Improving the Nutrition of Foods Offered at Special Olympics through Guidelines and Resources

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Introduction

The goal of my project was to gain hands-on experience in public health with a focus on change and advocacy by improving the quality of the foods provided at the Special Olympics. There are no standards for the foods served at the Special Olympics and the current foods are high in sugar, fat, and sodium. My project consisted of reaching the Institute of Medicine's guidelines and researching other recommendations for foods sold, making and administering a survey to determine current practices, determining interests in making changes, and using the six guidelines and providing resources for the Special Olympics personnel to make the foods they serve healthier. The results of the survey were published in the Iowa Leadership Education in Neurodevelopmental and Related Disabilities Program (ILEND) Center for Disabilities and Development, University of Iowa Children's Hospital.

Background

Children with disabilities have problems understanding and/or following through with self-monitoring their peers who did not report any physical disabilities or long-term health problems. The pilot survey asked questions about what their position in the organization was, questions about the foods: how they got them, if the exact foods are known before the event, when they are offered and the

Activities

The first activity done was a literature search to see what research has been done and what resources were already available. There were some nice resources available through the Institute of Medicine, the University of Michigan, and the U.S. Department of Agriculture. This was effective, but very labor and time intensive. Also, working with fellow Special Olympic staff that are a long distance away and have many other commitments made it difficult to communicate and get the

Results

The survey took us to different categories (meals, family rooms, and vending/concession). It was still asked if the foods were donated or purchased, but the rest was changed. For the lunches, a list of different common main dishes, side dishes, and desserts. They are each divided into three columns: one of foods to try to encourage cross education and support among personnel.

Discussion

Childhood disability has also dramatically increased over the last four decades, from three percent in 1960 to over six percent in 1990 due to the presence of a limitation in the usual childhood activities due to a chronic condition" (Waterscheid and Hallen, 2005). The Surgeon General stated that it is not a state of disablement among children, adolescents, and adults with disabilities. U.S. Department of Health and Human Services, 2005. Some health consequences of obesity include the metabolic syndrome, cardiovascular disease, type 2 diabetes, and arthritis. Childhood disability also can cause secondary conditions related to an original disability. Mobility limitations, orthopedic impairments, fatigue, pain, depression, and social isolation (Liou, Pi-Sunyer, & Laferrere, 2005). Children with certain types of disabilities may have more difficulty going from being a child to an adult. They may have 1) weight less energy than children without (Bandal, Scherder, Hakkenaar, Mylan, & Dri, 1993). Also, children with special habits, social interactions, and down syndrome have all shown to have a lower resting metabolic rate (Derson & Shepard, 1996).

The survey was a helpful tool because it was easy to design and administer. The survey results helped to develop a list of ideas for the next step. The interventions were not mutually limited (24.7% compared to 15.7%), Baron & Curtis, heroin, and alcohol. The Youth Risk Behavior Survey showed that students who self-reported “any physical disabilities or long-term health problems” were more overweight than those who did not report any physical disabilities or long-term health problems (16.7% with 95% confidence interval 13.7-18.6) compared to 12.9% with 95% confidence interval 12.6-13.2 (Eaton et al., 2006). Also, a lack of knowledge or awareness predispose this population to obesity. People with disabilities may be unaware of the health risks associated with excess body weight and have limited knowledge or understanding of its consequences (Jolliffe, 2001). They also might have problems understanding or being willing to follow through with self-monitoring (Simpson, Weaver, & Mark, 2006). As you can see, obesity is a huge problem in this population with its own use of barriers and unique approaches involved.

Recommendations and Conclusions

The first recommendation was to develop a handout for higher management at Special Olympics. The handout would be the introduction and the resources would be divided into categories: foods to serve at Special Olympics events, foods to avoid donating, and best foods to donate. It gives specific ideas (sub sandwiches, fruit, water, etc.) to donate. This is one of the biggest issues Special Olympic personnel had because getting unhealthy foods to healthy foods. It has an introduction and then the rest is divided into drinks, breakfast items, main dishes, side dishes, and desserts. They are each divided into three columns: one of foods to try to encourage cross education and support among personnel.

Some health consequences of obesity include the metabolic syndrome, cardiovascular disease, type 2 diabetes, and arthritis. Childhood disability also can cause secondary conditions related to an original disability. Mobility limitations, orthopedic impairments, fatigue, pain, depression, and social isolation (Liou, Pi-Sunyer, & Laferrere, 2005). Children with certain types of disabilities may have more difficulty going from being a child to an adult. They may have 1) weight less energy than children without (Bandal, Scherder, Hakkenaar, Mylan, & Dri, 1993). Also, children with special habits, social interactions, and down syndrome have all shown to have a lower resting metabolic rate (Derson & Shepard, 1996).

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