Robert Wood Johnson Foundation

Declining Childhood Obesity Rates: Where Are We Seeing Signs of Progress?

Photo: Josh Kohanek

Top Takeaways

After increasing steadily for decades, the national childhood obesity rate has leveled off. This policy brief examines reports from across the country to learn more about where progress is being made to address childhood obesity.

Recent reports show declining rates of childhood obesity in some school districts, cities, counties, and states.

Many of these places have made comprehensive changes in schools and communities to help children grow up at a healthy weight.

Progress in reducing racial, ethnic, and socioeconomic disparities in obesity rates has been more limited.

Key Facts

Since 2003–2004, the obesity rate among U.S. youth ages 2 to 19 has held steady at

17%.

Among children ages 2 to 5, the obesity rate decreased from

13.9%

in 2003–2004 to

8.9%

in 2011–2014.

The national obesity rate was

14.7%
among white youth,

19.5%
among black youth, and

21.9%
among Hispanic youth in 2011–2014.

In 2011–2014, 20.2% of Asian American youth were overweight. Among Asian ethnic groups, Chinese youth (11.8%) had the lowest prevalence of overweight; Filipinos (29.5%) and Southeast Asians (27.3%) had the highest rates.

States and Communities Take Action

Places where childhood obesity rates have been reduced have implemented a wide range of strategies to make healthy foods and beverages available in schools and communities and have integrated physical activity into daily life. Each community has taken a unique approach and no single strategy is directly linked with declining rates, but the collective effect of their far-reaching changes may be helping to support healthier choices and behaviors among kids and families.

New York City requires childcare centers to offer healthier foods, improve nutrition education, increase physical activity, and limit screen time. A Mississippi law sets specific requirements for physical education, health education, and wellness policies in schools, as well as nutrition standards for school meals, snacks, and drinks. Lincoln, Nebraska, started a

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"Rethink Your Drink" public service campaign and encouraged employers to stock, promote, and competitively price healthy beverage options. Other communities have created incentives to bring supermarkets to underserved areas, expanded use of Supplemental Nutrition Assistance Program benefits at farmers' markets, highlighted healthier options on local restaurant menus, and developed walking and biking trails connecting homes to schools, parks, and businesses.

Collaboration among diverse partners is a common theme for many of the places reporting declining obesity rates. In Cherokee County, South Carolina, the school district, local government agencies, faith-based organizations, hospitals, and other health care providers are working together to host healthy field day events, build school gardens, and offer free courses that teach families how to shop for and prepare affordable, healthy meals. Kaiser Permanente has partnered with the city of Whittier, the Safe Routes to School National Partnership, the National Parent Teacher Association, and many local organizations to offer a variety of community programs that help children throughout Southern California eat healthier and be more active.


Photo: Josh Kohanek

Lincoln, Nebraska, started a "Rethink Your Drink" public service campaign and encouraged employers to stock, promote, and competitively price healthy beverage options.

Inequities Persist

Childhood obesity disproportionately affects communities of color, and in communities with high levels of poverty, families often lack access to healthy foods and beverages and safe places to be physically active. There has been limited progress to reduce childhood obesity rates among these populations, but some places have seen modest success.

Communities of color and low-income communities have been hit especially hard by the obesity epidemic.

For example, the widespread progress in reducing obesity among preschool children reported by the Centers for Disease Control and Prevention marks the first time in decades that rates have dropped among young children from low-income families. Between 2008 and 2011, 18 states and one U.S. territory measured declines in obesity rates among children ages 2 to 4 who were enrolled in federal health and nutrition programs, like the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Colorado recently reported a 7.4 percent relative decline in rates of overweight and obesity among preschoolers participating in the state's WIC program, from 22.9 percent in 2012 to 21.2 percent in 2015.


Photo: Josh Kohanek

In 2012, Philadelphia reported significant reductions in obesity rates among youth from low-income families and among African-American males and Hispanic females, making the city the only place to see such progress within ethnic/racial groups traditionally at greatest risk. However, data released in 2015 show the obesity rates among Hispanic females in Philadelphia may be going back up. Additionally, while obesity rates among youth overall in several locations have declined, those declines have been most pronounced among whites and higher-income students, an indicator that disparities are getting worse.

Building a Culture of Health

More efforts are needed to implement broad, far-reaching changes that support healthy eating and regular physical activity, especially among underserved communities and populations. The experiences and lessons learned from places reporting progress can help other communities identify and pursue a mix of policy and environmental approaches that may work best for them. Building an inclusive Culture of Health in this country, in which every person has the equal opportunity to live the healthiest life they can, will require: making health a shared value, fostering cross-sector collaboration, creating healthier communities, and integrating health services and systems.

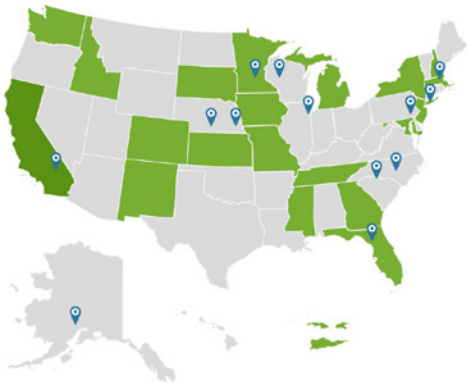
Building a Culture of Health means ensuring that every person has the equal opportunity to live the healthiest life they can.

The Agenda

In order to spread progress to every community, our nation must place a higher priority on increasing investments in policies and programs that give all children the opportunity to grow up at a healthy weight. Some recommendations include:

- The federal government, states, and localities should continue to prioritize and fund efforts to increase access to affordable healthy foods and beverages among low-income families.
- Every community should build and support sidewalks, bike lanes, parks, playgrounds, and safer road crossings to make it easier and safer for children and adults to be active.
- Child care and other early childhood education facilities should provide healthy food and beverages and ample physical activity opportunities for our youngest children.
- School districts, with support from local, state, and federal governments, should provide regular physical education and physical activity opportunities to help children and adolescents be active for at least 60 minutes each day.
- The U.S. Department of Agriculture (USDA) should continue to provide training and technical assistance to help school administrators and staff achieve and continue to meet the healthier school meals and snacks standards.
- As the USDA updates its guidelines for local school wellness policies, it should use the Smart Snack standards—at a minimum—for school marketing to maintain consistency with the school food sales environment, facilitate implementation, and help reduce confusion.
- Schools and communities should sign shared-use agreements to provide access to school recreational facilities outside of school hours.

Photo: Josh Kohanek



Interactive map shows progress in childhood obesity rates throughout the United States.

Table 1. National and Statewide Declines in Childhood Obesity Rates

Place	Ages	Time 1	Obesity or Obesity and Overweight Rate at Time 1	Time 2	Rate at Time 2	Relative Percent Decline	Absolute Percent Decline
National							
National	Ages 2–5	2003–04	13.9%	2011–14	8.9%	-35.9%	-5.0%
State or Territory							
California	Grades 5, 7, 9	2005	38.4%†	2010	38%†	-1.1%	-0.4%
California	Ages 2–4, from low-income families	2008	17.3%	2011	16.8%	-2.9%	-0.5%
Colorado	Ages 2–4, enrolled in Colorado WIC*	2012	22.9%†	2015	21.2%†	-7.4%	-1.7%
Florida	Ages 2–4, from low-income families	2008	14.1%	2011	13.1%	-7.1%	-1.0%
Georgia	Ages 2–4, from low-income families	2008	14.8%	2011	13.2%	-10.8%	-1.6%
Idaho	Ages 2–4, from low-income families	2008	12.3%	2011	11.5%	-6.5%	-0.8%
Iowa	Ages 2–4, from low-income families	2008	15.1%	2011	14.4%	-4.6%	-0.7%
Kansas	Ages 2–4, from low-income families	2008	13.3%	2011	12.7%	-4.5%	-0.6%
Maryland	Ages 2–4, from low-income families	2008	15.7%	2011	15.3%	-2.5%	-0.4%
Massachusetts	Ages 2–4, from low-income families	2008	16.7%	2011	16.4%	-1.8%	-0.3%
Michigan	Ages 2–4, from low-income families	2008	13.9%	2011	13.2%	-5.0%	-0.7%
Minnesota	Ages 2–4, from low-income families	2008	13.4%	2011	12.6%	-6.0%	-0.8%
Mississippi	Grades K–5	2005	43.0%†	2013	38.0%†	-11.6%	-5.0%
Mississippi	Ages 2–4, from low-income families	2008	14.6%	2011	13.9%	-4.8%	-0.7%
Missouri	Ages 2–4, from low-income families	2008	13.9%	2011	12.9%	-7.2%	-1.0%
New Hampshire	Ages 2–4, from low-income families	2008	15.5%	2011	14.6%	-5.8%	-0.9%
New Jersey	Ages 2–4, from low-income families	2008	17.9%	2011	16.6%	-7.3%	-1.3%
New Mexico	Grade 3	2010	38.7%†	2015	34.4%†	-11.1%	-4.3%
New Mexico	Kindergarten	2010	30.3%†	2015	25.6%†	-15.5%	-4.7%
New Mexico	Ages 2–4, from low-income families	2008	12.0%	2011	11.3%	-5.8%	-0.7%
New York	Ages 2–4, from low-income families	2008	14.6%	2011	14.3%	-2.1%	-0.6%
South Dakota	Ages 2–4, from low-income families	2008	16.2%	2011	15.2%	-6.2%	-1.0%
Tennessee	Grades K, 2, 4, 6, 8, High School	2007–08 school year	41.1%†	2012–13 school year	38.5%†	-6.3%	-2.6%
U.S. Virgin Islands	Ages 2–4, from low-income families	2008	13.6%	2011	11.0%	-19.1%	-2.6%
Washington	Ages 2–4, from low-income families	2008	14.4%	2011	14.0%	-2.8%	-0.4%

Table 2. Local Declines in Childhood Obesity Rates

Place	Ages	Time 1	Obesity or Obesity and Overweight Rate at Time 1	Time 2	Rate at Time 2	Relative Percent Decline	Absolute Percent Decline
School District, City, County, or Region							
Anchorage, AK	Grades K, 1, 3, 5, 7	2003–04 school year	35.4%†	2013–14 school year	33.5%†	-5.4%	-2.9%
Cherokee County, SC[1]	Grade 1	2012	43.0%†	2015	34.3%†	-20.2%	-8.7%
Cherokee County, SC[1]	Grade 3	2012	51.5%†	2015	40.7%†	-21.0%	-10.8%
Chetek-Weyerhaeuser School District, WI[2]	Grades K–12	2009	43.0%†	2013	30%†	-30.2%	-13%
Eastern MA	Under age 6	2004	9.8%	2008	7.7%	-21.4%	-2.1%
DuPage Co., IL	Grades K, 6, 9	2011	31.1%†	2014	29.7%†	-4.5%	-1.4%
Granville, NC	Ages 2–18	2005	40.1%†	2009	38.7%†	-3.5%	-2.4%
Greater St. Cloud Region, MN[3]	Age 12	2008	17.0%	2015	13.0%	-24.0%	-4.0%
Kearney, NE[4]	Grades K–5	2006	16.4%	2011	14.2%	-13.4%	-2.2%
Lincoln, NE	Grades K–8	2010	17.2%	2013	15.8%	-8.2%	-1.4%
New York City	Grades K–8	2006–07 school year	21.9%	2010–11 school year	20.7%	-5.5%	-1.2%
Philadelphia, PA	Grades K–12	2006–07 school year	21.7%	2012–13 school year	20.3%	-6.5%	-1.2%
Seminole Co., FL	Grades 1, 3, 6	2006–07 school year	34.3%†	2013–14 school year	29.6%†	-13.7%	-4.7%
Southern Calif. (Kaiser Permanente members)	Ages 2–19	2008	19.1%	2013	17.5%	-8.4%	-1.6%
Vance, NC	Ages 2–18	2005	31.9%†	2009	26.5%†	-16.9%	-5.4%

Notes: Declines reported in this table are based on objective height and weight measures. Data obtained by other means, such as parent- or youth self-reports, have been excluded. The absolute percent decline is the difference between the rate at time one and the rate at time two. The relative percent decline is this difference as a percentage of the rate at time one.

†Indicates combined rates of overweight and obesity.

*Colorado's Special Supplemental Nutrition Program for Women, Infants and Children.

Sources not posted online were received via direct communication, and are available upon request from *media@rwjf.org*.

[1]"Cherokee County School District 2015 Body Mass Index Report"
[2]"Chetek-Weyerhauser Roselawn Elementary 2013–14 BMI Analysis";
"Chetek-Weyerhauser School District Cumulative BMI Comparison"
[3]"Child Obesity Rate Changes in Areas Served by CentraCare Health and BLEND Initiative 2015"
[4]"Kearney Public Schools: BMI Report Card Summary Report 2006–2011"

Background

After increasing steadily for decades, the national childhood obesity rate has leveled off, but it is still alarmingly high compared to a generation ago. The obesity rate among children ages 6 to 11 has more than quadrupled in the last 40 years; for adolescents 12 to 19, it has more than tripled. Among young children 2 to 5, rates more than doubled between the mid–1970s and 2000s before beginning a decline.

Children who are overweight or obese are at greater risk for high blood pressure, type 2 diabetes, and heart disease. The longer children are overweight or obese, the more likely they are to remain so into adulthood. Obesity also carries a hefty price tag: childhood obesity is estimated to cost $14 billion every year, and adult obesity could cost between $147 billion and $210 billion annually. Helping children maintain a healthy weight from an early age is essential to preventing a wide range of health problems and avoiding billions in health care costs.

Want to Know More?

Signs of Progress

Childhood Obesity

State of Obesity