NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in ALABAMA?

KEY POINTS:

- Approximately 177,000 of 512,000 Alabama children ages 10-17 years (34.6%) are considered overweight or obese according to BMI-for-age standards.
- Higher-income children in Alabama have the fifth highest prevalence of overweight and obesity in the country (27.3%).
- Almost one in three (30.3%) white, non-Hispanic children in Alabama are overweight or obese, the sixth highest state rate in the country.
- Alabama children are more likely than their counterparts nationwide to be physic ally active at least 4 days per week, but they're also more likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 28.7% of low-income children ages 2 to 5 years in Alabama are overweight or obese.

OVERALL PREVALENCE	ALABAMA %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	34.6%*	30.6%
State Rank for overweight or obese children (1 is best)	43	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	69.2%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	50.7%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**ALABAMA %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	37.4%	39.8%
>400 % FPL	27.3%	22.9%
Income Disparity Ratio	1.37	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	5	
% Overweight or Obese by Type of Insurance		
Public Insurance	42.8%	39.6%
Private Insurance	30.0%	26.7%
Insurance Disparity Ratio	1.43	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	18	
% Overweight or Obese by Race		
Black, non-Hispanic	41.9%	41.2%
White, non-Hispanic	30.3%	26.6%
Race Disparity Ratio	1.38	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	6	
% Overweight or Obese by Hispanic Origin		
Hispanic	NA	37.7%
Non-Hispanic	34.7%	29.5%
Hispanic Origin Disparity Ratio	NA	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	NA	

* Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th percentile) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data… Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

What is ALABAMA doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities as of 2006 with others.

OBESITY-RELATED STATE INITIATIVES - 2007	ALABAMA	NATIONAL
Snack and/or soda tax	No	17 states + D.C.
CDC state-based nutrition and physical activity program	No	28 states
Federal STEPS grant recipient	Yes	7 states
Laws that limit liability for obesity and obesity-related health problems	No	24 states
OBESITY-RELATED SCHOOL STANDARDS - 2007	**ALABAMA**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	Yes	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	Yes	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	Yes	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**ALABAMA**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

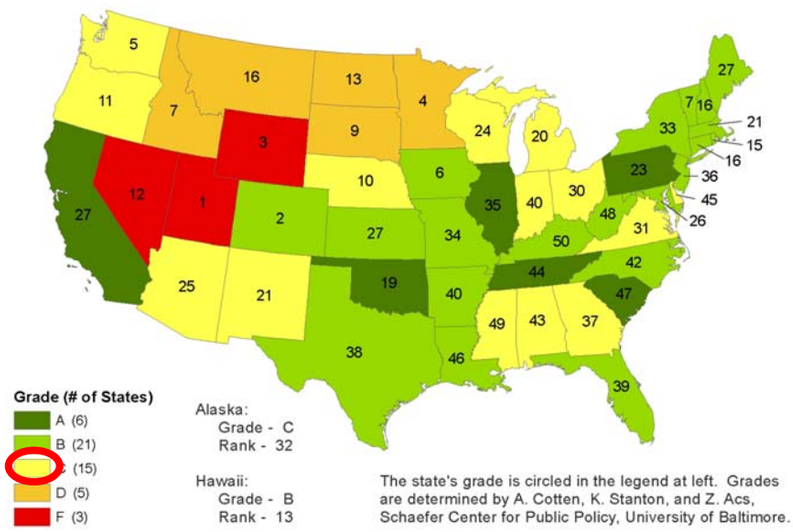
NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

In July 2005, the Alabama State Board of Education adopted Healthy Snack Standards for foods and beverages sold in vending machines, school stores, and a la carte. Under the standards, snacks (in single servings) must meet the following nutrient content guidelines: low or moderate in fat; have less than 30 grams of carbohydrate; and have less than 360 mg of sodium.

Effective with the 2005-2006 school year the state's Healthy Snack Standards require that no carbonated soft drinks shall be available for sale to students in elementary schools at any time during the school day. Beverages that may be sold include non-carbonated flavored and unflavored water, 100 percent fruit juices, milk, tea, and sports drinks.

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in ALASKA?

KEY POINTS:

- Approximately 26,000 of 84,000 Alaska children ages 10-17 years (30.7%) are considered overweight or obese according to BMI-for-age standards.
- Alaska publicly insured children have the fourth lowest prevalence of overweight and obesity in the country at 30.8%, only two percentage points above the rate for privately insured kids. The state's insurance disparity ratio is second best in the nation.
- The overweight/obese prevalence rate for white non-Hispanic children is 28.9%, which places Alaska in the bottom tier of states, with a rank of 42nd for white non-Hispanic kids.
- Alaska children are more likely than their counterparts nationwide to be physically active for at least 4 days per week, and less likely to spend 2 hours or more in front of a television or computer screen.

OVERALL PREVALENCE	ALASKA %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	30.7%	30.6%
State Rank for overweight or obese children (1 is best)	32	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	65.3%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	41.8%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**ALASKA %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	39.8%	39.8%
>400 % FPL	21.5%	22.9%
Income Disparity Ratio	1.85	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	18	
% Overweight or Obese by Type of Insurance		
Public Insurance	30.8%	39.6%
Private Insurance	28.8%	26.7%
Insurance Disparity Ratio	1.07	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	2	
% Overweight or Obese by Race		
Black, non-Hispanic	NA	41.2%
White, non-Hispanic	28.9%	26.6%
Race Disparity Ratio	NA	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	NA	
% Overweight or Obese by Hispanic Origin		
Hispanic	NA	37.7%
Non-Hispanic	30.1%	29.5%
Hispanic Origin Disparity Ratio	NA	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	NA	

* Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th percentile) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is ALASKA doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities as of 2006 with others.

OBESITY-RELATED STATE INITIATIVES - 2007	ALASKA	NATIONAL
Snack and/or soda tax	No	17 states + D.C.
CDC state-based nutrition and physical activity program	No	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	No	24 states
OBESITY-RELATED SCHOOL STANDARDS - 2007	**ALASKA**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	No	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	No	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	No	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**ALASKA**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

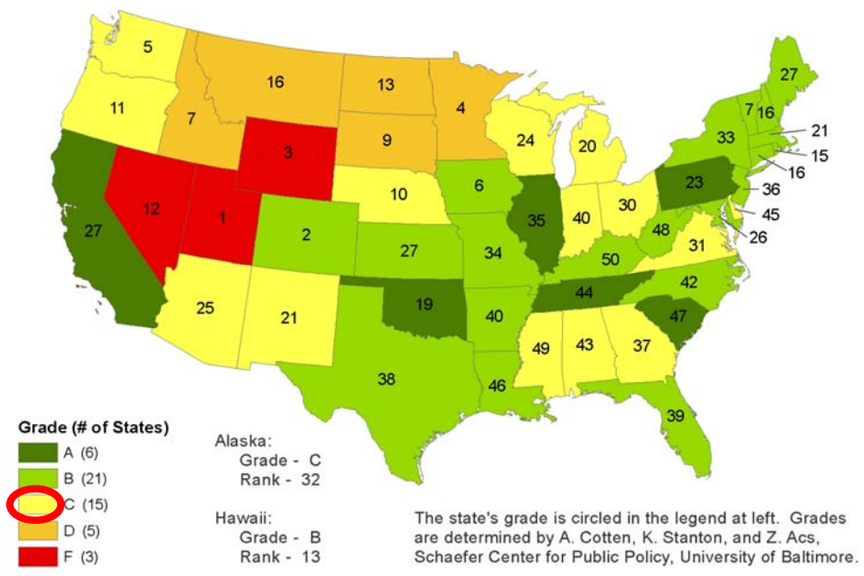
NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

One credit (two semesters) of health or physical education is required for high school graduation (4 AAC 06.075).

Legislation established the Alaska Schools Physical Activity Task Force to develop recommendations for maximizing physical activity and education within the state's schools (HB 128).

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in ARIZONA?

KEY POINTS:

- Approximately 173,000 of 583,000 Arizona children ages 10-17 years (29.7%) are considered overweight or obese according to BMI-for-age standards.
- The prevalence of overweight and obesity for children in poverty (39.4%) is twice as high as the rate for higher-income children (19.1%) in Arizona.
- Arizona children are slightly more likely than their counterparts nationwide to be physically active for at least 4 days per week, and equally likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 28.6% of low-income children ages 2 to 5 years in Arizona are overweight or obese.

OVERALL PREVALENCE	ARIZONA %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	29.7%	30.6%
State Rank for overweight or obese children (1 is best)	25	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	60.1%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	44.6%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**ARIZONA %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	39.4%	39.8%
>400 % FPL	19.1%	22.9%
Income Disparity Ratio	2.06	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	30	
% Overweight or Obese by Type of Insurance		
Public Insurance	43.1%	39.6%
Private Insurance	23.2%	26.7%
Insurance Disparity Ratio	1.86	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	44	
% Overweight or Obese by Race		
Black, non-Hispanic	NA	41.2%
White, non-Hispanic	23.4%	26.6%
Race Disparity Ratio	NA	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	NA	
% Overweight or Obese by Hispanic Origin		
Hispanic	38.4%	37.7%
Non-Hispanic	26.7%	29.5%
Hispanic Origin Disparity Ratio	1.44	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	12	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is ARIZONA doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities as of 2006 with others.

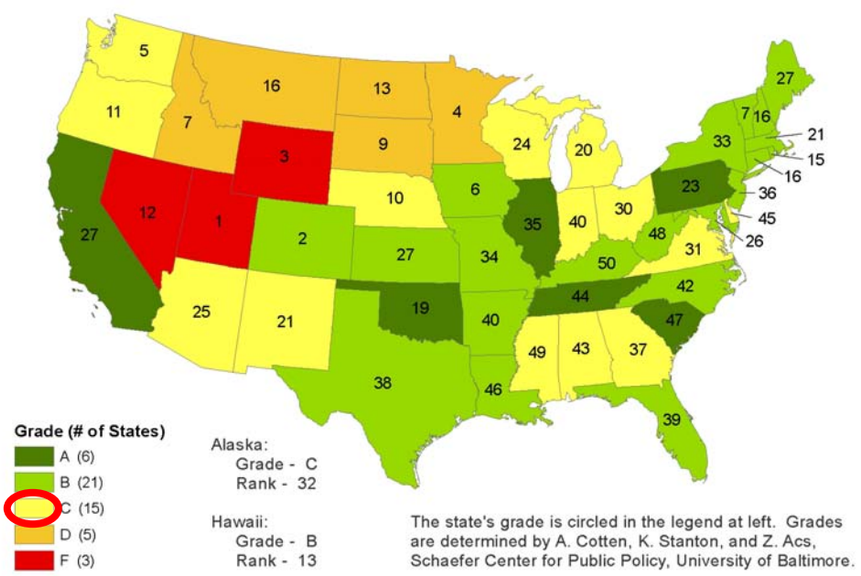
OBESITY-RELATED STATE INITIATIVES - 2007	ARIZONA	NATIONAL
Snack and/or soda tax	No	17 states + D.C.
CDC state-based nutrition and physical activity program	Yes	28 states
Federal STEPS grant recipient	Yes	7 states
Laws that limit liability for obesity and obesity-related health problems	Yes	24 states
OBESITY-RELATED SCHOOL STANDARDS - 2007	**ARIZONA**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	Yes	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	Yes	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	Yes	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**ARIZONA**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

Arizona's Department of Education released the final Arizona Nutrition Standards in January 2006, to be effective on July 1, 2006 (ARS 15-242). Foods sold in vending machines, snack bars, a la carte, fundraisers, and at school events during the normal school day must meet specified standards, including the following: (1) No more than 35% of total calories from fat; (2) 10% or less of total calories from saturated and trans fatty acids (combined); (3) No more than 35% total sugar by weight; (4) Must contain at least 1 gram of fiber; (5) Maximum 400 calories per serving and 800 mg of sodium for entrée items sold as a la carte; and (6) Maximum 300 calories per serving and 600 mg of sodium for all other snack items. Finally, all deep-fat fried chips and crackers and deep-fat fried final preparation methods are prohibited. Additional legislation in 2006 specifically applies the standards to high schools (HB2557).

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in ARKANSAS?

KEY POINTS:

- Approximately 96,000 of 293,000 Arkansas children ages 10-17 years (32.9%) are considered overweight or obese according to BMI-for-age standards.
- The state's income disparity ratio of 1.28 is third best in the nation. Arkansas ranks fifth in the prevalence of overweight and obesity among poor children (35.5%), but 48th for higher-income children, with a prevalence rate of 27.8%.
- Two of five (40.9%) black children in Arkansas are overweight or obese. The prevalence rate for white children is lower, at 29.9%, but Arkansas ranks 45th in the prevalence of overweight or obesity among white non-Hispanic children.
- Arkansas children are more likely than their counterparts nationwide to be physically active for at least 4 days per week, but they're also more likely to spend 2 hours or more in front of the television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 28.4% of low-income children ages 2 to 5 years in Arkansas are overweight or obese.

OVERALL PREVALENCE	ARKANSAS %	NATIONAL %
Percent age of children ages 10-17 years who are overweight or obese	32.9%	30.6%
State Rank for overweight or obese children (1 is best)	40	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	61.5%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	51.8%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**ARKANSAS %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	35.5%	39.8%
>400 % FPL	27.8%	22.9%
Income Disparity Ratio	1.28	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	3	
% Overweight or Obese by Type of Insurance		
Public Insurance	38.7%	39.6%
Private Insurance	30.2%	26.7%
Insurance Disparity Ratio	1.28	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	10	
% Overweight or Obese by Race		
Black, non-Hispanic	40.9%	41.2%
White, non-Hispanic	29.9%	26.6%
Race Disparity Ratio	1.37	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	5	
% Overweight or Obese by Hispanic Origin		
Hispanic	NA	37.7%
Non-Hispanic	32.8%	29.5%
Hispanic Origin Disparity Ratio	NA	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	NA	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th) can be estimated. Children with BMI between the 85th and at or above the 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is ARKANSAS doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities as of 2006 with others.

OBESITY-RELATED STATE INITIATIVES - 2007	ARKANSAS	NATIONAL
Snack and/or soda tax	Yes	17 states + D.C.
CDC state-based nutrition and physical activity program	Yes	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	No	24 states
OBESITY-RELATED SCHOOL STANDARDS - 2007	**ARKANSAS**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	Yes	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	Yes	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	Yes	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	Yes	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**ARKANSAS**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

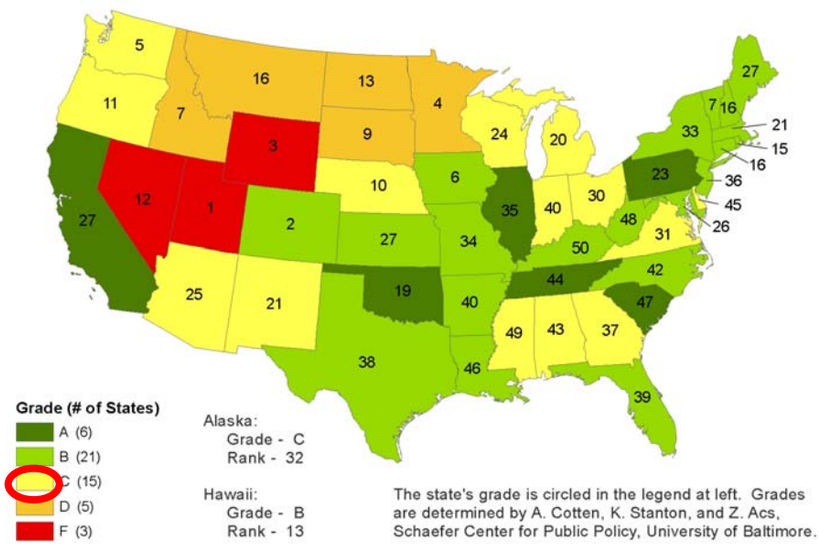
NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

Every school district shall, beginning with kindergarten, and then in even numbered grades, require schools to include as a part of a student health report to parents a body mass index percentile by age for each student. Permits any parent to refuse to have their child's body mass index percentile for age assessed and reported, by providing a written refusal to the school. Students in grades 11 and 12 are exempt from any policy or requirement of a public school or the state for measuring or reporting body mass index (HB 1173, Amends §20-7-135).

SB 965 enhances the authority of school district Nutrition and Physical Activity Committees, including the authority to set nutritional standards for school lunch programs.

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in CALIFORNIA?

KEY POINTS:

- Approximately 1,064,000 of 3,541,000 California children ages 10-17 years (30.0%) are considered overweight or obese according to BMI-for-age standards.
- The prevalence of overweight and obesity among poor children in California (31.0%) is considerably lower than the national prevalence (39.8%). Only one state, Pennsylvania, has a lower rate among poor children.
- Disparities in childhood overweight and obesity by income and insurance are less glaring in California compared to the country as a whole. California ranks fourth on the income disparity ratio and sixth on the insurance disparity ratio.
- California children are more likely than their counterparts nationwide to be physically active for at least 4 days per week, and less likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 33.2% of low-income children ages 2 to 5 years in California are overweight or obese.

OVERALL PREVALENCE	CALIFORNIA %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	30.0%	30.6%
State Rank for overweight or obese children (1 is best)	27	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	61.2%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	42.8%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**CALIFORNIA %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	31.0%	39.8%
>400 % FPL	23.5%	22.9%
Income Disparity Ratio	1.32	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	4	
% Overweight or Obese by Type of Insurance		
Public Insurance	34.1%	39.6%
Private Insurance	27.3%	26.7%
Insurance Disparity Ratio	1.25	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	6	
% Overweight or Obese by Race		
Black, non-Hispanic	NA	41.2%
White, non-Hispanic	26.1%	26.6%
Race Disparity Ratio	NA	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	NA	
% Overweight or Obese by Hispanic Origin		
Hispanic	36.3%	37.7%
Non-Hispanic	27.2%	29.5%
Hispanic Origin Disparity Ratio	1.33	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	7	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

What is CALIFORNIA doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities as of 2006 with others.

OBESITY-RELATED STATE INITIATIVES - 2007	CALIFORNIA	NATIONAL
Snack and/or soda tax	Yes	17 states + D.C.
CDC state-based nutrition and physical activity program	No	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	No	24 states
OBESITY-RELATED SCHOOL STANDARDS - 2007	**CALIFORNIA**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	Yes	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	Yes	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	Yes	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	Yes	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**CALIFORNIA**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	Yes	19 states introduced

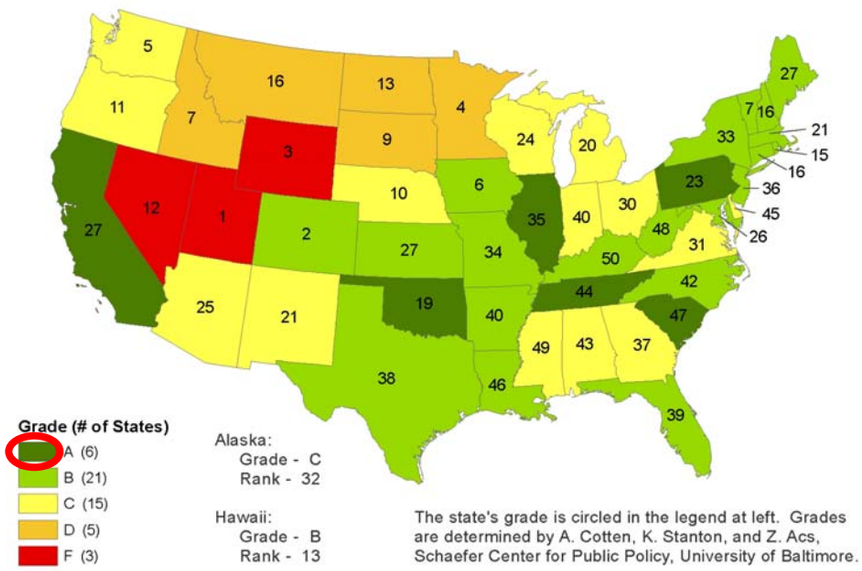
NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

Individual student BMI is reported to parents via confidential letter as part of a non-invasive diabetes screening pilot program for 7th and 8th graders (California Education Code §49452.6).

The Fresh Start Pilot Program encourages public schools to provide fruits and vegetables that have not been deep-fried, for free when appropriate, to pupils in grades 1 through 12, in order to promote consumption of such foods by school-age children (SB 281).

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in COLORADO?

KEY POINTS:

- Approximately 107,000 of 487,000 Colorado children ages 10-17 years (21.9%) are considered overweight or obese according to BMI-for-age standards. Colorado ranks second only to Utah in overall prevalence.
- Colorado ranks first or second among the states in overweight/obesity prevalence for several subgroups of children: higher-income (1st), Hispanic (1st), publicly insured (2nd), white non-Hispanic (2nd), and non-Hispanic (2nd). The state ranks third on privately insured children.
- Only about one in seven (14.7%) children in higher-income families are overweight or obese in Colorado.
- Colorado children are less likely than their counterparts nationwide to be physically active for at least 4 days per week, but they're also less likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 24.3% of low-income children ages 2 to 5 years in Colorado are overweight or obese.

OVERALL PREVALENCE	COLORADO %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	21.9%*	30.6%
State Rank for overweight or obese children (1 is best)	2	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	57.1%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	38.4%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**COLORADO %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	NA	39.8%
>400 % FPL	14.7%	22.9%
Income Disparity Ratio	NA	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	NA	
% Overweight or Obese by Type of Insurance		
Public Insurance	26.6%	39.6%
Private Insurance	20.3%	26.7%
Insurance Disparity Ratio	1.31	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	12	
% Overweight or Obese by Race		
Black, non-Hispanic	NA	41.2%
White, non-Hispanic	18.3%	26.6%
Race Disparity Ratio	NA	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	NA	
% Overweight or Obese by Hispanic Origin		
Hispanic	32.4%	37.7%
Non-Hispanic	19.9%	29.5%
Hispanic Origin Disparity Ratio	1.63	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	16	

* Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is COLORADO doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities as of 2006 with others.

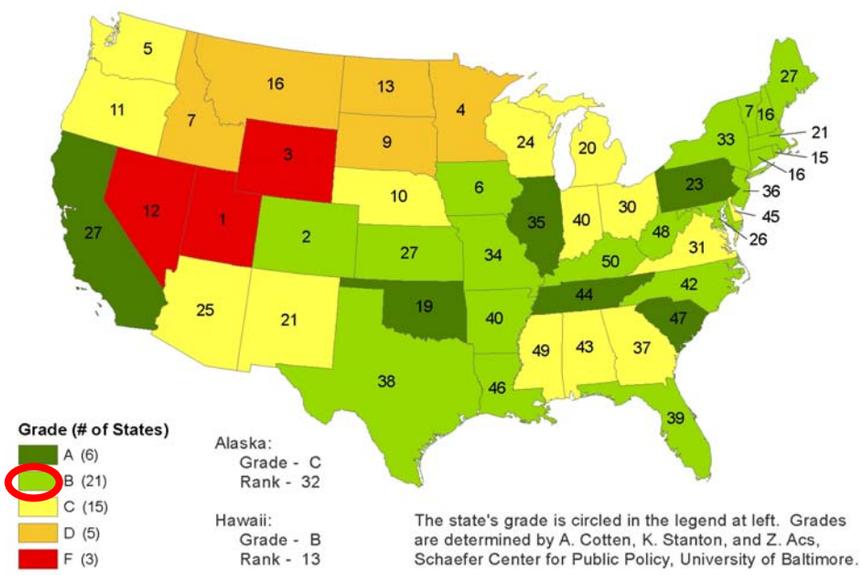
OBESITY-RELATED STATE INITIATIVES - 2007	COLORADO	NATIONAL
Snack and/or soda tax	No	17 states + D.C.
CDC state-based nutrition and physical activity program	Yes	28 states
Federal STEPS grant recipient	Yes	7 states
Laws that limit liability for obesity and obesity-related health problems	Yes	24 states
OBESITY-RELATED SCHOOL STANDARDS - 2007	**COLORADO**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	No	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	Yes	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	No	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	Yes	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**COLORADO**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

Subject to the availability of funds, recent legislation creates the Fresh Fruits and Vegetables Pilot Program for the 2006-07 and 2007-08 school years. The pilot program shall be modeled after the U.S. Department of Agriculture's Fruit and Vegetable Pilot Program to make free fruits and vegetables available to students throughout the school day in one or more places designated by the participating school. The law requires that at least 75% of the students participating in the pilot program are from school districts where at least 50% of the students are eligible for free or reduced-cost lunch under the federal "National School Lunch Act" (SB 127, Chapter 242).

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in CONNECTICUT?

KEY POINTS:

- Approximately 98,000 of 357,000 Connecticut children ages 10-17 years (27.3%) are considered overweight or obese according to BMI-for-age standards.
- Black children in Connecticut are almost two times more likely than white children to be overweight or obese (44.9% to 23.2%). Connecticut's race disparity ratio of 1.94 ranks near the bottom on this equity measure, exceeded only by New Jersey and the District of Columbia.
- Almost one in three (32.4%) Hispanic children in Connecticut are obese or overweight. This prevalence rate ties Colorado for lowest in the nation.
- Connecticut children are less likely than their counterparts nationwide to be physically active for at least 4 days per week, and more likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 32.7% of low-income children ages 2 to 5 years in Connecticut are overweight or obese.

OVERALL PREVALENCE	CONNECTICUT %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	27.3%	30.6%
State Rank for overweight or obese children (1 is best)	16	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	52.6%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	40.0%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**CONNECTICUT %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	NA	39.8%
>400 % FPL	23.0%	22.9%
Income Disparity Ratio	NA	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	NA	
% Overweight or Obese by Type of Insurance		
Public Insurance	40.3%	39.6%
Private Insurance	24.3%	26.7%
Insurance Disparity Ratio	1.66	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	35	
% Overweight or Obese by Race		
Black, non-Hispanic	44.9%	41.2%
White, non-Hispanic	23.2%	26.6%
Race Disparity Ratio	1.94	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	21	
% Overweight or Obese by Hispanic Origin		
Hispanic	32.4%	37.7%
Non-Hispanic	26.8%	29.5%
Hispanic Origin Disparity Ratio	1.21	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	3	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is CONNECTICUT doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities as of 2006 with others.

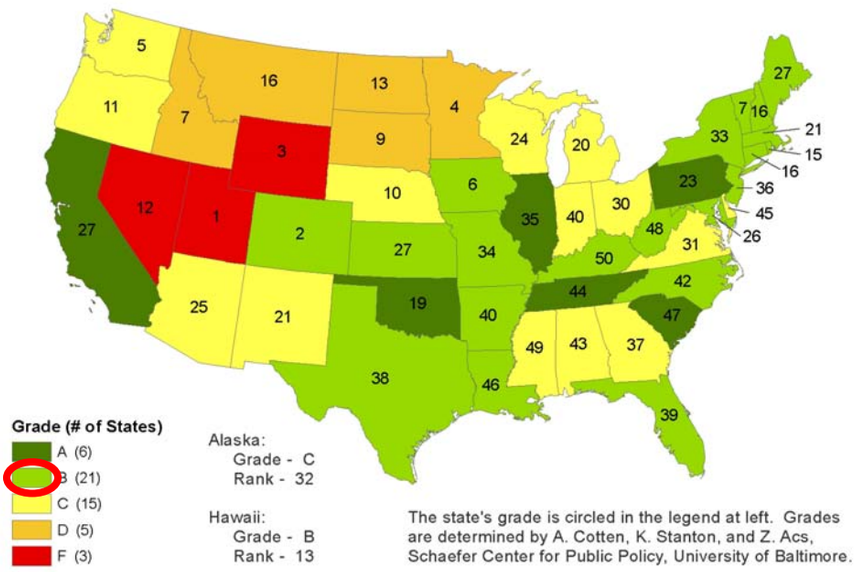
OBESITY-RELATED STATE INITIATIVES - 2007	CONNECTICUT	NATIONAL
Snack and/or soda tax	No	17 states + D.C.
CDC state-based nutrition and physical activity program	No	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	No	24 states
OBESITY-RELATED SCHOOL STANDARDS - 2007	**CONNECTICUT**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	Yes	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	Yes	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	Yes	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**CONNECTICUT**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	proposed	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

Effective July 1, 2006, schools will restrict the sale of beverages available from school stores, vending machines, school cafeterias, and any fund-raising activities on the school premises, whether or not school sponsored, to the following: (1) Milk that may be flavored but contain no artificial sweeteners and no more than four grams of sugar per ounce; (2) Nondairy milks such as soy or rice milk, which may be flavored but contain no artificial sweeteners, no more than four grams of sugar per ounce, no more than 35% of calories from fat per portion and no more than 10% of calories from saturated fat per portion; (3) 100% fruit juice, vegetable juice or combination of such juices, containing no added sugars, sweeteners or artificial sweeteners; (4) Beverages that contain only water and fruit or vegetable juice and have no added sugars, sweeteners, or artificial sweeteners; (5) Water, which may be flavored but contain no added sugars, sweeteners, artificial sweeteners or caffeine. Portion sizes of beverages listed above (other than water) that are offered for sale shall not exceed 12 ounces.

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in DELAWARE?

KEY POINTS:

- Approximately 31,000 of 86,000 Delaware children ages 10-17 years (35.5%) are considered overweight or obese according to BMI-for-age standards.
- More than half of Delaware children in poverty (54.3%) or receiving public insurance (53.5%) are obese or overweight. The state ranks last among all states on overweight/obese prevalence among poor children, and next-to-last on publicly insured children.
- Nearly half (48.9%) of Delaware's black non-Hispanic children are classified as overweight or obese. Only one other state (New Jersey) has a higher prevalence rate among black children.
- Delaware children are less likely than their counterparts nationwide to be physically active for at least 4 days per week, and more likely to spend 2 hours or more in front of a television or computer screen.

OVERALL PREVALENCE	DELAWARE %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	35.5%*	30.6%
State Rank for overweight or obese children (1 is best)	45	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	56.2%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	46.0%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**DELAWARE %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	54.3%	39.8%
>400 % FPL	26.7%	22.9%
Income Disparity Ratio	2.03	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	28	
% Overweight or Obese by Type of Insurance		
Public Insurance	53.5%	39.6%
Private Insurance	29.9%	26.7%
Insurance Disparity Ratio	1.79	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	41	
% Overweight or Obese by Race		
Black, non-Hispanic	48.9%	41.2%
White, non-Hispanic	28.8%	26.6%
Race Disparity Ratio	1.70	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	16	
% Overweight or Obese by Hispanic Origin		
Hispanic	56.6%	37.7%
Non-Hispanic	34.0%	29.5%
Hispanic Origin Disparity Ratio	1.67	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	19	

* Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th at or above the percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is DELAWARE doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

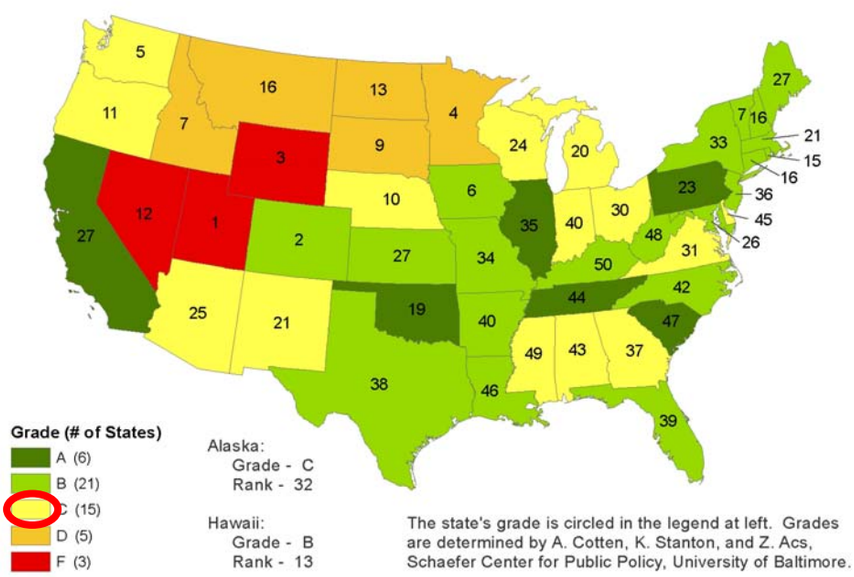
OBESITY-RELATED STATE INITIATIVES	DELAWARE	NATIONAL
Snack and/or soda tax	No	17 states + D.C.
CDC state-based nutrition and physical activity program	No	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	No	24 states
OBESITY-RELATED SCHOOL STANDARDS	**DELAWARE**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	No	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	No	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	No	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	Yes	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**DELAWARE**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	Yes	19 states introduced

NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

Recent legislation requires the Department of Education to develop a regulation requiring each local school district and charter school to assess the physical fitness of each student at least once at the elementary, middle and high school level and outlining the grades at which the assessment will be given. The assessment results are to be provided to the parent, guardian or relative caregiver. The intent is to provide baseline and periodic updates for each student and his or her parent, guardian or relative caregiver sharing in the knowledge of obesity and other chronic illnesses. Includes measuring body mass index as part of the testing in some local school districts (HB 372).

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in the DISTRICT OF COLUMBIA (DC)?

KEY POINTS:

- Approximately 16,000 of 41,000 District of Columbia children ages 10-17 years (39.5%) are considered overweight or obese according to BMI-for-age standards. The District ranks 51st in overall prevalence.
- More than half (51.9%) of poor children in the District of Columbia are overweight or obese. This prevalence rate is nearly double the rate among higher-income children (26.3%) in the District.
- The prevalence of overweight and obesity among white, non-Hispanic children in the District of Columbia (12.7%) is lower than the comparable rate in any state. In contrast, the prevalence rate for black, non-Hispanic children (43.6%) is more than three times higher. The District's race disparity ratio is worst among the 23 states and state equivalents that had reliable estimates.
- District of Columbia children are less likely than their counterparts nationwide to be physically active for at least 4 days per week, and more likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 30.2% of low-income children ages 2 to 5 years in the District of Columbia are overweight or obese.

OVERALL PREVALENCE	DC %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	39.5%*	30.6%
State Rank for overweight or obese children (1 is best)	51	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	52.8%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	49.9%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**DC %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	51.9%	39.8%
>400 % FPL	26.3%	22.9%
Income Disparity Ratio	1.97	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	25	
% Overweight or Obese by Type of Insurance		
Public Insurance	47.3%	39.6%
Private Insurance	32.7%	26.7%
Insurance Disparity Ratio	1.45	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	20	
% Overweight or Obese by Race		
Black, non-Hispanic	43.6%	41.2%
White, non-Hispanic	12.7%	26.6%
Race Disparity Ratio	3.44	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	23	
% Overweight or Obese by Hispanic Origin		
Hispanic	45.4%	37.7%
Non-Hispanic	39.0%	29.5%
Hispanic Origin Disparity Ratio	1.16	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	1	

* Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is the DISTRICT OF COLUMBIA doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

OBESITY-RELATED STATE INITIATIVES	DISTRICT OF COLUMBIA	NATIONAL
Snack and/or soda tax	Yes	17 states + D.C.
CDC state-based nutrition and physical activity program	No	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	No	24 states
OBESITY-RELATED SCHOOL STANDARDS	**DISTRICT OF COLUMBIA**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	No	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	No	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	No	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**DISTRICT OF COLUMBIA**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

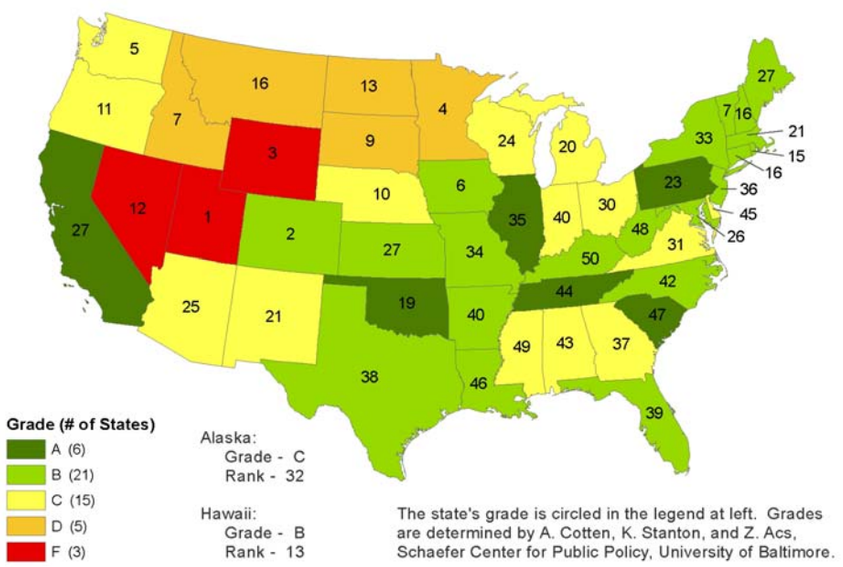
NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

The school district requires 1.5 credits of health education for high school graduation.

The school district requires 1.5 credits of physical education for high school graduation.

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The District of Columbia did not receive a grade. The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in FLORIDA?

KEY POINTS:

- Approximately 553,000 of 1,702,000 Florida children ages 10-17 years (32.5%) are considered overweight or obese according to BMI-for-age standards.
- The prevalence rate of overweight and obesity is more than two of five for Florida children who are poor (43.1%), on public health insurance (40.8%), or black non-Hispanic (45.3%).
- Overweight and obese prevalence among white non-Hispanic children in Florida (25.4%) is 20 percentage points lower than the prevalence for black non-Hispanic kids. Florida's race disparity ratio is one of the worst in the nation, surpassed by only Connecticut, Delaware, and the District of Columbia.
- Florida children are more likely than their counterparts nationwide to be physically active for at least 4 days per week, and equally likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 29.3% of low-income children ages 2 to 5 years in Florida are overweight or obese.

OVERALL PREVALENCE	FLORIDA %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	32.5%	30.6%
State Rank for overweight or obese children (1 is best)	39	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	61.2%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	44.8%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**FLORIDA %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	43.1%	39.8%
>400 % FPL	25.7%	22.9%
Income Disparity Ratio	1.68	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	13	
% Overweight or Obese by Type of Insurance		
Public Insurance	40.8%	39.6%
Private Insurance	26.7%	26.7%
Insurance Disparity Ratio	1.53	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	28	
% Overweight or Obese by Race		
Black, non-Hispanic	45.3%	41.2%
White, non-Hispanic	25.4%	26.6%
Race Disparity Ratio	1.78	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	20	
% Overweight or Obese by Hispanic Origin		
Hispanic	38.2%	37.7%
Non-Hispanic	31.0%	29.5%
Hispanic Origin Disparity Ratio	1.23	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	4	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is FLORIDA doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

OBESITY-RELATED STATE INITIATIVES	FLORIDA	NATIONAL
Snack and/or soda tax	No	17 states + D.C.
CDC state-based nutrition and physical activity program	Yes	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	Yes	24 states
OBESITY-RELATED SCHOOL STANDARDS	**FLORIDA**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	No	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	No	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	Yes	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	Yes	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**FLORIDA**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	Yes	19 states introduced

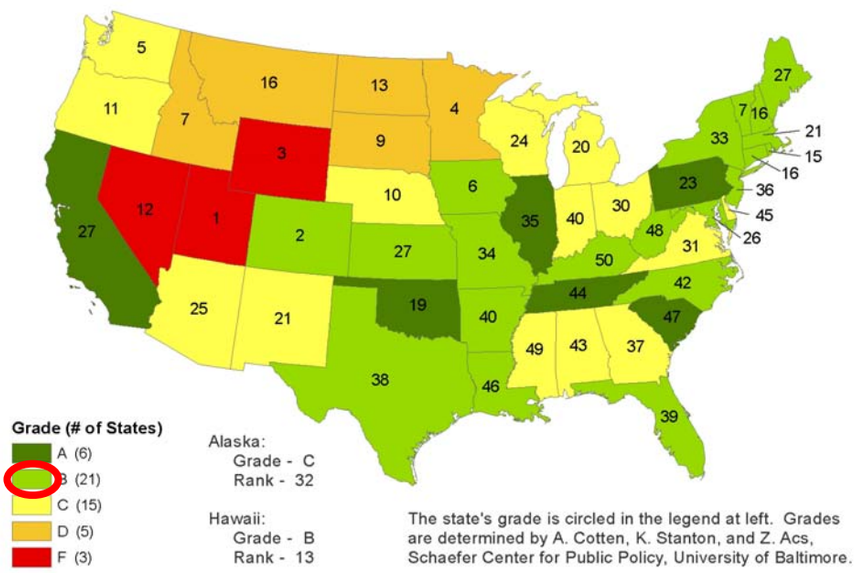
NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

Florida Statute §381.0056(5) requires school health services programs administered jointly by the Department of Health and the Department of Education to administer growth and development screening for students. BMI is encouraged as part of these screenings for all students in 1st, 3rd, 6th, and, optionally, 9th grades.

Each Florida school district board shall provide 150 minutes of physical education each week for students in grades K-5. Each district school board is encouraged to provide 225 minutes of physical education each week for students in grades 6-8 (HB 967, Chapter 2007-28).

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in GEORGIA?

KEY POINTS:

- Approximately 301,000 of 948,000 Georgia children ages 10-17 years (31.7%) are considered overweight or obese according to BMI-for-age standards.
- About half (46.9%) of Georgia children receiving public health insurance are overweight or obese, double the rate among privately insured children (23.6%). The state's insurance disparity ratio ranks 48th among 49 states with reliable estimates.
- Poor children in Georgia are twice as likely to be overweight or obese as those in higher-income families.
- Georgia children are more likely than their counterparts nationwide to be physically active for at least 4 days per week, and equally likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 30.9% of low-income children ages 2 to 5 years in Georgia are overweight or obese.

OVERALL PREVALENCE	GEORGIA %	NATIONAL %
Percent age of children ages 10-17 years who are overweight or obese	31.7%	30.6%
State Rank for overweight or obese children (1 is best)	37	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	60.7%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	44.2%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**GEORGIA %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	41.1%	39.8%
>400 % FPL	20.6%	22.9%
Income Disparity Ratio	2.00	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	27	
% Overweight or Obese by Type of Insurance		
Public Insurance	46.9%	39.6%
Private Insurance	23.6%	26.7%
Insurance Disparity Ratio	1.98	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	48	
% Overweight or Obese by Race		
Black, non-Hispanic	41.6%	41.2%
White, non-Hispanic	26.2%	26.6%
Race Disparity Ratio	1.59	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	12	
% Overweight or Obese by Hispanic Origin		
Hispanic	NA	37.7%
Non-Hispanic	31.0%	29.5%
Hispanic Origin Disparity Ratio	NA	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	NA	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is GEORGIA doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

OBESITY-RELATED STATE INITIATIVES	GEORGIA	NATIONAL
Snack and/or soda tax	No	17 states + D.C.
CDC state-based nutrition and physical activity program	Yes	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	Yes	24 states
OBESITY-RELATED SCHOOL STANDARDS	**GEORGIA**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	No	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	No	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	Yes	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**GEORGIA**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	proposed	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

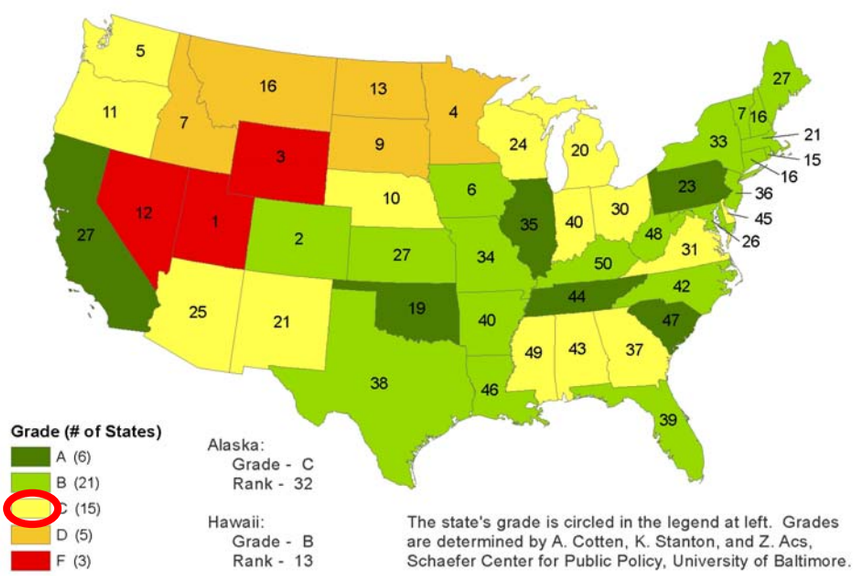
NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

Georgia prohibits the sale of foods of minimal nutritional value in elementary schools from the beginning of the day until the end of the last lunch period.

Georgia requires 90 hours of health and physical education in elementary school. There are no health education requirements for middle school, but schools must offer health education. One unit (140 hours) of health education is required for high school graduation.

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in HAWAII?

KEY POINTS:

- Approximately 34,000 of 128,000 Hawaii children ages 10-17 years (26.9%) are considered overweight or obese according to BMI-for-age standards.
- Publicly insured children in Hawaii are 1.5 times more likely than those with private health insurance to be obese or overweight (36.7% to 24.2%).
- More than one in three (35.7%) Hawaii children in families below the poverty line are overweight or obese.
- Hawaii children are more likely than their counterparts nationwide to be physically active for at least 4 days per week, and about equally likely to spend 2 hours or more in front of a television or computer screen.

OVERALL PREVALENCE	HAWAII %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	26.9%*	30.6%
State Rank for overweight or obese children (1 is best)	13	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	61.6%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	44.1%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**HAWAII %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	35.7%	39.8%
>400 % FPL	25.1%	22.9%
Income Disparity Ratio	1.42	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	8	
% Overweight or Obese by Type of Insurance		
Public Insurance	36.7%	39.6%
Private Insurance	24.2%	26.7%
Insurance Disparity Ratio	1.52	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	25	
% Overweight or Obese by Race		
Black, non-Hispanic	NA	41.2%
White, non-Hispanic	23.6%	26.6%
Race Disparity Ratio	NA	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	NA	
% Overweight or Obese by Hispanic Origin		
Hispanic	39.8%	37.7%
Non-Hispanic	25.3%	29.5%
Hispanic Origin Disparity Ratio	1.57	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	15	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is HAWAII doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

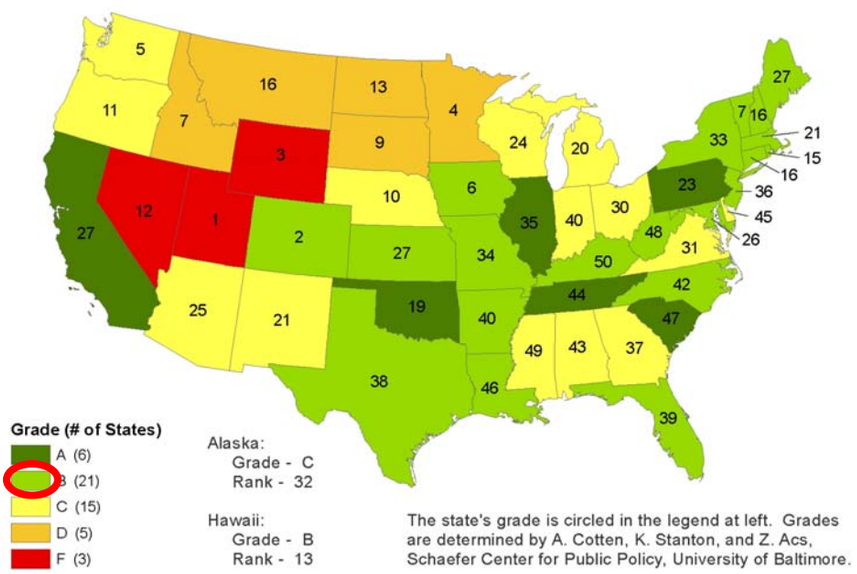
OBESITY-RELATED STATE INITIATIVES	HAWAII	NATIONAL
Snack and/or soda tax	No	17 states + D.C.
CDC state-based nutrition and physical activity program	No	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	No	24 states
OBESITY-RELATED SCHOOL STANDARDS	**HAWAII**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	No	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	Yes	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	Yes	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**HAWAII**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

Hawaii places the following nutritional requirements on supplementary food and beverage items that can be sold during the meal periods in secondary schools: (1) Maximum calories from fat: 25% of total calories; (2) Maximum calories from saturated fat: 10% of total calories; (3) Maximum percent of sugar: 25% of total calories with the exception of fruits and vegetables; (4) 80% of beverage selections from each vending machine in schools shall be "healthy beverages," defined as milk, flavored milk, water, and fruit juice containing at least 50% juice, or other choices deemed appropriate by the Department of Education. The School Community Council and principal will determine the combination of beverages to be sold, including the remaining 20 % of beverage selections, and shall have the discretion to ban caffeinated products. No alcoholic beverages, coffee, or coffee-based beverages may be dispensed.

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in IDAHO?

KEY POINTS:

- Approximately 41,000 of 160,000 Idaho children ages 10-17 years (25.6%) are considered overweight or obese according to BMI-for-age standards. Idaho ranks seventh in the nation in overall prevalence.
- The prevalence rate of overweight and obesity among Hispanic children in Idaho is almost one in two (49.2%), double the rate among non-Hispanic children (23.7%). The state's Hispanic origin disparity ratio of 2.08 ranks last among states with adequate Hispanic sample size.
- Idaho ranks fifth in the nation in overweight/obese prevalence for children with private health insurance (21.8%).
- Idaho children are about as likely as their counterparts nationwide to be physically active for at least 4 days per week, and less likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 29.3% of low-income children ages 2 to 5 years in Idaho are overweight or obese.

OVERALL PREVALENCE	IDAHO %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	25.6%*	30.6%
State Rank for overweight or obese children (1 is best)	7	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	59.7%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	39.8%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**IDAHO %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	NA	39.8%
>400 % FPL	17.7%	22.9%
Income Disparity Ratio	NA	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	NA	
% Overweight or Obese by Type of Insurance		
Public Insurance	39.8%	39.6%
Private Insurance	21.8%	26.7%
Insurance Disparity Ratio	1.83	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	43	
% Overweight or Obese by Race		
Black, non-Hispanic	NA	41.2%
White, non-Hispanic	23.0%	26.6%
Race Disparity Ratio	NA	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	NA	
% Overweight or Obese by Hispanic Origin		
Hispanic	49.2%	37.7%
Non-Hispanic	23.7%	29.5%
Hispanic Origin Disparity Ratio	2.08	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	21	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data… Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is IDAHO doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

OBESITY-RELATED STATE INITIATIVES	IDAHO	NATIONAL
Snack and/or soda tax	No	17 states + D.C.
CDC state-based nutrition and physical activity program	No	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	Yes	24 states
OBESITY-RELATED SCHOOL STANDARDS	**IDAHO**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	No	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	No	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	No	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**IDAHO**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

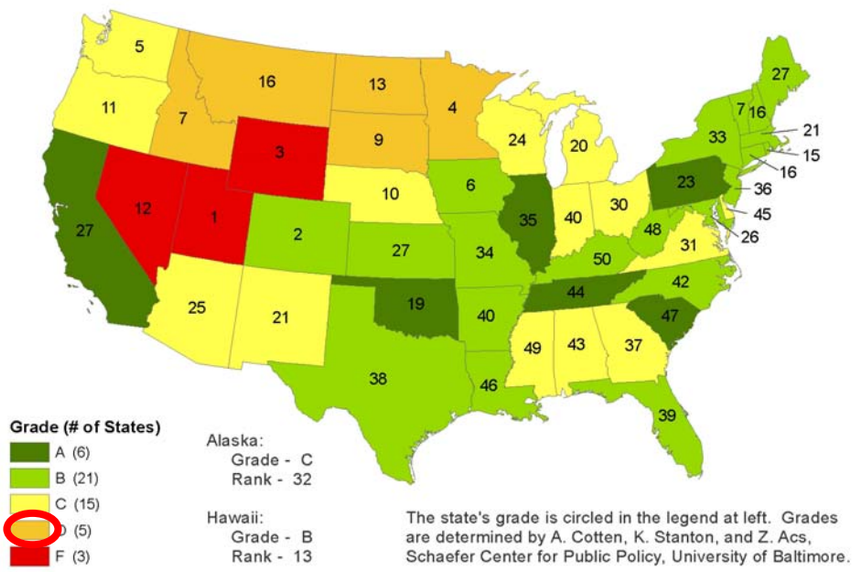
NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

Idaho requires health education in elementary and middle school. One credit is required for high school graduation. The state Board of Education developed health education content standards that are a minimum requirement for schools.

April 2004 legislation protects a manufacturer, packer, distributor, carrier, holder, seller, marketer, or advertiser of any food or beverage, or an association of those entities, from civil liability for any claim arising from weight gain, obesity, a health condition associated with weight gain or obesity, or other generally known condition allegedly caused by, or likely to result from, the long-term consumption of food. The limitation of civil liability shall not bar a claim based on material violation of adulteration or misbranding or any other violation of federal or state law.

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in ILLINOIS?

KEY POINTS:

- Approximately 418,000 of 1,339,000 Illinois children ages 10-17 years (31.2%) are considered overweight or obese according to BMI-for-age standards.
- A majority (55.6%) of publicly insured children in Illinois are overweight or obese, the highest prevalence in the nation.
- Nearly two in five (39.1%) black non-Hispanic children in Illinois are overweight or obese, ranking the state third in prevalence for this subgroup. Only Michigan and Texas have a lower prevalence of overweight and obesity for black children.
- Illinois children are slightly less likely than their counterparts nationwide to be physically active for at least 4 days per week, and slightly more likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 29.8% of low-income children ages 2 to 5 years in Illinois are overweight or obese.

OVERALL PREVALENCE	ILLINOIS %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	31.2%	30.6%
State Rank for overweight or obese children (1 is best)	35	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	57.8%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	45.6%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**ILLINOIS %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	48.4%	39.8%
>400 % FPL	22.2%	22.9%
Income Disparity Ratio	2.18	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	32	
% Overweight or Obese by Type of Insurance		
Public Insurance	55.6%	39.6%
Private Insurance	25.2%	26.7%
Insurance Disparity Ratio	2.20	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	49	
% Overweight or Obese by Race		
Black, non-Hispanic	39.1%	41.2%
White, non-Hispanic	27.8%	26.6%
Race Disparity Ratio	1.41	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	9	
% Overweight or Obese by Hispanic Origin		
Hispanic	40.1%	37.7%
Non-Hispanic	30.0%	29.5%
Hispanic Origin Disparity Ratio	1.34	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	8	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is ILLINOIS doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

OBESITY-RELATED STATE INITIATIVES	ILLINOIS	NATIONAL
Snack and/or soda tax	Yes	17 states + D.C.
CDC state-based nutrition and physical activity program	Yes	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	Yes	24 states
OBESITY-RELATED SCHOOL STANDARDS	**ILLINOIS**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	No	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	Yes	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	Yes	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	Yes	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**ILLINOIS**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	Yes	19 states introduced

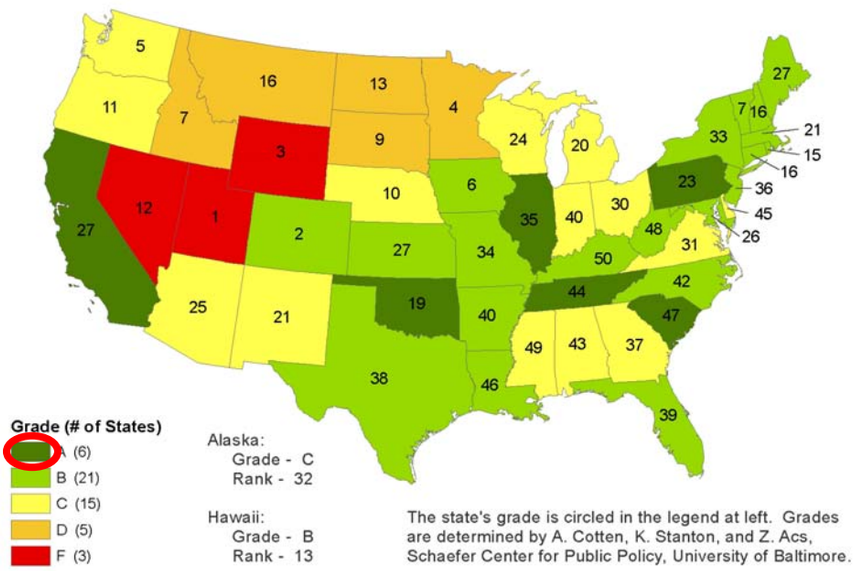
NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

Illinois Administrative Code (23 IAC Ch. 1, Section 305.15) requires all schools participating in the free lunch and breakfast programs in which grades five and below are operating to prohibit the sale of all confections, candy and potato chips to students during meal periods (effective the first day of the 2006-2007 school year).

Illinois authorizes local school officials to regulate the sale of competitive foods to students during the regular breakfast and lunch periods in junior and senior high schools, if so desired.

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in INDIANA?

KEY POINTS:

- Approximately 220,000 of 667,000 Indiana children ages 10-17 years (32.9%) are considered overweight or obese according to BMI-for-age standards.
- Indiana ranks 50th in overweight/obese prevalence among children in higher-income families (29.4%), six percentage points above the national rate, and exceeded only by Louisiana.
- Almost one in three (32.8%) white non-Hispanic children in Indiana is overweight or obese. Indiana ranks 48th in overweight/obese prevalence for this subgroup, lower than only three other states (Tennessee, West Virginia, Kentucky).
- Indiana children are less likely than their counterparts nationwide to be physically active for at least 4 days per week, and more likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 30.4% of low-income children ages 2 to 5 years in Indiana are overweight or obese.

OVERALL PREVALENCE	INDIANA %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	32.9%	30.6%
State Rank for overweight or obese children (1 is best)	40	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	57.8%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	46.7%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**INDIANA %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	49.3%	39.8%
>400 % FPL	29.4%	22.9%
Income Disparity Ratio	1.54	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	11	
% Overweight or Obese by Type of Insurance		
Public Insurance	45.2%	39.6%
Private Insurance	29.8%	26.7%
Insurance Disparity Ratio	1.52	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	25	
% Overweight or Obese by Race		
Black, non-Hispanic	NA	41.2%
White, non-Hispanic	32.8%	26.6%
Race Disparity Ratio	NA	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	NA	
% Overweight or Obese by Hispanic Origin		
Hispanic	NA	37.7%
Non-Hispanic	32.8%	29.5%
Hispanic Origin Disparity Ratio	NA	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	NA	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at t or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is INDIANA doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

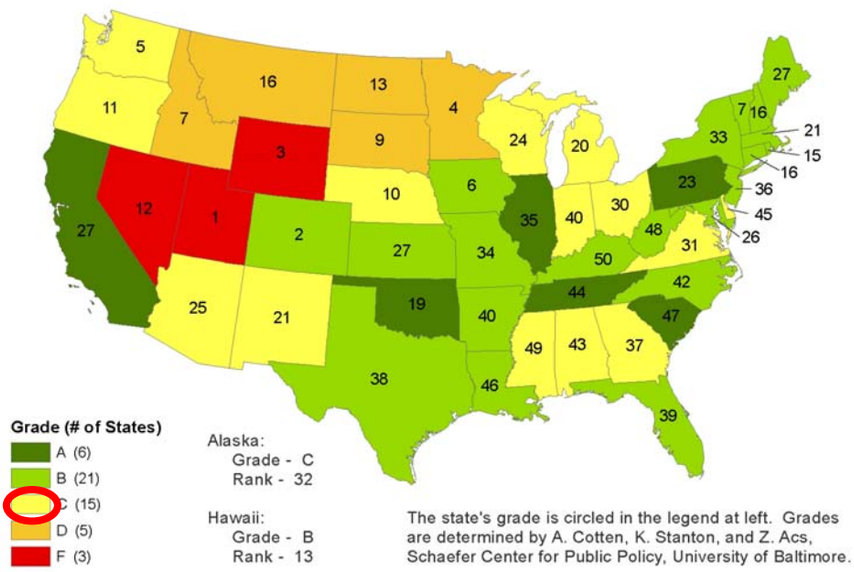
OBESITY-RELATED STATE INITIATIVES	INDIANA	NATIONAL
Snack and/or soda tax	Yes	17 states + D.C.
CDC state-based nutrition and physical activity program	No	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	Yes	24 states
OBESITY-RELATED SCHOOL STANDARDS	**INDIANA**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	No	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	Yes	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	Yes	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**INDIANA**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	proposed	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

Indiana requires that vending machines in elementary schools that sell food or beverage items not be accessible to students. At least 50% of food and beverage choices for sale on school grounds must be "better food choices," defined as: (1) Fruit or vegetable drinks that are at least 50% juice and do not contain additional caloric sweeteners; (2) Water that does not contain added caloric sweeteners; (3) Low and fat-free milk; (4) Isotonic beverages; and (5) Foods that contain not more than 30% of total calories from fat, not more than 10% of total calories from saturated and trans fat, and not more than 35% of their weight from sugars not naturally occurring in fruits, vegetables, or dairy products (SB 111, 2006; IAC 20-26-9-19).

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in IOWA?

KEY POINTS:

- Approximately 80,000 of 314,000 Iowa children ages 10-17 years (25.5%) are considered overweight or obese according to BMI-for-age standards.
- The prevalence of overweight and obesity among children in poor families is roughly double the rate for children in higher-income families (39.6% to 21.4%).
- Iowa children are slightly more likely than their counterparts nationwide to be physically active for at least 4 days per week, and less likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 32.5% of low-income children ages 2 to 5 years in Iowa are overweight or obese.

OVERALL PREVALENCE	IOWA %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	25.5%*	30.6%
State Rank for overweight or obese children (1 is best)	6	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	60.5%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	42.2%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**IOWA %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	39.6%	39.8%
>400 % FPL	21.4%	22.9%
Income Disparity Ratio	1.85	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	18	
% Overweight or Obese by Type of Insurance		
Public Insurance	38.5%	39.6%
Private Insurance	22.8%	26.7%
Insurance Disparity Ratio	1.69	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	37	
% Overweight or Obese by Race		
Black, non-Hispanic	NA	41.2%
White, non-Hispanic	24.1%	26.6%
Race Disparity Ratio	NA	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	NA	
% Overweight or Obese by Hispanic Origin		
Hispanic	NA	37.7%
Non-Hispanic	24.8%	29.5%
Hispanic Origin Disparity Ratio	NA	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	NA	

* Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is IOWA doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

Obesity-Related State Initiatives	Iowa	National
Snack and/or soda tax	No	17 states + D.C.
CDC state-based nutrition and physical activity program	Yes	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	No	24 states
Obesity-Related School Standards	**Iowa**	**National**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	No	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	No	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	No	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	Yes	16 states
2006 Obesity-Related Policy Options	**Iowa**	**National**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	Yes	19 states introduced

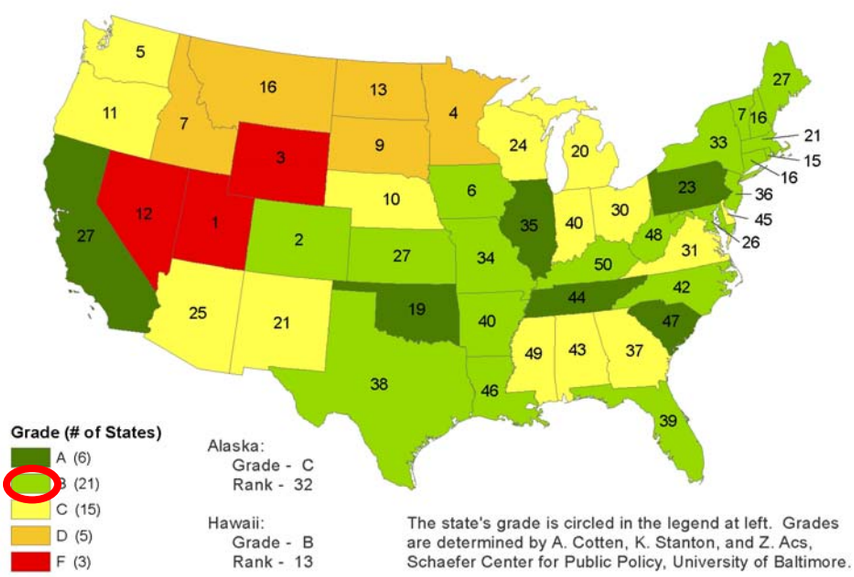
NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

SB 2124 (2006) establishes a pilot grant program (in six communities) to increase the physical activity and fruit and vegetable consumption of targeted youth of elementary school age. Grant requirements include the measurement, reporting and tracking of the height and weight of students in participating elementary schools.

All physically able students in grades 9-12 shall be required to participate in physical education activities during each semester they are enrolled in school. A minimum of one-eighth unit each semester is required (Code 256.11).

State Obesity Prevalence Ranking and Report Card Grade for Childhood Obesity-related Activities



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in KANSAS?

KEY POINTS:

- Approximately 94,000 of 313,000 Kansas children ages 10-17 years (30.0%) are considered overweight or obese according to BMI-for-age standards.
- The prevalence of overweight and obesity in Kansas among children in poor families is more than double the rate for children in higher-income families (45.1% to 20.6%).
- The overweight/obese prevalence for Hispanic children in Kansas is roughly one third higher than the prevalence among non-Hispanic children. The state's Hispanic origin disparity ratio of 1.29 is sixth best in the country.
- Kansas children are more likely than their counterparts nationwide to be physically active for at least 4 days per week, and less likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 30.8% of low-income children ages 2 to 5 years in Kansas are overweight or obese.

OVERALL PREVALENCE	KANSAS %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	30.0%	30.6%
State Rank for overweight or obese children (1 is best)	27	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	63.9%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	40.7%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**KANSAS %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	45.1%	39.8%
>400 % FPL	20.6%	22.9%
Income Disparity Ratio	2.19	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	33	
% Overweight or Obese by Type of Insurance		
Public Insurance	43.7%	39.6%
Private Insurance	26.8%	26.7%
Insurance Disparity Ratio	1.63	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	33	
% Overweight or Obese by Race		
Black, non-Hispanic	NA	41.2%
White, non-Hispanic	27.4%	26.6%
Race Disparity Ratio	NA	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	NA	
% Overweight or Obese by Hispanic Origin		
Hispanic	36.9%	37.7%
Non-Hispanic	28.6%	29.5%
Hispanic Origin Disparity Ratio	1.29	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	6	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data… Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is KANSAS doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

OBESITY-RELATED STATE INITIATIVES	KANSAS	NATIONAL
Snack and/or soda tax	No	17 states + D.C.
CDC state-based nutrition and physical activity program	No	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	Yes	24 states
OBESITY-RELATED SCHOOL STANDARDS	**KANSAS**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	No	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	No	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	No	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	Yes	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**KANSAS**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

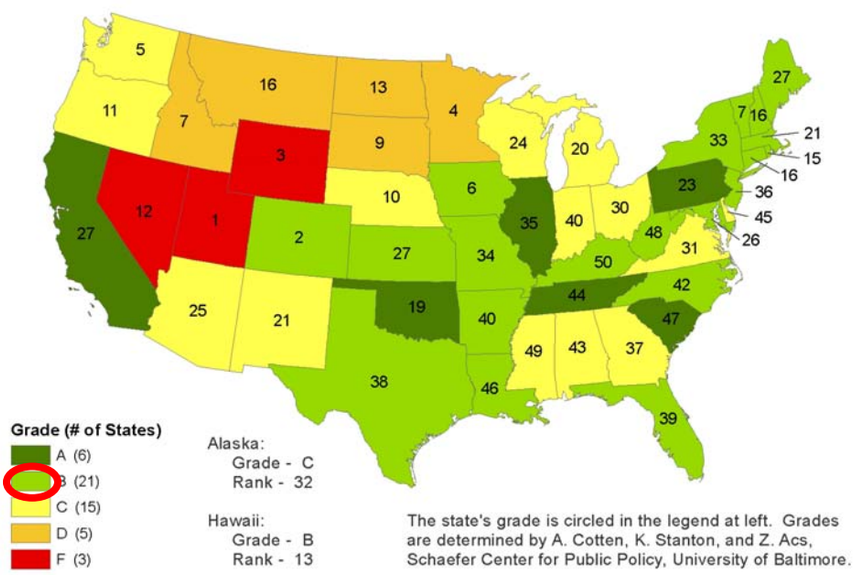
NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

Taking Steps Together, a joint effort between the Kansas Department of Health and Environment and the Kansas State Department of Education, continues to work with 77 schools and others that express interest to collect BMI data from students voluntarily.

Recent legislation supports physical education classes for all grades from kindergarten through 12, and urges the Kansas State Board of Education to require some type of physical education class for all grades from kindergarten through 12 (HR 6011).

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in KENTUCKY?

KEY POINTS:

- Approximately 175,000 of 458,000 Kentucky children ages 10-17 years (38.2%) are considered overweight or obese according to BMI-for-age standards. Kentucky ranks last among the 50 states in overall prevalence.
- Half of Kentucky's children in poor families are overweight or obese. Only three other states and D.C. have a higher prevalence among poor children.
- Kentucky ranks in the bottom four among 50 states and D.C. in three categories that represent the vast majority of children in the state and nation. Kentucky ranks 51st for white non-Hispanic, 50th for non-Hispanic, and 48th for privately insured children.
- Kentucky children are less likely than their counterparts nationwide to be physically active for at least 4 days per week, and more likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 35.3% of low-income children ages 2 to 5 years in Kentucky are overweight or obese.

OVERALL PREVALENCE	KENTUCKY %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	38.2%*	30.6%
State Rank for overweight or obese children (1 is best)	50	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	56.6%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	49.0%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**KENTUCKY %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	50.5%	39.8%
>400 % FPL	26.2%	22.9%
Income Disparity Ratio	1.93	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	23	
% Overweight or Obese by Type of Insurance		
Public Insurance	46.5%	39.6%
Private Insurance	32.2%	26.7%
Insurance Disparity Ratio	1.44	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	19	
% Overweight or Obese by Race		
Black, non-Hispanic	43.5%	41.2%
White, non-Hispanic	37.5%	26.6%
Race Disparity Ratio	1.16	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	2	
% Overweight or Obese by Hispanic Origin		
Hispanic	NA	37.7%
Non-Hispanic	38.0%	29.5%
Hispanic Origin Disparity Ratio	NA	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	NA	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is KENTUCKY doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

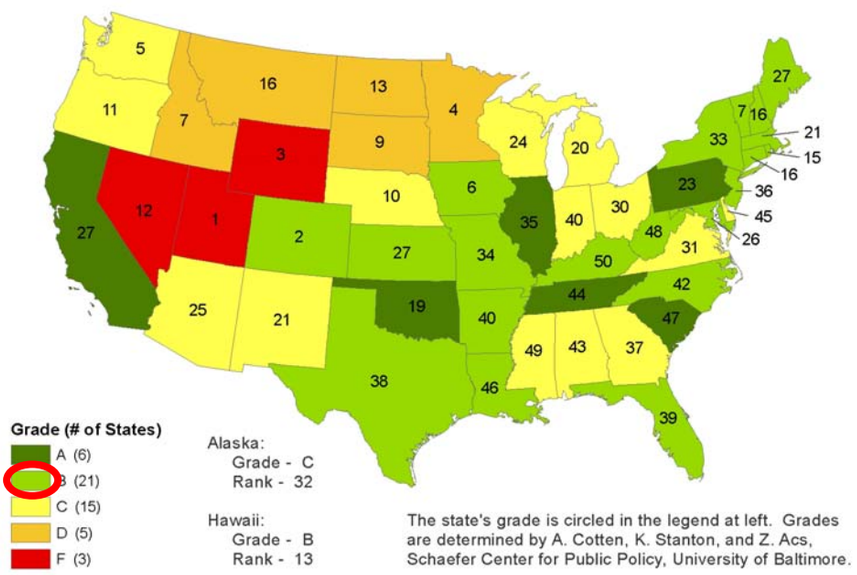
OBESITY-RELATED STATE INITIATIVES	KENTUCKY	NATIONAL
Snack and/or soda tax	Yes	17 states + D.C.
CDC state-based nutrition and physical activity program	Yes	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	Yes	24 states
OBESITY-RELATED SCHOOL STANDARDS	**KENTUCKY**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	Yes	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	Yes	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	Yes	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**KENTUCKY**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	Yes	19 states introduced

NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

Effective February 3, 2006, Kentucky administrative regulation (720 KAR 6:090) requires that during the period of time beginning 30 minutes after the last lunch period until the end of the last instructional period, food and beverages offered for sale through a vending machine, school store, canteen, or fundraiser on school property must meet nutritional standards, including the following: calories from saturated fat shall not exceed 10%; calories from sugar shall not exceed 32% by weight; chips, cereals, crackers, baked goods and other snack items shall not contain more than 300 milligrams of sodium per serving; pastas, meats and soups shall not contain more than 450 milligrams of sodium per serving; and portion sizes for chips, crackers, popcorn, cereal, trail mix, nuts, seeds, or jerky shall not exceed two ounces.

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in LOUISIANA?

KEY POINTS:

- Approximately 189,000 of 531,000 Louisiana children ages 10-17 years (35.6%) are considered overweight or obese according to BMI-for-age standards. The state ranks 46th among the 50 states and D.C. in overall prevalence.
- Louisiana has the highest overweight/obese prevalence in the country for children in higher-income families (36.6%) and children with private health insurance (33.9%).
- The state's disparity ratios put Louisiana near the top in state rankings, but this is generally due to very high overweight/obese prevalence in the more advantaged group, *e.g.*, children in higher-income families and children with private insurance.
- Louisiana children are more likely than their counterparts nationwide to be physically active for at least 4 days per week, but they're also more likely to spend 2 hours or more in front of a television or computer screen.

OVERALL PREVALENCE	LOUISIANA %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	35.6%*	30.6%
State Rank for overweight or obese children (1 is best)	46	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	63.8%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	53.0%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**LOUISIANA %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	36.6%	39.8%
>400 % FPL	36.6%	22.9%
Income Disparity Ratio	1.00	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	1	
% Overweight or Obese by Type of Insurance		
Public Insurance	38.5%	39.6%
Private Insurance	33.9%	26.7%
Insurance Disparity Ratio	1.13	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	4	
% Overweight or Obese by Race		
Black, non-Hispanic	40.5%	41.2%
White, non-Hispanic	31.9%	26.6%
Race Disparity Ratio	1.27	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	3	
% Overweight or Obese by Hispanic Origin		
Hispanic	NA	37.7%
Non-Hispanic	35.8%	29.5%
Hispanic Origin Disparity Ratio	NA	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	NA	

* Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is LOUISIANA doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

OBESITY-RELATED STATE INITIATIVES	LOUISIANA	NATIONAL
Snack and/or soda tax	No	17 states + D.C.
CDC state-based nutrition and physical activity program	No	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	Yes	24 states
OBESITY-RELATED SCHOOL STANDARDS	**LOUISIANA**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	No	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	Yes	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	Yes	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	Yes	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**LOUISIANA**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	proposed	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

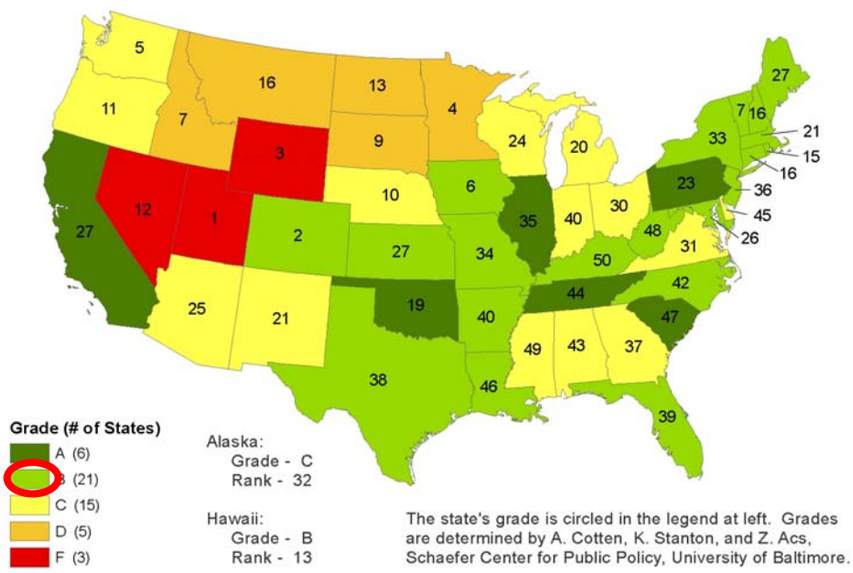
NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

SB 871 (Act 734, 2004) established a three-year pilot program involving nutrition and physical activity interventions for no more than eight schools from each of the eight regional service districts. Requirements of the program include an assessment of the changes in weight status of students in participating schools who are receiving the interventions.

Louisiana prohibits a la carte meal service, but some food items may be sold as extra sale items to those who have completed a meal. Extra sale items must be from the menu that day. Exceptions to the extra sale items include milkshakes, yogurt, frozen yogurt, ice cream, ice milk, and unflavored, non-carbonated water.

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in MAINE?

KEY POINTS:

- Approximately 42,000 of 140,000 Maine children ages 10-17 years (30.0%) are considered overweight or obese according to BMI-for-age standards.
- The prevalence of overweight and obesity is about one in three for Maine children either in poverty (32.8%) or on public health insurance (34.2%).
- Among white non-Hispanic children in Maine, 29.5% are obese or overweight, ranking the state 44th on this measure. Only seven other states had higher prevalence rates among white non-Hispanic children.
- Maine children are less likely than their counterparts nationwide to be physically active for at least 4 days per week, but they're also less likely to spend 2 hours or more in front of a television or computer screen.

OVERALL PREVALENCE	MAINE %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	30.0%	30.6%
State Rank for overweight or obese children (1 is best)	27	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	57.1%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	38.0%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**MAINE %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	32.8%	39.8%
>400 % FPL	23.6%	22.9%
Income Disparity Ratio	1.39	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	6	
% Overweight or Obese by Type of Insurance		
Public Insurance	34.2%	39.6%
Private Insurance	27.4%	26.7%
Insurance Disparity Ratio	1.25	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	6	
% Overweight or Obese by Race		
Black, non-Hispanic	NA	41.2%
White, non-Hispanic	29.5%	26.6%
Race Disparity Ratio	NA	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	NA	
% Overweight or Obese by Hispanic Origin		
Hispanic	NA	37.7%
Non-Hispanic	30.1%	29.5%
Hispanic Origin Disparity Ratio	NA	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	NA	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data… Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is MAINE doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

Obesity-Related State Initiatives	Maine	National
Snack and/or soda tax	Yes	17 states + D.C.
CDC state-based nutrition and physical activity program	Yes	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	Yes	24 states
Obesity-Related School Standards	**Maine**	**National**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	No	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	Yes	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	Yes	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	Yes	16 states
2006 Obesity-Related Policy Options	**Maine**	**National**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

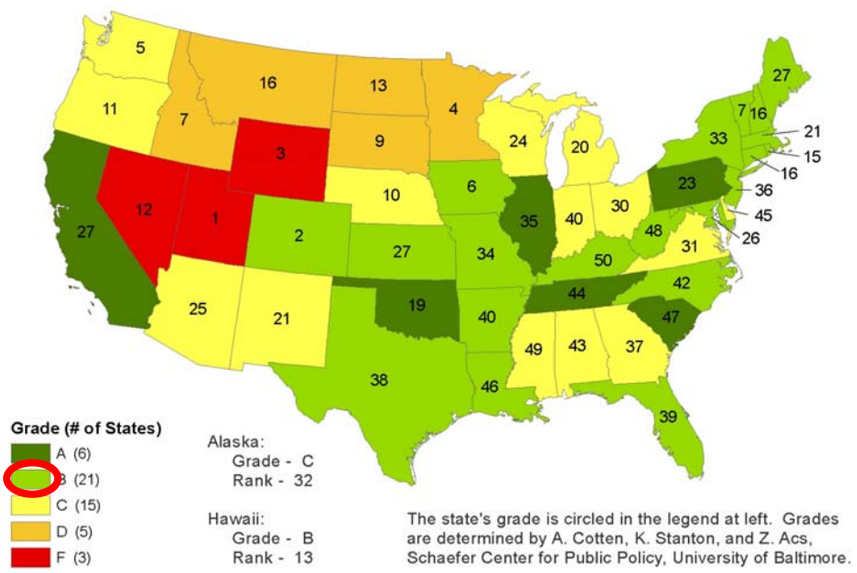
NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

The school board must require all public school students in grades 1, 3, 5, 7, and 9 to have their BMI measured. All data are to be analyzed by an epidemiologist or statistician in the Department of Health and Human Services. Parents will be given a confidential report concerning their child's BMI, an explanation of BMI as a screening tool, and references to local community programs for physical activity and nutrition resources (LD 796; SP 263).

Foods must adhere to single serving standards established by the FDA. Carbonated soft drinks of any kind or candy cannot be sold. Milk must be 1% fat or less. Juices must contain 100% fruit or vegetable juice (LD 796).

State Obesity Prevalence Ranking and Report Card Grade for Childhood Obesity-related Activities



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in MARYLAND?

KEY POINTS:

- Approximately 176,000 of 587,000 Maryland children ages 10-17 years (29.9%) are considered overweight or obese according to BMI-for-age standards.
- The prevalence rate of overweight and obesity in Maryland is more than 40% for children in the following categories: poor (43.0%), publicly insured (40.7%), or black non-Hispanic (41.6%).
- Maryland children are less likely than their counterparts nationwide to be physically active for at least 4 days per week, and slightly less likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 31.1% of low-income children ages 2 to 5 years in Maryland are overweight or obese.

OVERALL PREVALENCE	MARYLAND %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	29.9%	30.6%
State Rank for overweight or obese children (1 is best)	26	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	52.2%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	43.8%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**MARYLAND %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	43.0%	39.8%
>400 % FPL	23.5%	22.9%
Income Disparity Ratio	1.85	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	17	
% Overweight or Obese by Type of Insurance		
Public Insurance	40.7%	39.6%
Private Insurance	26.8%	26.7%
Insurance Disparity Ratio	1.52	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	25	
% Overweight or Obese by Race		
Black, non-Hispanic	41.6%	41.2%
White, non-Hispanic	23.5%	26.6%
Race Disparity Ratio	1.77	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	19	
% Overweight or Obese by Hispanic Origin		
Hispanic	NA	37.7%
Non-Hispanic	29.9%	29.5%
Hispanic Origin Disparity Ratio	NA	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	NA	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is MARYLAND doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

OBESITY-RELATED STATE INITIATIVES	MARYLAND	NATIONAL
Snack and/or soda tax	No	17 states + D.C.
CDC state-based nutrition and physical activity program	Yes	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	No	24 states
OBESITY-RELATED SCHOOL STANDARDS	**MARYLAND**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	No	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	Yes	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	Yes	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**MARYLAND**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	proposed	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

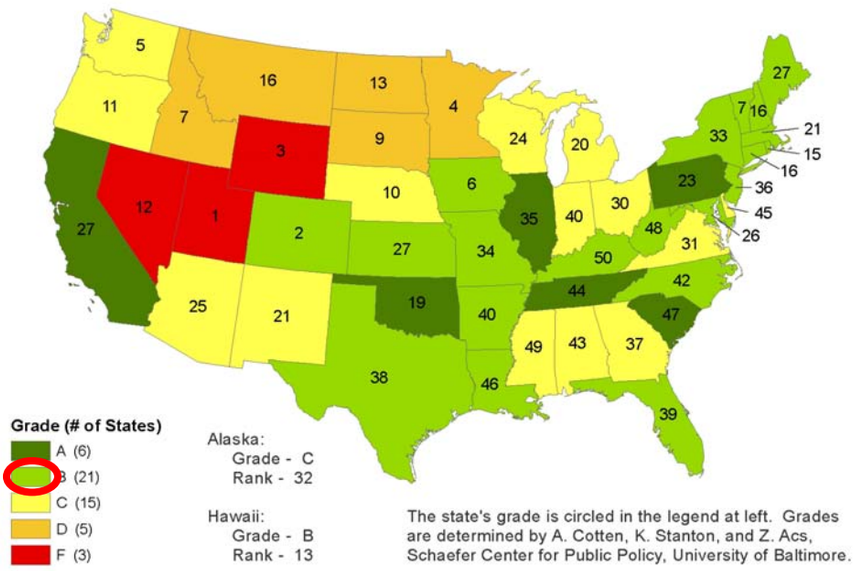
NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

Maryland requires all vending machines in public schools to have and use a timing device to automatically prohibit or allow access in accordance with nutrition policies established by local county boards of education by August 1, 2006 (SB 473).

In elementary and middle schools, all other food sold (typically food sold a la carte), including packaged snacks, should be offered only in single-serving portions. The unit sold, regardless of the number of portions in the package, should contain: no more than 9 grams of total fat, excluding packaged nuts and seeds; no more than 2 grams of saturated fat; and no more than 15 grams of sugar, excluding dried fruit with no added sugar.

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in MASSACHUSETTS?

KEY POINTS:

- Approximately 191,000 of 660,000 Massachusetts children ages 10-17 years (28.9%) are considered overweight or obese according to BMI-for-age standards.
- The prevalence rate of overweight and obesity is more than 40% for Massachusetts children who are poor (44.8%), on public health insurance (42.6%), or Hispanic (45.2%). The Hispanic prevalence rate is surpassed by only four other states.
- Massachusetts children are less likely than their counterparts nationwide to be physically active for at least 4 days per week, but they're also less likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 34.0% of low-income children ages 2 to 5 years in Massachusetts are overweight or obese.

OVERALL PREVALENCE	MASSACHUSETTS %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	28.9%	30.6%
State Rank for overweight or obese children (1 is best)	21	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	51.5%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	42.8%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**MASSACHUSETTS %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	44.8%	39.8%
>400 % FPL	24.1%	22.9%
Income Disparity Ratio	1.86	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	20	
% Overweight or Obese by Type of Insurance		
Public Insurance	42.6%	39.6%
Private Insurance	24.8%	26.7%
Insurance Disparity Ratio	1.72	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	39	
% Overweight or Obese by Race		
Black, non-Hispanic	NA	41.2%
White, non-Hispanic	23.8%	26.6%
Race Disparity Ratio	NA	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	NA	
% Overweight or Obese by Hispanic Origin		
Hispanic	45.2%	37.7%
Non-Hispanic	27.1%	29.5%
Hispanic Origin Disparity Ratio	1.67	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	19	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data… Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is MASSACHUSETTS doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities as of 2006 with others.

OBESITY-RELATED STATE INITIATIVES - 2007	MASSACHUSETTS	NATIONAL
Snack and/or soda tax	No	17 states + D.C.
CDC state-based nutrition and physical activity program	Yes	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	No	24 states
OBESITY-RELATED SCHOOL STANDARDS - 2007	**MASSACHUSETTS**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	No	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	No	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	No	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	Yes	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**MASSACHUSETTS**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

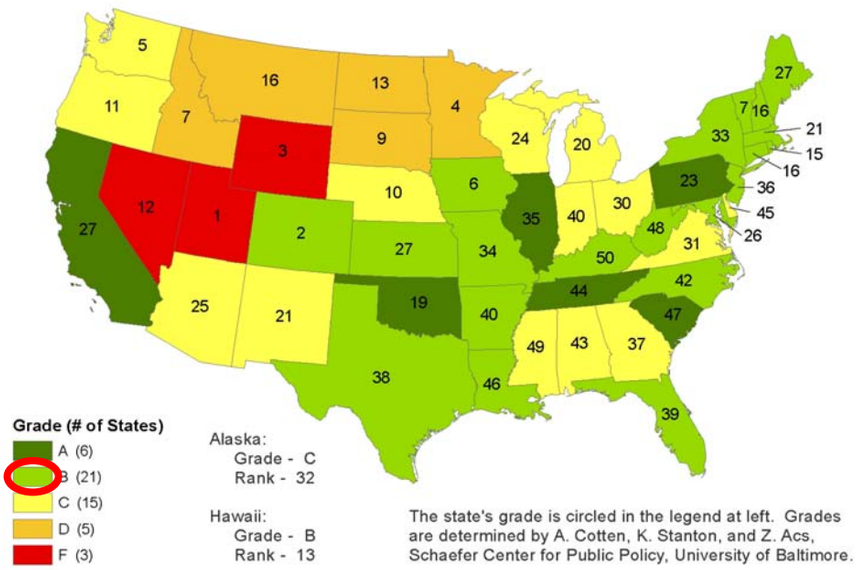
NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

Department of Public Health Code (105 CMR 200.500, 1994) requires each student's height and weight to be measured annually.

General Law 71.1 requires that schools give instruction and training in health education, which shall include, but shall not limited to: consumer health, ecology, community health, body structure and function, safety, nutrition, fitness and body dynamics, dental health, emotional development, and training in the administration of first aid, including cardiopulmonary resuscitation. Grade levels are not specified.

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in MICHIGAN?

KEY POINTS:

- Approximately 334,000 of 1,163,000 Michigan children ages 10-17 years (28.8%) are considered overweight or obese according to BMI-for-age standards.
- Although more than one third (35.6%) of black children in Michigan are overweight or obese, this prevalence is five percentage points below the national rate. Michigan ranks first in the nation for overweight/obese prevalence among black children.
- The prevalence of overweight and obesity among children in poor families is more than double the prevalence for children in higher-income families (40.8% to 17.3%). Michigan's income disparity ratio is among the worst in the country.
- Michigan children are equally likely as their counterparts nationwide to be physically active for at least 4 days per week, but they're more likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 29.5% of low-income children ages 2 to 5 years in Michigan are overweight or obese.

OVERALL PREVALENCE	MICHIGAN %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	28.8%	30.6%
State Rank for overweight or obese children (1 is best)	20	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	58.8%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	46.5%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**MICHIGAN %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	40.8%	39.8%
>400 % FPL	17.3%	22.9%
Income Disparity Ratio	2.36	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	35	
% Overweight or Obese by Type of Insurance		
Public Insurance	35.7%	39.6%
Private Insurance	26.8%	26.7%
Insurance Disparity Ratio	1.34	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	13	
% Overweight or Obese by Race		
Black, non-Hispanic	35.6%	41.2%
White, non-Hispanic	26.9%	26.6%
Race Disparity Ratio	1.32	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	4	
% Overweight or Obese by Hispanic Origin		
Hispanic	NA	37.7%
Non-Hispanic	28.9%	29.5%
Hispanic Origin Disparity Ratio	NA	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	NA	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is MICHIGAN doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

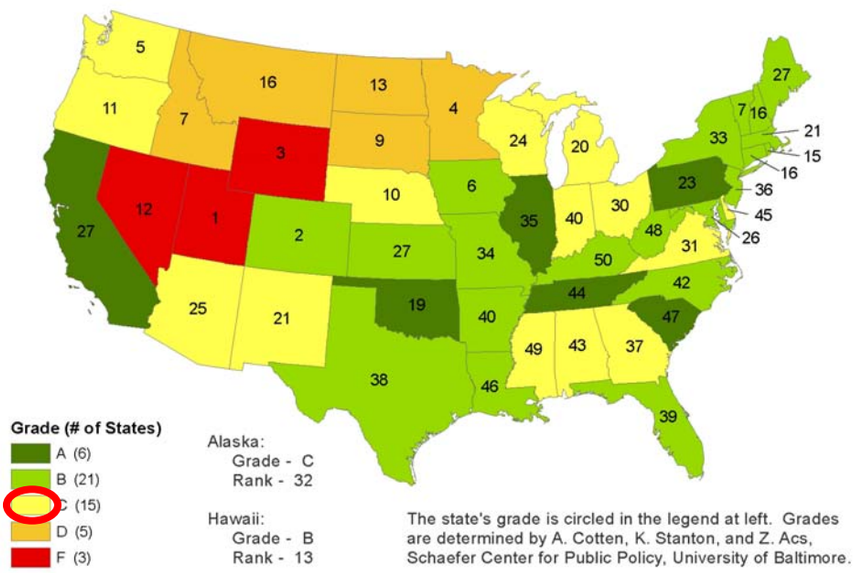
OBESITY-RELATED STATE INITIATIVES	MICHIGAN	NATIONAL
Snack and/or soda tax	No	17 states + D.C.
CDC state-based nutrition and physical activity program	Yes	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	Yes	24 states
OBESITY-RELATED SCHOOL STANDARDS	**MICHIGAN**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	No	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	No	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	No	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**MICHIGAN**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

The Michigan Department of Education developed Grade Level Content Expectations (GLCE) in Health Education for K-8. The GLCEs were approved by the Michigan State Board of Education on February 13, 2007.

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in MINNESOTA?

KEY POINTS:

- Approximately 132,000 of 552,000 Minnesota children ages 10-17 years (23.9%) are considered overweight or obese according to BMI-for-age standards. Minnesota ranks fourth among all states in overall prevalence.
- Minnesota is unranked on the four disparity ratios reported below because on each dimension (income, insurance, race and Hispanic origin), the state lacked adequate sample size in the traditionally disadvantaged group.
- Minnesota children are more likely than their counterparts nationwide to be physically active for at least 4 days per week, and less likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 29.6% of low-income children ages 2 to 5 years in Minnesota are overweight or obese.

OVERALL PREVALENCE	MINNESOTA %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	23.9%*	30.6%
State Rank for overweight or obese children (1 is best)	4	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	62.2%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	38.3%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**MINNESOTA %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	NA	39.8%
>400 % FPL	22.1%	22.9%
Income Disparity Ratio	NA	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	NA	
% Overweight or Obese by Type of Insurance		
Public Insurance	NA	39.6%
Private Insurance	24.0%	26.7%
Insurance Disparity Ratio	NA	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	NA	
% Overweight or Obese by Race		
Black, non-Hispanic	NA	41.2%
White, non-Hispanic	21.8%	26.6%
Race Disparity Ratio	NA	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	NA	
% Overweight or Obese by Hispanic Origin		
Hispanic	NA	37.7%
Non-Hispanic	22.9%	29.5%
Hispanic Origin Disparity Ratio	NA	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	NA	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is MINNESOTA doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

OBESITY-RELATED STATE INITIATIVES	MINNESOTA	NATIONAL
Snack and/or soda tax	Yes	17 states + D.C.
CDC state-based nutrition and physical activity program	No	28 states
Federal STEPS grant recipient	Yes	7 states
Laws that limit liability for obesity and obesity-related health problems	No	24 states
OBESITY-RELATED SCHOOL STANDARDS	**MINNESOTA**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	No	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	No	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	No	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**MINNESOTA**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

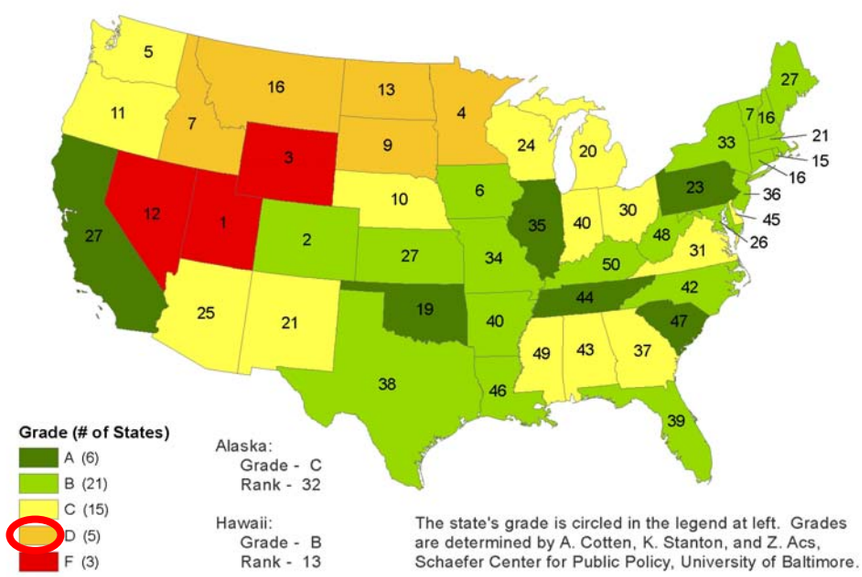
NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

Instruction must be provided in health and physical education (Statute 120A.22.9). Grade levels are not specified in the statute.

Health and physical education, for which locally developed academic standards apply, are required for statewide accountability (Statute 120B.021). Each Minnesota school district is required to develop local standards in health education and physical education.

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in MISSISSIPPI?

KEY POINTS:

- Approximately 122,000 of 334,000 (36.7%) Mississippi children ages 10-17 years are considered overweight or obese according to BMI-for-age standards. Mississippi ranks 49th among the 50 states and D.C. in overall prevalence.
- More than one in four (28.3%) Mississippi children in higher-income families are overweight or obese. The state ranks 49th in prevalence for this subgroup of children.
- Mississippi children are more likely than their counterparts nationwide to be physically active for at least 4 days per week, but they're also more likely to spend 2 hours or more in front of a television or computer screen.

OVERALL PREVALENCE	MISSISSIPPI %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	36.7%*	30.6%
State Rank for overweight or obese children (1 is best)	49	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	60.5%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	52.4%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**MISSISSIPPI %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	43.2%	39.8%
>400 % FPL	28.3%	22.9%
Income Disparity Ratio	1.53	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	10	
% Overweight or Obese by Type of Insurance		
Public Insurance	42.9%	39.6%
Private Insurance	30.8%	26.7%
Insurance Disparity Ratio	1.39	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	15	
% Overweight or Obese by Race		
Black, non-Hispanic	45.4%	41.2%
White, non-Hispanic	29.4%	26.6%
Race Disparity Ratio	1.55	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	11	
% Overweight or Obese by Hispanic Origin		
Hispanic	NA	37.7%
Non-Hispanic	37.0%	29.5%
Hispanic Origin Disparity Ratio	NA	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	NA	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is MISSISSIPPI doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

OBESITY-RELATED STATE INITIATIVES	MISSISSIPPI	NATIONAL
Snack and/or soda tax	No	17 states + D.C.
CDC state-based nutrition and physical activity program	No	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	No	24 states
OBESITY-RELATED SCHOOL STANDARDS	**MISSISSIPPI**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	No	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	No	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	Yes	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**MISSISSIPPI**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	Yes	19 states introduced

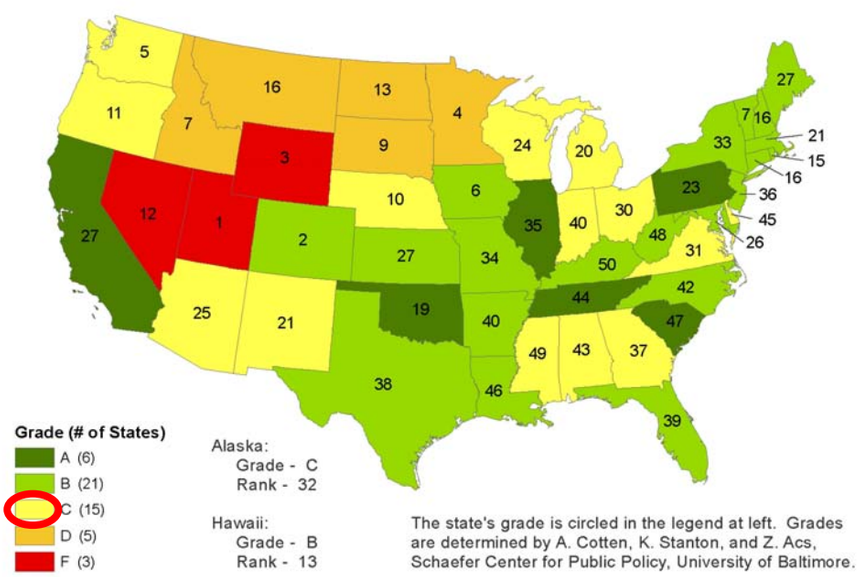
NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

Mississippi permits school food services to sell only those foods that are components of the approved federal meal pattern being served, with the exception of milk. A student may only purchase individual components of a meal if a full meal is also purchased. The state policy is a minimum requirement, and local school boards may choose to adopt more restrictive policies. State policy also indicates that no food be sold on campus for one hour before breakfast or one hour before lunch and until the end of either serving period.

In 2007, Mississippi passed legislation (SB 2369, Code 37-13-134) that requires 45 minutes per week of health education instruction in grades K-8.

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in MISSOURI?

KEY POINTS:

- Approximately 198,000 of 639,000 Missouri children ages 10-17 years (31.0%) are considered overweight or obese according to BMI-for-age standards.
- Nearly half (48.2%) of Missouri children in poor families are overweight or obese. The prevalence rate for poor children is more than double the rate for children in higher-income families. (21.6%).
- The prevalence of overweight and obesity is almost one in two (48.8%) for black children in Missouri, ranking the state 21st of 23 states with reliable estimates for this subgroup.
- Missouri children are slightly more likely than their counterparts nationwide to be physically active for at least 4 days per week, but also more likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 30.2% of low-income children ages 2 to 5 years in Missouri are overweight or obese.

OVERALL PREVALENCE	MISSOURI %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	31.0%	30.6%
State Rank for overweight or obese children (1 is best)	34	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	60.5%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	48.3%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**MISSOURI %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	48.2%	39.8%
>400 % FPL	21.6%	22.9%
Income Disparity Ratio	2.23	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	34	
% Overweight or Obese by Type of Insurance		
Public Insurance	40.1%	39.6%
Private Insurance	27.5%	26.7%
Insurance Disparity Ratio	1.46	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	21	
% Overweight or Obese by Race		
Black, non-Hispanic	48.8%	41.2%
White, non-Hispanic	28.3%	26.6%
Race Disparity Ratio	1.73	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	17	
% Overweight or Obese by Hispanic Origin		
Hispanic	NA	37.7%
Non-Hispanic	31.2%	29.5%
Hispanic Origin Disparity Ratio	NA	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	NA	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is MISSOURI doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

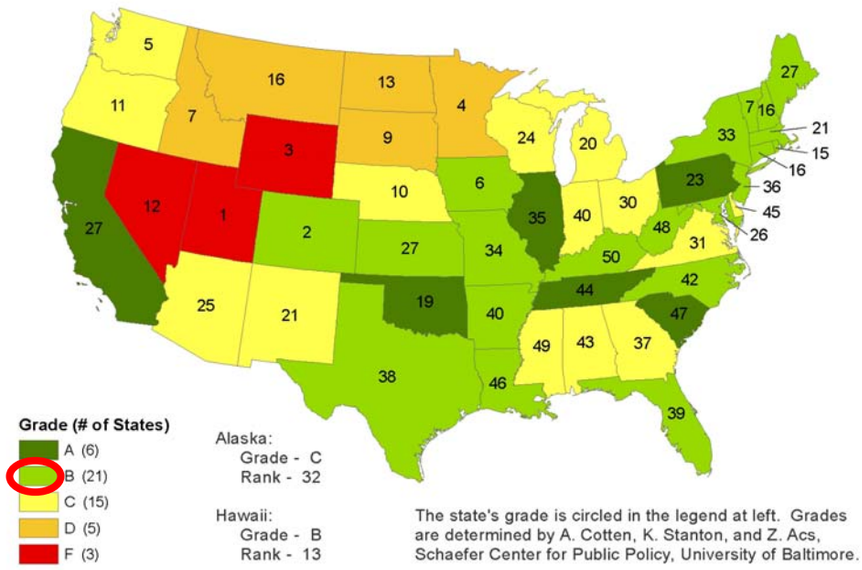
OBESITY-RELATED STATE INITIATIVES	MISSOURI	NATIONAL
Snack and/or soda tax	Yes	17 states + D.C.
CDC state-based nutrition and physical activity program	Yes	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	Yes	24 states
OBESITY-RELATED SCHOOL STANDARDS	**MISSOURI**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	No	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	No	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	No	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	Yes	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**MISSOURI**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	proposed	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

Missouri requires the department of elementary and secondary education to establish a "Model School Wellness Program," which will create school-based pilot programs (for grades K-5) that will promote balanced dietary patterns and physical activity to prevent becoming overweight or obese, and will include discussion of serious and chronic medical conditions that are associated with being overweight. Following completion of the 2005-06 school year, requires department to evaluate the effectiveness of the model school wellness program through various measures, including changes in body mass index (Chapter 167, Section 167.229).

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in MONTANA?

KEY POINTS:

- Approximately 28,000 of 104,000 Montana children ages 10-17 years (27.3%) are considered overweight or obese according to BMI-for-age standards.
- One in three (33.1%) Montana children on public health insurance are overweight or obese. The state's prevalence rate for publicly insured children is six percentage points below the national rate.
- Montana children are more likely than their counterparts nationwide to be physically active for at least 4 days per week, and less likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 28.2% of low-income children ages 2 to 5 years in Montana are overweight or obese.

OVERALL PREVALENCE	MONTANA %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	27.3%	30.6%
State Rank for overweight or obese children (1 is best)	16	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	63.1%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	37.5%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**MONTANA %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	37.7%	39.8%
>400 % FPL	21.2%	22.9%
Income Disparity Ratio	1.78	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	15	
% Overweight or Obese by Type of Insurance		
Public Insurance	33.1%	39.6%
Private Insurance	24.1%	26.7%
Insurance Disparity Ratio	1.37	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	14	
% Overweight or Obese by Race		
Black, non-Hispanic	NA	41.2%
White, non-Hispanic	25.5%	26.6%
Race Disparity Ratio	NA	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	NA	
% Overweight or Obese by Hispanic Origin		
Hispanic	NA	37.7%
Non-Hispanic	27.0%	29.5%
Hispanic Origin Disparity Ratio	NA	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	NA	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is MONTANA doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

OBESITY-RELATED STATE INITIATIVES	MONTANA	NATIONAL
Snack and/or soda tax	No	17 states + D.C.
CDC state-based nutrition and physical activity program	Yes	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	No	24 states
OBESITY-RELATED SCHOOL STANDARDS	**MONTANA**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	No	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	No	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	No	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**MONTANA**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

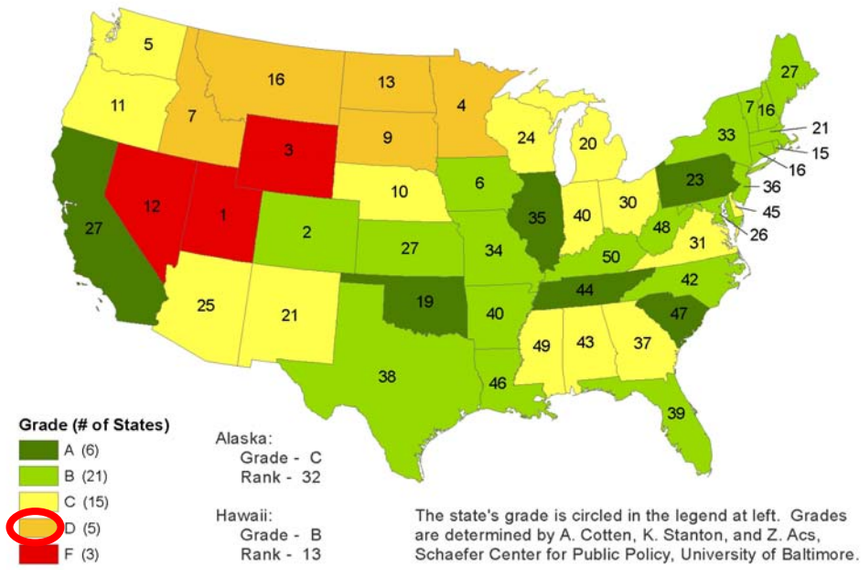
NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

Montana encourages greater opportunities for students to participate in physical activity and sports programs (MT HJR 17).

Health education is required in elementary and middle school. One unit (135 hours) is required for high school graduation.

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in NEBRASKA?

KEY POINTS:

- Approximately 51,000 of 195,000 Nebraska children ages 10-17 years (26.3%) are considered overweight or obese according to BMI-for-age standards.
- One in six (17.0%) Nebraska children in higher-income families, and one in five (20.8%) with private health insurance, are overweight or obese. The state's prevalence rate for each of these child subgroups is almost six percentage points below the national rate. Nebraska ranks fourth among the 50 states and D.C. in overweight/obese prevalence for both subgroups.
- Nebraska's insurance disparity ratio of 1.91 is among the worst in the country, exceeded only by North Dakota, Georgia, and Illinois.
- Nebraska children are more likely than their counterparts nationwide to be physically active for at least 4 days per week, and less likely to spend 2 hours or more in front of the television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 28.8% of low-income children ages 2 to 5 years in Nebraska are overweight or obese.

OVERALL PREVALENCE	NEBRASKA %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	26.3%*	30.6%
State Rank for overweight or obese children (1 is best)	10	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	61.6%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	41.6%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**NEBRASKA %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	NA	39.8%
>400 % FPL	17.0%	22.9%
Income Disparity Ratio	NA	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	NA	
% Overweight or Obese by Type of Insurance		
Public Insurance	39.8%	39.6%
Private Insurance	20.8%	26.7%
Insurance Disparity Ratio	1.91	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	46	
% Overweight or Obese by Race		
Black, non-Hispanic	NA	41.2%
White, non-Hispanic	24.9%	26.6%
Race Disparity Ratio	NA	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	NA	
% Overweight or Obese by Hispanic Origin		
Hispanic	NA	37.7%
Non-Hispanic	25.9%	29.5%
Hispanic Origin Disparity Ratio	NA	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	NA	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is NEBRASKA doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

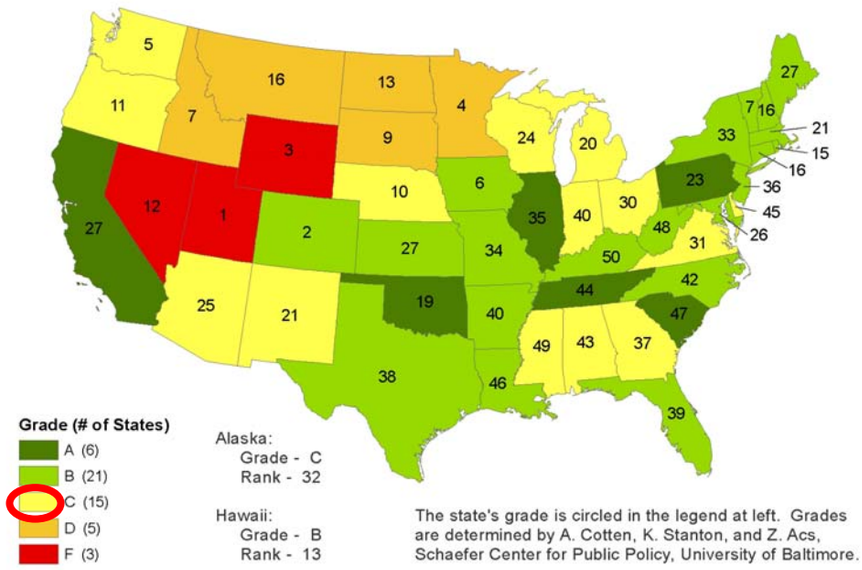
OBESITY-RELATED STATE INITIATIVES	NEBRASKA	NATIONAL
Snack and/or soda tax	No	17 states + D.C.
CDC state-based nutrition and physical activity program	No	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	No	24 states
OBESITY-RELATED SCHOOL STANDARDS	**NEBRASKA**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	No	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	No	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	Yes	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**NEBRASKA**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

Nebraska's Department of Education clarified its Competitive Food Policy for schools participating in the National School Lunch Program in June 2006. According to the clarification, no food or beverages can be sold to children anywhere on school premises beginning one half hour before breakfast and/or lunch service until one half hour after meal service unless all proceeds earned during these time periods go to the school nutrition program. No foods of minimal nutritional value (FMNV) can be sold in the food service areas beginning one half hour before breakfast and/or lunch service until one half hour after meal service under any circumstances.

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in NEVADA?

KEY POINTS:

- Approximately 62,000 of 233,000 Nevada children ages 10-17 years (26.6%) are considered overweight or obese according to BMI-for-age standards.
- There is no difference in overweight/obese prevalence between Nevada's publicly insured and privately insured children (25.9% and 26.0%, respectively). The state's insurance disparity ratio is best in the nation, and the prevalence rate for publicly insured children also ranks first.
- Nevada children are slightly more likely than their counterparts nationwide to be physically active for at least 4 days per week, but they're also more likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 29.7% of low-income children ages 2 to 5 years in Nevada are overweight or obese.

OVERALL PREVALENCE	NEVADA %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	26.6%*	30.6%
State Rank for overweight or obese children (1 is best)	12	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	60.2%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	50.6%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**NEVADA %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	NA	39.8%
>400 % FPL	21.7%	22.9%
Income Disparity Ratio	NA	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	NA	
% Overweight or Obese by Type of Insurance		
Public Insurance	25.9%	39.6%
Private Insurance	26.0%	26.7%
Insurance Disparity Ratio	1.00	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	1	
% Overweight or Obese by Race		
Black, non-Hispanic	NA	41.2%
White, non-Hispanic	23.2%	26.6%
Race Disparity Ratio	NA	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	NA	
% Overweight or Obese by Hispanic Origin		
Hispanic	34.6%	37.7%
Non-Hispanic	24.8%	29.5%
Hispanic Origin Disparity Ratio	1.40	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	9	

* Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is NEVADA doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

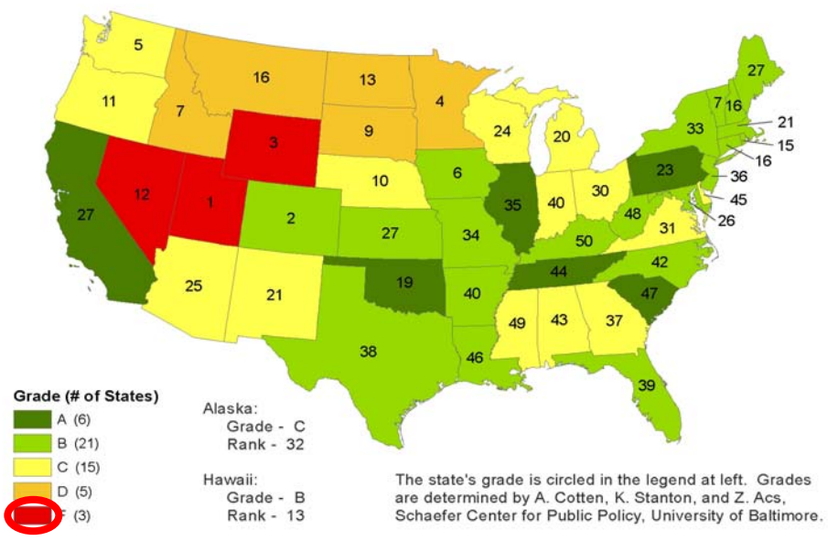
OBESITY-RELATED STATE INITIATIVES	NEVADA	NATIONAL
Snack and/or soda tax	No	17 states + D.C.
CDC state-based nutrition and physical activity program	No	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	No	24 states
OBESITY-RELATED SCHOOL STANDARDS	**NEVADA**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	Yes	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	Yes	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	Yes	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**NEVADA**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

Effective July 2005, school servings will not exceed the following portion sizes: (1) Elementary Schools: chips (regular) – 1 ounce; chips (baked or no more than 5 grams of fat per ounce), crackers, popcorn, cereal, trail mix, nuts, seeds, dried fruit, jerky, and pretzels – 1.5 ounces; cookies/cereal bars (plain) – 2 ounces; cookies/cereal bars (with nuts, raisins, chocolate pieces and/or fruit purees) – 2.2 ounces; bakery items – 3 ounces; frozen desserts – 4 ounces; water – no limit; and fruit drinks and frozen slushes (must contain a minimum of 50% fruit juice) – 16 ounces. (2) Middle/Junior/High Schools: chips (regular) – 1.25 ounces; chips (baked or no more than 5 grams of fat per ounce), crackers, popcorn, cereal, trail mix, nuts, seeds, dried fruit, jerky, and pretzels – 1.5 ounces; cookies/cereal bars – 2 ounces; cookies/cereal bars (with nuts, raisins, chocolate pieces and/or fruit purees) – 2.2 ounces; bakery items – 3 ounces; frozen desserts – 4 ounces; water – no limit; electrolyte replacement beverages – 12 ounces; and fruit drinks and frozen slushes (must contain a minimum of 50% fruit juice) – 16 ounces.

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in NEW HAMPSHIRE?

KEY POINTS:

- Approximately 40,000 of 1482,000 New Hampshire children ages 10-17 years (27.3%) are considered overweight or obese according to BMI-for-age standards.
- More than one in four (26.5%) New Hampshire children in higher-income families are overweight or obese. The state ranks 45th among the 50 states and D.C. in overweight/obese prevalence for children in higher-income families.
- New Hampshire children are less likely than their counterparts nationwide to be physically active for at least 4 days per week, but they're also less likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 34.0% of low-income children ages 2 to 5 years in New Hampshire are overweight or obese.

OVERALL PREVALENCE	NEW HAMPSHIRE %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	27.3%	30.6%
State Rank for overweight or obese children (1 is best)	16	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	55.9%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	38.3%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**NEW HAMPSHIRE %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	NA	39.8%
>400 % FPL	26.5%	22.9%
Income Disparity Ratio	NA	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	NA	
% Overweight or Obese by Type of Insurance		
Public Insurance	40.1%	39.6%
Private Insurance	23.7%	26.7%
Insurance Disparity Ratio	1.69	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	37	
% Overweight or Obese by Race		
Black, non-Hispanic	NA	41.2%
White, non-Hispanic	27.1%	26.6%
Race Disparity Ratio	NA	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	NA	
% Overweight or Obese by Hispanic Origin		
Hispanic	NA	37.7%
Non-Hispanic	26.9%	29.5%
Hispanic Origin Disparity Ratio	NA	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	NA	

* Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is NEW HAMPSHIRE doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

OBESITY-RELATED STATE INITIATIVES	NEW HAMPSHIRE	NATIONAL
Snack and/or soda tax	No	17 states + D.C.
CDC state-based nutrition and physical activity program	No	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	Yes	24 states
OBESITY-RELATED SCHOOL STANDARDS	**NEW HAMPSHIRE**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	No	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	No	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	No	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**NEW HAMPSHIRE**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

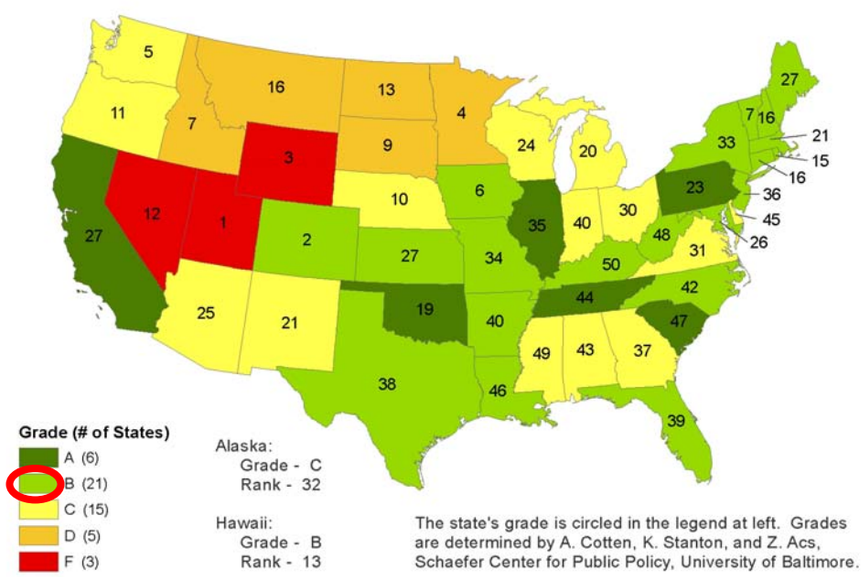
NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

New Hampshire requires health education in elementary and middle school. One-half credit is required for high school graduation.

Legislation protects manufacturers, sellers and distributors of food and beverages from liability regarding weight gain, obesity, or related health conditions due to long-term consumption of a food or beverage (SB 408).

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in NEW JERSEY?

KEY POINTS:

- Approximately 291,000 of 924,000 New Jersey children ages 10-17 years (31.5%) are considered overweight or obese according to BMI-for-age standards.
- More than half (54.0%) of black non-Hispanic children in New Jersey are overweight or obese, double the rate among white non-Hispanic children (25.2%). The state's race disparity ratio is exceeded only by the District of Columbia.
- Poor children in New Jersey are twice as likely to be overweight or obese compared to children in higher-income families (51.4% to 24.5%).
- New Jersey children are less likely than their counterparts nationwide to be physically active for at least 4 days per week, and slightly more likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 35.6% of low-income children ages 2 to 5 years in New Jersey are overweight or obese.

OVERALL PREVALENCE	NEW JERSEY %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	31.5%	30.6%
State Rank for overweight or obese children (1 is best)	36	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	53.4%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	46.0%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**NEW JERSEY %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	51.4%	39.8%
>400 % FPL	24.5%	22.9%
Income Disparity Ratio	2.10	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	31	
% Overweight or Obese by Type of Insurance		
Public Insurance	45.2%	39.6%
Private Insurance	27.8%	26.7%
Insurance Disparity Ratio	1.62	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	32	
% Overweight or Obese by Race		
Black, non-Hispanic	54.0%	41.2%
White, non-Hispanic	25.2%	26.6%
Race Disparity Ratio	2.14	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	22	
% Overweight or Obese by Hispanic Origin		
Hispanic	36.9%	37.7%
Non-Hispanic	31.0%	29.5%
Hispanic Origin Disparity Ratio	1.19	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	2	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is NEW JERSEY doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

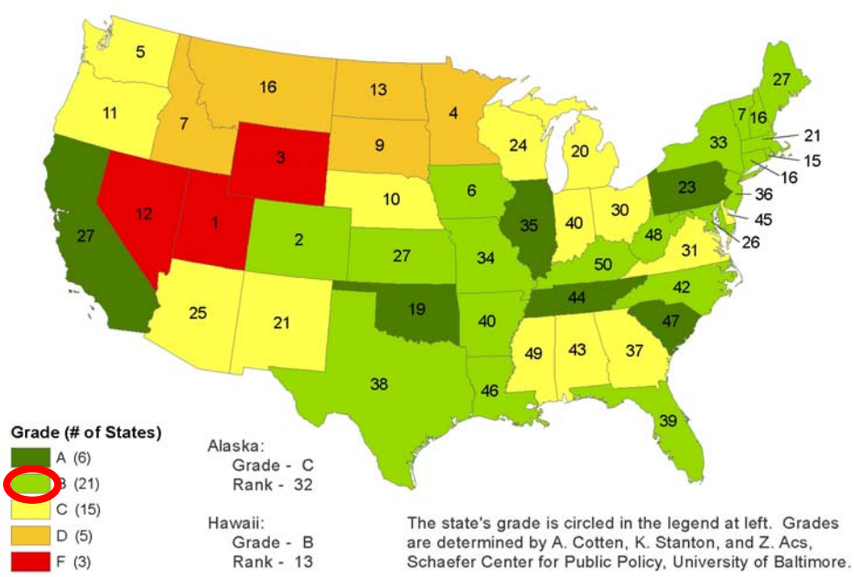
OBESITY-RELATED STATE INITIATIVES	NEW JERSEY	NATIONAL
Snack and/or soda tax	Yes	17 states + D.C.
CDC state-based nutrition and physical activity program	No	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	No	24 states
OBESITY-RELATED SCHOOL STANDARDS	**NEW JERSEY**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	Yes	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	Yes	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	Yes	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**NEW JERSEY**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	proposed	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

As of September 2007, the following items shall not be served, sold or given away as a free promotion anywhere on school property at any time before the end of the school day, including items served in reimbursable After School Snack Program: (1) Foods of minimal nutritional value, as defined by the U.S. Department of Agriculture; (2) All food and beverage items listing sugar, in any form, as the first ingredient; and (3) All forms of candy as defined by the New Jersey Department of Agriculture. Food and beverages served during special school celebrations or during curriculum-related activities shall be exempt from the provisions above, with the exception of foods of minimal nutritional value as defined by the U.S. Department of Agriculture (SB 1218, Chapter 45).

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in NEW MEXICO?

KEY POINTS:

- Approximately 62,000 of 216,000 New Mexico children ages 10-17 years (28.9%) are considered overweight or obese according to BMI-for-age standards.
- New Mexico's overweight/obese prevalence rate among Hispanic children (34.6%) is lower than the national rate of 37.7%, and ranks the state fourth for this subgroup.
- The prevalence of overweight and obesity among white non-Hispanic children in New Mexico (19.2%) is well below the national prevalence of 26.6%. The state ranks fourth among 50 states and D.C. for this subgroup.
- New Mexico children are less likely than their counterparts nationwide to be physically active for at least 4 days per week, and slightly more likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 25.5% of low-income children ages 2 to 5 years in New Mexico are overweight or obese.

OVERALL PREVALENCE	NEW MEXICO %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	28.9%	30.6%
State Rank for overweight or obese children (1 is best)	21	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	57.7%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	46.0%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**NEW MEXICO %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	46.1%	39.8%
>400 % FPL	18.6%	22.9%
Income Disparity Ratio	2.47	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	38	
% Overweight or Obese by Type of Insurance		
Public Insurance	37.0%	39.6%
Private Insurance	24.2%	26.7%
Insurance Disparity Ratio	1.53	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	28	
% Overweight or Obese by Race		
Black, non-Hispanic	NA	41.2%
White, non-Hispanic	19.2%	26.6%
Race Disparity Ratio	NA	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	NA	
% Overweight or Obese by Hispanic Origin		
Hispanic	34.6%	37.7%
Non-Hispanic	24.3%	29.5%
Hispanic Origin Disparity Ratio	1.43	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	11	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is NEW MEXICO doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

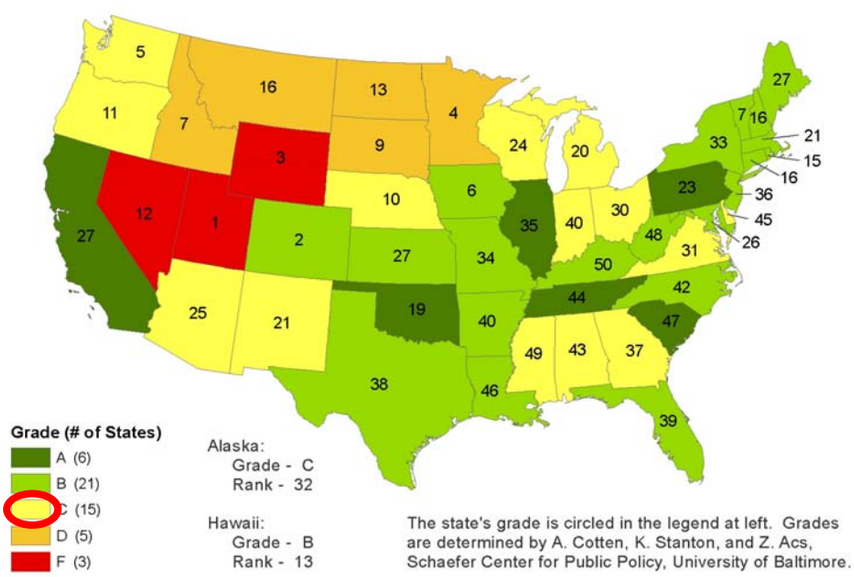
OBESITY-RELATED STATE INITIATIVES	NEW MEXICO	NATIONAL
Snack and/or soda tax	No	17 states + D.C.
CDC state-based nutrition and physical activity program	Yes	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	No	24 states
OBESITY-RELATED SCHOOL STANDARDS	**NEW MEXICO**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	No	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	Yes	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	Yes	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**NEW MEXICO**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

New Mexico administrative code (6.12.5) restricts carbonated beverages and competitive food products from being sold in vending machines to students in elementary schools. Carbonated beverages also shall not be sold in vending machines to students in middle schools. Food products other than nuts, seeds, cheese, yogurt, and fruit sold in vending machines in middle schools shall only be sold after the last lunch period is completed. Carbonated beverages or soft drinks, non-carbonated flavored water and sports drinks shall not be sold in a la carte offerings in elementary, middle and high schools.

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in NEW YORK?

KEY POINTS:

- Approximately 612,000 of 1,979,000 New York children ages 10-17 years (30.9%) are considered overweight or obese according to BMI-for-age standards.
- More than one in three New York children with public health insurance (36.4%) or living in poverty (35.6%) is overweight or obese.
- Among black non-Hispanic children in New York, 39.5% are overweight or obese, lower than the 41.2% prevalence nationally. New York ranks fifth among 50 states and D.C. in prevalence for black non-Hispanic children.
- New York children are less likely than their counterparts nationwide to be physically active for at least 4 days per week, and slightly more likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 32.2% of low-income children ages 2 to 5 years in New York are overweight or obese.

OVERALL PREVALENCE	NEW YORK %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	30.9%	30.6%
State Rank for overweight or obese children (1 is best)	33	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	51.6%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	45.8%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**NEW YORK %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	35.6%	39.8%
>400 % FPL	24.5%	22.9%
Income Disparity Ratio	1.45	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	9	
% Overweight or Obese by Type of Insurance		
Public Insurance	36.4%	39.6%
Private Insurance	29.1%	26.7%
Insurance Disparity Ratio	1.25	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	6	
% Overweight or Obese by Race		
Black, non-Hispanic	39.5%	41.2%
White, non-Hispanic	26.8%	26.6%
Race Disparity Ratio	1.47	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	10	
% Overweight or Obese by Hispanic Origin		
Hispanic	37.0%	37.7%
Non-Hispanic	29.8%	29.5%
Hispanic Origin Disparity Ratio	1.24	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	5	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is NEW YORK doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

OBESITY-RELATED STATE INITIATIVES	NEW YORK	NATIONAL
Snack and/or soda tax	Yes	17 states + D.C.
CDC state-based nutrition and physical activity program	Yes	28 states
Federal STEPS grant recipient	Yes	7 states
Laws that limit liability for obesity and obesity-related health problems	No	24 states
OBESITY-RELATED SCHOOL STANDARDS	**NEW YORK**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	No	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	No	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	Yes	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	Yes	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**NEW YORK**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

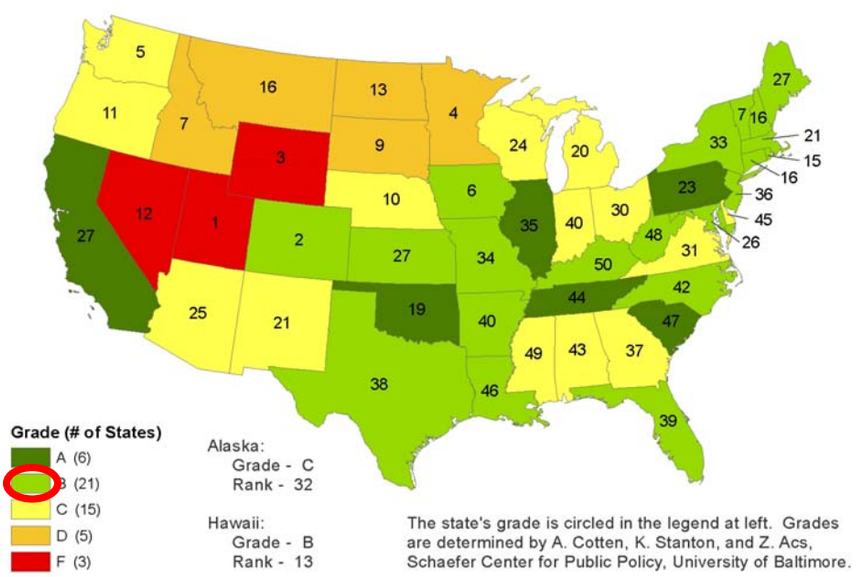
NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

SB 3668 requires the development of a BMI-for-age screening program for children ages 2 to 18; parents will be notified of child's BMI measurement and any health recommendations.

New York prohibits sweetened soda water, chewing gum, candies including hard candy, jellies, gum, marshmallow candies, fondant, licorice, spun candy, candy-coated popcorn, and water ices, except for those that contain fruit or fruit juices, from being sold in any public school from the beginning of the school day until the end of the last scheduled meal period.

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in NORTH CAROLINA?

KEY POINTS:

- Approximately 311,000 of 917,000 North Carolina children ages 10-17 years (33.9%) are considered overweight or obese according to BMI-for-age standards.
- Half (50.9%) of North Carolina's publicly insured children are overweight or obese. North Carolina stood near the bottom of the state ranking on this particular subgroup, surpassed only by Delaware and Illinois.
- The overweight/obese prevalence rate for North Carolina children in poor families is more than double the rate among children in higher-income families (45.0% and 18.5%). The state's income disparity ratio of 2.43 is exceeded only by New Mexico and Wisconsin.
- North Carolina children are more likely than their counterparts nationwide to be physically active for at least 4 days per week, and equally likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 31.1% of low-income children ages 2 to 5 years in North Carolina are overweight or obese.

OVERALL PREVALENCE	NORTH CAROLINA %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	33.9%	30.6%
State Rank for overweight or obese children (1 is best)	42	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	61.2%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	45.1%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**NORTH CAROLINA %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	45.0%	39.8%
>400 % FPL	18.5%	22.9%
Income Disparity Ratio	2.43	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	37	
% Overweight or Obese by Type of Insurance		
Public Insurance	50.9%	39.6%
Private Insurance	27.2%	26.7%
Insurance Disparity Ratio	1.87	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	45	
% Overweight or Obese by Race		
Black, non-Hispanic	47.2%	41.2%
White, non-Hispanic	26.9%	26.6%
Race Disparity Ratio	1.75	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	18	
% Overweight or Obese by Hispanic Origin		
Hispanic	NA	37.7%
Non-Hispanic	33.2%	29.5%
Hispanic Origin Disparity Ratio	NA	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	NA	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is NORTH CAROLINA doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

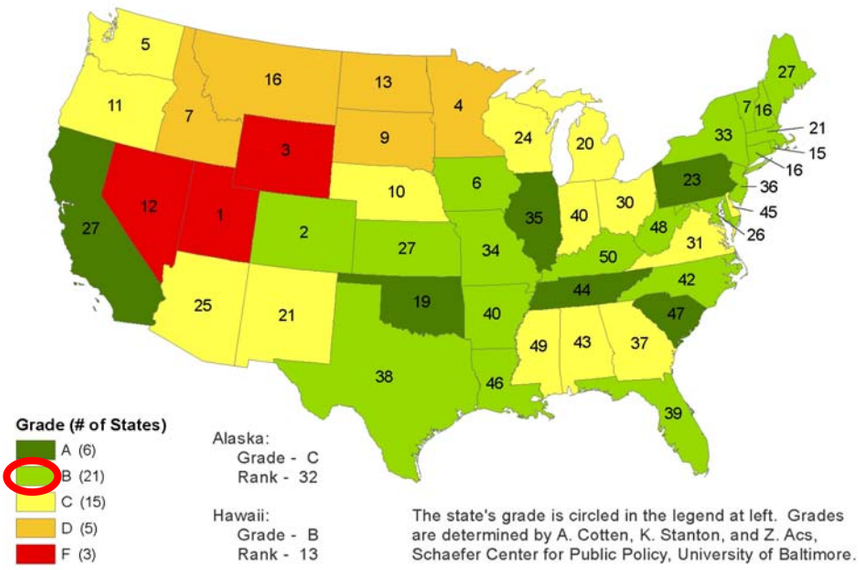
OBESITY-RELATED STATE INITIATIVES	NORTH CAROLINA	NATIONAL
Snack and/or soda tax	No	17 states + D.C.
CDC state-based nutrition and physical activity program	Yes	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	No	24 states
OBESITY-RELATED SCHOOL STANDARDS	**NORTH CAROLINA**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	Yes	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	Yes	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	Yes	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**NORTH CAROLINA**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

North Carolina mandates the following vending machine standards: (1) Soft drinks are not sold during breakfast or lunch, at elementary schools, or in contradiction with the National School Lunch Program; (2) Sugared carbonated drinks (excluding diet carbonated drinks) are not sold in middle schools; (3) No more than 50% of products available to high school students are sugared carbonated drinks; and bottled water is available in every vending machine. In addition, by the 2006-2007 school year, no snack vending will be available to elementary school students and at least 75% of snacks in middle/high school vending machines must contain no more than 200 calories per portion.

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in NORTH DAKOTA?

KEY POINTS:

- Approximately 18,000 of 67,000 North Dakota children ages 10-17 years (26.9%) are considered overweight or obese according to BMI-for-age standards.
- North Dakota children with publicly financed health insurance have an overweight/obese prevalence rate of 43.7%, almost twice as high as the rate for children with private insurance (22.7%). The state's insurance disparity ratio of 1.93 is exceeded only by Georgia and Illinois.
- North Dakota children are more likely than their counterparts nationwide to be physically active for at least 4 days per week, but they're less likely to spend 2 hours or more in front of a television or computer screen.

OVERALL PREVALENCE	NORTH DAKOTA %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	26.9%*	30.6%
State Rank for overweight or obese children (1 is best)	13	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	63.5%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	39.1%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**NORTH DAKOTA %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	NA	39.8%
>400 % FPL	23.4%	22.9%
Income Disparity Ratio	NA	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	NA	
% Overweight or Obese by Type of Insurance		
Public Insurance	43.7%	39.6%
Private Insurance	22.7%	26.7%
Insurance Disparity Ratio	1.93	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	47	
% Overweight or Obese by Race		
Black, non-Hispanic	NA	41.2%
White, non-Hispanic	24.8%	26.6%
Race Disparity Ratio	NA	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	NA	
% Overweight or Obese by Hispanic Origin		
Hispanic	NA	37.7%
Non-Hispanic	26.9%	29.5%
Hispanic Origin Disparity Ratio	NA	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	NA	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is NORTH DAKOTA doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

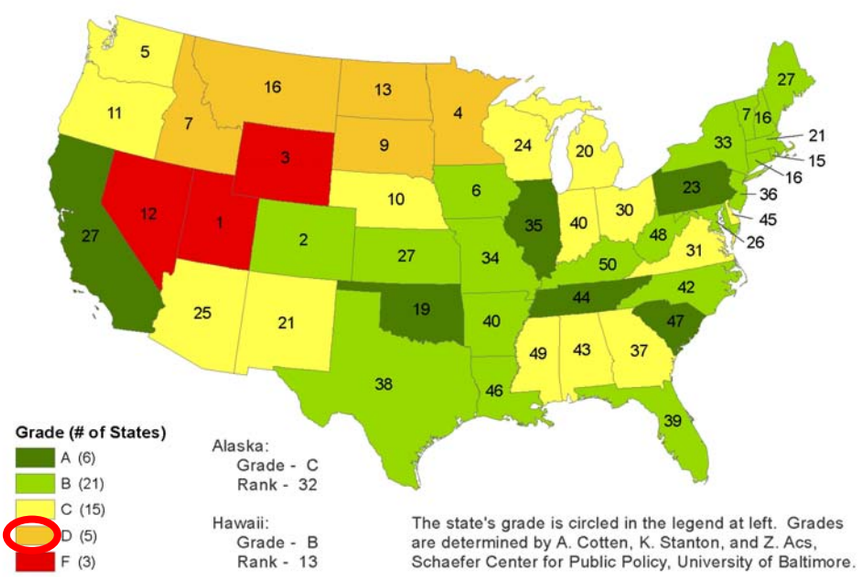
OBESITY-RELATED STATE INITIATIVES	NORTH DAKOTA	NATIONAL
Snack and/or soda tax	Yes	17 states + D.C.
CDC state-based nutrition and physical activity program	No	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	Yes	24 states
OBESITY-RELATED SCHOOL STANDARDS	**NORTH DAKOTA**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	No	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	No	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	No	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**NORTH DAKOTA**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

In order to be approved by the state superintendent of public instruction, each public and nonpublic elementary and middle school shall provide to students instruction in health (Code 15.1-21-01). North Dakota requires a minimum of 40 minutes per week for grades 1-3; a minimum of 80 minutes per week for grades 4-6; and a minimum of 50 minutes per week for grades 7-8 (Administrative Rules 67-19-01-34 and 67-19-01-35). Beginning with the 2008-09 school year, one unit of physical education, which may include up to one-half unit of health, is required for high school graduation (Code 15.1-21-02.2).

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in OHIO?

KEY POINTS:

- Approximately 380,000 of 1,251,000 Ohio children ages 10-17 years (30.4%) are considered overweight or obese according to BMI-for-age standards.
- More than two of five (43.0%) poor children in Ohio are overweight or obese.
- Among black non-Hispanic children in Ohio, 39.3% are overweight or obese, lower than the 41.2% national prevalence rate. Ohio ranks fourth among the 50 states and D.C. in prevalence for black non-Hispanic children.
- Ohio children are less likely than their counterparts nationwide to be physically active for at least 4 days per week, and more likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 27.2% of low-income children ages 2 to 5 years in Ohio are overweight or obese.

OVERALL PREVALENCE	OHIO %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	30.4%	30.6%
State Rank for overweight or obese children (1 is best)	30	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	57.9%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	48.1%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**OHIO %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	43.0%	39.8%
>400 % FPL	22.0%	22.9%
Income Disparity Ratio	1.95	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	24	
% Overweight or Obese by Type of Insurance		
Public Insurance	39.9%	39.6%
Private Insurance	26.9%	26.7%
Insurance Disparity Ratio	1.48	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	22	
% Overweight or Obese by Race		
Black, non-Hispanic	39.3%	41.2%
White, non-Hispanic	28.5%	26.6%
Race Disparity Ratio	1.38	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	6	
% Overweight or Obese by Hispanic Origin		
Hispanic	NA	37.7%
Non-Hispanic	30.3%	29.5%
Hispanic Origin Disparity Ratio	NA	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	NA	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is OHIO doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

Obesity-Related State Initiatives	Ohio	National
Snack and/or soda tax	No	17 states + D.C.
CDC state-based nutrition and physical activity program	No	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	Yes	24 states
Obesity-Related School Standards	**Ohio**	**National**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	No	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	No	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	No	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 Obesity-Related Policy Options	**Ohio**	**National**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

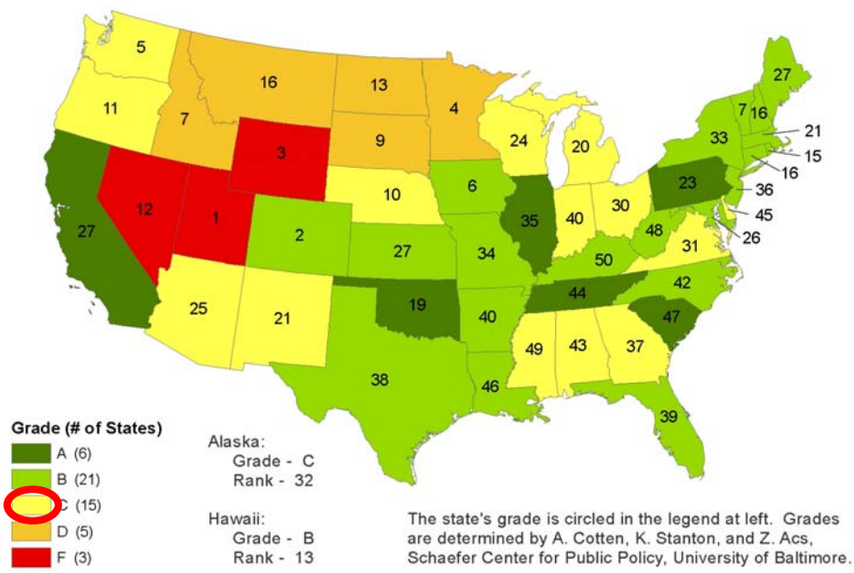
NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

Ohio Revised Code 3313.60 requires schools to offer a curriculum that includes health education. However, there are no specifics about grade levels or amounts of instruction.

One-half unit of health education is required for high school graduation (Revised Code 3313.603).

State Obesity Prevalence Ranking and Report Card Grade for Childhood Obesity-related Activities



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in OKLAHOMA?

KEY POINTS:

- Approximately 110,000 of 389,000 Oklahoma children ages 10-17 years (28.2%) are considered overweight or obese according to BMI-for-age standards.
- The prevalence of overweight and obesity for Oklahoma children in poverty is more than one in three (36.3%).
- One third (33.9%) of Oklahoma's publicly insured children are either overweight or obese.
- Oklahoma children are more likely than their counterparts nationwide to be physically active for at least 4 days per week, but they're also more likely to spend 2 hours or more in front of a television or computer screen.

OVERALL PREVALENCE	OKLAHOMA %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	28.2%	30.6%
State Rank for overweight or obese children (1 is best)	19	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	63.4%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	54.2%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**OKLAHOMA %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	36.3%	39.8%
>400 % FPL	22.0%	22.9%
Income Disparity Ratio	1.65	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	12	
% Overweight or Obese by Type of Insurance		
Public Insurance	33.9%	39.6%
Private Insurance	24.3%	26.7%
Insurance Disparity Ratio	1.39	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	15	
% Overweight or Obese by Race		
Black, non-Hispanic	NA	41.2%
White, non-Hispanic	24.5%	26.6%
Race Disparity Ratio	NA	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	NA	
% Overweight or Obese by Hispanic Origin		
Hispanic	NA	37.7%
Non-Hispanic	27.8%	29.5%
Hispanic Origin Disparity Ratio	NA	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	NA	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is OKLAHOMA doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

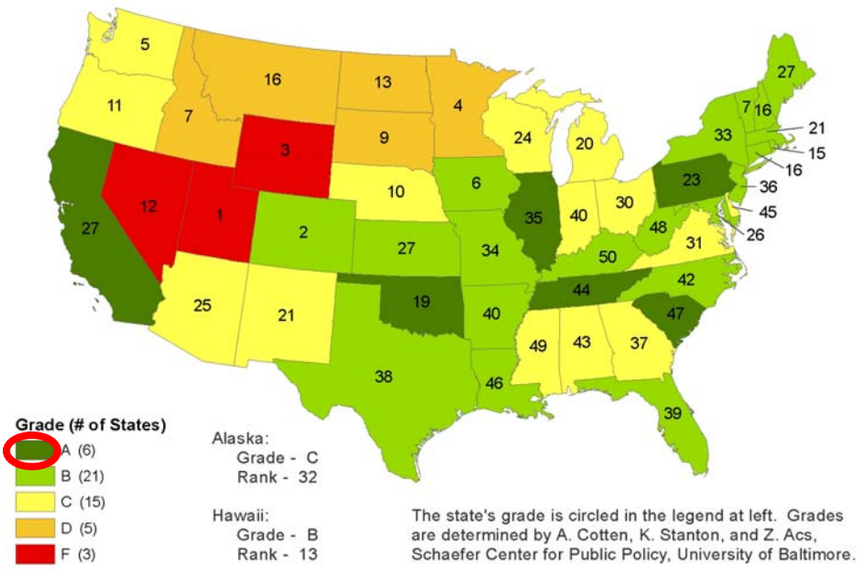
OBESITY-RELATED STATE INITIATIVES	OKLAHOMA	NATIONAL
Snack and/or soda tax	No	17 states + D.C.
CDC state-based nutrition and physical activity program	Yes	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	No	24 states
OBESITY-RELATED SCHOOL STANDARDS	**OKLAHOMA**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	No	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	Yes	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	Yes	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	Yes	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**OKLAHOMA**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	proposed	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	Yes	19 states introduced

NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

Each school district board must ensure that the following requirements are met (SB 265): (1) Elementary school students do not have access to foods of minimal nutritional value, except on special occasions; (2) Middle and junior high school students do not have access to foods of minimal nutritional value, with the exception of diet sodas with less than 10 calories per serving, except after school, at evening events, and on special occasions; and (3) High school students must have access to healthy food choices in addition to foods of minimal nutritional value. Incentives such as lower prices should be provided to encourage selection of healthy food choices.

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in OREGON?

KEY POINTS:

- Approximately 100,000 of 378,000 Oregon children ages 10-17 years (26.5%) are considered overweight or obese according to BMI-for-age standards.
- More than two in five (41.6%) Oregon children in families below the poverty line are obese or overweight.
- Oregon children are more likely than their counterparts nationwide to be physically active for at least 4 days per week, and less likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 31.8% of low-income children ages 2 to 5 years in Oregon are overweight or obese.

OVERALL PREVALENCE	OREGON %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	26.5%*	30.6%
State Rank for overweight or obese children (1 is best)	11	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	63.8%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	40.6%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**OREGON %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	41.6%	39.8%
>400 % FPL	23.8%	22.9%
Income Disparity Ratio	1.75	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	14	
% Overweight or Obese by Type of Insurance		
Public Insurance	38.9%	39.6%
Private Insurance	23.2%	26.7%
Insurance Disparity Ratio	1.68	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	36	
% Overweight or Obese by Race		
Black, non-Hispanic	NA	41.2%
White, non-Hispanic	25.0%	26.6%
Race Disparity Ratio	NA	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	NA	
% Overweight or Obese by Hispanic Origin		
Hispanic	41.3%	37.7%
Non-Hispanic	25.3%	29.5%
Hispanic Origin Disparity Ratio	1.63	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	16	

* Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is OREGON doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

OBESITY-RELATED STATE INITIATIVES	OREGON	NATIONAL
Snack and/or soda tax	No	17 states + D.C.
CDC state-based nutrition and physical activity program	Yes	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	Yes	24 states
OBESITY-RELATED SCHOOL STANDARDS	**OREGON**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	No	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	No	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	No	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**OREGON**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

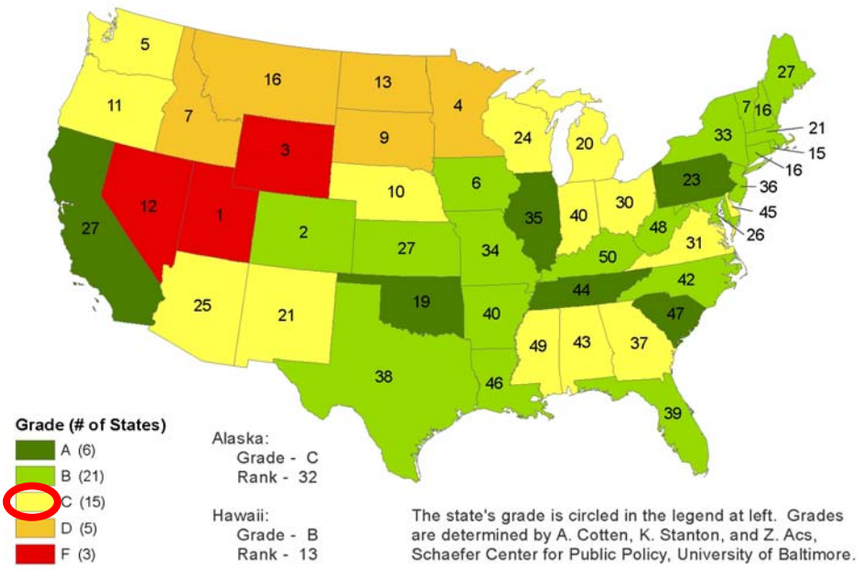
NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

Oregon requires physical education in elementary, middle and high school, although duration and frequency are not specified. One unit of credit of physical education is required for high school graduation (OAR 581-022-1130).

State law prohibits a person from maintaining action for a claim or injury or death caused by a food-related condition against a person involved in the selling of food, unless food is adulterated, misbranded, or violates the Federal Food, Drug, and Cosmetic Act (HB 2591).

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in PENNSYLVANIA?

KEY POINTS:

- Approximately 390,000 of 1,333,000 Pennsylvania children ages 10-17 years (29.3%) are considered overweight or obese according to BMI-for-age standards.
- Pennsylvania ranks first (i.e. best) in overweight/obese prevalence among children in poor families with a rate of 26.7%. The state's income disparity ratio of 1.18 ranks second.
- Pennsylvania children with public health insurance have an overweight/obese prevalence rate of 31.2%, roughly two percentage points higher than the rate for privately insured children (28.8%). The state ranks fifth in prevalence rate for publicly insured children, and the insurance disparity ratio of 1.08 is third lowest in the country.
- Pennsylvania children are less likely than their counterparts nationwide to be physically active for at least 4 days per week, and more likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 24.7% of low-income children ages 2 to 5 years in Pennsylvania are overweight or obese.

OVERALL PREVALENCE	PENNSYLVANIA %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	29.3%	30.6%
State Rank for overweight or obese children (1 is best)	23	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	54.2%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	46.7%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**PENNSYLVANIA %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	26.7%	39.8%
>400 % FPL	22.6%	22.9%
Income Disparity Ratio	1.18	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	2	
% Overweight or Obese by Type of Insurance		
Public Insurance	31.2%	39.6%
Private Insurance	28.8%	26.7%
Insurance Disparity Ratio	1.08	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	3	
% Overweight or Obese by Race		
Black, non-Hispanic	43.2%	41.2%
White, non-Hispanic	27.0%	26.6%
Race Disparity Ratio	1.6	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	13	
% Overweight or Obese by Hispanic Origin		
Hispanic	NA	37.7%
Non-Hispanic	29.7%	29.5%
Hispanic Origin Disparity Ratio	NA	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	NA	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is PENNSYLVANIA doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

OBESITY-RELATED STATE INITIATIVES	PENNSYLVANIA	NATIONAL
Snack and/or soda tax	No	17 states + D.C.
CDC state-based nutrition and physical activity program	Yes	28 states
Federal STEPS grant recipient	Yes	7 states
Laws that limit liability for obesity and obesity-related health problems	No	24 states
OBESITY-RELATED SCHOOL STANDARDS	**PENNSYLVANIA**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	No	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	No	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	No	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	Yes	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**PENNSYLVANIA**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	Yes	19 states introduced

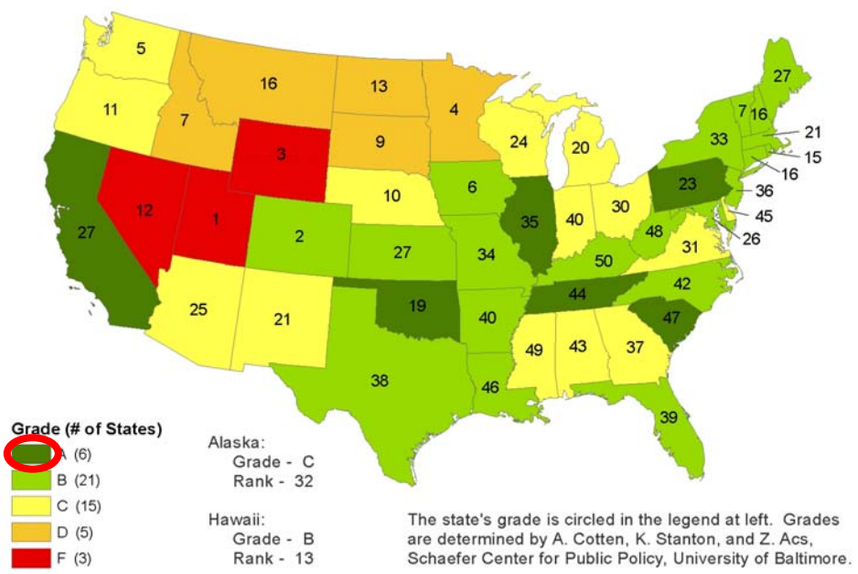
NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

The Pennsylvania Department of Health requires school nurses to compute body mass index for students in grades 1-8 during annual growth screenings. BMI measurement will be required for students in all grades in the 2007-08 school year. Parents receive letters about the BMI results that encourage them to share the information with their family's physician.

Recent legislation requires the establishment of an interagency coordinating council for child health, nutrition and physical education that shall offer recommendations on physical education curriculum (HB 185, Act 114).

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in RHODE ISLAND?

KEY POINTS:

- Approximately 28,000 of 104,000 Rhode Island children ages 10-17 years (34.4%) are considered overweight or obese according to BMI-for-age standards.
- Nearly one third (32.7%) of Rhode Island children in poor families are either overweight or obese. This prevalence rate is seven percentage points below the national rate, placing Rhode Island third in the state ranking for this child subgroup.
- Rhode Island children are less likely than their counterparts nationwide to be physically active for at least 4 days per week, and slightly less likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 34.4% of low-income children ages 2 to 5 years in Rhode Island are overweight or obese.

OVERALL PREVALENCE	RHODE ISLAND %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	27.0%	30.6%
State Rank for overweight or obese children (1 is best)	15	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	48.6%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	43.9%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**RHODE ISLAND %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	32.7%	39.8%
>400 % FPL	23.2%	22.9%
Income Disparity Ratio	1.41	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	7	
% Overweight or Obese by Type of Insurance		
Public Insurance	32.1%	39.6%
Private Insurance	25.2%	26.7%
Insurance Disparity Ratio	1.28	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	10	
% Overweight or Obese by Race		
Black, non-Hispanic	NA	41.2%
White, non-Hispanic	24.4%	26.6%
Race Disparity Ratio	NA	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	NA	
% Overweight or Obese by Hispanic Origin		
Hispanic	39.1%	37.7%
Non-Hispanic	25.5%	29.5%
Hispanic Origin Disparity Ratio	1.53	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	14	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is RHODE ISLAND doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

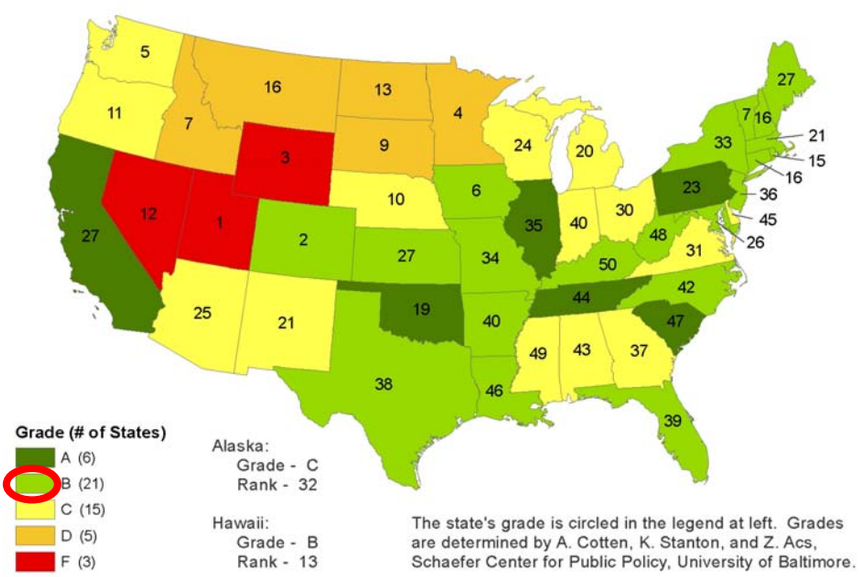
OBESITY-RELATED STATE INITIATIVES	RHODE ISLAND	NATIONAL
Snack and/or soda tax	Yes	17 states + D.C.
CDC state-based nutrition and physical activity program	Yes	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	No	24 states
OBESITY-RELATED SCHOOL STANDARDS	**RHODE ISLAND**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	Yes	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	Yes	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	No	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**RHODE ISLAND**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

Rhode Island requires all elementary, middle, and junior high schools to offer healthier snacks by January 1, 2008. Healthier snacks are defined as: (1) Individually sold portions of nuts, nut butters, seeds, eggs, and cheese packaged for individual sale, fruit and vegetables that have not been deep fried, and legumes; (2) Individually sold portions of low fat yogurt with not more than four grams of total carbohydrates (including both naturally occurring and added sugars) per ounce and reduced fat or low fat cheese packaged for individual sale; and (3) Individually sold enriched or fortified grain or grain products or whole grain foods that contain no more than 30% calories from fat, no more than 10% total calories from saturated fat, and no more than seven grams of total sugar per ounce.

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in SOUTH CAROLINA?

KEY POINTS:

- Approximately 162,000 of 449,000 South Carolina children ages 10-17 years (36.1%) are considered overweight or obese according to BMI-for-age standards. South Carolina ranks in the bottom five states on overall prevalence.
- One third (33.3%) of South Carolina children with private health insurance are overweight or obese. Only Louisiana has a higher overweight/obese prevalence for this subgroup of children. Due to this extraordinarily high rate for the privately insured group, the state's insurance disparity ratio is only 1.16 and ranks fifth best in the nation.
- The overweight/obese prevalence for black children in South Carolina in nearly one in two (48.1%).
- South Carolina children are less likely than their counterparts nationwide to be physically active for at least 4 days per week, and more likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 28.1% of low-income children ages 2 to 5 years in South Carolina are overweight or obese.

OVERALL PREVALENCE	SOUTH CAROLINA %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	36.1%*	30.6%
State Rank for overweight or obese children (1 is best)	47	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	58.0%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	50.1%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**SOUTH CAROLINA %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	46.3%	39.8%
>400 % FPL	24.7%	22.9%
Income Disparity Ratio	1.87	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	22	
% Overweight or Obese by Type of Insurance		
Public Insurance	38.7%	39.6%
Private Insurance	33.3%	26.7%
Insurance Disparity Ratio	1.16	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	5	
% Overweight or Obese by Race		
Black, non-Hispanic	48.1%	41.2%
White, non-Hispanic	28.6%	26.6%
Race Disparity Ratio	1.69	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	15	
% Overweight or Obese by Hispanic Origin		
Hispanic	NA	37.7%
Non-Hispanic	36.4%	29.5%
Hispanic Origin Disparity Ratio	NA	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	NA	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is SOUTH CAROLINA doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

OBESITY-RELATED STATE INITIATIVES	SOUTH CAROLINA	NATIONAL
Snack and/or soda tax	No	17 states + D.C.
CDC state-based nutrition and physical activity program	Yes	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	No	24 states
OBESITY-RELATED SCHOOL STANDARDS	**SOUTH CAROLINA**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	Yes	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	Yes	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	Yes	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	Yes	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**SOUTH CAROLINA**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	proposed	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	Yes	19 states introduced

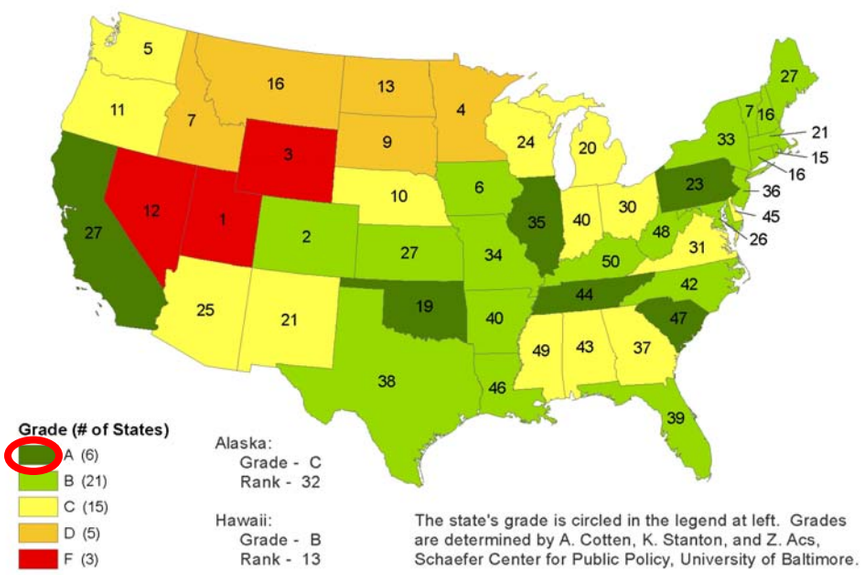
NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

The Student Health and Fitness Act (HB 3499) requires all K-12 schools in the state to participate in the South Carolina Physical Education Assessment and requires that an individual's fitness status must be reported to his parent or guardian during a student's fifth grade, eighth grade, and high school physical education courses.

South Carolina's State Board of Education has restricted access to competitive foods in elementary schools (R43-168). Effective June 23, 2006, elementary schools cannot sell or serve the following beverages to students until after the last regularly scheduled class: soda, soft drinks, sports drinks, punches, iced teas and coffees, and fruit-based drinks that contain less than 100% real fruit juice or that contain added sweeteners.

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in SOUTH DAKOTA?

KEY POINTS:

- Approximately 24,000 of 92,000 South Dakota children ages 10-17 years (25.8%) are considered overweight or obese according to BMI-for-age standards.
- The prevalence of overweight and obesity among South Dakota children in higher-income families is less than one in six (15.6%), seven percentage points below the national rate and second lowest among the 50 states and D.C., trailing only Colorado.
- About one in five (21.3%) white children in South Dakota are overweight or obese. South Dakota ranks fifth for this subgroup.
- South Dakota children are just as likely as their counterparts nationwide to be physically active for at least 4 days per week, and less likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 32.0% of low-income children ages 2 to 5 years in South Dakota are overweight or obese.

OVERALL PREVALENCE	SOUTH DAKOTA %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	25.8%*	30.6%
State Rank for overweight or obese children (1 is best)	9	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	59.2%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	41.0%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**SOUTH DAKOTA %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	37.3%	39.8%
>400 % FPL	15.6%	22.9%
Income Disparity Ratio	2.40	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	36	
% Overweight or Obese by Type of Insurance		
Public Insurance	32.4%	39.6%
Private Insurance	21.9%	26.7%
Insurance Disparity Ratio	1.48	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	22	
% Overweight or Obese by Race		
Black, non-Hispanic	NA	41.2%
White, non-Hispanic	21.3%	26.6%
Race Disparity Ratio	NA	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	NA	
% Overweight or Obese by Hispanic Origin		
Hispanic	NA	37.7%
Non-Hispanic	25.4%	29.5%
Hispanic Origin Disparity Ratio	NA	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	NA	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is SOUTH DAKOTA doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

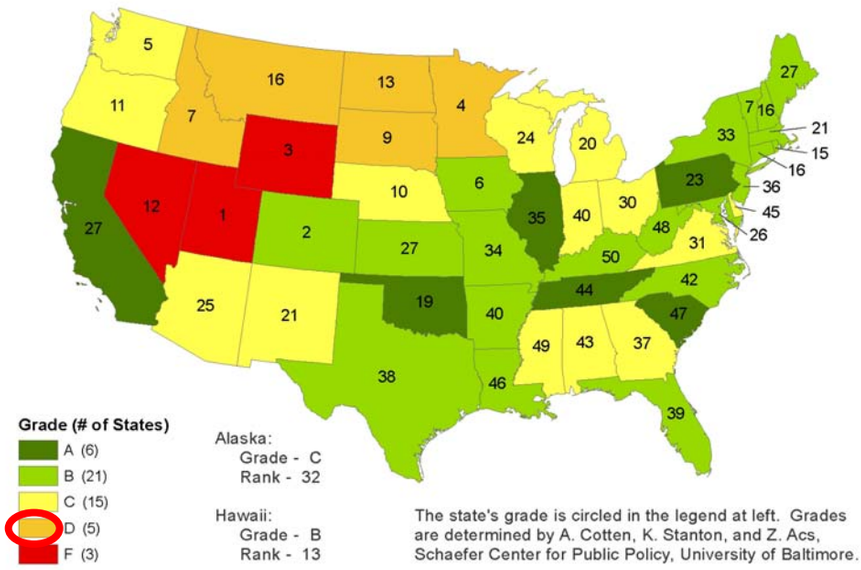
OBESITY-RELATED STATE INITIATIVES	SOUTH DAKOTA	NATIONAL
Snack and/or soda tax	No	17 states + D.C.
CDC state-based nutrition and physical activity program	Yes	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	Yes	24 states
OBESITY-RELATED SCHOOL STANDARDS	**SOUTH DAKOTA**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	Yes	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	No	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	No	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**SOUTH DAKOTA**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

South Dakota sets additional standards beyond U.S. Department of Agriculture requirements for sodium, cholesterol and fiber: (1) For breakfast (all grades), the following standards apply: Sodium must be no more than 800 mg, cholesterol no more than 75 mg, and fiber no less than 4.5 mg; (2) For lunch (all grades), the following standards apply: Sodium must be no more than 1300 mg, and cholesterol no more than 75 mg. Fiber standards differ by grade level.

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in TENNESSEE?

KEY POINTS:

- Approximately 214,000 of 607,000 Tennessee children ages 10-17 years (35.3%) are considered overweight or obese according to BMI-for-age standards.
- More than one in three (34.8%) white non-Hispanic children in Tennessee are overweight or obese, ranking the state 49th for this race subgroup, ahead of only West Virginia and Kentucky.
- Nearly two in five (39.6%) black non-Hispanic children in Tennessee are classified as overweight or obese. The state's race disparity ratio of 1.14, however, is best in the nation.
- Tennessee children are less likely than their counterparts nationwide to be physically active for at least 4 days per week, and more likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 27.8% of low-income children ages 2 to 5 years in Tennessee are overweight or obese.

OVERALL PREVALENCE	TENNESSEE %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	35.3%*	30.6%
State Rank for overweight or obese children (1 is best)	44	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	55.9%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	48.8%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**TENNESSEE %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	44.1%	39.8%
>400 % FPL	24.6%	22.9%
Income Disparity Ratio	1.79	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	16	
% Overweight or Obese by Type of Insurance		
Public Insurance	45.5%	39.6%
Private Insurance	29.4%	26.7%
Insurance Disparity Ratio	1.55	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	31	
% Overweight or Obese by Race		
Black, non-Hispanic	39.6%	41.2%
White, non-Hispanic	34.8%	26.6%
Race Disparity Ratio	1.14	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	1	
% Overweight or Obese by Hispanic Origin		
Hispanic	NA	37.7%
Non-Hispanic	35.8%	29.5%
Hispanic Origin Disparity Ratio	NA	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	NA	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is TENNESSEE doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

OBESITY-RELATED STATE INITIATIVES	TENNESSEE	NATIONAL
Snack and/or soda tax	Yes	17 states + D.C.
CDC state-based nutrition and physical activity program	No	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	Yes	24 states
OBESITY-RELATED SCHOOL STANDARDS	**TENNESSEE**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	Yes	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	Yes	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	No	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	Yes	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**TENNESSEE**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	proposed	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	Yes	19 states introduced

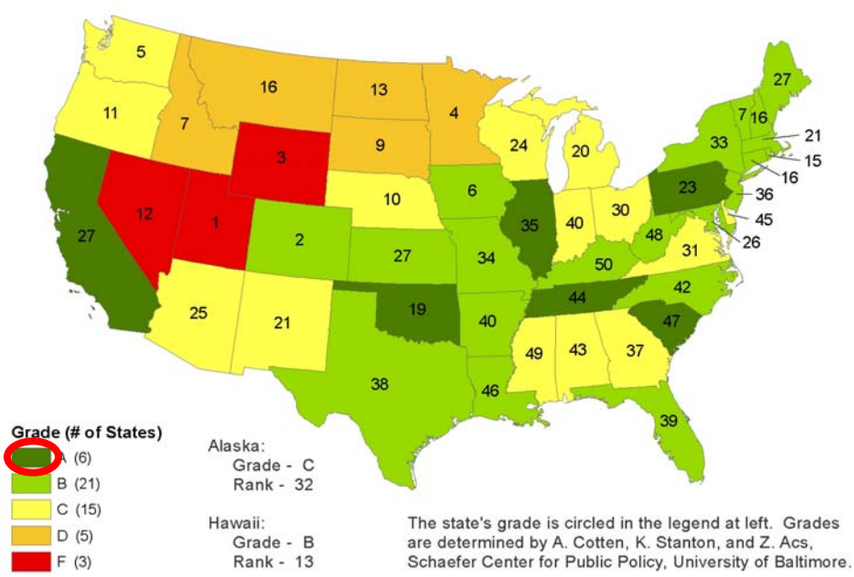
NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

Tennessee requires that parents be provided with a confidential health report card for their children, including BMI levels. Schools with high aggregate BMI levels are encouraged to improve nutritional and physical activity programs (TN HB445, P.C. 194).

Tennessee also enacted legislation to authorize local education agencies to implement a program that identifies public school children who are at risk for obesity (SB 247).

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in TEXAS?

KEY POINTS:

- Approximately 766,000 of 2,364,000 Texas children ages 10-17 years (32.4%) are considered overweight or obese according to BMI-for-age standards.
- The prevalence of overweight and obesity among black children in Texas is more than one in three (36.8%), placing the state four percentage points below the national rate for black children. Only Michigan has a lower prevalence rate for black children.
- Texas children are more likely than their counterparts nationwide to be physically active for at least 4 days per week, and equally likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 32.5% of low-income children ages 2 to 5 years in Texas are overweight or obese.

OVERALL PREVALENCE	TEXAS %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	32.4%	30.6%
State Rank for overweight or obese children (1 is best)	38	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	62.7%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	45.1%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**TEXAS %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	43.5%	39.8%
>400 % FPL	23.4%	22.9%
Income Disparity Ratio	1.86	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	20	
% Overweight or Obese by Type of Insurance		
Public Insurance	39.3%	39.6%
Private Insurance	27.6%	26.7%
Insurance Disparity Ratio	1.42	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	17	
% Overweight or Obese by Race		
Black, non-Hispanic	36.8%	41.2%
White, non-Hispanic	26.4%	26.6%
Race Disparity Ratio	1.39	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	8	
% Overweight or Obese by Hispanic Origin		
Hispanic	41.5%	37.7%
Non-Hispanic	28.3%	29.5%
Hispanic Origin Disparity Ratio	1.47	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	13	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is TEXAS doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

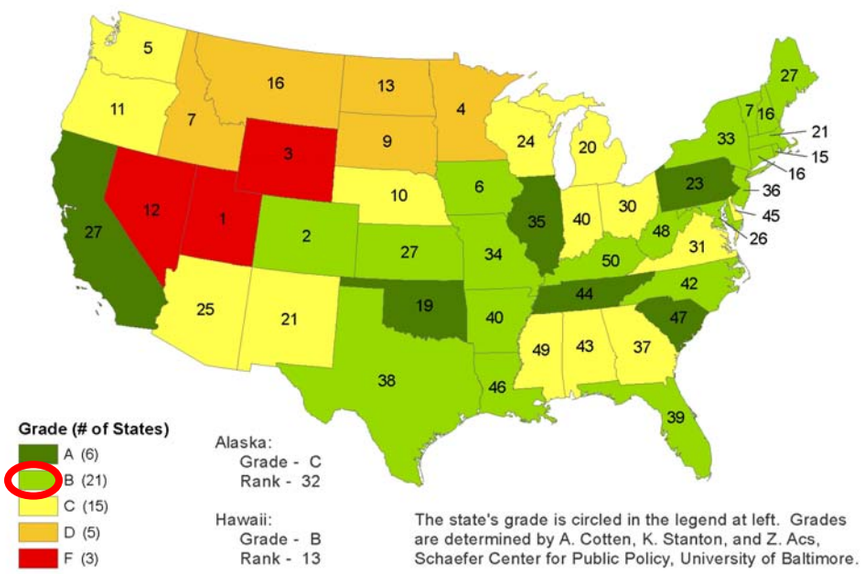
Obesity-Related State Initiatives	Texas	National
Snack and/or soda tax	Yes	17 states + D.C.
CDC state-based nutrition and physical activity program	Yes	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	Yes	24 states
Obesity-Related School Standards	**Texas**	**National**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	Yes	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	Yes	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	Yes	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 Obesity-Related Policy Options	**Texas**	**National**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

Notes:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

The Texas Public School Nutrition Policy sets nutrition and portion size standards for food and beverage items sold as school meals or à la carte, and those offered as a nutritious classroom snack. Portion restrictions are not placed on federal school meals offered to students. Current standards include: (1) Schools and other vendors may not serve food items containing more than 28 grams of fat per serving size more than twice per week; (2) French fries and other fried potato products must not exceed three ounces per serving and may not be offered more than once per week in elementary schools and three times per week in middle and junior high schools. Students may only purchase one serving at a time; (3) Requires that fruits and vegetables be offered daily at all points of service.

State Obesity Prevalence Ranking and Report Card Grade for Childhood Obesity-Related Activities



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in UTAH?

KEY POINTS:

- Approximately 62,000 of 299,000 Utah children ages 10-17 years (20.9%) are considered overweight or obese according to BMI-for-age standards. Utah ranks first among the 50 states and D.C. with the lowest overall prevalence.
- The prevalence of overweight and obesity in Utah is one in five for children in higher-income families and for privately insured children (20.0% and 20.1%, respectively).
- Utah ranks second, behind only the District of Columbia, in overweight/obese prevalence among white children (18.3%).
- Small numbers of poor, uninsured, and minority children in Utah prevent the publication of reliable disparity ratios for the state.
- Utah children are less likely than their counterparts nationwide to be physically active for at least 4 days per week, but they're also far less likely to spend 2 hours or more in front of a television or computer screen.

OVERALL PREVALENCE	UTAH %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	20.9%*	30.6%
State Rank for overweight or obese children (1 is best)	1	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	53.5%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	37.5%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**UTAH %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	NA	39.8%
>400 % FPL	20.0%	22.9%
Income Disparity Ratio	NA	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	NA	
% Overweight or Obese by Type of Insurance		
Public Insurance	NA	39.6%
Private Insurance	20.1%	26.7%
Insurance Disparity Ratio	NA	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	NA	
% Overweight or Obese by Race		
Black, non-Hispanic	NA	41.2%
White, non-Hispanic	18.3%	26.6%
Race Disparity Ratio	NA	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	NA	
% Overweight or Obese by Hispanic Origin		
Hispanic	NA	37.7%
Non-Hispanic	19.5%	29.5%
Hispanic Origin Disparity Ratio	NA	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	NA	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is UTAH doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

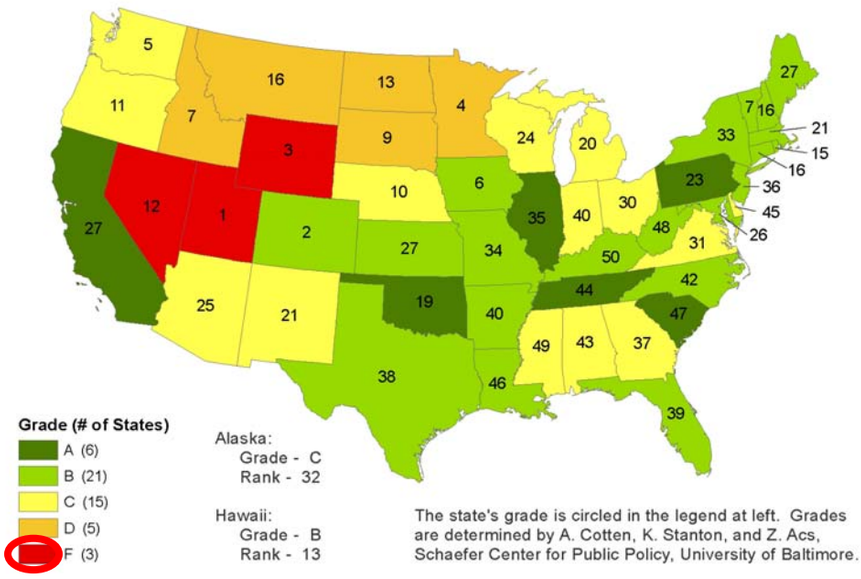
OBESITY-RELATED STATE INITIATIVES	UTAH	NATIONAL
Snack and/or soda tax	No	17 states + D.C.
CDC state-based nutrition and physical activity program	No	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	Yes	24 states
OBESITY-RELATED SCHOOL STANDARDS	**UTAH**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	No	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	No	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	No	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**UTAH**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

Physical education is required in elementary, middle and high school. One unit of credit of physical education is required in grades 7-8. For high school graduation, two units of credit of physical and health education are required and must be composed of ½ credit of health; ½ credit of participation skills; ½ credit of fitness for life; and ½ credit of individualized lifetime activities or team sport/athletic participation (Administrative Code R277-700).

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in VERMONT?

KEY POINTS:

- Approximately 17,000 of 68,000 Vermont children ages 10-17 years (25.6%) are considered overweight or obese according to BMI-for-age standards. Vermont ranks seventh among the 50 states and D.C. in overall prevalence.
- Nearly one third (32.6%) of publicly insured children in Vermont are overweight or obese, but the state's prevalence rate is seven percentage points below the national rate. Vermont ranks eighth among the 50 states and D.C. in overweight/obese prevalence for children with public health insurance, and seventh for children with private insurance.
- Vermont children are more likely than their counterparts nationwide to be physically active for at least 4 days per week, and far less likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 28.7% of low-income children ages 2 to 5 years in Vermont are overweight or obese.

OVERALL PREVALENCE	VERMONT %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	25.6%*	30.6%
State Rank for overweight or obese children (1 is best)	7	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	60.8%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	34.3%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**VERMONT %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	NA	39.8%
>400 % FPL	23.3%	22.9%
Income Disparity Ratio	NA	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	NA	
% Overweight or Obese by Type of Insurance		
Public Insurance	32.6%	39.6%
Private Insurance	22.1%	26.7%
Insurance Disparity Ratio	1.48	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	22	
% Overweight or Obese by Race		
Black, non-Hispanic	NA	41.2%
White, non-Hispanic	25.5%	26.6%
Race Disparity Ratio	NA	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	NA	
% Overweight or Obese by Hispanic Origin		
Hispanic	NA	37.7%
Non-Hispanic	25.8%	29.5%
Hispanic Origin Disparity Ratio	NA	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	NA	

* Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is VERMONT doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

OBESITY-RELATED STATE INITIATIVES	VERMONT	NATIONAL
Snack and/or soda tax	No	17 states + D.C.
CDC state-based nutrition and physical activity program	Yes	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	No	24 states
OBESITY-RELATED SCHOOL STANDARDS	**VERMONT**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	Yes	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	No	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	No	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**VERMONT**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

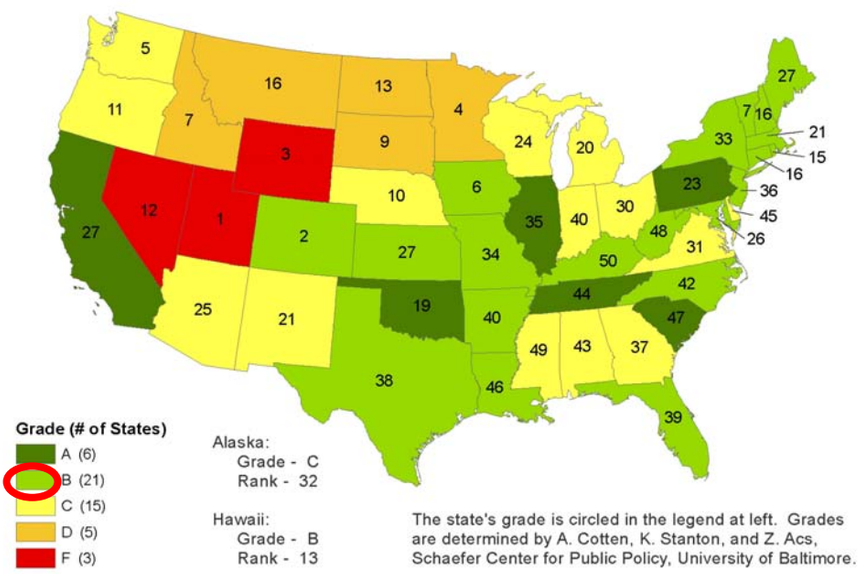
NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

New legislation creates a local foods mini-grant program in the agency of agriculture, food and markets to help Vermont schools develop relationships with local farmers and producers. The intent of the legislation is to encourage local school districts to serve food that is as fresh and as nutritious as possible and to increase school meal participation by increasing the selection of foods available to students. A school, a school district, a consortium of schools, or a consortium of school districts may apply for a mini-grant award to purchase equipment, resources, and materials that will help to increase use of local foods in the school food service program (HB 465, Act 145).

Legislation from 2005 required the Department of Education to develop a model fitness policy (H544, S 241).

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in VIRGINIA?

KEY POINTS:

- Approximately 250,000 of 820,000 Virginia children ages 10-17 years (30.5%) are considered overweight or obese according to BMI-for-age standards.
- Virginia children in poor families have an overweight/obese prevalence rate that is double the rate for children in higher-income families (45.8% and 22.3%).
- The prevalence of overweight and obesity among publicly insured children in Virginia is 46.9%, seven percentage points higher than the national rate.
- Virginia children are less likely than their counterparts nationwide to be physically active for at least 4 days per week, and less likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 35.1% of low-income children ages 2 to 5 years in Virginia are overweight or obese.

OVERALL PREVALENCE	VIRGINIA %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	30.5%	30.6%
State Rank for overweight or obese children (1 is best)	31	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	57.7%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	43.5%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**VIRGINIA %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	45.8%	39.8%
>400 % FPL	22.3%	22.9%
Income Disparity Ratio	2.05	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	29	
% Overweight or Obese by Type of Insurance		
Public Insurance	46.9%	39.6%
Private Insurance	25.9%	26.7%
Insurance Disparity Ratio	1.81	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	42	
% Overweight or Obese by Race		
Black, non-Hispanic	41.0%	41.2%
White, non-Hispanic	24.6%	26.6%
Race Disparity Ratio	1.66	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	14	
% Overweight or Obese by Hispanic Origin		
Hispanic	48.2%	37.7%
Non-Hispanic	29.3%	29.5%
Hispanic Origin Disparity Ratio	1.65	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	18	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is VIRGINIA doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

OBESITY-RELATED STATE INITIATIVES	VIRGINIA	NATIONAL
Snack and/or soda tax	Yes	17 states + D.C.
CDC state-based nutrition and physical activity program	No	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	No	24 states
OBESITY-RELATED SCHOOL STANDARDS	**VIRGINIA**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	No	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	No	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	No	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**VIRGINIA**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	proposed	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

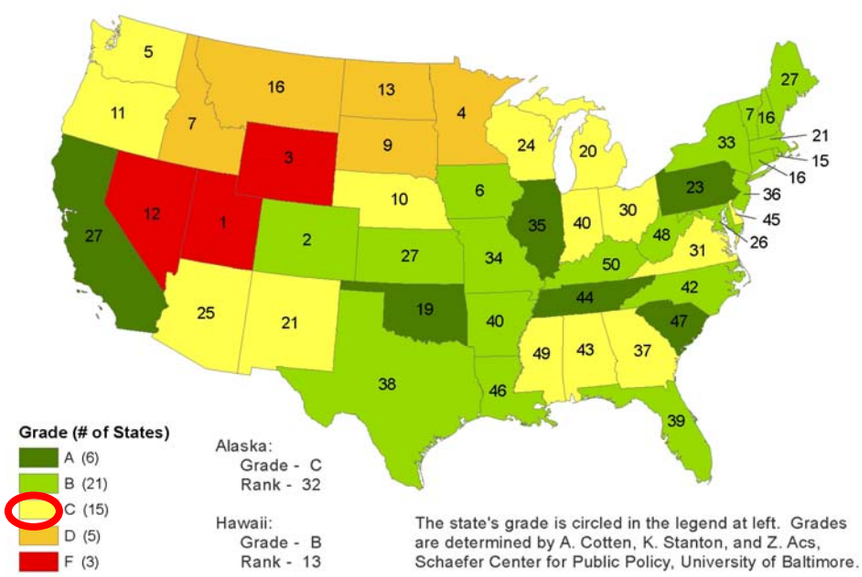
NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

Recent legislation incorporates physical and health education as part of elementary school curriculum, in addition to including health and physical education as components of programs of instruction for grades K through 12 (SB 795).

Virginia levies a small excise tax on wholesalers and distributors based on total sales of carbonated soft drinks.

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in WASHINGTON?

KEY POINTS:

- Approximately 168,000 of 672,000 Washington children ages 10-17 years (25.0%) are considered overweight or obese according to BMI-for-age standards. Washington ranks fifth in overall prevalence.
- The prevalence of overweight and obesity among Washington's publicly insured children is 29.4%, 10 percentage points below the national prevalence rate, and ranking third among the 50 states and D.C.
- Hispanic children in Washington are less likely to be overweight or obese than Hispanic children in the country as a whole. Washington ranks third among states in overweight/obese prevalence for Hispanic children.
- Washington children are more likely than their counterparts nationwide to be physically active for at least 4 days per week, and less likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 32.5% of low-income children ages 2 to 5 years in Washington are overweight or obese.

OVERALL PREVALENCE	WASHINGTON %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	25.0%*	30.6%
State Rank for overweight or obese children (1 is best)	5	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	63.8%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	38.5%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**WASHINGTON %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	NA	39.8%
>400 % FPL	20.8%	22.9%
Income Disparity Ratio	NA	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	NA	
% Overweight or Obese by Type of Insurance		
Public Insurance	29.4%	39.6%
Private Insurance	23.5%	26.7%
Insurance Disparity Ratio	1.25	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	6	
% Overweight or Obese by Race		
Black, non-Hispanic	NA	41.2%
White, non-Hispanic	23.5%	26.6%
Race Disparity Ratio	NA	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	NA	
% Overweight or Obese by Hispanic Origin		
Hispanic	34.1%	37.7%
Non-Hispanic	24.4%	29.5%
Hispanic Origin Disparity Ratio	1.40	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	9	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is WASHINGTON doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

OBESITY-RELATED STATE INITIATIVES	WASHINGTON	NATIONAL
Snack and/or soda tax	Yes	17 states + D.C.
CDC state-based nutrition and physical activity program	Yes	28 states
Federal STEPS grant recipient	Yes	7 states
Laws that limit liability for obesity and obesity-related health problems	Yes	24 states
OBESITY-RELATED SCHOOL STANDARDS	**WASHINGTON**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	No	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	No	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	No	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**WASHINGTON**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

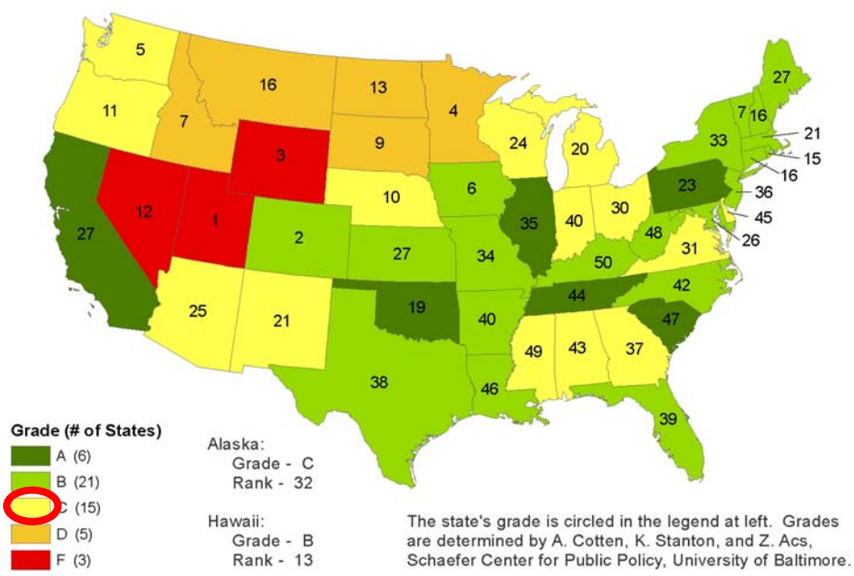
NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

By the end of the 2008-09 school year, school districts shall have in place in elementary schools, middle schools, and high schools assessments or other strategies to assure that students have an opportunity to learn the essential academic learning requirements in health and fitness (RCW 28A.230.095). The goals of each school district, with the involvement of parents and community members, shall be to provide opportunities for all students to develop the knowledge and skills essential to know and apply the core concepts and principles of health and fitness (RCW 28A.150.210). The statute does not include specifics on grades or amounts or instruction.

Two credits (300 hours) of health and fitness education are required for high school graduation.

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in WEST VIRGINIA?

KEY POINTS:

- Approximately 67,000 of 184,000 West Virginia children ages 10-17 years (36.4%) are considered overweight or obese according to BMI-for-age standards. West Virginia ranks 48th in overall prevalence, surpassed only by Mississippi, Kentucky, and the District of Columbia.
- More than one in three (35.6%) white non-Hispanic children in West Virginia is overweight or obese. The state's prevalence rate for white children is nine percentage points above the national rate, and ranks 50th, ahead of only Kentucky.
- West Virginia children are more likely than their counterparts nationwide to be physically active for at least 4 days per week, but they're also more likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 26.6% of low-income children ages 2 to 5 years in West Virginia are overweight or obese.

OVERALL PREVALENCE	WEST VIRGINIA %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	36.4%*	30.6%
State Rank for overweight or obese children (1 is best)	48	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	65.2%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	48.8%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**WEST VIRGINIA %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	47.0%	39.8%
>400 % FPL	23.9%	22.9%
Income Disparity Ratio	1.97	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	25	
% Overweight or Obese by Type of Insurance		
Public Insurance	46.1%	39.6%
Private Insurance	30.1%	26.7%
Insurance Disparity Ratio	1.53	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	28	
% Overweight or Obese by Race		
Black, non-Hispanic	NA	41.2%
White, non-Hispanic	35.6%	26.6%
Race Disparity Ratio	NA	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	NA	
% Overweight or Obese by Hispanic Origin		
Hispanic	NA	37.7%
Non-Hispanic	36.3%	29.5%
Hispanic Origin Disparity Ratio	NA	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	NA	

* Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is WEST VIRGINIA doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

OBESITY-RELATED STATE INITIATIVES	WEST VIRGINIA	NATIONAL
Snack and/or soda tax	Yes	17 states + D.C.
CDC state-based nutrition and physical activity program	Yes	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	No	24 states
OBESITY-RELATED SCHOOL STANDARDS	**WEST VIRGINIA**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	No	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	Yes	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	Yes	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	Yes	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**WEST VIRGINIA**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

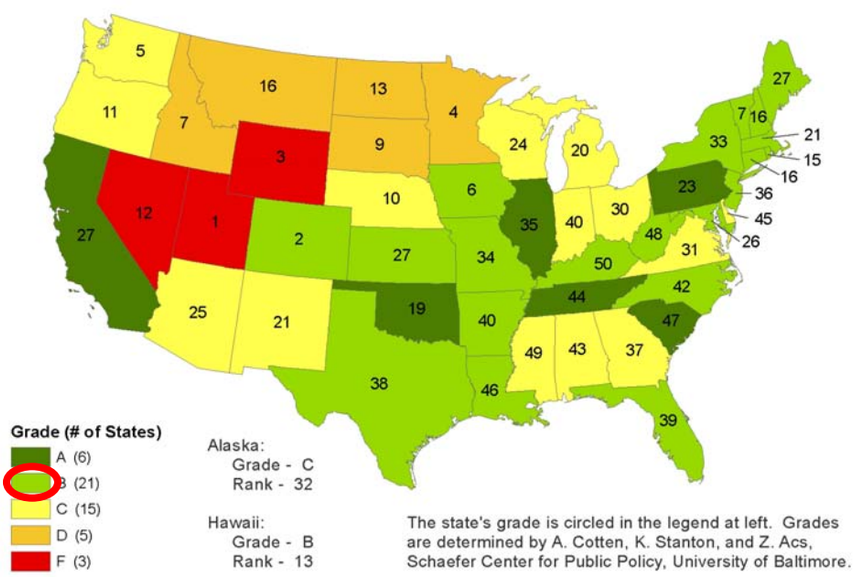
NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

New legislation changes the state's former BMI measurement policy by requiring BMI testing for only a scientifically drawn sample of students. Requires data to be collected and reported in a manner that protects student confidentiality. Data are to be reported to the Department of Education and in aggregate to the Governor, the State Board of Education, the Healthy Lifestyles Coalition and the Legislative Oversight Commission on Health and Human Resources Accountability (SB 785, §18-2-7a).

West Virginia prohibits the sale of soft drinks through vending machines, school stores, or on-site fundraisers during the school day in elementary, middle, and junior high schools. These schools are permitted only to sell "healthy beverages." High schools may allow the sale of soft drinks, but "healthy beverages" must account for at least 50% of the total beverages ordered and must be located near vending machines containing soft drinks (HB 2816).

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in WISCONSIN?

KEY POINTS:

- Approximately 174,000 of 593,000 Wisconsin children ages 10-17 years (29.4%) are considered overweight or obese according to BMI-for-age standards.
- More than half (54.1%) of Wisconsin children in poor families are overweight or obese. This prevalence rate is almost three times higher than the rate among children in higher-income families (18.1%). The state's income disparity ratio of 2.98 ranks last among the 39 states with reliable estimates for both income groups.
- Wisconsin children are just as likely as their counterparts nationwide to be physically active for at least 4 days per week, and less likely to spend 2 hours or more in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 29.3% of low-income children ages 2 to 5 years in Wisconsin are overweight or obese.

OVERALL PREVALENCE	WISCONSIN %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	29.4%	30.6%
State Rank for overweight or obese children (1 is best)	24	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	59.6%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	40.4%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**WISCONSIN %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	54.1%	39.8%
>400 % FPL	18.1%	22.9%
Income Disparity Ratio	2.98	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	39	
% Overweight or Obese by Type of Insurance		
Public Insurance	43.2%	39.6%
Private Insurance	26.1%	26.7%
Insurance Disparity Ratio	1.65	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	34	
% Overweight or Obese by Race		
Black, non-Hispanic	NA	41.2%
White, non-Hispanic	26.9%	26.6%
Race Disparity Ratio	NA	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	NA	
% Overweight or Obese by Hispanic Origin		
Hispanic	NA	37.7%
Non-Hispanic	29.4%	29.5%
Hispanic Origin Disparity Ratio	NA	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	NA	

***** Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

Data Resource Center for Child & Adolescent Health
Your Data... Your story
www.childhealthdata.org
A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is WISCONSIN doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness or value of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

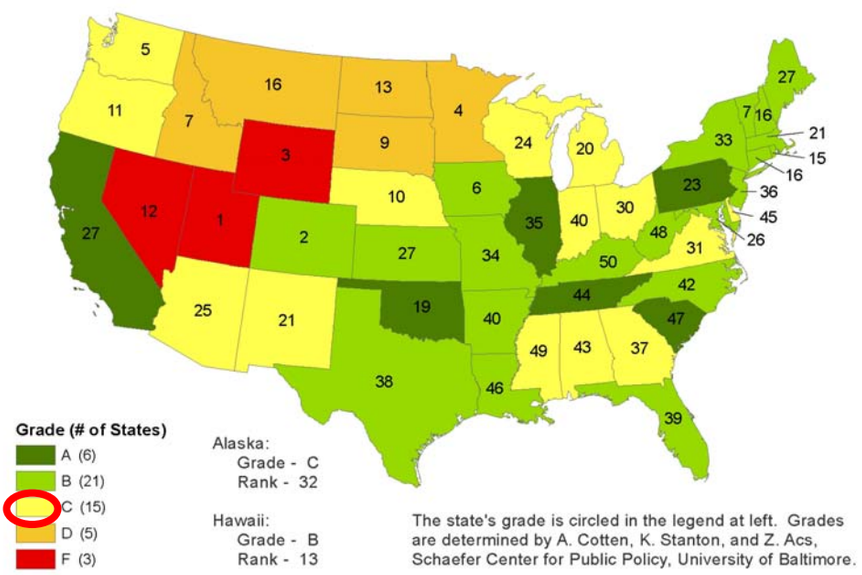
OBESITY-RELATED STATE INITIATIVES	WISCONSIN	NATIONAL
Snack and/or soda tax	No	17 states + D.C.
CDC state-based nutrition and physical activity program	Yes	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	Yes	24 states
OBESITY-RELATED SCHOOL STANDARDS	**WISCONSIN**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	No	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	No	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	No	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**WISCONSIN**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

According to the Department of Public Instruction's school district standards and Statute 121.02, physical education is required at least three times per week for grades K-6 and weekly for middle school.

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

How much do you know about the childhood obesity epidemic in WYOMING?

KEY POINTS:

- Approximately 13,000 of 57,000 Wyoming children ages 10-17 years (22.9%) are considered overweight or obese according to BMI-for-age standards. Wyoming ranks third among the 50 states and D.C. in overall prevalence.
- Only one in six (16.3%) Wyoming children in higher-income families are overweight or obese. The state ranks third in prevalence among higher-income children.
- One in five (20.2%) Wyoming children with private health insurance are overweight or obese.
- Wyoming children are more likely than their counterparts nationwide to be physically active for at least 4 days per week, and less likely to spend 2 hours or more in front of a television or computer screen.

OVERALL PREVALENCE	WYOMING %	NATIONAL %
Percentage of children ages 10-17 years who are overweight or obese	22.9%*	30.6%
State Rank for overweight or obese children (1 is best)	3	
Percentage of children ages 6–17 years who participate in 4 or more days of vigorous physical activity per week	64.2%	59.0%
Percentage of children ages 6-17 years who engage in 2 or more hours of screen time per day (includes TV, videos, computer games, etc.)	39.4%	44.9%
DISPARITIES – ACROSS AND WITHIN STATES	**WYOMING %**	**NATIONAL %**
% Overweight or Obese by Family Income		
<100% Federal Poverty Level (FPL)	NA	39.8%
>400 % FPL	16.3%	22.9%
Income Disparity Ratio	NA	1.74
State Rank on Income Disparity Ratio (1 is best, 39 is worst)	NA	
% Overweight or Obese by Type of Insurance		
Public Insurance	34.7%	39.6%
Private Insurance	20.2%	26.7%
Insurance Disparity Ratio	1.72	1.48
State Rank on Insurance Disparity Ratio (1 is best, 49 is worst)	39	
% Overweight or Obese by Race		
Black, non-Hispanic	NA	41.2%
White, non-Hispanic	22.2%	26.6%
Race Disparity Ratio	NA	1.55
State Rank on Race Disparity Ratio (1 is best, 23 is worst)	NA	
% Overweight or Obese by Hispanic Origin		
Hispanic	NA	37.7%
Non-Hispanic	22.6%	29.5%
Hispanic Origin Disparity Ratio	NA	1.28
State Rank on Hispanic Origin Disparity Ratio (1 is best, 21 is worst)	NA	

* Difference between state and national overall prevalence is statistically significant at the .05 level of significance.
NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.
State rankings on disparity ratios include only those states with reliable estimates for both groups.
Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.
Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

The 2003 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Two important aspects of children's health measured in the survey are physical activity and overweight, which is calculated from the child's height and weight as reported by the parent or guardian. Using survey results and sex-specific BMI-for-age growth charts developed by CDC, the prevalence of children with BMI scores in two separate percentile ranges (85th to 95th and at or above the 95th) can be estimated. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. Childhood and adolescent obesity measures based on parental report may not accurately reflect the true prevalence of overweight and obesity. However, previous research and comparisons of NSCH with data from the National Health and Nutrition Examination Surveys (NHANES) have shown that parental reports are reliable and provide a fairly close correspondence for children 10-17 years (Ogden et al., *Advance Data From Vital and Health Statistics*, 2004).

NICHQ

Childhood Obesity Action Network

www.nichq.org/obesityactionnetwork

What is WYOMING doing about obesity?

The table below is derived from the 2007 edition of *F as in Fat*, published by Trust for America's Health (www.healthyamericans.org). The effectiveness of any one state approach is not known; the summary below is intended only for comparing a state's activities with others.

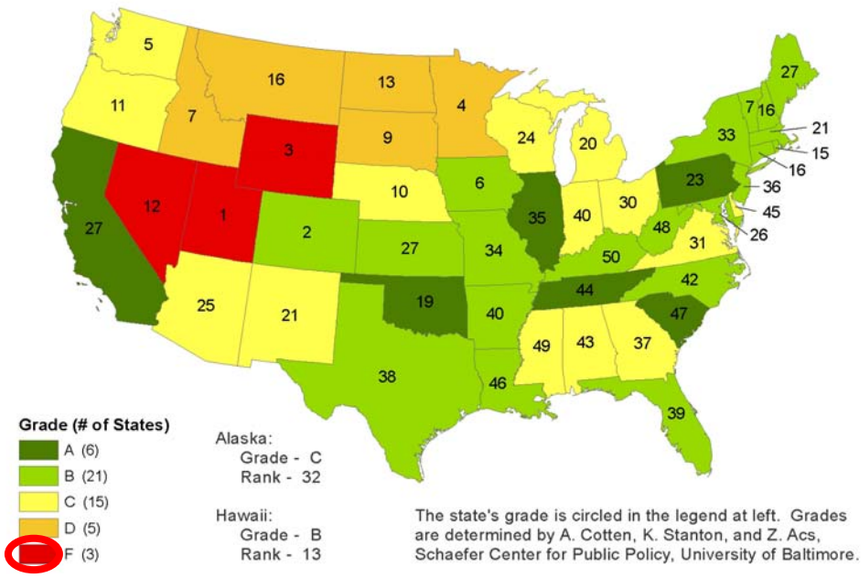
OBESITY-RELATED STATE INITIATIVES	WYOMING	NATIONAL
Snack and/or soda tax	No	17 states + D.C.
CDC state-based nutrition and physical activity program	No	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	Yes	24 states
OBESITY-RELATED SCHOOL STANDARDS	**WYOMING**	**NATIONAL**
Physical education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	50 states + D.C.
Health education requirement *(Note: There is variation in whether states enforce these standards)*	Yes	48 states + D.C.
Nutritional standards for school meals and snacks that go beyond existing USDA requirements	No	17 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	No	22 states
Limitation (beyond federal requirements) on when and where competitive food products may be sold	No	26 states
BMI or health information collected *(Note: There is variation in whether states enforce these standards)*	No	16 states
2006 OBESITY-RELATED POLICY OPTIONS	**WYOMING**	**NATIONAL**
Provision for strengthening of private insurance coverage for obesity prevention or treatment, especially for the morbidly obese (BMI of 40 or higher). Children may or may not be covered.	No	8 states introduced
Legislation or resolutions to create obesity-related task forces, commissions, studies or other special programs	No	19 states introduced

NOTES:

The federal Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108 - 265) required each local school district participating in the National School Lunch and Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. To view model school wellness policies, see www.schoolwellnesspolicies.org/.

According to Statute §21-9-101, each school district within the state shall provide educational programs sufficient to meet uniform student content and performance standards at the level established by the state board of education in a common core of knowledge and skills, including health and safety.

STATE OBESITY PREVALENCE RANKING AND REPORT CARD GRADE FOR CHILDHOOD OBESITY-RELATED ACTIVITIES



Note: The numbers shown in the map above represent the state's ranking on the prevalence of overweight and obesity among children ages 10-17. Utah ranks first with the lowest overweight/obese prevalence, while Kentucky ranks 50th. The child obesity report card grade developed for each state is a composite of the state score on five types of childhood obesity-related legislation: (1) Nutrition standards in schools, (2) Vending machine prohibitions in schools, (3) Body mass index measured in school, (4) Recess and physical education requirements, and (5) Obesity programs and education. For more information, see www.ubalt.edu/experts/obesity/index.html.