



II. Empowering Parents and Caregivers

Fundamentally, parents and caregivers are responsible for their children’s health and development. They instill and promote certain values, reward or reinforce specific behaviors, and shape choices that form life-long healthy habits. Each day, parents and caregivers make decisions on food selection, eating patterns, physical activity, and sedentary habits like television viewing. Children learn from the choices adults make. Often it is an entire family that experiences being overweight or obese.

Changes in the food and social environment over the past 20 years have made parents’ and caregivers’ roles in promoting health more challenging. Parents and caregivers want to provide good nutrition and regular physical activity, but often lack information that is clearly understandable and actionable. Communities, businesses, health care providers, and governments can play a supportive role in providing helpful information and fostering environments that support parents’ and caregivers’ healthy choices. For information to be useful to busy and overworked parents and caregivers, both the “what” and the “how” to deliver information must be considered. With a myriad of messages about what to eat and how to be active, the consistent delivery of specific, unambiguous, and actionable messages is critically important. In addition, the broader environment—including confusing claims or labels on food packages and marketing campaigns—can become a serious obstacle, by making unhealthy choices easy and healthy choices hard.

This chapter describes current and proposed initiatives to empower parents and caregivers by:

- making nutrition information useful,
- improving food marketing and labeling practices, and
- strengthening health care providers’ role.

A. Making Nutrition Information Useful

Good nutrition plays an essential role in overall health. Healthy eating habits in childhood and adolescence are important for positive growth and development and can help children achieve and maintain a healthy weight. Today, the eating habits of many young people are inconsistent with the recommendations in the Federal *Dietary Guidelines for Americans (Dietary Guidelines)*,¹¹⁴ thus increasing the risk of obesity.

To assist parents and caregivers in establishing healthy eating habits for children, they should have greater access to the right tools and resources that increase nutritional knowledge and help them make healthier choices.

Dietary Guidelines for Americans and the Food Pyramid

The *Dietary Guidelines for Americans* provide science-based advice for individuals over age two to promote health and reduce the risk of major chronic diseases through diet and physical activity. HHS and USDA work in partnership to review and update these guidelines every five years, based on an analysis of scientific evidence. The current *Dietary Guidelines*, issued in 2005, encourage most Americans to eat

fewer calories, be more physically active, and make wiser food choices. The *2010 Dietary Guidelines* are under development, and will be released later this year.

The **Dietary Guidelines** provide science-based advice about good dietary habits that can promote health and reduce the risk of major chronic disease.

The *Dietary Guidelines* are intended to be the primary source of dietary health information for policymakers, nutrition educators, and health providers, helping to inform nutrition research priorities, influence industry product development, and support education initiatives. They affect the decisions both private and public institutions make, and ultimately, they are meant to inform consumers, including parents and caregivers, about how to make healthy choices.

The *Dietary Guidelines* also form the basis of Federal nutrition policy. For example, they must be applied in menu planning in the National School Lunch Program (NSLP), in education materials used by the Supplemental Nutrition Assistance Program (SNAP, formerly called food stamps), and in the development of information on the Nutrition Facts panel that appears on food packages.

The Food Pyramid is an educational system developed by USDA to translate the *Dietary Guidelines* into food-based recommendations and applications for the public. The broader MyPyramid Food Guidance System provides educational resources, messages and personalized tips about nutrition and physical activity, and extensive online interactive healthy eating tools.

MyPyramid.gov has reached millions of consumers, health professionals, and educators since it was launched in 2005, and is consistently one of the top five most popular federal web sites. Despite its popularity and prominence, the Food Pyramid has been subject to significant criticism for failing to communicate effective, actionable messages to consumers, which many observers have suggested are critical in changing behavior.¹¹⁵ The MyPyramid system is currently being studied for improvements.

In addition, the recently-enacted Affordable Care Act requires HHS, in consultation with private-sector experts, to maintain a website that provides science-based information to health care providers and consumers on guidelines for areas such as nutrition, regular exercise, and obesity reduction. The legislation also requires HHS to create a web-based prevention plan tool to help families make informed health decisions.¹¹⁶ Parents and caregivers can also currently find information about nutrition and healthy eating at www.FruitsandVeggiesMatter.gov and through the We Can childhood obesity prevention program developed by the National Institutes of Health (wecan.nhlbi.nih.gov). Given the broad array of federal tools to help consumers make healthy choices, it is critical that these tools be developed and maintained in a manner that is coordinated and sending consistent messages.

Food Package Labeling

Parents and children need accurate, clear, and consistent information on food packages in order to choose healthier foods. At present, the main source of consistent information is the detailed Nutrition Facts panel on food packages, designed by the Food and Drug Administration (FDA) pursuant to the Nutrition Labeling and Education Act of 1990. USDA regulates the labeling of meat and poultry products, and currently requires the Nutrition Facts to be displayed on processed products. USDA is in the process of requiring that the Nutrition Facts panel be displayed on other meat and poultry products, including

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ground beef and cuts of meat, as well.¹¹⁷ According to recent FDA surveys, consumers are increasingly seeking nutrition information about the food they purchase.

The percent of the U.S. population that reports “often” reading a food label the first time they buy a product increased from 44% in 2002 to 54% in 2008. Of those that read food labels when purchasing a product for the first time in 2008, the food label was most often used to:

- See how high or low a food is in things like calories, salt, vitamins or fat (two-thirds of consumers).
- Get a general idea of the nutritional content of the food (over one-half of consumers).

Use of the Nutrition Facts nearly doubled in only four years, from 32% in 2004 to 52% in 2008.¹¹⁸

Nutritional or health claims on the front of food packages have also increased, but these claims are sometimes seen as misleading. An FDA survey found that only about half or less of Americans trust the claims on the front of food packages.¹¹⁹ FDA has the authority to review scientific evidence for nutrient content and health claims on food packages before they are used, and is increasingly taking action to help prevent the spread of misinformation. FDA has taken action recently to address some of the inappropriate use of claims in food labeling.¹²⁰

Despite its value and importance, the Nutrition Facts panel has been criticized as unduly detailed and complex. To make it easier for consumers to get information at a quick glance, FDA is currently investigating options for a standard, front-of-

“Spot the Block” Campaign

HHS has launched a program called “Spot the Block” to encourage children and caregivers to read the Nutrition Facts panel. They have recently launched an education campaign based on “Spot the Block” that targets African-American and Hispanic communities.

Nutrition Facts	
Serving Size 1 cup (228g)	
Servings Per Container 2	
Amount Per Serving	
Calories 260	Calories from Fat 120
% Daily Value*	
Total Fat 13g	20%
Saturated Fat 5g	25%
Trans Fat 2g	
Cholesterol 30mg	10%
Sodium 660mg	28%
Total Carbohydrate 31g	10%
Dietary Fiber 0g	0%
Sugars 5g	
Protein 5g	
Vitamin A 4%	Vitamin C 2%
Calcium 15%	Iron 4%
<small>*Percent Daily Values are based on a 2,000 calorie diet. Your Daily Values may be higher or lower depending on your calorie needs:</small>	
	Calories: 2,000 2,500
Total Fat	Less than 65g 80g
Sat Fat	Less than 20g 25g
Cholesterol	Less than 300mg 300mg
Sodium	Less than 2,400mg 2,400mg
Total Carbohydrate	300g 375g
Dietary Fiber	25g 30g
Calories per gram:	
Fat 9	Carbohydrate 4 Protein 4

Sample Nutritional Label

HHS tested the “Spot the Block” program with the Cartoon Network and the research findings showed the program is effective in getting children to respond to the messages. Specifically, there were significant increases in:

- children who think the Nutrition Fact panel is important to them (+21%);
- the likelihood children would tell their friends to check the Nutrition Facts panel (+48%); and
- the perceived importance of knowing the serving sizes of the food they eat (+71%).

package label. FDA is also working to update the Nutrition Facts panel based on new scientific information and consumer research.

Serving sizes also play an important role. In 2005, FDA began the process of reviewing data to update the reference amounts used to determine serving sizes on food packages. A specific concern was the presentation of serving size information on packages that may contain multiple servings but could reasonably be consumed at one time. For example, a 20 ounce bottle of soda is currently labeled as having multiple servings, but is often consumed all at once. FDA is currently analyzing comments and food intake survey data to determine steps to take and how changes in serving size will impact updates to the Nutrition Facts panel.

Menu Labeling

The recently-enacted Affordable Care Act requires display of calorie counts by chain restaurants with 20 or more locations and vending machine operators with 20 or more machines.¹²¹ Chain restaurants must also make available for customers, upon request, more detailed nutritional information such as sodium and sugars, and the menu or menu board must also include a clear statement indicating the availability of this information. Chain restaurants must display this information on menus, menu boards, self-service lines, and in drive-through lanes. Vending machines must provide a clear and noticeable statement disclosing the calorie counts near each item or the selection button. Restaurants, retail food establishments, and vending machine owners who are not subject to these requirements can voluntarily register with HHS to be subject to these requirements. New York City implemented a similar law prior to enactment of the Affordable Care Act, and early research indicates it may have favorably affected eating habits, although firm conclusions cannot yet be drawn.¹²²

A recent study showed that both information and convenience can have a beneficial effect on how customers choose their meals. The study indicates that when presented with calorie information (how many calories are contained in each menu item) and a calorie recommendation (how many calories men and women of varying activity levels should consume), people on average order meals with significantly fewer calories. Indeed, the effect of providing this information reduced meals by almost 100 calories.¹²³ The study also showed that making healthier meal choices more convenient has a significant impact on consumption decisions. For example, if healthier options are featured on a menu page and other options require a more active choice, it is likely that fast-food customers will order lower calorie meals. This finding is consistent with other studies showing that changes in how and where food is located can help promote healthy choices, suggesting the effectiveness of possible changes like moving vending machines farther from school cafeterias or moving fruit next to cash registers.¹²⁴

Research has also shown that plate size in restaurants or at home can make a significant difference in how much food is consumed,¹²⁵ and that portion sizes have grown substantially over time.¹²⁶ Eating dinner as a family is also associated with healthier eating.¹²⁷

Recommendations

Recommendation 2.1: The Federal government, working with local communities, should disseminate information about the 2010 Dietary Guidelines for Americans through simple, easily actionable messages for consumers and a next generation Food Pyramid. As HHS and USDA launch the

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updated Dietary Guidelines in late 2010, they should include simple advice and messages for consumers. Incorporating information about knowing daily caloric needs will be useful as menu labeling is implemented. For example, these messages could include:

- Drink water instead of soda or juice with added sugar;
- Avoid foods that consist mainly of added sugars or fats;
- Eat more fruits, vegetables, whole grains, and lean proteins;
- Choose low-fat or fat-free dairy products (such as 1% or skim milk); and
- When possible, eat dinner together as a family.

Other important messages to share with parents include:

- The recommended amount of daily physical activity (one hour a day for children, as recommended by the companion *Physical Activity Guidelines for Americans*);
- The recommended amount of screen time; and
- The recommended amount of sleep (more than 10.5 hours a night for preschool-aged children and 12 hours for infants).¹²⁸

Any specific messages should be coordinated with the scientific recommendations of the Dietary Guidelines Advisory Committee. They should also be coupled with practical tips for parents on how to make these changes in their children's lives. The tips should recognize the juggling act and time pressures that many parents and caregivers are facing. Suggestions for how to deliver these messages should also be sensitive to the risk of eating disorders among young people.

USDA and HHS should also research and disseminate information about the most effective ways to promote the Dietary Guidelines among children to impact their eating habits. This includes modernizing the "SNAP Ed" program, a nutrition education program for participants in SNAP (formerly known as food stamps), in a way that provides influential information to parents and caregivers. A recent study recommended that SNAP Ed be improved in a number of ways.¹²⁹

Recommendation 2.2: The FDA and USDA's Food Safety and Inspection Service should collaborate with the food and beverage industry to develop and implement a standard system of nutrition labeling for the front of packages. The labeling system should be based on scientific research that assesses the formats people will notice, understand, and use to make healthy choices. To complement this effort, FDA should address portion size and continue its work to prevent misleading claims on food packages.

Recommendation 2.3: Restaurants and vending machine operators subject to the new requirement in the Affordable Care Act should be encouraged to begin displaying calorie counts as soon as possible.

Recommendation 2.4: Restaurants should consider their portion sizes, improve children's menus, and make healthy options the default choice whenever possible. The improvements are particularly important since one-third of meals are consumed in restaurants,¹³⁰ including many meals eaten by children at fast-food establishments.

Benchmarks of Success

An increase in the number of parents who are better able to notice, understand, and use food labels. FDA collects data on use of nutrition labels by adult consumers in households with children through the Health and Diet Survey and will be looking for a steady increase in the percentage using the labels.

In addition, as noted earlier in this report, it will be critically important to monitor the overall health of children's diets and make steady progress toward improvements such as reducing added sugars and increasing fruit and vegetable consumption.

B. Food Marketing

Food marketing to children and adolescents is a big business. The Federal Trade Commission (FTC) estimates that, in 2006, food, beverage, and quick-serve restaurant companies spent more than \$1.6 billion to promote their products to young people.¹³¹ Children and adolescents are an important demographic for marketers for several reasons: (1) they are customers themselves; (2) they influence purchases made by parents and caregivers; and (3) they are the future adult market.¹³² For many years, public health experts and others have argued that the marketing of energy-dense, low-nutrient food products to children and adolescents is one of many factors contributing to the obesity epidemic. While a causal link between marketing and increasing childhood obesity rates has yet to be firmly established,¹³³ research indicates that advertising can have a strong influence on children. Young children in particular have difficulty distinguishing between television programming content and advertising, or comprehending the purpose of advertising.¹³⁴ Older children, and even adults, are influenced by advertising too.

The marketing of food products can also be a powerful tool to drive the purchase of healthy products and to communicate important information about healthy eating choices. For example, one study found that children ages 3-5 preferred the taste of the same foods if they thought they were from McDonald's, rather than another source.¹³⁵ Key actors—from food and beverage companies, to restaurants, food retailers, trade associations, the media, government and others—all have an important role to play in creating a food marketing environment that supports, rather than undermines, the efforts of parents and other caregivers to encourage healthy eating among children and prevent obesity.

Current Climate, Recent Initiatives, and Industry Self-Regulation

Television advertising is the dominant form of marketing to both children and adolescents, comprising almost half of total youth-directed marketing expenditures according to the FTC.¹³⁶ However, food and beverage companies utilize a full range of other marketing techniques including print, internet advertising (such as advergaming), product packaging, in-school marketing, cross-promotions, prizes and contests, and the use of popular licensed characters that appeal to children and adolescents.¹³⁷ Notably, many advertising campaigns are fully integrated, using common themes across multiple promotional platforms.¹³⁸

The use of licensed characters to market foods to children is particularly effective and pervasive. Research conducted by the Sesame Street Workshop in 2005 found a strong influence of popular

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licensed characters on preschoolers' food preferences.¹³⁹ When preschoolers were asked if they would rather eat broccoli or a Hershey's chocolate bar, 78% of the children chose the chocolate bar and only 22% chose broccoli. When an Elmo sticker was placed on the broccoli, however, 50% of the children chose broccoli. Not surprisingly, food marketers' use of licensed characters in cross promotions targeting children has increased in recent years.¹⁴⁰ At the same time, the nutritional quality of the products promoted by these characters has decreased.¹⁴¹

In 2006, a Joint Task Force on Media and Childhood Obesity was established to examine the impact of media on childhood obesity and to develop voluntary industry standards to limit advertising that targets children. Senators Sam Brownback and Tom Harkin, former Federal Communications Commission (FCC) Chairman Kevin Martin, and former FCC Commissioner Deborah Taylor Tate convened the Task Force and members spanned from industry to government, and many others. The Task Force was unable to agree on either a uniform set of nutritional standards for defining healthy versus unhealthy foods, or media companies' obligations to enforce advertising limits.

That same year, the Council of Better Business Bureaus established the Children's Food and Beverage Advertising Initiative (CFBAI) in response to growing public concern and calls for the food and beverage industry to self-regulate. CFBAI was intended to change the ratio of food and beverage advertising messages directed to children under the age of 12 to encourage healthier eating and lifestyles.¹⁴² Its 16 current member companies (Burger King, Cadbury Adams, Campbell Soup, Coca-Cola, ConAgra Foods, Dannon, General Mills, Hershey, Kellogg, Kraft, Mars, McDonald's, Nestle, PepsiCo, Post Foods, and Unilever) have agreed upon five central components:

1. 100% of child-directed television, print, radio, and internet advertising must promote "healthier dietary choices" or "better-for-you" products;¹⁴³
2. Products depicted in child-directed interactive games must be "better-for-you" foods or the games must incorporate healthy lifestyle messages;
3. Companies must reduce their use of third-party licensed characters in advertising that does not promote healthy dietary choices or healthy lifestyles;
4. Companies must not pay for or actively seek placement of their products in entertainment directed at children; and
5. Companies must not advertise food or beverage products in elementary schools.

Since its implementation, the efficacy of the CFBAI's efforts has been subject to debate. FTC's 2008 report noted that the participating companies' nutritional standards, as well as their definitions of "child-directed," vary by company.¹⁴⁴ Within certain guidelines, each company developed its own nutritional standards for what constitutes a "better for you" food or a "healthy dietary choice." Moreover, the FTC criticized the program for applying these standards only to certain forms of advertising. It recommended, among other things, that the CFBAI improve the quality and consistency of the nutritional standards and extend those standards to all advertising and promotional techniques, including product packaging and "point-of-sale" advertising (such as displays near a check-out counter).¹⁴⁵

A recent study analyzed the effectiveness of the CFBAI and found that it had not substantially shifted advertising for children toward healthier products.¹⁴⁶ Using one measure of nutritional quality, the study determined that, in 2009, advertisements for healthy products accounted for a very small fraction of all advertising by participating companies, while most advertising promoted foods of low nutritional value.¹⁴⁷ The study also found that companies participating in the CFBAI nearly doubled the use of licensed characters over the past four years, increasing from use in 8.8% of advertisements in 2005 to 15.2% in 2009. Roughly half of all advertisements with these characters are for foods in the lowest nutritional category.¹⁴⁸ The CFBAI has criticized this study, and argues that its voluntary efforts have led to significant improvements in foods advertised to children.¹⁴⁹

Some media and entertainment companies have adopted policies limiting the types of foods for which they will license their popular characters.¹⁵⁰ In addition, one company has set nutritional standards for the food advertising it accepts on child-directed programming.¹⁵¹ However, not all companies with popular entertainment properties have instituted similar policies, and the ones that have often use varying guidelines.

Concern about the ineffectiveness of industry self-regulation led Congress in 2009 to direct the formation of an Interagency Working Group on Food Marketed to Children (IWG).¹⁵² This group, comprised of representatives of the FTC, FDA, CDC, and USDA, was tasked with developing recommendations for uniform standards for foods marketed to children ages 17 and under, as well as the scope of media to which such standards should apply. The group released tentative voluntary standards in December 2009 and is expected to publish proposed standards in the Federal Register for public comment in the near future.

An examination of the food and beverage industry's efforts to voluntarily limit marketing to children suggests the following conditions are necessary for meaningful improvement to occur through industry-directed initiatives:

1. First, self-regulatory groups must adopt a uniform set of nutritional standards. Without clear, consistent standards, there can be no objective basis for comparing different food products or measuring progress. The freedom of the CFBAI members to define what constitutes a "better-for-you" food product has resulted in variations in the nutritional criteria used from one company to the next.¹⁵³ The IWG's forthcoming recommendations on standards should be helpful here. More generally, Federal agencies with expertise in this area should work with industry to establish consistent standards based on the *Dietary Guidelines* that can be easily understood by both consumers and industry.
2. Second, any framework for voluntary reform must provide a level competitive playing field within the industry. If compliance results in significant competitive disadvantages to participating companies, long-term compliance becomes unsustainable. It is therefore critical to have broad participation by all companies that market food and beverage products to children. These efforts must be supported by cooperation from the major media companies that target child audiences. Media companies can directly control the type and volume of advertisements shown on their platforms. Accordingly, they can impose limits on advertising, regardless of

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advertisers' participation in a voluntary scheme. Media companies' use of uniform nutritional criteria would facilitate these efforts.

3. Third, to create a meaningful impact, self-regulation must apply to all forms of marketing across multiple platforms. The current voluntary guidelines allow extensive marketing of non-nutritious foods in a myriad of ways that target children.
4. Finally, effective voluntary reform will only occur if companies are presented with sufficient reasons to comply. The prospect of regulation or legislation has often served as a catalyst for driving meaningful reform in other industries and may do so in the context of food marketing as well.

The Role of Federal Regulation of Advertising

The Federal Communications Commission (FCC)'s regulatory authority varies across industries and platforms. The FCC has some direct authority to regulate advertising on children's television programs. The Children's Television Act limits the amount of commercial matter aired during children's programming to no more than 10.5 minutes per hour on weekends and no more than 12 minutes per hour on weekdays. As implemented by the FCC, these limits apply to commercial television licensees, cable operators, and satellite television (DBS) providers. In addition, the Act specifically authorizes the FCC to review and evaluate the advertising duration limitations, and to modify them in accordance with the public interest based on demonstrated need.¹⁵⁴

The FTC, which has extensively studied food marketing to children,¹⁵⁵ is responsible for protecting consumers by preventing unfair or deceptive advertising. However, its ability to regulate child-directed advertising is limited. In 1981, in response to the FTC's effort to regulate the advertising of sugary foods to children, Congress prohibited the agency from using its authority over unfair practices to adopt rules regarding children's food advertising.

While new or revised rules to limit advertising during children's programming may be helpful or even necessary to fully address the childhood obesity epidemic, such efforts must carefully consider freedom of speech interests. Furthermore, even if efforts to limit marketing to children are successful, they would only provide a partial solution given that children are heavily exposed to advertising not specifically directed to them. For example, half of the food advertisements children see on television occur on prime-time and other non-child directed programs.¹⁵⁶ Programs like *American Idol* and *The Simpsons*, which are popular among children and teens, are regarded as general audience or family programming because adults form such a large share of the audience.¹⁵⁷ In addition, children are increasingly exposed to many forms of marketing other than television advertising, including billboards, point-of-purchase displays, and content accessed through the Internet, mobile phones, and MP3 players.

Recommendations

The Federal government can play a crucial role in improving the media environment for children with respect to the marketing of foods and beverages. It can do so while fully respecting the First Amendment right to free speech. Generally, this role includes:

- Bringing together key stakeholders to develop collaborative solutions;
- Providing guidance to industry on voluntary initiatives;
- Conducting consumer education and outreach campaigns; and
- Promulgating laws and regulations when other methods prove insufficient.

Recommendation 2.5: The food and beverage industry should extend its self-regulatory program to cover all forms of marketing to children, and food retailers should avoid in-store marketing that promotes unhealthy products to children. Currently, the CFBAI guidelines limit only certain types of child-directed advertising—including television, print, radio, and Internet—but do not apply to in-store advertising, product packaging, and many other forms of marketing. For truly meaningful and effective self-regulation, all forms of child-directed marketing should be covered. Retailers have an important role to play in this effort as well, since they control what products are placed at children’s eye level and can impact in-store advertising, including at the point-of-sale.

Recommendation 2.6: All media and entertainment companies should limit the licensing of their popular characters to food and beverage products that are healthy and consistent with science-based nutrition standards.

Recommendation 2.7: The food and beverage industry and the media and entertainment industry should jointly adopt meaningful, uniform nutrition standards for marketing food and beverages to children, as well as a uniform standard for what constitutes marketing to children. All nutrition standards should be based on the Dietary Guidelines. As part of this effort, the food and beverage industry should develop aggressive targets and metrics for increasing the proportion of advertisements for healthy foods and beverages across all marketing channels and platforms. The media and entertainment industry should develop uniform guidelines to ensure that a higher proportion of advertisements shown on their networks and platforms are for healthy foods and beverages.

Recommendation 2.8: Industry should provide technology to help consumers distinguish between advertisements for healthy and unhealthy foods and to limit their children’s exposure to unhealthy food advertisements. The food and beverage industry and the media and entertainment industry should create an on-air labeling system that helps consumers easily distinguish between advertising for healthy and unhealthy foods. The FCC could also urge these industries to create innovative technologies that allow parents to block unhealthy food and beverage advertising from all programming. The nutritional standards should be uniform and based on the Dietary Guidelines.

Recommendation 2.9: If voluntary efforts to limit the marketing of less healthy foods and beverages to children do not yield substantial results, the FCC could consider revisiting and modernizing rules on commercial time during children’s programming.

Benchmarks of Success

A substantial yearly increase in the proportion of healthy food and beverage advertisements targeting children such that, within three years, the majority of food and beverage advertisements directed to children promote healthy foods.

A substantial yearly decrease in the use of licensed characters to promote foods and beverages that are not healthy such that, within three years, licensed characters are used only to promote healthy foods and beverages.

To measure progress, data-driven studies are needed to evaluate the nutritional content of foods advertised to children. The FTC's follow up study, expected in 2011, will explore this issue, as well as shifts in consumption that have occurred following the implementation of industry self-regulation. It is critical to monitor and evaluate progress to support marketing efforts that reduce childhood obesity. If industries and government begin implementing recommendations immediately, meaningful progress could be achieved in three years.

C. Health Care Services

BMI Measurement and Obesity Prevention

Parents and caregivers often do not realize when a child is overweight or obese. In fact, studies have consistently shown that parents do not accurately perceive the weight of their overweight or obese child.¹⁵⁸ To inform and make potentially serious health issues salient to parents and caregivers, several states and municipalities now require children's BMI to be measured and shared with parents or caregivers. When aggregated, this data can also show the weight status over time in a student population, monitor progress of national health objectives,¹⁵⁹ and monitor the effects of school-based physical activity and nutrition policies and programs.

BMI is a measure of weight status at one point in time, so it is important for students, families, and policy-makers to respond to trends in BMI measurements rather than one measurement point. For children and teenagers, BMI is used as a screening tool, not a diagnostic tool, meaning that it can suggest a child has a weight concern but does not determine a child's weight status.¹⁶⁰ To understand a BMI score more accurately, health care providers often look at other measures. Additional assessments and tests can include a patient's medical history, family history, diet, physical activity habits, and blood pressure, and laboratory tests such as cholesterol levels. By performing follow up assessments and tests, practitioners can determine if the student actually has excess body fat or other health risks related to obesity.

A recent survey of practicing pediatricians found that nearly all respondents reported measuring height and weight at well-child visits, using growth charts as a reference. However, only about half calculate and assess BMI percentile for gender and age for children older than two years of age.¹⁶¹ Most pediatricians reported that they lacked time to counsel on overweight or obesity and counseling alone has poor results, yet they noted that having simple diet and exercise recommendations would be helpful. In another survey, only about 37% of overweight children and adolescents reported being told by a health care provider they were overweight.¹⁶²

Some states are implementing school-based BMI measurement programs. These screening programs are designed to assess the weight status of individual students to detect those who are at risk for weight-related health problems. Screening results are sent to parents and typically include: the child's BMI-for-age percentile; an explanation of the results; recommended follow up actions, if any; and tips on healthy eating, physical activity, and healthy weight management. To date, few studies have assessed the utility of these programs in preventing increases in obesity or their impact on weight-related knowledge, attitudes, and the behaviors of young people and their families.¹⁶³ These approaches merit further evaluation and review.

It is critical that health providers engage in BMI measurement. As the Surgeon General has noted, "people access the health care system through multiple channels, and medical care settings are an important avenue for preventing and controlling overweight and obesity. Clinicians are often the most trusted source of health information and can be powerful role models for healthy lifestyle habits."¹⁶⁴ While uninsured families have decreased access to well-child care and thus BMI screening, the recently-enacted Affordable Care Act will expand health care coverage and provide additional opportunities to support children's health.

Parents and families should also receive specific information and counseling on healthy behaviors from their health care providers. These behaviors include increasing fruit and vegetable intake and physical activity time, limiting unhealthy behaviors such as consumption of high calorie foods with little nutritional value and sugar sweetened beverage intake, and reducing sedentary time. Providers should also be able to refer parents and caregivers to the appropriate community resources.

An expert committee, convened by the American Medical Association (AMA), HHS's Health Resources and Services Administration (HRSA), and the CDC, made recommendations, which have been endorsed by the American Academy of Pediatrics (AAP), on the prevention, assessment, and treatment of children who are overweight or obese.¹⁶⁵ The committee noted that health care provider offices and health care systems may need to change their organizational approach to effectively address obesity prevention. More comprehensive and more useful care can be provided by integrating community resources, health care, and patient and family self-management. Health care providers may also need training on how to raise these issues most effectively with parents, since the stigma often associated with obesity can sometimes prevent clinicians from feeling comfortable discussing the implications of a high BMI.¹⁶⁶ Similarly, it is important to avoid children feeling stigmatized due to their weight.¹⁶⁷

Obesity Treatment

The AAP-endorsed recommendations of the expert committee described above include four stages of treating obesity. The first stage is brief counseling, which can be delivered in a health care office. Subsequent stages require more time and resources. Stage two is a structured plan, consisting of a balanced diet, supervised physical activity, reduced screen time, and logs to monitor behavior change. Stages three and four include intensive interventions administered by expert obesity management professionals.¹⁶⁸

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The chronic care model also creates a new structure for treatment of chronic diseases by integrating community resources with health care and patient self-management. This approach is recommended for children who are overweight or obese.¹⁶⁹ The United States Preventive Services Task Force (USPSTF) found that effective, comprehensive weight-management programs for obese children ages 6 years and older incorporated counseling and other interventions that targeted diet and physical activity. Interventions also included behavioral management techniques to assist behavior change, and those that focused on younger children incorporated parental involvement.¹⁷⁰

Recommendations

Recommendation 2.10: Pediatricians should be encouraged to routinely calculate children’s BMI and provide information to parents about how to help their children achieve a healthy weight. As part of the First Lady’s Let’s Move Initiative, the AAP pledged in February 2010 to engage in a range of efforts to achieve two primary goals:

- Calculate BMI for every child at every well-child visit beginning at age 2, and provide information to parents about how to help their child achieve a healthy weight.
- Provide “prescriptions” for healthy active living, including good nutrition and physical activity, at every well-child visit, along with information for families about the impact of healthy eating habits and regular physical activity on overall health. Pediatricians can use their own prescription pads or existing handouts, or they can opt to use the healthy active living prescriptions created by the AAP and available at www.aap.org/obesity/whitehouse.

Recommendation 2.11: Federally-funded and private insurance plans should cover services necessary to prevent, assess, and provide care to overweight and obese children. HHS’s Center for Medicare and Medicaid Services is planning to send a letter to State Medicaid directors to clarify how these services are currently covered in Medicaid and the Children’s Health Insurance Program. The recently-enacted Affordable Care Act also requires each State to design a public awareness campaign on preventive and obesity-related services available to Medicaid enrollees.¹⁷¹ Starting this year, the Act also requires new private plans to cover preventive services at no charge by exempting these benefits from deductibles and other cost-sharing requirements.¹⁷² The Indian Health Service covers these services and has proposed an initiative on early identification and treatment of childhood and adult obesity in primary care in the President’s FY2011 Budget.

Recommendation 2.12: Dentists and other oral health care providers should be encouraged to promote healthy habits and counsel families on childhood obesity prevention as part of routine preventive dental care.

Recommendation 2.13: Medical and other health professional schools, health professional associations, and health care systems should ensure that health care providers have the necessary training and education to effectively prevent, diagnose, and treat obese and overweight children.

Benchmarks of Success

All primary care physicians should be assessing BMI at all well-child and adolescent visits by 2012.

All parents and caregivers should routinely receive nutrition and physical activity counseling from their children's health care providers by 2012.

BMI assessment and counseling trends can be tracked using the National Ambulatory Medical Care Survey. Additionally, in 2009 the National Committee on Quality Assurance (NCQA) added rates of BMI assessment and nutrition and physical activity counseling for children and adolescents to its "HEDIS" (Healthcare Effectiveness Data and Information Set) quality measures. The NCQA HEDIS measures provide a complementary tool for future tracking of provider assessment and counseling trends.

Key Questions for Future Research

Building the science for prevention will help to strengthen childhood obesity prevention efforts. Below are identified research areas for consideration when developing national research agendas:

- Research the link between traditional as well as non-television forms of advertising, such as the internet, and food preferences and consumption by children and adolescents.
- Test studies of family-based interventions (such as studies of parenting style, home availability of healthful food, and opportunities for physical activity).
- Identify and test approaches for community partnerships to disseminate and implement evidence-based obesity prevention programs.
- Understand how individuals interpret and are influenced by dietary and physical activity messages (such as interpersonal, cultural, and media messages, as well as food labels) through research on learning, cognition, information processing, persuasive communications, and message framing.
- Determine whether federal farm promotion ("check-off") programs that promote certain agricultural products have an impact on Americans' compliance with the *Dietary Guidelines*.
- Compare medical and surgical treatments and lifestyle changes to identify those that are most effective in improving obesity and health outcomes in children and adolescents.
- Test models for delivering obesity prevention and treatment to change the behaviors of health practitioners and translate or disseminate evidenced-based therapies to primary care practices.
- Examine effects of targeted strategies focused on subpopulations at elevated obesity risk, such as those in racial and ethnic minority populations, tribal populations, lower socioeconomic status, rural communities, people with disabilities, and individuals taking medications that can increase body weight (such as psychotropics or insulin).
- Examine the efficacy of increased habitual sleep time on metabolic regulation such as reducing body weight, regulating appetite, and improving glucose tolerance and insulin sensitivity.