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Obese Children Ages 5-10 in Los Angeles

Research Paper

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Introduction

Obesity among children has turned to be an epidemic affecting children all around different nations. An inspiring quote shared by Thomas Richard Harkin, a former United States Senator who served from 1985 to 2015 was, “If we are serious about combating the childhood obesity epidemic and improving child nutrition, then everyone must chip in – parents, schools, and yes even Congress”. The high-risk behavior topic for this analysis will be focusing on overweight and/or obesity on children of ages 5 to 10. The World Health Organization (2020) defined obesity as accumulation of abnormal or excessive fat that impairs the health of a child or an adult and their ability to do daily activities. Statistics given by WHO (2020) shows that in 1975 only 1% of children/adolescents between the ages of 5 and 19 were obese, whereas now in 2016, more than over 340 million worldwide children/adolescents reported being obese. The spotlight of the analysis is on children in Los Angeles “Los Feliz Elementary School”. There are countless of negative health outcomes that could be associated to this behavior. Some health risks for children who are obese shared by the Centers for Disease Control and Prevention (2021) are high blood pressure and cholesterol, breathing problems such as asthma, musculoskeletal discomfort, fatty liver disease, and the child may have a low self-esteem. In this analysis, epidemiological data will be covered to understand how children who are overweight/obese are negatively impacted. A list of risk factors for this behavior will be described, in addition to modified risk factors for individual, relationship, and community level to understand how childhood obesity can be prevented, and to acknowledge how activities can be improved to reduce the numbers of this high-risk behavior.

Epidemiological Data/Prevalence

Childhood obesity is a serious problem among all children around the world. In the following, the prevalence of childhood obesity in the United States will be explained to understand the population of the affected children putting them at risk for poor health. Based on the data estimated by The Centers for Disease Control and Prevention (2021), they stated that in 2017-2018, the prevalence of obesity was 19.3%, and a total of 14.4 million children from the ages 2 to 19 were affected. For children of ages 2 to 5, the obesity prevalence was at 13.4%, and for adolescents of age 6 to 11 was at 20.3%. The obesity prevalence among children and adolescents continues to grow. The childhood obesity population differentiates depending on the age, race/ethnicity, levels of income, the access to nutritional food, and the style of living, for example the access to safely exercise or playground outdoors. According to the Centers of Disease Control and Prevention, "Obesity prevalence was 25.6% among Hispanic children, 24.2% among non-Hispanic Black children, 16.1% among non-Hispanic White children, and 8.7% among non-Hispanic Asian children" (2021). The CDC compared the child obese prevalence by race. By looking at the percentage, Hispanic children have the highest prevalence of obesity. Hispanic families tend to eat more heavy food with higher sodium.

Modifiable Risk Factor- Individual Level

Children can experience stress for multiple reasons, such as pressure inflicted at home due to lack of outdoor activities to distract themselves. Parents may maltreat them increasing the chances to raise their levels of pressure and/or anxiety. In addition, school, peer pressure, and difficulties to complete homework may also raise their levels of stress.

They could also experience anxiety due to any physical and emotional abuse. Studies have shown that maltreatment/abuse, and anxiety could decrease or increase the appetite of a person. Childhood trauma is considered a major risk to develop eating disorders. Eating disorders are associated with binge eating and bulimia nervosa, which increases the risks of becoming overweight or obese.

The research article that focuses on child abuse, and neglect confirmed that any abuse towards the child increases the chances of eating disorder. In the study Imperatori et al. stated, "Specifically, the authors showed that: (i) childhood physical abuse was related to any eating disorders; (ii) childhood emotional abuse and sexual abuse were significantly and positively associated with both bulimia nervosa and binge eating disorder; and (iii) the relationship between childhood sexual abuse and anorexia nervosa was not significant after controlling for publication bias (Imperatori et al. 2016)). Trauma can make a child feel anxiety and fear which increasingly raises the chances for them to not understand what is right to do but instead escape by eating. In addition, the study pointed out, "CT severity was moderately and positively associated with both FA ($r = 0.37$; $p < 0.001$) and BE ($r = 0.36$; $p < 0.001$) severity" (Imperatori, Innamorati et al. 2016). This evidence-based data is informing that childhood trauma has been positively associated with food addiction, and binge eating. Therefore, the article states that exposure to traumatic events during childhood can elevate the risks of being obese not only as a child but as well as an adult. The results from the study have suggested that clinicians should assessed the case of childhood trauma among everyone who report dysfunctional eating patterns carefully. In addition to childhood trauma, it is associated with severe psychological problems such as anxiety, and depressive symptoms. Additionally, the study suggests that treatments should be given for individual who are overweight and/or obese with a history of childhood trauma.

Modifiable Risk Factor- Relationship Level

Relationship level is considered the connection or circumstances that happens between two or more people. Negative issues that occur between the parents or guardians of the child could possibly increase the chances to childhood trauma, and obesity. The parents or guardians of the child may bring stress that could affect the household. Due to the severe housing-cost in the United States focusing in metropolitan areas such as in New York, San Francisco, and Los Angeles it is affecting low-income families. Difficulties to pay mortgage or rent increases the stress or tensity in families, and on children from ages 5 to 10. A child could be considered underage or "little" to understand the conflict or struggles that their parents or guardians are facing. Children may not understand the actual reason of the argument, but they do feel, see, and hear the tension, and stress of parents.

Housing is a primary, and basic need that a human being cannot live without. Owning a shelter provides a safety and healthy environment for an individual, and families. As mentioned before, difficulties to financially meet mortgage or rents costs every month can be a major stress for the head of the family. Experiencing chronic stress among this issue can create a cold and neglectful habitat for the child resulting in uncertain confidence among their parents or guardians (Nobari, Whaley, Blumenberg et al. 2019). Chronic stress affects the connection between parents and children in multiple ways. According to the study, "Stressed parents might also be less inclined to cook for their children, relying instead on highly-caloric fast food" ((Nobari, Whaley, Blumenberg et al. 2019). Low-income families may not only struggle in paying the monthly mortgage payments but as well to afford nutritional food. The majority of the nutritional food prices such as salmon, fruits, vegetables, and multiple types of nuts ranges in the highest prices

at grocery stores. Using a sociodemographic table with the results from a survey held by Los Angeles County WIC (Women, Infants, and Children), the percentage of severe housing cost burden for Hispanic was 84.7%. The percentage for Hispanic is the highest compared to other races such as White, African American, Asian, and others. Those in severe housing cost burden had a percentage of 39.5% of some high school, and 23.7% with no high school at all. The results for college were at 36.8%. Moving on, the results continued to exceed, for those who rented their percent was at 69.5%. Therefore, the percentage ranged very high for those who lived with relatives which was 24.8%, compared to those who lived on their own it was 4.6% which ranged extremely low. Lastly, Food insecurity among those in severe costing burden it was at 54.5%, and for childhood obesity it was 21.5%, who continued to be at the highest compared to those with no severe housing cost ((Nobari, Whaley, Blumenberg et al. 2019. The program concluded that housing-cost burden and chronic stress are major risk factors for childhood obesity.

Modifiable Risk Factor- Community Level

A community plays major importance in the health of children. A safe community always guarantees safe outdoor activities for children to maintain their body active, and with motivation to get daily chores done. Communities, neighborhoods, environmental factors, social economic status, health care, and school education are all sectors with high chances of affecting child obese. Having access to a grocery stores in their hometown that offers safe food such as fruits, and vegetables could help prevent, and reduce the number of those children who are obese. Most towns offer fast-food places which is easier and faster to go buy in a busy day. Fast-food places are a major risk for obesity for those families who do not have control over buying daily. A

program called CA-CORD held a study of 1,183 children of ages 2 to 11 years to change body mass index, and to improve four health behaviors such as increasing the consumption of fruit, vegetables, and water, and improve physical activity, and number of hours of sleeping.

As a result, many agreed to participate on the study such as a total of three community health care clinics, thirteen early care/education centers, and eleven schools. According to the study, "…respondents from these organizations were aged 45 years and had been with their organization for 8 years. Most were female (86%) and Latino/Hispanic (69)" (Chuang, Brunner, Moody, Ibarra, et al. 2016). It is gratifying to observe how many clinics, centers, and schools volunteered to promote changes for better to help improve the health of children who are considered overweight and/or obese. In the following, a demonstration of results will be listed down to understand how the respondents contributed to the study. The three health care clinics stated, "Clinics previously distributed educational materials to families but otherwise no experience promoting healthy behaviors among children" (Chuang, Brunner, Moody, Ibarra, et al. 2016). Those in early care, and education centers only 10 out of 13 had experience on programs promoting healthy behavior among children, and adults. Lastly, all eleven schools did had experience with programs on promoting healthy behaviors among children. It is not surprising that these schools did had experience since their may main dedication is to serve children, and adolescents.

Based on the results from the three-sector mentioned, there were multiple barriers. In the health care sector, community health workers would delay implementation of workshops to educate the families. In the school sector, "turnover of principals and other administrative personal negatively affected leadership support for CA-CORD" (Chuang, Brunner, Moody,

Ibarra, et al. 2016). Lastly, most of the early care and education centers are large agencies that had to purposely rotate staffs each year. In addition, the providers and supervisor of these centers was a major barrier that needs to be closely planned out before implementing a study or program. These respondents shared their frustration on that their efforts to promote the healthy behaviors for children were not taken in consideration by other members in the population or community due to limited resources or lack of support. Moreover, parents of children were not seriously engaging to the implementation of improving the behaviors due to income or language barriers. However, the respondents of these study continued to distribute materials to parents that could be useful at home.

Conclusion

In conclusion, this analysis focuses on discussing the overweight and/or obese among children from the ranging age of 5 to 10. Obesity has multiple risk factors that could affect the child health, development, and their future life as an adult. During this analysis, the prevalence of obesity among children was higher in Hispanics. As cultural competence, additional help could be offered to provide services in Spanish since this is the preferred language for Hispanics families. For families who are in low-income, programs could offer free nutritional foods for a limited of time to help the child to begin eating healthy. The communities can work together to provide safer walk-side so that students could walk before or after school toward their destination. Neighborhoods should gather up and bring awareness all together for safeness. Having a safe town or neighborhood can allow children to play outdoors, or exercise after school rather than staying in watching T.V. or playing video games. Many Hispanics parents do not speak English, most of the statistical data information online is found English, not in Spanish or

their preferred language. As a community changes can be made to inform parents or guardians that the rates of childhood obesity are increasing. After school programs could properly inform parents by helping them understand the high risks factor and demonstrate nutritional food guidelines for their children of the grade taught at that school. Promoting a safe nutritional food guideline could convince parents or the guardian of the child on changing their eating habit or style.

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