Health

Introduction

The past three decades have seen a startling increase in obesity rates among American children. Recent statistics show that one-third of U.S. children and adolescents (more than 22 million) are overweight or obese\(^1\) (Ogden, 2009). In the past 30 years, the obesity rate has doubled among young children ages 2 to 5 and adolescents ages 12 to 19, and has tripled among children ages 6 to 11 (Institute of Medicine, 2006). Obese children are being diagnosed with health problems previously considered to be “adult” illnesses, such as Type II diabetes, hypertension, high cholesterol, sleep apnea, and fatty liver disease (Robert Wood Johnson Foundation, 2009).

Overweight and obese children are at risk for a host of serious future illnesses, including heart disease, stroke, asthma, and certain types of cancer. Often, health complications place children at risk for psychological, social, and educational complications (Grey, 2008). Indeed, health complications resulting from obesity may slow or reverse the gains in life expectancy that Americans have enjoyed over the last half-century.

Disparities in Childhood Obesity

Like most childhood risk factors, obesity and related complications disproportionately affect racial and ethnic minority children and children living in poverty. Nationwide, 38 percent of Hispanic children are obese or overweight, compared with 35 percent of African American and 31 percent of White children. Those children most at-risk appear to be Hispanic boys and African American girls, sub-groups with obesity rates at or near 40 percent (Ogden, Carroll, & Flegal, 2008). Obesity has also risen faster among minority groups. Obesity increased by more than 120 percent among African American and Hispanic children between 1986 and 1998. During that same time, the rate of increase among White children was 50 percent (Strauss & Pollack, 2001). Geographic disparities also exist; eight of the 10 states with the highest rates of childhood obesity are in the South (Levi, 2008). The strong connection between low socioeconomic status and obesity bodes ill for these children, as the stigmatization and discrimination they may face as obese adults may further diminish their occupational and educational opportunities (Adler and Stewart, 2009).

Roots of the Childhood Obesity Crisis

Many factors have contributed to the childhood obesity crisis. The last 30 years have witnessed the creation of a physical environment that includes home computers, video games, and greater television choices, which reinforces a sedentary lifestyle among children of all income levels. Children today live in a less nutritious environment, replete with easy access to fast food, vending machines, and...
bigger portion sizes, as well as exposure to a barrage of marketing for energy-dense, highly sugared food. Busy parents are substituting high-calorie restaurant and take-out meals for home-cooked ones; children are walking less and traveling by car more. Schools have cut back on physical education classes while continuing to offer high-fat, federally subsidized commodities in school lunches.

Children in poor and minority communities face additional burdens. African American and Hispanic children are more likely than White children to live in unsafe neighborhoods with inadequate recreational opportunities (Lumeng, Appugliese, Cabral, Bradley, & Zuckerman, 2006). High-poverty, inner-city communities are often deemed “food deserts” because of the limited access to nutritious food (Hendrix and Harris, 2008). Because nutritious food is frequently more expensive, experts suggest that the recent economic downturn will create greater food insecurity among poor families, resulting in more consumption of cheaper, processed food and less consumption of fruits, vegetables, and whole grain products (Lesley, 2008).

U.S. food assistance programs have been slow to respond to the need for greater access to more nutritious food among low-income populations. The U.S. Department of Agriculture (USDA) only recently modified the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC program) to allow recipients to purchase fresh fruits and vegetables. However, the USDA continues to provide high-fat commodities such as whole milk, sweetened flavored milk, and cheese to low-income children through the school breakfast and lunch programs.

**Bridging the Medical and Public Health Models**

Childhood obesity has been addressed through both the medical and public health models. The former focuses on changing the child’s and family’s eating and activity patterns. The latter concentrates on changing the “obesogenic” environment through preventive approaches that encourage and support healthy diet and activity choices. Adler and Stewart (2009) suggest blending the medical and public health models and viewing obesity through a “behavioral justice” lens, which conveys the principle that individuals are responsible for engaging in health-promoting behaviors but should be held accountable only when they have adequate resources to do so. Behavioral justice argues that no group should bear a disproportionate share of health problems resulting from inadequate resources for engaging in healthy behaviors. Adler and Stewart’s approach is consistent with the Social Work Code of Ethics, which promotes individual well-being while recognizing and addressing the environmental forces that create and contribute to problems in living (NASW, 2008).

**Unique Social Work Contribution to Preventing and Treating Childhood Obesity**

Social workers are especially suited to addressing childhood obesity with individual children and families. With their holistic perspective, social workers understand that the multifaceted nature of obesity requires a biopsychosocial approach that addresses both the medical and mental health needs of the child. With their strengths-based perspective, social workers can encourage children and families to be self-advocates in addressing obesity. Training in cultural competence ensures that social workers understand that different communities have different norms and traditions related to food, which must be understood and respected. With their training in systems theory, social workers understand the pivotal role that advocacy plays in preventing childhood obesity and that macro-level change ultimately will have the broadest impact on the obesogenic environment.

**Social Work Clinical Interventions**

Social work is an essential component of treatment programs for obese children and their families. Social workers have been directly involved in designing and implementing family-centered, hospital-based programs for children with high body mass index levels (M. Ferris, LCSW, personal communication, October 8, 2009). These programs focus on weight management and treatment of the child’s comorbidities, address the child’s mental health needs, and coach parents and children in adopting better
nutrition and physical activity practices (S. Peterson, LICSW, personal communication, October 20, 2009).

There are also simple, evidence-based interventions that social workers can use with families regardless of a child’s weight. Social workers in clinical practice (e.g., hospitals, ambulatory clinics, school-based health centers) and case management settings (e.g., family service agencies) can routinely ask children and caregivers about family eating and physical activity patterns and make suggestions for change, if necessary. All direct practice social workers who interface with parents and children should also consider using the “5-2-1-0” message developed by pediatric obesity experts (National Initiative for Children’s Healthcare Quality, 2007):

- Five fruits and vegetables daily
- No more than two hours of screen time daily (and no TV in rooms where children sleep)
- At least one hour of physical activity daily
- Zero sugar-sweetened beverages

**Social Work Advocacy Interventions**

Regarding advocacy, experts in the field suggest that the first action social workers should take is to become educated about anti-obesity advocacy efforts in their states and communities. As importantly, social workers should empower the adults and children with whom they work, by enlisting them in local and state advocacy efforts (E. Nahar, MSW, personal communication, October 27, 2009).

**School Advocacy**

- Social workers should ask to see a copy of the school’s wellness plan and offer to serve on the committee tasked with the plan’s implementation.
- School lunches that are high in fat and low in fruits and vegetables are of concern in all communities. Social workers can play an active role in advocating for healthier school lunches and should encourage children and families to do the same (Eliadis, 2006). Social workers should examine the use of “competitive foods” in the school environment (foods sold à la carte in school cafeterias and in vending machines and snack bars, which are generally exempt from nutrition standards). Social workers can advocate for limiting or restricting unhealthy competitive foods and promoting the sale of healthy snack and beverage choices for students.
- Social workers can encourage daily physical education (PE) requirements for all students. Studies consistently show that more time in PE and other school-based physical activity does not adversely affect academic performance. In some cases, more time in PE leads to improved grades and standardized test scores (Active Living Research, 2009). Social workers can also promote the establishment of in-school programs that teach adolescents healthy cooking, non–team sport physical activities, and behavioral skills (Hendrix & Harris, 2008).

**Neighborhood/Community Advocacy**

- Social workers should encourage the development of after-school programming that promotes physical activity. For example, a social worker–led program in Chicago, “Girls in the Game,” works with girls in multiple sites to promote exercise through increased access to after-school sports and other physical activities (A. Steen, MSW, personal communication, October 9, 2009). Social workers can also encourage community and school facilities to allow recreation programs to be open after hours.
- Social workers can publicize the existence of food deserts – neighborhoods with limited or no access to fresh, affordable food. They should encourage local governments to offer incentives for supermarkets and farmers’ markets to open in such areas.
- Social workers can partner with others in their communities to advocate for the development of bike paths, sidewalks, and parks; the elimination of outdoor advertising for high-calorie, low nutrient foods near schools; and enactment of restrictive zoning for fast food outlets.

Moreover, social workers need to look closely at – and try to address – the safety issues that compromise socially disadvantaged neighborhoods. Research has shown that safety concerns, real or perceived, influence many families’ approach to outdoor physical activity (Cecil-Karb & Grogan-Kaylor, 2009).
### Legislative Advocacy

Menu labeling laws are an example of legislative advocacy to prevent childhood obesity. Many states and localities have instituted menu labeling, which requires restaurants and fast food outlets to post calorie information on their menus. Social workers can encourage their professional associations to embrace this issue. The West Virginia NASW chapter, for example, included advocacy for a state menu labeling law on their recent legislative agenda (NASW West Virginia, 2009).

### Conclusion

Childhood obesity is a multifaceted problem requiring intervention at the individual, community, and national levels. Indeed, obesity has become one of the leading public health priorities and a focus of national health care reform. As two former surgeons general recently stated,

> We all need to understand that obesity is not a simple matter of lifestyle choice. People do not become obese or overweight all on their own. The reality is that their communities may not include safe places to exercise. Their incomes may not allow them to purchase healthy food...The burdens caused by the obesity epidemic are unsustainable. Unless we do something now, the cost burden of obesity — currently nearly $150 billion each year — will be an ever-tightening yoke around the neck of future generations of Americans. The emotional burden from stigma [caused by obesity] bears down every day in the form of an inability to be successful at school, work and in numerous other unseen ways. Helping Americans make healthier choices and enjoy a better quality of life can no longer be compromised by political bickering or continued inaction. Instead it must be a national priority. (Satcher & Carmona, 2009)

The urgency of addressing childhood obesity cannot be overstated. And social workers in all practice settings can play a role in reversing this epidemic.

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1 Defined as a body mass index (BMI) in the 85th percentile or above for age.

### Resources

#### Robert Wood Johnson Foundation Childhood Obesity Initiative.

The Robert Wood Johnson Foundation is devoting $500 million over 5 years (2007–2012) to tackling obesity in children, with the goal of reversing the childhood obesity epidemic by 2015 through improved access to affordable healthy foods and increased opportunities for physical activity in schools and communities across the nation. The foundation is placing special emphasis on reaching the children at greatest risk for obesity: African American, Latino, Native American, and Asian/Pacific Islander children and children living in low-income communities. The Foundation issues periodic calls for proposals to support new projects in childhood obesity.

[www.rwjf.org/childhoodobesity/fundingops.jsp](http://www.rwjf.org/childhoodobesity/fundingops.jsp)

#### The Alliance for a Healthier Generation.

The Alliance was formed in 2005 as a joint initiative of the American Heart Association and the William J. Clinton Foundation. The organization seeks to address childhood obesity through interventions delivered in settings that can most affect children’s health: homes, schools, restaurants, health care settings and communities.

[www.healthiergeneration.org/](http://www.healthiergeneration.org/)

#### National Business Group on Health.

This industry consortium, focused on the health care concerns of large U.S. employers, has produced “Childhood Obesity: It’s Everyone’s Business,” a toolkit designed to help employers address overweight and obesity in children and understand the implications on health care costs for the current and future work force. The toolkit is built around four key levers available to most or all employers — benefits, employee education, on-site facilities, and philanthropic opportunities. Topics include the business case for employer action and ways employers can use benefits design or incentives to help combat childhood obesity. The toolkit is available at:

[www.businessgrouphealth.org/benefitstopics/et_chobesity.cfm](http://www.businessgrouphealth.org/benefitstopics/et_chobesity.cfm)
American Academy of Pediatrics and National Initiative for Children’s Healthcare Quality. The AAP and NICHQ offer professional education materials and parenting resources on preventing and treating childhood obesity.

www.aap.org/obesity/index.html
www.nichq.org/childhood_obesity/index.html

Institute of Medicine, Committee on Childhood Obesity Prevention. This IOM committee has produced six reports on the subject of childhood obesity since 2004, including a set of national recommendations for specific actions for families, schools, industry, communities, and government.

www.iom.edu/Reports.aspx?search=childhood%20obesity

Federal Web sites. The following web sites offer tools that social workers can use in school, health care, and other community settings to help children engage in physical activity and healthy eating:

Office of the Surgeon General, Childhood Overweight and Obesity Prevention Initiative: www.surgeongeneral.gov/obesityprevention/

The Centers for Disease Control and Prevention Healthy Youth Initiative: www.cdc.gov/HealthyYouth/obesity/index.htm


References


