

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

KEY POINTS:

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

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

* Difference between state and national overall prevalence is statistically significant at the .05 level of significance.

NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an unweighted sample of fewer than 25 children, are considered unreliable and are not reported.

State rankings on disparity ratios include only those states with reliable estimates for both groups.

Data Source: CAHMI/Data Resource Center analysis of the 2003 National Survey of Children's Health.

Developed by the Child Policy Research Center and the Child and Adolescent Health Measurement Initiative/Data Resource Center (www.childhealthdata.org) on behalf of the NICHQ Childhood Obesity Action Network.

TECHNICAL NOTES:

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

What is HAWAII doing about obesity?

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

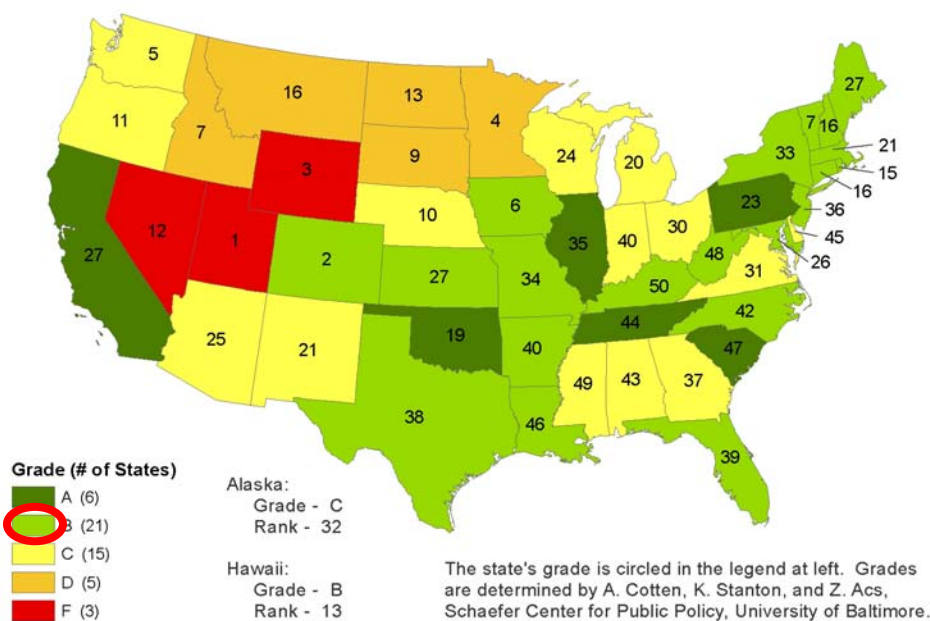
OBESITY-RELATED STATE INITIATIVES	HAWAII	NATIONAL
Snack and/or soda tax	No	17 states + D.C.
CDC state-based nutrition and physical activity program	No	28 states
Federal STEPS grant recipient	No	7 states
Laws that limit liability for obesity and obesity-related health problems	No	24 states
OBESITY-RELATED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

NOTES:

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

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

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



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