SOCIETY FOR PUBLIC HEALTH EDUCATION
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25 March 2010

Director, Office of Secretariat
U.S. Department of Agriculture
1400 Independence Avenue, SW, Room 116-A
Whitten Building
Washington, DC 20250

RE: COMMENTS ON OBESITY ACTION PLAN

Dear Members of the Task Force on Childhood Obesity:

The Society for Public Health Education (SOPHE) is pleased to offer the following comments for your consideration in developing a plan for the public and private sectors to address the problem of childhood obesity. We applaud President Obama for creating the first-ever federal task force to tackle childhood obesity and First Lady Mrs. Obama's leadership of a national public awareness effort to stem the tide of obesity in youth.

SOPHE's 4,000 national and local members work in schools, universities, medical care settings, corporations, voluntary health agencies, international organizations, and federal, state and local government. As a 501c3 non-profit professional society, we provide leadership to the profession of public health education and contribute to the health of all people and the elimination of disparities through advances in health education theory and research, excellence in professional preparation and practice, and advocacy for public policies conducive to health. Founded in 1950, our organization and its members have long been involved in educating professionals and the public, as well as conducting research and implementing policy and systems changes related to healthy eating and physical activity. Moreover, our 20 chapters cover 35 states to help address the health education and health promotion needs at the state and local levels.

SOPHE endorses collaboration among the White House, Office of Management and Budget, and the Departments of Health and Human Services, Education, and Agriculture to developing a comprehensive interagency national action plan that meets the objectives to: (1) ensure access to healthy, affordable food; (2) increase physical activity in schools and communities; (3) provide healthier food in schools; and (4) empower parents with information and tools to make good choices for themselves and their families.

To help achieve these objectives, SOPHE offers the following responses and recommendations to questions posed in the *Federal Register* notice announcing this effort:

1. For each of the four objectives described above, what key topics should be addressed in the report?

The report should seek to combine the evidence-based recommendations contained in the Centers for Disease Control and Prevention's (CDC's) *Recommended Community Strategies and Measurements to Prevent Obesity in the United States* as well as the goals and objectives anticipated in the forthcoming DHHS Healthy People 2020 Objectives for the Nation. Topics addressed in these

documents relate to how communities, worksites, schools, and other venues can support both individual- and population-based changes to achieve a healthier lifestyle, including:

1. Increased Availability of Healthier Food and Beverage Choices in Public Service Venues
2. Improved Availability of Affordable Healthier Food and Beverage Choices in Public Service Venues
3. Improved Geographic Availability of Supermarkets in Underserved Areas
4. Incentives to Food Retailers to Locate in and/or Offer Healthier Food and Beverage Choices in Underserved Areas
5. Improved Availability of Mechanisms for Purchasing Foods from Farms
6. Incentives for the Production, Distribution, and Procurement of Foods from Local Farms
7. Restrictions on the Availability of Less Healthy Foods and Beverages in Public Service Venues
8. Promotion of Smaller Portion Size Options in Public Service Venues
9. Limitations on Advertisements of Less Healthy Foods and Beverages
10. Encouraging alternatives to the Consumption of Sugar-Sweetened Beverages
11. Increased Support for Breastfeeding
12. Requirements for Physical Education in Schools
13. Increases in the Amount of Physical Activity in PE Programs in Schools
14. Increased Opportunities for Extracurricular Physical Activity
15. Reduced Screen Time in Public Service Venues
16. Improved Access to Outdoor Recreational Facilities
17. Enhanced Infrastructure Supporting Bicycling
18. Enhanced Infrastructure Supporting Walking
19. Enhanced Infrastructure Supporting Walking
20. Improved Access to Public Transportation
21. Improved Zoning for Mixed-Use Development
22. Enhanced Personal Safety in Areas Where Persons Are or Could Be Physically Active
23. Enhanced Traffic Safety in Areas Where Persons Are or Could Be Physically Active
24. Join Community Coalitions or Partnerships to Address Obesity

SOPHE especially encourages the full funding of many of the prevention and wellness initiatives included in the newly enacted health reform legislation. With at least 70 percent of all health dollars spent on chronic disease, it is vital that we use evidence-based interventions to prevent disease and reduce disability. Racial and ethnic communities are disproportionately burdened by obesity, and we must incorporate culturally and linguistically competent prevention and wellness policies for both children and their families – as well as address the social determinants of health and environmental factors contributing to obesity. With regard to empowering parents with information and tools to make good choices for themselves and their families, it is especially important to fully support community wellness councils and parental involvement.

2. For each of the four objectives, what are the most important actions that Federal, State, and local governments can take?

Two of the most important actions that Federal, State, and local governments can take to address childhood obesity are: A) requiring health education in schools; and B) requiring physical education in schools. Schools provide critical outlets to reach millions of children and adolescents to promote lifelong healthy behaviors, as well as provide a setting for students to engage in these behaviors, such as eating healthy and participating in physical activity.

Only 6.4 percent of elementary schools, 20.6 percent of middle schools, and 35.8 percent of high schools require health instruction, according to the CDC 2006 *School Health Policies and Programs Study*. Among 38 states that participated in the CDC's *School Health Policies and Programs Study*

(2006), the percentage of schools that required a health education course decreased between 1996 and 2000, as did the percentage of schools that taught about dietary behaviors and nutrition.

The National Health Education Standards (NHES) are written expectations for what students should know and be able to do by grades 2, 5, 8, and 12 to promote personal, family, and community health. The standards provide a framework for curriculum development and selection, instruction, and student assessment in health education.

The goal of school health education is to help students adopt and maintain healthy behaviors. Research findings from the National Institutes of Health and the CDC have demonstrated that school health education programs can and do result in improved dietary and health habits when implemented with appropriate teacher development and program fidelity.

A key element in empowering parents to help their children make healthy food choices is expansion of CDC's coordinated school health program (CSHP). Coordinated school health programs use a holistic approach by addressing eight key components: health education, physical education, school meals, health services, healthy school environments, staff health promotion, and family/community involvement. Funding for CDC's CHSP provides a catalyst for collaboration between state education and health agencies to improve students' health and well-being. The funding assists states to improve the health of children and youth and to remove barriers to students' academic success by improving the high quality and coordination of efforts of school-level programs. Qualified, trained and credentialed teachers are needed to provide instruction in school health education.

CSHP programs have a unique advantage in fighting the obesity epidemic because they better link the state departments of education and health, strategically plan for statewide impact, apply state-of-the-art obesity prevention policies and programs, and more effectively leverage resources and engage partners. In 2008, 43 states (plus five tribal governments and four territorial education agencies) applied for funding to support a coordinated school health program; however, because of limited resources, only 22 states and 1 tribal government were funded.

At the preschool level, SOPHE strongly encourages the Task Force to address the role of day care providers and early childhood settings (including Head Start programs) in providing nutrition education and physical activity. Such facilities and programs often lay the foundation for a lifetime of eating and exercise habits.

Despite strong evidence that school-based physical education is effective in increasing the levels of physical activity and improving physical fitness, only 30 percent of high school students participate in daily physical education classes. Various studies show increases in energy expenditure as well as increases in physical fitness as measured through sit-and reach tests and muscular strength. Providing more opportunity for increased physical activity (by reducing class time) does not lead to a decrease in achievement. Conversely, there is no evidence that eliminating physical education for classroom time improves academic performance. Qualified, trained and credentialed teachers are needed to provide instruction in physical education.

Moreover, state and local school health policies should also require youth fitness testing. Nationwide only 28 percent of districts require fitness testing at the elementary level, 26 percent at the middle school level and 24 percent at the high school level. However, in 73 percent of schools, fitness testing was required in at least one course; teachers in more than half of the schools that administered fitness tests compared their students' results to national results. Of those providing fitness testing:

- 70 percent compared current results to students' prior results;
- 88.2 percent of schools provided students with an explanation of what tests signified; and
- 90.8 percent of schools shared results with the students' parents.

Several studies have noted a correlation between fitness and achievement. An analysis of by the State of California found a perfect correlation between the scores of 353,000 fifth graders, 322,000 seventh graders and 279,000 ninth graders' scores on six fitness tests. For each additional FITNESSGRAM test passed, students on average scored higher on the standardized achievement tests. Students who passed all six FITNESSGRAM tests on average almost doubled their scores in mathematics and language arts in comparison to those students who only passed one of the FITTNESSGRAM tests.

3. Which Federal government actions aimed at combating childhood obesity are especially in need of cross-agency coordination?

SOPHE recommends the establishment of a Federal Interagency Coordinating Council, with the Centers for Disease Control and Prevention as the lead agency. This Interagency Council should be appropriately staffed and resourced and involve the Assistant Secretaries of Education, Health and Human Services, and Agriculture to address programmatic and policy solutions at the national, state, and local levels to address childhood obesity prevention.

5. For each of the four objectives, what strategies will ensure that efforts taken by all of the entities mentioned above reach across geographic areas and to diverse racial, ethnic, socioeconomic, and geographic groups, including children who are at highest risk of obesity and children with disabilities?

Data show that certain minority youth are at particularly high risk of developing overweight and obesity:

Percentage overweight among children and adolescents 6–11 years of age, 2003–2006			
	Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black/ Non-Hispanic White Ratio**
Girls	24.0	14.4	1.7
Boys	18.6	15.5	1.2

Source: : CDC, 2009. Health United States, 2008. Table 76.
http://www.cdc.gov/nchs/data/hus/hus08.pdf[PDF | 8.2MB]

Overweight among children and adolescents 6–11 years of age 2003–2004			
	African American	**Non-Hispanic White**	**African American/ Non-Hispanic White Ratio**
Boys	17.5	18.5	1.0
Girls	26.5	16.9	1.6
Total	22.0	17.7	1.2

Source: : Federal Interagency Forum on Child and Family Statistics. *America's Children: Key National Indicators of Well-Being, 2007*. Table HEALTH5.
http://www.childstats.gov/pdf/ac2007/ac_07.pdf[PDF | 2MB]

Overweight among children and adolescents 12–17 years of age 2003–2004			
	African American	Non-Hispanic White	African American/ Non-Hispanic White Ratio
Boys	19.1	19.0	1.0
Girls	24.1	14.6	1.6
Total	21.5	16.9	1.3

Source: : Federal Interagency Forum on Child and Family Statistics. *America's Children: Key National Indicators of Well-Being, 2007*. Table HEALTH5. http://www.childstats.gov/pdf/ac2007/ac_07.pdf[PDF | 2MB]

Overweight among children and adolescents 6-17 years of age 2003 - 2004			
	African American	Non-Hispanic White	African American/ Non-Hispanic White Ratio
Boys	18.3	18.8	1.0
Girls	25.3	15.7	1.6
Total	21.7	17.3	1.3

Source: : Federal Interagency Forum on Child and Family Statistics. *America's Children: Key National Indicators of Well-Being, 2007*. Table HEALTH5. http://www.childstats.gov/pdf/ac2007/ac_07.pdf[PDF | 2MB]

Disadvantaged poor and minority students are less likely to engage in physical activity. Only 31.1 percent of African American students met recommended levels of physical activity; 30.2 percent of Hispanic students and 37 percent of white students met recommended levels of physical activity by being physically active doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time for a total of at least 60 minutes per day on 5 or more days during the 7 days before the survey. While 22.6 percent of white students played video or computer games or used a computer for something that was not school work for 3 or more hours per day on an average school day; 26.3 percent of Hispanic students and 30.5 percent of African American students did so. While 27.2 percent of white students watched television 3 or more hours per day on an average school day, 62.7 percent of African American and 43 percent Hispanic students did so.

The concept of culture must be incorporated into health promotion and disease prevention programming and is an essential feature in health disparity reduction work. If cultural beliefs and values are integrated into the interventions, it is more likely that the service recipient will hear and heed the health promotion or disease prevention message. Yet, it is also vital to acknowledge that even if, for example, cultural competency for Hispanic-Americans has been achieved, there are different sub-groups of the Latino culture (Puerto Rican or Mexican) that may respond to services in different manners or have linguistic differences. There is also a great amount of diversity in the American Indian/Alaskan Native population; there are more than 500 federally-recognized tribes and more than 300 state-recognized tribes in the United States. In addition to targeting messages appropriately to appeal to different cultures and subcultures, it is also to examine the environmental and contextual factors that prevent them from being more physically active (e.g. no safe places to play) or select healthy food options (e.g. food desserts).

6. What goals should we set within each objective to ensure that we meet our overall goal of solving the problem of childhood obesity in this Nation in a generation?

SOPHE supports the proposed Healthy People 2020 Objectives for the Nation in providing the major goals and direction for addressing the problem of childhood overweight and obesity, and in particular, the objectives related to requiring health education in schools.

The Joint Committee on National Health Standards (2007) recommends that students in Pre-K to 2 receive a minimum of 40 hours per academic year. Students in grades 3 to 12 should receive 80 hours of instruction in health education per academic year. Health education is a planned, sequential, K-12 curriculum that addresses the physical, mental, emotional and social dimensions of health. A health education curriculum is designed to motivate and assist students to maintain and improve their health, prevent disease, and reduce health-related risk behaviors. It allows students to develop and demonstrate increasingly sophisticated health-related knowledge, attitudes, skills, and practices. Health education also builds health literacy.

In addition to requiring health education in schools, the Task Force should examine ways to encourage increase rates of high school completion. High school graduates have better health and lower medical costs than high school dropouts. High school is associated with an increase in average lifespan of six to nine years. Research has shown that improving graduation rates may be more cost effective than most medical interventions to reduce health disparities as well as increase the quality and years of healthy life.

Additional Healthy People 202o content areas that should receive attention by the Task Force include:

- Increase the proportion of college and university students who receive information from their institution on each of the priority health-risk behavior areas (all priority areas; unintentional injury; violence; suicide; tobacco use and addiction; alcohol and other drug use; unintended pregnancy, HIV/AIDS, and STD infection; contraception and sexual-decision making; unhealthy dietary patterns; and inadequate physical activity).

- Increase the proportion of state, county, and local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs.

- Increase the proportion of worksites that offer a comprehensive employee health promotion program to their employees.

With regard to the latter area, one of the major barriers to parental involvement in school or community-led approaches to youth health promotion is parents' obligations to work long hours, multiple jobs, and often during nights and weekends. Such work schedules severely limits their time to attend school and community education programs. Therefore, worksite health promotion programs are one important avenue to educate parents about their children's healthy eating and physical activity habits. Given the rising cost of health insurance premiums for families experiencing chronic disease such as pediatric Type II diabetes, corporate provision of health promotion programs targeting parents would be timely and provide a significant return on investment. (Moreover, recent studies also demonstrate that comprehensive worksite wellness programs enhance worker productivity).

9. What important factors should be considered that do not easily fit under one of the four objectives?

It is vital to improve collection of surveillance data at the district and local level. While the CDC Behavioral Risk Factor Surveillance Survey does provide obesity and physical activity data for youth at the state and larger metropolitan catchment areas, collecting data at the district and local levels could assist policymakers and the public to make more informed decisions about local school and

community policies to address childhood obesity. Improved data and surveillance also are needed on physical activity levels in early childhood. Both CDC and the Heath Resources and Services Administration (HRSA) should be involved in this effort.

10. What are the key unanswered research questions that need to be answered with regard to solving childhood obesity and how should the Federal Government, academia, and other research organizations target their scarce resources on these areas of research?

With improved funding, the CDC Guide to Community Preventive Services could evaluate studies and make available evidence-based practices to public health, education and agriculture agencies.

Improved research is also needed in the area of impact of physical activity on cognition and attention. Breaks in the classroom appear to improve both classroom behavior and cognitive performance. One study found that 5-10 minute breaks within a classroom to engage in physical activity (aerobic, muscular strengthening, and flexibility) increased daily physical activity to 60 minutes a day as well as increased achievement scores on standardized tests in language arts and mathematics.

12. Specifically with regard to objective 1 (empowering parents): How can Federal, State, and local governments, the private sector, and community organizations best communicate information to help parents make healthy choices about food and physical activity?

With regard to empowering parents, effective and targeted health education and communications is vital to helping parents make healthy choices about food and physical activity. One public health profession, health educators, have unique competencies that must be enlisted to achieve this goal. Health educators are professionals (trained at the baccalaureate, masters or doctoral levels) who design, conduct and evaluate activities that help improve the health of all people. These activities can take place in a variety of settings that include schools, communities, health care facilities, businesses, universities and government agencies. The profession is recognized by the U.S. Department of Labor in the federal Standard Occupational Classification (SOC) system. Health educators are employed under a range of job titles such as patient educators, health education teachers, health coaches, community organizers, public health educators, and health program managers. The following are core competencies of a certified health education specialist:

1. Assess individual and community needs for health education.
2. Plan health education strategies, interventions, and programs.
3. Implement health education strategies, interventions, and programs.
4. Conduct education and research related to health education.
5. Administer health education strategies, interventions, and programs.
6. Serve as a health education resource person.
7. Communicate and advocate for health and health education.

The National Commission for Health Education Credentialing, Inc. (NCHEC) is a national body that is dedicated to enhancing "the professional practice of health education by promoting and sustaining a credentialed body of health education specialists. ... NCHEC certifies health education specialists, promotes professional development, and strengthens professional preparation and practice." (http://nchec.org/aboutnchec/mission/, retrieved on 12/16/09). The concept of credentialing health educators began in the 1970s with a concerted effort to clarify the role of health educators and to establish standards of professional practice, along with identifying the competencies and responsibilities of health educators.

The following information provides specific examples of how health educators are at the forefront, addressing challenging issues that affect youth and school health.

Individual Level

- Assist schools in conducting assessments like the School Health Index to identify strengths or weaknesses in the provision of coordinated school health programs;
- Assist children and families in adopting behavioral health plans

Community & School District Level

- Participate on school health advisory councils;
- Assist in the planning of local wellness policies;
- Work as K-12 health education teachers;
- Work as School Health coordinators at state and local health and education agencies;
- Develop classroom health education materials for school districts;
- Lead and direct community based health and youth serving organizations aimed at supporting youth in adopting healthy lifestyles;
- Plan, implement, and evaluate health promotion programs that take place in community based health and youth serving organizations.

University Level

- Prepare community health education students' through undergraduate and graduate course work that focuses on or encompasses child, adolescent, and school health;
- Establish partnerships with area schools and community organizations to:
    - conduct research on child health behavior, health status, and academic performance;
    - create service learning opportunities for community health and public health education students that occur in schools and state and local health and education agencies; and
    - partner with schools and communities to improve the health of students through a variety health activities and programs.

National & Federal Level

- Lead and direct national programs whose mission supports and promotes school health
- Assist policymakers in making effectives policies that address the health of children and adolescents;
- Advocate for funding and programs that support and sustain Coordinated School Health Programs;
- Fund and support state and local initiatives aimed at building and sustaining school and health programs for youth, communities, and families.

16. What other input should the Task Force consider in writing the report?

SOPHE applauds enhanced coordination between private sector companies, not for profits, agencies within the Federal government and other organizations to address the problem of childhood obesity. However, we also strongly encourage the development of program and incentives to

promote such cross-sector collaboration and engagement at the state and local levels for sustainable action and improved health outcomes.

Education of all professionals working in health/medicine, education, agriculture, housing, transportation and other sectors is vital for effective coordination and success of this national program. Attention should be directed in the national plan for both pre-service and in-service education among the disciplines.

Thank you again for the opportunity to provide input. SOPHE looks forward to working with this national Task Force and Mrs. Obama to help provide evidence-based solutions to address the childhood obesity challenge.

Sincerely,

M. Elaine Auld, MPH, CHES
Chief Executive Officer