CITY OF BALTIMORE
COUNCIL BILL 06-0230R
(Resolution)

Introduced by: Councilmembers Welch, Curran, Young, Branch, Kraft, Mitchell, Clarke, Reisinger, Spector, Rawlings Blake, Harris, President Dixon, Councilmembers Holton, Conaway
Introduced and adopted: October 30, 2006

A COUNCIL RESOLUTION CONCERNING

1 **Organizational Hearing – Baltimore City Council Task Force**
2 **on Childhood Obesity – A Call to Action**

3 FOR the purpose of calling together school, preschool, and after-school personnel, health care
4 providers, parents, community groups, faith-based organizations, and other stakeholders in a
5 campaign to address the critical problem of childhood obesity by creating a partnership
6 across sectors with the mission to identify the specific roles that must be undertaken to
7 prevent the onset of childhood obesity, to formulate a plan to combat the escalation of the
8 problem among those children at-risk, and to devise a medical and behavioral treatment
9 model to treat the diseases caused by this epidemic and to prevent the onset of sickness in the
10 target population.

11 **Recitals**

12 In a research brief published in August 2004, the National Institute for Health Care
13 Management (NIHCM) Foundation reported that childhood obesity in the U.S. is threatening
14 child health gains made over the past 3 decades. A study by the Centers for Disease Control and
15 Prevention (CDC) concluded that poor diet and inactivity are close to overtaking cigarette
16 smoking as the leading cause of preventable death and that at this rate the current generation of
17 children will not live as long as their parents.

18 The prevalence of childhood obesity in the United States, it was reported, is growing rapidly
19 for children of all ages – over 15% of children ages 6-19 were overweight in 2000; for 6-11 year
20 olds, the percentage is double the prevalence in 1980; the impact is even greater for 12-19 year
21 olds with triple the rate; and even more alarming is the increase in overweight among young
22 children 2-5 years old, from 7% 10 years ago to 10% in 2000.

23 By 2004, the Centers for Disease Control (CDC) reports that overweight among children
24 aged 6-11 had reached 18.8% and for 12-19 year olds, 17.1%, and that an estimated 61% of
25 overweight young people have at least 1 additional risk factor for heart disease, such as high
26 cholesterol or high blood pressure. In addition, children who are overweight are at greater risk
27 for bone and joint problems, sleep apnea, and social and psychological problems such as
28 stigmatization and poor self esteem.

29 The American Obesity Association reports that many adverse health effects associated with
30 overweight are observed in children and adolescents:

EXPLANATION: Underlining indicates matter added by amendment.
~~Strike out~~ indicates matter deleted by amendment.

1 - **Asthma**: Prevalence of overweight is reported to be significantly higher in children and
2 adolescents with moderate to severe asthma compared to a peer group.

3 - **Diabetes (Type 2)**: The increase of Type 2 diabetes in children and adolescents in a
4 dramatically short time is most significantly impacted by a parallel increase in childhood
5 obesity. Obesity is the most significant factor in the skyrocketing increase in Type 2 in
6 children – from 2-4% of childhood diabetes before 1992, to 16% by 1994.

7 - **Hypertension**: Persistently elevated blood pressure levels have been found to occur 9
8 times more frequently among obese children and adolescents (ages 5 to 18) than in non-
9 obese.

10 - **Orthopedic Complications**: Among growing youth, bone and cartilage in the process of
11 development are not strong enough to bear excess weight. In young children, excess
12 weight can lead to bowing and overgrowth of leg bones, and increased weight on the
13 growth plate of the hip can cause pain and limit range of motion.

14 - **Psychosocial Effects and Stigma**: Adolescent females who are overweight have
15 reported experiences with stigmatization such as direct and intentional weight-related
16 teasing, jokes, and derogatory name calling, as well as less intentional, potentially hurtful
17 comments by peers, family members, employers, and strangers. Overweight children and
18 adolescents also report negative assumptions made about them by others, including being
19 inactive or lazy, being stronger and tougher than others, not having feelings, and being
20 unclean.

21 - **Sleep Apnea**: Sleep apnea, the absence of breathing during sleep, occurs in about 7% of
22 children with obesity. Deficits in logical thinking are common in children with obesity
23 and sleep apnea.

24 A study performed by officials from the Johns Hopkins School of Medicine, the Johns
25 Hopkins School of Public Health, and the Baltimore City Health Department, *Social Economic*
26 *Status and Obesity Among Urban Youth: A Geographic Analysis*, found, in part, that many
27 patients in urban school-based health centers are overweight or at-risk for overweight and that
28 gender, age, and individual level measures of poverty are associated with BMI.. Given the
29 number of affected students overall, exploration of the potential role of school-based
30 interventions for obesity prevention and intervention is essential.

31 To address this problem, the Baltimore City Council Task Force on Childhood Obesity is
32 formed, based on a model formed by the Institute of Medicine that was established in 1970
33 under the charter of the National Academy of Sciences to provide independent, objective,
34 evidence-based advice to policy makers, health professionals, the private sector, and the public.
35 The Institute of Medicine, in its role as adviser to the nation to improve health, was charged by
36 Congress, in 2002, with developing a prevention-focused action plan to decrease the number of
37 obese children and youth in the United States.

38 The Institute of Medicine's charge followed the 2001 U.S. Surgeon General's *Call to Action*
39 *to prevent and Decrease Overweight and Obesity* to stimulate the development of specific
40 agendas and actions targeting this public health problem that, in 2000, was causing 30% of boys
41 and 40% of girls to be at risk of developing Type 2 diabetes and causing obesity-associated
42 annual hospital costs to triple over 2 decades, rising from $35 million in 1979-1981 to $127
43 million in 1997-1999. After adjusting for inflation and converting 2004 dollars, the national

1 healthcare expenditures related to obesity and overweight in adults alone range from $98 billion
2 to $129 billion annually.

3 According to the 2005 Institute of Medicine report, *Preventing Childhood Obesity: Health in*
4 *Balance*, an aspiration for local governments is to provide coordinated leadership and support for
5 a collaborative effort of stake holders to increase resources and opportunities:

- 6 **Schools** should provide a consistent environment that is conducive to healthful eating
7 behaviors and regular physical activity by, in part, (1) developing and implementing
8 nutritional standards for all foods and beverages sold or served in schools; (2) ensuring
9 that all school meals meet the Dietary Guidelines for Americans; (3) ensuring that all
10 children and youth participate in a minimum of 30 minutes of moderate to vigorous
11 physical activity during the school day; (4) enhancing school health curricula; (5)
12 ensuring that schools are as advertising-free as possible; (6) conducting annual
13 assessments of students' weight, height, and body mass index and making that
14 information available to parents; and (7) assessing school policies and practices related to
15 nutrition, physical activity, and obesity prevention.

- 16 **Industry** should make obesity prevention in children and youth a priority by, in part, (1)
17 developing and promoting products and information that will encourage healthy eating
18 and regular physical activity; and (2) food and beverage industries should develop
19 product and packaging innovations that address total calorie content, energy density,
20 nutrient density, and standard serving sizes to help consumers make healthful choices.

- 21 **Parents** should (1) promote healthful eating behaviors and regular physical activity for
22 their children; (2) provide healthful food and beverage choices for children by carefully
23 considering nutrient quality and energy density; (3) assist and educate children in making
24 healthful decisions regarding types of foods and beverages to consume, how often, and in
25 what portion size; (4) encourage and support physical activity; (5) limit children's
26 television viewing and other recreational screen time to fewer that 2 hours per day; (6)
27 discuss weight status with their child's health care provider and monitor age and gender
28 specific body mass index (BMI) percentile; and (7) serve as positive role models for the
29 children regarding eating and physical activity behaviors.

- 30 **Community Programs**: Local governments, public health agencies, schools, and
31 community organizations should collaboratively develop and promote programs that
32 encourage healthful eating behaviors and regular physical activity, particularly for high-
33 risk populations.

- 34 **Built Environment**: (1) Local governments, private developers, and community groups
35 should expand opportunities for physical activity, including recreational facilities, parks,
36 playgrounds, sidewalks, bike paths, routes for walking or bicycling to school, safe streets
37 and neighborhoods, especially for high-risk populations; (2) communities should
38 prioritize capital improvement projects to increase opportunities for physical activity; and
39 (3) communities should improve the street, sidewalk, and street-crossing safety routes to
40 school, developing programs to encourage walking and bicycling to school and building
41 schools within walking and bicycling distance of the neighborhoods they serve.

- 42 **Health Care Sector and Providers**:(1) Pediatricians, family physicians, nurses, and
43 other clinicians should engage in the prevention of childhood obesity by routinely
44 tracking BMI, offering counseling and guidance, and providing leadership in their

1 communities for obesity prevention efforts; and (2) professional organizations should
2 disseminate evidence-based clinical guidance and establish programs on childhood
3 obesity prevention and training programs, and certifying entities should require obesity
4 prevention knowledge and skills in their curricula and examinations.

5 • **Government Leadership**: at all levels should provide coordinated leadership for the
6 prevention of obesity in children and youth. State and local government should (1)
7 provide coordinated leadership and support for childhood obesity prevention efforts,
8 particularly those focused on high risk populations, by increasing resources and
9 strengthening policies that promote opportunities for physical activity and healthful
10 eating in communities, neighborhood, and schools; and (2) support public health agencies
11 and community collaborative efforts to promote and evaluate obesity prevention
12 interventions.

13 In what might serve as an advisory model for the Baltimore City Council Task Force on
14 Childhood Obesity, San Mateo County, California translated the Institute of Medicine's
15 guidelines for a childhood obesity initiative into the *Blueprint For Prevention of Childhood*
16 *Obesity – A Call To Action: A Community Health Improvement Initiative to Eliminate Health*
17 *Disparities.* The county's action plan incorporates 5 priority areas:

18 • **Priority Area 1**: Community/Environment - goal to improve and sustain access to
19 healthy food and physical activity at the community organizational, and environmental
20 levels.

21 • **Priority Area 2**: Schools - goal to improve and sustain access to healthy food and
22 physical activity in the school setting.

23 • **Priority Area 3**: After School - goal to improve and sustain healthy eating and physical
24 environments in the "after school"setting.

25 • **Priority Area 4**: Preschool/Child Care Services - goal to improve nutrition and physical
26 activity environments in the preschool and child care services setting.

27 • **Priority Area 5**: Healthcare - goal to improve and sustain access to healthy nutrition and
28 physical activity information and environments in the healthcare setting.

29 In forming this Task Force on Childhood Obesity, the City Council will work to ensure that
30 our children live healthier, happier, educational childhoods that transition into personally
31 rewarding, socially meaningful and economically productive adult hoods.

32 **NOW, THEREFORE, BE IT RESOLVED BY THE CITY COUNCIL OF BALTIMORE**, That this
33 Body is calling together school, preschool, and after-school personnel, health care providers,
34 parents, community groups, faith-based organizations, and other stakeholders in a campaign to
35 address the critical problem of childhood obesity by creating a partnership across sectors with
36 the mission to identify the specific roles that must be undertaken to prevent the onset of
37 childhood obesity, to formulate a plan to combat the escalation of the problem among those
38 children at-risk, and to devise a medical and behavioral treatment model to treat the diseases
39 caused by this epidemic and to prevent the onset of sickness in the target population.

40 **AND BE IT FURTHER RESOLVED**, That membership on the Task Force shall include, but not
41 be limited to, representatives from:

- Baltimore City Health Department
- Baltimore City Public Schools
- Baltimore Parent/Teacher Associations and Organizations
- Community Associations listed in the Planning Department Directory
- Mayor's Office of Children and Youth
- Interdenominational Ministerial Alliance
- NAACP
- Pepsi Cola, Inc.
- Baltimore Ravens
- Baltimore Orioles
- Johns Hopkins School of Public Health
- area hospitals
- area institutions of higher learning
- the Greater Baltimore Committee
- the Chamber of Commerce

AND BE IT FURTHER RESOLVED, That a copy of this Resolution be sent to the Mayor, the Commissioner of Health, the CEO Baltimore City Public School System, Community Associations of the Planning Department Directory, the Executive Director of the Mayor's Office of Children and Youth, the Chair of the Interdenominational Ministerial Alliance, the President of the Baltimore NAACP, the Dean, Johns Hopkins School of Public Health, and the Mayor's Legislative Liaison to the City Council.