Despite the growing popularity and marketing of organic foods, no solid scientific evidence shows that organic food is better than food grown using other methods. In 2002, legal labeling of foods as “USDA Organic” began. To use this label, a food grower must follow certain practices that meet national standards of the United States Department of Agriculture (USDA). Foods with the “USDA Organic” label must be 95% organically produced following federal regulations.

The foods covered by the federal law are fruits, vegetables, mushrooms, grains, dairy products, eggs, livestock feed, meats, poultry, seafood, and honey. Registered certifiers check that growers did not use prohibited substances on their land for at least 3 years before harvesting the food. Growers may use animal and crop waste, as well as approved synthetic materials and biologic controls.

Marketing to consumers suggests that organic food is healthier and safer than conventionally grown foods. However, experts suggest that the claimed benefits of organic foods are overstated and misleading. Some of the concerns are:

- Not all foods sold or labeled as “organic” have the USDA label. Use of the “USDA Organic” seal is voluntary. Anyone may advertise or sell food labeled with the word “organic” without meeting the criteria for the “USDA Organic” label.
- The label “organic” does not indicate anything about the nutrient quality of the food. Studies comparing the nutrients in organic and conventionally grown foods have not found any significant differences.
- Many factors affect food quality. These include the work conditions and practices of the farm laborers and others who handled the food. Both organic or conventionally grown foods can cause food-borne illness. This can be the result of using insufficiently sanitized manure fertilizers, unclean picking conditions, a time delay between harvesting and selling the food, and improper handling of the food at any point before the food is eaten.
- The “USDA Organic” seal does not mean that the food is free of pesticides. Many pesticides persist in the environment for decades. In addition, wind drift of pesticides, water contamination from adjacent field applications, irrigation or contamination after harvesting can occur.
- Some studies have found that children who eat organic produce have lower levels of pesticide chemicals in their bodies. However, research does not show that the amount of pesticide found in conventionally grown foods is harmful to adults or children. In fact, the reduced use of chemicals that control the fungi and bacteria in organically grown foods could lead to higher concentrations of this type of harmful contamination.

(continued on page 2)

IOM ‘Weighs In’ About Sleep Needs and Obesity

In June 2011, the Institute of Medicine (IOM) released a report titled: *Early Childhood Obesity Prevention Policies*. The report includes specific recommendations in 5 areas:

1. Growth Monitoring
2. Physical Activity
3. Healthy Eating
4. Limiting Screen Time and Marketing Exposure for Children
5. Sufficient Sleep

(continued on page 2)
In a 2008 report, expert reviewer Charles Benbrook cited data about pesticide residues in organic and conventional foods. Some foods consistently pose low dietary pesticide risks, whether or not they are labeled “organic.” These include citrus fruits, bananas, pineapples, onions, meats (beef, pork, lamb, and poultry), grains, most processed foods, and dried fruits. The U.S. Environmental Protection Agency (EPA) assesses the pesticide residue dietary risk index of specific foods. For example, the dietary risk index of U.S.-grown fresh green beans was nearly three times as high as the index for U.S.-grown fresh sweet bell peppers. However, the dietary risk index of imported sweet bell peppers was much higher than for U.S.-grown green beans. Imported grapes, nectarines, peaches, and pears all are higher risk than these items U.S.-grown. Whether imported or grown in the United States, cucumbers, lettuce, celery, and peas have a lower dietary risk index compared with other types of foods. Imported foods with a lower dietary risk index include green beans, broccoli, processed peas, and carrots, cherries, cantaloupe, and apples. U.S.-grown foods with a lower dietary risk index include nectarines, peaches, strawberries, pears, apples, and cherries.

The less humid conditions west of the Mississippi River inhibit pest populations. That explains why so many of ‘organic’ foods in the United States come to eastern markets from western growers. Higher production and transportation costs often make organic foods more expensive. Nutrient quality of organic or conventionally grown food is better if the food is flash-frozen and packed immediately after harvest. Locally grown, freshly-picked foods may have a higher nutrient quality than those that travel. In sum, being labeled “organic” does not mean the food is necessarily better quality or safe.

References:
Nutrition Research Reviews, Putting the safety of organic food into perspective

(continued from page 1 – IOM ‘Weighs In’)

The IOM recommendations in the first four areas are consistent with national campaigns now underway. For example, the White House “Let’s Move Campaign in Child Care” focuses on nutrition, physical activity, and screen time. The unique recommendation from the IOM about sleep cites research finding that children are more likely to be obese when they get too little sleep. This is true for infants and children less than 5 years of age as well as school-age children. The IOM’s specific recommendations to promote healthy sleep as an anti-obesity measure are:

“Recommendation 6.1: Child care regulatory agencies should require child care providers to adopt practices that promote age-appropriate sleep durations. Potential actions include:
• Creating environments that ensure restful sleep, such as no screen media in rooms where children sleep and low noise and light levels during napping;
• Encouraging sleep-promoting behaviors and practices, such as calming nap routines;
• Encouraging practices that promote child self-regulation of sleep, including putting infants to sleep drowsy but awake; and
• Seeking consultation yearly from an expert on healthy sleep durations and practices.”

Sleep experts are health and education professionals who counsel parents and teachers about child behaviors. The early care and education program’s Child Care Health Consultant or Technical Assistance Specialist may provide the annual consultation. If they are not experts themselves, they may know of others who are.

Early educators should ask each child’s parents about individual children’s sleep patterns at home. This information helps to coordinate sleep and rest at the child care facility and at home.

Children of the same age differ greatly in the number of hours of sleep they require. Many studies have documented the average and range of hours of sleep for healthy children. In a 2003 review in Pediatrics, Ivo Iglowstein et al looked at previous research. Then they reported their own study of sleep patterns for nearly 500 healthy children whom they followed from 1 month to 16 years of age.

All children in the study napped during the day until they were 1 year of age. After 1 year of age, an increasing portion of children did not nap during the day. By 3 years of age, only half still took daytime naps. For readers familiar with means and percentiles, the following table shows selected detailed data from the report.

(See table and text continued on page 3)
What matters is the total number of hours of sleep per 24 hours. Some children shorten their night-time sleep to be awake with their parents. Some get up early to be dropped off at the facility. These children may need more nap time. Children who routinely go to bed early may not need much if any nap time.

Transitions can help children get ready to sleep or rest. This can be listening to a quiet story or a soothing song, or any other wind-down, quiet activities before naptime. Teachers and families should share with each other what seems to help individual children relax and rest. Plan for children who are not ready for sleep at naptime to do restful activities while their peers sleep.

The naptime environment should support rest or sleep. No child should be made to lie down if not sleepy. Ambient noise should be soft, even if it is pleasant music. Lowering the lighting is OK as long as teachers can see all the children to supervise and care for them. Pennsylvania regulations and national standards require that teachers must supervise children by seeing and hearing them, including those who are sleeping. Children who are awake and doing rest-time activities need enough light too.

Meeting the varying sleep needs of individual children can be challenging in early education programs and in family life. Staff brainstorming may help generate ideas for modifying room layouts, lighting and noise levels for sleep and rest times. Discuss sleep and rest promotion with families too. Point out that when children get enough sleep and rest, they are better behaved and more competent learners. Research shows they are less likely to be overweight or obese too.


New Online Self-Learning Module—Common Illnesses

A 2011 revised and updated online interactive module about common illnesses has videos, handouts and changed guidelines for exclusion of ill children. To use the module, download the document packet from the ECELS website and videos from the website of the American Academy of Pediatrics. Users learn about exclusion and inclusion of ill children, how to decrease the spread of infectious diseases, and ways to prevent common illnesses in group care. (ECERS-ITERS: Personal Care Routines, Parents and Staff. K7C2-84; 2 hours credit.) This module meets STAR Level 2 Performance Standard for Health and Safety.

Locate the module at: www.ecels-healthychildcarepa.org. Select “Child Care Provider Training Opportunities,” scroll to “Self-Learning Modules,” click “View All,” and then select “SLM Online—Common Illnesses in Child Care.”

<table>
<thead>
<tr>
<th>Age in Years</th>
<th>Hours slept per 24 hours</th>
<th>Hours of Nighttime Sleep</th>
<th>Hours of Daytime Sleep</th>
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</thead>
<tbody>
<tr>
<td>0.5</td>
<td>Mean = 14.2</td>
<td>Mean = 11.0</td>
<td>Mean = 3.4</td>
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<td></td>
<td>2nd to 98th % tile:10.4 to 18.1</td>
<td>2nd to 98th % tile: 8.8 to13.2</td>
<td>100% of children nap</td>
</tr>
<tr>
<td>1</td>
<td>Mean = 13.9</td>
<td>Mean = 11.7</td>
<td>Mean = 2.4</td>
</tr>
<tr>
<td></td>
<td>2nd to 98th % tile: 1.4 to 16.5</td>
<td>2nd to 98th % tile: 9.7 to13.6</td>
<td>100% of children nap</td>
</tr>
<tr>
<td>2</td>
<td>Mean = 13.2</td>
<td>Mean = 11.5</td>
<td>Mean = 1.8</td>
</tr>
<tr>
<td></td>
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<td>2nd to 98th % tile: 9.7 to13.4</td>
<td>87% of children nap</td>
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<tr>
<td>3</td>
<td>Mean = 12.5</td>
<td>Mean = 11.4</td>
<td>Mean = 1.7</td>
</tr>
<tr>
<td></td>
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<td>2nd to 98th % tile: 9.7 to13.1</td>
<td>50% of children nap</td>
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<td>Mean = 11.8</td>
<td>Mean = 11.2</td>
<td>Mean = 1.5</td>
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<tr>
<td></td>
<td>2nd to 98th % tile: 9.7 to 14.0</td>
<td>2nd to 98th % tile: 9.6 to12.8</td>
<td>35% of children nap</td>
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<td>Mean = 11.1</td>
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<tr>
<td></td>
<td>2nd to 98th % tile=9.5 to 13.3</td>
<td>2nd to 98th % tile=9.6 to12.6</td>
<td></td>
</tr>
</tbody>
</table>

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Social Emotional Development

Pediatric health professionals focus on supporting both physical and social-emotional health. During early childhood, the development of the structure and function of the brain is “fed” both by good nutrition and by warm positive relationships. ‘Bonding’ to others who are trustworthy and responsive to a child’s needs is essential to learning. Most children will adapt within a small circle of positive relationships, even if those in that circle differ somewhat in their approach. However, the circle must be small enough and supportive enough to allow children to adapt.

Reassurance and support from loving adults limits harmful responses in stressful situations. Very young children learn about coping for themselves when the person who is teaching them has nurturing interactions with them. Children learn best when their caregivers warmly and positively reinforce their efforts to talk, wait, sit, stand, walk, run, climb, feed themselves, practice socially appropriate behavior, draw, use scissors properly, understand science, nature, math etc.

Every child is unique. Some acquire skills easily; others need more encouragement and support. Meeting the physical needs of the child is important for the child to benefit from learning opportunities. Children must be offered healthful food in a manner that fosters appropriate self-regulation of eating. They must have both active and restful times in their day. They must be protected from serious infections by vaccinations. They need routine screening examinations to detect problems early when they are easiest to manage.

Role-modeling is a very important teaching tool. What you do is a much more effective lesson for the child than what you say. Be respectful when family members differ with program staff. Reach out to help and reassure during times of stress. This teaches a behavior that pays big dividends throughout life. Those who reach out to help others sometimes need support too. Caring for one another makes everyone stronger. Be a good role-model. Show parents and co-workers how to support optimal social-emotional development of young children and everyone else.

Pediatricians & Early Educators Share Developmental Screening

Optimum intervention for developmental delay depends on early identification. Now, more early educators and pediatric health care professionals routinely use formal, standardized developmental screening tools. These screenings supplement informal professional and family observations.

In a survey of Fellows of the American Academy of Pediatrics in 2009, nearly half (48%) of pediatricians reported that they always or almost always use one or more screening tools as part of well child care. Nearly a quarter of respondents reported they used Ages and Stages Questionnaire (ASQ). Many early educators are using the ASQ too. The reports of teachers/caregivers can contribute valuable information to a pediatric assessment of the child’s development. Use of the same tool offers opportunities for health and early education professionals to collaborate. Sharing developmental screening results and plans for follow-up of the results lets everyone do a better job.

Early educators can ask parents to give the results of developmental screening done in the early education and child care program to their child’s health care professional to review. When screening suggests the possibility of developmental delay, both types of professionals should refer the family to Early Intervention for evaluation. Thus, early educators and health professionals can form an influential partnership to support follow-up by the family.

It is a good idea to call the child’s health care office to ask how to initiate a reciprocal dialog about the child related to the screening information. With parent involvement and consent, the early educator can call, fax, e-mail or surface mail developmental screening information directly to the child’s health care professional. This will help deliver the information promptly.
TICKS Spread Disease

Like mosquitoes, ticks spread disease in the US. Ticks are arthropods, and include hundreds of species. Among the diseases they carry are Lyme disease, Rocky Mountain Spotted Fever, Tularemia, Ehrlichiosis, and Babesiosis. There are two general varieties, hard and soft ticks. The hard ticks include more commonly known deer tick, dog tick, wood tick and lone star tick.

A hard tick has a back plate and often resembles a small seed. Hard ticks tend to attach and feed for longer periods than the soft tick. The hard tick transmits disease at the end of a meal. The soft tick lacks a hard back plate. It feeds for less than an hour and transmits disease within minutes of the bite. A tick bite is the only way tick-borne diseases spread.

Ticks are more of a problem in the summer and fall. They tend to live in areas of low lying bushes. Since they feed on blood, they need animals or humans. A tick has a barbed mouth that it uses to firmly attach to its host. It burrows into the skin and secretes ‘cementum’. Unless the host has a painful allergic reaction to it, the bite itself generally goes unnoticed. Both prevention of tick bites as well as proper and timely removal of ticks that have bitten someone is vital.

The most effective way to prevent tick bites is to avoid tick-infested areas. In places where ticks are common, some studies have shown a 30% chance of being bitten by a tick by sitting on a log or leaning against a tree for 5 minutes. In any area where there are ticks, people should wear proper clothing and protection. Wear clothes that cover arms, legs and any exposed areas. Choose light colors so you can see ticks easily. Tuck pants into socks and button sleeves.

Chemical repellents help too. For adults you can spray permethrin onto clothing, but not on the skin. Do not use this chemical for children. You can use DEET (diethyltoluamide) on the skin of children older than 2 months of age. Alternate options include picardin, oil of lemon or eucalyptus oil. Oil of lemon and eucalyptus oil should not be used for children who are less than 3 years of age. See Caring for Our Children 3rd edition, STANDARD 3.4.5.2 at www.nrckids.org for how to reduce the risk of insect bites and use insect repellents. Be sure to do a ‘tick check’ after being outdoors. Ticks are more likely to attach to the head, neck, backs of the ears, arm pits, and groin.

If you find a tick, carefully remove it, immediately. Grasp the tick with tweezers as close to the skin as possible. Then pull the whole tick out in a gentle, straight motion without squeezing or twisting. Do not remove it with fingers or using the end of a hot matchstick. These methods may leave parts of the tick in the skin or cause the tick to secrete more of its infected body fluids before it is pulled off. You don’t want the infected fluids on anyone’s skin.

Wash the tick bite site thoroughly. If parts of the tick remain under the skin, have a doctor remove them. If you have a tightly closed jar, you can put the tick in it for the parent to show to the child’s health professional.

Whenever someone has been where there are ticks or has had a tick bite, watch for rashes or symptoms of tick-borne diseases in the weeks afterward. The rash may look like a bulls-eye. If someone who had a tick bite develops a rash, fever, joint pain or swelling, flu-like symptoms, weakness, headache or confusion, seek immediate medical care and treatment for them.

Article contributed by Neha Mehta, MD, FAAP

BATS!! - A Health Policy Test

A south central PA early education and child care program found two bats in the hallway of their facility in July. When a member of the ECELS staff read of the incident in the newspaper, she contacted the center to see whether the program needed technical assistance. She learned that the center Director was on vacation when the incident occurred.

The Director told ECELS, “Our Assistant Director provided excellent leadership for the evacuation. She was the designated ‘point of contact’ for the media. Staff and children remained calm. Everyone followed the emergency evacuation plans/policies we had identified and practiced as they moved to the temporary relocation site.

(continued on page 6)
The staff used cell phones to contact parents. Each classroom brought their ‘get up and go bag’ which contains emergency contact information, a first aid kit and medications for children with special needs. Our parents were understanding and excellent partners with us.”

Wildlife officials from the state Game Commission came to inspect the site. They found a colony of brown bats in the attic of the program’s facility. Staff notified the state Department of Public Welfare and the Department of Health. The program continued at the temporary relocation site for approximately 3 weeks as a tapering 'funnel' system allowed the bats to fly out of the attic, but they could not re-enter.

One four-year-old boy was near the bats found in the hallway. His family took him to his health care provider for evaluation of possible rabies exposure. The examination results were negative. This was an important precaution. Bats can transmit rabies without an obvious bite mark. Rabies is a fatal disease if not treated early.

At each monthly staff meeting, the Director gives an award for ‘teacher of the month’. She said, “I gave the award to our entire staff in July. They all worked closely together during the evacuation and in the following weeks.”

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- BATS!! - A Health Policy Test

This program’s experience reminds us about how important it is to have well thought out written policies and procedures for emergencies. The best-practice standard for the content of written policies for early learning and child care programs is in *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, 3rd Edition, 2011* Standard 9.2.1.1: Content of Policies. This document is online at [www.nrckids.org](http://www.nrckids.org).

For examples of fill-in-the-blank policies, see *Model Child Care Health Policies (MCCHP)* in the Publications/Media section at the ECELS website: [www.ecels-healthychildcarepa.org](http://www.ecels-healthychildcarepa.org). This 74 page booklet is available in hard copy from NAEYC. The appendices of MCCHP include handy model forms that early educators can use to make site-specific documents. ECELS is working on updates of MCCHP to match the new standards in *Caring for Our Children, 3rd Edition*.

ECELS has already posted updated model policies for nutrition, physical activity and screen time on the ECELS website. Select the section heading, “Publications and Media,” then the subsection “Print Publications.” The update follows the listing for the current edition of *MCCHP*.

Policies, plans, and procedures should be written, updated periodically, and practiced. Make sure that staff, families and appropriate consultants review and revise the policies at least annually and whenever change is needed to make them appropriate for the site. This helps keep everyone aware of what the documents say. Routine review and updating of the documents improves program performance over time.

A Child Care Health Consultant can be very helpful in reviewing and revising health policies and procedures. For information about finding and using a Child Care Health Consultant, put Child Care Health Consultant into the search box at [www.ecels-healthychildcarepa.org](http://www.ecels-healthychildcarepa.org). Pennsylvania programs may ask ECELS for help to identify a Child Care Health Consultant. Send an e-mail to ecels@paaap.org or call 1-800-24-ECELS.

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