Statement on Childhood Obesity

Student National Medical Association

Health Policy and Legislative Affairs Committee

Statement on Childhood Obesity

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Introduction

Founded in 1964 by medical students from Howard University School of Medicine and Meharry Medical College, the Student National Medical Association (SNMA) is the nation's oldest and largest, independent, student-governed organization focused on the needs and concerns of medical students of color. The SNMA is committed to supporting current and future underrepresented minority medical students, addressing the needs of underserved communities, and increasing the number of clinically excellent, culturally competent and socially conscious physicians.

Childhood obesity is defined as a body mass index (BMI) at or above 95% of the Centers for Disease Control and Prevention (CDC) BMI-for-age-growth charts for children aged 2-19 years. Childhood obesity in America has almost tripled in the past three decades and can partially be attributed to physical inactivity, parental influence, and socioeconomic status.[1] According to the CDC, the prevalence of childhood obesity in 2018 was 19.3% of the United States (US) population and affected 14.4 million people at or below the age of 19. The current prevalence of childhood obesity is 25.6% for Hispanic/Latinx children and 24.2% of non-Hispanic Black/African American children, compared to 16.1% among non-Hispanic White children.[2]

The current interventions to treat and prevent pediatric obesity are summarized into primary care, family, immersion, surgical, and pharmacological methods. Family-based behavioral treatment (FBT) is a multi-component lifestyle intervention that targets the behaviors of both the child and the parent.[3] FBT has been consistently proven as one of the most effective ways to intervene and produce both short-term and long-term weight loss. However, regardless

of this proven success, it is evident that Black/African American and Hispanic/Latinx children still have a higher prevalence of obesity in comparison to their White counterparts.

Therefore, childhood obesity can be used to investigate the social determinants of health and inadequate interventions for this demographic. The disproportionate gap in obesity prevalence continues into adulthood, further contributing to health disparities, comorbidities, and, ultimately, life expectancy by race. The SNMA is committed to highlighting the increased burden of childhood obesity on the Black/AfricanAmerican community, need for culturally sensitive medical treatments, and the adverse effects this disparity has on the ultimate health and wellbeing of Black/African American patients.

Background

Childhood obesity has tripled in the United States over the last three decades.[4] Not only has this been shown to cause health implications during childhood, but it can also lead to health implications as adults.[4] In addition to being a risk factor for morbidity and mortality in adulthood, childhood obesity can lead to chronic diseases such as diabetes, coronary heart disease, atherosclerosis, hip fracture, and gout.[4] Several factors contribute to the rise of childhood obesity, including decreased physical activity, increased portion size of food and beverages, and increased snacking between meals. Unfortunately, this lifestyle has affected Hispanic/Latinx and Black/African American communities more than other races and ethnicities.[5] Fortunately, the causes of childhood obesity can be improved by lifestyle modification.

Legislation is key in combating childhood obesity with a united front. Several states have enacted laws to include school nutrition, physical education and activity, joint-shared use agreements, health insurance coverage for obesity, and task forces.[6] Former US First Lady, Michelle Obama, started the initiative *Let's Move!* to raise awareness of childhood obesity and implement change within the education system by focusing on providing healthier, affordable foods options. The SNMA is committed to addressing the needs of underserved communities and increasing the awareness of culturally sensitive physicians within these communities.

Socioeconomic status can play a pivotal role in resources and support systems for obese youth. We recognize cost and access is often a barrier to fresh produce and healthy food options for many families, which affects children's diets. Furthermore, we recognize limited access to healthcare and insurance coverage for obesity-related care poses a barrier to effective weight management for many children due to the recommendations for obesity prevention, including annual BMI calculation, medical risk calculation, and motivational interviewing.[7] There is currently limited data measuring the efficacy of enacted changes of legislature and educational curricula; however, a multifaceted approach within home and school should improve the overvall success of promoting weight loss among obese children.

Scope of the Problem

According to the CDC, if children are obese, the obesity is likely to worsen in adulthood and become complicated by chronic conditions, such as type 2 diabetes mellitus, hypertension, hypercholesterolemia, obstructive sleep apnea, osteoarthritis, cholelithiasis, anxiety, and depression.[8] Some emerging studies even suggest that development of type 2 diabetes and

coronary heart disease begins in childhood and can be closely linked to childhood obesity. The alarming increase in the prevalence of childhood obesity and its link to later development of cardiovascular disease is a concern, especially in Hispanic and Black/African American communities.[9] These communities account for 20.3% and 23.5% of deaths from heart disease in the US, respectively.[10] For this reason, it is important to address childhood obesity early and systematically to prevent poor health outcomes and decrease health disparities that affect Black/African American and Hispanic communities.

The etiology of childhood obesity is thought to be multifactorial with contributions from genetics, metabolism, diet, and, even, parenting.[11] Research shows one of the strongest predisposing factors is genetics, which cannot be solved with policy changes.[12] However, research also shows genetic predisposition must be coupled with behavioral and environmental factors in order to cause childhood obesity.[13] Therefore, genetics alone can not account for the dramatic increase in childhood obesity in developed countries. Some of the environmental and behavioral factors most closely associated with childhood obesity are availability and exposure to healthy foods, opportunity for physical activity in safe environments, and fast food consumption.[14] These factors are of particular importance in Black/African American and Hispanic/Latinx communities, who face several barriers in these areas. According to the USDA, there were an estimated 6.1 million children living in food insecure households in 2020.[15] Black/African American households disproportionately accounted for 21.7% of all food insecure households—the highest among all racial groups—while Hispanic/Latinx households accounted for 7.9%.[16]

An estimated 19 million Americans also live in food deserts (areas with low access to healthy and affordable foods). Black/African American and Hispanic/Latinx communities are more likely to be living in geographic areas with this designation.[17] Not only do Black/African American communities lack access to supermarkets and healthy food, but there also exists an overabundance of unhealthy fast food in these communities. Research shows the average distance to fast food restaurants was 3.6 miles closer to predominantly Black/African American neighborhoods compared to all other neighborhoods. In neighborhoods with a population of Black/African American residents greater than 80%, there is an average of 2.4 fast food restaurants per square mile compared to 1.5 fast food restaurants per square mile in neighborhoods with only 20% Black/African American population.[16] These factors are directly linked to decreased consumption of low calorie, low fat food options and a simultaneous increase in consumption of fast food options and other dietary habits contributing to development of childhood obesity.

Minority communities are priced out of healthier food options, are physically excluded from healthier food options, and inundated with unhealthy food, which drives the health disparities in childhood obesity and resultant adult health outcomes. In order to impact the prevalence of childhood obesity, we must focus on policy changes eliminating food insecurity and food deserts, and regulate the predatory fast food industry.

Statement of Position & Recommendations

The SNMA is the nation's oldest and largest, independent, student-governed organization focused on the needs and concerns of medical students of color. We are committed to supporting

current and future underrepresented minority medical students, addressing the needs of underserved communities, and increasing the number of clinically excellent, culturally competent and socially conscious physicians. The COVID-19 pandemic has exacerbated various health disparities within marginalized communities, particularly food insecurities.[18] This disparity is in part the cause of the significant increase in childhood obesity rates among underserved communities.[19] As we transition into another year, it is imperative we push for more preventive health efforts within medicine and healthcare to address childhood obesity especially within Black/African American communities. In order to combat obesity in Black/African American children, the SNMA recommends the following institutional advancements:

1. Expansion from current childhood obesity interventions such as, family-based behavioral treatment (FBT) to a more focused approach addressing experiences of Black/African American children and the environments in which they live. Educational institutions and corporations should also provide research funding and partner with community-based centers and grassroot movement activists. With this funding, the intentionality behind creating high-impact intervention and prevention plans will be fueled. Examining the lifestyle of Black/African American children in underserved urban and rural communities is essential for creating initiatives that are uniquely tailored to them. A great example is the Dimock Community Health Center in Boston, which hosts various interventions such as the "Road To Wellness" event supporting Black/African American children with weekly summer interactive training to complete a 5K Run/Walk.[20]

2. Extensive policy and economic support to address food insecurities and food deserts. Lobbying for policy change focused on the narrative of Black/African American obese children is essential to creating change. Institutions, such as the CDC, should provide grants[21] to community health clinics, health departments, and physicians looking to integrate culturally competent obesity prevention programs. Medical students would also have the opportunity to be involved by partnering with local food banks and community gardens to center nutrition for Black/African American patients. A series of nutrition classes will assist in building self-efficacy for Black/African American children. This should be swiftly implemented to preserve the health of past, current, and future patients from underserved backgrounds.

3. Enhanced medical school curriculum that intentionally trains medical students on culturally competent childhood obesity interventions. Curriculums should have cultural competency components integrated into every semester during both the pre-clinical and clinical years. Curriculums should emphasize preventive medicine and include hands-on

training, didactic lectures, role playing, and standardized patient interaction. This variety in teaching methods will increase medical students' knowledge, attitudes, and skills regarding obesity intervention. There should also be a special focus on addressing medical student bias towards overweight and obese patients.[22] Unique features to add to the curriculum could potentially include hosting a panel of community leaders and local residents to speak on their experiences with obesity. This would assist in receiving candid feedback from those who are most affected. Creative solutions develop from collaboration and community care.

4. Stricter Continuing Medical Education (CME) requirements and enhanced cultural competency skills. Training should focus on obesity interventions, racial bias, pain management, bedside manner, trauma-informed care, communicating with empathy, proper treatment/diagnosis, and other racially conscious topics. In order to satisfy the requirements, any CME program of instruction should be at least six hours in duration, offered in the classroom, through workshops over the internet, or through venues such as conferences.[23]

5. Stronger focus on the recruitment and retention of Black/African American, Native American, and other physicians of color within faculty roles. Medical schools must have policies that recruit and build the capacity of culturally competent teachers. Faculty must not only have the relevant qualifications to care for diverse communities but should also actively enhance their cultural competency through mandatory training requirements set by strict guidelines. There must exist an integrated evaluation component in which medical students have the opportunity to provide honest feedback regarding their faculty.[19] The increase in faculty members who are underrepresented in medicine (URiM) will add to the diversity of the staff, increase cultural competence for the medical students, and increase health outcomes for future patients.

6. Intentional screening process for prospective medical students during the application process. There must be a focus on the holistic view of each applicant, with a strong emphasis on the social and interpersonal skills of the prospective students, which can be evaluated through programs such as the Computer-Based Assessment for Sampling Personal Characteristics (CASPer) exam, personal statement, letter of recommendations, and interview process. The applicant pool each year should widen the access to medical education for those students coming from underrepresented backgrounds.[24] The increase in medical students of color will add to the diversity of the staff, increase cultural competence amongst peers, and increase health outcomes for future patients.

7. Funding for pipeline programs that support URiM students (pre-Kindergarten to postgraduate) who aspire to pursue health professions. Supporting the next generation of health professionals will fuel the ideals we aim to implement and will shape their education on cultural sensitivity early. Serving as a sustainable tool in enhancing representative medicine and cultural sensitivity, we would be able to meet the demands of an ever-growing diverse patient pool by 2050.[25]

8. Obesity-related insurance coverage reform. Policy changes should focus on promoting weight loss through provider-guided counseling on weight management and using a personalized approach for each patient.

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