

DOWNLOAD PDF PT. 4. OBESITY ISSUES FOR SPECIAL POPULATIONS AND THE PREVENTION OF OBESITY

Chapter 1 : Obesity – Global Issues

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Open in a separate window a Source: Health Resources and Services Administration 1. Obesity estimates from NSCH are based on parent-reported measures of weight and height. Estimates from the National Health and Nutrition Examination Survey , based on direct measures of weight and height using a standard protocol, also indicate a higher prevalence of obesity among children with developmental disorders compared to children without such conditions 3. Estimates derived from smaller nonrepresentative samples also suggest that children with SHCN have an elevated risk for obesity 8 - Risk factors for obesity Obesogenic environments, characterized by unhealthy food choices, limited opportunities for physical activity, and many opportunities to be sedentary, challenge most US families and children, including children with SHCN Children with SHCN also face risk factors that are uniquely related to their special needs Certain obesity risk factors are associated with underlying conditions eg, Prader-Willi syndrome. More commonly, risk factors are secondary to underlying conditions. Children with SHCN, for example, may have less healthy dietary and physical activity patterns because of medical conditions eg, spina bifida or cerebral palsy that limit or restrict opportunities to be physically active 13 , According to nationally representative data, fewer children with SHCN aged y are engaged in recommended vigorous physical activity at least 4 days per week compared to children without SHCN No nationally representative data exist regarding the degree to which children with SHCN meet national dietary guidelines, although studies report dietary deficiencies 13 - Medication-induced weight gain may partially explain the higher obesity prevalence among children with SHCN, although it is believed to be responsible for only a limited proportion of childhood obesity nationwide. Approximately 8 of 10 children with SHCN take at least 1 prescription drug 1. Medications associated with weight gain in children include the atypical antipsychotic medications eg, risperidone , antidepressants, mood stabilizers, and anticonvulsants eg, valproate 16 , Competing political perspectives on child obesity policy Competing political perspectives figure into the discussion of obesity 6. Proponents of one perspective view obesity as a personal responsibility. They typically oppose policy responses to obesity and view them as unethical because they interfere with personal autonomy. Proponents of a competing perspective see obesity as a consequence of obesogenic environments amenable to government intervention. Children with SHCN and their families have a policy history that reflects both perspectives. Families have always assumed major personal responsibilities for the health of children with SHCN above those required of other families. Most families acknowledge that government has been instrumental in expanding opportunities for children with SHCN and improving their quality of life. Families of children with SHCN are heterogenous, and their responses to obesity prevention initiatives vary. Families that view childhood obesity as requiring solutions involving both personal responsibility and government involvement see themselves as having an important role in encouraging their children to eat well and be physically active They are also open to policies designed to help all families promote healthy weights. Families appreciate mainstream initiatives that allow their children to benefit from being like their peers, but they are also aware that their children might not be able to participate fully in mainstream activities. Efforts must be made to assure families that their children will be included and welcomed in community initiatives. The policy history for these families probably will encourage support for child obesity policy; meanwhile, the dilemma of difference influences which approaches families deem feasible or desirable. The stewardship model The stewardship model for state interventions, developed by the Nuffield Council on Bioethics, outlines ethical principles to guide government in fulfilling its responsibility to protect the health of vulnerable populations Public policies to support the health of children with SHCN precede the stewardship model but are consistent with its ethical principles. Beginning in the s, the federal government, working with states, assumed responsibility for the health of children with SHCN through

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policies to establish subspecialty clinics for "crippled" children. This approach, although ideal for managing complex medical and behavioral conditions, is less suited for addressing health threats related to obesity; these require policies that support family- and community-based initiatives in addition to health services. Policies that help families and communities encourage children with SHCN to maintain healthy weights are consistent with the stewardship model. The dilemma of difference The dilemma-of-difference construct 20 identifies policy concerns that are specific to children with SHCN and ethically might require different approaches. Under inclusive policies, children with SHCN and their families benefit from the multiple advantages associated with being "like all the other kids," but some may benefit more from policies that support specialized services. According to the dilemma of difference, the benefits of specialized services must be weighed against potential costs, including stigmatization, when children are labeled as different. Policies that support designated services and special accommodations for children with SHCN eg, different educational materials will be essential to enable certain children to reduce obesity risks. Families whose children have benefited from specialized services will respond well to policy-based efforts to prevent obesity, both inclusive and specialized. Families who seek specialized services, however, sometimes report roadblocks and disappointing outcomes " despite legal protections " that can influence their responsiveness to specialized obesity prevention approaches. Families facing disadvantages related to their race, ethnicity, or language when advocating for their children with SHCN may be discouraged from taking advantage of what is legally available. Determining the appropriate mix of inclusive and special obesity prevention initiatives to optimize benefits for children with SHCN may need to be decided at the level of the individual child and family. Although the confluence of the policy domains of school-based obesity prevention and educational opportunities should support inclusion of children with special needs in school-based wellness initiatives, the extent to which these children are included is unknown. Section of the Rehabilitation Act of 22 and the Americans with Disabilities Act of 23 provide additional protections. As schools continue to serve as sites for obesity prevention, and wellness initiatives are integrated into curricula, anything less than the full participation of children with SHCN in these initiatives is unethical, and perhaps illegal, because their exclusion violates their rights to a free and appropriate public education. Systemic change is required to create healthy school environments for all children, including children with SHCN. The federal Patient Protection and Affordable Care Act, signed into law in , will " if fully implemented " ensure that all children have health insurance and access to routine preventive health care Although an American Academy of Pediatrics policy calls for physicians to screen all children annually for excess weight gain, no published data exist regarding the degree to which children with SHCN receive preventive screening Because children with SHCN often see subspecialists rather than primary care providers, routine preventive services may not be consistently delivered In a review of 51 proposed federal policy options for addressing childhood obesity, none focused on the health care system Policy initiatives designed to promote the health of children with SHCN traditionally acknowledge the additional responsibilities and challenges their families face and often include provisions for extra information and support. Similar designated support for families will be essential in initiatives to prevent obesity among children with SHCN. Dietary and physical activity guidelines that read as if one size fits all will fail to provide families of children with SHCN with the resources they need to encourage their children to eat well and be physically active. Policy makers involved in the processes of developing, implementing, and evaluating policies for children with SHCN have learned the value of including families. From an ethical perspective, this approach respects the autonomy of families, in contrast to more paternalistic policy-making approaches. Although families believe that their involvement helps ensure usability and flexibility, broad-based obesity policy initiatives have rarely involved them. Given this history and federal laws and regulations requiring family involvement eg, in policy making and oversight roles in state Title V programs [28] , many families of children with SHCN will expect and come to demand that policy responses to obesity for all children include both supports for families and provisions to include families formally in the policy formulation and implementation process. The stewardship model stresses the importance of consulting with

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people about policy measures that affect them and would support a policy-making role for families. Promises and Challenges Data indicate that children with SHCN account for part of the increasing prevalence of childhood obesity in the general population. The federal government, in partnership with states, supports a network of services to promote the health of this vulnerable population through increased access to quality health services. Addressing new health risks associated with obesity requires policies that support family- and community-based initiatives in addition to health services. Ethical concerns about child obesity policy, however, may slow or prevent development of workable solutions 6. We examined 4 ethical considerations that influence responses to child obesity policy from the perspective of children with SHCN. Our goal was to identify issues that are pertinent to efforts to optimize the benefits of child obesity policy for these children. The policy history of children with SHCN and their families is likely to result in support for broad-based multifactorial efforts to promote healthy weights in children. Still, children with SHCN will benefit from governmental policy solutions for obesity intended for the wider world of children if and only if they are guaranteed participation. Policy responses must also be sufficiently robust to address the needs of certain children and families who require more specialized initiatives. Calibrating the correct mix of inclusive and special obesity prevention initiatives and determining the strategies that ensure full participation in school and community activities present challenges. Program models, methods, and materials to enable children with SHCN to participate fully in activities that promote healthy weights in their schools and communities are in short supply. Families of children with SHCN “ collectively and individually “ can help determine which policy responses most benefit their children and advocate for their inclusion; families have demonstrated their effectiveness in other policy domains. Policy solutions designed to address the needs of all children, including children with SHCN, are required to create healthy environments for children and to ensure that all children have a healthy life. They work together on initiatives to promote the health and wellness of children with SHCN and disabilities through family-based interventions. Footnotes The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention. Suggested citation for this article: Children with special health care needs: Prev Chronic Dis ;8 5: Contributor Information Paula M. Child and Adolescent Health Measurement Initiative. Prevalence of obesity among children with chronic conditions. Associations between overweight and obesity with bullying behaviors in school-aged children. A new definition of children with special health care needs; [PubMed] 8. Prevalence of overweight in children and adolescents with attention deficit hyperactivity disorder and autism spectrum disorders: Prevalence of obesity in International Special Olympic athletes as determined by body mass index. J Am Diet Assoc. J Intellect Disabil Res. Institute of Medicine Preventing childhood obesity: National Academies Press; What does the epidemic of childhood obesity mean for children with special health care needs? J Law Med Ethics. Lifestyle health behaviors of 10-year-old youth with physical disabilities. Health Educ Res ;11 2: Obesity and developmental disabilities: J Dev Phys Disabil ;10 3: Eating habits of children with autism. Body weight changes associated with psychopharmacology. Pijl H, Meinders AE. Bodyweight change as an adverse effect of drug treatment. Ethical family interventions for childhood obesity. Nuffield Council on Bioethics. Learning to live with the dilemma of difference:

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Chapter 2 : How Obesity Relates to Socioeconomic Status – Population Reference Bureau

SPECIAL POPULATIONS 1 Obesity Treatment in Special Populations – Smokers - All smokers, regardless of weight, should quit smoking. - Implement weight gain prevention, treatment efforts as necessary. – Older adults - Evaluate risk-to-benefit ratio. – Diverse patient populations - Tailor treatments to patient needs.

Taking a more global view, the prestigious British Medical Journal BMJ looks at various attempts to tackle obesity and notes that obesity is caused by a complex and multitude of inter-related causes, fuelled by economic and psychosocial factors as well as increased availability of energy dense food and reduced physical activity. The authors broke down the causes into the following areas: Food systems causes of obesity The main problem has been the increased availability of high energy food, because of: Liberalized international food markets Food subsidies that have arguably distorted the food supply in favour of less healthy foodstuffs Transnational food companies [that] have flooded the global market with cheap to produce, energy dense, nutrient empty foods Supermarkets and food service chains [that are] encouraging bulk purchases, convenience foods, and supersized portions Healthy eating often being more expensive than less healthy options, despite global food prices having dropped on average. Marketing, especially food advertising through television [which] aims to persuade individuals – particularly children – that they desire foods high in saturated fats, sugars, and salt. The local environment and obesity How people live, what factors make them active or sedentary are also a factor. For example, Research, mainly in high income countries, indicates that local urban planning and design can influence weight in several ways. For example, levels of physical activity are affected by Connected streets and the ability to walk from place to place Provision of and access to local public facilities and spaces for recreation and play The increasing reliance on cars leads to physical inactivity, and while a long-time problem in rich countries, is a growing problem in developing countries. Social conditions and obesity BMJ noted here include Working and living conditions, such as having enough money for a healthy standard of living, underpin compliance with national health guidelines Increasingly less job control, security, flexibility of working hours, and access to paid family leave – undermining the material and psychosocial resources necessary for empowering individuals and communities to make healthy living choices. Inequality, which can lead to different groups being disadvantaged and having less access to needed resources and healthier foods Back to top Addressing Obesity Globally, Nationally, Locally, Individually British celebrity-chef-turned-food-activist, Jamie Oliver, recently won the prestigious TED Prize for his campaigning in the UK to fight obesity. His wish that the TED Prize speech asks him to share was to help to create a strong, sustainable movement to educate every child about food, inspire families to cook again and empower people everywhere to fight obesity. He explained this in his video: Teach every child about food, TED, February Given the complex, inter-related causes of obesity, addressing it also requires a multi-pronged approach: Dealing with inequalities in obesity requires a different policy agenda from the one currently being promoted. Action is needed that is grounded in principles of health equity. Action must tackle the inequities in this system, aiming to ensure an equitable distribution of ample and nutritious global and national food supplies; built environments that lend themselves to easy access and uptake of healthier options by all; and living and working conditions that produce more equal material and psychosocial resources between and within social groups. This will require action at global, national, and local levels. While important, on its own, they feel it is not sufficient; there is limited evidence for sustainability [of this direct approach] and transferability to other settings, for example. Furthermore, the recent UK Foresight Report makes clear the complexity of drivers that produce obesity; it highlights that most are societal issues and therefore require societal responses. The therefore describes some examples of initiatives at these various levels: Addressing obesity at the global level This involves international institutions, agreements, trade and other policies. A joint program of the United Nations Food and Agriculture Organization and the World Health Organization, the experience of the Codex Alimentarius Commission highlights the challenges at international level. The

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Commission was set up to help governments protect the health of consumers and ensure fair trade practices in the food trade. But challenges and obstacles persist. For example, industry representatives hugely outnumber representatives from public interest groups, resulting in an imbalance between the goals of trade and consumer protection. In addition, Ensuring that global food marketing does not target vulnerable societies the BMJ feels there needs to be binding international codes of practice related to production and marketing of healthy food, supported at the national level by policy and regulation. Emphasis added For example, regulating television advertising of foods high in fat or sugar to children is a highly cost effective upstream intervention. Addressing obesity at the national level National policies typically aimed at healthier food production include targeted and appropriate domestic subsidies. For example, Norway successfully reversed the population shift towards high fat, energy dense diets by using a combination of food subsidies, price manipulation, retail regulations, clear nutrition labelling, and public education focused on individuals. Mauritius relatively successful program includes price policy, agricultural policy, and widespread educational activity in various settings. Ireland is an example of the also-needed multi-agency approach with their Healthy Food for All initiative seeking to promote access, availability, and affordability of healthy food for low income groups. Addressing obesity at the local level Examples of local level action the BMJ mentioned include The success of the Brazilian population-wide Agita Sao Paulo physical activity program which successfully reduced the level of physical inactivity in the general population by using a multi-strategy approach of building pathways; widening paths and removing obstacles; building walking or running tracks with shadow and hydration points; maintaining green areas and leisure spaces; having bicycle storage close to public transport stations and at entrances of schools and workplaces; and implementing private and public incentive policies for mass active transport. The London Development Agency plans to establish a sustainable food distribution hub to supply independent food retailers and restaurants. However, a key challenge they note is the lack of systematic evaluation of initiatives, particularly with an equity focus, [which] makes it difficult to generalize policy solutions in this field. So while there are many measures possible at many levels, a cultural shift in attitude is needed. The benefits of a healthier diet is obvious. Dean Ornish, a clinical professor and founder of the Preventive Medicine Research Institute, explains, the large number of cardiovascular diseases that kill so many around the world is not only preventable, but reversible, often by simply changing our diets and lifestyle: Another BMJ article notes in a prognosis in obesity that we need to move a little more and eat a little less: New economic analyses help dispel the myth of people getting fatter but eating less. The first 20 years of our adult obesity epidemic, from the s to s, was explained mainly by declining physical activity: Americans believe they have less time to do things but in reality are spending more time watching television and being inactive. Subsequently, the obesity epidemic appears to have been fuelled by largely increased food consumption. A paradoxical increase and deregulation of appetite during inactivity has been matched by an increasing supply of food at lower real cost. Consumption of supersize food portions will accelerate this process, reflecting a failure of the free market that demands government intervention. At the end of the industrial food chain, you need an industrial eater. What you eat, and how you eat are equally important issues. There is a lot of talk and interesting comparisons drawn between us and the French on the subject of food. They live a little bit longer, they have less obesity, less heart disease. Well, according to the people who study this: They eat smaller portions; they do not snack as a rule; they do not eat alone. When you eat alone, you tend to eat more. So the French show you can eat just about whatever you want, as long as you do it in moderation. That strikes me as a liberating message. We have a food system here that is all about quantity, rather than quality. Maybe this hints at how extreme the problem might be for a medical doctor to be so extreme in a possible solution, as there are problems with this type of suggestion. For example, This sounds like an extremist and reactionary measure to deal with the issue, and raises concerns about rights of individuals to make their own choices. Furthermore, it could lead to a form of prejudice and hostility towards certain types of people. More effective could be to address the deeper issues discussed further above and below. For example, the fast food industry is not effectively charged for their contribution to environmental

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destruction around the world, or even their indirect contribution to world hunger by making poor people grow food for export rather than to feed themselves. These examples just touch the surface, but these all add up to hidden costs for society but savings for the fast food companies. But the underlying concern of the doctor is still important. At the end of April, the British government urged the public to exercise five times a week. Levels of physical activity among the general population have fallen significantly over the past 25 years the government had also noted. Compelling scientific evidence shows that more active people are less likely to become obese and develop heart disease. And many resources are deployed to support that industry. This is another example of hidden waste. Soaring diabetes rates are inextricably tied to the global obesity epidemic, as Inter Press Service IPS notes. Yet, the political will to be able to change certain cultural habits and to take on powerful industries promoting such habits that lead to these problems, is where the challenge lies. In theory were it not for these political and cultural challenges, the cost of addressing the problem could be quite low regular exercise, sensible eating habits, for example. But, There is not enough resolve to take on these monster industries and to force changes that will make our environment promote healthy rather than unhealthy choices when it comes to food and physical activity says Dr. The WHO [World Health Organisation] is basically powerless to do anything about the problem other than draw attention to it and perhaps develop some recommendations that will be very difficult for governments to implement Schlundt also notes. Talk of banning ads to kids met with resistance from industry As a small example, in November, another UK government member of Parliament had suggested a bill to ban TV ads promoting food and drink high in fat, salt and sugar aimed at young children. This received a lot of support as well, as groups and other members of Parliament felt that self-governing by the industry was not working. Some of these groups are leading medical and related organizations in Britain. However, as the BBC also noted, a UK government minister said she was skeptical about the merits of banning junk food ads and, in concert with what the food and drink industry said, sound science was needed to ensure that this was indeed a major cause of health problems. Encouraging healthier living and eating would be better it was noted. The food and drink industry are on the defensive because of the potential loss in sales. However, while true, advertising is so much part of culture that it would be overly simplistic to say ads do not have an effect and that it is only through exercise and personal discipline that these issues can be overcome. Furthermore, if it is individual choice, then food companies would not need to market and create perceived food needs; the necessity to eat would be enough to drive the market. Side Note Oversimplifying a bit, Were it not for advertising, how would companies including those in the food and drink industry advertise their products? See for example, the sugar and beef sections later on this site on how luxury products were turned into almost unhealthy necessities. Furthermore, how would the unhealthy food and drinks become so popular when parents are the other major influence would typically discourage excessive unhealthy eating and drinking? But, saying that, with parents themselves having grown up with these same advertising influences, they can indirectly or directly encourage more unhealthy eating for their children. With the health services typically under strain, the resources to counter-advertise effectively, is limited. In that context, then, while an important aspect, blaming the individual and parents alone does not address all the issues and influences. The above example about pressure to ban advertising and the associated skepticism on its merits comes from the UK. In the US, industry has offered to self regulate. However, it looks as though pledges to reduce junk food advertising have not been met: It found that the fast food industry continues to relentlessly market to youth. For example, The average preschooler sees almost three ads per day for fast food; children see three-and-a-half; and teens see almost five. Children see more than just ads intended for kids. Rather than restrictions only applying when the program is created solely for children, it wants a broader standard, such as the total number of children that watch a program. That would extend the reach of child friendly advertising guidelines to such broadly popular shows as American Idol.

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Chapter 3 : Special issues regarding obesity in minority populations.

Children with special health care needs (SHCN) account for part of the increasing prevalence of childhood obesity in the general population and can face an elevated risk for obesity. The federal government, in partnership with states, has assumed the role of steward for this vulnerable population and supports a network of services designed to promote their health through increased access to quality health services.

See Table for data sources associated with each indicator. Using the four criteria for choosing indicators and objectives described above, the Committee consolidated the list into 83 indicators and concomitant objectives—13 overarching and 70 goal-area indicators and objectives. Table presents the 83 indicators identified by the Committee to 1 inform the national, state, and community plans; 2 to recommend items for strengthening surveillance systems with indicators that would have comparability across jurisdictions; and 3 as examples of indicators that could be used by independent evaluators who wish to design their own obesity prevention evaluation studies. Evaluating Obesity Prevention Efforts: A Plan for Measuring Progress. The National Academies Press. Because the indicators and objectives were drawn from existing, readily available data sources and because priority was given to indicators and objectives that had been previously vetted e. Across these multiple data sources, there is variable information available on the reliability and validity of the systems and measures. For example, at the national level, the burden of obesity can be accurately assessed for various subgroups because large national surveys e. Estimates based on self-reported weight and height will differ from, and be potentially biased compared to, estimates based on objective measurements Gillum and Sempos, ; Yun et al. Estimation may be biased across various socio-demographic groups and across time periods where body mass index underestimation may be increasing over time Le et al. The list of indicators is intended to illustrate the range of indicators that may be considered by evaluators based on currently available data sources, but in no way is it intended to be exhaustive, nor does it necessarily include the best indicators for a given strategy or goal. The discussion below provides recommendations for future work on indicator development. Many factors contribute to the intractability of disparities in the prevalence of obesity, ranging from the social, built, policy, and economic environments to individual behaviors, physiology, and epigenetics. Thus, tracking and monitoring of differential rates of exposures to these factors and their subsequent influence on obesity incidence and prevalence is important. Rather than developing a separate set of indicators specifically for disadvantaged populations, the Committee recommends that available indicators, such as those included in Table , be used broadly, expanded as needed, and include traditionally disadvantaged groups in an effort to evaluate progress on obesity efforts among populations most affected. In Chapter 5 of this report, the Committee provides context for obesity prevention in disadvantaged populations, related challenges, and a summary of the methods and tools that are likely to be useful. Page Share Cite Suggested Citation: These surveys and surveillance systems differ according to the geographic level of data e. Surveillance systems in the United States focus more on nutrition-related measures than on physical activity. Furthermore, as indicated in Table , most of the indicators included in Table are available from large, national data systems providing data estimates at the national or state levels primarily, with only a few systems providing data estimates below the state level. Appendix D provides detailed information on each of the data sources listed in Table , including the sponsoring organization, study design, periodicity, and populations studied. Tables and list specific indicator topics and data sources at the national and state levels and at the community level, respectively.

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Chapter 4 : Course Details: Level 4 Obesity & Diabetes Management - NRPT

Increased attention to obesity as it occurs in and affects diverse ethnic groups can help to address critical minority health issues. Such efforts can also broaden and enrich aspects of obesity research for which models based on white populations are inappropriate or limited.

A person who is obese may experience: Fatigue when performing simple daily activities. Joint pain, especially in the legs and back from increased stress that excess fat and weight put on the joints and muscles of the body. Difficulty performing daily activities, such as walking, climbing stairs, or playing physically active games. Frustration or depression about the condition and the inability to lose weight. How Is It Diagnosed? If you see your physical therapist first, your physical therapist will conduct a thorough evaluation that includes taking your health history. Your physical therapist will also ask you detailed questions about your condition, such as: Do you have any joint pain? Do you have difficulty with any daily activities? How much daily exercise do you get? Do you have any other medical conditions or problems? Do you take any medication for your obesity or any other condition? Have you had any surgery related to your obesity? Are you under the care of a physician? What are your goals? Your physical therapist will perform tests, such as motion, strength, coordination, and balance checks to help assess your overall physical ability. Your physical therapist may also perform specific obesity tests, such as calculating your BMI, or measuring your waist circumference, "skinfold" thickness, or percentage of body fat. Your physical therapist may consult with your physician or other health care providers about your condition, who may order further tests to rule out other medical conditions that may affect the type of physical therapy you receive. How Can a Physical Therapist Help? Physical therapists can help people who are obese to be more physically active and fit by teaching them to exercise in pain free and fun ways. The right exercise is very important because it helps burn calories, get rid of fat, preserve muscle tissue, and protect your joints. When you start a fun exercise routine, it also helps you make better choices about your diet. Your physical therapist will work with you to design a specific treatment program to address your needs, including exercises you can do at home. Aerobic exercise and strength training will likely be included in your program, as they both help in weight loss and weight control. Physical therapists are trained to create safe, effective physical activity programs for people of all ages and abilities, taking into account the Centers for Disease Control and Prevention physical activity recommendations for children and adults. Physical therapists can also help individuals address any underlying reasons for their unhealthy behaviors; they are trained to identify any barriers to developing healthy habits, setting individual goals, and sticking to the program. Your physical therapist can help you: Your physical therapist will design a personalized exercise program to help you safely perform activities with the least amount of pain. Just getting up and getting moving can help relieve pain! Physical therapists help people, including adults and children with disabilities find fun aerobic activities they can perform at their own comfortable level. Your physical therapist will teach you exercises to address any muscle weakness you may have, or to improve your overall muscle strength. Building strength in muscles can help burn calories, make daily activities easier, and relieve joint pain. Gentle and low-impact forms of weight training performed with exercise bands can help avoid joint stress. Your physical therapist will choose specific activities and treatments to help restore normal movement of stiff joints. These might begin with "passive" motions that the physical therapist performs for you, and progress to active exercises that you do yourself. Improve flexibility and posture. Your physical therapist will determine if any of your major muscles are tight, and teach you how to gently stretch them. Your physical therapist will also assess your posture, and teach you exercises to improve your ability to maintain proper posture. Good posture can make difficult activities easier and less painful, and even improve your breathing. Your physical therapist will discuss your activity goals with you, and design your exercise program to address your individual needs and goals. Your physical therapist will help you reach those goals in the safest, fastest, and most effective way possible. If Surgery Is Necessary Gastric bypass or bariatric surgery is sometimes chosen by patients and their doctors to treat severe

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obesity. Your physical therapist can help you prepare for and recover from surgery by designing and teaching you a preoperative and postoperative physical therapy program. Your physical therapist can guide you through each session, help you avoid injury to joints and muscles, and increase and adjust your program as needed. Preoperative programs often involve strength training and aerobic conditioning, while postoperative programs often start with deep breathing and lower-extremity legs, ankles, feet exercises, gently increasing to strength and aerobic training. Your physical therapist will help you minimize pain, regain motion and strength, and return to normal activities in the speediest manner possible after surgery. Can this Injury or Condition be Prevented? To help prevent obesity or prevent weight gain after weight loss, your physical therapist will likely advise you to: Include physical activities you enjoy into your daily routine so you can avoid returning to a sedentary lifestyle. Avoid watching TV more than 2 hours per day. Use your body as much as you can to walk, climb stairs, garden, wash dishes by hand, and other daily activities that keep you moving. Educate yourself about nutrition, and especially about portion sizes, to help you understand and control your calorie intake. Exercise daily for at least 30 minutes adults or 1 hour children. This advice also applies to disabled individuals as well as those suffering from most medical conditions. Always check with your physical therapist or a health care professional before beginning any exercise program. Be sure to follow the special instructions your physical therapist gives you regarding your specific health conditions. Your physical therapist will also prescribe a home-exercise program specific to your needs to prevent future problems or injuries. This program can include strength and flexibility exercises, posture retraining, and aerobic conditioning. Real Life Experiences Ryan is a year-old computer programmer who has been obese for years. He has lived a sedentary life since he discovered his talent for programming computers at age 10. At that time, he gave up sports and most physical activities to spend long hours at his computer, mastering code and creating software that millions of people use around the world. Recently, Ryan went to see his doctor about chronic knee and back pain. His doctor performed standard tests and found that Ryan was prediabetic. His doctor told him his joint pain and prediabetes diagnosis were a result of his obesity, and his obesity was a result of his sedentary lifestyle. His doctor recommended that Ryan immediately address his condition by learning about nutrition and to start exercising. Ryan expressed fear that he might worsen his knee and back pain if he tried to exercise by himself. His doctor referred him to a physical therapist. She calculated his BMI, measured his waist circumference, and recorded his "skinfold" thickness over his triceps muscle. She checked his overall flexibility, strength, and posture. She talked to Ryan about his physical activity levels over the last 30 years, and asked about his personal goals. Ryan revealed that he would like to join his friends in a weekly bowling night and play Frisbee golf with his family on Saturdays, but he was too weak and overweight to do those activities right now. His primary goal, however, was to not suffer back pain when sitting, and knee pain when trying to stand and walk, which he had dealt with for a long time. He also reported shortness of breath walking up half a flight of stairs. She also included some aerobic conditioning on a stationary bike. Ryan and his physical therapist also discussed what factors made him want to eat more calories than he was supposed to each day. He noted that staying up late at night, or working at the computer longer than 3 hours without a break, seemed to trigger his desire for sugary and unhealthy foods. They discussed strategies to help break the cycle of unhealthy eating, such as setting an earlier bedtime, and using an alarm during his work hours to cue him to take a quick walk for 5 minutes every hour. Ryan attended physical therapy 3 times per week for 6 weeks. He participated eagerly in his program of strengthening, stretching, aerobics, and posture training. He was soon able to do a full 30 minutes of aerobic training in each session, and he felt invigorated, rather than exhausted, as his body adapted to his new activity level. He noted that he quickly felt stronger overall, and his knee pain reduced significantly. After 2 weeks, he could walk quickly up a flight of stairs with almost no shortness of breath. He proudly reported he was enjoying his new diet full of fresh, healthy foods. After 4 weeks, he lost 10 lbs. After 6 weeks, he lost 18 lbs, his BMI measurement was improved, and his back pain was less frequent. Ryan was encouraged by his progress, and decided to continue going to physical therapy for another month. At the end of that month, he could walk quickly up 2 flights of stairs without shortness of breath or knee pain, sit for 2

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hours without back pain, andâ€”most exciting for himâ€”he was able to join his friends for bowling night! He reported he had a terrific time, with no knee or back pain. Ryan was discharged as a patient, but visited the physical therapy clinic during open gym hours to continue his program of weight loss, physical activity improvement, and prevention, under the knowledgeable eye of his physical therapist. Three months after starting his physical therapy program, Ryan joined his family for their Saturday Frisbee golf gameâ€”and won! All physical therapists are prepared through education and experience to treat obesity and its muscular and joint consequences. However, you may want to consider: A physical therapist who is experienced in treating people with orthopedic injuries. Some physical therapists have a practice with an orthopedic or sports medicine focus. A physical therapist who is a board-certified clinical specialist, or who completed a residency or fellowship in orthopedic or sports physical therapy. This therapist has advanced knowledge, experience, and skills that may apply to your condition. You can find physical therapists who have these and other credentials by using Find a PT , the online tool built by the American Physical Therapy Association to help you search for physical therapists with specific clinical expertise in your geographic area. Get recommendations from family and friends or from other health care providers. During your first visit with the physical therapist, be prepared to describe your symptoms in as much detail as possible, and say what makes your symptoms worse.

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Chapter 5 : Preventing Childhood Obesity | Issues in Science and Technology

Special attention must be given to obesity as it occurs in and affects ethnic minorities (that is, black Americans, Hispanic Americans, Asian and Pacific Islander Americans, American Indians and Alaska Natives, and Native Hawaiians) in the United States.

Despite the appeal of prevention as an ideal, it appears that this country as a whole has been unable to prevent obesity. The results of more limited and focused efforts at prevention, described later in this chapter, have hardly been more successful. These facts led a recent review to conclude that "we have not been able to prevent obesity in the past and we do not have the tools to do better in the future" Stunkard, in press. It has been proposed that genetic vulnerability may lie at the root of the current epidemic of obesity and the problem of controlling, let alone preventing, obesity Bouchard, However, there has been no real change in the gene pool during this period of increasing obesity. The root of the problem, rather, must lie in the powerful social and cultural forces that promote an energy-rich diet and a sedentary lifestyle. But if social and cultural forces can promote obesity, these same forces should be able to control it. Therein lies the still unrealized potential for preventing obesity. There is some ambiguity of terminology in the prevention literature. The verb prevent implies taking an action or interposing an impediment to stop or keep something from happening. Different ideas about what it is that should be stopped or kept from happening have been suggested in terms of obesity prevention. Is it the incidence of obesity itself? Criteria for Evaluating Weight-Management Programs. The National Academies Press. Does the success of prevention efforts depend upon the effect on comorbid medical disabilities e. Is what should be stopped or kept from happening an underlying risk condition or predisposition factor for obesity development? A recent Institute of Medicine IOM report recommends an approach to clarifying definitions of prevention that, although developed in relation to mental disorders, apply to obesity IOM, This IOM report reviews existing classification systems for preventive interventions for physical illness. The familiar public health classification system designates three types of prevention: The goal of primary prevention is to decrease the number of new cases incidence of a disorder. In secondary prevention, the goal is to lower the rate of established cases of the disorder in the population prevalence. Tertiary prevention seeks to stabilize or decrease the amount of disability associated with an existing disorder. For obesity, tertiary prevention could refer to decreasing the progression to more severe obesity or decreasing the likelihood of associated musculoskeletal, metabolic, or vascular disorders e. When this prevention classification system was introduced more than 25 years ago, the implicit disease model was one of an acute condition with a specific and unifactorial cause. It was assumed that mechanisms linking the cause of a specific disease to its subsequent occurrence could be identified. In the intervening years, many chronic diseases prevalent in this country have been recognized as having multifactorial etiologies. Research on these diseases has advanced our knowledge about the complicated relations that exist between risk factors and protective factors for disease and the outcomes of preventive interventions. But this knowledge can breed the pessimistic view that prevention efforts will be futile until the etiologies of diseases are better understood IOM, According to this analysis, the concept of risk reduction is critical to prevention programs and research. Addressing the degrees of risk for a condition supplants the more simplistic concept of prevention in which a disease is simply present or absent. Risk factors refer to those characteristics that, if present for a particular individual, make it more likely that this person compared to someone selected from the general population will develop a disorder Werner and Smith, Both risk and protective factors are included here. Research also shows that many at-risk individuals have factors in their background or environment that protect against the development of a disorder Garmezy, In furthering the establishment of successful preventive intervention programs, the IOM report recommends instituting a "preventive intervention Page Share Cite Suggested Citation: At the current stage of research into preventing obesity, work is still in the first two phases of this research cycle: We recommend continuing this early research on the determinants of obesity and pilot-testing

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promising interventions before funds are allocated for large-scale community prevention trials. Promising research studies that have already appeared in the scientific literature are reviewed later in this chapter. The recent IOM report also recommended an alternative terminology for physical disease prevention, proposed by Gordon, and we adopt it here (see Figure 4.1). This terminology identifies three types of prevention: Each category represents a population group, rather than a disorder or disease state, to whom preventive interventions are directed. Universal preventive measures or interventions are designed for everyone in the eligible population. Page Share Cite Suggested Citation: Indicated preventive interventions are targeted to high-risk individuals identified as having minimal but detectable signs or symptoms that foreshadow the disorder, or exhibiting biological markers indicating predisposition, who do not meet the full diagnostic criteria for the disorder itself. The earlier IOM report reserves the term prevention for those interventions that occur before the onset of a diagnosed disorder. What was previously known as tertiary prevention is redefined as maintenance intervention, whose aim is to reduce the disability associated with an ongoing disorder. Consistent with the IOM definition of prevention (1). Factors affecting long-term weight management in the obese are discussed in Chapter 7. The primary aim of obesity prevention is to reduce the number of new cases of obesity. This can be accomplished by means of a risk-reduction model. Even if the obesity outcomes are in the distant future, the decrease in risk factors and increase in protective factors for obesity can be identified. An important secondary aim is to delay the onset of obesity. The goals of indicated prevention programs are harder to define than those of universal and selective prevention programs. They might be framed in terms of reducing the length of time initial weight gain persists beyond certain pre-obese limits and halting its progression before diagnostic criteria for obesity are met. Even if the individual does eventually develop obesity, the prior preventive intervention may still have had an effect by reducing the duration or severity of the disorder. The remainder of the chapter describes all three areas of prevention with reference to the prevention of obesity. Each area is described with respect to rationale, outcome measures, specific examples of programs, and criteria for evaluating prevention outcomes. Examples of universal prevention measures which can often be applied without professional assistance include prenatal care, use of seat belts, prevention of smoking, and consuming a nutritionally adequate Page Share Cite Suggested Citation: Such programs have advantages when their cost per person is low and the intervention is acceptable, low risk, and effective for the population involved. It is important to note that the target population (2). As discussed in Chapter 2, obesity is becoming more rather than less prevalent in the United States. Universal prevention programs may help stabilize or even reverse the trend toward increased obesity in the general population. Universal programs can be classified into two broad categories: Programs in the first category often are derived from an individual clinical treatment model and evaluated in terms of weight change and the health habits of individual participants. Programs in the second category often are linked with a public health model, and results can be evaluated in terms of changes in the population distribution of body mass index (BMI). Outcome Measures for Universal Prevention Six outcome measures for this type of prevention can be identified:

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Chapter 6 : America's obesity is threatening national security, according to this study

NEW YORK STATE Overweight and Obesity Prevention STRATEGIC PLAN for Developed through partnerships with the New York State Department of Health supported by Cooperative Agreement USB/CCU

Koplan , Catharyn T. Liverman , Vivica I. Kraak The nation must act now, or it will watch its children grow into adults with excessive levels of diabetes, heart disease, cancer, and other weight-related ailments. After improving dramatically during the past century, the health of children and youth in the United States now faces a dangerous setback: It is occurring in boys and girls in every state, in younger children and adolescents, across all socioeconomic strata, and among all ethnic groups. Traditionally, most people have considered weight to be a personal statistic, of concern only to themselves or, on occasion, to their physicians. Both science and statistics, however, argue that this view must change. As researchers learn ever more about the health risks of obesity, the rise in the prevalence of obesity in children and in adults as well is increasingly becoming a major concern to society at large and hence a public health problem demanding national attention. Since the 1980s, when the epidemic began to take hold, the prevalence of obesity has nearly tripled for children aged 6 to 11 years from 4 percent to 12 percent. Although no demographic group is untouched, some subgroups have been affected more than others. Today, more than 9 million children over age 6 are considered obese, which means that they face serious immediate and long-term health risks. They are at increased risk as they grow older of a number of diseases, including type 2 diabetes, cardiovascular disease, hypertension, osteoarthritis, and cancer. By being obese in a society that stigmatizes this condition, they also may develop severe psychosocial burdens, such as shame, self-blame, and low self-esteem, that may impair academic and social functioning and carry into adulthood. Pared to its core, the solution is simple: Preventing obesity will require ensuring that children maintain a proper energy balance. This means that each child will consume enough of the right kinds of food and beverages and get enough physical activity to maintain a healthy weight while supporting normal growth and development and protecting overall health. At work are a multitude of factors—genetic, biological, psychological, sociocultural, and environmental—acting independently and in concert. Thus, combating the epidemic will be challenging. But there is precedent for success in other public health endeavors of comparable complexity and scope. Major gains have been made, for example, in reducing tobacco use, including preventing youth from smoking, and in improving automobile safety, including promoting the use of car seats and seatbelts to protect young passengers. Some lessons can be drawn from these efforts, past and current, and many new ideas and approaches will be needed to meet conditions specific to the task at hand. One overarching principle is clear: Preventing childhood obesity on a national scale will require a comprehensive approach that is based soundly on science and involves government, industry, communities, schools, and families. Such an approach is detailed in *Preventing Childhood Obesity: Health in the Balance*, issued by the Institute of Medicine in September 2002. The report examines the various factors that promote childhood obesity, identifies promising methods for prevention, describes continuing research needs, and assigns responsibilities for action across a broad sweep of society. Some highlights of the report are offered in the following sections.

Strengthening political muscle As many other public health programs have demonstrated, catalyzing national action to prevent childhood obesity will require the full commitment of government at all levels. The federal government should take the lead by declaring this a top public health priority and dedicating sufficient funding and resources to support policies and programs that are commensurate to the scale of the problem. The government also should ensure that prevention efforts are coordinated across all departments and agencies, as well as with state and local governments and various segments of the private sector. Toward this end, the president should request the Department of Health and Human Services DHHS to convene a high-level task force including the secretaries or senior officials of all departments and agencies whose work relates in any way to childhood obesity to be responsible for establishing priorities and promoting effective collaborations. In order to foster full and free communication,

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the task force should meet regularly with local and state officials; representatives from nongovernmental organizations, including civic groups, youth groups, advocacy groups, and foundations; and representatives from industry. In addition to providing broad leadership, the federal government should take a variety of specific steps. For example, funding should be increased for surveillance and monitoring systems that gather information needed for tracking the spread of childhood obesity and for designing, conducting, and evaluating prevention programs. In particular, the National Health and Nutrition Examination Survey, which for years has been used to monitor the population through home interviews and health examinations, should be strengthened, with more attention being paid to collecting and analyzing data that will inform prevention efforts. Special efforts should be made through this and other surveillance systems to better identify and monitor the populations most at risk of childhood obesity, as well as the social, behavioral, and environmental factors contributing to that elevated risk. Among other steps, the government should increase support for public and private programs that educate children, youth, and their families about the importance of good nutrition and regular physical activity. Congress should request independent assessments of these assistance programs to ensure that each provides adequate access to healthful dietary choices for the populations served. In addition, pilot studies should be expanded within these programs to identify new ways to promote a healthful diet and regular physical activity behaviors. Test programs that prove successful should be scaled up as quickly as possible. Congress also should call for an independent assessment of federal agricultural policies, including subsidies and commodity programs that may affect the types and quantities of foods available to children through food assistance programs. For example, concern has been expressed about whether the increasing amounts of caloric sweeteners primarily derived from sugarcane, beets, and corn that people are consuming are contributing to the obesity epidemic, and whether subsidies for these crops are promoting the production of inexpensive caloric sweeteners. These possible relationships warrant further investigation. If problems are confirmed in this or other cases, then the government should revise its policies and programs to promote a U. Preventing childhood obesity will require a comprehensive science-based approach that involves government, industry, communities, schools, and families. For their part, state and local governments should join in making the prevention of childhood obesity a priority by providing the leadership and resources needed to launch and evaluate a slate of programs and activities that promote physical activity and healthful eating in communities, neighborhoods, and schools. One important step, for example, will be for governments to strengthen their public health agencies. As the front line of the public health system, these agencies are ideally positioned to assess the childhood obesity epidemic; to identify local conditions that are fueling it; and then to develop, implement, and evaluate prevention programs. In order to perform most effectively, however, many agencies will need restructuring to make them better able to work collaboratively with diverse community partners. Such partners can include schools, child-care centers, nutrition services, civic and ethnic organizations, faith-based groups, businesses, and community planning boards. Harnessing the market Children, youth, and their families are surrounded by a commercial environment that strongly influences their purchasing and consumption behaviors as well as the choices they make in how to spend their leisure time. Thus, a variety of industries including the food, beverage, restaurant, entertainment, leisure, and recreation industries must share responsibility for preventing childhood obesity. Government can help strengthen industry efforts by providing technical assistance, research expertise, and, as necessary, targeted support and regulatory guidance. As a general goal, industries should develop and promote products, opportunities, and information that will encourage healthful eating behaviors and regular physical activity. Such efforts can help to reverse the recent trend that has seen people spending more time in passive sedentary pursuits and less in active leisure activities. Some companies already are setting the pace, apparently convinced that fostering physical activity will help to create significant markets for their products. For example, Nike, a manufacturer of athletic apparel, provides funding to build or refurbish sports courts and other public athletic facilities nationwide and supports physical education classes in elementary schools, among other projects. More projects of this kind are needed. Foods with low energy densities, such as fruits

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and vegetables, promote satiety and reduce total caloric intake, but they sometimes meet resistance in the marketplace, especially among people who have become used to foods of higher energy densities. Manufacturers, perhaps motivated by some form of government incentive, should continue to push for healthful new products that are more appealing to a range of people. They also should speed up modifying existing products—for example, by replacing fat with protein, fruit or vegetable puree, fiber, or even air—to reduce energy density but maintain palatability without substantially reducing product size. As another line of attack, manufacturers should develop new forms of product packaging that would help consumers choose smaller, standard serving sizes without reducing product profitability. Full-service and fast-food restaurants have important roles to play as well, given that people are consuming an increasing share of their meals and snacks outside of the home. Among a range of steps they should take, restaurants should continue to expand their healthier meal options by offering more fruits, vegetables, low-fat milk, and calorie-free beverages, and they should mount information campaigns to provide consumers at the point of purchase with easily understandable nutrition information about all of their products. The industry also should explore price incentives that encourage consumers to order smaller meal portions. Industry also should make better use of nutrition labeling, which has been mandatory since 2006, to provide parents and youth with clear and useful information that will enable them to compare products and make informed food choices. Here, government can help. But in many instances, people consume all at once quantities that are much larger than a standardized serving size. This is often the case for vending-machine items, single-serving snack foods, and ready-to-eat foods purchased at convenience stores. Such consumers are left on their own to calculate the nutritional content of their purchases. To help them out, the FDA should mandate that manufacturers prominently add the total calorie content to the nutrition facts panels on products typically consumed at one eating occasion. Together, these industries are the second-largest advertising group in the U.S. Current evidence suggests that the quantity and nature of advertisements to which children are exposed daily, reinforced through multiple media channels, appear to contribute to choices that can adversely affect their energy balance. Thus, industry has an important responsibility and opportunity to help foster healthier choices. As a catalyst, DHHS should convene a national conference, bringing together representatives from industry, public health organizations, and consumer advocacy groups, to develop guidelines for the advertising and marketing of foods, beverages, and sedentary entertainment directed at children and youth. The guidelines would cover advertising content, promotion, and placement. They should pay particular attention to protecting children under the age of 8, as they are especially susceptible to the persuasive intent of advertising. Industry would then be responsible, on a voluntary basis, for implementing the guidelines. However, the Federal Trade Commission should be given the authority and resources to monitor compliance and to propose more stringent regulations if industry fails in its actions.

Building healthy communities Many factors in the community setting affect the overall health and fitness of children and youth. Writ large, a community can be a town, city, or other type of geographic entity where people share common institutions and, usually, a local government. In turn, each of these communities contains many interdependent smaller networks of residential communities, faith-based communities, work communities, and social communities. Thus, there is a host of leverage points at which communities can help foster social norms that promote attitudes and behaviors that will help their young members maintain a healthy weight. Many youth organizations, such as Boys and Girls Clubs, Girl Scouts, Boy Scouts, and 4H, already have a number of programs under way that illustrate the gains possible. In one Girl Scout program, for example, girls who participated with their troops in nutrition classes, which included tasting sessions and sending foods home, were found to consume more fruits and vegetables on a regular basis. Youth groups also can help get more kids involved in physical activity by pursuing innovative approaches that reach beyond traditional competitive sports. These sports are not of interest to everyone, so it will be important for communities to expand their range of offerings to include noncompetitive team and individual sports as well as other types of physical activities, such as dance and martial arts. To ensure equal access to physical activity programs, communities should help families overcome potential obstacles by

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providing transportation, paying fees, or providing special equipment. Wide-ranging intervention programs are needed now, based on the best evidence available. Communities also should take a hard look at their built environments and expand the opportunities for children to be physically active outside, especially in their neighborhoods. Creating places to walk, bike, and play will require not only providing adequate space but also reducing risks from traffic or crime. Local governments, private developers, and community groups should work collaboratively to develop more parks, playgrounds, recreational facilities, sidewalks, and bike paths. It will be especially important for communities to ensure that children and youth have safe walking and bicycling routes between their homes and schools and that they are encouraged to use them. Making such improvements often will require local governments to revise their development plans, zoning and subdivision ordinances, and other planning practices, and to prioritize the projects in their capital improvement programs. Similarly, communities should expand efforts to provide their residents with access to healthful foods within walking distance, particularly in low-income and underserved neighborhoods. It is within local communities, of course, where most health care is provided, and health care professionals have an influential role to play in preventing childhood obesity. They also have the authority to elevate concern about childhood obesity and advocate preventive efforts. By conducting workshops at schools, testifying before legislative bodies, working in local organizations, or speaking out in any number of other ways, health care professionals can press for changes within their communities that support and facilitate healthful eating and physical activity. In their everyday practices, health care professionals pediatricians, family physicians, nurses, and other clinicians should routinely measure the height and weight of their patients and track their body mass indices BMIs.

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Chapter 7 : Strategies to Prevent Obesity | Overweight & Obesity | CDC

Trends in Obesity among Participants Aged Years in the Special Supplemental Nutrition Program for Women, Infants, and Children—United States, Author National Center for Chronic Disease Prevention and Health Promotion.

Obesity is an epidemic in the United States. This condition puts people at a higher risk for serious diseases, such as type 2 diabetes, heart disease, and cancer. Obesity is defined as having a body mass index BMI of 30 or more. However, BMI does have some limitations. Eating more calories than you burn in daily activity and exercise on a long-term basis causes obesity. Over time, these extra calories add up and cause you to gain weight. Common specific causes of obesity include: Genetics Some people possess genetic factors that make it difficult for them to lose weight. Environment and community Your environment at home, at school, and in your community, can all influence how and what you eat and how active you are. Psychological and other factors Depression can sometimes lead to weight gain, as people turn to food for emotional comfort. Certain antidepressants can also increase risk of weight gain. Medications such as steroids or birth control pills can also put you at greater risk for weight gain. How is obesity diagnosed? Obesity is defined as having a BMI of 30 or more. Other more accurate measures of body fat and body fat distribution include skinfold thickness, waist-to-hip comparisons, and screening tests such as ultrasound, computed tomography CT, and magnetic resonance imaging MRI scans. Your doctor may also order certain tests to help diagnose obesity as well as obesity-related health risks. These may include blood tests to examine cholesterol and glucose levels, liver function tests, diabetes screen, thyroid tests, and heart tests, such as an electrocardiogram. A measurement of the fat around your waist is also a good predictor of risk for obesity-related diseases. What are complications of obesity? Obesity leads to much more than simple weight gain. Having a high ratio of body fat to muscle puts strain on your bones as well as your internal organs. It also increases inflammation in the body, which is thought to be a cause of cancer. Obesity is also a major cause of type 2 diabetes. Obesity has been linked to a number of health complications, some of which are life-threatening:

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Chapter 8 : Obesity - calendrierdelascience.com

The prevention of obesity is a topic that must be considered given the major increases both in the prevalence of obesity and in the mean body weights of people in the United States over the past decade (see Chapter 2). Despite the appeal of prevention as an ideal, it appears that this country as a

Key facts Worldwide obesity has nearly tripled since In , more than 1. Of these over million were obese. Over million children and adolescents aged were overweight or obese in What are obesity and overweight Overweight and obesity are defined as abnormal or excessive fat accumulation that may impair health. Body mass index BMI is a simple index of weight-for-height that is commonly used to classify overweight and obesity in adults. Adults For adults, WHO defines overweight and obesity as follows: BMI provides the most useful population-level measure of overweight and obesity as it is the same for both sexes and for all ages of adults. However, it should be considered a rough guide because it may not correspond to the same degree of fatness in different individuals. For children, age needs to be considered when defining overweight and obesity. Children under 5 years of age For children under 5 years of age: Children aged between 5â€™19 years Overweight and obesity are defined as follows for children aged between 5â€™19 years: Facts about overweight and obesity Some recent WHO global estimates follow. Of these over million adults were obese. The worldwide prevalence of obesity nearly tripled between and In , an estimated 41 million children under the age of 5 years were overweight or obese. Once considered a high-income country problem, overweight and obesity are now on the rise in low- and middle-income countries, particularly in urban settings. In Africa, the number of overweight children under 5 has increased by nearly 50 per cent since Nearly half of the children under 5 who were overweight or obese in lived in Asia. The rise has occurred similarly among both boys and girls: Overweight and obesity are linked to more deaths worldwide than underweight. Globally there are more people who are obese than underweight â€™ this occurs in every region except parts of sub-Saharan Africa and Asia. What causes obesity and overweight? The fundamental cause of obesity and overweight is an energy imbalance between calories consumed and calories expended. Globally, there has been: Changes in dietary and physical activity patterns are often the result of environmental and societal changes associated with development and lack of supportive policies in sectors such as health, agriculture, transport, urban planning, environment, food processing, distribution, marketing, and education. What are common health consequences of overweight and obesity? Raised BMI is a major risk factor for noncommunicable diseases such as: The risk for these noncommunicable diseases increases, with increases in BMI. Childhood obesity is associated with a higher chance of obesity, premature death and disability in adulthood. But in addition to increased future risks, obese children experience breathing difficulties, increased risk of fractures, hypertension, early markers of cardiovascular disease, insulin resistance and psychological effects. Facing a double burden of disease Many low- and middle-income countries are now facing a "double burden" of disease. While these countries continue to deal with the problems of infectious diseases and undernutrition, they are also experiencing a rapid upsurge in noncommunicable disease risk factors such as obesity and overweight, particularly in urban settings. It is not uncommon to find undernutrition and obesity co-existing within the same country, the same community and the same household. Children in low- and middle-income countries are more vulnerable to inadequate pre-natal, infant, and young child nutrition. At the same time, these children are exposed to high-fat, high-sugar, high-salt, energy-dense, and micronutrient-poor foods, which tend to be lower in cost but also lower in nutrient quality. These dietary patterns, in conjunction with lower levels of physical activity, result in sharp increases in childhood obesity while undernutrition issues remain unsolved. How can overweight and obesity be reduced? Overweight and obesity, as well as their related noncommunicable diseases, are largely preventable. At the individual level, people can: Individual responsibility can only have its full effect where people have access to a healthy lifestyle. Therefore, at the societal level it is important to support individuals in following the recommendations above, through sustained implementation of evidence

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based and population based policies that make regular physical activity and healthier dietary choices available, affordable and easily accessible to everyone, particularly to the poorest individuals. An example of such a policy is a tax on sugar sweetened beverages. The food industry can play a significant role in promoting healthy diets by: The Strategy calls upon all stakeholders to take action at global, regional and local levels to improve diets and physical activity patterns at the population level. The Political Declaration of the High Level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases of September , recognizes the critical importance of reducing unhealthy diet and physical inactivity. The political declaration commits to advancing the implementation of the "WHO Global Strategy on Diet, Physical Activity and Health", including, where appropriate, through the introduction of policies and actions aimed at promoting healthy diets and increasing physical activity in the entire population. The World Health Assembly welcomed the report of the Commission on Ending Childhood Obesity and its 6 recommendations to address the obesogenic environment and critical periods in the life course to tackle childhood obesity. The implementation plan to guide countries in taking action to implement the recommendations of the Commission was welcomed by the World Health Assembly in

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Chapter 9 : Obesity Prevention - Public Health - Oxford Bibliographies

Evaluating Obesity Prevention Efforts develops a concise and actionable plan for measuring the nation's progress in obesity prevention efforts--specifically, the success of policy and environmental strategies recommended in the IOM report *Accelerating Progress in Obesity Prevention: Solving the Weight of the Nation*. This book offers a framework that will provide guidance for systematic and routine planning, implementation, and evaluation of the advancement of obesity prevention efforts.

Obesity issues are, therefore, an important subset of a much larger set of issues related to the increasing dominance of chronic diseases not only in high-income countries such as the United States or the United Kingdom, but also in low- and middle-income countries. Like obesity treatment, the target of obesity prevention involves a balance of energy intake from foods and beverages and energy output through various types of physical activity. In light of higher obesity prevalence rates, specific strategies to prevent the development of clinically significant overweight and obesity have been articulated separately from strategies to treat established obesity. This article takes a multidisciplinary perspective to identify books, scientific journals, evidence reviews, practice guidelines, and other resources relevant to understanding obesity prevention. Citations include resources that explain obesity prevention concepts and the social, economic, and public policy contexts for undertaking obesity prevention, highlighting controversies, and providing guidance on the evidentiary and methodological underpinnings for planning and evaluating interventions. General Overviews The impetus for large-scale efforts to prevent obesity begins with recognition that the problem affects whole populations and that clinically oriented treatment approaches do not address the constant influx of more people becoming obese. Also, the fact that obesity, once established, is very difficult to reverse adds to the rationale for preventing excess weight gain. With respect to children, the comprehensive review for the International Obesity Task Force Lobstein, et al. Publication of the Global Strategy on Diet, Physical Activity and Health report World Health Organization signaled a global commitment to taking population-level actions on chronic diseases and risk factors, including obesity. Health in the balance. Institute of Medicine, National Academies Press. Recommendations are directed to government, industry, media, schools, communities, and families. Frameworks for identifying potential targets for environmental and policy changes and the types of intervention strategies that can be used to address these targets are presented. Sections address measurement issues, prevalence and trends, health outcomes, and treatment and management and emphasize the importance of prevention for both developed and developing countries. David Satcher was the US Surgeon General, gave official federal government recognition to the epidemic of obesity in the United States and set forth some key principles for action. This was a forerunner of the Institute of Medicine report Koplan, et al. Preventing and managing the global epidemic. Technical Report Series No. This detailed report provides a comprehensive overview of obesity etiology, health consequences, treatment, and prevention considerations. This strategy marked the culmination of several WHO expert consultations and resolutions on these issues and is now in the implementation phase. Users without a subscription are not able to see the full content on this page. Please subscribe or login. How to Subscribe Oxford Bibliographies Online is available by subscription and perpetual access to institutions. For more information or to contact an Oxford Sales Representative click here.