Background and purpose of the meeting
On June 22 and 23, 2015, The American Academy of Pediatrics (AAP) Institute for Healthy Childhood Weight (the Institute) convened a meeting of experts from a variety of fields and sectors to discuss and highlight the policy opportunities for pregnancy and the first year of life (the P-1 period) with the greatest potential to prevent childhood obesity. Attachment 1 lists the meeting’s attendees.

This meeting was the first of three such roundtables to be convened by the Institute and sponsored by the Robert Wood Johnson Foundation (RWJF), as part of the AAP focus on healthy childhood weight and RWJF’s ongoing childhood obesity initiative, which seeks to insure that, by 2025, 85 percent of children will be at a healthy weight, no matter who they are or where they live. The goal of this series of meetings is to identify and prioritize the most strategic and powerful obesity prevention policy opportunities in the window between pregnancy and a child’s fifth birthday, with a focus on high-risk populations.

“Obesity is the canary in the mine for what’s not working well for our children,” noted Sandra Hassink, M.D., the chair of the roundtable series’ project advisory committee. Hassink then stressed the developmental nature of the roundtables’ approach to policy: that it is critical to work from the various evidence-informed protective and risk factors that fall along the developmental timeline of a pregnant woman and infant, using these as the focal points for intervening. Focusing on the factors that affect a mother and her child in the progression from pregnancy to childbirth through infancy highlights opportunities for policy that are anchored in the needs of mothers and children, rather than in the functions of institutions. “By doing it this way,” Hassink said, “you break down the…silos that occur when you look at sectors or levels.”

The second key aspect of the roundtable’s approach was its emphasis on examining policy opportunities through the lens of vulnerable populations. Current trends that show a tempering of the growth of childhood obesity “are not favoring children who are most impoverished,” Hassink observed; race/ethnicity and geography also enhance risk factors for obesity—and an effective policy agenda needs to recognize, and address, such issues.

Summary: the policy recommendations from this roundtable
With this context in mind, roundtable participants moved through a series of discussions and exercises (attachment 2 contains the meeting’s agenda). By the end of the second day, the participants identified:

- A set of new policies, or significant revisions of existing policies, warranting consideration (Box 1).
- A set of existing policies relevant to the P-1 period that should be reaffirmed (Box 2).

While these two sets of policies form the core of this roundtable’s recommendations, in the course of the meeting participants also developed a larger collection of policies and policy gaps warranting ongoing focus. Table 1, on pages 5-6, contains this list.
Set 1: The new/revised policies

Roundtable members followed the process described below to identify 13 new or significantly revised policy areas for consideration (Box 1). At the end of the meeting, participants informally prioritized these; two of the 13 were widely endorsed while support for the remainder was more evenly distributed. Roughly in their order of prioritization, these 13 policies were:

- Institute reimbursement for weight management services during pregnancy.
- Develop and implement a guideline to counsel about breastfeeding, screen for food insecurity, and refer to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), the Supplemental Nutrition Assistance Program and the Food Distribution Program on Indian Reservations during pre-partum, pregnancy and infancy periods.
- Establish a home visitation program for all expectant mothers and new families (from 16 weeks gestation through at least age 1); participation would be assumed although women and families would have the option to opt-out of the program.
- Make group prenatal and postnatal care (aligned to gestational age) accessible to all pregnant women; again, participation would be assumed although women would have the option to opt-out of this type of care.
- Insure health care providers and institutions are not used to co-market infant formulas.
- Integrate healthy weight competencies into health care provider training.
- Reaffirm the Institute of Medicine’s guidelines for weight management during pregnancy, and revise the guideline for women with greater than Class II obesity to advise that, with appropriate fetal monitoring, women in this category not gain any weight during pregnancy.
- Reiterate and elevate existing recommendations for physical activity during pregnancy, i.e., for 150 minutes of moderate-to-vigorous physical activity per week, and/or 75 minutes vigorous physical activity in women for whom there is no contraindication.
- Institute universal paid parental leave with post-partum health benefits for mothers.
- Promote broader awareness and uptake of baby-friendly clinic designation.
- Include, as a condition for funding food retail under the Healthy Food Financing Initiative and comparable programs, limits on product placement and promotion of unhealthy beverages.

Box 1: Recommended new/revised policy opportunities for the P-1 period:
- Reimbursed weight management services in pregnancy
- Guidelines for breastfeeding support and food insecurity screening
- Home visits for expectant mothers and new families
- Group pre- and post-natal care that is accessible to all
- No co-marketing of infant formula by health care institutions
- Healthy weight competency training for health care providers
- Broader circulation and updating of IOM weight management guidelines for pregnancy
- Greater use of recommendations for physical activity in pregnancy
- Universal paid parental leave and post-partum health benefits
- Broader uptake of baby-friendly clinic designation
- Increased limits on the promotion of unhealthy beverages
- Improved sharing of successful strategies
- Healthy weight competency training for early childhood educators
- Convene a cross-sectional group of those providing services to pregnant women and infants to analyze what is already being done in each sector and how these approaches could be shared.
- Integrate healthy weight competencies into early education and child care provider training.

**Set 2: The reaffirmed policies**

Roundtable participants also reviewed a comprehensive list of existing evidence-based or evidence-influenced policies or policy recommendations for preventing childhood obesity during the P-1 period, and identified a subset of these as warranting reaffirmation, i.e., of value for this developmental period whether currently implemented or not, and needing at most minor modification. Box 2, at left, lists these policies.

**Building the context for these recommendations**

In developing these recommendations, roundtable participants first discussed and clarified a number of aspects of the essential building blocks for any policy. These included:

- What does the evidence show are factors in pregnancy and the first year of life that protect against childhood obesity, or that, conversely, increase its risk? What should a policy strategy seek to strengthen, and what should it seek to mitigate?

- What opportunities and threats occur in the environment, and should inform policy?

- What characteristics should be considered when developing and/or assessing policy?

**Protective and risk factors**

As its first task, roundtable participants reviewed, amended and reached consensus on a set of evidence-based factors, relevant from preconception through the first year of life, that may either protect against, or increase the risk of, childhood obesity. Figure 1 and Figure 2, below, presents these factors—aligned along a developmental timeline (and with the concomitant opportunities and threats to be discussed below)—in graphic form.

**Box 2: Reaffirmed existing policies for the P-1 period:**

- Payment for Body Mass Index screening
- Support for breastfeeding in public places
- Standard methods for weight and height/length measurement
- Facilities for nursing mothers
- Government agencies to promote access to affordable healthy foods
- Support for baby-friendly hospitals
- The Affordable Care Act’s provisions for prenatal care, breastfeeding and access to health services
- Promotion of exclusive breastfeeding for six months and continuation for one year or more
- Smoke-free policies
- Access to safe, clean drinking water
- Restrictions on the availability of sugar-sweetened beverages
- Support for physical activity in the built environment
- Menu labeling
Obesity Prevention: Can a Developmental Perspective Inform Policy? (Pregnancy)

**PROTECTIVE AND RISK FACTORS**
- Genetics
- Healthy weight prior to pregnancy (maternal and paternal)
- Emerging Areas: endocrine disrupters, antibiotics (food and medicinal), food additives, maternal depression
- Smoking during pregnancy
- Appropriate maternal weight gain during pregnancy
- Gestational diabetes
- Maternal undernutrition during pregnancy
- Regular exercise during pregnancy
- Healthy diet (quality and quantity)
- Prenatal care and breastfeeding/lactation classes
- Full term healthy weight baby
- Breastfeeding initiation
- Returning to a healthy weight after pregnancy sets the stage for healthy future pregnancies.
- Parents as role models and authoritative parenting style

**OPPORTUNITIES AND THREATS**
- 1 in 5 American women is obese at the start of pregnancy
- Most pregnant women have between 10-15 prenatal visits
- Of the women who smoked 3 months before pregnancy only 55% quit during pregnancy
- Less than 1 in 3 women gain within the IOM pregnancy weight guidelines
- 18% of pregnant women develop gestational diabetes. American Indian, African American, Asian, and Hispanic and women over 35 are most at risk.
- 52% of pregnant women enroll in WIC during their 1st trimester of pregnancy.
- Participation in lactation and infant care classes during pregnancy linked to breastfeeding success and better capacity to soothe the infant.
- 1 in 4 pregnant women get the recommended amount of exercise
- Prevalence of low birthweight is higher for African American infants
- Prevalence of high birthweight is higher for American Indian or Alaska Native infants
- Baby-friendly hospitals have elevated rates of breastfeeding initiation and exclusivity. Only 8% of live births in the U.S. occur in baby-friendly hospitals
- Peer support and lactation specialists are positively associated with increased breastfeeding rates (across all populations)
Obesity Prevention: Can a Developmental Perspective Inform Policy? (Infancy)

PROTECTIVE AND RISK FACTORS

- Full Term Healthy Weight Baby
- Breastfeeding exclusively for 12 months
- Appropriate bottle feeding (proper formula preparation, no bottle propping, nipple size, etc)
- Understanding hunger and satiety cues
- Healthy sleep routines
- Appropriate complementary food introduction (1, timing 2, variety of foods and textures)
- Healthy Drinks (Offer H2O and limit juice and SSBs)
- Foster self-feeding
- Healthy Snacking (appropriate timing, amount, and quality)
- Establish food, activity, and snacking routines
- Daily active play to foster motor development
- Limited exposure to screens

OPPORTUNITIES AND THREATS

- - 80% of mothers intend to breastfeed exclusively but only 14% are exclusively breastfeeding at 6 months
- Transition home is critical period when breastfeeding decreases
- Significant decrease in breastfeeding rates when mothers return to work
- Disparities in breastfeeding by race/ethnicity, socioeconomic status, and geography persist
- Young maternal age, low educational level, smoking during pregnancy, and cultural factors are associated with early food introduction
- There are 8 pediatric well-visits in the first year of life.
- Infants who spend too much time in confining equipment experience delayed motor skills
- 80% of 6-9 month old infants drink juice regularly, WIC recipients are more likely to introduce juice early
- Significant drop in fruit and vegetable intake and increase in non-nutritive finger and snack foods at 9 months
- The most common snack foods are cereal, cookies, crackers, and French fries
- 19% of 1-year-olds have a TV in their bedroom
As it discussed these factors, roundtable participants observed:

- It is important to think about the genetic risk for obesity in terms of epigenetics: “Call it that,” one participant said, “because that’s modifiable.”

- While noting that the promotion of breastfeeding is an area particularly amenable to policy intervention and serves to highlight the issue of appropriate nutrition for infants, participants agreed that the appropriate related policy target was really to “normalize” breastfeeding through dissemination of current guidelines, education, peer support and institutional change.

- Participants discussed how other aspects of infant feeding are also critical: “there’s more evidence that bottle feeding is a risk factor [for obesity] than that breast feeding is protective,” one roundtable member noted. Responsive feeding practices that build an understanding of hunger and satiety cues, following best practices for formula feeding and the appropriate introduction of complementary foods were all cited as protective factors that should be emphasized.

- Roundtable members emphasized the importance of the specific ways in which poverty manifests itself as a risk factor for childhood obesity. Stress during pregnancy, adverse childhood experiences for both mother and child, food insecurity, access to health services, and opportunity for exercise all can be affected by socio-economic status.

**Opportunities and threats**

Figure 1 also displays, on the same developmental timeline, several key factors that either provide opportunities for policy-based interventions or might threaten the effectiveness of a policy strategy. These can therefore inform the timing and appropriate sector or change agent for a given policy. For example:

- Prenatal and first-year well-child visits, the WIC program and hospitals all are structures playing a major role in pregnancy and infancy and therefore provide opportunities for education about, and support of, factors that protect against childhood obesity.

- Basic statistics about women’s weight at the start of pregnancy, their weight gain and exercise levels during pregnancy, breastfeeding percentages and food consumption patterns in older infants show both the extent of the problem and the potential opportunity for policy to have an impact.

- Many of these opportunities and threats highlight the impact of socio-economic, racial and ethnic disparities on the incidence of gestational diabetes, low- or high-birth weight, breastfeeding and early food introduction.

**Characteristics to be sought**

Roundtable participants reviewed a list of characteristics previously identified as needing to be considered when assessing and drafting policy recommendations, and then further refined them. In summary, participants recommended that policies be evaluated on the extent to which they are:

- Designed to reach those in most need
- Able to promote health equity
- Targeted to pregnant women, infants, or the mother/infant dyad
• Feasible and low-cost to implement
• Politically feasible
• Evidence-informed
• Actionable at the local, state and federal level
• Supportive of community buy-in and involvement
• Able to yield cost saving or cost avoidance, ideally without a large initial investment
• Sustainable
• Designed to include some mechanism for enforcement/accountability.

Assessment of existing policies and policy gaps
The final piece of contextual work undertaken by roundtable participants involved review of a comprehensive list of existing evidence-based or evidence-influenced policies or policy recommendations for preventing childhood obesity during the P-1 period (attachments 3 and 4). Participants then voted to categorize each of these policies as warranting reaffirmation (valuable, or valuable with minor updating even if not being currently implemented), revision (needing updating or other refining in order to have the potential to affect populations at greatest risk) or retirement (no longer valuable).

The policies warranting reaffirmation and revision fell into two tiers: the first tier received overwhelming support from roundtable participants. The second tier generated less consensus for reaffirmation or revision at this roundtable meeting, often because these policies related more generally to health and well-being than specifically to the P-1 period.

“Tier 1” policies for reaffirmation became part of the recommendations of this roundtable and are listed in box 2 on page 3. Attachment 5 lists the “tier 2” policies to be reaffirmed. Attachment 6 contains the “tier 2” policies for revision. Attachment 7 gives the policies that participants suggested be retired.

Only those policies that garnered overwhelming support for revision were considered for the subsequent exercise.

In additional discussions, roundtable participants also identified gaps existing in the policy landscape for the P-1 period: those most relevant to the roundtable’s work were identified and highlighted for inclusion in the next exercise.

Table 1, below, shows the results of this work: pregnancy and infancy-related policies identified as needing revision to be most effective with high-risk populations; and policy gaps (related to pregnancy or to infancy) identified as needing further consideration by the roundtable.

<table>
<thead>
<tr>
<th>Table 1: Policies or policy gaps for ongoing focus</th>
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<tbody>
<tr>
<td><strong>Pregnancy</strong></td>
</tr>
<tr>
<td><strong>Existing policy areas chosen for revision</strong></td>
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<tr>
<td>A. Ensure access to prenatal care</td>
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<tr>
<td>B. Accurate and ongoing clinical guidance on appropriate weight gain, diet and exercise at prenatal visits</td>
</tr>
<tr>
<td>C. Eliminate marketing for unhealthy foods and beverages</td>
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<tr>
<td>D. Consistency of resident training regarding gestational weight gain</td>
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<tr>
<td>Policy gaps that should be addressed</td>
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<td>-------------------------------------</td>
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<tr>
<td>E. Interconception counseling</td>
</tr>
<tr>
<td>F. Enrollment in, access to and participation in WIC and the Supplemental Nutrition Assistance Program</td>
</tr>
<tr>
<td>G. Food insecurity: historical experience, access to healthy food</td>
</tr>
<tr>
<td>H. Educating pregnant women about child development and feeding to pacify</td>
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<tr>
<td>I. Centering pregnancy: peer support</td>
</tr>
<tr>
<td>J. Changing social norms around obesity, nutrition and activity</td>
</tr>
<tr>
<td>K. Adverse childhood events and their effect on both mother and child</td>
</tr>
<tr>
<td>L. Screening for gestational diabetes</td>
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<td>M. Mental health screening for maternal depression</td>
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</table>

<table>
<thead>
<tr>
<th>Policy gaps that should be addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>E. Baby-friendly offices – Affordable Care Act compliance</td>
</tr>
<tr>
<td>F. Marketing and distribution of formula</td>
</tr>
<tr>
<td>G. Improving parental paid leave</td>
</tr>
<tr>
<td>H. Medical home – postpartum mom (gestational diabetes, mental health)</td>
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<tr>
<td>I. Expansion of parental skill-building on all levels</td>
</tr>
<tr>
<td>J. Expansion of skill-building and education on health behaviors</td>
</tr>
<tr>
<td>K. Focus on family behaviors, especially at home</td>
</tr>
<tr>
<td>L. Multi-generational co-parenting</td>
</tr>
<tr>
<td>M. Home visitation</td>
</tr>
<tr>
<td>N. Link maternal and infant health records.</td>
</tr>
</tbody>
</table>

**Defining the new/revised recommendations: the process**

Roundtable participants received a list of all policies to be revised as well as the identified policy gaps (Table 1). Participants then worked in sub-groups to identify key categories reflected in both; these areas of focus were:

**For pregnancy:**
- Supporting appropriate weight gain during pregnancy
- Supporting the integration of education, screening and referral around adequate nutrition for both mothers and infants into the medical care that surrounds pregnancy and childbirth.

**For infancy:**
- Supporting the effectiveness of the health care delivery system in promoting evidence-based obesity prevention approaches.
- Supporting mothers as they seek to give their children the best start.

Again working in small groups, roundtable participants then identified thirteen potential policies (revisions or new options) as ways to address these four areas categories. Participants were asked, in addition to formulating policies, to elaborate on policy goals, implications for vulnerable populations, target audiences and approaches, research needs and feasibility.
The new/revised recommendations: the details

Table 2, on the following pages, presents the details of each of the 13 new or revised recommended policies, to the extent roundtable participants were able to define them during the meeting.

In discussing these policies, roundtable participants made several key points.

- "Providers are ready," as one participant said, to work with pregnant women on appropriate weight gain. They will need, however, resources to support this work:
  - Clearly-understood and well-disseminated guidelines and recommendations
  - Endorsement of such guidelines by the U.S. Preventive Services Task Force
  - Payment for weight management services
  - Electronic health records with tools such as weight gain management curves that can be used by both pregnant women and providers
  - Positively-presented information for patients about pregnancy and weight gain, such as that prepared by the Academy of Nutrition and Dietetics.

- Food-insecurity is an issue that providers can and should more actively address with their patients. Roundtable participants, for example, noted the availability of a validated, two-question food-insecurity screening tool. And while some participants questioned the value of screening that stands alone, others observed that WIC, the Supplemental Nutrition Assistance Program and the Food Distribution Program on Indian Reservations provide referral opportunities.

- New mothers (and fathers) need support, and programs that promote such support are promising. In the United States, Healthy Start programs and the Nurse-Family Partnerships, among others, provide models and form a constituency for post-partum home visiting that has resulted in the recent (February, 2015) re-funding of the Maternal, Infant, and Early Childhood Home Visiting Program. Group visits are another model generating positive outcomes in other settings and for other conditions, and paid parental leave can reduce maternal depression. Roundtable participants highlighted, however, the need for stronger evidence that these programs do, in fact, help prevent childhood obesity.

- Stigmatization of women who are unable to breastfeed continues to be a concern in the discussion and design of policies to support breastfeeding. Roundtable participants stressed the need to differentiate between medically-necessary and replacement formulas in these conversations.
### Table 2: Key aspects of new policies

<table>
<thead>
<tr>
<th>Policy</th>
<th>Related risk/protective factors and health goals</th>
<th>Key considerations for at-risk populations</th>
<th>Target entity and approach</th>
<th>Data/Research needs</th>
<th>Rationale</th>
<th>Likelihood of being established</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institute reimbursement for weight management services during pregnancy.</td>
<td>- Maternal weight gain during pregnancy: seek to improve weight management during pregnancy and thereby establish a healthier weight outlook for the child.</td>
<td>-ACOG and AND as possible entities to develop Guidelines -USPSTF to review evidence</td>
<td>Need to determine specifics: - How many visits - Timing - Delivered by whom?</td>
<td>- Excessive gestational weight gain in half of pregnancies - More among women with overweight or obesity (&gt; ½ US women)</td>
<td></td>
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</tr>
<tr>
<td>Develop and implement a guideline to counsel about breastfeeding, screen for food insecurity, and refer to WIC, SNAP and FDPIR during pre-partum, pregnancy and infancy periods.</td>
<td>- Weight prior to pregnancy - Diet quality - Regular exercise during pregnancy - Maternal weight gain during pregnancy - Gestational diabetes - Seek to: - Improve education about breastfeeding in pregnancy - Increase enrollment in WIC and SNAP - Protect access to SNAP for vulnerable populations</td>
<td>Need to address legislation that limits access to SNAP for: - People with drug felony convictions - Documented immigrants not meeting length-of-U.S. residency requirements - People without children</td>
<td>Target: Mother-infant dyads. Agents for clinical counseling and referral include: -Providers (clinicians) -Hospitals (pre and during delivery) -Health Plans ACOG and AAP possible entities to develop guideline Federal and state legislators as target audience for SNAP assurance</td>
<td>- Food insecurity and childhood obesity often are interwoven, and adversely impact the nation’s most vulnerable populations. - Pediatricians in various parts of the country have been piloting efforts to conduct a brief 2-question screen so that they may identify those experiencing or at-risk for food insecurity and link them to programs and resources such as WIC, SNAP and food banks. - Given the recommended number of healthcare touchpoints during pregnancy and infancy and the possibility of impacting those at high risk for childhood obesity, the group recommended that obstetric and pediatric healthcare providers screen for food insecurity and facilitate linkages to community programs and resources</td>
<td>Such a guideline would be comparatively easy to implement: - Simple screening tools exist to assess food insecurity - Resources exist for referral Legislative change for SNAP assurance will involve the political process</td>
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<td>Begin a home visitation program for all expectant mothers and new families (from 16 weeks gestation)</td>
<td>- Maternal weight gain - Rate of weight gain during infancy</td>
<td>This approach allows for individualization, and provides opportunities to address cultural,</td>
<td>Targets: mothers and families. Change agent: health worker. Approach:</td>
<td>Evidence leaps: Hypothesized – effective in preventing obesity.</td>
<td>Home visitation allows for skill building and social support to improve adoption of healthy behaviors and reduction of adverse childhood experiences</td>
<td>Opportunities to build on/learn from experiences of programs like Healthy Start.</td>
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through at least age 1; participation would be assumed although women and families would have the option to opt-out of the program.

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<th>Parent feeding practices</th>
<th>regional, or familial strengths/barriers</th>
<th>- Adopt and leverage existing home visiting movement (MIECHV money)</th>
<th>Value added and cost-effective for more resourced families</th>
<th>(ACES) within “home” environment (sample factors: breastfeeding initiation/continuation, appropriate bottle feeding, responsive feeding, sleep hygiene, introduction/ adoption of physical activity)</th>
<th>Pilot programs as good way to build evidence.</th>
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<td>- Diet quality and quantity</td>
<td>- Family support of breastfeeding</td>
<td>- Safe and appropriate bottle feeding practices</td>
<td>- Parent feeding practices</td>
<td>This approach allows for individualization, and provides opportunities to address cultural, regional, or familial strengths/barriers</td>
<td>Target: mothers, fathers, families.</td>
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<td>- Rate of weight gain during infancy</td>
<td>- Parent feeding practices</td>
<td>- Diet quality and quantity</td>
<td>- Family support of breastfeeding</td>
<td>- Safe and appropriate bottle feeding practices</td>
<td>- Change agents: peers as well as caregiver that runs the program.</td>
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Make group prenatal and postnatal care (aligned to gestational age) accessible to all pregnant women; again, participation would be assumed although women would have the option to opt-out of this type of care.

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<th>Insure Healthcare providers and institutions are not used to co-market infant formulas.</th>
<th>Parent feeding practices within certain populations.</th>
<th>- Cultural competency</th>
<th>- Sensitivity in messaging</th>
<th>- Stigmatization of women who have to use infant formula</th>
<th>- Peer support, especially within a context of faith-based organizations, may mitigate these</th>
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<tbody>
<tr>
<td>- Breast feeding initiation, continuation and exclusivity when appropriate</td>
<td>- Family support of breast feeding</td>
<td>- Current feeding practices</td>
<td>- Diet quality and quantity</td>
<td>- Parent feeding practices</td>
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<tr>
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<td>Peer support, especially within a context of faith-based organizations, may mitigate these</td>
<td>- Current feeding practices within certain populations.</td>
<td>- Cultural competency</td>
<td>- Sensitivity in messaging</td>
<td>- Stigmatization of women who have to use infant formula</td>
</tr>
</tbody>
</table>

Federal: 
- Revive FDA report on marketing to align with WHO standards. 
- Seek statutory permission for FDA to follow IOM guidelines. 
- Local: 
  - Legislation that requires adoption of baby friendly hospitals. 
  - Formula marketing within state legislation. 
- Local: 
  - Restrict formula distribution in hospitals (e.g., giveaway bags). 
  - Baby-friendly offices
- More research is needed on the relationship between breastfeeding and obesity. 
- Need to better understand how to explain the value of breastfeeding to the target, at-risk populations. 
- More research needed on current marketing practices

Hospitals and providers continue to provide free formula and giveaway bags (containing infant formula) without proper counseling on the benefits of breastfeeding. Even if counseling is taking place, delivery of giveaway bags often undermine physician guidance and/or parental commitment to breastfeeding.

Barriers: 
- Infant Formula Council – powerful lobbying group. 
- Financial incentives (hospitals and practices getting free formula). 
- Lack of information for mothers, other than what is coming from the formula companies. Opportunities: 
- Removing barriers to allow mothers to make an informed choice 
- Empowering mothers and families to make the best possible choice for them and carry it out
| Integrate healthy weight competencies into health care provider training. | - Diet quality  
- Regular exercise during pregnancy  
- Maternal weight gain during pregnancy | - Increase knowledge base for providers  
- Increase provider confidence and practice | Health care providers are not adequately trained in medical school or residency on the core elements that influence a patient or families’ ability to lead a healthy active lifestyle. |
|---|---|---|---|
| Reaffirm the Institute of Medicine’s guidelines for weight management during pregnancy, and revise the guideline for women with greater than Class II obesity to advise that, with appropriate fetal monitoring, women in this category not gain any weight during pregnancy. | - Maternal weight gain during pregnancy  
Seek:  
- More women achieve appropriate weight gain throughout pregnancy, according to IOM guidelines.  
- Social norms around weight and pregnancy begin to change | Primary focus involves increased training for health care providers (of all types) on the guidelines and on how to support their use in an obesigenic environment.  
Providers then work with women and their families on use of the guidelines.  
Institutions that work with women during pregnancy (e.g., WIC, other social service agencies) also can help explain guidelines to women/families. | Should be ways for the health care delivery system also to support guideline use: these need to be explored further |
| Reiterate and elevate existing recommendations for physical activity during pregnancy, i.e., for 150 minutes of moderate-to-vigorous physical activity per week, and/or 75 minutes vigorous physical activity in women for whom there is no contraindication. | - Regular exercise during pregnancy: seek to increase awareness of appropriate physical activity during pregnancy | Expectation that providers will welcome the information and support such guidelines can provide. |
| Institute universal paid parental leave with post-partum health benefits for mothers. | - Breast feeding continuation  
- Family support for breast feeding  
- Feeding to schedule  
- Short sleep duration  
- Amount of time spent in devices that restrain movement  
95% of lower-income workers do not have access to paid parental leave | Need to address at national (existing proposals in Congress) and local (working with employers and employer groups) levels.  
Some municipalities are embracing the concept and could be possible partners | Should facilitate breast feeding, infant soothing and complementary food introduction.  
Can reduce maternal depression, maternal stress |

Large-scale issue: requires building a strong constituency. Impact on GDP of women not participating in the workforce could help make the case; Dept. of Labor is evaluating
| **Promote broader awareness and uptake of baby-friendly clinic designation.** | - Rate of weight gain during infancy  
- Breast feeding initiation and continuation  
- Parent feeding practices  
- Diet quality and quantity  
- Safe and appropriate bottle feeding practices |
| **Include, as a condition for funding food retail under the Healthy Food Financing Initiative and comparable programs, limits on product placement and promotion of unhealthy beverages.** | - Weight prior to pregnancy  
- Diet quality in pregnancy  
- Maternal weight gain during pregnancy  
- Rate of weight gain during infancy  
- Parent feeding practices  
- Diet quality and quantity |
| **Integrate healthy weight competencies into early education and child care provider training.** | - Rate of weight gain during infancy  
- Diet quality and quantity  
- Amount of time spent in devices that restrain movement |
| **Convene a cross-sectional group of those providing services to pregnant women and infants to analyze what is already being done in each sector and how these approaches could be shared.** | |

Roundtable participants were not able, during the meeting, to flesh out the aspects of these recommended policies.
Conclusion

This first early obesity prevention policy roundtable meeting resulted in a set of policy opportunities aimed at a range of aspects of the experience of pregnant women and of children in their first year. At this meeting, clear themes emerged:

- The people who care for pregnant women and infants need good, clear, consistent and actionable information in order to engage patients and families in discussions about food, its role in pregnancy and child development and the resources available to those who may find themselves food-insecure.

- The institutions in which this care is provided can respond more effectively to the needs of new parents: coordinating their services and facilitating access to them, as well as supporting families around all aspects of living healthy, active lives.

- Ultimately, children develop in the community, and approaches to obesity prevention that stop at the office, hospital or clinic door will fail. New families—and families with new members—need ongoing support, information, opportunities to learn from each other, access to healthy food, and time to integrate a new child into the family’s routine.

Some of these needs are specific to the P-1 period, but many are not. Roundtable participants closed their meeting by listing issues they wished to highlight for those attending the second and third roundtables in this series (which will focus on children from ages 1 to 5, and on overall family health). Attachment 8 contains the full list; it shows the additional partners to be involved, and additional policy opportunities to be explored, as the focus broadens in efforts to ensure children grow up at a healthy weight.
List of Attachments

1) Roundtable participants
2) Meeting agenda
3) Initial policy map: Pregnancy
4) Initial policy map: Infancy
5) “Tier 2” policies to be reaffirmed
6) “Tier 2” policies to be revised
7) Policies to be retired
8) Brainstormed list of considerations for roundtables 2 and 3
Attachment 1

AAP Institute for Healthy Childhood Weight
Shaping the Health of the Next Generation: Early Obesity Prevention Policy Roundtable Series
Roundtable 1: Pregnancy – Infancy
June 22 – 23, 2015
Participant List

Steven Abrams, MD, FAAP, University of Texas, Austin
Laura Annunziata, MSN, FNP, Zero to Three
Leann Birch, PhD, University of Georgia
Sandia Bishop-Josef, PhD, ReadyNation
Renee Boynton-Jarrett, MD, ScD, FAAP, Boston Medical Center
Ronette Briel, DrPH, Mathematica
Diana Torres-Burgos, MD, MPH, FAAP, National Hispanic Medical Association
Jill Castle, MS, RDN, CDN, Academy of Nutrition and Dietetics
William Dietz, MD, PhD, FAAP, Redstone Global Center for Prevention and Wellness
Ditra Edwards, The Praxis Project
Lacy Fehrenbach, MPH, Association of Maternal & Child Health Programs
Jennifer Frost, MD, American Academy of Family Physicians
Dianne Gerken, MSN, E-MBA-HA, FNP, Nurse Family Partnership
Matthew Gillman, MD, MS, Harvard Medical School
Douglas Greenaway, MDiv, WIC Association
Debra Hawks, MPH, American College of Obstetricians and Gynecologists
Diana Hu, MD, FAAP, Indian Health Service
Manel Kappagoda, JD, MPH, ChangeLab Solutions
Joan Meek, MD, MS, FAAP, U.S. Breastfeeding Committee
Natalie Muth, MD, RD, MPH, FAAP, Children's Primary Care Medical Group
Andrea Sharma, PhD, MPH, Centers for Disease Control and Prevention
Leslie Sim, MPH, Institute of Medicine
Karen VanLandeghem, MPH, National Academy for State Health Policy
Kimberly Vesco, MD, MPH, FACOG, Kaiser Permanente Sunnyside Medical Center
James D. Weill, JD, Food Research and Action Center

Project Advisory Committee
Sandra Hassink, MD, FAAP (Chair)
Lucy Sullivan, MBA (Member)

Consultants
Brad Sperber, MDiv (Meeting Facilitator)
Katherine Garrett, MBA (Technical Writer)

Program Staff – Institute for Healthy Childhood Weight
Alison Baker, MS
Mala Bedient, MPH
Jeanne Lindros, MPH
Corrie Pierce

Program Staff – Robert Wood Johnson Foundation
Jamie Bussel, MPH
Abbey Cofsky, MPH
Karen Ellis
Tracy Fox, MPH, RD
Tina Kauh, MS, PhD
AAP Institute for Healthy Childhood Weight
Shaping the Health of the Next Generation: Early Obesity Prevention Policy
Roundtable Series Roundtable 1: Pregnancy – Infancy
June 22 – 23, 2015
Agenda

Day 1, Monday, June 22:
12:30 p.m. Lunch
1:30 p.m. Opening Remarks
1:45 p.m. Introductions and Meeting Overview
2:45 p.m. Overview and Confirmation: Protective and Risk Factors
3:45 p.m. Break
4:00 p.m. Characteristics of Desired Policy (Step 1)
4:15 p.m. Review and Categorize Existing Policy Recommendations
5:15 p.m. Identifying Unmet Needs and Policy Gaps
6:00 p.m. Adjourn
6:30 p.m. Dinner

Day 2, Tuesday, June 23:
7:30 a.m. Breakfast and Recap of Day 1
7:45 a.m. Characteristics of Desired Policy (Step 2)
8:15 a.m. Designing Impactful Policies (Setting the stage)
8:30 a.m. Designing Impactful Policies (Breakout Group Exercise)
10:30 a.m. Break
10:45 – 11:30 a.m. Designing Impactful Policies Report Out (Group A)
11:30 p.m. Lunch
12:00 – 12:45 p.m. Designing Impactful Policies Report Out (Group B)
12:45 – 1:30 p.m. Designing Impactful Policies Report Out (Group C)
1:30 – 2:15 pm. Designing Impactful Policies Report Out (Group D)
2:15 p.m. Prioritization Discussion
2:45 p.m. Closing and Next Steps
3:00 p.m. Adjourn
## Initial policy map: Pregnancy

<table>
<thead>
<tr>
<th>Policies</th>
<th>Federal</th>
<th>State</th>
<th>Local</th>
<th>Healthcare</th>
<th>Employer</th>
<th>Preconception/ during pregnancy</th>
<th>During pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affordable Care Act and access to prenatal care, breastfeeding support, and access to care for women of childbearing age more generally.</td>
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<tr>
<td>Require menu labeling in all restaurants</td>
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<td>x</td>
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<tr>
<td>Tax food and beverages with minimal nutritional value</td>
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<tr>
<td>Require farmers’ markets to accept WIC and SNAP</td>
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<tr>
<td>Provide tax breaks or community development grants to communities which limit the number of fast food retail outlets through zoning restrictions</td>
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<tr>
<td>Provide financial incentives to restaurants that provide healthier meal options</td>
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<td>x</td>
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<tr>
<td>Provide financial incentives to grocery and convenience stores that reduce point of sale marketing</td>
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**Source:**
- HHS
- AAP, CDC, IOM, NGA, RWJF
<table>
<thead>
<tr>
<th>Requirement</th>
<th>AAP</th>
<th>CDC</th>
<th>IOM</th>
<th>RWJF</th>
<th>NGA</th>
<th>Funding</th>
<th>AAP, CDC</th>
<th>IOM</th>
<th>RWJF</th>
<th>NGA</th>
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<tbody>
<tr>
<td>Require all mobile vending units provide healthy food options and limit unhealthy options in public venues</td>
<td>x</td>
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<td></td>
<td>AAP, CDC, IOM, RWJF</td>
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<tr>
<td>Fund additional parks, green space, walking trails, etc.</td>
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<td>AAP, CDC, IOM, NGA, RWJF</td>
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<td>Implement tax policy to make health club and recreational program fees tax deductible from state income tax.</td>
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<td>AAP, CDC, IOM</td>
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<tr>
<td>Provide funding to communities to ensure access to safe, clean drinking water</td>
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<td>AAP, CDC, IOM</td>
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<td>Smoke-free policies</td>
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<td>AAP, CDC</td>
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<td>Tobacco excise taxes</td>
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<td>AAP, CDC</td>
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<td>Comprehensive coverage of cessation services</td>
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<td>AAP, CDC</td>
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<tr>
<td>Ensure geographic availability of supermarkets via incentives, zoning requirements or small business programs</td>
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<td>CDC, IOM, RWJF</td>
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<tr>
<td>Modify land use policies/zoning regulations to encourage farmers’ markets</td>
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<td>CDC, IOM, RWJF</td>
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<tr>
<td>Increase access to supermarkets via public safety efforts or adjusting transportation routes.</td>
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<td>CDC, IOM</td>
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<tr>
<td>Implement zoning ordinances to limit the number of fast food establishments</td>
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<td>IOM</td>
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<td>Restrict availability of less healthy foods in public service venues</td>
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<td>CDC, IOM</td>
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<tr>
<td>Establish joint use agreements to promote and encourage affordable and free physical activity opportunities</td>
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<td>AAP, CDC, IOM, RWJF</td>
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<tr>
<td>Adopt community policing strategies to improve safety and security</td>
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<td>AAP, CDC, IOM, RWJF</td>
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<tr>
<td>Require access to safe, clean drinking water</td>
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<td>AAP, CDC, IOM</td>
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<tr>
<td>Accurate and ongoing clinical guidance on appropriate weight gain, diet and exercise at prenatal visits.</td>
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<td>ACOG, CDC, IOM</td>
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<tr>
<td>Consistency of resident training regarding gestational weight gain</td>
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<td>ACOG, CDC, IOM</td>
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<td>Appropriate and ongoing clinical guidance on smoking cessation.</td>
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<td>AAP, ACOG, CDC, IOM</td>
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<td>Subsidize health club/fitness class</td>
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<td>CDC, IOM</td>
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<td>Ensure built environment provides opportunities for physical activity</td>
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<td>CDC, IOM</td>
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<td>Eliminate vending machines with low nutrient, high density foods</td>
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<td>CDC, IOM</td>
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<td>Require meu labeling in cafeteria</td>
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<td>x</td>
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<td>IOM, RWJF</td>
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<td>Eliminate marketing for unhealthy foods and beverages</td>
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<td>AAP, CDC, IOM, RWJF</td>
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<td>Restrict availability of sugar-sweetened beverages (cafeteria, vending machines, etc.)</td>
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<td>AAP, CDC</td>
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</table>
## Initial policy map: Infancy

| Policies                                                                 | Federal | State | Local | Healthcare | Employer | Birth weight | Rate of weight gain during infancy | Prenatal WIC | Breastfeeding initiation | Breastfeeding continuation | Workplace support for breastfeeding | Family support of breastfeeding | Early introduction to complementary foods | Parent feeding practices | Diet quality and quantity | Safe and appropriate bottle feeding practices | Formula feeding | Suckling behavior | Amount of time spent in devices that restrain movement | Feeding to schedule | Short sleep duration |
|-------------------------------------------------------------------------|---------|-------|-------|------------|----------|--------------|-------------------------------|--------------|--------------------------|-------------------------------|----------------------------------|-----------------------------|----------------------------------|-----------------------------|--------------------------|--------------------------|----------------------------------|----------------------|-------------------|
| Health care providers should measure weight and length or height in a standardized way. |         |   x   |     |   x        |         |              |                               |              |                          |                               |                                  |                            |                                |                            |                          |                         |                                |                 |                   |
| Ensure payment for BMI screening.                                       |   x  x  |       |     |            |         |              |                               |              |                          |                               |                                  |                            |                                |                            |                          |                         |                                |                 |                   |
| Health care professionals should consider risk factors in assessing which young children are at highest risk of later obesity and its adverse consequences. |         |       |     |   x        | x        |              |                               |              |                          |                               |                                  |                            |                                |                            |                          |                         |                                |                 |                   |
| Health and education professionals should be trained on how to counsel parents and those working with young children on age-appropriate physical activity, food and feeding, sleep routines etc. |         |       |     |   x        | x        |              |                               |              |                          |                               |                                  |                            |                                |                            |                          |                         |                                |                 |                   |

AAP
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<tr>
<th>Create opportunities for physical activity in the clinical settings for employees, patients and their families via events or design/built environment.</th>
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<th>CDC, IOM</th>
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</thead>
<tbody>
<tr>
<td>Provide lactation room and adequate breaks for nursing mothers.</td>
<td>x</td>
<td>x</td>
<td>AAP, CDC, IOM</td>
</tr>
<tr>
<td>Provide onsite lactation support and consultation.</td>
<td>x</td>
<td>x</td>
<td>AAP, CDC, IOM, WHO</td>
</tr>
<tr>
<td>Ensure hospitals are baby friendly.</td>
<td>x</td>
<td>x</td>
<td>AAP, CDC, IOM, WHO</td>
</tr>
<tr>
<td>Ensure access to prenatal care.</td>
<td>x</td>
<td>x</td>
<td>HHS, ACOG</td>
</tr>
<tr>
<td>Child care regulatory agencies should require child care providers and early childhood educators provide infants with opportunities to be physically active throughout the day.</td>
<td>x</td>
<td>x</td>
<td>IOM</td>
</tr>
<tr>
<td>Child care regulatory agencies should require child care providers and early childhood educators to allow infants to move freely by limiting the use of</td>
<td>x</td>
<td>x</td>
<td>IOM</td>
</tr>
<tr>
<td>Requirement</td>
<td>AAP, CDC, IOM</td>
<td>IOM</td>
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<tr>
<td>Equipment that restricts infants’ movement.</td>
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<tr>
<td>Child care regulatory agencies should require child care providers to adopt practices that promote age-appropriate sleep durations among young children.</td>
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<tr>
<td>State child care regulatory agencies should require that child care providers and early childhood educators practice responsive feeding.</td>
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<tr>
<td>Require creation of lactation rooms in child care and early education settings.</td>
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<tr>
<td>Adults who work with infants and their families should promote and support exclusive breastfeeding for 6 months and continuation of breastfeeding in conjunction with complementary foods for 1 year or more.</td>
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<tr>
<td>Proposal</td>
<td>AAP, CDC, IOM</td>
<td>IOM</td>
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<tr>
<td>Government agencies should promote access to affordable healthy foods for infants and young children from birth to age 5 in all neighborhoods, including those in low-income areas, by maximizing participation in federal nutrition assistance programs and increasing access to healthy foods at the community level.</td>
<td>x x x x x x x</td>
<td>IOM</td>
<td></td>
</tr>
<tr>
<td>Permit breastfeeding in public places and rescind laws that discourage breastfeeding in public places.</td>
<td>x x x x x x x</td>
<td>AAP, CDC, IOM</td>
<td></td>
</tr>
<tr>
<td>Child care regulatory agencies should regulate introduction of solids and formula feeding.</td>
<td>x x x x x x x</td>
<td>IOM</td>
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</tr>
</tbody>
</table>
“Tier 2” policies to be reaffirmed

- Require farmers’ markets to accept WIC and SNAP
- Fund additional parks, green space, walking trails, etc.
- Tobacco excise taxes
- Comprehensive coverage of cessation services
- Ensure geographic availability of supermarkets via incentives, zoning requirements or small business programs
- Increase access to supermarkets via public safety efforts or adjusting transportation routes
- Restrict availability of less healthy foods in public service venues
- Require access to safe, clean drinking water
- Appropriate and ongoing clinical guidance on smoking cessation
“Tier 2” policies to be revised

- Tax food and beverages with minimal nutritional value
- Provide tax breaks or community development grants to communities which limit the number of fast food retail outlets through zoning restrictions
- Provide financial incentives to restaurants that provide healthier meal options
- Require all mobile vending units provide healthy food options and limit unhealthy options in public venues
- Modify land use policies/zoning regulations to encourage farmers’ markets
- Implement zoning ordinances to limit the number of fast food establishments
- Establish joint use agreements to promote and encourage affordable and free physical activity opportunities
- Adopt community policing strategies to improve safety and security
- Eliminate vending machines with low nutrient, high density foods
- Require menu labeling in cafeteria
- Create opportunities for physical activity in the clinical settings for employees, patients and their families via events or design/built environment
Policies to be retired

- Subsidize health club/fitness classes
- Implement tax policy to make health club and recreational program fees tax deductible from state income tax
- Provide financial incentives to grocery and convenience stores that reduce point of sale marketing
Brainstormed list of considerations for roundtables 2 and 3

- Food marketing (e.g., complementary foods). Labeling dimension relevant too.
- Pre-school as a venue for implementation.
- Early care and education – meals being eaten in out-of-home environments.
- Pregnancy B recommendation carries across into early childhood.
- Expanding WIC *through* age 5.
- Summer programs – how regulations affect these.
- Summer programs – food that is offered.
- Food programs and child care/school standards, proposed new nutrition standards—getting them implemented.
- Pre-K eating in school-based food programs.
- USPSTF A/B standard: obesity screening and counseling recommended for children only over the age of 6 (affects insurance coverage) – Being updated, need to address.
  - Medicaid standards: “medically necessary” language might provide loopholes.
- For third roundtable: family, friends and neighbors as caregivers (grandparents too)
- Foster care, child welfare system.
- Farm to childcare.
- Physical literacy – knowledge about movement, fine motor skills.
- Tax implications of marketing food to children on TV.
- Sleep.
- Screen time.
- Large-scale policies relating to Head Start, child care and home visiting.
- Built environment especially as it relates to early childhood.