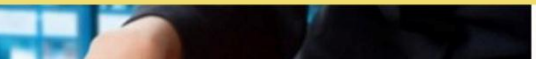
Section VI: Advocacy Toolbox



Section I: The Community Advocacy Call to Action

Appendix A: Glossary of Obesity Advocacy Terms

DISCLAIMER – These terms are provided as a resource to assist you in your advocacy efforts and do not necessarily reflect policy or endorsement of National Initiative for Child Healthcare Quality, American Academy of Pediatrics, or California Medical Association Foundation.

As Of Right: Zoning standards that are determined in advance of development and are self-enforcing. These types of development do not require special approval from a government agency. [1]

Baby Friendly Hospital: A maternity facility can be designated 'baby-friendly' when it does not accept free or low-cost breast milk substitutes, feeding bottles or teats, and has implemented 10 specific steps to support successful breastfeeding. A baby- friendly hospital:

- Maintains a written breastfeeding policy
- Trains all staff in skills needed to implement this policy
- Informs all pregnant women about the benefits and management of breastfeeding
- Helps mothers initiate breastfeeding within one hour of birth
- Shows mothers how to breastfeed even if they are separated from their infants
- Gives infants no food or drink other than breast milk unless medically indicated
- Allows mothers and infants to remain together 24 hours a day
- Encourages unrestricted breastfeeding
- Gives no pacifiers or artificial nipples to breastfeeding infants
- Refers mothers to breastfeeding support groups[2]

Beverage Contracts: Standard contracts, the most common type for schools, are signed between a school or school district and a bottler/distributor for a period of years. A standard contract facilitates the sale and marketing of beverages in schools and lays out the terms for compensation for the school/school district. These contracts are legal arrangements that integrate a school or school district into a beverage company's marketing strategy and, simultaneously, integrate a beverage company into a school/district's fundraising plan. Other contracts include: Request for Responses Contracts and Purchase Order Contracts.[3]

Bike Lanes: As defined by the American Association of State Highway and Transportation Officials, portions of a roadway that have been designated by striping, signing, and pavement markings for the preferential or exclusive use of bicyclists.[4]

Bike Routes: Cycling routes on roads shared with motorized vehicles or on specially marked sidewalks.[4]

Body Mass Index (BMI): One of the most commonly used measures for defining overweight and obesity, calculated as weight in kilograms divided by height in meters squared.[5]

Built Environment: Encompasses all of the man-made elements of the physical environment, including buildings, infrastructure, and other physical elements created or modified by people and the functional use, arrangement in space, and aesthetic qualities of these elements.[6]

Calorie-Dense, Nutrient-Poor Foods: Foods and beverages that contribute few vitamins and minerals to the diet, but contain substantial amounts of fat and/ or sugar and are high in calories. Consumption of these foods, such as sugar-sweetened beverages, candy, and chips, may contribute to excess calorie intake and unwanted weight gain in children.[7]

Child Nutrition Program: The National School Lunch Program (NSLP) is a federally assisted meal program operating in public and nonprofit private schools and residential child care institutions. It provides nutritionally balanced, low-cost or free lunches to children each school day. The program was established under the National School Lunch Act, signed by President Harry Truman in 1946.[8]

Coalition: A group of persons representing diverse public-or private-sector organizations or constituencies working together to achieve a shared goal through coordinated use of resources, leadership, and action.[9]

Community Gardens: Any piece of land gardened by a group of people. It can be urban, suburban, or rural. It can be one community plot, or can be many individual plots. It can be at a school, hospital, or in a neighborhood. It can also be a series of plots dedicated to "urban agriculture" where the produce is grown for a market.[10]

Competitive Foods and Beverages: All foods and beverages served or sold in schools that are not part of Federal school meal programs, including “à la carte” items sold in cafeterias and items sold in vending machines. As defined by the Institute of Medicine (2005), competitive foods and beverages typically are lower in nutritional quality than those offered by school meal programs.[11]

Competitive Pricing: The principal vendor selection criterion used for cost containment is a competitive pricing standard to exclude high-priced vendors. States with this criterion require that vendors charge a “fair and competitive price.” States differ in defining this price and in whether they use a competitive pricing criterion at application or in evaluating redemptions.[12]

Complete Streets: Streets that support all users—motorists, bicyclists, pedestrians, transit users, young, old, and disabled—by featuring safe access along and across the street via sidewalks, bicycle lanes, wide shoulders, crosswalks, and other features. Complete streets enable safe, attractive, and comfortable access and travel.[13]

Conditional Use Permit: A variance granted to a property owner that allows a use otherwise prevented by zoning, through a public hearing process. These permits allow a city or county to consider special uses of land that may be essential or desirable to a particular community but are not allowed as a matter of right within a zoning district. These permits can also control certain uses that could have detrimental effects on a community or neighboring properties. They provide flexibility within a zoning ordinance.[14]

Connectivity: The directness of travel to destinations. Sidewalks and paths that are in good condition and without gaps can promote connectivity. [15]

Counter-Advertising Media: The Recovery Act Communities Putting Prevention to Work- Community Initiative suggests using media as a key strategy to:

- Promote healthy foods/drinks and increase activity
- Restrict advertising and employ counter-advertising for unhealthy foods/drinks[16]

Media can be a key element to increase awareness and motivation and can be used to promote healthy eating, portion size awareness, eating fewer calorie-dense, nutrient-poor foods and to raise awareness of weight as a health issue. High-frequency television and radio advertising, as well as signage, may stimulate improvements in attitudes toward a healthy diet Counter-advertising media promote healthy foods/drinks/lifestyle in an attempt to counteract the barrage of marketing and media messaging for unhealthy products. This technique was used successfully to reach youth in the tobacco and alcohol prevention fields.

Density: Population per unit of area measure.[17]

Dietary Guidelines For Americans: The Dietary Guidelines for Americans have been published jointly every 5 years since 1980 by the Department of Health and Human Services (HHS) and the Department of Agriculture (USDA). The Guidelines provide authoritative advice for people 2 years and older on how good dietary habits can promote health and reduce risk for major chronic diseases. They serve as the basis for federal nutrition assistance and nutrition education programs.[18]

Discretionary Calories: The number of calories in one's "energy allowance" after one consumes sufficient amounts of foods and beverages to meet one's daily calorie and nutrient needs while promoting weight maintenance.[19]

Eating Occasion: A single meal or snack.[20]

Energy-Dense Foods: Foods that are high in calories.[21]

Energy Density: The number of calories per gram in weight.[22]

Environmental Change: An alteration or change to physical, social, or economic environments designed to influence people's practices and behaviors.[23]

Exactions: Requirements placed on developers as a condition of development approval, generally falling into two categories: impact fees (see below) or physical exactions such as dedication of land or provision of infrastructure. Exactions must be related to the expected impacts of a project. For example, new homes create the need for more parks and schools, and an exaction might dedicate land in the developer's plans for more parks and schools.[24]

Family Friendly Store Displays: When we shop, our purchases are influenced not only by what's available and affordable, but also by how products are organized and advertised inside the store. The overall layout of the store affects what we buy. When high-sugar cereals are shelved at children's eye level, parents are more likely to be pestered into choosing them over healthier breakfast options. When fruit and granola bars, rather than candy and chips, are stocked in the check-out lanes, people are much less likely to make an unhealthy, last-minute impulse buy.[25]

Farm Bill: The Farm Bill sets overall U.S. agricultural policy and is usually renewed at 5-year intervals. It encompasses all federal policy related to commodities, price supports for certain crops, conservation, food safety, agricultural disaster assistance and much more.[26]

Farm Stand: Multiple and single vendors that are not part of a licensed farmers market.[27]

Farmer-Day: Any part of a calendar day spent by a farmer (vendor) at a farmers market (excluding craft vendors and prepared food vendors). The total number of annual farmer-days for a given farmers market is based on the number of days that the farmers market is open in a year multiplied by the number of farm vendors at the market on a given day.[28]

Farm To School: Farm to School brings healthy food from local farms to school children nationwide. The program teaches students about the path from farm to fork, and instills healthy eating habits that can last a lifetime. At the same time, use of local produce in school meals and educational activities provides a new direct market for farmers in the area and mitigates environmental impacts of transporting food long distances.[29]

Farm To Hospital: The farm to hospital approach extends beyond local fruits and vegetables to include other sustainable and health-promoting food purchasing options such a focus on organic food, sustainably raised produce and meats, antibiotic free meat, and rBGH-free (recumbent Bovine Growth Hormone) dairy products. Farmers' markets on hospital grounds and community health promotion activities are also integral components of the farm to hospital model.[30]

Food Access: The extent to which a community can supply people with the food needed for health. Communities with poor food access lack the resources necessary to supply people with the food needed for a healthy lifestyle. Availability of high quality, affordable food and close proximity to food stores increase food access.[31]

Food Desert: ''Food desert'' means an area in the United

States with limited access to affordable and nutritious food. Food desserts often exist in areas composed of predominantly lower-income neighborhoods and communities.[32]

Form-Based Code: A method of regulating development to achieve a specific urban form. Form-based codes create a predictable public realm primarily by controlling physical form, with a lesser focus on land use, through city or county regulations.[33]

Health Disparities: Differences in the incidence and prevalence of health conditions and health status between groups. Most health disparities affect groups marginalized because of socioeconomic status, race/ethnicity, sexual orientation, gender, disability status, geographic location, or some combination of these. People in such groups not only experience worse health but also tend to have less access to the social determinants

or conditions (e.g., healthy food, good housing, good education, safe neighborhoods, freedom from racism and other forms of discrimination) that support health.[34]

Health Equity: When everyone has the opportunity to "attain their full health potential" and no one is "disadvantaged from achieving this potential because of their social position or other socially determined circumstance."[35]

Health Inequities: When health disparities are the result of the systematic and unjust distribution of certain critical conditions (eg, healthy food, good housing, good education, safe neighborhoods, freedom from racism and other forms of discrimination).[36]

Health Impact Assessment: Health impact assessment (HIA) is commonly defined as "a combination of procedures, methods, and tools by which a policy, program, or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population"[37] HIA is used to evaluate objectively the potential health effects of a project or policy before it is built or implemented.[38]

Healthy Eating Environment: An environment that provides access to and encourages the consumption of healthy foods, as described by the Dietary Guidelines for

Americans.[39]

Healthier Foods And Beverages: As defined by Institute of Medicine (2005), foods and beverages with low energy density and low content of calories, sugar, fat, and sodium.[40]

Home Zone: A residential street or group of streets that is designed to operate primarily as a space for social use. The needs of residents take priority over the needs of car drivers. Home zones are designed to be shared by pedestrians, playing children, bicyclists, and low-speed motor vehicles. Traffic-calming methods such as speed humps are avoided in favor of methods that make slower speeds more natural to drivers, rather than an imposition. Home zones encourage children's play and neighborhood interaction and also increase road safety. [41]

Impact Fee: A monetary exaction placed on developers related to the expected impacts of a project. For example, to lessen the effect of increased traffic at a new shopping center, a developer might be required to pay an impact fee that would be used for construction of a left-turn lane and traffic lights.[42]

Joint Use Agreement: A joint use agreement (JUA) is a formal agreement between two separate government entities—often a school and a city or county—setting forth the terms and conditions for shared use of public property or facilities. JUAs can range in scope from relatively simple (e.g., opening school playgrounds to the public outside of school hours) to complex (allowing community individuals and groups to access all school recreation facilities, and allowing schools to access all city or county recreation facilities).[43]

Largest School District Within a Local Jurisdiction: The school district that serves the largest number of students within a local jurisdiction.[44]

Less Healthy Foods And Beverages: As defined by Institute of Medicine (2005), foods and beverages with a high content of calories, sugar, fat, and sodium, and low content of nutrients, including protein, vitamins A and C, niacin, riboflavin, thiamin, calcium, and iron.[45]

Local Food: Practically speaking, local food production can be thought of in concentric circles that start with growing food at home. The next ring out might be food grown in our immediate community - then state, region, and country. For some parts of the year or for some products that thrive in the local climate, it may be possible to buy closer to home. At other times, or for less common products, an expanded reach may be required.[46]

Local Government Facilities: Facilities owned, leased, or operated by a local government (including facilities that might be owned or leased by a local government but operated by contracted employees). For the purposes of this project, and according to the definition established by ICMA, local government facilities might include facilities in the following categories:

- 24-hour "dormitory-type" facilities: facilities that generally are in operation 24 hours per day, 7 days per week, such as firehouses (and their equipment bays), women's shelters, men's shelters, and group housing facilities for children, seniors, and physically or mentally challenged persons, not including regular public housing;
- administrative/office facilities: general office buildings, court buildings, data processing facilities, sheriff's offices (including detention facilities), 911 centers, social service intake centers, day care/preschool facilities, historical buildings, and other related facilities;
- detention facilities: jails, adult detention centers, juvenile detention centers, and related facilities;
- health care facilities: hospitals, clinics, morgues, and related facilities;
- recreation/community center facilities: senior centers, community centers, gymnasiums, public parks and fields, and other similar recreation centers, including concession stands located at these facilities; and
- other facilities: water treatment plants, airports, schools, and all other facilities that do not explicitly fall into the categories listed above.[47]

Low Energy Dense Foods And Beverages: Foods and beverages with a low calorie-per-gram ratio. Foods with a high water and fiber content are low in energy density, such as fruits, vegetables, and broth-based soups and stews.[48]

Macronutrients: Nutrients needed in relatively large quantities, such as protein, carbohydrates, and fat.[49]

Measure: For the purpose of this project, a measure is defined as a single data element that can be collected through an objective assessment of the physical or policy environment and used to quantify without bias an obesity prevention strategy.[50]

Micronutrients: Nutrients needed in relatively small quantities, such as vitamins and minerals.[51]

Mixed Land Use: A mixed land use development incorporates many sectors of a community, including retail, office, and residential. Communities with a balanced mix of land use give residents the option to walk, bike, or take transit to nearby attractions.[52]

Mixed-Use Development: Zoning that combines residential land use with one or more of the following types of land use: commercial, industrial, or other public use.[53]

Motivational Interviewing: Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence. Compared with nondirective counseling, it is more focused and goal-directed. The examination and resolution of ambivalence is its central purpose, and the counselor is intentionally directive in pursuing this goal.[54]

National School Lunch Program: The National School Lunch Program (NSLP) is a federally assisted meal program operating in public and nonprofit private schools and residential child care institutions. It provides nutritionally balanced, low-cost or free lunches to children each school day. The program was established under the National School Lunch Act, signed by President Harry Truman in 1946.[55]

Network Distance: Shortest distance between two locations by way of the public street network.[56]

No Child Left Behind: The No Child Left Behind Act of 2001 (No Child Left Behind) is a landmark in education reform designed to improve student achievement and change the culture of America's schools. Enacted under President George W. Bush.

With passage of No Child Left Behind, Congress reauthorized the Elementary and Secondary Education Act (ESEA)--the principal federal law affecting education from kindergarten through high school. In amending *ESEA*, the new law represents a sweeping overhaul of federal efforts to support elementary and secondary education in the United States. It is built on four common-sense pillars: accountability for results; an emphasis on doing what works based on scientific research; expanded parental options; and expanded local control and flexibility.[57]

No Child Left Inside: A movement thought to help address the childhood obesity problem by increasing the time students spend learning about nature, both in and outside the classroom. [58]

Nonmotorized Transportation: Any form of transportation that does not involve the use of a motorized vehicle, such as walking and biking.[59]

Nutrient-Dense Foods: Foods that provide substantial amounts of vitamins, minerals, and other health-promoting components such as fiber and relatively few calories. Foods that are low in nutrient density supply calories but no or small amounts of vitamins, minerals, and health-promoting components.[60]

Nutrition Standards: Criteria that determine which foods and beverages may be offered in a particular setting (e.g., schools or local government facilities). Nutrition standards may be defined locally or adopted from national standards.[61]

Obesity And Overweight: Children and adolescents are defined as obese if they have a body mass index (BMI) equal to or greater than the 95th percentile for their age and sex, and overweight if they have a BMI at the 85th percentile to less than the 95th percentile for their age and sex, according to growth charts (http://www.cdc.gov/growthcharts).[62]

Partnership: A business-like arrangement that might involve two or more partner organizations.[63]

Physical Activity: Body movement produced by the contraction of muscle that increases energy expenditure above the resting level.[64]

Pocket Park: A small park frequently created on a vacant building lot or on a small, irregular piece of land, sometimes created as a component of the public space requirement of large building projects. Pocket parks provide greenery, a place to sit outdoors, and sometimes playground equipment. They may be created around a monument, historic marker, or art project.[65]

Point Of Purchase Decision Making: Refers to labeling /signage/placement to increase consumption of healthy foods/drinks, and prompt physical activity. Example: Require menu labeling to assist families and individuals in making healthy choices when eating away from home. Another example is replacing unhealthy foods with healthy foods in prominent display areas such as check out lines.[66]

Policy: Laws, regulations, rules, protocols, and procedures designed to guide or influence behavior. Policies can be either legislative or organizational in nature.[67]

Portion Size: The amount of a single food item served in a single eating occasion (e.g., a meal or a snack). Portion size is the amount (e.g., weight, caloric content, or volume) of food offered to a person in a restaurant, the amount in the packaging of prepared foods, or the amount a person chooses to put on his or her plate. One portion of food might contain several USDA food servings.[68]

Pricing Strategies: Intentional adjustment to the unit cost of an item (e.g., offering a discount on a food item, selling a food item at a lower profit margin, or banning a surcharge on a food item).[69]

Public Recreation Facility: Facility listed in the local jurisdiction's facility inventory that has at least one amenity that promotes physical activity (e.g., walking/hiking trail, bicycle trail, or open play field/play area).[70]
Public Recreation Facility Entrance: The point of entry to a facility that permits recreation. For the purposes of this project, geographic information system (GIS) coordinates of the entrance to a recreational facility or the street address of the facility.[71]

Public Service Venue: Facilities and settings open to the public that are managed under the authority of government entities (e.g., schools, child care centers, community recreational facilities, city and county buildings, prisons, and juvenile detention centers).[72]

Public Transit Stop: Point of entrance to a local jurisdiction's transportation and public street network, such as bus stops, light rail stops, and subway stations.[73]

Quality Physical Education: Appropriate actions must be taken in four main areas to ensure a high quality physical education program: (1) curriculum, (2) policies and environment, (3) instruction, and (4) student assessment (5) healthy school environment; (6) counseling, psychological, and social services; (7) health promotion for staff; and (8) family and community involvement.

Policy and environmental actions that support high quality physical education require the following:

- Adequate instructional time (at least 150 minutes per week for elementary school students and 225 minutes per week for middle and high school students),
- All classes be taught by qualified physical education specialists,
- Reasonable class sizes, and
- Proper equipment and facilities.
- Instructional strategies that support high-quality physical education emphasize the following:
- The need for inclusion of all students,
- Adaptations for students with disabilities,
- Opportunities to be physically active most of the class time,
- Well-designed lessons,
- Out-of-school assignments to support learning, and
- Not using physical activity as punishment.
- Regular student assessment within a high-quality physical education program features the following:
- The appropriate use of physical activity and fitness assessment tools,
- Ongoing opportunities for students to conduct self-assessments and practice self-monitoring of physical activity,
- Communication with students and parents about assessment results, and
- Clarity concerning the elements used for determining a grading or student proficiency system.[74]

Retrofit: Modification of infrastructure and facilities in existing areas of the community rather than the provision of infrastructure and facilities in new areas of development.[75]

Road Diet: Involves reducing the amount of lanes in a road to include a bike lane and/or sidewalks. Road diets are intended to slow traffic and make the road safer for pedestrians and cyclists.[76]

Safe Communities: According to the Leadership for Healthy Communities: Action Strategies Toolkit, keeping communities safe and free from crime encourage outdoor activity. Parents' perceptions of safety in their neighborhoods, from concerns about traffic to strangers, can determine the level of activity in which their children engage. Strategies identified to combat these issues include: street patrols, neighborhood watch groups, and community design and aesthetics.[77]

Safe Routes to Schools: Communities use many different approaches to make it safer for children to walk and bicycle to school and to increase the number of children doing so. Programs use a combination of education, encouragement, enforcement and engineering activities to help achieve their goals.[78]

School Siting: The process of locating schools and school facilities.[79]

School Wellness Council: Many states require local School Wellness Councils or Health Advisory councils that are usually made up school staff, students, parents and community members and which implement the School Wellness Policy.

School Wellness Councils:

- Advise the school board/district on school/community health issues.
- Identify student/staff health needs.
- Monitor and evaluate implementation of school wellness policies.
- Support the school in developing a healthier school environment.
- Assist with policy development to support a healthy school environment.
- Plan and implement programs for students and staff.
- Tap into funding and resources for student and staff wellness.[80]

School Wellness Policy: Section 204 of Public Law 108 – 265, the Child Nutrition and WIC Reauthorization Act of 2004, requires that every school district receiving funding through the National School Lunch and/or Breakfast Program develop a local wellness policy that promotes the health of students with a particular emphasis on addressing the growing problem of childhood obesity.[81]

Screen (Viewing) Time: Time spent watching television, playing video games, and engaging in non-educational computer activities.[82]

Shared-Use Paths: As defined by the American Association of State Highway and Transportation Officials, bikeways used by cyclists, pedestrians, skaters, wheelchair users, joggers, and other nonmotorized users that are physically separated from motorized vehicular traffic by an open space or barrier and within either the highway right-of-way or an independent right-of-way.[83]

Sidewalk Network: An interconnected system of paved walkways designated for pedestrian use, usually located beside a street or roadway.[84]
Street Network: A system of interconnecting streets and intersections for a given area.[85]

Smart Growth: An approach to urban planning that is more town centered and transit and pedestrian oriented, and has a greater mix of housing, commercial, and retail uses. It also preserves open space and many other environmental amenities.[86]

Social Environment: Includes interactions with family, friends, coworkers, and others in the community. It also encompasses social institutions, such as the workplace, places of worship, and schools. Housing, public transportation, law enforcement, and the presence or absence of violence in the community are among other components of the social environment. The social environment has a profound effect on individual health, as well as on the health of the larger community, and is unique because of cultural customs; language; and personal, religious, or spiritual beliefs. At the same time, individuals and their behaviors contribute to the quality of the social environment (definition from *Healthy People 2010*).[87]

Social Marketing: Using the same marketing principles that are used to sell Products to consumers to "sell" ideas, attitudes, and behaviors. Social marketing is often used to change health behaviors.[88]
Stranger Danger: The perceived danger to children presented by strangers. The phrase is intended to sum up the various concerns associated with the threat presented by unknown adults.[89]

Sugar-Sweetened Beverages: Beverages that contain added caloric sweeteners, primarily sucrose derived from cane, beets, and corn (high-fructose corn syrup), including non-diet carbonated soft drinks, flavored milks, fruit drinks, teas, and sports drinks.[90]
Supermarket: A large, corporate-owned food store with annual sales of at least $2 million.[91]

Supplemental Nutrition Assistance Program (SNAP): SNAP helps low-income people and families buy the food they need for good health. You apply for benefits by completing a State application form. Benefits are provided on an electronic card that is used like an ATM card and accepted at most grocery stores. Through nutrition education partners, SNAP helps clients learn to make healthy eating and active lifestyle choices.[92]

Traffic Calming: Measures that attempt to slow traffic speeds and increase pedestrian and bicycle traffic through physical devices designed to be self-enforcing. These include speed humps and bumps, raised intersections, road narrowing, bends and deviations in a road, medians, central islands, and traffic circles.[93]

Transportation Equity Act: Every five to seven years, Congress updates and renews federal transportation policies. This legislation encompasses road-building and related improvements; airline, ship, and rail transportation issues; safety measures; transit and community design; and a range of other aspects of transportation policy.[94]

Underserved Census Tract: Within metropolitan areas, a census tract that is characterized by one of the following criteria: (i) a median income at or below 120% of the median income of the metropolitan area and a minority population of 30% or greater; or (ii) a median income at or below 90% of median income of the metropolitan area. In rural, nonmetropolitan areas, the following criteria should be used instead: (i) a median income at or below 120% of the greater of the State nonmetropolitan median income or the nationwide non-metropolitan median

income and a minority population of 30% or greater; or (ii) a median income at or below 95% of the greater of the State nonmetropolitan median income or nationwide nonmetropolitan median income (Department of Housing and Urban Development, 1995).[95]

United States Federal Communications Commission (FCC): The FCC is charged with the regulation of broadcast television and has the authority to make rules "to assure that broadcasters operate in the public interest." Special FCC rules designed to protect children require that broadcasters limit the amount of advertising shown during children's programming (to no more than 10.5 minutes/hour on weekends and no more than 12 minutes/hour on weekdays); clearly separate program content from commercial messages; and distinguish when a program will transition to a commercial**.**[96]

VERB Campaign: A national, multicultural, social marketing campaign to increase and maintain physical activity among tweens. It was coordinated by the U.S. Department of Health and Human Services and the Centers for Disease Control and Prevention and ran from 2002 to 2006.[97]

Violent Crime: A legal offense that involves force or threat of force. According to the Federal Bureau of Investigation's Uniform Crime Reporting (UCR) Program, violent crime includes murder, forcible rape, robbery, and aggravated assault http://www.fbi.gov/ucr/cius2007/offenses/violent_crime/index.html.[98]

Walking School Bus: A walking school bus is a group of children walking to school with one or more adults.[99]

Women Infants Children Program (WIC): WIC provides Federal grants to States for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk.[100]

Section II: Obesity Epidemic

Appendix B: State Fact Sheets[101]

child policy RESEARCH CENTER
www.cincinnatichildrens.org/cprc

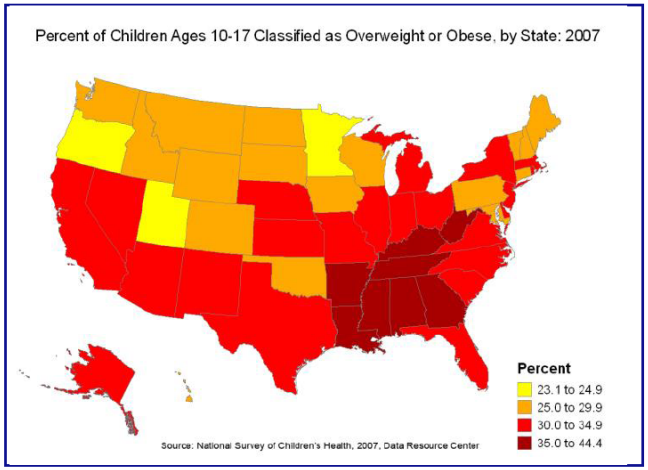
NICHQ
National Initiative for Children's Healthcare Quality
www.nichq.org

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

ALABAMA STATE FACT SHEET

KEY POINTS

- Alabama ranks 46th in overall prevalence with 36.1% of children considered either overweight or obese.
- The Alabama prevalence of overweight and obese children has risen since 2003.
- According to the 2008 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 28.9% of low-income children age 2-5 are overweight or obese in Alabama.



OVERALL PREVALENCE AND RANK[1]:	AL	National	Change in Alabama since 2003[2]
Percentage of children ages 10- 17 years who are overweight or obese	36.1%	31.6%	↑
State Rank for overweight or obese children (1 is best)	46		Rank in2003: 43
RISK FACTORS			
Percentage of children ages 6-17 years who participate in 4 or more days of vigorous physical activity per week	72.2%	64.3%	↑
Percentage of children ages 1-5 who engage in 4 or more hours of screen time per weekday (includes TV, videos, etc.)	14.2%	12.8%	
Percentage of children ages 6-17 who engage in 4 or more hours of screen time per weekday (includes TV, videos, video games, etc.)	16.8%	10.8%	↑
DISPARITIES—ACROSS AND WITHIN STATES			
% Overweight or Obese by Family Income			
<100% Federal Poverty Level[3]	36.8%	44.8%	↓
>400% FPL	28.5%	22.2%	↑
State Rank on Income Disparity Ratio (This figure represents calculated disparity ratios and ranks these ratios – A rank of 1 is best, 35 is worst)[4]	3		
% Overweight or Obese by Type of Insurance			
Public Insurance	37.02%	43.2%	↓
Private Insurance	34%	27.3%	↑
State Rank on Insurance Disparity Ratio (This figure represents calculated disparity ratios and ranks these ratios – A rank of 1 is best, 50 is worst)	2		
% Overweight or Obese by Race			
Black, non-Hispanic	39.0%	41.1%	↓
White, non-Hispanic	33.5%	26.8%	↑
State rank on Race Disparity Ratio (This figure represents calculated disparity ratios and ranks these ratios – A rank of 1 is best, 22 is worst)	3		
% Overweight or Obese by Hispanic Origin			

What is ALABAMA doing about obesity?

KEY POLICY and GRANT INITIATIVES available in ALABAMA:

- Alabama is one of only 4 states to have a state policy on vending machines in child care centers.
- Birmingham, Alabama currently receives a *Pioneering Healthier Communities 2008* grant through the YMCA Activate America Initiative.

The table below is derived from the 2009 edition of *F as in Fat*, published by Trust for America's Health. The summary below is intended for comparing a state's activities as of 2008 with others and provides information on state-specific policies as well as the number of states implementing a particular policy. For more information on recommended policy strategies, go to: www.reversechildhoodobesity.org.

ECONOMIC INDICATORS	AL	National
Estimated adult obesity-attributable medical expenditures, 1998-2000 (in 2003 dollars)	$1,320 M	$75 Billion
OBESITY-RELATED STATE INITIATIVES		
Snack and/or soda tax	NO	29 states + DC
Menu labeling law	NO	2 states
Complete the Streets policy	NO	9 states
OBESITY-RELATED SCHOOL STANDARDS		
Nutritional standards for school meals and snacks that go beyond existing USDA requirements.	YES	19 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	YES	27 states
Limited access to competitive food	YES	28 states
BMI or health information collected	NO	21 states
CHILD CARE CENTER LICENSING REGULATIONS		
Meals and snacks should follow meal requirements	YES	29 states
Meals and snacks should be consistent with Dietary Guidelines for Americans	NO	2 states
Have policy prohibiting or limiting foods of low nutritional value	NO	12 states
Have policy on vending machines	YES	4 states
Require vigorous or moderate physical activity	NO	8 states

TECHNICAL NOTES

The 2007 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Overweight and obesity are calculated from the child's height and weight as reported by the parent or guardian. 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. For more information on survey methods and analysis, visit: ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/slaits/nsch07/2_Methodology_Report/NSCH_Design_and_Operations_052109.pdf

1. Data Source: 2007 National Survey of Children's Health. Data analysis provided by the Child and Adolescent Health Measurement Initiative, Data Resource Center. http://www.childhealthdata.org/
2. Compares data, where available, between 2003 and 2007. This column does not take into account the significance of the change since 2003.
3. Federal Poverty level is defined by 2007 data according to HHS poverty guidelines. The 2007 definition defines 100% of poverty as $20,650 per year for a family of four.

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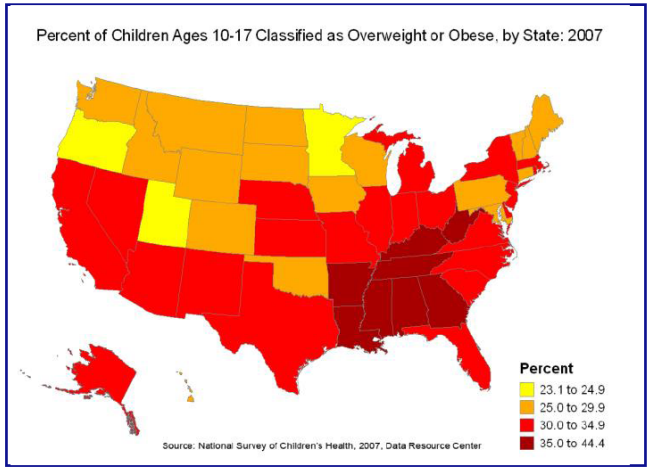
ARKANSAS STATE FACT SHEET

KEY POINTS

- The Arkansas Center for Health Improvement (ACHI) Surveys reports prevalence data suggesting that of children 10-17, obesity prevalence has remained flat since 2003, with 39.9% of children considered overweight or obese in 2007 compared to 40.1% in 2003.[1]
- According to the 2008 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 29.8% of low-income children age 2-5 are overweight or obese in Arkansas.



OVERALL PREVALENCE AND RANK[2]:	AR	National	Change in Arkansas since 2003[3]
Percentage of children ages 10- 17 years who are overweight or obese	37.5%	31.6%	↑
State Rank for overweight or obese children (1 is best)	50		Rank in 2003: 40
RISK FACTORS			
Percentage of children ages 6-17 years who participate in 4 or more days of vigorous physical activity per week	65.6%	64.3%	↑
Percentage of children ages 1-5 who engage in 4 or more hours of screen time per weekday (includes TV, videos, etc.)	14.6%	12.8%	
Percentage of children ages 6-17 who engage in 4 or more hours of screen time per weekday (includes TV, videos, video games, etc.)	15%	10.8%	↑
DISPARITIES—ACROSS AND WITHIN STATES			
% Overweight or Obese by Family Income			
<100% Federal Poverty Level[4]	50.6%	44.8%	↑
>400% FPL	28.9%	22.2%	↑
State Rank on Income Disparity Ratio (This figure represents calculated disparity ratios and ranks these ratios – A rank of 1 is best, 35 is worst)[5]	15		
% Overweight or Obese by Type of Insurance			
Public Insurance	44.7%	43.2%	↑
Private Insurance	32.8%	27.3%	↑
State Rank on Insurance Disparity Ratio (This figure represents calculated disparity ratios and ranks these ratios – A rank of 1 is best, 50 is worst)	12		
% Overweight or Obese by Race			
Black, non-Hispanic	48.2%	41.1%	↑
White, non-Hispanic	31.9%	26.8%	↑
State rank on Race Disparity Ratio (This figure represents calculated disparity ratios and ranks these ratios – A rank of 1 is best, 22 is worst)	13		
% Overweight or Obese by Hispanic Origin			
Hispanic *(footnote on definition)*[6]	NA[7]	41.9%	NA

What is ARKANSAS doing about obesity?

KEY POLICY and GRANT INITIATIVES available in ARKANSAS:

- Arkansas houses the Robert Wood Johnson Foundation Center to Prevent Childhood Obesity in partnership with PolicyLink in Oakland, CA.
- Arkansas has received a state-wide grant from the *Pioneering Healthier Communities* program through the YMCA Activate America Initiative.

The table below is derived from the 2009 edition of *F as in Fat*, published by Trust for America's Health. The summary below is intended for comparing a state's activities as of 2008 with others and provides information on state-specific policies as well as the number of states implementing a particular policy. For more information on recommended policy strategies, go to: www.reversechildhoodobesity.org.

ECONOMIC INDICATORS	AR	National
Estimated adult obesity-attributable medical expenditures, 1998-2000 (in 2003 dollars)	$663 M	$75 Billion
OBESITY-RELATED STATE INITIATIVES		
Snack and/or soda tax	NO	29 states + DC
Menu labeling law	NO	2 states
Complete the Streets policy	NO	9 states
OBESITY-RELATED SCHOOL STANDARDS		
Nutritional standards for school meals and snacks that go beyond existing USDA requirements.	YES	19 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	YES	27 states
Limited access to competitive food	YES	28 states
BMI or health information collected	YES	21 states
CHILD CARE CENTER LICENSING REGULATIONS		
Meals and snacks should follow meal requirements	YES	29 states
Meals and snacks should be consistent with Dietary Guidelines for Americans	NO	2 states
Have policy prohibiting or limiting foods of low nutritional value	NO	12 states
Have policy on vending machines	NO	4 states
Require vigorous or moderate physical activity	NO	8 states

TECHNICAL NOTES

The 2007 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Overweight and obesity are calculated from the child's height and weight as reported by the parent or guardian. 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. For more information on survey methods and analysis, visit: ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/slaits/nsch07/2_Methodology_Report/NSCH_Design_and_Operations_052109.pdf

1. Data Source: The Arkansas Center for Health Care Improvement Survey from both 2007 and 2003. http://www.achi.net/childob.asp
2. Data Source: 2007 National Survey of Children's Health. Data analysis provided by the Child and Adolescent Health Measurement Initiative, Data Resource Center. http://www.childhealthdata.org/
3. Compares data, where available, between 2003 and 2007. This column does not take into account the significance of the change since 2003.
4. Federal Poverty level is defined by 2007 data according to HHS poverty guidelines. The 2007 definition defines 100% of poverty as $20,650 per year for

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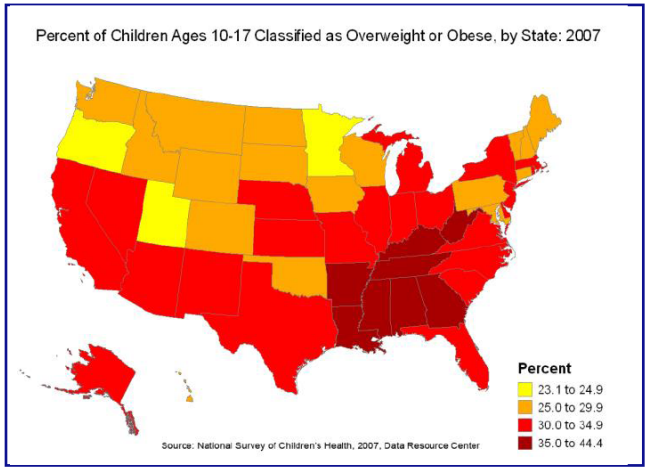
KENTUCKY STATE FACT SHEET

KEY POINTS

- Kentucky ranks 48 in overall prevalence with 37.1% of children considered either overweight or obese.
- The Kentucky prevalence of overweight and obese children has fallen since 2003.
- According to the 2008 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 32.3% of low-income children age 2-5 are overweight or obese in Kentucky.



OVERALL PREVALENCE AND RANK[1]:	KY	National	Change in Kentucky since 2003[2]
Percentage of children ages 10- 17 years who are overweight or obese	37.1%	31.6%	↓
State Rank for overweight or obese children (1 is best)	48		Rank in 2003: 50
RISK FACTORS			
Percentage of children ages 6-17 years who participate in 4 or more days of vigorous physical activity per week	62.5%	64.3%	↑
Percentage of children ages 1-5 who engage in 4 or more hours of screen time per weekday (includes TV, videos, etc.)	13.5%	12.8%	
Percentage of children ages 6-17 who engage in 4 or more hours of screen time per weekday (includes TV, videos, video games, etc.)	10.6%	10.8%	↑
DISPARITIES—ACROSS AND WITHIN STATES			
% Overweight or Obese by Family Income			
<100% Federal Poverty Level [3]	48.3%	44.8%	↓
>400% FPL	25.8%	22.2%	↓
State Rank on Income Disparity Ratio (This figure represents calculated disparity[4] ratios and ranks these ratios – A rank of 1 is best, 35 is worst)	22		
% Overweight or Obese by Type of Insurance			
Public Insurance	50.0%	43.2%	↑
Private Insurance	28.6%	27.3%	↓
State Rank on Insurance Disparity Ratio (This figure represents calculated disparity ratios and ranks these ratios – A rank of 1 is best, 50 is worst)	42		
% Overweight or Obese by Race			
Black, non-Hispanic	NA[5]	41.1%	NA
White, non-Hispanic	NA	26.8%	NA
State rank on Race Disparity Ratio (This figure represents calculated disparity ratios and ranks these ratios – A rank of 1 is best, 22 is worst)	NA		
% Overweight or Obese by Hispanic Origin			
[6]			

What is KENTUCKY doing about obesity?

KEY POLICY and GRANT INITIATIVES available in KENTUCKY:

- Kentucky currently receives 2 grants from the Robert Wood Johnson Foundation's Healthy Kids, Healthy Communities Fund to battle overweight and obesity in children.
- Kentucky is one of only 9 states with a *Complete the Streets* program.

The table below is derived from the 2009 edition of *F as in Fat*, published by Trust for America's Health. The summary below is intended for comparing a state's activities as of 2008 with others and provides information on state-specific policies as well as the number of states implementing a particular policy. For more information on recommended policy strategies, go to: www.reversechildhoodobesity.org.

ECONOMIC INDICATORS	KY	National
Estimated adult obesity-attributable medical expenditures, 1998-2000 (in 2003 dollars)	$1,163 M	$75 Billion
OBESITY-RELATED STATE INITIATIVES		
Snack and/or soda tax	NO	29 states + DC
Menu labeling law	NO	2 states
Complete the Streets policy	YES	9 states
OBESITY-RELATED SCHOOL STANDARDS		
Nutritional standards for school meals and snacks that go beyond existing USDA requirements.	YES	19 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	YES	27 states
Limited access to competitive food	NO	28 states
BMI or health information collected	NO	21 states
CHILD CARE CENTER LICENSING REGULATIONS		
Meals and snacks should follow meal requirements	NO	29 states
Meals and snacks should be consistent with Dietary Guidelines for Americans	NO	2 states
Have policy prohibiting or limiting foods of low nutritional value	NO	12 states
Have policy on vending machines	NO	4 states
Require vigorous or moderate physical activity	NO	8 states

TECHNICAL NOTES

The 2007 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Overweight and obesity are calculated from the child's height and weight as reported by the parent or guardian. 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. For more information on survey methods and analysis, visit: ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/slaits/nsch07/2_Methodology_Report/NSCH_Design_and_Operations_052109.pdf

1. Data Source: 2007 National Survey of Children's Health. Data analysis provided by the Child and Adolescent Health Measurement Initiative, Data Resource Center. http://www.childhealthdata.org/
2. Compares data, where available, between 2003 and 2007. This column does not take into account the significance of the change since 2003.
3. Federal Poverty level is defined by 2007 data according to HHS poverty guidelines. The 2007 definition defines 100% of poverty as $20,650 per year for

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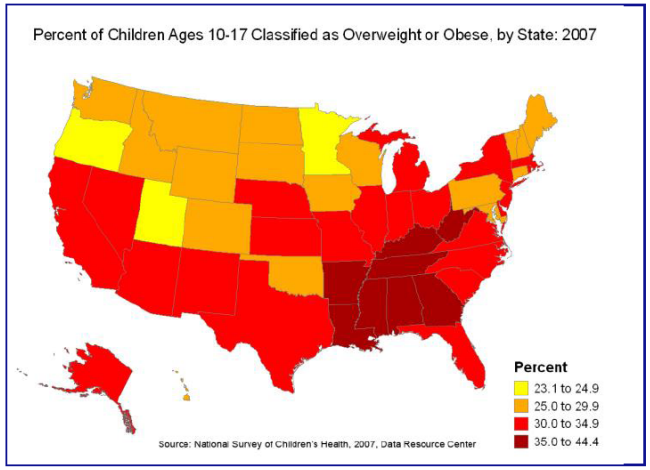
MISSISSIPPI STATE FACT SHEET

KEY POINTS

- Mississippi ranks 51th in overall prevalence with 44.4% of children considered either overweight or obese.
- The Mississippi prevalence of overweight and obese children has risen since 2003.
- According to the 2008 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 30.1% of low-income children age 2-5 are overweight or obese in Mississippi.



OVERALL PREVALENCE[1]:	MS	National	Change in Mississippi since 2003[2]
Percentage of children ages 10- 17 years who are overweight or obese	44.4%	31.6%	↑
State Rank for overweight or obese children (1 is best)	51		Rank in 2003: 34
RISK FACTORS			
Percentage of children ages 6-17 years who participate in 4 or more days of vigorous physical activity per week	65.4%	64.3%	↑
Percentage of children ages 1-5 who engage in 4 or more hours of screen time per weekday (includes TV, videos, etc.)	19.7%	12.8%	
Percentage of children ages 6-17 who engage in 4 or more hours of screen time per weekday (includes TV, videos, video games, etc.)	14.8%	10.8%	↑
DISPARITIES—ACROSS AND WITHIN STATES			
% Overweight or Obese by Family Income			
<100% Federal Poverty Level [3]	54.8%	44.8%	↑
>400% FPL	34.4%	22.2%	↑
State Rank on Income Disparity Ratio (This figure represents calculated disparity ratios and ranks these ratios – A rank of 1 is best, 35 is worst)[4]	7		
% Overweight or Obese by Type of Insurance			
Public Insurance	52.5%	43.2%	↑
Private Insurance	37.8%	27.3%	↑
State Rank on Insurance Disparity Ratio (This figure represents calculated disparity ratios and ranks these ratios – A rank of 1 is best, 50 is worst)	19		
% Overweight or Obese by Race			
Black, non-Hispanic	54.3%	41.1%	↑
White, non-Hispanic	36%	26.8%	↑
State rank on Race Disparity Ratio (This figure represents calculated disparity ratios and ranks these ratios – A rank of 1 is best, 22 is worst)	12		
% Overweight or Obese by Hispanic Origin			

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What is MISSISSIPPI doing about obesity?

KEY POLICY and GRANT INITIATIVES available in MISSISSIPPI:

- Mississippi currently receives one grant from the Robert Wood Johnson Foundation's Healthy Kids, Healthy Communities Fund to battle overweight and obesity in children.
- Mississippi is one of only 4 states to have a state policy on vending machines.

The table below is derived from the 2009 edition of *F as in Fat*, published by Trust for America's Health. The summary below is intended for comparing a state's activities as of 2008 with others and provides information on state-specific policies as well as the number of states implementing a particular policy. For more information on recommended policy strategies, go to: www.reversechildhoodobesity.org.

ECONOMIC INDICATORS	MS	National
Estimated adult obesity-attributable medical expenditures, 1998-2000 (in 2003 dollars)	$757 M	$75 Billion
OBESITY-RELATED STATE INITIATIVES		
Snack and/or soda tax	YES	29 states + DC
Menu labeling law	NO	2 states
Complete the Streets policy	NO	9 states
OBESITY-RELATED SCHOOL STANDARDS		
Nutritional standards for school meals and snacks that go beyond existing USDA requirements.	YES	19 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	YES	27 states
Limited access to competitive food	YES	28 states
BMI or health information collected	NO	21 states
CHILD CARE CENTER LICENSING REGULATIONS		
Meals and snacks should follow meal requirements	YES	29 states
Meals and snacks should be consistent with Dietary Guidelines for Americans	NO	2 states
Have policy prohibiting or limiting foods of low nutritional value	YES	12 states
Have policy on vending machines	YES	4 states
Require vigorous or moderate physical activity	NO	8 states

TECHNICAL NOTES

The 2007 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Overweight and obesity are calculated from the child's height and weight as reported by the parent or guardian. 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. For more information on survey methods and analysis, visit: ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/slaits/nsch07/2_Methodology_Report/NSCH_Design_and_Operations_052109.pdf

1. Data Source: 2007 National Survey of Children's Health. Data analysis provided by the Child and Adolescent Health Measurement Initiative, Data Resource Center. http://www.childhealthdata.org/
2. Compares data, where available, between 2003 and 2007. This column does not take into account the significance of the change since 2003.
3. Federal Poverty level is defined by 2007 data according to HHS poverty guidelines. The 2007 definition defines 100% of poverty as $20,650 per year for

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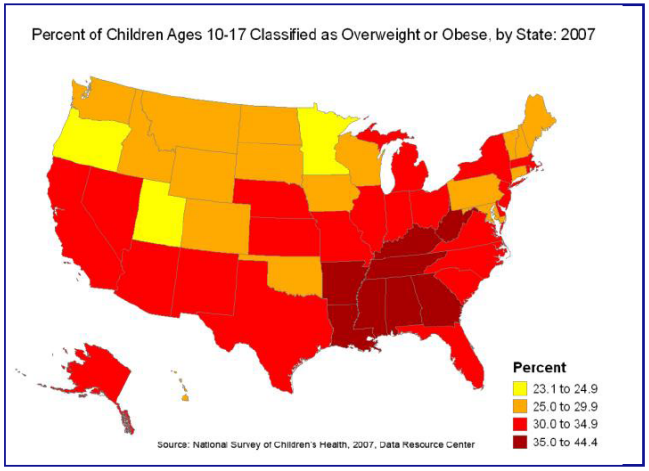
NEW MEXICO STATE FACT SHEET

KEY POINTS

- New Mexico ranks 33rd in overall prevalence with 32.7% of children considered either overweight or obese.
- The New Mexico prevalence of overweight and obese children has risen since 2003.
- According to the 2008 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 25.9% of low-income children age 2-5 are overweight or obese in New Mexico.



OVERALL PREVALENCE[1]:	NM	National	Change in New Mexico since 2003[2]
Percentage of children ages 10- 17 years who are overweight or obese	32.7%	31.6%	↑
State Rank for overweight or obese children (1 is best)	33		Rank in 2003: 21
RISK FACTORS			
Percentage of children ages 6-17 years who participate in 4 or more days of vigorous physical activity per week	62.7%	64.3%	↑
Percentage of children ages 1-5 who engage in 4 or more hours of screen time per weekday (includes TV, videos, etc.)	14.2%	12.8%	
Percentage of children ages 6-17 who engage in 4 or more hours of screen time per weekday (includes TV, videos, video games, etc.)	9.9%	10.8%	↑
DISPARITIES—ACROSS AND WITHIN STATES			
% Overweight or Obese by Family Income			
<100% Federal Poverty Level [3]	46.8%	44.8%	↑
>400% FPL	15.2%	22.2%	↓
State Rank on Income Disparity Ratio (This figure represents calculated disparity ratios and ranks these ratios – A rank of 1 is best, 35 is worst) [4]	33		
% Overweight or Obese by Type of Insurance			
Public Insurance	43.5%	43.2%	↑
Private Insurance	23.6%	27.3%	↓
State Rank on Insurance Disparity Ratio (This figure represents calculated disparity ratios and ranks these ratios – A rank of 1 is best, 50 is worst)	44		
% Overweight or Obese by Race			
Black, non-Hispanic	NA[5]	41.1%	NA
White, non-Hispanic	NA	26.8%	NA
State rank on Race Disparity Ratio (This figure represents calculated disparity ratios and ranks these ratios – A rank of 1 is best, 22 is worst)	NA		
% Overweight or Obese by Hispanic Origin			
Hispanic (footnote on definition)[6]	37.9%	41.9%	↑

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What is NEW MEXICO doing about obesity?

KEY POLICY and GRANT INITIATIVES available in NEW MEXICO:

- New Mexico currently receives one grant from the Robert Wood Johnson Foundation's Healthy Kids, Healthy Communities Fund to battle overweight and obesity in children.
- *Action for Healthy Kids* has a New Mexico coalition geared towards advocating for the prevention of childhood obesity and the spread of innovations that promote healthy communities.

The table below is derived from the 2009 edition of *F as in Fat*, published by Trust for America's Health. The summary below is intended for comparing a state's activities as of 2008 with others and provides information on state-specific policies as well as the number of states implementing a particular policy. For more information on recommended policy strategies, go to: www.reversechildhoodobesity.org.

ECONOMIC INDICATORS	NM	National
Estimated adult obesity-attributable medical expenditures, 1998-2000 (in 2003 dollars)	$324 M	$75 Billion
OBESITY-RELATED STATE INITIATIVES		
Snack and/or soda tax	YES	29 states + DC
Menu labeling law	NO	2 states
Complete the Streets policy	NO	9 states
OBESITY-RELATED SCHOOL STANDARDS		
Nutritional standards for school meals and snacks that go beyond existing USDA requirements.	NO	19 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	YES	27 states
Limited access to competitive food	YES	28 states
BMI or health information collected	NO	21 states
CHILD CARE CENTER LICENSING REGULATIONS		
Meals and snacks should follow meal requirements	YES	29 states
Meals and snacks should be consistent with Dietary Guidelines for Americans	NO	2 states
Have policy prohibiting or limiting foods of low nutritional value	NO	12 states
Have policy on vending machines	NO	4 states
Require vigorous or moderate physical activity	NO	8 states

TECHNICAL NOTES

The 2007 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Overweight and obesity are calculated from the child's height and weight as reported by the parent or guardian. 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. For more information on survey methods and analysis, visit: ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/slaits/nsch07/2_Methodology_Report/NSCH_Design_and_Operations_052109.pdf

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2. Compares data, where available, between 2003 and 2007. This column does not take into account the significance of the change since 2003.
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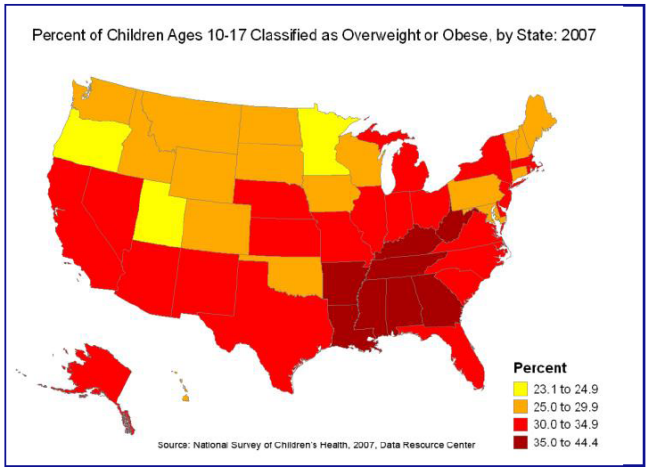
NORTH CAROLINA STATE FACT SHEET

KEY POINTS

- North Carolina ranks 38th in overall prevalence with 33.5% of children considered either overweight or obese.
- The North Carolina prevalence of overweight and obese children has fallen since 2003.
- According to the 2008 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 32.0% of low-income children age 2-5 are overweight or obese in North Carolina.



OVERALL PREVALENCE[1]:	NC	National	Change in North Carolina since 2003[2]
Percentage of children ages 10- 17 years who are overweight or obese	33.5%	31.6%	↓
State Rank for overweight or obese children (1 is best)	38		Rank in 2003: 42
RISK FACTORS			
Percentage of children ages 6-17 years who participate in 4 or more days of vigorous physical activity per week	69.6%	64.3%	↑
Percentage of children ages 1-5 who engage in 4 or more hours of screen time per weekday (includes TV, videos, etc.)	11.9%	12.8%	
Percentage of children ages 6-17 who engage in 4 or more hours of screen time per weekday (includes TV, videos, video games, etc.)	10.8%	10.8%	↑
DISPARITIES—ACROSS AND WITHIN STATES			
% Overweight or Obese by Family Income			
<100% Federal Poverty Level [3]	41.5%	44.8%	↓
>400% FPL	17.3%	22.3%	↓
State Rank on Income Disparity Ratio (This figure represents calculated disparity ratios and ranks these ratios – A rank of 1 is best, 35 is worst)[4]	29		
% Overweight or Obese by Type of Insurance			
Public Insurance	48.2%	43.2%	↓
Private Insurance	26.4%	27.3%	↓
State Rank on Insurance Disparity Ratio (This figure represents calculated disparity ratios and ranks these ratios – A rank of 1 is best, 50 is worst)	43		
% Overweight or Obese by Race			
Black, non-Hispanic	46.4%	41.1%	↓
White, non-Hispanic	28.2%	26.8%	↑
State rank on Race Disparity Ratio (This figure represents calculated disparity ratios and ranks these ratios – A rank of 1 is best, 22 is worst)	19		
% Overweight or Obese by Hispanic Origin			
Hispanic *(footnote on definition)*[5]	NA[6]	41.0%	NA

What is NORTH CAROLINA doing about obesity?

KEY POLICY and GRANT INITIATIVES available in NORTH CAROLINA:

- North Carolina currently receives two grants from the Robert Wood Johnson Foundation's Healthy Kids, Healthy Communities Fund to battle overweight and obesity in children.
- Five schools in North Carolina received a Healthy Schools Program National Recognition Award from the Alliance for a Healthier Generation.

The table below is derived from the 2009 edition of *F as in Fat*, published by Trust for America's Health. The summary below is intended for comparing a state's activities as of 2008 with others and provides information on state-specific policies as well as the number of states implementing a particular policy. For more information on recommended policy strategies, go to: www.reversechildhoodobesity.org.

ECONOMIC INDICATORS	NC	National
Estimated adult obesity-attributable medical expenditures, 1998-2000 (in 2003 dollars)	$2,138 M	$75 Billion
OBESITY-RELATED STATE INITIATIVES		
Snack and/or soda tax	YES	29 states + DC
Menu labeling law	NO	2 states
Complete the Streets policy	NO	9 states
OBESITY-RELATED SCHOOL STANDARDS		
Nutritional standards for school meals and snacks that go beyond existing USDA requirements.	YES	19 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	YES	27 states
Limited access to competitive food	YES	28 states
BMI or health information collected	YES	21 states
CHILD CARE CENTER LICENSING REGULATIONS		
Meals and snacks should follow meal requirements	YES	29 states
Meals and snacks should be consistent with Dietary Guidelines for Americans	NO	2 states
Have policy prohibiting or limiting foods of low nutritional value	YES	12 states
Have policy on vending machines	NO	4 states
Require vigorous or moderate physical activity	YES	8 states

TECHNICAL NOTES

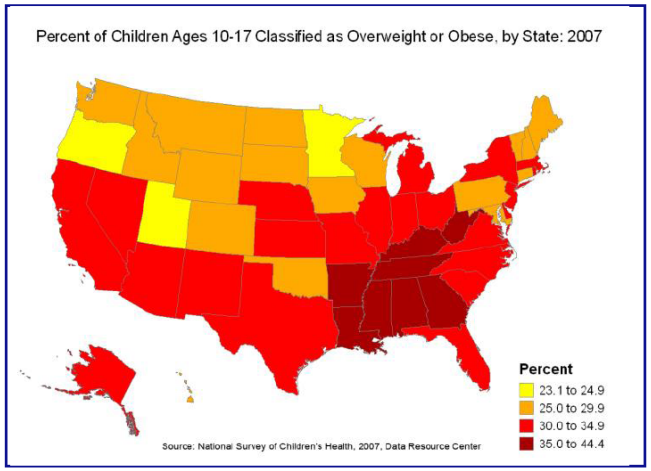
The 2007 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Overweight and obesity are calculated from the child's height and weight as reported by the parent or guardian. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. For more information on survey methods and analysis, visit: ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/slaits/nsch07/2_Methodology_Report/NSCH_Design_and_Operations_052109.pdf

1. Data Source: 2007 National Survey of Children's Health. Data analysis provided by the Child and Adolescent Health Measurement Initiative, Data Resource Center. http://www.childhealthdata.org/
2. Compares data, where available, between 2003 and 2007. This column does not take into account the significance of the change since 2003.
3. Federal Poverty level is defined by 2007 data according to HHS poverty guidelines. The 2007 definition defines 100% of poverty as $20,650 per year for

TEXAS STATE FACT SHEET

KEY POINTS

- Texas ranks 32 in overall prevalence with 32.2% of children considered either overweight or obese.
- The Texas prevalence of overweight and obese children has fallen since 2003.
- According to the 2008 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 34.1% of low-income children age 2-5 are overweight or obese in Texas.



OVERALL PREVALENCE[1]:	TX	National	Change in Texas since 2003[2]
Percentage of children ages 10- 17 years who are overweight or obese	32.2%	31.6%	↓
State Rank for overweight or obese children (1 is best)	32		Rank in 2003: 39
RISK FACTORS			
Percentage of children ages 6-17 years who participate in 4 or more days of vigorous physical activity per week	59.9%	64.3%	↓
Percentage of children ages 1-5 who engage in 4 or more hours of screen time per weekday (includes TV, videos, etc.)	16.4%	12.8%	
Percentage of children ages 6-17 who engage in 4 or more hours of screen time per weekday (includes TV, videos, video games, etc.)	12.3%	10.8%	↑
DISPARITIES—ACROSS AND WITHIN STATES			
% Overweight or Obese by Family Income			
<100% Federal Poverty Level [3]	53.1%	44.8%	↑
>400% FPL	16.8%	22.2%	↓
State Rank on Income Disparity Ratio (This figure represents calculated disparity ratios and ranks these ratios – A rank of 1 is best, 35 is worst)[4]	34		
% Overweight or Obese by Type of Insurance			
Public Insurance	50.1%	43.2%	↑
Private Insurance	23.1%	27.3%	↓
State Rank on Insurance Disparity Ratio (This figure represents calculated disparity ratios and ranks these ratios – A rank of 1 is best, 50 is worst)	48		
% Overweight or Obese by Race			
Black, non-Hispanic	26.3%	41.1%	↓
White, non-Hispanic	22.9%	26.8%	↓
State rank on Race Disparity Ratio (This figure represents calculated disparity ratios and ranks these ratios – A rank of 1 is best, 22 is worst)	2		
% Overweight or Obese by Hispanic Origin			

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NICHQ
National Initiative for Children's Healthcare Quality
www.nichq.org

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

What is TEXAS doing about obesity?

Appendix C: Obesity Disparities Presentation[102]

KEY POLICY and GRANT INITIATIVES available in TEXAS:

- Dallas, Texas currently receives a *Pioneering Healthier Communities* grant through the YMCA Activate America Initiative.
- *Action for Healthy Kids* has a Texas coalition geared towards advocating for the prevention of childhood obesity and the spread of innovations that promote healthy communities.

The table below is derived from the 2009 edition of *F as in Fat*, published by Trust for America's Health. The summary below is intended for comparing a state's activities as of 2008 with others and provides information on state-specific policies as well as the number of states implementing a particular policy. For more information on recommended policy strategies, go to: www.reversechildhoodobesity.org.

ECONOMIC INDICATORS	TX	National
Estimated adult obesity-attributable medical expenditures, 1998-2000 (in 2003 dollars)	$5,340 M	$75 Billion
OBESITY-RELATED STATE INITIATIVES		
Snack and/or soda tax	YES	29 states + DC
Menu labeling law	NO	2 states
Complete the Streets policy	NO	9 states
OBESITY-RELATED SCHOOL STANDARDS		
Nutritional standards for school meals and snacks that go beyond existing USDA requirements.	YES	19 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	YES	27 states
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TECHNICAL NOTES

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1. Data Source: 2007 National Survey of Children's Health. Data analysis provided by the Child and Adolescent Health Measurement Initiative, Data Resource Center. http://www.childhealthdata.org/
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The Childhood Obesity Action Network

The Healthcare Campaign to Stop the Epidemic

Obesity Disparities

Lisa Simpson, MB, BCh, MPH, FAAP
Professor & Director

Childhood Obesity Action Network
The Healthcare Campaign to Stop the Epidemic

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Overview & Agenda

- Purpose
  - Explore relationships between SES and childhood obesity including how disparities and SES is conceptualized and measured
  - Explore within and across state patterns of disparities in obesity prevalence
  - Propose a set of goals and recommendations for the health system to respond to these prevailing disparities
- Structure
  - Elizabeth Goodman, MD
  - Lisa Simpson, MB, BCh, MPH
  - Discussion

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Overview

- The Childhood Obesity Action Network
- Study Methods
- National Findings
- State Variation
  - By Race
  - By Income
  - By Insurance
- Strategies to address disparities
- Recommendations

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Childhood Obesity Action Network & Policy Program

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NICHQ

What is the NICHQ Childhood Obesity Action Network?

- **Over 2,000 Health Professionals**
- **50 States**
- **5 Countries**
- **5 Major Sponsors**
  - Robert Wood Johnson
  - The California Endowment
  - Nemours
  - Kaiser Permanente
  - The HSC Foundation

What are its goals?

- **10-Year Goal - To reverse the childhood obesity epidemic in all 50 states**
- **5-Year Goals**
  - To improve the quality of care for over 20 million children in all 50 states concerning the assessment, prevention and treatment of childhood obesity
  - To identify and disseminate successful practices in preventing and treating childhood obesity
  - To facilitate health care professionals becoming advocates for environmental improvements in their communities
  - To build the network as the recognized "go to resource" for

Policy Activities

- Develop policy **recommendations** to promote the prevention, identification, and management of childhood obesity.
- Develop strategic **partnerships** at all policy levels, including national, state, city and county, to move these recommendations forward.
- Principal foci and activities:
  - **Health** care policy but may expand to include other aspects of policy
  - Initial foci:
    - Role of health policy
    - Coverage & reimbursement
    - Disparities
  - Range of policy "products" to meet diverse audience needs

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Overview

- The Childhood Obesity Action Network
- Study Methods
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- Strategies to address disparities
- Recommendations

Childhood Obesity Action Network
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Acknowledgments

- Christina Bethell, PhD, MBA, MPH
- Debra Read, MPH
- Elizabeth Goodman, MD
- Jessica Johnson, BA
- John Besl, MA
- Julie Cooper, MPA

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Methods

- Data from 2003 National Survey of Children's Health PUF
- Age and gender specific weight status – underweight, normal, overweight and obese using CDC guidelines
- Examined age, gender, race/ethnicity, household income, education level, insurance, household where English is not primary language
- Four disparity indices calculated for each state & ranks developed
- States with estimates >30% relative standard error and/or less than 25 overweight/obese children eliminated from indices
- Correlation between overall ranks and specific disparity ranking determined

Childhood Obesity Action Network
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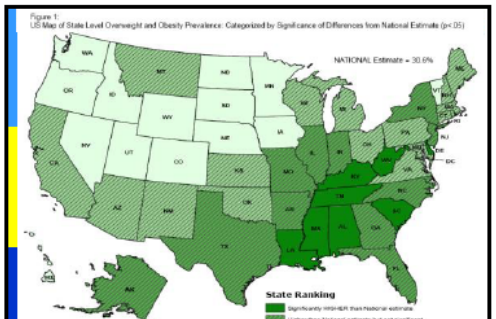
Overview

- The Childhood Obesity Action Network
- Study Methods
- National Findings
- State Variation
  - By Race
  - By Income
  - By Insurance
- Strategies to address disparities
- Recommendations



Variation by Family Income (39 states)

Low: <100% Federal Poverty Level

High: >400% Federal Poverty Level

National Index of Disparity between Low and High:

Overall: 1.74

State Range: LA – 1.00 to WI – 2.98

- Low
  - Overall – 39.8%
  - Low: PA - 26.7%
  - High: DE – 54.3%
  - Ratio of High vs. Low: 2.03
- High
  - Overall – 22.9%
  - Low: SD – 15.6%
  - High: LA – 36.6%
  - Ratio of High vs. Low: 2.35

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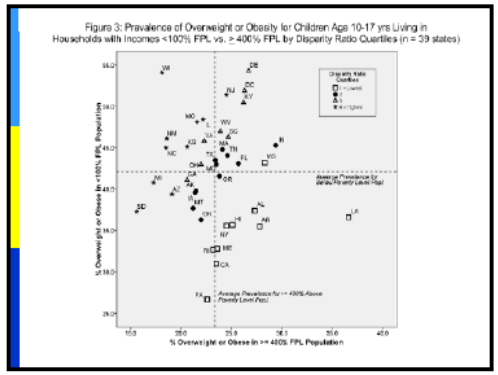

Variation by Health Insurance (49 states)

National Index of Disparity between Public and Private:

Overall: 1.48

State Range: NV – 1.00 to IL – 2.20

- Public
  - Overall – 39.6%
  - Low: NV - 25.9%
  - High: IL – 55.6%
  - Ratio of High vs. Low: 2.15
- Private
  - Overall – 26.7%
  - Low: WY – 20.2%
  - High: LA – 33.9%
  - Ratio of High vs. Low: 1.68

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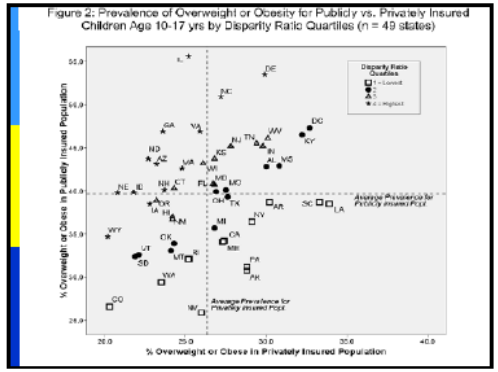


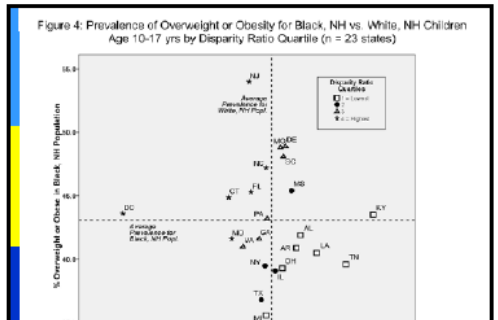
Variation by Race (23 states)

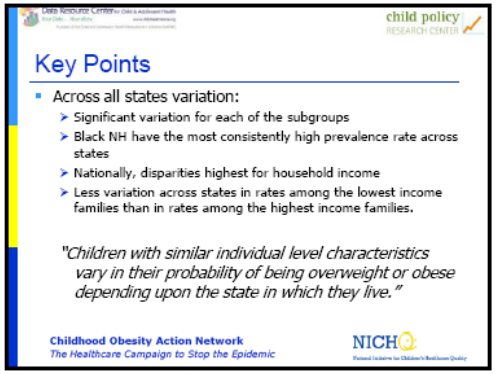
National Index of Disparity between Black, NH and White, NH:

Overall: 1.55

State Range: TN – 1.00 to DC – 3.44

- Black, NH
  - Overall – 41.2%
  - Low: MI – 35.6%
  - High: NJ – 54.0%
  - Ratio of High vs. Low: 1.52
- White, NH
  - Overall – 26.6%
  - Low: DC – 12.7%
  - High: KY – 37.5%
  - Ratio of High vs. Low: 2.95




child policy RESEARCH CENTER
Key Points
Across all states variation:
Significant variation for each of the subgroups
Black NH have the most consistently high prevalence rate across states
Nationally, disparities highest for household income
Less variation across states in rates among the lowest income families than in rates among the highest income families.
"Children with similar individual level characteristics vary in their probability of being overweight or obese depending upon the state in which they live."
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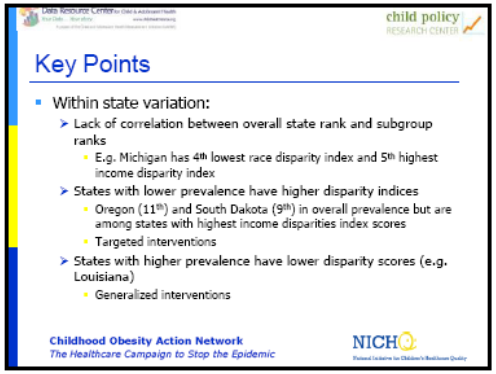
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Key Points
Within state variation:
Lack of correlation between overall state rank and subgroup ranks
E.g. Michigan has 4th lowest race disparity index and 5th highest income disparity index
States with lower prevalence have higher disparity indices
Oregon (11th) and South Dakota (9th) in overall prevalence but are among states with highest income disparities index scores
Targeted interventions
States with higher prevalence have lower disparity scores (e.g. Louisiana)
Generalized interventions
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Overview
The Childhood Obesity Action Network
Study Methods
National Findings
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Strategies to address disparities
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Childhood Obesity Action Network
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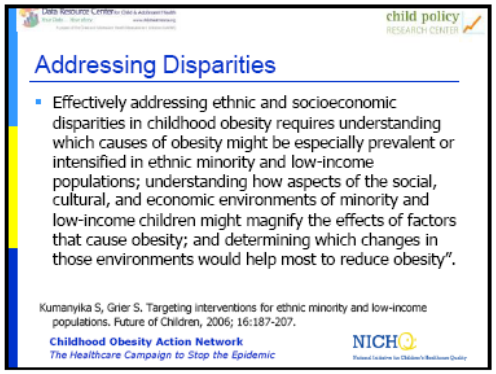
child policy RESEARCH CENTER
Addressing Disparities
Effectively addressing ethnic and socioeconomic disparities in childhood obesity requires understanding which causes of obesity might be especially prevalent or intensified in ethnic minority and low-income populations; understanding how aspects of the social, cultural, and economic environments of minority and low-income children might magnify the effects of factors that cause obesity; and determining which changes in those environments would help most to reduce obesity".
Kumanyika S, Grier S. Targeting interventions for ethnic minority and low-income populations. Future of Children, 2006; 16:187-207.
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The Healthcare Campaign to Stop the Epidemic
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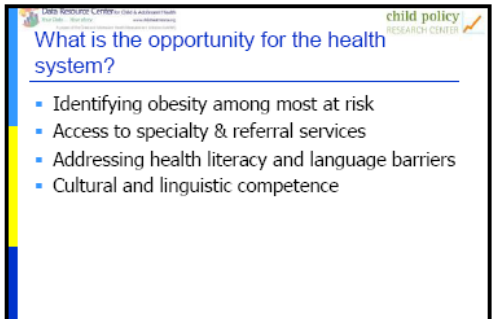
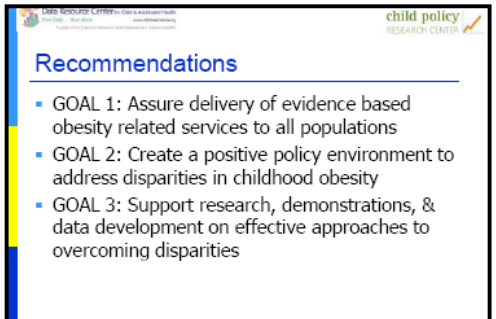

child policy RESEARCH CENTER
What is the opportunity for the health system?
Identifying obesity among most at risk
Access to specialty & referral services
Addressing health literacy and language barriers
Cultural and linguistic competence


child policy RESEARCH CENTER
Recommendations
GOAL 1: Assure delivery of evidence based obesity related services to all populations
GOAL 2: Create a positive policy environment to address disparities in childhood obesity
GOAL 3: Support research, demonstrations, & data development on effective approaches to overcoming disparities


child policy
RESEARCH CENTER
Goal 1: Assure delivery of evidence based obesity related services to all populations
Strategy 1: Raise awareness & understanding among providers of obesity disparities
Strategy 2: Apply, and adapt where needed, quality improvement approaches
Strategy 3: Provide culturally and linguistically competent services to maximize the effectiveness of services delivered
Health professional training
Legal, regulatory & certification approaches
Identify and spread innovations
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GOAL 2: Create a positive policy environment to address disparities in childhood obesity
Strategy 1: Support health professional advocacy, especially at the state level
Strategy 2: Develop relevant information and tools on disparities for use in advocacy
Strategy 3: Support communities, states and national social marketing approaches
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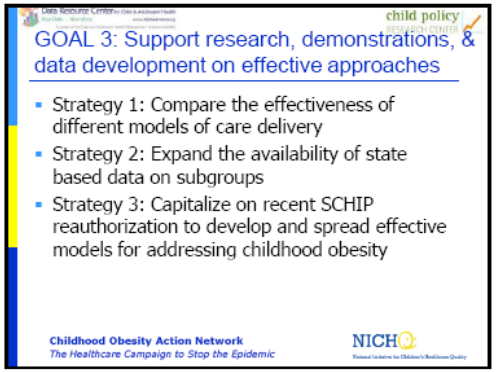
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GOAL 3: Support research, demonstrations, & data development on effective approaches
Strategy 1: Compare the effectiveness of different models of care delivery
Strategy 2: Expand the availability of state based data on subgroups
Strategy 3: Capitalize on recent SCHIP reauthorization to develop and spread effective models for addressing childhood obesity
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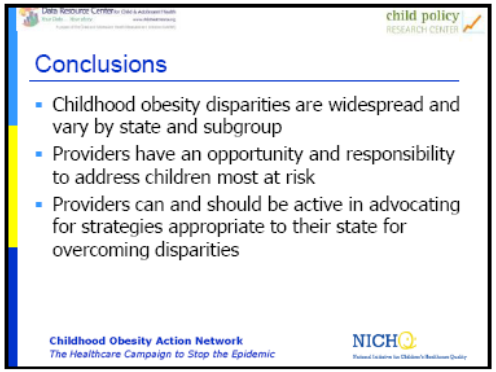
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Conclusions
Childhood obesity disparities are widespread and vary by state and subgroup
Providers have an opportunity and responsibility to address children most at risk
Providers can and should be active in advocating for strategies appropriate to their state for overcoming disparities
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Section III: Advocacy

Appendix D: CDC and RWJF Obesity Prevention Projects[103]

HIGHLIGHTS OF KEY LOCAL STRATEGIES TO ADDRESS CHILDHOOD OBESITY

The Robert Wood Johnson Foundation Center to Prevent Childhood Obesity is a national organization dedicated to reversing the childhood obesity epidemic by changing public policies and creating healthier environments in schools and communities. The center seeks to identify and promote the most promising obesity-prevention strategies in support of the nationwide movement to improve food and physical activity environments.

Leading national organizations have focused on communities' essential front-line role and actions that local governments can take to prevent childhood obesity. Policymakers have a plethora of options that can positively change our access to the consumption of healthy foods and beverages and promote regular, safe physical activity. These are well described by the Institute of Medicine (IOM), Centers for Disease Control and Prevention (CDC), and Leadership for Healthy Communities (LHC):

- The IOM report, *Local Government Actions to Prevent Childhood Obesity*[1] (released September 2009) identified 58 action steps, with 12 slated as *most promising.* The IOM report is specifically focused on strategies that are likely to directly affect children and that take place *outside* of the school day.
- The CDC report, *Recommended Community Strategies and Measurements to Prevent Obesity*[2] (released July 2009) identified 24 recommendations and suggested measurements. The CDC recommendations apply to both children and adults, and include those that can take place during school hours.
- The LHC *Action Strategies Toolkit*[3] (released May 2009) identified 10 action strategies and 31 policy and program options with an emphasis on childhood obesity preventio It includes strategies that can take place during school ho and outside of the school day. The toolkit also contains tip for getting started, state and local examples, and other resources.

This document highlights the leading policies that are most li to change the local landscape to enable our children to achiev healthy lifestyle and enable communities to reverse the obesi epidemic that threatens our children. The summary provided starts with the 12 main action steps identified by the IOM, wh focus on time outside of school, and is supplemented with tw additional action steps to address the need for policy change inside the school, during the school day. Comparable recommendations and policy options identified by CDC and L are included side-by-side with the highlighted IOM recommendations.

This list is not comprehensive and includes only local government strategies that the IOM considered the most likel reduce childhood obesity, based on criteria including evidenc effectiveness and effect size, potential reach, impact, cost, and feasibility. Other strategies for addressing childhood obesity– such as providing incentives to enable small food store owner carry healthy, affordable food; creating farmers' markets and community gardens; serving locally grown fruits and vegetab in schools; improving stairway access and appeal; and zoning mixed-use development —can be stepping stones toward implementing the highlighted action steps. Those interested local policy change are urged to learn about all of the policy options outlined in the three reports.

Key Local Strategies to Address Childhood Obesity

HEALTHY EATING		
IOM Action Steps[1]	**CDC Recommendations[2]**	**LHC Policy Options[3]**
Create incentive programs to attract supermarkets and grocery stores to underserved neighborhoods.	Communities should improve geographic availability of supermarkets in underserved areas.	State and local policymakers can provide grants and loan programs, small business development programs, and tax incentives that encourage grocery stores to locate in underserved areas. In addition, local policymakers can relax zoning requirements that make it difficult for supermarke to move into densely populated urban areas.
Require menu labeling in chain restaurants to provide consumers with calorie information on in-store menus and menu boards.		Local policymakers can consider adopting polici to require fast-food and chain restaurants to provide calorie or nutrition information on their menus or menu boards.
Mandate and implement strong nutrition standards for foods and beverages available in government-run or regulated after-school programs, recreation centers, parks, and childcare facilities, including limiting access to unhealthy foods and beverages.	Communities should improve and increase the availability of affordable healthier food and beverage choices in public service venues. Communities should restrict availability of less healthy foods and beverages in public service venues. Communities should discourage consumption of sugar-sweetened beverages by, in part, banning their use in licensed childcare facilities.	
Adopt building codes to require access to, and maintenance of, fresh drinking water fountains (e.g., public restrooms).		
Implement a tax strategy to discourage consumption of foods and beverages that have minimal nutritional value, such as sugar-sweetened beverages.		
*Improve the nutritional quality of foods and beverages served and sold in schools and as part of school-related activities.[4]	Communities should increase and improve availability of healthier food and beverage choices in public service venues. Communities should restrict availability of less healthy foods and beverages in public service venues.	Schools and school district officials can adopt vending machine policies that prohibit the sale o unhealthy foods and beverages, and can enforc strong local wellness policy that limits the sale o competitive foods and beverages. State legislatures can support bills, amendments and state boards of education policies that impro

HEALTHY EATING		
IOM Action Steps[1]	**CDC Recommendations[2]**	**LHC Policy Options[3]**
		access to and the quality of school meals. They can also implement strict competitive foods and local wellness policy standards. State legislatures can support bills, amendments, and state boards of education policies that improv access to and the quality of school meals. They can also implement strict competitive foods and local wellness policy standards.

*Note, the IOM focus was on actions that can be taken outside of the school and school setting; thus this recommendation is not included in *Local Government Actions to Prevent Childhood Obesity* (see reference 4). CDC and LHC address actions both outside of and within the school setting.

PHYSICAL ACTIVITY		
IOM Action Steps	**CDC Recommendations**	**LHC Policy Options**
Plan, build, and maintain a network of sidewalks and street crossings that connect schools, parks, and other destinations.	Communities should improve access to outdoor recreational facilities and enhance infrastructure supporting bicycling, walking, and access to public transportation.	State and local policymakers can support policies and funding to build trails through neighborhoods to connect homes with schools; ensure sidewalk continuity and direct routes for pedestrians and bicyclists; convert out-of-service rail corridors into trails and policies that increase access to walking trails; and develop or re-evaluate long-term transportation plans to set "active transportation" goals for walking and biking.
Adopt community policing strategies that improve safety and security of streets and park use, especially in higher-crime neighborhoods.	Communities should enhance personal safety in areas where persons are or could be physically active. Communities should enhance traffic safety in areas where persons are or could be physically active.	Local policymakers can increase policing in high-crime areas, pedestrian walkways, and parks; wo with communities to employ alternative policing strategies, such as neighborhood watch groups; adopt problem-oriented policing, which promotes the systematic analysis of problems to identify potential solutions and partnerships with organizations and communities to reduce crime; and adopt community design strategies that discourage crime.
Collaborate with schools to develop and implement a Safe Routes to Schools program to increase the number of children safely walking and bicycling to school.	Communities should support locating schools within easy walking distance of residential areas.	Local government and school policymakers can adopt a Safe Routes to Schools program, as well as support walking school buses. State policymakers can apply for funding and ensure th the funding is available to local communities in a timely manner.

PHYSICAL ACTIVITY		
IOM Action Steps	**CDC Recommendations**	**LHC Policy Options**
Build and maintain parks and playgrounds that are safe and attractive for playing, and in close proximity to residential areas.	Communities should improve access to outdoor recreational facilities. Communities should zone for mixed-use development.	State and local policymakers can approve construction of new recreational facilities along trails or public transit routes; assess the viability and sustainability of redeveloping blighted areas and vacant lots into productive economic and recreational opportunities, including community gardens, parks and other green spaces. Local policymakers can support policies that maintain create neighborhood parks.
Collaborate with school districts and other organizations to establish agreements that would allow playing fields, playgrounds, and recreation centers to be used by community residents when schools are closed (joint-use agreements).	Communities should improve access to outdoor recreational facilities. Communities should increase opportunities for extracurricular physical activity.	School officials can work with local government policymakers to allow community residents to us school facilities for physical activity and students use community facilities.
Institute regulatory policies mandating minimum play space, physical equipment, and duration of play in preschool, afterschool, and childcare programs.		
*Increase opportunities for frequent, more intensive, and engaging physical activity during and after school.[4]	Communities should require physical education in schools; increase the amount of physical activity in physical education programs in schools; and increase opportunities for extracurricular physical activity.	State policymakers can make 30 minutes of qual daily physical activity a requirement for all school School officials can create a comprehensive sch physical activity program that includes opportunities to engage in daily physical activity throughout the school day, as well as in before a after-school programs. State and school officials can require minimum levels of regular, high-quali physical education per school day and ensure th students are active at least half of the time they spend in physical education.

*Note, the IOM focus was on actions that can be taken outside of the school and school setting; thus this recommendation is not included in *Local Government Actions to Prevent Childhood Obesity* (see reference 4). CDC and LHC address actions both outside of and within the school setting.

SOCIAL MARKETING		
IOM Action Steps	**CDC Recommendations**	**LHC Policy Options**
Develop media campaigns, utilizing multiple channels (print, radio, internet, television, social networking, and other promotional materials) to promote healthy eating (and active living) using consistent messages.	Communities should limit advertisements of less healthy foods and beverages.	School district officials and state and local policymakers can adopt vending machine policies that prohibit the marketing and sale of unhealthy foods and beverages in youth centers, schools, and parks department facilities in addition to other facilities owned or operated by state and local governments. They can also decline offers from food and beverage … *(continued on page 5)* marketers to sponsor before and after-school programs and they can turn down donations.

References

[1]Institute of Medicine. *Local Government Actions to Prevent Childhood Obesity.* Editors; Committee on Childhood Obesity Prevention Actions for Local Governments; Institute of Medicine; National Research Council. September 2009. Available at http://www.iom.edu/CMS/3788/59845/72798.aspx.

[2]Centers for Disease Control and Prevention. Recommended Community Strategies and Measurements to Prevent Obesity in the United States. *MMWR* 2009;58(No. RR-7):1-30. Available at www.cdc.gov/mmwr/PDF/rr/rr5807.pdf.

[3]Leadership for Healthy Communities. *Action Strategies Toolkit: A Guide for Local and State Leaders Working to Create Healthy Communities and Prevent Childhood Obesity*. May 2009. Available at www.leadershipforhealthycommunities.org/actionstrategies.

[4]Institute of Medicine. *Preventing Childhood Obesity: Health in the Balance.* [Report Brief]. September 2004. Available at http://www.iom.edu/~/media/Files/Report%20Files/2004/Preventing-Childhood-Obesity-Health-in-the-Balance/ChildhoodObesity4pagerfixforwebpdf.ashx.

Appendix E: Key Data Resources

The section below outlines the key data resources available to you as you begin shaping and bolstering your policy recommendations and messages with data. Please note there are many resources available. Feel free to contact us for assistance in navigating through the different sources.

In outlining available data on childhood obesity, it is worthwhile to first consult two of the most comprehensive resources for childhood obesity data: the National Survey of Children's Health (NSCH) and the Youth Risk Behavior Survey (YRBS). Beyond data on obesity prevalence, as measured by BMI, the NSCH and YRBS provide rich data on many domains related to risk factors, impacts of obesity, and local responses. Similar data is available in other resources, and there are many additional contextual variables not available in the NSCH or YRBS. However, reviewing this list (Table 1) will help you recognize the "core" data for obesity assessment and advocacy.

Descriptions of these datasets and indicators are below. A major limitation of these data is that they are generally not available below the state level, e.g. at the level of your city, county, or community. For additional data sources and sources below the state level, proceed to the "Additional data resources" section.

National Survey of Children's Health (NSCH)

The NSCH was sponsored by the Maternal and Child Health Bureau of the Health Resources and Services Administration and administered by the National Center for Health Statistics at the CDC. The NSCH is a national survey which collected information on nearly 100,000 children in both 2003 and 2007. The survey examined the physical and emotional health of children ages 0-17. Although information is available through other surveys on the physical and emotional health, the purpose of this survey was to collect data on the target population, as well as obtain both sufficient national and state-level sample sizes so that data could be meaningfully compared nationally and across states. Special emphasis was placed on factors that may relate to children's well-being, including family interactions, parental health, school and after-school experiences, and safe neighborhoods. Where possible, questions from existing surveys were used to allow for comparisons across databases. Data were collected through telephone interviews with a parent of a child selected from the household between the ages of 0-17. Details regarding the data definitions and parameters are included below:

- **BMI:** Self-reported height and weight.
- **Nutrition:** Breastfeeding, family eating habits, receive free or reduced-price school breakfast or lunch, concerns about eating disorders, food stamps, WIC, TANF/ADC/AFDC.

- **Physical Activty:** Participation in heavy and light physical activities (i.e., bike, scooter, skateboard, roller skates, roller blades), participation in physical activities for at least 20 minutes, computer/video game usage and television watching habits, family rules about TV watching.
- **Geocode:** State
- **Fact sheet**: NICHQ (CPRC + CAHMI) http://www.nichq.org/online_communities/coan/document_download.html
- **Drill-down data:** (Data Resource Center) http://www.childhealthdata.org/content/Default.aspx

Youth Risk Behavior Survey (YRBS)

The CDC developed the cross-sectional school-based YRBS in 1990 in order to monitor priority health risk behaviors that contribute markedly to the leading causes of death, disability, and social problems among youth in the United States as well as monitor the progress toward achieving the Healthy People 2010 objectives and other program indicators. These behaviors include dietary behaviors; physical activity; tobacco, alcohol, and drug use; sexual behaviors; and violence. The YRBS includes national, state, and local school-based surveys of representative samples of 9th through 12th grade students. These surveys are conducted every two years (starting in 1991), usually during the spring semester. The state and local surveys, conducted by departments of health and education, provide data representative of public and private high school students in each state or local school district. The YRBS also includes additional national surveys conducted by CDC, such as The Youth Risk Behavior Survey, conducted in 1992 as a follow up to the National Health Interview Survey among nearly 11,000 persons aged 12–21 years old. Not all states participate. For example, in 2005, California, Louisiana, Minnesota, Pennsylvania, Virginia, and Washington did not participate. The YRBS contains basic questions regarding the frequency of consumption of fruit, vegetables, and milk. However, these questions were added in varying years and, therefore, do not allow for the examination of consistent trends over time. Full details regarding data parameters and measures are included below:

- **BMI:** Self-reported height and weight.
- **Nutrition:** Frequency of consumption of fruit, vegetables, and milk, dietary behaviors.
- **Physical activity:** Physical activity (level and amount spent on vigorous/moderate PA), participation in physical education classes and sports teams, strength exercises, exercises to lose/maintain weight.
- **Geocode:** Public use: state for schools.
- **Fact sheet:** Focus on students and schools + School Health Policies and Programs Study http://www.cdc.gov/HealthyYouth/obesity/facts.htm
- **Drill down data:** (Youth Online) http://apps.nccd.cdc.gov/yrbss/

State and Large Urban School District Fact Sheets from the CDC are quickly available reports which synthesize findings from multiple data sources. These fact sheets combine results from the 2007 state and district YRBS and 2008 state and district profiles to identify the percent of high school students who are obese, engage in unhealthy dietary behaviors, or are physically inactive. They also describe state and local characteristics of health education, physical education, opportunities for physical activity, and the school environment among middle and high schools that may help address the problem.

Table 1. Key Indicators in the NSCH and YRBS

Risk	Impact	Response
Physical Activity	**Physical Health**	**Education**
PA 20 min	Chronic illnesses	Afterschool participation
TV/Video 0-5 y/o	Asthma	PE 3 days
TV/Video 6-17 y/o	Diabetes (national only)	PE 40 min
Sports teams	**Mental Health**	**Healthcare**
PA 60 min	Mental/emotional conditions	Preventive medical care
TV viewing	Socio-emotional difficulties	Provider spent enough time
Video games	Feel sad	Coordination of care
Nutrition	Difficulty concentrating, getting along	Access to care (qualitative)
Breastfeeding	Youth risk behaviors	BMI as clinical tool (qualitative)
Soda, Milk, Fruit-vegetables, Snacks	Perceptions of body weight	Provider training in obesity (qualitative)
Family	Youth trying to lose weight	
Single headed households	Exercise and diet to lose weight	
O/O and family stress, parental difficulty, family relationships, conflict	Extreme weight loss methods	
Frequency of family meals	Stigma of obesity (qualitative)	
Parent PA	Hidden aspect of obesity (qualitative)	
Need for parent education and inclusion in programs (qualitative)	Youth suicide	
Community	School performance	
Feel safe in your community or neighborhood		
Feel safe at school		**Color Key**
Sidewalks or walking paths		National Survey of Children's Health
Park or playground area		Youth Risk Behavior Survey
Safe neighborhoods		Both NSCH and YRBS
Recreation center, community center, or boys' or girls' club		

ADDITIONAL DATA RESOURCES

There are well over 50 different existing national datasets which could provide relevant information for childhood obesity advocacy. However, many of the these data allow for only nationally-representative estimates, have limited direct and actionable measures of obesity, nutrition and physical activity, have no recent data available, or are not freely and publically available. As well, there are many resources unqiue to individual

states and jurisdictions, such as state-sponsored surveys. Table 2 lists those data which provide at least state-level estimates for most if not all states, have some direct and actionable measures related to obesity, and are freely and publically available. The datasets are evaluated based on the quantity and quality of indicators available.

Each resource listed in table 2 offers unique parameters for advocating against obesity. For example, CDC's Diabetes Indicators and Data Sources Internet Tool allows point-and-click county-level mapping of (adult) obesity prevalence. Walkscore.com provides a score of neighborhood walkability, accounting for proximity to neighborhood amenities including food stores and public transit. Table 3 provides links to the resources and comments on important features. All of these resources are readily and freely available in some form on the internet.

TABLE 2. ADDITIONAL DATA RESOURCES FOR CHILDHOOD OBESITY ADVOCACY

Data source	Smallest geo-level	Indicators			Most recent year
		Obesity prevalence	Nutrition	Physical Activity	
Food Environment Atlas	County-MSA	+	+++	+++	Varies
PedNSS	County	+	+		2007
PNSS	State		+		2007
School Health Profiles	State		+++	+++	2008
ACS	City, School District		+	+	2008
Walkscore.com	Address		+	+	2010
NHTS	Census tract			++	2009
CDC-DIDIT	County	+	+	+	2007
FARS	County			+	2008

Ratings are as based on the qunatity and quality of indicators.

+++ Estimates with standard deviation and confidence intervals, direct nutirion and physical activity measures

++ Direct or proxy measures of risk factors and outcomes

+ Indirect measures, environmental risk factors or outcomes

PedNSS=Pediatric Nutrition Surveillance System, PNSS=Pregnancy Nutrition Surveillance System, ACS=American Community Survey NHTS=National Household Transportation Survey, CDC=Centers for Disease Control, FARS=Fatality Analysis Reporting System,

TABLE 3. ADDTIONAL DATA RESOURCES, LINKS

Data source	Link
Food Environment Atlas	http://maps.ers.usda.gov/FoodAtlas/
PedNSS	http://www.cdc.gov/PEDNSS/
PNSS	http://www.cdc.gov/PEDNSS/
School Health Profiles	http://www.cdc.gov/healthyYouth/profiles/
ACS	http://www.census.gov/acs/www/
Walkscore.com	http://www.walkscore.com/
NHTS	http://nhts.ornl.gov/
CDC-DIDIT	http://apps.nccd.cdc.gov/ddtstrs/
FARS	http://www-fars.nhtsa.dot.gov/Main/index.aspx

COUNTY HEALTH RANKINGS

The *County Health Rankings by Mobilizing Action Toward Community Health (MATCH)* shows us that where we live matters to our health. The health of a community depends on many different factors – ranging from individual health behaviors, education and jobs, to quality of health care, to the environment. This first-of-its-kind collection of 50 reports – one per state – helps community leaders see that where we live, learn, work, and play influences how healthy we are and how long we live. The state rankings were developed by Robert Wood Johnson Foundation in

collaboration with the University of Wisconsin Population Health Institute to develop these Rankings for each state's counties. For more information, visit: http://www.countyhealthrankings.org/

FOOD ENVIRONMENT ATLAS

The Atlas assembles statistics on three broad categories of food environment factors:

- Food Choices—Indicators of the community's access to and acquisition of healthy, affordable food, such as: access and proximity to a grocery store; number of foodstores and restaurants; expenditures on fast foods; food and nutrition assistance program participation; quantities of foods eaten; food prices; food taxes; and availability of local foods
- Health and Well-Being—Indicators of the community's success in maintaining healthy diets, such as: food insecurity; diabetes and obesity rates; and physical activity levels
- Community Characteristics—Indicators of community characteristics that might influence the food environment, such as: demographic composition; income and poverty; population loss; metro-nonmetro status; natural amenities; and recreation and fitness centers

The Atlas currently includes 90 indicators of the food environment. The year and geographic level of the indicators vary to better accommodate data from a variety of sources. Some data are from the last Census of Population in 2000 while others are as recent as 2009. Some are at the county level while others are at the State or regional level. The most recent county-level data are used whenever possible.

PEDIATRIC NUTRITION SURVEILLANCE SYSTEM (PEDNSS)

The majority of PedNSS records (83.5%) are from the WIC Program, while other programs include Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT), Title V Maternal and Child Health Program (MCH), and other programs (including Head Start). It uses already available data collected on infants and children who visit public health clinics for routine care, nutrition education, and supplemental foods. These primarily include health, nutrition, and food assistance programs for infants and children, such as the Women, Infants, and Children Supplemental Food Program (WIC); Early Periodic Screening, Diagnosis and Treatment (EPSDT); and clinics funded by Maternal and Child Health Program (MCH) Block Grants. The PedNSS is designed as a child-based public health surveillance system to monitor the nutritional status of low-income infants, children, and women in federally funded maternal and child health and nutrition programs. The surveillance system was initiated in 1973 in five states and by 2006 has expanded to include 40 states, 1 territory, 5 Indian Tribal Organizations, and the District of Columbia collecting information on 7,600,000 children below the age of 5 years old. State health departments that choose to participate in the PedNSS submit data to CDC on a monthly basis. Data are sent to CDC on computer tapes or disks. Monthly reports listing children at high nutritional risk and reported errors are sent back to surveillance participants. Data are collected on socio-demographic variables (ethnicity/race, age, geographic location), birth weight, anthropometric indices (height/length, weight), iron status (hemoglobin and/or hematocrit), breastfeeding, and health risk behaviors (TV/Video viewing, smoking in the household). PedNSS also provides a framework for tabulating and interpreting state-specific information on the nutritional characteristics of low-income children. These data can be used to identify prevalent nutrition-related problems; identify high risk groups; monitor trends; target resources for program planning; and evaluate the effectiveness of interventions.

These surveillance data also can be used for program planning, management, and evaluation; for the development of health and nutrition interventions; and to monitor progress toward the Healthy People 2010 objectives for the United States. Data details are below:

- **BMI:** Measured height and weight.
- **Nutrition:** Initiation and duration of breastfeeding.
- **PA:** TV/Video viewing.
- **Geocode:** State and county.

PREGNANCY NUTRITION SURVEILLANCE SYSTEM (PNSS)

The PNSS is directed by the CDC. It is a program-based public health surveillance system which is collected annually and is designed to monitor risk factors associated with infant mortality and poor birth outcomes among low-income pregnant women who participate in two federally funded public health programs for nutrition surveillance, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and Title V Maternal and Child Health Program (MCH). The PNSS started in 1979 with 5 participating states and 10,000 surveillance records, and has been growing ever since. In 2006, 26 states, 1 U.S. territory, and 5 Indian Tribal Organizations contributed data, representing approximately 1,100,000 women. The data include information on maternal health indicators (pre-pregnancy weight status, maternal weight gain, parity, inter-pregnancy intervals, anemia, diabetes, and hypertension during pregnancy), maternal behavioral indicators (medical care, WIC enrollment, multivitamin consumption, smoking, and drinking), and infant health indicators (birth weight, preterm births, full term low-birth weight, and breastfeeding initiation). One of the limitations of the data is that they are not nationally representative, as contributing states, U.S. territories, and tribal governments participate voluntarily in the PNSS. Similarly, PNSS is not representative of all low-income pregnant women or pregnant women in the general population. Data details are below:

- **BMI:** pre-pregnancy BMI, gestational (i.e. maternal) weight gain, baby's birth weight.
- **Nutrition:** infant feeding, WIC enrollment, multivitamin consumption, smoking and drinking.
- **PA:** n/a.
- **Geocode:** State and county

SCHOOL HEALTH PROFILES

The School Health Profiles (Profiles) is a system of surveys assessing school health policies and practices in states, large urban school districts, territories, and tribal governments. Profiles are conducted biennially by education and health agencies among middle and high school principals and lead health education teachers. Indicators include health education, physical education and activity, healthy and safe school environment, health services, school health coordination, and family and community involvement.

AMERICAN COMMUNITY SURVEY (ACS)

The American Community Survey (ACS) is a nationwide survey designed to provide communities a fresh look at how they are changing. It is a critical element in the Census Bureau's reengineered decennial census program. The ACS collects and produces population and housing information every year instead of every ten years. Beginning with the 2005 ACS, and continuing every year thereafter, 1-year estimates of

demographic, social, economic and housing characteristics are available for geographic areas with a population of 65,000 or more. This includes the nation, all states and the District of Columbia, all congressional districts, approximately 800 counties, and 500 metropolitan and micropolitan statistical areas, among others. In 2008, the ACS will release its first multiyear estimates based on ACS data collected from 2005 through 2007. These 3-year estimates of demographic, social, economic and housing characteristics will be available for geographic areas with a population of 20,000 or more, including the nation, all states and the District of Columbia, all congressional districts, approximately 1,800 counties, and 900 metropolitan and micropolitan statistical areas, among others. For areas with a population less than 20,000, 5-year estimates will be available. The first 5-year estimates, based on ACS data collected from 2005 through 2009, will be released in 2010. Data on relevant to obesity include food stamps benefits and journey-to-work.

NATIONAL HOUSEHOLD TRANSPORTATION SURVEY

People in various fields outside of transportation use the NHTS data to connect the role of transportation with other aspects of our lives. Medical researchers use the data to determine crash exposure rates of drivers and passengers, including the elderly, who have heightened morbidity and mortality rates. Safety specialists study the accident risk of school-age children, particularly when they are traveling on their own by walking or biking. Social service agencies need to know more about how low-income households currently meet their travel needs.

The survey is used to examine:

- Travel behavior at the individual and household level
- The characteristics of travel, such as trip chaining, use of the various modes, amount and purpose of travel by time of day and day of week, vehicle occupancy, and a host of other attributes;
- The relationship between demographics and travel; and
- The public's perceptions of the transportation system.

WALKSCORE

Walk Score uses a patent-pending system to measure the walkability of an address. The Walk Score algorithm awards points based on the distance to the closest amenity in each category. If the closest amenity in a category is within .25 miles (or .4 km), we assign the maximum number of points. The number of points declines as the distance approaches 1 mile (or 1.6 km)—no points are awarded for amenities further than 1 mile. Each category is weighted equally and the points are summed and normalized to yield a score from 0–100. The number of nearby amenities is the leading predictor of whether people walk. The Walk Score may change as data sources are updated or the algorithm is improved.

CDC-DIDIT

The Diabetes Indicators and Data Sources Internet Tool (DIDIT) is a user-friendly web-based tool designed to support surveillance, epidemiology, and program evaluation activities of state diabetes control programs. The primary indicator - Age-Adjusted Estimates of the Percentage of Adults Who Are Obese - is automatically mapped Statewide by county. The tool provides data in trends or quartiles since 2004.

FATALITY ANALYSIS REPORTING SYSTEM (FARS)

The Fatality Analysis Reporting System (FARS) database contains a census of fatal crashes within the 50 states, the District of Columbia, and Puerto Rico. FARS data have been collected since 1975 and contain over 100 different data elements that characterize the crash, vehicle and people involved. The data are currently publicly available through 2003. Included in the data is information on accidents involving pedestrians and bicyclists, as well as information on the time and location of the crash. It is administered by the National Highway Traffic Safety Administration (NHSTA) at the US Department of Transportation.

MAKING THE BUSINESS CASE: COST DATA

Datasets such as PedNSS and FARS contain "transaction" data. Rather than surveying a sample of people, households or institutions, these datasets contain all records from a given population participating in a particular program. For example, PedNSS contains records from the Medicaid, Women Infants and Children (WIC), and Supplemental Nutrition Assistance Program (SNAP) programs. The large size and detail in these datasets make them very powerful, especially where cost data is included. Another transaction source to consider is utilization data from clinics and hospitals. As a healthcare provider, you may have institutional access to these data. However, their utility depends on the accuracy of coding for obesity and co-morbid conditions. There are several resources with cost findings, included some in prepared reports. This includes recent resources such as Centers for Disease Control and Prevention Overweight and Obesity, Economic Consequences http://www.cdc.gov/obesity/causes/economics.html and projected such as *The Future Costs of Obesity: National and State Estimates of the Impact of Obesity on Direct Health Care Expenses*.[104] These reports used both transaction data and survey data such as the Medical Expenditure Panel Survey.

USE DATA FOR CONTEXT

Other resources specific to children can put obesity data into context. For example, KIDS Count (http://datacenter.kidscount.org/) has data available below the State level, in an easy to use online format. Though there are generally no measures of obesity, nutrition or physical data, there is a wealth of data on demographics, education, economic well-being, health, and safety and risky behaviors. The American Fact Finder (http://factfinder.census.gov/home/saff/main.html?_lang=en) can provide much of the same data at a more granular level. The online Fact Finder tool queries data from the census and other large national surveys for population, housing, economic, and geographic data.

GOING LOCAL

Though some of the datasets already mentioned provide statistics below the State level, within States there are many unique data sources which will help in the advocacy effort. Many states and locales have surveys which are unique to their jurisdiction; these are often conducted by partnerships of government and academic institutions. State and Local health departments are the first stop for this sort of information. As well, many Health Departments will have data on schools. For example, in Northern Kentucky, the Health Department collects data on physical activity and nutrition practices in school as part of its annual school tobacco survey. In addition to health departments, school districts, planning agencies, universities and organizations often have access to or knowledge of unique local data.

IDENTIFYING ADDITIONAL RESOURCES

If the resources recommended here and found locally are not sufficient to support your advocacy effort, there are still many additional ones available. The trick is identifying those which are appropriate. There are several reports such as *Assessing Environmental Influences Associated with Diet, Physical Activity and Obesity: An Inventory of Existing Surveillance Systems*,[105] which may help.

APPLYING THE FINDINGS

Like datasets, there are many existing resources to help you apply the findings. One of the more practical sites is: Using Data to State Your Case at http://www.healthpolicyguide.org/advocacy.asp?id=5209.

DATA RESOURCES FOR PREVENTION OF POLICY OPPORTUNITIES TOOL

		Indicators	NSCH	YRBS	FEA	PedNSS	PNSS	SHP	ACS	Walkscore	Other sources
5	5ST1: Increased Access to Healthy Food	consumption & availability of healthy food, education programs									PERSPCS, SNESCPS, SIPP/SPD, NSAF, CE, Nielsen
	5ST2: Limit Unhealthy Foods	consumption & availability of unhealthy foods									PERSPCS, SNESCPS, SIPP/SPD, NSAF, CE, Nielsen
	5ST3: Point of Purchase	availability of nutrition info									
	5ST4: Media Campaigns	presense of food marketing (healthy and unhealthy), contracts									Nielsen
	5ST5: Change Relative Pricing	tax rate on unhealthy foods, relative cost of healthy food, prevalence of mobile vending									Impacteen
2	2ST1: Restrict Screen Time	amount of screen time, availability of alternative activity, screen time in after-school and child care settings									
1	1ST1: Increased Access to Safe and Attractive Places for Physical Activity	amount of physical activty, availability of exercise opportunities, education programs, walkability									SIPP/SPD, NHTS, SRTS
	1ST2: Increase Physical Activity	amount of physical activty, health and wellness programing and marketing									SIPP/SPD, NHTS
0	0ST1: Access to Healthy Beverages	consumption & availability of drinking water									PERSPCS, SNESCPS
	0ST2: Limit Access to Unhealthy Beverages	consumption & availability of sugar-sweetened beverages									PERSPCS, SNESCPS
	0ST3: Point of Purchase	availability of nutrition info									
	0ST4: Media Campaigns	presense of beverage marketing (healthy and unhealthy), contracts									Nielsen
	0ST5: Change Relative Pricing	tax rate on sugar-sweetened beverages, relative cost of healthy beverages									Impacteen
BF	0BFST1: Breastfeeding Friendly	proportion breast-feeding, availability of laction rooms and breaks									

DATA FOR ADDITIONAL STRATEGIES

CDC STRATEGY 14: INCREASE OPPORTUNITIES FOR EXTRACURRICULAR PHYSICAL ACTIVITY

- California has an online tool for finding local facilites opened by joint-use agreements (http://www.jointuse.org/resources/joint-use-locator/)

CDC STRATEGIES 17 AND 18: ENHANCE INFRASTRUCTURE SUPPORTING BICYCLING AND WALKING

- Some states have inventories of sidewalks, e.g. New Jersey (http://www.state.nj.us/transportation/refdata/countysidewalks/)
- Consider also not just sidewalks present, but investments in sidewalks. Local government budgets will have data on such capital spending. State SRTS coordinators may also have information.
- Large local health departments may have someone capable of using geographic information systems. If not, rely on local, metropolitan or regional planning agency. Can provide amount of pavement verus natural space.[7] Local planning agencies will also be able to indicate the miles of sidewalks, trails and bike lanes.
- TrailLink provides a quick online search of trails, though the list may not be as comprehensive as those maintained by local agencies (http://www.traillink.com/home.aspx)
- Data on bike and pedestrian crashes, as well as cars, are always available from police departments.Government and non-profit advocacy agencies alike may have data on pedestrian conditions collected to ensure compliace with Americans with Disabilities Act (ADA). (http://www.bellevuewa.gov/pdf/Transportation/ada_report_summary0708.pdf)

CDC STRATEGY 19: SUPPORT LOCATING SCHOOLS WITHIN EASY WALKING DISTANCE OF RESIDENTIAL AREAS

- National Center for Education Statistics has comprehensice data on enrollment, student performance, builing characteristics at the school district and school level (http://nces.ed.gov/ccd/districtsearch/)
- Council of Educational Facility Planners International (CEFPI) has links to State Facilities Planning Agencies (http://www.cefpi.org/i4a/pages/index.cfm?pageid=4315) as well as an inventory of State policies related to school location practices. Note that school districts are separate entities of governement, and school boards generally make siting decisions.

CDC STRATEGY 20: IMPROVE ACCESS TO PUBLIC TRANSPORTATION

- City-Go-Round helps find useful transit applications (apps) for the internet and mobile devices. It also encourages public transit agencies to open their data to software developers. You may choose to advocate for open data (http://www.citygoround.org/)

CDC STRATEGY 21 ZONE FOR MIXED USE DEVELOPMENT

- All local governments have comprehensive plans available, with regulatory zoning and land-use maps. These are updated periodically (~ 10 years) but ammended frequently.

CDC STRATEGIES 22 AND 23 ENHANCE PERSONAL AND TRAFFIC SAFETY IN AREAS WHERE PERSONS ARE OR COULD BE PHYSICALLY ACTIVE

- Local governments have publically available data on housing vacancies, e.g. Indianapolis (http://imaps.indygov.org/vacanthousing/defaultdown.htm)

- The Dangerous by Design report has Metro Area measures of Pedestrian Danger Index, Pedestrian Fatalities, and Pedestrian spending (http://t4america.org/docs/dangerousbydesign/dangerous_by_design.pdf)

Appendix F: Website Resources

American Academy of Pediatrics (AAP)
http://www.aap.org/

California Medical Association (CMA) Foundation
http://www.thecmafoundation.org/

Center for Community Health (CCH)
http://www.centerforcommunityhealth.org/

Centers for Disease Control and Prevention (CDC) Healthy Communities
http://www.cdc.gov/HealthyCommunitiesProgram/

Center for Science in the Public Interest (CSPI)
http://www.cspinet.org/

Healthy Kids
https://www.healthykids.org/

Kaiser Permanente's Community Health Initiatives for Healthy Eating, Active Living (HEAL)
http://info.kp.org/communitybenefit/

National Conference of State Legislatures (NCSL)
State Legislatures Internet Links
http://www.ncsl.org/

National Initiative for Children's Healthcare Quality (NICHQ)
http://www.nichq.org/

Safe Routes to Schools
http://www.saferoutesconference.org/

The Robert Wood Johnson Foundation Center to Prevent Childhood Obesity
The Network Resources
http://www.reversechildhoodobesity.org/

U.S. Department of Health and Human Services
WE CAN: Ways to Enhance Children's Activity and Nutrition
http://www.nhlbi.nih.gov/health/public/heart/obesity/wecan/

Advocacy Plan Template

Appendix G: Sample Advocacy Work Plan[106,107]

Framing the Issue & Policy Intervention	
Advocacy Issue	**IN THIS SECTION, SUMMARIZE YOUR ADVOCACY ISSUE:** Children in my county surpass the national average for overweight and obesity, with over 35% being overweight or obese. Children in my community have limited access to accessible and affordable resources for physical activity. Many of the neighborhoods in my community are not safe, not well lit and have few community park spaces available, and are often without sidewalks.
Advocacy Solution	**IDENTIFY THE SOLUTION YOU WOULD LIKE TO TARGET TO ADDRESS YOUR ISSUE:** Increase supervised physical activity offered on school campuses in the county's one school district.
Type of Policy Intervention	**DESCRIBE THE TYPE OF POLICY INTERVENTION YOU WILL ATTEMPT:** Many teachers have eliminated or restricted recess and other opportunities for children to be physically active during the school day in favor of having the children with seat time to do school assignments for which the children and classrooms are evaluated. As a result, many children in our school district do not have access to physical activity on a daily basis. The proposed policy intervention is to change existing policy to increase adoption of supervised physical activity programs on campus.
Focus of Advocacy	**IDENTIFY THE GOVERNMENTAL FOCUS OF YOUR ADVOCACY:** The focus of the advocacy campaign is the school district and local school site.

Advocacy Plan Template

Partners & Target for Change	
Key Partners	**LIST THE KEY ORGANIZATIONS THAT WILL BE PARTNERS IN THE POLICY ADVOCACY CAMPAIGN.** Think about those who may have children or grandchildren in school, business leaders, those in faith based organizations, local medical and healthcare organizations, local hospitals and health department, parent organizations, youth organizations, and other community organizations with an interest in improving the health of their community.
Change Agents	**IDENTIFY THE CHANGE AGENTS YOU WILL TARGET WHO WILL EDUCATE AND ADVOCATE FOR THE CHANGE YOU ARE PROPOSING.** In this example, parents, students themselves and healthcare professionals may be your agents of change.
Targets for Change	**DESCRIBE THE TARGETS FOR CHANGE WHO WILL ACTUALLY MAKE THE DECISION AND ALTER THEIR BEHAVIOR IF YOU ARE TO ACHIEVE YOUR GOALS.** In this example, the school board, superintendent, and school principals will be the primary targets for change.
Support and Opposition	**IN THIS SECTION, LIST YOUR EXPECTED ALLIES AND OPPONENTS.** In this example, you will likely count on local parent groups, as well as local organizations involved in physical activity like the YMCA, possibly local employers. Think about those who have children or grandchildren in schools and how you can reach them. Opposition will come from those whose behavior and approaches will need to change. In this example, the local school board and school administrators may be your opposition. Teachers might be in opposition if they did not support the notion that increased physical activity resulted in higher academic performance.

Advocacy Plan Template

Long Term & Intermediate Goals

Long Term Goal	**A long term goal spells out what the advocate would like to achieve in a measureable way through their advocacy campaign. For example:** Within five years, increase the number of schools in the district that require daily physical activity by 50%.
Intermediate Goals	**Intermediate goals focus on systems changes, modified policies or programs, providing concrete building blocks toward reaching the long term goal. Examples include:** 1. The school district will modify its existing Wellness Policy to include supervised physical activity as a key component for improving student health. 2. Parents will increase their awareness and acceptance of the link between physical activity and academic performance. 3. School sites will develop a plan to expand the availability of supervised physical activity on their campus, including identifying their site champion.

Strategies

Strategies **Key Questions to ask about our strategies. Do they help us to –** • **Reach our goals?** • **Use our allies to maximize support?** • **Minimize our opposition?**	**Strategies identify key actions that advocates can take to maximize the chances of achieving their intermediate goals. They provide the "what" that should happen for these goals to be achieved. For example:** • Identify business leaders whose children or grandchildren attend local schools. • Secure site champions to be advocates within the school district. • Students become advocates for change. • Recruit local sports celebrities • Make the economic case as well.

Short Term Goals/Objectives

Short Term Goals/Objectives	**Short term goals or objectives provide more immediate benchmarks necessary to achieve intermediate and long term goals. These build off of the strategies identified as well providing timeframes that link to the intermediate and long term goals. For example:**

1. By January 2010, recruit a diverse group of individuals to collaborate on this advocacy campaign.
2. By May 2010, complete a scan of physical activity policies of school districts statewide.
3. By September 2010, identify school sites more likely to develop a physical activity plan.
4. By November 2010, provide the parents and community with data about the linkage between physical activity and academic performance, identifying the amount of physical activity available to their children.
5. Determine the economic impact of improved student performance and wellness.

Short Term Goal/Objectives & Action Steps or Tactics

Short Term Goal/Objective: By November 2010, provide the parents and community with data about the linkage between physical activity and academic performance, identifying the amount of physical activity available to their children.

Action Step	By Whom	By When	Resources and Support Needed	Possible Opponents	Evaluation Measures
Create a task force to work on the issue.	Advocate	03/2010	Volunteers from throughout the school district and district staff	District Personnel Teachers	# members overall # parent members by school site #school site staff members # business leaders on task force District's SES reflected on TF
Complete the research documenting the link between physical activity and academic performance.	College Student Intern Volunteer	04/2010	Access to data from prominent organizations Volunteer to conduct the research	"	# Reports reviewed Breadth of report detailing linkage of physical activity and academic performance
Identify key business and civic leaders whose children attend the school district.	Advocate	05/2010	Volunteer to identify and interview	District Personnel	# business leaders identified # interested in participating
Complete an assessment of each school in the district and the amount of physical activity by grade level.	Task Force Members	08/2010	Volunteers to conduct assessment Approval from principals	District Personnel Principals Teachers	Results of report detailing physical activity by school and grade level
Share the results with the school superintendent and invite her participation to work on strategies to bring about change.	Advocate and TF Leaders	10/2010	Volunteer to develop the report for the superintendent.	Superintendent	Response from superintendent to report Interest in participating in campaign
Finalize report to parents.	Task Force	11/2010	Volunteer to complete report.	"	Completeness of report
Conduct meeting with parents to share the data.	Task Force	12/2010	Leadership to organize and conduct meeting. Summarize mtg. results	"	# of parents attending Diversity of parents Parent response to data

Advocacy Plan Template

Putting It All Together

Advocacy Solution	**Increase supervised physical activity offered on school campuses in the county's one school district.**
Long Term Goal	**Within five years, increase the number of schools in the district that require daily physical activity by 50%.**
Intermediate Goals	1. The school district will modify its existing Wellness Policy to include supervised physical activity as a key component for improving student health. 2. Parents will increase their awareness and acceptance of the link between physical activity and academic performance. 3. School sites will develop a plan to expand the availability of supervised physical activity on their campus, including identifying their site champion.
Short Term Goals/Objectives	1. By January 2010, recruit a diverse group of individuals to collaborate on this advocacy campaign. 2. By May 2010, complete a scan of physical activity policies of school districts statewide. 3. By September 2010, identify school sites more likely to develop a physical activity plan. 4. By November 2010, provide the parents and community with data about the linkage between physical activity and academic performance, identifying the amount of physical activity available to their children. 5. Determine the economic impact of improved student performance and wellness.

Advocacy Plan Template

Short Term Goal/Objective: By November 2010, provide the parents and community with data about the linkage between physical activity and academic performance, identifying the amount of physical activity available to their children.

Action Step	By Whom	By When	Resources and Support Needed	Possible Opponents	Evaluation Measures
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Complete the research documenting the link between physical activity and academic performance.	College Student Intern Volunteer	04/2010	Access to data from prominent organizations Volunteer to conduct the research	"	# Reports reviewed Breadth of report detailing linkage of physical activity and academic performance
Identify key business and civic leaders whose children attend the school district.	Advocate	05/2010	Volunteer to identify and interview	District Personnel	# business leaders identified # interested in participating
Complete an assessment of each school in the district and the amount of physical activity by grade level.	Task Force Members	08/2010	Volunteers to conduct assessment Approval from principals	District Personnel Principals Teachers	Results of report detailing physical activity by school and grade level
Share the results with the school superintendent and invite her participation to work on strategies to bring about change.	Advocate and TF Leaders	10/2010	Volunteer to develop the report for the superintendent.	Superintendent	Response from superintendent to report Interest in participating in campaign
Finalize report to parents.	Task Force	11/2010	Volunteer to complete report.	"	Completeness of report
Conduct meeting with parents to share the data.	Task Force	12/2010	Leadership to organize and conduct meeting. Summarize meeting results.	"	# of parents attending Diversity of parents Parent response to data

Long Term & Mid-Range Evaluation Measures

1. Adoption of Expanded Wellness Policy to include supervised physical activity by school district.

2. Number of schools developing and implementing Physical Activity Site Plans.

3. Change in the number of teachers supporting supervised physical activity in their classroom and school.

4. Number of children/youth participating in supervised physical activity annually by grade level, school site, gender and race/ethnicity.

5. Change in student academic performance by grade level, site, gender and race/ethnicity.

Advocacy Plan Template

Planning Checklist

What follows are some key questions to review as you are completing your Advocacy Plan:

1. **When should you make a plan?**

- ☐ The plan was made up front.
- ☐ The parts fit together.
- ☐ You have changed what you couldn't do.

2. **What's the best way to plan?**

- ☐ Planning was done as a group.
- ☐ Plans were recorded in a way that is easy to access and use later.

3. **What should the plan cover:**

- ☐ Advocacy Issue
- ☐ Advocacy Solution
- ☐ Type of Policy Intervention
- ☐ Focus of Advocacy
- ☐ Partners
- ☐ Change Agents
- ☐ Targets for Change
- ☐ Support and Opposition
- ☐ Goals
- ☐ Resources
- ☐ Strategies
- ☐ Tactics
- ☐ Evaluation
- ☐ Reporting

4. **How do we plan for goals or objectives?**

- ☐ Planning was done for long-term, intermediate, and short-term goals.
- ☐ Short Term Goals or Objectives are SMART + C: Specific; Measurable; Achievable; Relevant; Timed; and Challenging.

5. **How should resources and assets be included in the plan?**

- ☐ The following resources were included: funds; people available, and likely to be available in the future; important contacts; facilities.

6. **How should degrees of community support be included in the plan?**

- ☐ An inventory of allies and opponents has been made.
- ☐ You have checked if people who are normally opposed to you may support you and if those who normally support you may oppose.

7. **Which specific people or agencies should be included as targets or agents of change?**

- ☐ You have referred to your work in digging up the root causes of the problem.
- ☐ You have identified the individuals (or agencies) that absolutely need to make a change if your goals are to be achieved.
- ☐ You have thought about people who can be agents of change. You have included those who at first sight might look like targets for change, but may be able to be "turned," so they become agents for the group's goals.

8. **How should you plan your strategy?**

- ☐ You have decided on your strategies.
- ☐ You are prepared to be flexible, reacting to changing needs and conditions.
- ☐ You have made sure that each strategy you consider will help reach your goals; will suit your style; will use your allies appropriately; and will work.

9. **How should you plan your tactics?**

- ☐ You have picked those that best carry out your strategy.
- ☐ As you plan each tactic, you have decided who will do it, when, with what resources, using which allies, and you have pondered what opposition and resistance it might meet.

Advocacy Plan Template

Framing the Issue & Policy Intervention	
Advocacy Issue	**IN THIS SECTION, SUMMARIZE YOUR ADVOCACY ISSUE:**
Advocacy Solution	**IDENTIFY THE SOLUTION YOU WOULD LIKE TO TARGET TO ADDRESS YOUR ISSUE:**
Type of Policy Intervention	**DESCRIBE THE TYPE OF POLICY INTERVENTION YOU WILL ATTEMPT:**
Focus of Advocacy	**IDENTIFY THE GOVERNMENTAL FOCUS OF YOUR ADVOCACY:**

Advocacy Plan Template

Partners & Target for Change	
Key Partners	**LIST THE KEY ORGANIZATIONS THAT WILL BE PARTNERS IN THE POLICY ADVOCACY CAMPAIGN.**
Change Agents	**IDENTIFY THE CHANGE AGENTS YOU WILL TARGET WHO WILL EDUCATE AND ADVOCATE FOR THE CHANGE YOU ARE PROPOSING.**
Targets for Change	**DESCRIBE THE TARGETS FOR CHANGE WHO WILL ACTUALLY MAKE THE DECISION AND ALTER THEIR BEHAVIOR IF YOU ARE TO ACHIEVE YOUR GOALS.**
Support and Opposition	**IN THIS SECTION, LIST YOUR EXPECTED ALLIES AND OPPONENTS.**

Advocacy Plan Template

Long Term & Intermediate Goals

Long Term Goal	**A long term goal spells out what the advocate would like to achieve in a measureable way through their advocacy campaign.**
Intermediate Goals	**Intermediate goals focus on systems changes, modified policies or programs, providing concrete building blocks toward reaching the long term goal.**

Strategies

Strategies **Key Questions to ask about our strategies. Do they help us to –** • **Reach our goals?** • **Use our allies to maximize support?** • **Minimize our opposition?**	**Strategies identify key actions that advocates can take to maximize the chances of achieving their intermediate goals. They provide the "what" that should happen for these goals to be achieved.**

Short Term Goals/Objectives

Short Term Goals/Objectives	**Short term goals or objectives provide more immediate benchmarks necessary to achieve intermediate and long term goals. These build off of the strategies identified as well providing timeframes that link to the intermediate and long term goals.**

Advocacy Plan Template

Putting It All Together

Advocacy Solution	
Long Term Goal	
Intermediate Goals	
Short Term Goals/Objectives	

Advocacy Plan Template

Short Term Goal/Objective:

Action Step	By Whom	By When	Resources and Support Needed	Possible Opponents	Evaluation Measures

Long Term & Mid-Range Evaluation Measures

Section IV: Public Policy

Appendix H: Policy Opportunities[108]

American Academy of Pediatrics
Welcome to the American Academy of Pediatrics Web site dedicated to the prevention of childhood overweight and obesity. The purpose of this site is to bring awareness to the serious health problem of childhood overweight and obesity; empower pediatricians and families to take action in their homes, offices and communities to prevent childhood obesity; and to support pediatricians, families and community advocates in improving the health status of those children who are already overweight and obese.
http://www.aap.org/obesity/index.html

POLICY RESOURCES:

Robert Wood Johnson Foundation
A Nation at Risk: Obesity in the United States
http://www.rwjf.org/pr/product.jsp?id=20889

Robert Wood Johnson Foundation
Leadership for Healthy Communities
Supporting Healthy Communities Through the American Recovery and Reinvestment Act of 2009
http://www.leadershipforhealthycommunities.org/images/stories/lhc_policybrief_econ_4.6.09_final.pdf

The National Governors Association (NGA) Center for Best Practices
Shaping a Healthier Generation:
Successful State Strategies to Prevent Childhood Obesity
http://www.nga.org/Files/pdf/0909HEALTHIERGENERATION.PDF

NGA Center for BEST PRACTICES

Issue Brief

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Preventing Obesity in Youth through School-Based Efforts

Summary
Obesity has reached epidemic proportions in the United States and threatens to impact the health and well-being of numerous children and adolescents. The number of overweight youth has more than doubled since the early 1970s. Today, approximately 13 percent of children and adolescents—nearly 5.3 million youth—are seriously overweight.[1, 2]

Since most children and adolescents are enrolled in schools, schools present a unique opportunity to promote healthy eating and regular physical activity. States, school districts and schools are addressing childhood obesity through multi-pronged strategies that include developing school nutrition and physical activity policies, implementing classroom instruction in nutrition and physical education, and creating a supportive school environment. States can help prevent and reduce obesity in school-age youth by:

- **Developing policy and program guidelines for schools.**
- **Strengthening physical activity requirements, standards and programs in schools.**
- **Implementing nutrition policies and education programs.**
- **Fostering school and community partnerships that promote regular physical activity.**
- **Engaging students, school faculty, families, and communities in promoting healthy eating and regular physical activity.**
- **Creating public awareness and education campaigns.**

Childhood Obesity

The increase in children that are overweight or obese is attributable to multiple factors including an increase in sedentary lifestyles and intake of high-caloric foods.[9] Environment, race/ethnicity, and gender also play a factor in determining whether children will have a higher likelihood of becoming obese. Some facts on obesity:

- Children with obese mothers, low family incomes, and lower cognitive stimulation are at greater risk than their peers for becoming obese.[10]
- Mexican American male children tend to have a higher prevalence of being overweight than non-Hispanic black and non-Hispanic white male children. Non-

Use of the Term *Obesity*
Body Mass Index (BMI) provides a guideline based on weight and height to determine *overweight* and *obese* for adults. For children and adolescents, obesity is calculated based on growth charts, physical development, gender, and age; and therefore, child measures do not have the same cut-points for BMI as adults. Based on current recommendations of expert committees, children with BMI values at or above the 95th percentile of the sex-specific BMI growth charts are categorized as overweight. To avoid stigma, the terms *at-risk* and *overweight* are used when referring to children and youth and correspond to *overweight* and *obese* for adults.

Despite this technical language, the use of *obesity* when referring to children is widely accepted. For simplicity and clarity, the terms *overweight* and *obesity,* and their variation have been used throughout this issue brief.

Source: Centers for Disease Control and Prevention, BMI Table for Children and Adolescents.

Hispanic black female children tend to have a higher prevalence of being overweight when compared with non-Hispanic white and Mexican American female children.[11]
- Breastfeeding may reduce the likelihood of a child becoming obese.[12]
- Healthy eating and regular physical activity are established in children at young ages and are affected by factors including parents' eating habits.[13]

Overweight and obese children place significant health, social and economic costs on states. Youth who are obese are at an increased risk for obesity-related illnesses including heart disease, diabetes, high blood pressure, gallbladder disease, and osteoarthritis.[14] They are more likely than their peers to be absent from school, experience low self-esteem, and become obese adults.[15, 16] Costs due to obesity-related illnesses in children have more than tripled since the 1970s, from $35 million in 1979 to $127 million in 1999.[17]

The Role of Schools in Promoting Healthy Living

Children's health and well-being play a critical role in their ability to come to school ready to learn and in their overall academic achievement.[18] Schools have a unique opportunity to provide children and adolescents the skills and support they need to adopt healthy behaviors. They have regular access to children and youth — more than 95 percent of all children and adolescents aged 5-17 are enrolled in school.[19] Teachers and other school personnel can educate, support and reinforce students' health behaviors, including promoting healthy eating and regular physical activity. States can take several steps to encourage healthy lifestyles through school-based efforts such as:

- **Developing policy and program guidelines for schools.**
- **Strengthening physical activity requirements, standards and programs in schools.**
- **Implementing nutrition policies and education programs.**
- **Fostering school and community partnerships that promote regular physical activity.**
- **Engaging students, school faculty, families, and communities in promoting healthy eating and regular physical activity.**
- **Creating public awareness and education campaigns.**

Develop Policy and Program Guidelines for Schools

Many states are developing physical activity and nutrition guidelines and recommendations for schools. In addition to using national research to inform policy, some states are supporting state-level research to determine the status of diet and physical activity in youth, and craft policy recommendations.

In **California**, the Public Health Institute and the California Department of Health Services conducted a survey of California adolescents, ages 12 to 17 years, to gather information on adolescents' diet and physical activity. The results of the study formed the basis of policy recommendations for improving the health status of California adolescents that were highlighted in the report, "California Teen Eating, Exercise, and Nutrition Survey."[20]

The **Kentucky** State Department of Education is in the final stages of crafting a "Comprehensive Plan for Coordinated School Health" that provides objectives and activities that support schools in developing coordinated school health programs. Physical activity, nutrition education, and the decrease of tobacco usage are major areas of emphasis. The Lieutenant Governor's Task Force on Nutrition and Fitness introduced a bill during the last legislative session that would have required daily physical activity for elementary school students, limited the sale of certain foods during school hours, and established training requirements and continuing education for school food service directors and managers. The bill received widespread support from numerous stakeholder groups but did not pass.

Maine is using a significant percentage of its tobacco settlement funds to support "Healthy Maine Partnerships." Under this initiative, the state employs 54 school health coordinators located in school districts or schools in 31 regions of the state to promote physical activity, nutrition, and tobacco prevention and education programs and policies. In one site, nutrition activities have been so successful that area grocery stores have had to improve the variety of available fruits and vegetables, due to increased demand from families.

In **Michigan,** the Departments of Education and Community Health, and the Governor's Council on Physical Fitness, Health and Sports formed a Healthy Weight Advisory Group comprised of experts representing universities, health professional associations, schools and other key groups. The advisory group developed a consensus paper, "The Role of Michigan Schools in Promoting Healthy Weight" to provide practical guidelines and policy recommendations to school districts for promoting healthy weight for all students[21].

Strengthen Physical Activity Requirements, Standards, and Programs in Schools

Regular physical activity promotes numerous health, social and educational benefits in youth. It can help control weight, improve strength and endurance, reduce stress, and improve self-esteem.[22] It can increase concentration, reduce disruptive behavior and improve academic achievement, even when time for physical education reduces time spent on academics.[23] In fact, students who participate in interscholastic sports are less likely to smoke or use drugs, and are more likely to have high academic achievement and overall good conduct.[24] In spite of the benefits of regular physical activity, only one in three (35 percent) of students in grades 9-12 participate regularly in vigorous physical activity.[25]

National guidelines recommend that elementary school children receive 150 minutes per week of physical activity, and that middle school and high school students receive 225 minutes per week. [26] Nearly all states have some type of legislative mandate for physical activity. However, many of these mandates are broad and leave local school districts to determine such parameters as the number of hours students spend in physical education.

Education reform efforts have spawned the development of educational standards, which in nearly all states (i.e., 44 states) include state standards for physical education. Over 80 percent of the states with physical education standards follow national guidelines. A few states include physical education as part of state assessments and graduation requirements.[27] In spite of these efforts, physical education requirements continue to be eroded by academic requirements that place greater emphasis on subjects such as reading, writing and arithmetic.

Illinois is the only state in the nation that requires daily physical education for all students, grades kindergarten through 12. Certified physical education specialists teach physical education at the elementary, middle and high school levels. Daily time is to be commensurate with other subjects. At the secondary level, individual waivers are available, at local district discretion, for varsity athletics, marching band, and ROTC.

School Physical Activity Facts:

- Only 6-8 percent of senior, middle, and elementary schools provide daily physical education for the entire school year for students in all grades.
- Approximately 71 percent of elementary schools provide regularly scheduled recess for students in all grades kindergarten through 5.
- Only 49 percent of all schools offer intramural activities or physical activity clubs for students.
- 65 percent of high school students participate in vigorous physical activity on 3 or more days a week; 27 percent participate in moderate physical activity on 5 or more days a week.

Sources: Centers for Disease Control and Prevention (CDC), School Health Policies and Programs Study, 2000; CDC National Youth Risk Behavior Survey, 1999.

The **Maine** Move and Improve program, of Eastern Maine Medical Center and endorsed by the Governor's Council on Physical Fitness and Sports, is designed as a twelve-week, free physical activity program to reduce the risk of disease associated with physical inactivity. Originally initiated as a worksite wellness program, the effort has

grown to include schools, seniors and community groups. Participants commit to be physically active 30 minutes per day, four days a week for 10 of the 12 weeks of the program. Maine businesses donate incentive prizes including monetary prizes, and canoes, kayaks and mountain bikes.

Minnesota's state graduation standards include physical activity. High school students in most school districts have to complete physical activity standards in order to graduate. Students are asked to write independent fitness plans as part of the requirement.

In **Texas**, SB19 authorized the State Board of Education to require elementary school students to participate in daily physical activity. Implementation of the law resulted in recent Texas Education Agency (TEA) guidelines requiring elementary students to participate in at least 30 minutes of physical activity a day or 135 minutes per week. The legislation also requires that all elementary schools implement a coordinated school health program by 2007.

Implement Nutrition Policies and Education Programs

Proper nutrition is an important building block to a child's ability to learn and their overall health status. Children who are hungry are more likely to have behavioral, emotional and academic problems at school.[28] School food service programs contribute a significant amount of the nutrition that many children receive in a given day, particularly for those youth who are low-income and thus qualify for free or reduced-price breakfasts and lunches. Effective nutrition policies and education programs promote and reinforce healthy eating habits, create supportive environments, and teach youth the importance of eating right.

Schools face numerous challenges in assuring that youth eat healthy meals during the school day. Many school food service programs follow federal nutritional guidelines and must do so if they participate in federal school meal programs (i.e., the National School Lunch and School Breakfast Programs). However, efforts to provide nutritious foods in schools often compete with the wide availability of junk foods, the strong impact of advertising on youth's food choices, and diminishing school budgets that spawn private fund-raising through the sale of candy and other junk foods to fund athletic and extra-curricular activities.

Most schools have increased children's food options through the sale of foods in vending machines, school stores and snack bars.[29] Schools faced with dwindling education budgets have turned to "pouring rights contracts" to supplement school and food service budgets through the sale of soft drinks. Nearly 50 percent of schools have contracts with soft drink companies; 92 percent of these schools receive a specific percentage of soft drink sales receipts.[30]

School Food Service and Nutrition Facts:

- Nearly 93 percent of senior high schools operate vending machines, school stores, or snack bars; only 21 percent sell low fat yoghurt or fruits and vegetables in these venues.
- Nearly 20 percent of schools usually give students less than 20 minutes to eat lunch once they are seated.
- Only 2 percent of school-aged children meet the Food Guide Pyramid serving recommendations for all five major food groups.
- Overall, 56 to 85 percent of children consume soda on any given day.

Sources: Centers for Disease Control and Prevention, School Health Policies and Programs Study, 2000; U.S. Department of Agriculture, Foods Sold in Competition with USDA School Meal Programs: A Report to Congress, January 2001.

To address the growing prevalence of overweight and obese youth, states and school districts are implementing policies to restrict or significantly limit the sale of junk food and soft drinks during school hours. Some states and school districts have found creative approaches that minimize the sale of soft drinks and junk foods in school vending machines while maintaining revenues. Finally, many states are implementing nutrition education curricula and increasing the qualifications of school nutrition staff.

In **California**, the school board of the *Los Angeles Unified School District* unanimously voted to ban the sale of soft drinks in all district schools, effective January 2004. In addition, the new policy requires that schools and the district not enter into any new contracts, or renew or extend contracts for non-approved beverages. Statewide, soft drink sales are prohibited in elementary schools and may be sold only after the end of the last

USDA Requirements for School Meal Programs
Schools that participate in the USDA school meal programs (i.e., school lunch, school breakfast and after-school snack programs):

- Must meet the Dietary Guidelines for Americans, which recommend that no more than 30 percent of an individual's calories come from fat, and less than 10 percent from saturated fat.
- Must provide one-third of the Recommended Dietary Allowances (RDA) of protein, Vitamin A, Vitamin C, iron, calcium and calories through school lunches and one fourth of the RDA requirements through school breakfasts.
- Must not sell "foods of minimal nutritional value (FMNV)" as defined by federal regulations, in food service areas during the school meal periods.
- Can sell FMNV outside of the food service area at any time during the school day. All other foods including foods and beverages from vending machines, school stores and snack bars can be sold anywhere on the school campus.

Source: U.S. Department of Agriculture, Food and Nutrition Service, National School Lunch Program and National School Breakfast Program at

lunch period in middle schools. The state requirement will go into effect in 2004, pending allocation of funds for increased meal reimbursement in the budget act of 2003.[31]

In **Minnesota**, *North Community High School* (Minneapolis) worked with its beverage vending company to provide healthier drink choices in the school's vending machines. As a result, soda machines available to students were reduced to one; several 100 percent fruit and vegetable juice, and water vending machines were added throughout the school; and students are now allowed to bring water to class.

West Virginia prohibits the sale or serving of candy, soft drinks, chewing gum or flavored ice bars during the school day. County school boards may permit the sale of soft drinks in high schools except during breakfast and lunch periods. In addition, all county school superintendents are required to designate a school nutrition program director. The director must meet specific nutrition education and training qualifications.

Foster School and Community Partnerships That Promote Regular Physical Activity

States are developing unique partnerships between schools, communities, park and recreation programs, and biking programs to promote regular physical activity for youth, school faculty, and community members. As a result, schools and communities are creating safe walking and bike paths, encouraging walking and biking to school, and promoting the use of school and community facilities for exercise during extended hours. In communities where safe physical activity is a concern because of violence, ill-equipped walkways, or a lack of parks, these efforts are critical to providing important options for physical fitness. After-school care programs, and community sports and recreation programs also play a critical role in providing youth access to sports, physical activity, and active play.

In **Minnesota**, the state education agency and health department in partnership with Be Active Minnesota, a non-profit organization, partnered to fund "walk-to-school" grants. Funds were provided directly to local schools for creating activities that promoted walking to school.

In **Texas**, the Public Health Promotion Program within the State Department of Health worked with schools and communities in selected regions of the state to establish walking trails to promote accessible physical activity in community parks and schools, and on school grounds. In addition, the Program fostered collaboration between local schools, agencies, community and worksite wellness staff, and others to encourage the use of school buildings and community facilities for physical activity.

Engage Students, School Faculty, Families, and Communities in Promoting Healthy Eating and Regular Physical Activity

Youth are an important voice and partner in making nutrition and physical activity changes in schools. Engaging youth in promoting and advocating for health and fitness not only contributes to improved policies in schools but also provides youth with an important learning tool. School faculty and parents provide

important reinforcement and can also benefit from a school's physical activity and nutrition program improvements.

In **California**, Project LEAN, a partnership between the California Department of Health Services and Public Health Institute, works with state and local physical activity and nutrition leaders across the state to promote healthy eating habits and regular physical activity. Food on the Run, one of Project LEAN's key programs, engaged low-income high school students in studying their school's school nutrition and physical activity policies and developing strategies to advocate for healthier alternatives. As a result, high school students created walking clubs and bike trails, and improved the nutritional value of foods served in their high school cafeterias.

In **Maine**, the Department of Education's state-sponsored School Site Health Promotion Wellness Conference is held for school wellness teams. In its 17th year, the conference prepares teams to promote activities that focus on providing support for teachers and other school staff to be healthy. Activities include health fairs, health screenings, Move and Improve, and stress management workshops. These efforts have resulted in numerous positive outcomes. For instance, some schools have their entire staff wearing pedometers to track their daily walking, aiming for 10,000 steps a day.

Create Public Awareness and Education Campaigns

Public awareness and education campaigns are a critical component of a multi-pronged statewide effort. For youth who are highly-influenced by media, these campaigns can become an important counterweight to junk food advertising and serve as an important motivator for physical activity and healthy eating. In addition to using strategies to reach youth, states are using innovative approaches to educate other key stakeholders such as school board members.

The VERB Campaign, launched by the U.S. Department of Health and Human Services to encourage physical activity and healthy behaviors for kids, is a driving force behind many states' more recent youth campaign efforts targeted at increasing physical activity. The multicultural media campaign is designed to promote healthier lifestyles in youth by reaching them through television, radio spots and the Internet. VERB focuses on physical activity, pro-social activity and an effort to reduce "screen time."

California Project Lean, with support from the California Department of Health Services, has partnered with the California School Boards Association to help prepare local school board members to better address school nutrition policy. The effort includes a set of tools that school boards can use to examine their school's nutrition policy, a series of school nutrition advertisements that can be placed in local school board magazines, and nutrition policy case studies from around the state.

In **Maine**, the Governor's Council on Physical Fitness and Sports promotes All Children Exercise Simultaneously (ACES), a one-day physical activity promotion program held the first Wednesday in May. ACES works with schools to promote public awareness and education about the importance of regular physical activity. Nearly 17,000 Maine school children participated in May 2002.

In **Minnesota**, efforts are underway to plan VERB events throughout the state in conjunction with the state's park and recreation association. Activities will infuse the VERB message through walking campaigns, basketball clinics, cross-country skiing, and other events that highlight the importance of regular physical activity. The Mall of America is also interested in partnering with the state to conduct VERB activities using its facilities and regular access to youth.

Conclusion

Today's youth live in a society where they are bombarded with advertisements for junk food, rewarded with food, and entertained by watching television. It is no surprise that the numbers of overweight and obese children and adolescents has reached epidemic proportions. Schools are a critical part of the solution because of their regular access to children and adolescents. Many states concerned with the obesity epidemic are

responding through innovative school-based policies and programs. However, schools are not the only partners needed in this effort. Health care providers, community based organizations, businesses and policymakers can also play a core role in helping to prevent and reduce the prevalence of overweight and obese children.

Selected Sources for Further Information and Guidance

Numerous federal agencies and organizations provide resources, technical assistance, and comprehensive guidelines to states for addressing overweight and obesity in youth through school-based strategies.

1. The American Alliance for Health, Physical Education, Recreation and Dance provides a summary of state physical education and activity policies in the report, "2001 Shape of the Nation Report: Status of Physical Education in the USA" at http://aahperd.org
2. The American Dietetic Association can be found at http://www.eatright.org
3. The American Obesity Association can be found at http://www.obesity.org
4. "Bright Futures in Practice: Physical Activity" and "Bright Futures in Practice: Nutrition", supported by the Health Resources and Services Administration, Maternal and Child Health Bureau, provide guidelines to health professionals for promoting physical activity and nutrition in infants, children and adolescents at http://www.mchb.hrsa.gov/
5. California Project LEAN can be found at http://www.caprojectlean.org
6. The Centers for Disease Control and Prevention, Division of Adolescent and School Health includes resources such as the School Health Index; comprehensive guidelines in areas including healthy eating and physical activity; and data from the School Health Policies and Programs, and the Youth Risk Behavior Surveillance studies at http://www.cdc.gov/nccdphp/dash/
7. The Centers for Disease Control and Prevention, Nutrition and Physical Activity Program includes resources on promoting physical activity, healthy eating, and addressing overweight and obesity at http://www.cdc.gov/nccdphp/dnpa/
8. The National Association of State Boards of Education has resources for state school boards including "Fit, Healthy and Ready to Learn: A School Health Policy Guideline. Part 1. Physical Activity, Healthy Eating and Tobacco Use Prevention" at http://www.nasbe.org/HealthySchools/fithealthy.mgi
9. The Office of the Surgeon General provides access to key reports including: "Physical Activity and Health" and "The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity, 2001" at http://www.surgeongeneral.gov/sgoffice.htm
10. The U.S. Department of Agriculture provides comprehensive information about the child nutrition program at http://www.fns.usda.gov/cnd/Default.htm and school resources including the school kit "Changing the Scene: Improving the School Nutrition Environment" at http://www.fns.usda.gov/tn/
11. The U.S. Department of Health and Human Services' VERB Campaign can be found at http://www.verbnow.com

Endnotes:

This brief was written by Karen VanLandeghem, consultant to NGA, and prepared under a cooperative agreement with the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau.

[1] National Center for Health Statistics, Centers for Disease Control and Prevention. *Prevalence of Overweight Among Children and Adolescents: United States, 1999*. Available at: http://www.cdc.gov/nchs/products/pubs/pubd/hestats/overwght99.htm

Products, Tools, and Research Briefs Linked to Local Strategies to Address Childhood Obesity

Introduction

In 2008, the Institute of Medicine (IOM) Standing Committee on Childhood Obesity identified local government actions as key to front-line efforts addressing childhood obesity prevention. A direct result of that recommendation was the formation and subsequent development of the IOM *Local Government Actions to Prevent Childhood Obesity* report issued in September 2009. In addition to the IOM report, two other resources have been published to help localities in their efforts to promote healthy eating and physical activity environments. While the three reports were issued by different organizations, there is much consistency and agreement on the steps local communities can take as they seek to start – or continue – their efforts to address childhood obesity.

- The IOM report Local Government Actions to Prevent Childhood Obesity[1] identified 58 action steps, with 12 slated as *most promising.* The IOM report was specifically focused on strategies likely to directly affect children and that take place *outside* of the school day.
- The Centers for Disease Control and Prevention (CDC) report Recommended Community Strategies and Measurements to Prevent Obesity[2] identified 24 recommendations and suggested measurements. The CDC report recommendations apply to both children and adults, and include those that can take place during school hours.
- The Leadership for Healthy Communities (LHC) Action Strategies Toolkit[3] identified 10 action strategies with 31 policy options and resources to create healthy communities and prevent childhood obesity. The LHC report includes school-based strategies.

Building upon the work of the IOM, CDC, and LHC, the Robert Wood Johnson Foundation Center to Prevent Childhood Obesity has identified 14 action steps (using the 12 priority action steps identified by the IOM, and two additional school-based ones) to focus on setting policy and technical assistance priorities. The center has also folded additional IOM action steps into the 12 main steps where appropriate. For example, creating incentives to enable small food store owners to carry healthy, affordable food can be a stepping stone for the highlighted action step of creating incentives to attract supermarkets and grocery stores to underserved neighborhoods.

These action steps will drive the center's efforts in working with federal, state, and local policy-makers, as well as the National Program Offices (NPOs), the rest of the Robert Wood Johnson Foundation network, and other organizations in collective efforts to drive policy changes that make the healthy choice the easy choice.

An important component to the action steps is the identification of the products, tools, research briefs, and other resources that can help drive policy change. The table below highlights the various resources currently online from NPOs and external organizations that complement the 14 action steps. The resources listed are intended to help policy-makers implement the targeted action steps and drive policy change. Resources and materials such as press releases, research papers, and testimony are not included in this list because while they may serve as good background information, they are not actual products that can help advance a movement.

In addition to the specific products listed below, a number of other documents and reports provide excellent background and case studies critical in helping drive the policy agenda. These key documents include:

- Leadership for Healthy Communities (LHC[1]) *Action Strategies Toolkit*: In addition to the policy options and resources described above, this toolkit provides case studies of local entities that have successfully promoted health and wellness policies.
- Robert Wood Johnson Foundation (RWJF) and Trust for America's Health *F as in Fat*: This annual report provides an extensive overview of federal and state-by-state obesity trends, policies, and statistics, as well as recommended action steps at all levels.
- Institute of Medicine (IOM) Food and Nutrition Board reports: Two reports, *Preventing Childhood Obesity: Health in the Balance* and *Progress in Preventing Childhood Obesity: How do we Measure Up?*, provide the evidence base, recommended actions, and assessment of obesity-prevention efforts in the U.S.
- Centers for Disease Control and Prevention (CDC) *Guide to Community Preventive Services*: This guide for policy-makers features programs and policy interventions that have proved effective in a variety of areas, including nutrition, obesity, and physical activity.
- The National Governor's Association (NGA) *Shaping a Healthier Generation: Successful State Strategies to Prevent Childhood Obesity*: The report offers direction to governors and other policy-makers attempting to craft children's health policies that prevent obesity and advance the well-being of all families.
- Convergence Partnership *Promising Strategies for Creating Healthy Eating and Active Living Environments*: This report offers a comprehensive and cross-cutting review of policy, strategy, and program recommendations to promote healthy eating and active living.
- The United States Conference of Mayors (USCM) *Mayors' Guide to Fighting Childhood Obesity*: This guide provides information on sample policies and selected funded opportunities to help mayors implement childhood obesity prevention efforts.
- National Conference of State Legislatures (NCSL) *Promoting Healthy Communities and Reducing Childhood Obesity: Legislative Options*: This document summarizes state legislation proposed and passed during 2007 and 2008 in the broad categories of healthy eating and physical activity and healthy community design and access to healthy food, divided into 17 topic areas.
- National League of Cities (NLC) *Combating Childhood Obesity Action Kit for Municipal Leaders*: This toolkit provides mayors and city council members with policy options for addressing childhood obesity at the city level and includes relevant facts and successful examples.
- YMCA of the USA *Community Healthy Living Index*: This index is a set of five community assessment tools that measure opportunities for physical activity and healthy eating in areas that impact an individual's daily life. These tools also facilitate discussion about how to improve the community environment to increase opportunities for healthy living.
- YMCA of the USA *Healthy Family Home*: This website is designed to help any family in any community make healthier decisions and lead healthier lives at home.

The action steps are organized into three categories: Healthy Eating, Physical Activity, and Social Marketing.

[1] A list of acronyms is provided at the end of the document

Key Local Strategies to Address Childhood Obesity

HEALTHY EATING	
IOM Action Steps	**Products, Tools, and Research Briefs**
Create incentive programs to attract supermarkets and grocery stores to underserved neighborhoods. *[Other recommendations that can serve as stepping stones for communities while working towards this larger goal include incentive programs to help purchase refrigeration equipment, highlight best practices, or reduce point-of-sale marketing of junk food, and encouraging farmers markets, community gardens, community kitchens, and farm-to-school programs.]*	Food Trust. Building Healthy Communities: Expanding Access to Fresh Food Retail. Food Trust. The Need for More Supermarkets in Chicago. Food Trust. The Need for More Supermarkets in New York. Food Trust. Building Healthy Communities: Expanding Access to Fresh Food Retail in New Orleans. HER. Bringing Healthy Foods Home: Examining Inequalities in Access to Food Stores. RWJF. Associations Between Access to Food Stores and Adolescent Body Mass Index. Prevention Institute/RWJF. The Links Between the Neighborhood Food Environment and Childhood Nutrition. PHLP. Getting to Grocery: Tools for Attracting Healthy Food Retail to Underserved Neighborhoods. PHLP. Establishing Land Use Protections for Farmers' Markets. NPLAN. Establishing Land Use Protections for Community Gardens. PHLP. Funding Sources for Healthy Food Retail. NPLAN. Healthy Mobile Vending Policies: A Win-Win for Vendors and Childhood Obesity Prevention Advocates. PHLP. Changes in the WIC Food Packages: A Toolkit for Partnering with Neighborhood Stores. PHLP. How to Use Economic Development Resources to Improve Access to Healthy Food. Rudd Center for Food Policy and Obesity. Policy Brief on Access to Healthy Foods in Low Income Neighborhoods. ICMA. Community Health and Food Access: The Local Government Role. PolicyLink. Healthy Food Retailing. PolicyLink. Designed for Disease: The Link Between Local Food Environments and Obesity and Diabetes.
Require menu labeling in chain restaurants to provide consumers with calorie information on in-store menus and menu boards. *[The creation of incentive programs to promote healthier options may be a stepping stone for communities looking to achieve the larger goal of menu labeling.]*	HER. Menu Labeling: Does Point of Purchase Nutrition Information Affect Consumer Behavior? HER. Restaurant Realities: Inequalities in Access to Healthy Restaurant Choices. NPLAN. Model Menu Labeling Ordinance. NPLAN. Menu Labeling Laws: A Comparative Analysis. NPLAN. Model Menu Labeling Ordinance: Background and Legal Issues. Prevention Institute/RWJF. The Links Between the Neighborhood Food Environment and Childhood Nutrition. CSPI. Comparison of Menu Labeling Policies. CSPI. Map of State and Local Menu Labeling Policies. Rudd Center for Food and Policy. Menu Labeling in Chain Restaurants: Opportunities for Public Policy. JAMA. Ludwig and Brownell. Public Health Action Amid Scientific Uncertainty.
Mandate and implement strong nutrition standards for foods and beverages available in government-run or regulated after-school programs, recreation centers, parks, and childcare facilities, including limiting access to unhealthy foods and beverages.	AFHG. Before and After School Programs Toolkit. AFHG. Healthy Schools Product Calculator. AFHG. Product Navigator. AFHG. Guidelines for Competitive Foods Sold in Schools to Students. AFHG. Competitive Beverage Guidelines. HKHC. Lessons from the Field: Promoting Healthy Eating in Communities. HER. Promoting Good Nutrition and Physical Activity in Child Care. RWJF. Local Wellness Policies: How Are Schools Implementing the Congressional Mandate? LHC. Supporting Healthy Communities Through the American Recovery and Reinvestment Act of 2009. NGA Center for Best Practices. Shaping a Healthier Generation: Successful State Strategies to Prevent Childhood Obesity. HHS. Promoting Physical Activity and Healthy Nutrition in Afterschool Settings; Strategies for Program Leaders and Policy Makers.

HEALTHY EATING	
IOM Action Steps	**Products, Tools, and Research Briefs**
	FRAC. Child Care Wellness Tool Kit: Child and Adult Care Food Program. UNC Nutrition and Physical Activity. Self-Assessment for Child Care (NAPP SAC). *See other resources under school based nutrition*
Adopt building codes to require access to, and maintenance of, fresh drinking water fountains (e.g., public restrooms).	
Implement a tax strategy to discourage consumption of foods and beverages that have minimal nutritional value, such as sugar-sweetened beverages.	BTG/HER. Sugar- sweetened Beverage Taxes and Public Health. Rudd Center for Food Policy and Obesity. Policy brief on Soft Drink Taxes. Rudd Center for Food Policy and Obesity. Revenue Calculator for Soft Drink Taxes. ImpactTeen. State Snack and Soda Sales Tax Data. NEJM. Commentary by Kelly Brownell, Joe Thompson, Frank Chaloupka, et al. The Public Health and Economic Benefits of Taxing Sugar-Sweetened Beverages. California Center for Public Health Advocacy. Bubbling Over: Soda Consumption and Its Link to Obesity in California.
*Improve the nutritional quality of foods and beverages served and sold in schools and as part of school-related activities.[4]	AFHG. Healthy Schools Product Calculator. AFHG. Product Navigator. AFHG. Policy and Systems Toolkit. AFHG. Competitive Foods Toolkit. AFHG. Guidelines for Competitive Foods Sold in Schools to Students. AFHG. Competitive Beverage Guidelines. AFHG. The Healthy Schools Program Framework. BTG. Local Wellness Policies: Assessing School District Strategies for Improving Children's Health. BTG. Executive Summary- Local Wellness Policies: Assessing School District Strategies for Improving Children's Health. BTG. Local Wellness Policy Coding Tool. RWJF. Local School Wellness Policies: How Are Schools Implementing the Congressional Mandate. CSPI. Model Local Wellness Policies on Nutrition and Physical Activity. CSPI. Sweet Deals: School Fundraising Can be Healthy and Profitable. CSPI. Raw Deal: School Beverage Contracts Less Lucrative Than They Seem. NPLAN. Developing a Healthy Beverage Vending Agreement. NPLAN. District Policy Establishing a Healthy Vending Program. NPLAN. How to Enforce a Wellness Policy: A Guide for Parents and Community Advocates. HKHC/HEbD. Lessons from the Field: Promoting Healthy Eating in Schools. HER. Impact of Federal Commodity Programs on School Meal Nutrition. HER. School Foods Sold Outside of Meals (Competitive Foods). Rudd Center for Food Policy and Obesity. School Food: Opportunities for Improvement. Rudd Center for Food Policy and Obesity. School Wellness Policies. RWJF. Improving Child Nutrition Policy: Insights from National USDA Study of School Food Environment. RWJF Center. Child Nutrition Programs: Federal Options and Opportunities. University of Arkansas for Medical Sciences. Evaluation: Arkansas Act 1220 of 2003 to Combat Childhood Obesity. Public Health Advocacy Institute. Mapping School Food: A Policy Guide. California School Boards Association. School Wellness Policy Development, Implementation and Evaluation. LHC. Supporting Healthy Communities Through the American Recovery and Reinvestment Act of 2009. Local Government Commission and the Cities, Counties, and School Partnership. Healthy Kids, Healthy Communities: School and Local Government Collaborations.

HEALTHY EATING	
IOM Action Steps	**Products, Tools, and Research Briefs**
	BMSG. Debates from Four States Over Selling Soda in Schools. BMSG. Obesity Crisis or Soda Scapegoat? The Debate over Selling Soda in Schools.

*Note, the IOM focus was on actions that can be taken outside of the school and school setting; thus this recommendation is not included in *Local Government Actions to Prevent Childhood Obesity* (see reference 4). CDC and LHC address actions both outside of and within the school setting.

PHYSICAL ACTIVITY	
IOM Action Steps	**Products, Tools, and Research Briefs**
Plan, build, and maintain a network of sidewalks and street crossings that connect schools, parks, and other destinations.	ALR: Making the Link between Transportation, Physical Activity, and Obesity. ALR. Walking and Biking to School, Physical Activity, and Health Outcomes. ALR. Designing for Active Living Among Children. Convergence Partnership. Promising Strategies for Creating Healthy Eating and Active Living Environments. NACo. Planning and Land Use Solutions to Create Active, Healthy Counties. NCSL. Complete Streets. RWJF Center Report. Federal Agencies - Programs and Physical Activity Initiatives and Opportunities. ALR. Models for Changes: Lessons for Creating Active Living Communities. LHC. Supporting Healthy Communities Through the American Recovery and Reinvestment Act of 2009. ALRC. Neighborhood Safety. ALRC. How Garfield, NJ Got its Kids Moving More and Eating Better. PHLP. Complete Streets Talking Points. PolicyLink/ Prevention Institute/ Convergence Partnership. The Transportation Prescription: Bold New Ideas for Transportation Reform in America. Complete Streets. Fact Sheet. SRTSNP. Making roads safe for all users. SRTSNP. Strategic Highway Safety Plan: Potential funding for Safe Routes to School.
Adopt community policing strategies that improve safety and security of streets and park use, especially in higher-crime neighborhoods.	ALR. Making the Link between Transportation, Physical Activity, and Obesity. ALR. Designing for Active Living Among Children. NCSL. Complete Streets. LHC. Supporting Healthy Communities Through the American Recovery and Reinvestment Act of 2009. PI. Several resources on violence prevention. SRTSNP. Fine-based Resources for Safe Routes to School. Local Models and State Recommendations.
Collaborate with schools to develop and implement a Safe Routes to Schools program to increase the number of children safely walking and bicycling to school.	ALR. Walking and Biking to School, Physical Activity, and Health Outcomes. ALR. Designing for Active Living Among Children. RWJF Center Report. Federal Agencies - Programs and Physical Activity Initiatives and Opportunities. ALRC. A Safe Routes to School Campaign Action Plan. SRTSNP. State Level Policies that Influence Safe Routes to Schools. SRTSNP. Safe Routes to School State Network Project: 2008 Annual Progress Final Report, 2007-2009. SRTSNP. Safe Routes to School 2009 Policy Report. Moving to the Future: Building on Early Achievements. SRTSNP. State Policies: Best Practices. SRTSNP. Safe Routes to School Improves the Built Environment. SRTSNP. Simple Steps to Get Started: SRTS Resources and information. SRTSNP. Safe Routes to School 2009 Policy Report – Moving to the Future: Building on Early Achievements. SRTSNP. Safe Routes to School: Leads to Greater Collaboration with Public Health and School Officials.

PHYSICAL ACTIVITY	
IOM Action Steps	**Products, Tools, and Research Briefs**
	SRTSNP. Safe Routes to School: Increases Physical Activity and Improves Health. SRTSNP. Safe Routes to School: A Catalyst for Building Partnerships and Leveraging Resources. SRTSNP. Walking and Bicycling to School and the Heavy Backpack. SRTSNP. School Bicycling and Walking Policies: Addressing Policies that Hinder and Implementing Policies that Help. PHP. Safe Routes to School Talking Points. PolicyLink/Prevention Institute/Convergence Partnership. The Transportation Prescription: Bold New Ideas for Transportation Reform in America.
Build and maintain parks and playgrounds that are safe and attractive for playing, and in close proximity to residential areas.	LHC. Supporting Healthy Communities Through the American Recovery and Reinvestment Act of 2009.
Collaborate with school districts and other organizations to establish agreements that would allow playing fields, playgrounds, and recreation centers to be used by community residents when schools are closed (joint-use agreements).	NPLAN. Joint Use Agreement 1: Opening Outdoor School Facilities for Use During Non-School Hours. NPLAN. Joint Use Agreement 2: Opening Indoor and Outdoor School Facilities for Use During Non-School Hours. NPLAN. Joint Use Agreement 3: Opening School Facilities for Use During Non-School Hours & Authorizing Third Parties to Operate Programs. NPLAN. Joint Use Agreement 4: Joint Use of District and City Recreation Facilities. NPLAN. Checklist for Developing a Joint Use Agreement. NPLAN. Liability Risks for After-Hours Use of Public School Property: A 50-State Survey. NPLAN. What is a Joint Use Agreement? A Fact Sheet for Parents, Students, and Community Members. NPLAN. Fifty-State Scan of Laws Addressing Community Use of Schools. NPLAN. Liability Risks for After-Hours Use of Public School Property: A 50-State Survey. PI & BMSG. Joint Use. SRTSNP. Addressing Childhood Obesity through Shared School Facilities. SRTSNP. Location Affects The Potential to Walk or Bike.
Institute regulatory policies mandating minimum play space, physical equipment, and duration of play in preschool, afterschool, and childcare programs.	HER. Promoting Good Nutrition and Physical Activity in Child Care. NPLAN. Model Physical Activity Standards for Child-Care Providers (For Infant Through Preschool-Age Children). HHS. Promoting Physical Activity and Healthy Nutrition in Afterschool Settings; Strategies for Program Leaders and Policy Makers. UNC Nutrition and Physical Activity. Self-Assessment for Child Care (NAPPSAC). *See other resources under school based physical activity.*
*Increase opportunities for frequent, more intensive, and engaging physical activity during and after school.[4]	AFHG. Before and After School Programs Toolkit. AFHG. Physical Activity Toolkit. ALR. Active Education: Physical Education, Physical Activity, and Academic Performance. Alliance for a Healthier Generation. Physical Education Toolkit. BTG. Executive Summary- Local Wellness Policies: Assessing School District Strategies for Improving Children's Health. Rudd Center for Food Policy and Obesity. School Wellness Policies. RWJF. Local School Wellness Policies: How Are Schools Implementing the Congressional Mandate. University of Arkansas for Medical Sciences. Evaluation: Arkansas Act 1220 of 2003 to Combat Childhood Obesity. California School Boards Association. School Wellness Policy Development, Implementation and Evaluation. RWJF. Sports Participation and Physical Education in American Secondary Schools: A Research Highlight. CSPI. Model Local Wellness Policies on Nutrition and Physical Activity. Team-Up For Youth. Learning to Play and Playing to Learn.

PHYSICAL ACTIVITY	
IOM Action Steps	**Products, Tools, and Research Briefs**
	SRTSNP. Youth Bicycle and Pedestrian Safety Education Curriculum: Local Models and State Recommendations. SRTSNP. School Wellness Policies: Local Models and State Recommendations. SRTSNP. Addressing School Bus Costs through Walking and Bicycling: State Policies and Local Models. SRTSNP. Powerpoint on School Bus Cuts and Safe Routes to School.

*Note, the IOM focus was on actions that can be taken outside of the school and school setting; thus this recommendation is not included in *Local Government Actions to Prevent Childhood Obesity* (see reference 4). CDC and LHC address actions both outside of and within the school setting.

SOCIAL MARKETING	
IOM Action Steps	**Products, Tools, and Research Briefs**
Develop media campaigns, utilizing multiple channels (print, radio, internet, television, social networking, and other promotional materials) to promote healthy eating (and active living) using consistent messages. *[This recommendation encompasses federal policy efforts – both legislative and regulatory – that address marketing to kids and industry self-regulation initiatives.]*	NPLAN. Creating a Healthy Food Zone Around Schools. NPLAN. Model Healthy Food Zone Ordinance. NPLAN. Restricting Food and Beverage Advertising in Schools. NPLAN. First Amendment Implications of Restricting Food and Beverage Marketing in Schools. NPLAN. District Policy Restricting Food and Beverage Advertising on School Grounds. NPLAN. District Policy Restricting the Advertising of Food and Beverages Not Permitted to be Sold on School Grounds. Rudd Center for Food Policy and Obesity. Cereal FACTS (Food Advertising to Children and Teens Score) Report. Rudd Center for Food Policy and Obesity. Cereal FACTS (Food Advertising to Children and Teens Score) Web Site. RWJF Center. Food Marketing to Children Toolkit. CSPI. Food Marketing to Children: State and Local Policy Options. CSP. Guidelines for Responsible Food Marketing to Children. CSPI. Model City Resolution on Food Marketing Aimed at Children. VERB. Youth Media Campaign. BMSG. Fighting Junk Food Marketing to Kids: A Toolkit for Advocates.

Acronyms/Abbreviations

(note: National Program Offices are italicized):

ALHG: Alliance for a Healthier Generation
ALR: Active Living Research
ALRC: Active Living Resource Center
BMSG: Berkeley Media Studies Group
BTG: Bridging the Gap
CSPI: Center for Science in the Public Interest
FRAC: Food Research and Action Center
HKHC: Healthy Kids, Healthy Communities
HER: Healthy Eating Research
HHS: Department of Health and Human Services
ICMA: International City/County Management Association
LHC: Leadership for Healthy Communities
LGC: Local Government Commission
NACo: National Association of Counties
NAP SACC: Nutrition and Physical Activity Self Assessment for Child Care
NCSL: National Conference of State Legislatures
NGA: National Governor's Association
NLC: National League of Cities Institute for Youth, Education and Families
NEJM: New England Journal of Medicine
NPLAN: National Policy & Legal Analysis Network to Prevent Childhood Obesity
NPO: National Program Office of the Robert Wood Johnson Foundation effort to prevent childhood obesity
PHLP: Public Health Law and Policy
PI: Prevention Institute
RWJF: Robert Wood Jonson Foundation
SRTSNP: Safe Routes to Schools National Partnership
USCM: United States Conference of Mayors
VERB: A Center for Disease Control and Prevention Youth Media Campaign

References

[1]Institute of Medicine. *Local Government Actions to Prevent Childhood Obesity.* Editors; Committee on Childhood Obesity Prevention Actions for Local Governments; Institute of Medicine; National Research Council. September 2009. Available at: http://www.iom.edu/CMS/3788/59845/72798.aspx.

[2]Centers for Disease Control and Prevention. Recommended Community Strategies and Measurements to Prevent Obesity in the United States. July 2009. *MMWR* 2009;58 (No. RR-7):1-30. Available at: www.cdc.gov/mmwr/PDF/rr/rr5807.pdf.

[3]Leadership for Healthy Communities. *Action Strategies Toolkit: A Guide for Local and State Leaders Working to Create Healthy Communities and Prevent Childhood Obesity*. May 2009. Available at: www.leadershipforhealthycommunities.org/actionstrategies.

[4]Institute of Medicine. *Preventing Childhood Obesity: Health in the Balance*. [Report Brief]. September 2004. Available at: http://www.iom.edu/~/media/Files/Report%20Files/2004/Preventing-Childhood-Obesity-Health-in-the-Balance/ChildhoodObesity4pagerfixforwebpdf.ashx.

Appendix I: State and Federal Advocacy Glossary[109]

As you begin to get involved in state and federal advocacy, it is often useful to have a common understanding of the various terms and definitions that are used.

AMENDMENT: Any change—including adding, substituting, or omitting certain language—made or proposed to be made in a bill, motion, or clause. An amendment is often debated and voted on in the same manner as a bill.

APPROPRIATION: A directive given by a legislature to obligate or spend funds for a specific purpose. Appropriations do not always match the recommendation made by the authorization section of the bill. AUTHOR: A title used to identify a legislator who has introduced a bill into a legislature. Also referred to as sponsor or patron.

AUTHORIZATION: Legislation creating the program or activity and setting a reasonable estimate of its cost. Authorizations serve as a guide for appropriations committees and limit the amount of money that can be allocated for the provisions established by a bill.

BILL: A proposal introduced into a legislature for the enactment of a new law, amendment or repeal of an existing law, or appropriation of public funds. Bills move by agreement of a majority of the membership through the various legislative stages of committee consideration, chamber debate and vote, and approval or disapproval by a chief executive.

BUDGET: An official document that includes detailed information about the authorized expenditures of a state or the federal government.

BUDGET BILL: A suggested allocation of public funds presented annually to legislatures and the Congress by governors and the president, respectively. Many states have agencies that assist governors in preparing budgets.

CAUCUS: A meeting of a group of members, in this case legislators, usually from the same political party or sharing a similar background or interest, assembled to discuss strategy on selected topics.

COMMITTEE: A division of the legislature or Congress entrusted to complete assigned tasks, such as formally reviewing bills and investigating related issues, on behalf of the entire legislature. Committees generally hold hearings and recommend a course of action on a bill to their parent chambers. Most committees are permanently established by chamber rules, and membership and rank are usually determined by party affiliation and seniority. Committees are usually chaired by a member of the chamber's majority party.

COMPANION BILL: A bill introduced in one chamber of a legislature that is identical to another introduced in the other chamber.

CONCURRENCE: An action by one chamber of a legislature to indicate its agreement with an action or proposal that has been approved by the other chamber.

CONFERENCE COMMITTEE: A committee, comprising members from each chamber of a legislature or the Congress, appointed to reconcile differences between the bills passed by each chamber.

DISTRICT: One of the territorial areas into which an entire state, county, municipality, or other political subdivision is divided for judicial, political, electoral, or administrative purposes. Most districts are created by law and are based on population.

FIRST READING: A term used to describe the initial presentation of a bill before a legislature for consideration. Often the title of a bill may simply be read at this time. Some states allow the first reading to occur at the time of introduction.

FISCAL NOTE: A portion of a bill that estimates the cost or describes the economic impact of the program or activity being proposed.

FISCAL YEAR (FY): The 12-month period established for budgeting purposes. Most state fiscal years run from July 1 to June 30 of the following calendar year. The federal government's fiscal year runs from October 1 to September 30 of the following calendar year.

HEARING: A procedure conducted by the committees of a legislature during which testimony in support of, or in opposition to, a bill is presented. Hearing witnesses generally include experts on the issue, government officials, and members of the public that are likely to be affected by the legislation.

INITIATIVES AND REFERENDUMS: Also known as ballot measures, questions, and propositions, this political process allows the residents of nearly half of the states to vote directly on legislative proposals as opposed to such matters being considered by state legislatures. Initiatives generally require an individual or group to gather a required number of signatures of registered voters to qualify their measure for the ballot. Common forms of initiatives are statutory initiatives and constitutional amendments, which generally require more signatures than statutory initiatives to appear on a ballot. Although the terms are often used interchangeably, referendums have historically been used to overturn, by means of a popular vote, existing law passed by a legislature. Referendums have also been used to recall public officials. More recently, referendums have not been limited to this repeal and recall procedure, but have become similar to initiatives. In some jurisdictions, referendums are considered to be nonbinding. In addition to nearly half of the states, initiatives and referendums are popular in municipal government.

LEGISLATION: A generic term used to describe bills, proposals, resolutions and, at times, laws that are reviewed and acted on by legislatures.

LOBBYING: Attempting to educate legislators or other government officials about an issue or problem; persuading lawmakers to seek a legislative solution to an issue or problem; attempting to influence passage or defeat of a bill.

OMNIBUS BILL: A piece of legislation often created by the consolidation of several bills that address related issues. Other omnibus bills are collections of unrelated bills attached to another piece of legislation (eg, a budget bill) that is likely to be enacted, thus allowing other measures to become law as well.

PREFILING: The process, allowed in some states, whereby bills are introduced before the formal opening of a legislative session.

REDISTRICTING: The procedure by which state legislatures redraw legislative and representative district lines for both state legislatures and the US House of Representatives. Redistricting takes place every 10 years after the national census.

RESOLUTION: A formal expression of the opinion or will of a legislature or the Congress that is adopted by a vote of the legislative body.

SECOND READING: The formal presentation of a bill to the entire chamber of a legislature after it has been heard by a committee or a number of committees with oversight. Although there are exceptions, many state legislatures, like Congress, debate bills and consider amendments after the second reading.

TERM LIMITS: Restrictions on the amount of time legislators, governors, presidents, and other public officials may serve in office. Term limits may be consecutive or lifetime in nature. Consecutive limits allow legislators to serve defined terms in one chamber and, if they choose, run for a seat and serve in the other chamber for the legally allowed term limit in that chamber. After a designated period out of office, the legislator may run again for his or her original seat. Lifetime limits prohibit legislators from ever seeking reelection to their previously held offices once they have reached their legally defined term limit.

THIRD READING: The final presentation of a bill to the chamber of a legislature before a vote is called.

VETO: The refusal of a governor or the president to sign into law a bill that has been passed by a legislature or the Congress. In most states, governors may also "item veto" appropriations bills. This procedure allows governors to eliminate or reduce items within a bill without vetoing the entire bill.

VETO OVERRIDE: A vote by a legislature to pass a bill despite a governor's veto, or a vote by Congress to pass a bill despite a veto by the president. Most veto override votes in state legislatures, like Congress, require a two-thirds majority of the chamber to pass.

Appendix J: Visits with Decision Makers[110]

LEGISLATIVE VISIT SCENARIO #1: "Don't Call Us, We'll Call You"

The decision maker (and/or staff) listens carefully and asks few or no questions. When you ask about his/her position, you are told he/she will think about your comments. You are thanked politely for your time. This is a totally noncommittal meeting.

What do you do?
First, you should realize this is probably the single most common type of legislative meeting. Nor is it a bad one. You have established who you are, whom you represent, what the issue is, and what your position is. For some meetings, this is as much as you can expect or hope to accomplish.

But you can do more.

- First, respect the fact that the decision maker has not made a decision; don't try to press him/her for a commitment he/she is not ready to make.
- Do ask questions to find out what forces might influence the decision. For example, are there other active constituent groups in the district that could influence – either positively or negatively – the passage of the legislation.
- Build your case – cite the impact on the pediatric population in your community or district. Cite other supporting groups.
- Discern the level of grassroots pressure. For example, you might find out whether mail has been received and, if so, is it for or against your position. Also, try to discover if he/she has been contacted by other groups.
- Always ask whether you can provide additional information. **The single most persuasive document you can provide is a one-page fact sheet outlining how this bill will directly affect your state or district.** Other useful information could include a list of cosponsors, especially in the decision maker's party. (Your local AAP chapter may be able to provide you with this information).
- Always leave your name, address, and phone number (if you don't have a business card, write this on the fact sheet you leave) and the phone number for the local AAP chapter office.
- Talk about another issue – briefly. Don't waste time. This is a good time to discover his/her interests and other information which could provide the personal touch that adds to the relationship. You might be surprised to learn how much you have in common.

As with any important meeting, **follow-up is crucial.** This is particularly true for the undecided. Write a thank you letter, including any information requested at the meeting. For the undecided, it is also helpful to get others to write and/or phone the decision maker to urge him/her to support your position.

LEGISLATIVE VISIT SCENARIO #2: "I'm New" or "I Don't Know Anything about Children's Health."

Although this might happen when you meet with your decision maker, it is more likely to happen with staff. Many staff – particularly those in the personal offices (with whom you will meet most often) – are young and may know little about children's health issues. In fact, unless your decision maker sits on a key health committee, don't expect the staff to know much about the issue. Decision makers, as well as their staff cannot be experts on all issues.

Alternately, there are also times when it's to your advantage to meet with staff. Some staff specialize in children's health and may have more time to spend on the issue. The congressperson also listens to their staff and looks to them for information. If you can begin to build a relationship with staff, then you can likely get them to gain the congressperson's attention.

But contrary to what you think, this is not bad news!

This is the best time to begin to develop your position as a valuable resource to decision makers and their staff – the expert on child health issues. Best of all, you are an expert from back home rather than an "insider." You are the constituent on whom they can rely for accurate information, even when it is very technical. You become an asset; you can make them look good; you can make his/her job easier.

- Start with the basics. State who you are, what type of pediatrics you practice, where your office or hospital is. Tell them who and what the Academy is.
- Give simple information on the issue or issues. Material pertinent to your state or district is particularly valuable.
- Don't use medical jargon. Assess level of comprehension. Don't talk down.
- Let them ask questions. In fact, encourage them do so. And treat all questions seriously.
- In addition to the follow-up outlined previously, do what you can to develop the relationship. Letters, phone calls, and visits are all tools to use.
- Remember, new staff becomes experienced staff. Personal staff can and do move to committee assignments. If you encourage an interest in health, he/she could become a good friend in future years.

LEGISLATIVE VISIT SCENARIO #3: "I Agree" or "Preaching to the Choir"

After you introduce the issue, you are told that the decision maker agrees with your position.

Great! Now what?

Instead of ending the conversation right then and there, you can use this opportunity to establish your position and to gather information.

- First, don't waste time, but do ensure that there is a commitment at this time.
- Ask if the decision maker is a cosponsor (if there is a bill) or would he/she be willing to sponsor, cosponsor, or introduce the bill (if there isn't one already).
- Ask if more information would be helpful, particularly relative to how this issue affects your community, state, district, or how many children would be affected. If more information is needed, try to get a specific idea of what would be helpful without overloading them. (Your AAP chapter may be able to provide you with the additional information you're looking for.)
- Ask if they know other decision makers who should be approached.
- Ask what they are hearing in support and opposition to the issue.
- Ask about other organizations that support/oppose the decision maker's position.
- Ask if you or the Academy can help solidify support or identify the opposition.

Follow-up to this meeting may not be as difficult as with scenario two, but you will need to keep lines of communication open, so that you can be useful as the expert resource.

LEGISLATIVE VISIT #3A: "I Agree, But…."

This is a variation of the #3, but with a twist. You may hear many excuse at the end of "I agree, but…..", including, "there is no money, so how can we…?"

Don't let this throw you!

You may not have all the answers; the Academy may not have all the answers. But, find out what the objections are and how the decision maker can be satisfied. If you cannot supply the answers at the meeting, ensure them you will find out more information and get back to them soon.

LEGISLATIVE VISIT SCENARIO #4: "That is Not My Position" or "I Disagree" (Politely)

After opening the discussion and presenting your issue, the decision maker or staff tells you politely he/she disagrees with your position.

The conversation does not necessarily end here.

First, this happens rarely. Decision makers do not like to directly disagree with constituents. Try the following tactics:

- Find out why there is disagreement. Time can be wasted by trying to argue against misconceptions. If you find out that he/she has misconceptions, you can respond to them, presenting facts about the needs of the children in your community, state, or district, and how the legislation will affect them.
- Attempt to discern whether the problem is the issue of politics, for example, competing interests from a key constituency or pressure from the decision maker's colleagues or party leaders. Lack of understanding about the issue can be handled with facts. Politics are a different story. A clue that this is the case is that it does no appear that there is an understandable reason (from your perspective) why the decision maker takes a particular stand.
- Listen carefully. Don't dismiss criticisms and opposition automatically. There may be a solid basis for his/her opposition. You may need to gather more information and facts to present at a different time. You could win points just because you listened seriously to his/her comments. Time also gives you the opportunity to judge the depth of the opposition.
- Don't try to negotiate during the initial meetings. Time should be taken to carefully consider his/her position and yours and whether his/her concerns can be addressed.

After the meeting, analyze how what you learned can be used or diffused. Draw upon expertise of others in your chapter and the Academy staff.

An extra postscript is needed here: Don't debate issues involving ideology, morals, or religious issue (i.e. bioethics, AIDS). If it appears a position has been taken due to ideological or religious grounds, just file that knowledge away. There are other, better, venues for a debate.

Legislative Visit Scenario #5: "I Disagree with Everything You Say, And…"

The adversarial visit is the one you are really worried about, but it almost never happens – honestly!

Decision makers and their staff may disagree with you, but they will not attack you or your position. In fact, they do not like to disagree with you at all. Remember, you are a constituent.

But, just to round out this exercise, say you do walk into a visit and discover you are in hostile territory. The other person essentially takes charge of the meeting and disputes everything you have tried to say.

What do you do?

- Keep calm. If you are meeting with staff, try to determine whether this is a personal opinion or the position of the decision maker. If it is the opinion of the staff, a meeting with the decision maker might be the next step.
- End the meeting as soon as possible.
- You will need to be in contact with the decision maker again, but you may need reinforcements. Reinforcements may be information, other members of your chapter, the AAP, or finding the right contact that can talk to him/her.

Appendix K: Sample Letters to Legislation[111]

Month Day, Year

The Honorable _____

United States Senate/ U.S. House of Representatives

Washington, DC 20510 (Senate)/ 20515 (House) **[or district office address]**

Dear Senator/ Representative _____,

As a constituent and American Public Health Association advocate, I am writing to urge you to ensure any legislation to reform our nation's health system provides universal coverage for health care and includes strong public health provisions, including population-based and community-based prevention, education and outreach programs. We believe that we must change the emphasis of our health system from one that focuses on treating people after they get sick to one that helps people stay healthy in the first place.

APHA recently released its 2009 Agenda for Health Reform (available at: http://www.apha.org/advocacy/now/resources/). This document highlights the most critical changes we must make to improve the public's health, based on longstanding APHA policies, as well as the best current evidence. Specifically, APHA is recommending that health reform legislation include the following provisions:

- Invest in population-based and community-based prevention, education and outreach programs,
- Maintain support for existing public programs such as Medicare, Medicaid, SCHIP, Veterans Health Administration,
- Assure consumer choice of a strong public plan option for insurance coverage (such as Medicare for all),
- Address the chronic underfunding of the nation's public health system,
- Account for the real cost savings and cost avoidance of preventive and early intervention services at the individual and • community levels through more accurate fiscal scoring methods,
- Develop, expand and monitor programs to reduce disparities in health,
- Require methods to assess the impact federal policies and programs have on public health,
- Establish health goals and outcomes and require an annual "State of the Nation's Health" report to hold ourselves accountable,
- Ensure access to comprehensive, affordable and high-quality health care for all
- Eliminate copayments and other fees for evidence-based clinical preventive services, and
- Expand the public health and primary care workforce.

We urge you to work to ensure that these key provisions are considered as Congress moves forward with efforts to reform our nation's health system. Thank you for your attention to my request and I look forward to hearing your position on this critical issue.

Sincerely,
[Name]
[Home address]
[Telephone number]
[Email address]

Sample Letter of Legislative Introduction

The Honorable (Name of Legislator)
Member of the Senate
State Capitol, Room (room number)
City, State, Zip Code

Dear (title of legislator):
I am a physician in your district with (name of your public practice/hospital if you want to include this), who has practiced in our community for more than [number] years.

Overweight and obesity is a growing national epidemic that affects more than 57 percent of all Californians. As an elected leader, you will be faced with many health-related legislative issues associated with obesity and overall wellness. As a (practice area) specialist, I would like to offer to be a resource to you on health and wellness issues related to this critical health problem. I am also a member of (professional society name), the leading professional association in (the state or nation), dedicated to (mission of the group).

I would welcome the opportunity to talk with you from time to time about issues relating to obesity and will contact your office with information. In addition, please feel free to contact me directly at any time when I might be of help to you in understanding issues surrounding obesity in California.

I hope that you will continue to make the health and wellness of Californians a priority. Thank you for your service to the citizens of our community.

Sincerely,

(Your Name, MD)
(Your contact information)

Sample Issue Letter to Your Legislator and/or Local Elected Official

The Honorable (Name of Legislator)
Member of the Senate
State Capitol, Room (room number)
City, State, Zip Code

Dear (title of legislator):

California families and children are faced with a growing epidemic that has spread across our country and has transcended all boundaries, ages, socioeconomic backgrounds and racial and ethnic groups – obesity.

As a physician, I see the devastating reality of obesity in my practice every day. Heart disease, diabetes and high blood pressure are just a few of the diseases that debilitate overweight and obese Americans, young and old.

Obesity plagues more than 57 percent of adult Californians and is a growing problem among children as well. The number of overweight children in California has now reached 28 percent. In addition, obesity and physical inactivity in adults placed an economic burden on the citizens of California in excess of $21.7 billion in 2000.

To successfully fight obesity, collaboration is critical. Children and families need access to resources and healthy options where they live, work and play. Communities need to work together to make sure there is access to affordable fruits and vegetables and safe opportunities for indoor and outdoor physical activity for our families.

As one of your constituents, I rank the fight against obesity as one of my top priorities. I urge you to do everything within your power to make important resources available to communities. Together, we can work to make a difference in the health of our friends and loved ones. I have enclosed some educational materials for you and would be happy to speak with you or a member of your staff concerning this issue. (Insert information on specific legislation if there is some and you want to refer to it.)

Thank you for your continued service to our community and your efforts to improve the health and wellness of Californians.

Sincerely,

(Your Name, MD)
(Your contact information)

Sample Letter to Legislator Regarding Specific Legislation

The Honorable (name of legislator)
Member of the Senate
State Capitol, Room (room number)
City, State, Zip Code

Dear Senator (name of legislator),

I recently became aware of Senate Bill (number), and I am writing to voice my concern because (state what the bill does and include your opinion).

(Emphasize how the bill affects people and use your own experience.)

(State what you oppose and particular concerns for your constituents.)

(If you know the legislator's voting record on related issues, let him/her know you approve or disapprove and why.)

Please oppose this legislation as it is now drafted and let me know if I can be of any assistance in this matter.

Sincerely,

(Your Name, MD)
(Your contact information)

Sample Testimonies

Distinguished members of the committee, thank you for the opportunity to speak with all of you today about menu labeling as it relates to an issue that is plaguing and physically debilitating nearly 60 percent of all Californians – obesity.

Obesity truly is a silent killer among us, and it knows no boundaries. It does not recognize age or socioeconomic background, and it is blind to race and ethnicity. It affects six in ten adults and one in seven children.

Over the past 10 years, Californians have put on 360 million excess pounds – one of the fastest growing rates in the country. The medical complications of being overweight and obese are devastating, and we in the medical community are seeing obesity's effects every day in our practices. Type II diabetes, once thought of as a disease affecting only adults, is now being seen in children throughout the state. Stroke, heart disease, high blood pressure and some cancers are crippling overweight and obese Californians, young and old. And, the economic burden of physical inactivity and obesity in adults exceeded $21.7 billion for California in 2000.

Why? Inadequate nutrition, poor diet, lack of physical activity and unhealthy environments all comprise the core causes of obesity in our society. Children ages 9 to 11 in California eat an average of 3.2 servings (about 1.6 cups) of fruits and vegetables on a typical day – far less than the recommended five to nine servings. And, only one-fourth of adults eat the recommended servings as well.

In terms of physical activity, nearly 40 percent of children in California assessed through the state's fitness program were considered unfit. More than 50 percent of U.S. adults do not get enough physical activity to provide health benefits, and 24 percent are not active at all in their leisure time.

While the rising trend in obesity rates do cut across all social classes, the prevalence of obesity is higher and the severity of consequences from obesity related diseases is particularly troublesome in California's ethnic communities.

Latinos and African Americans disproportionately live in communities that encourage unhealthy food choices and discourage physical activity. They often have many fast food outlets and small convenient stores with limited fresh produce, and they lack safe areas for children to play and be active.

What can we do? Helping our patients is our top priority, but societal changes must also occur to encourage overall wellness and prevention among Californians. We need to work together to find alternatives and resources for helping those obese and overweight among us.

Menu labeling is a tremendous first step in attacking the nutritional deficiencies among our citizens. Making people aware of what they are eating and educating them about fat and calorie intake will go a long way in helping people to make good food choices and overall lifestyle changes. It is a whole lot easier to eat a double quarter pounder with cheese, when you do not know that it contains 42 grams of fat and 740 calories – that's nearly one-half of the recommended daily calorie intake for an adult in one sandwich.

I encourage the Legislature to seriously consider this issue during the coming year. You have the opportunity to make a difference in the health of Californians by providing them with critical nutrition information in the community. You can help them learn to make healthy choices and develop good eating habits.

Prevention is our strongest tool to combat obesity. Children and families must have healthy options where they live, work and play. To take back control of their lives and start making healthier long-term decisions regarding their healthcare, people need to energize themselves and mobilize those around them to pursue a healthy lifestyle.

We know that obesity knows no boundaries, so it is up to us to rein it in. I sincerely hope that you will join with us in the fight against this deadly disease. Californians have an opportunity to take responsibility – to take ownership – of their health and work together to create positive change for a healthy community.

Oral Testimony of the American Dietetic Association[112]
Second Meeting of the Dietary Guidelines Advisory Committee
Presented by Constance J. Geiger, PhD, RD, CD
Director-at-Large, ADA Board of Directors

Good morning, my name is Constance Geiger and I'm a registered dietitian and president of Geiger & Associates, and a Research Associate Professor at the University of Utah.

I'm here representing the American Dietetic Association. I'm a Director-at-Large, ADA's Board of Directors, based in Chicago, Illinois, and I am presenting these comments on behalf of ADA and my fellow members, 68,000 food and nutrition professionals. The American Dietetic Association is the world's largest organization of food and nutrition professionals.

The American Dietetic Association is the world's largest organization of food and nutrition professionals. We are committed to improving the health of Americans through food and nutrition strategies. We seek to advance the scientific basis of the Dietary Guidelines and to facilitate consumer communication and implementation of the core messages.

ADA recommends 10-year intervals for issuing the Dietary Guidelines, which is consistent with the issuance of other public health guidance. Issuing the Dietary Guidelines every five years does not provide adequate time to conduct and review emerging nutrition research, nor does it provide enough time to effectively roll out and communicate key information about the Guidelines to consumers. It seems like we were just here for the 2005 Guidelines. So a ten-year interval would strengthen the research basis, the implementation and communication, and the impact and evaluation of the Guidelines.

The Guidelines should focus on food-based recommendations and meal patterns.
And while it is technically true that all foods can fit with careful planning, some fit more often than others and some fit very infrequently, especially when you get to my age.

Overweight and obesity continue to be major health concerns for our population. These conditions are often accompanied by inadequate nutrient intakes.

So we really need to consider research on meal patterns. Nutrient density and physical activity need to be reviewed and reflected in the Dietary Guidelines, and the recommendations should provide guidance on the types and amounts of foods people should consume, and should limit as the basis of their dietary intake.

Consumer research should be considered along with scientific diet and nutrition studies. Fewer than five percent of Americans consume diets consistent with the Dietary Guidelines.

So in conclusion, a ten year interval would allow for a full analysis of the data, and then systematic reviews of literature and evidence analysis of the key questions from both scientific and consumer research are vital for a strong Committee report.

We commend USDA and HHS for their commitment to the Nutrition Evidence Library and their support of Evidence Analysis System as the basis of the Dietary Guidelines for Americans.

Section V: Media & Communications Advocacy
Appendix L: Sample Op-Eds

There is a silent killer among us, and it knows no boundaries. It does not recognize age or socioeconomic background, and it is blind to race and ethnicity. It affects 65 percent of U.S. adults and one in seven children. It is physically debilitating, emotionally devastating and it is crippling the U.S. healthcare system. The perpetrator? Obesity.

Too often we have all seen in the pain in children's eyes when they are shunned on the playground because they are overweight and look different than the other kids. We have seen adults stare and ridicule obese adults, calling them lazy and unmotivated. People can be very cruel.

As a healthcare provider, I see the real anguish on the faces of my obese patients when they come to me for help. They are looking for guidance or some sort of magical cure to shed the pounds, take control of their health and undo the emotional damage they have suffered for so long.

While I would love to say that there is a silver bullet to cure obesity, unfortunately, there is not.

Former U.S. Surgeon General Dr. C. Everett Koop noted that, "Except for smoking, obesity is now the number one preventable cause of death in this country."

And, California is not immune to this epidemic. The prevalence of overweight Californians increased from 38 percent in 1984 to 57 percent in 2003. The number of overweight children increased 6.2 percent between 2001 and 2005 to an average of 28 percent of all children. The economic burden of physical inactivity and obesity in adults exceeded $21.7 billion for California in 2000.

Nationally, sky rocketing health care costs to treat obesity-related illnesses, such as heart disease, diabetes and stroke, are estimated at $93 billion annually. Healthcare for obese adults costs 37 percent more than for people of normal weight, adding $732 to the annual medical bills of every American.

As physicians, we saw an 88 percent increase in the number of patients we see for obesity between 1988 and 1998 – with 62.7 million physician visits. From the standpoint of an employer, it is estimated that across the country, 39.3 million workdays were lost annually to obesity-related causes. In addition, obesity was responsible for 239 million restricted-activity days and 89.5 million bed-days.

The numbers are staggering. But, how do we combat this deadly epidemic? How do we help those suffering from obesity make positive healthcare changes and improve their lives?

Inadequate nutrition, poor diet, lack of physical activity and unhealthy environments all comprise the core causes of obesity in our society. Helping our patients is our top priority, but societal changes must also occur to encourage overall wellness and prevention among Californians. We need to work together to find alternatives and resources for helping those obese and overweight among us.

Prevention is our strongest tool to combat obesity. Children and families must have healthy options where they live, work and play. To take back control of their lives and start making healthier long-term decisions regarding their healthcare, people need to energize themselves and mobilize those around them to pursue a healthy lifestyle.

Healthy eating and regular physical activity must be part of daily activities to create meaningful change for both children and adults. Increasing daily servings of fruits and vegetables and better access to outdoor activities can make a world of difference in their overall health.

We know that obesity knows no boundaries, so it is up to us to rein it in. I sincerely hope that my colleagues in the health profession as well as local business leaders, elected officials and the community will join me in this effort. Californians have an opportunity to take responsibility – to take ownership – of their health and work together to create positive change for a healthy community.

(Your Name)
(Your Address) *
(Your Daytime Phone Number) *

* Newspapers require an address and daytime number for anyone who submits an op-ed for verification purposes. Only your name and city will be published with the op-ed.

Sample Letters to the Editor

Dear (Editor's Name):

American families are facing a growing epidemic in this country that transcends all ages, all socioeconomic backgrounds and all racial and ethnic groups – obesity. In California alone, the prevalence of overweight Californians increased from 38 percent in 1984 to 57 percent in 2003. The economic burden of physical inactivity and obesity in adults exceeded $21.7 billion for California in 2000.

As a provider, I see first-hand the devastating reality of these numbers in my practice. Heart disease, diabetes and high blood pressure plague and debilitate overweight and obese Americans, young and old.

Prevention is our strongest tool to combat obesity. Children and families must have healthy options where they live, work and play. To take back control of their lives and start making healthier long-term decisions regarding their health, people need to energize themselves and mobilize those around them to pursue a healthy lifestyle.

We must work together to fight obesity.

(Your Name)
(Your Address) *
(Your Daytime Phone Number) *

* Newspapers require an address and daytime number for anyone who submits a letter to the editor

Sample *Be Our Voice* Recruitment Flyer

(Available electronically on thumb drive)

Mobilizing Healthcare Professionals as Community Leaders in the Fight Against Childhood Obesity

Be a Part of the Movement

A call to action:

Have you ever counseled a child for months about diet, exercise and healthy living only to have him leave your practice enthused but to return in a month, feeling defeated with little or no change in his health status?

Have you encountered a patient trying to exercise, using the street in front of her house due to the lack of sidewalks in her neighborhood, only to grow bored and give up?

Have you ever provided healthful recipes to patients only to hear back that while they try to cook healthier foods, they can't find the fresh fruit and vegetables in their local grocery store?

Your patients are frustrated and so are you.

You can do something, and it doesn't take much: There are millions of children and thousands of professionals in similar predicaments, and that is why we are asking you to be the voice of children to create healthier communities. By joining the *Be Our Voice* project and participating in local advocacy training, you will have the tools to maximize your role as a healthcare professional in combating childhood obesity -- helping children in your community and state be successful in their attempts to make healthy choices and live healthier lives. The *Be Our Voice* advocacy training offers the opportunity for you to learn:

how to work with a variety of decision makers and the media to create change;

the unique role of the healthcare professional outside the office setting; and

more about the obesity epidemic and how it disproportionately affects certain ethnic and disadvantaged populations.

You will also have access to our toolkit that will help you create your personal advocacy plan through resources and templates.

Give us some time, work to make your community healthier:

Your time outside the office is limited, and we respect that. We have created a project and training that requires a modest commitment but yields meaningful results. You can expect to leave the training as an activated advocate in your community. We are looking for a few passionate, interested and engaged professionals to:

Attend the Advocacy Training: [Customize here] hour session to be held [customize here]

Participate in monthly check-ins with the project team to help strategize obesity advocacy efforts with other healthcare professionals in your area: 1 hour a month

Engage in advocacy activities that support efforts that are important to you and your community: 1 hour a month

Connect with others working on similar issues within your state or across the country using the *Be Our Voice* website (www.nichq.org/advocacy)

Consider mentoring others in your area [customize here, if needed]

Are YOU willing to make the commitment?

(space to add details on who to call and when...)

Be Our Voice is a program of the National Initiative for Children's Healthcare Quality (NICHQ), in cooperation with the American Academy of Pediatrics and the California Medical Association Foundation. Sponsored by the Robert Wood Johnson Foundation.

Appendix O: End Notes

All Sections

American Academy of Pediatrics (AAP). *AAP Advocacy Guide: Pointing you in the right direction to become an effective advocate*. 2009. Available at: www.aap.org/moc/advocacyguide

California Medical Association (CMA) Foundation. *California Medical Association Foundation Media and Advocacy Toolkit*. 2009. Available at: www.thecmafoundation.org/projects/obesityproject.aspx

Appendix A: Glossary of Obesity Advocacy Terms

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Appendix B: State Fact Sheets

[101] The National Initiative for Children's Healthcare Quality. Visit: www.nichq.org for further information.

Appendix C: Obesity Disparities Presentation

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Appendix D: CDC and RWJF Obesity Prevention Projects

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Appendix E: Key Data Resources

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Appendix F: Policy Opportunities

Appendix
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