



March 3, 2016

Testimony before the Committee on Children in support of HB 5303: An Act Concerning Childhood Obesity

Chairwomen Bartolomeo and Urban and members of the Committee, my name is Sally Mancini and I am the Director of Advocacy Resources at the UConn Rudd Center for Food Policy and Obesity. The Rudd Center's mission is to promote solutions to childhood obesity, poor diet, and weight bias through research and policy. We believe that every child, regardless of who they are, where they live, and what they look like, deserves the opportunity to eat healthfully.

I am here today in support of HB 5303: An Act Concerning Childhood Obesity. I will focus my comments on the first two sections of the bill. In addition to providing an evidence-base for these provisions, I will also offer suggestions on ways to strengthen the current language in the bill in order to align Connecticut statutes with the best available science and practice.

Early childhood is a critical time for obesity prevention. According to the Centers for Disease Control, 8.4% of children in the United States between the ages of 2-5 are overweight or obese, with much higher rates among Latino and black children.ⁱ In Connecticut, 15.8% of 2-4 year olds from low-income families are obese.ⁱⁱ Research shows that if a child is obese by the age of 5, it is very difficult to reverse the trend. A recent study published in the *New England Journal of Medicine* found that an overweight 5 year old is four times more likely than their normal weight counterpart to become obese by age 14.ⁱⁱⁱ

Childhood obesity negatively impacts the physical and mental health of millions of young children. Obese children are at a much higher risk for developing type 2 diabetes and high blood pressure *before* reaching adulthood.^{iv} Rudd Center research confirms that children who are obese are more likely to experience weight-based bullying and discrimination from peers.^v

Furthermore, the costs of obesity on the United States economy are staggering. One research study found that if spending for obesity-related chronic conditions continues unchecked, healthcare costs could increase as much as \$66 billion per year by 2030.^{vi}

Early childhood programs present an opportunity for obesity prevention policies. It is estimated that 75% of children spend time in child care, for an average of 35 hours per week.^{vii} Given the amount of time that children are in child care, it is an ideal setting to provide a healthy environment for children to eat, play, and grow. Child care providers can also offer support and resources for parents on healthy foods and beverages and ways to increase physical activity.



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The Rudd Center has been a longstanding partner with the Connecticut State Department of Education and other community organizations in promoting strong nutrition standards in early childhood settings. We worked collaboratively on the Child and Adult Care Food Program (CACFP) Nutrition and Physical Activity Project, which led to the development of an Action Guide and the Connecticut Child Care Nutrition Standards (CCCNS). CCCNS is a voluntary set of standards reflecting current nutrition science and national health recommendations. Additionally, through our early childhood research, we have found that Connecticut's Head Start early childhood programs have stronger nutrition policies than other child care centers in the state. This bill would assist non-Head Start centers in improving their nutrition standards and allow for equity across the state.^{viii}

Connecticut is not alone in supporting obesity prevention in early childhood. Similar legislation addressing the food and beverage environment in child care centers has already passed in California, Maryland, and Texas. There is also legislation pending in Hawaii this year.

Sugary drink consumption among young children is cause for concern. Sugary drinks (soda; fruit, energy, and sports; sweetened teas and waters) have become a staple of the American diet. These drinks are inexpensive, in abundant supply, and are highly appealing. They are heavily marketed to children, and especially black and Latino children, often using celebrities and sports stars.^{ix} Drinking 1-2 sugary drinks per day puts people at a 26% higher risk for type 2 diabetes compared to those who drink less than one/month.^x More than half of toddlers consume one or more servings of sweetened beverages per day.^{xi} For every additional daily serving of sugar sweetened beverages, a child's risk of becoming obese increases by 60%.^{xii}

Section 1 of this bill addresses the consumption of sugary drinks in the childcare setting. The Rudd Center wholeheartedly supports these provisions. We have learned from our food marketing research that many people believe that fruit drinks such as Sunny D®, Hawaiian Punch®, Capri Sun®, and Hi-C® are actually 100% juice, especially when their labels advertise 100% Vitamin C.^{xiii} The way food is marketed is at times misleading and can cause confusion. The Committee may want to consider explicitly identifying beverages with added sweeteners, including, but not limited to, soda, fruitades, fruit drinks, and sports and energy drinks in Section 1(b).

In section 1(c) we recommend increasing the age prohibition for juice to under 12 months of age. The bill currently prohibits child care centers from providing juice to any child under 9 months of age. This change aligns the language in the bill with the USDA's proposed rule on updated meal pattern guidelines for CACFP.^{xiv} These guidelines will most likely be issued in a final rule by the USDA later this year and are based on recommendations by the American Academy of Pediatrics and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

We also recommend decreasing the amount of juice offered in a child care setting to 4 ounces from the 8 ounces that is currently in the bill. This change aligns the language in the bill with the current CACFP guidelines.

Increasing the availability and accessibility of drinking water in child care centers is another strategy to decrease sugary drink consumption in young children. The Rudd Center has published research on this



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topic and found that many child care centers needed additional guidance and support to adhere to federal guidelines promoting water consumption in the 2010 Child Nutrition Reauthorization Act.^{xv}

The importance of limiting screen time in early childhood settings. The Rudd Center fully supports the current language in Section 2 of the bill. Screen time provides no educational benefits for children under age 2 and leaves less room for activities that do, like interactions with peers and physical activity. The American Academy of Pediatrics also points to the health risks of excessive media usage by children.^{xvi} We would recommend adding guidelines for screen time for children 2 years of age or older in the early childhood setting, including limiting television, recorded media, and video time to 30 minutes per week and limiting computer and tablet time to non-consecutive 15 minute increments not to exceed 30 minutes per day.

A recent modeling study using National Health and Nutrition Examination Survey data found that to return childhood obesity rates to the level they were in the 1970s, the average caloric intake for children ages 2-5 would need only to decrease by 50 kcal/day.^{xvii} The elimination of sugar-sweetened beverages, easy access to drinking water, limiting of screen time, and increasing physical activity in the child care setting would significantly reduce caloric intake among young children.

Thank you for the opportunity to testify on such an important public health issue impacting the youngest and most at-risk children in our state. We are happy to answer questions and provide further research on this topic.

ⁱ Ogden CL, Carroll MD, Kit BK, Flegal KM. Prevalence of childhood and adult obesity in the United States, 2011-2012. *JAMA*. 2014; 211(8): 806-14.

ⁱⁱ The State of Obesity. Trust for America's Health and the Robert Wood Johnson Foundation. URL <http://stateofobesity.org/states/ct> Accessed February 26, 2016.

ⁱⁱⁱ Cunningham SA, Kramer MR, Narayan KM. Incidence of childhood obesity in the United States. *N Engl J Med*. 2014; 370(5): 403-11.

^{iv} F is for fat: how obesity threatens America's future. Trust for America's Health and the Robert Wood Johnson Foundation. 2012. URL <http://healthyamericans.org/report/108/> Accessed February 26, 2016.

^v Puhl R, Latner J, O'Brien K et al. Cross-national perspectives about weight-based bullying in youth: nature, extent, and remedies. *Pediatric Obesity*. 2015. URL http://www.uconnruddcenter.org/files/Pdfs/Puhl_et_al-2015-Pediatric_Obesity.pdf. Accessed February 26, 2016.

^{vi} Wang CY, McPherson K, Marsh T et al. Health and economic burden of the projected obesity trends in the USA and the UK. *Lancet*. 2011; 378:815-25.

^{vii} U.S. Census Bureau, Economic Research Service. Who's Minding the Kids? URL <http://www.census.gov/prod/2010pubs/p70-121.pdf>. Accessed February 26, 2016.

^{viii} Falbe J, Kenney E, Henderson K, Schwartz M. The Wellness Child Care Assessment Tool: A measure to assess the quality of written nutrition and physical activity policies. *Journal of the American Dietetic Association*. 2011; 111(12):1852-1860.



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- ^{ix} The Rudd Center for Food Policy and Obesity. www.sugarydrinkfacts.org
- ^x Malik VS, Hu FB. Sweeteners and risk of obesity and type 2 diabetes: The role of sugar-sweetened beverages. *Current Diabetes Report*. 2012; 12(2): 195-203.
- ^{xi} Institute of Medicine (IOM), Early Childhood Obesity Prevention Policies. Washington DC: The National Academies Press. 2011.
- ^{xii} Ludwig DS, Peterson KE, Gortmaker SL. Relation between consumption of sugar-sweetened drinks and childhood obesity: a prospective, observational analysis. *Lancet*. 2001;357:505-508.
- ^{xiii} Munsell C, Harris J, Vishnudas S, Schwartz M. Parents' beliefs about the healthfulness of sugary drink options: opportunities to address misperceptions. *Public Health Nutrition*. 2015; 1-9.
- ^{xiv} The proposed rules under consideration by the USDA would “prohibit the service of fruit juice to infants through 11 months. Summary of the Major Provisions of the Regulatory Action in Question. Federal Register. Child and Adult Care Food Program: Meal Pattern Revisions Related to the Healthy, Hunger-Free Kids Act of 2010. URL: <https://www.federalregister.gov/articles/2015/01/15/2015-00446/child-and-adult-care-food-program-meal-pattern-revisions-related-to-the-healthy-hunger-free-kids-act#h-13>. Accessed March 1, 2016.
- ^{xv} Middletown A, Henderson K, Swartz M. From Policy to Practice: Implementation of Water Policies in Child Care Centers in Connecticut. *Journal of Nutrition Education and Behavior*. 2013; 45(2): 119-125.
- ^{xvi} American Academy of Pediatrics “Media and Children.” URL <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Pages/Media-and-Children.aspx> Accessed on February 23, 2016.
- ^{xvii} Wang YC, Orleans CT, Gortmaker SL et al. Reaching the healthy people goals for reducing childhood obesity: closing the energy gap. *Am J Prev Med*. 2012; 42(5): 437-44.

