sedentary behaviors from carrying into adolescence and adulthood.[22]

According to a comprehensive review by the Institute of Medicine (IOM), food advertising affects children’s food choices, food purchase requests, diets, and health.[23] Multiple studies have shown children’s brand knowledge, in relation to food and beverage, is a significant predictor of their body mass index (BMI).[24] Marketing and advertising of unhealthy products in child care settings can be seen in cognitive development books (e.g., candy counting activity pages), toys in play areas (e.g., fast food happy meals), posters, and vending machines. Advertising of high-calorie, low nutrient-dense foods could contribute to higher consumption of those foods, therefore, should not be allowed in child care settings.

Controlling and reversing the childhood obesity epidemic will require comprehensive and multifaceted programs and policies, with caregivers (parents, guardians, child care providers) playing a critical part. They play a direct role in a child’s eating pattern by helping shape their behaviors, attitudes, and feeding styles around food and beverages.[25] They are important role models and are largely responsible for physical activity opportunities, the type of food offered to young children, the portion sizes presented, and the emotional environment in which food is eaten.[26] There is widespread agreement that involving caregivers is critical in childhood obesity prevention to ensure that children are developing healthful habits from an early age.[27]

Healthy Way to Grow[28] is an example of a comprehensive, multifaceted obesity prevention program. The program is a joint venture of the American Heart Association and Nemours that provides technical assistance for child care centers across the country. Its aim is to create healthier children, better-informed

parents and caregivers, and, ultimately, reduce childhood obesity. Components of the program include nutrition education for children and providers, family engagement, community partnering, center wellness policy implementation, screen time limitations, infant feeding, and recommendations for physical activity and healthy food and beverage choices. The best practices developed by *Healthy Way to Grow* relevant to obesity prevention in child care settings can be found in Appendix A of this document.

Policy Recommendations

To support the development of healthy early childhood habits surrounding diet and physical activity, the American Heart Association makes the following recommendations:

- Child care providers should meet minimum, uniform standards in nutrition, physical activity, screen time limitations, breastfeeding, and professional development (e.g. nutrition and physical activity education) such as the *Healthy Way to Grow* best practices, recommendations in the IOM's report *Child and Adult Care Food Program: Aligning Dietary Guidance for All*,[29] recommendations in the collaborative report *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs*,[30] and the CACFP program nutrition guidelines[31]. While awaiting the final ruling on CACFP nutritional standards, child care settings should closely align their nutrition requirements with the IOM's recommendations. In order to ensure compliance, licensing and accreditation should require providers and centers to meet these standards.

- Technical support and funding to child care settings should be expanded in order to assist those needing help reaching these standards. Attention should be given to centers/providers serving the needs of high-risk populations and underserved communities.

- Mandatory, statewide, quality rating recognition programs should be provided and funded. These programs would distinguish child care settings going above and beyond minimum requirements and help ensure continuous improvement throughout child care settings. These recognition programs should incorporate best practice standards for nutrition, physical activity, and screen time. They should be overseen by the appropriate state agency in collaboration with other relevant agencies such as the Department of Education, the Department of Agriculture, the Department of Health, and others. Oversight of recognition programs may differ by state. Additional funding should be provided to help centers/providers serving the needs of high-risk populations and underserved communities to participate in these programs and meet the requirements.

- States should disseminate research and best practices pertaining to nutrition, physical activity, screen time, breastfeeding, and professional development to child care providers. In order to help parents better understand the quality of child care in their communities, states should make available, potentially through a state-run website, easily understandable information on the quality rating recognition programs in the state and how settings rank. In addition to rankings, the state could also highlight improvements by providers over time.

- All forms of marketing and advertising of unhealthy foods and beverages to children should be prohibited in child care programs. Definitions for what qualifies as the marketing/advertising of unhealthy foods and beverages may be based on the IOM's report *Food Marketing to Children and Youth: Threat or Opportunity?*[24] or from the Robert Wood Johnson Foundation's Healthy Eating Research report *Recommendations for Responsible Food Marketing to Children*.[32]

Appendix A

Healthy Way to Grow Best Practices

Nutrition Education for Providers • Child care providers participate in professional development activities two or more times per year in order to effectively teach children about nutrition.
Infant Feeding and Nutrition • 100% juice (even if diluted with water) is not provided until age 1.
Fruits and Vegetables • All meals and snacks for children include a variety of fruits and vegetables, especially deeply colored ones, and should be included at every meal or snack. • Fried or pre-fried and then baked vegetables (e.g., French fries, tater tots, hash browns) are served less than once per month.
Meat and Meat Alternatives • Fried and baked pre-fried meats like chicken nuggets and fish sticks are provided less than one time per month.
Grains and Breads • Providers serve a variety of grains daily and make sure at least half of grains served are whole grains. • Foods high in saturated and *trans* fat, sugar and sodium, especially from refined grains, are served less than one time per week or are not served at all.
Drinking Water • Safe, fresh drinking water is available and accessible for children to serve themselves at all times, indoors and outdoors.
Milk • Skim (fat-free) or 1% (low-fat) milk is served to children aged 2 and older (unless otherwise directed by the child's health care provider). • Flavored milk is not served, even if reduced fat.
Juice • No more than 4-6 ounces of 100% juice is provided to toddlers and preschoolers in a day; including the amount of juice served at home.
Sugar Sweetened Beverages • Sugar-sweetened beverages are not served to children.
Eating Environment and Modeling Behavior • Providers encourage children to serve themselves meals and snacks with supervision (family style meals).
Supporting and Promoting Breastfeeding • Child care programs encourage, provide arrangements for and support breastfeeding. • Child care programs and their providers promote and support mothers who want to breastfeed or pump their breast milk by having a quiet, private area (not a bathroom) with an outlet, comfortable seating, and a place to wash their hands.
Screen Time • Children under 2 years old are not exposed to screen time. • Among children age 2 and older, screen time is limited to no more than 30 minutes once per week. Only quality, educational or physical activity programming is shown under direct supervision.
Physical Activity Learning Experiences and Education for Children and Child Care Providers • Child care providers, teachers and staff receive professional development on gross motor play

and learning as well as physical activity education at least two or more times per year.
Infant Physical Activity • While awake, infants will spend less than 15 minutes at a time in confining equipment such as swings, bouncy chairs, car seats, and strollers.
Physical Activity for Toddlers and Preschoolers • For toddlers: At least 60–90 minutes of active playtime are provided each day including 30-45 minutes of structured (teacher-led) physical activity and 30-45 minutes of unstructured (active play) time. • For preschoolers: At least 120 minutes of active playtime are provided each day including 60 minutes of structured (teacher-led) physical activity and 60 minutes of unstructured (active play) time. • Children have outdoor active playtime at least two times daily, weather and air quality permitting.

Source: Healthy Way to Grow Director

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