Find this report and interactive data features with the latest childhood obesity rates and trends, as well as policies and recommendations for helping all children grow up healthy, at stateofchildhoodobesity.org.
Introduction
A Letter from Rich Besser

Friends,

Throughout my career as a pediatrician, a public health professional, a television health journalist, and now as the head of a national health philanthropy, I have always continued to see patients in community clinics.

Many of my patients have been children of low-income families, working hard to stay as healthy as possible despite the many barriers they face. Many struggle with obesity. I got to know these families over the years and I’ve realized that obesity and other health concerns are symptoms of larger, more systemic problems regarding health and equity in our society. Poverty. Unstable and unsafe housing. Schools that don’t meet children’s needs. Neighborhoods that seldom offer families opportunities to thrive. These are all conditions that influence health.

Many of these community conditions are a result of discriminatory policies and systems that have been in place for decades. And they continue to contribute to the significant disparities in obesity rates by race, by income, and by geography. However, we have the power to change these outcomes and make our nation a more equitable society. The more we understand the barriers to good health, the more we can do to address them.

That is why we are releasing a new annual report, State of Childhood Obesity: Helping All Children Grow Up Healthy, which includes the best available data on national and state childhood obesity rates and, importantly, recommends policies to improve children’s health.

While we have seen backsliding at the federal level, we have seen glimmers of hope at the state and local levels. In Columbus, Ohio, for instance, the local WIC program hosts a farmers’ market right outside the Columbus Department of Public Health, where anyone can buy affordable fruits and vegetables. And the local Water First for Thirst campaign is working to improve access to drinking water, so it is the drink of choice at markets, outdoor events, and child-care centers.

The Robert Wood Johnson Foundation is committed to reducing the rates of childhood obesity across the nation. We know it won’t be easy, or quick. We know it will require policy changes at every level of government, and we’re working alongside others to implement shifts that will make it easier for kids and their families to be healthy.

We’re also working to address the broader community conditions—such as housing, employment at a living wage, transportation, community financing, and clean air and water—that will help to ensure that everyone in America has a fair and just opportunity to live as healthy as possible.

As you read this report and explore the website, I encourage you to think about what policies you can help to improve, and how you can collaborate with others to do it. By working together, we can build a nation that supports, sustains, and secures the well-being of all our children and their families.

Dr. Richard Besser
PRESIDENT & CEO, RWJF
Overview

After decades of increases, the national childhood obesity rate has held relatively stable in recent years. Yet childhood obesity rates remain stubbornly and historically high, putting millions of young people at greater risk for serious health conditions, including high blood pressure, type 2 diabetes, heart disease, and asthma. Obesity rates rise with age and there are significant inequities in rates, with black and Latinx youth at higher risk than white and Asian youth. Each year, the United States spends $14 billion on childhood obesity alone, and between $147 billion and $210 billion on adult obesity.

In many ways, obesity reflects larger, systemic problems regarding health and equity. The epidemic is complex and challenging to address. The underlying causes of obesity range from economic, policy, and environmental influences, to cultural norms, and individual factors. For example, where families and children live, learn, work, and play have a great impact on the choices available to them. When communities lack fresh, affordable, healthy foods or safe, accessible opportunities to get outside, healthy eating and physical activity can be out of reach for many children.

The policies that affect the foods and beverages available in daycare centers and schools are also critical for helping all children grow up healthy, as are federal nutrition assistance programs that millions of families rely on, such as the Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). To date, efforts and progress to address childhood obesity have been mixed, leaving communities of color and low-income families disproportionately affected.

This report provides findings from major federal datasets measuring childhood obesity among different age groups and describes policies and programs aimed at creating healthier child-care centers, schools, and communities. It also offers recommendations for helping all children grow up at a healthy weight, especially from an early age, which is essential to preventing a wide range of health problems and saving billions in health care costs.
When a mother brought her 13-year-old daughter to the health clinic with concerns about her dramatic weight gain, Dr. Renee Boynton-Jarrett wasn’t quick to prescribe a solution. Instead, she pulled out a growth chart to help the mother pinpoint when her daughter’s health began to change. After Dr. Boynton-Jarrett asked a couple of questions, the mother realized her daughter’s weight gain began one month after her father was incarcerated. From there and together, they created a plan to address it.

This exemplifies Dr. Boynton-Jarrett’s approach to care, serving as a listener and facilitator. It illustrates what she believes to be true: that we cannot continue to address childhood obesity reactively. Rather we must address its root causes: severe inequities that plague our underserved communities and leave families without access to healthy affordable foods, safe neighborhoods, safe streets, and opportunities for physical activity.

Renee believes that the answers for addressing childhood obesity lie within individuals and communities themselves. Together with local partners, she’s helping more families have access to healthy foods. There are healthy food trucks, nutrition and cooking classes for expectant mothers, and gardens both in the community and at the hospital itself for neighborhood parents.

Learn more about Dr. Boynton-Jarrett’s approach for building strong community partnerships at stateofchildhoodobesity.org.

“Everything around how a child grows and develops, what their ultimate life chances are, and chance for health and well-being, is intricately and inextricably connected to their family and community environments. If we present opportunities for people to own what health and well-being look like in their communities, they will take that opportunity and transform lives.

Dr. Renee Boynton-Jarrett
Pediatrician and Social Epidemiologist at Boston Medical Center
No matter what corner of San Antonio you visit—from the playgrounds at Hardberger Park to the toddler garden at the Witte Museum—you’ll find similar infrastructure and services or a plan for addressing the inequities that exist. That’s because Mayor Ron Nirenberg is focused on building a more equitable city where everyone benefits and children can thrive.

Mayor Nirenberg is committed to helping children grow up healthy and purposeful about allocating resources where they’re needed most. He leans on his Department of Public Health to tell him “what he doesn’t want to know about the health of his city,” so he can draft policies that address those challenges. For example, the city is working to ensure that new sidewalks are built wide enough to encourage people to walk on them, and building them in the historically under-resourced neighborhoods that never had sidewalks before.

Mayor Nirenberg recognizes the challenges of addressing childhood obesity in a city that was built more than 300 years ago and historically has struggled with intractable generational poverty and wide socioeconomic gaps. But he’s seeing results and remains hopeful about the future.

Learn more about how Mayor Nirenberg is working to build a more equitable San Antonio at

My hope for the children of San Antonio is that no matter where they are born in this community, they will grow up knowing that they can achieve anything that they want to. And that they will live a healthy life and be able to accomplish their dreams here in our city. We’re on our way to building that city.

Ron Nirenberg
Mayor of San Antonio, Texas
Childhood Obesity Rates & Trends

This report includes the latest data from major federal surveys that track obesity rates among children and teens, including the National Health and Nutrition Examination Survey; the National Survey of Children's Health; the WIC Participant and Program Characteristics Survey; and the Youth Risk Behavior Surveillance System. Because research shows that children who have obesity at an early age are more likely to have obesity later in life, this report also includes the latest findings from the Behavioral Risk Factor Surveillance System, which tracks state-by-state adult obesity rates. When describing differences by race and ethnicity, this section uses the racial and ethnic terms provided by the original dataset.

DEFINING OBESITY AMONG CHILDREN AND TEENS

Body mass index (BMI) is a measure commonly used to determine overweight and obesity. BMI is calculated by dividing a child’s weight (in kilograms) by height (in square meters). According to the Centers for Disease Control and Prevention, obesity is defined as a BMI that is at or above the 95th percentile for children and teens of the same age and sex. Overweight is defined as a BMI that is at or above the 85th percentile and below the 95th percentile for children and teens of the same age and sex.

Why is BMI age- and sex-specific for children and teens? A child’s weight status is determined using an age- and sex-specific percentile for BMI, which is different from BMI categories used for adults. Because children’s body fat levels change over the course of childhood and vary between boys and girls, their BMI levels are expressed relative to other children of the same age and sex.

Source: The Centers for Disease Control and Prevention
The National Survey of Children’s Health

The National Survey of Children’s Health (NSCH) collects health information for children ages 0 to 17 in the United States. Parents or caregivers are asked to report their child’s height and weight, which is used to calculate body mass index (BMI) for children ages 10 to 17 years. BMI-for-age percentiles are then used to identify children who have obesity (i.e., BMI at or above the 95th percentile).

An advantage of the NSCH is that it supports both national and state-by-state estimates, so obesity rates between states can be compared. A limitation is that the survey collects parents’ reports of their child’s height and weight, not direct measurement; parents may not always report accurate numbers, which impacts the assessment of obesity. In addition, parent-reported data are more reliable for children ages 10 to 17 than for younger children, which is why the survey does not provide BMI calculations for children ages 0 to 9.

In recent years, the NSCH was significantly redesigned, and the 2016 survey was the first to reflect those changes. Due to changes in the survey’s mode of data collection and sampling frame, it is not possible to directly compare results from the 2016 NSCH or later years to earlier iterations. Since 2016, the NSCH has been conducted as an annual survey and will continue to collect new data each year going forward, so trends over time can be evaluated, with 2016 data serving as a new baseline. In order to increase sample size and enable more reliable estimates, after a large initial sample size in 2016, data are pooled across two collection years, in this case 2017 and 2018.

The new data reinforce that childhood obesity remains a significant challenge for the country. Obesity puts young people at risk for a host of serious, long-term health consequences, such as heart disease, diabetes, high blood pressure, and even certain types of cancer. Seeing that one in six young people in the country has obesity reminds all of us that we still have a long way to go to truly turn these rates around.

Dr. Lydie Lebrun-Harris
Senior Social Scientist in the Office of Epidemiology and Research at the Health Resources and Services Administration’s Maternal and Child Health Bureau

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The Health Resources and Services Administration’s Maternal and Child Health Bureau (HRSA MCHB) funds and directs the NSCH and develops survey content in collaboration with a national technical expert panel and the U.S. Census Bureau, which then conducts the survey on behalf of HRSA MCHB.

**Key Findings**

- The national obesity rate for youth ages 10 to 17 in 2017-18 was 15.3 percent, compared with 16.1 percent in 2016. The difference is not statistically significant.

- Racial and ethnic disparities persist. Black and Hispanic youth had obesity rates (22.2 percent and 19.0 percent, respectively), that were significantly higher than white youth, 11.8 percent, or Asian youth, 7.3 percent.

- There are also disparities by income level: 21.9 percent of youth in households making less than the federal poverty level had obesity, significantly more than the 9.4 percent of youth in households making at least 400 percent of the federal poverty level.

- Mississippi had the highest overall youth obesity rate, 25.4 percent, and Utah had the lowest, 8.7 percent. Three states had obesity rates that were statistically significantly higher than the national rate in 2017-18: Mississippi (25.4%), West Virginia (20.9%), and Kentucky (20.8%).

- Six states had obesity rates statistically significantly lower than the national rate in 2017-18: Utah (8.7%), Minnesota (9.4%), Alaska (9.9%), Colorado (10.7%), Montana (10.8%), and Washington (11.0%).

- No states saw statistically significant changes in their overall obesity rates between 2016 and 2017-18, however additional years of data are needed before trends over time can be reliably assessed.
WIC Participant and Program Characteristics

About half of all infants born in the United States are served by the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). WIC provides lower-income women and children with healthy food, health care referrals, and nutrition education. Children are eligible for WIC up to their fifth birthday. WIC is administered by the U.S. Department of Agriculture (USDA).

The WIC Participant and Program Characteristics (WICPPC) survey gathers data from all states on all participants. A strength of these data is that they are a census of all WIC participants and not just a sample of them. The data include height and weight measurements for children, which are collected by medical staff during certification visits, and then are used to calculate BMI and obesity rates among children ages 2 to 4. The data are gathered in April of even-numbered years, and analyzed by the Centers for Disease Control and Prevention.

Key Findings

This analysis provides the latest strong evidence that WIC is an effective program for preventing and reducing childhood obesity—an epidemic that continues to threaten the health of our nation’s children from a young age. Research shows that children who are overweight or have obesity as preschoolers are five times more likely to be overweight or have obesity as adults, so preventing obesity in early childhood is critical.

Georgia Machell
Senior Director of Research and Program Operations for the National WIC Association

Key Findings

- The national obesity rate among 2- to 4-year-olds who participate in WIC declined significantly between 2010 and 2016, from 15.9 percent to 13.9 percent.

- The decline was statistically significant among all racial and ethnic groups studied: white, black, Hispanic, American Indian/Alaska Native, Asian/Pacific Islander.
OBESITY RATE: WIC PARTICIPANTS
AGES 2-4, 2016

National Rate 13.9%
Amer. Indian/Alaska Native 18.5%
Asian/Pacific Islander 10.0%
Black 11.4%
Hispanic 16.4%
White 12.1%

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OBESITY RATE: WIC PARTICIPANTS
AGES 2-4, BY RACE AND ETHNICITY, 2014

- 0–9.9%
- 10–14.9%
- 15–19.9%
- 20–24.9%

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Childhood Obesity Rates and Trends 11
The Youth Risk Behavior Surveillance System (YRBSS) collects a wide range of health data on students in grades 9 through 12. The survey is conducted every two years by the Centers for Disease Control and Prevention nationally, and by state departments of health and education. It is usually conducted during the spring. Not every state participates in every survey cycle. Minnesota, Oregon, Washington, and Wyoming did not take part in the most recent edition of the survey, conducted in 2017.

The survey asks students to self-report their height and weight and uses those data to calculate BMI rates and the percentage who have obesity. A limit of self-reported data is that people tend to over-report their height and under-report their weight, meaning the obesity rates may be underestimates. Because of sampling methodology, it is not possible to compare national rates with specific state-level rates.

These data can help us identify where more efforts are needed to help teens eat healthier and be more active. For example, schools and afterschool programs play a critical role in helping all kids grow up healthy. This can be especially true in underserved communities where families lack access to affordable, nutritious foods, and safe places for play.

Holly Hunt
Chief of the Centers for Disease Control and Prevention’s Healthy Schools
Key Findings

- Nationally, 14.8 percent of high school students had obesity in 2017. Obesity rates rose significantly from 1999 to 2017, but did not change significantly from 2015 to 2017.

- There were differences in rates between male students (17.5%) and female students (12.1%), as well as between black (18.2%), Hispanic (18.2%), and white students (12.5%). These were the only racial and ethnic groups for which obesity rate data were reported.
The National Health and Nutrition Examination Survey (NHANES) is conducted every two years by the National Center for Health Statistics within the Centers for Disease Control and Prevention. The survey has been conducted periodically since the 1970s and produces a wide range of health data for both children and adults. Children and youth ages 2 to 19 are included in the survey. The survey includes direct measures of participants' height and weight, making it the most accurate source of national obesity trends. However, it also has a relatively small sample size, which means it is important to look at data trends over time rather than on individual reporting periods. The most recent NHANES includes obesity rate data from 2015 to 2016.

The slowing down of the rate of increase in obesity that started around 2003 is real progress, but there is more work to be done. We should direct additional resources at promoting healthy weights in younger children, especially in preschool years and extending through elementary school years. We also need to keep working at finding successful strategies especially for black and Latinx children, where we have seen less progress.

Diane Schazenbach
Director of the Institute for Policy Research at Northwestern University
Key Findings

- The national obesity rate among youth ages 2 to 19 was 18.5 percent in 2015-16.

- Racial and ethnic disparities persist, with rates among Hispanic and black youth statistically significantly higher than among white and Asian youth. The obesity rate among Hispanic youth was 25.8 percent; among black youth, 22 percent; among white youth it was 14.1 percent and for Asian youth, 11 percent.²⁰

- There has been a statistically significant increasing trend in youth obesity rates from 1999–2000 to 2015-16. Rates have plateaued from 2013-14 to 2015-16.
The Behavioral Risk Factor Surveillance System (BRFSS) tracks adult obesity rates at the state level each year. The BRFSS is a health survey conducted via telephone, collecting health data from adults age 18 and older from all 50 states, the District of Columbia, and participating U.S. territories. The survey is administered by the states and the Division of Population Health in the National Center for Chronic Disease Prevention and Health Promotion.

All parts of society play a role in turning the tide on obesity. These data help by showing where the burden of obesity is greatest. Factors like neighborhood design; access to healthy, affordable foods and beverages; and access to safe and convenient places for physical activity can all impact obesity.

Captain Heidi Blanck
Branch Chief, Obesity Prevention and Control Branch, Division of Nutrition, Physical Activity and Obesity

The survey includes questions asking respondents for their height and weight; these data are not directly measured. The self-reported height and weight data are then used to calculate obesity rates for each state, territory, and D.C. A limit of self-reported data is that people tend to over-report their height and under-report their weight, meaning the obesity rates may be underestimates.
Key Findings

- Between 2017 and 2018, the adult obesity rate increased in seven states (Florida, Kansas, Minnesota, Missouri, New Mexico, New York, Utah); decreased in Alaska; and remained stable in the rest of states and D.C.

- Nationally, black adults were the most likely to have obesity (39.1%), compared to Hispanic adults (33.3%) and non-Hispanic white adults (29.3%). Those are the only racial and ethnic groups reported in the data.
# State-by-State Obesity Rates

<table>
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<th>State</th>
<th>Youth Ages 10-17 (NSCH, 2017-18)</th>
<th>Students in Grades 9-12 (YRBSS, 2017)</th>
<th>Children Ages 2-4 (WICPCC, 2014)</th>
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*The national rate of obesity in 2016.
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<td>39.5</td>
</tr>
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<td>14.2</td>
<td>13.7</td>
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<td>–</td>
<td>9.9</td>
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More information: [stateofchildhoodobesity.org/children1017](stateofchildhoodobesity.org/children1017) [stateofchildhoodobesity.org/high-school-obesity](stateofchildhoodobesity.org/high-school-obesity) [stateofchildhoodobesity.org/wic](stateofchildhoodobesity.org/wic) [stateofchildhoodobesity.org/adult-obesity](stateofchildhoodobesity.org/adult-obesity)
In the capital city of Columbus, Ohio, where about 1 in 4 kids who enter kindergarten are overweight or have obesity, advocates and organizations have been working together to provide kids with the earliest possible opportunities to develop healthy habits.

One local campaign, Water First for Thirst, which is led by the Growing Healthy Kids Columbus Coalition, encourages toddlers to drink water instead of soda, energy drinks, and other sugary beverages. The campaign is focused on making water the easy, appealing, and first beverage choice for children and families across the city.

To date, more than 23 counties have implemented the campaign, including at farmers’ markets, daycare and afterschool programs, schools, and hospitals. The impact is far-reaching.

Many local events offer only water or unsweetened beverages and people are more likely to find water coolers at outdoor events. All beverage vending machines located in student areas of Columbus City Schools sell only water.

Nationwide Children’s Hospital eliminated all sugary drinks from its campus and reduced the price of bottled water. And the Columbus Public Health department has eliminated all sugary drinks from its vending machines.

The campaign has been embraced across the state by communities from all walks of life. And with kids and families reaching for water instead of sugary drinks, there’s promise of healthier, happier communities all across Ohio.

Learn more about communities taking action to address childhood obesity at

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Water First for Thirst is a great, simple way for families to make one affordable decision to drink more water and to make that one step to being a little bit healthier.

Hannah Bills
MS, LD, RDN
Growing Healthy Kids
Program Director at Columbus Public Health
The way Vic Colman sees it, health is in all places—everywhere we live, learn, work, and play—so it should be in all policymaking as well. Especially when it comes to kids.

Colman directs the Childhood Obesity Prevention Coalition, in Seattle, Washington, which has partnered with the Washington State Department of Early Learning to update licensing requirements for family home and center-based early learning settings to better prioritize children’s health. The Coalition’s hard work paid off. Today, thanks to stronger requirements, those early care providers will serve kids healthier meals, get them moving more, and limit their screen time.

And in Washington, where nearly 5,800 licensed early learning providers serve more than 166,000 children, that’s a lot of potential impact.

For example, at St. Anne’s Children & Family Center in Spokane, toddlers pick fruits and vegetables from their own garden, learn about nutrition during family-style meal times, and practice yoga in their classrooms. At Spokane Community College’s Bigfoot Child Care Center’s Head Start program, young children enjoy cherry tomatoes, cucumbers, melons, apples, and corn from their garden and from local farms. The exposure to garden-fresh meals in the classroom has even inspired a culture of healthier eating for many kids and families at home.

Learn more about communities taking action to address childhood obesity at

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This is an example of bringing a health lens to a non-health sector. Health issues aren’t at the forefront of what early learning people think about, but that’s changing.

Vic Colman
Director at the Childhood Obesity Prevention Coalition
Policies & Recommendations

Strong policies can help children and families eat healthier foods and be active. By creating healthier child-care settings, schools, and communities, these efforts can help children grow up at a healthy weight. The following national policies and recommendations can serve as a set of priorities as federal, state, and local leaders work to address the nation’s childhood obesity epidemic.
Supplemental Nutrition Assistance Program

The Supplemental Nutrition Assistance Program (SNAP) is the nation’s largest nutrition assistance program, helping feed approximately 36 million Americans each month, nearly half of whom are children. The average SNAP participant in FY18 received $126.00 per month. SNAP received $73.5 billion in funding in FY19, which was $537 million less than the program’s FY18 level. The federal government funds the benefits and splits the cost of administering the program with the states.

SNAP-Ed is a nutrition education component of the program under which USDA provides grants to states to encourage participants to make healthy purchases with their benefits. The program is funded separately from SNAP—each state receives an allotment based on state participation rates—and the services offered are in addition to actual food assistance benefits.

In addition, the 2014 Farm Bill included $188 million over five years for the creation of the Food Insecurity Nutrition Incentive (FINI) program (now known as the Gus Schumacher Nutrition Incentive Program), which offers competitive grants to incentivize healthier food purchases by SNAP participants at the point-of-sale; the 2018 Farm Bill authorized an additional $250 million over five years and made the program permanent.

In 2018, SNAP lifted 3.1 million people out of poverty.
Recommendations

> Objective data and economic realities—such as family size, employment levels, wage growth, and food cost—should determine overall SNAP spending, enrollment and benefit levels. Any reforms to SNAP should reflect and advance the program’s primary goal of reducing food insecurity.

> SNAP and Supplemental Nutrition Education Program-Education (SNAP-Ed) should have sufficient resources to encourage participants to purchase more fruits and vegetables and help them make healthier purchases.

> The Administration should rescind proposed changes to SNAP—including the elimination of broad-based categorical eligibility, restrictions on states’ ability to receive waivers on federal time-limit rules, and the public charge rule—that would disproportionately affect some of SNAP’s most vulnerable families and cause millions of participants to lose eligibility and/or benefits.

Every $5 in new SNAP benefits generates as much as $9 in economic activity.\(^{31}\)
The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is one of the nation’s largest federal nutrition programs, serving approximately 6.3 million people, including about half of all infants born in the United States. WIC helps low-income pregnant, postpartum, and breastfeeding women, infants, and children up to age 5 achieve and maintain a healthy weight by providing healthy foods and nutrition education; promoting breastfeeding and supporting nursing mothers; and providing healthcare and social-service referrals.

WIC was funded at $6.17 billion in FY18, with $60 million designated for breastfeeding initiatives, and $18.5 million directed to the WIC Farmers’ Market Nutrition Program that provides fresh, locally grown produce to participants. The U.S. Department of Agriculture administers the funds and state agencies execute the program.

The WIC food package is required by law to be periodically re-evaluated to ensure it aligns with the latest Dietary Guidelines. In 2009, the WIC food package was updated to include more fruits, vegetables, whole grains, and lower-fat milk. Research shows that, following the changes, WIC participants are buying and eating more fruits, vegetables, whole grains, and low-fat dairy products.
Recommendations

- States should continue to work toward achieving WIC Electronic Benefit Transfer (EBT) by 2020.

- As the WIC food package is revised by USDA, all recommendations should be scientifically based.

- The Centers for Medicare and Medicaid Services should continue to support WIC for its role in lead screening.

31 states and three U.S. territories reported obesity rate declines among 2-to-4 year olds participating in WIC between 2010 and 2014.  

38
School Meals and Snacks

Nationwide more than 29 million children participate in the National School Lunch Program and nearly 15 million participate in the School Breakfast Program. For children from low-income families, school meals are an especially critical source of affordable, healthy foods; 51 percent of U.S. children now qualify for free and reduced-price school meals.

The Healthy, Hunger-Free Kids Act of 2010 (HHFKA), the most recent iteration of the Child Nutrition Act, updated nutrition standards for school meals programs for the first time in 15 years to reflect the latest nutrition science, and increased the federal reimbursements schools receive for serving meals that meet those standards. The updated standards, which took effect in 2012, require more whole grains; fruits and vegetables; fat-free and low-fat milk; and less sodium, saturated fats, and added sugars. A study by USDA finds that school meals are significantly healthier under the updated nutrition standards. The nutritional quality of school lunches and breakfasts rose by 41 percent and 44 percent, respectively, between 2009-10 and 2014-15, with student participation in meal programs highest in schools that serve the healthiest meals.

In 2018, USDA issued a final rule to roll back some of the 2012 standards, including a delay in further reductions to lower sodium levels; the reintroduction of flavored one-percent milk; and the continuation of waivers for schools to opt out of whole-grain provisions. These changes took effect for the 2019-2020 school year.

Congress may consider a reauthorization of the Child Nutrition Act during its 2019-2020 session.

99% Of schools nationwide have successfully implemented the healthier meals standards.
Recommendations

› Maintain nutrition standards for school meals that were in effect prior to USDA’s final rule from December 2018 (whole grains/sodium/milk), and current nutrition standards for school snacks.

› Continue to implement and expand the Community Eligibility Provision that allows schools in high-poverty areas to serve free meals to all students, regardless of family income.

› States should implement nutrition standards that strengthen the federal standards.

› USDA should expand guidance and technical assistance to support schools in meeting updated nutrition standards and managing new school kitchen equipment.

72% Of parents support nutrition standards for school lunches.45
Dietary Guidelines

Every five years, the U.S. Departments of Agriculture (USDA) and Health and Human Services (HHS) jointly publish the Dietary Guidelines for Americans, a series of recommendations reflecting the latest nutrition science. The latest Dietary Guidelines, covering 2015-2020, emphasizes combining nutrient-dense foods in the same meal and limiting saturated fats, added sugars, and sodium.

The next iteration of the Dietary Guidelines, which will cover 2020-2025, will for the first time include standards for pregnant women, infants, and toddlers. In February 2019, USDA and HHS announced the members of the 2020 Dietary Guidelines Advisory Committee, which reviews scientific evidence and makes associated recommendations. The public is invited to submit comments.

Several federal nutrition assistance programs are required by law to have nutrition standards that meet the Dietary Guidelines; these include the Child and Adult Food Care Program (CACFP), the National School Lunch and School Breakfast Programs and WIC. The healthy eating patterns recommended in the Dietary Guidelines can help prevent chronic diseases such as obesity, heart disease, high blood pressure, and type 2 diabetes.

6 in 10

Six in 10 youth and 5 in 10 adults drink a sugar-sweetened beverage on any given day.

STATE of CHILDHOOD OBESITY
Recommendations

USDA and HHS should work with the Dietary Guidelines Advisory Committee to:

- Maintain the scientific integrity of the Dietary Guidelines.
- Extend the Dietary Guidelines (currently under revision) to children under age 2, taking into account the most recent science including: Feeding Guidelines for Infant and Young Toddlers: A Responsive Parenting Approach and Healthy Beverage Consumption in Early Childhood: Recommendations from Key National Health and Nutrition Organizations.

Federal nutrition programs that are required to meet the Dietary Guidelines—such as CACFP, the National School Lunch and School Breakfast Programs, and WIC—serve one in four Americans.
Preemption

Preemption happens when a higher level of government discourages, limits, or even eliminates the power of a lower level of government to take action on a specific issue. Federal preemption laws can restrict state and local governments. And state preemption laws—as long as they don’t conflict with federal laws—can restrict the power of city and county officials in that state.

According to leading legal scholars and experts at ChangeLab Solutions, there are two main types of preemption: floor preemption and ceiling preemption. Ceiling preemption happens when a higher level of government prohibits lower levels of government from requiring anything more than or different from what the higher-level law requires. For example, state governments have passed laws prohibiting local governments from passing higher minimum wage laws, sugary drink taxes, or food-based health disparities.

Floor preemption happens when a higher level of government passes a law that establishes a minimum set of requirements and allows lower levels of government to pass and enforce laws that impose more rigorous requirements. For example, preemption by the federal government can advance health goals by setting baseline standards on issues such as civil rights, clean air, or water quality.

Depending on how it is applied, preemption can either advance or undermine public health goals and either help or hurt efforts to improve health equity. This is because local and state governments are often at the forefront of passing innovative laws to improve the health of their residents. When they are stopped from passing laws to do so, the health of their residents suffers.

12 states have passed laws that limit food and beverage policies at the local level. 

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57 ceiling preemption
58 passed laws
59 floor preemption
60 baseline standards
61 public health goals
62 states have passed laws that limit food and beverage policies at the local level.
Recommendations

- State policymakers should oppose legislation limiting the ability of cities and counties to regulate, tax, or otherwise enact legislation stronger than state laws related to children’s health and healthy communities.

- State policymakers should support the repeal of existing state laws limiting the ability of cities and counties to regulate, tax, or otherwise enact legislation stronger than state law related to children’s health and healthy communities.

Mayors from more than 150 U.S. cities say they see state interference as a barrier to local lawmaking.63
The Centers for Disease Control and Prevention (CDC) administers the Prevention and Public Health Fund (Prevention Fund), the first mandatory funding stream dedicated to improving our nation’s public health. The Prevention Fund supports health initiatives run by states, counties, cities, nonprofit organizations, and tribal organizations. Congress appropriated more than $8.1 billion between FY2010 and FY2018 for the Prevention Fund. A variety of Prevention Fund grants have focused on healthy eating and active living—two core pillars of the National Prevention Strategy.

The Centers for Disease Control and Prevention's Division of Nutrition, Physical Activity, and Obesity (DNPAO) seeks to ensure that all Americans can maintain a healthy weight through healthy eating and regular physical activity. DNPAO, which was funded at $103.8 million in FY2019, focuses on improving nutrition, supporting breastfeeding, increasing physical activity, reducing obesity, and reducing health inequities among different geographic, racial, ethnic, and socioeconomic groups. For example, the Racial and Ethnic Approaches to Community Health (REACH) Program supports local community initiatives prioritizing good nutrition and physical activity in communities whose residents have higher-than-average rates of obesity and chronic disease.

CDC Healthy Schools, a branch of the Division of Population Health, works with states, school systems, communities and national partners to promote the health and well-being of children and teens in school. CDC Healthy Schools, which was funded at $15.4 million in FY2019, focuses on analyzing data and translating research, funding state education agencies and school health partners, training school staff and other priorities to help promote policies and practices that support healthy eating and physical activity in schools. For example, CDC Healthy Schools uses integrated research and best practices to provide school health guidelines and other resources for nutrition, physical education and physical activity, and the management of chronic health conditions.

In FY 2019, Congress appropriated $15.4 million for school health to CDC Healthy Schools.

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Recommendations

> CDC’s Division of Nutrition, Physical Activity and Obesity should have adequate resources to support grants to all 50 states to implement multi-sector campaigns to address obesity.

> The CDC’s REACH program should have adequate resources to support programs across the country working to address racial and ethnic health disparities.

$2M
DNPAO’s Farm to School Program received $2 million in funding in FY2019.71
Sources


12. Ibid.


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