

HEALTHCARE INCLUSION OR ILLUSION:



1

The Examination of a Fact or Fiction

Presented by:
The Mound City Bar Association

¹ Cover adopted by <http://www.cdc.gov/HealthyYouth/KeyStrategies>

The General Body of the Mound City Bar Association has approved this report pursuant to the Association's by-laws.

The views contained herein do not represent the official policy of any law firm which the Commissioners or MCBA members are affiliated.

Copyright 2007 Mound City Bar Association. All rights reserved.

Healthcare Commission

Inclusion or Illusion:

The Examination of a Fact or Fiction



HEALTHCARE COMMISSION

CHAIR: Mavis Thompson

COMMISSIONERS:

Yuri Walker

Pamela Meanes

Representative Mound City Medical Forum

Dr. Denise Hooks-Anderson, Second Vice-President

ACKNOWLEDGMENTS

The Mound City Bar Association (“MCBA”) would like to acknowledge and express its sincere gratitude to the St. City public schools and the St. Louis County public school districts that participated in the survey. In addition, MCBA would like to thank the Honorable Robin Wright-Jones, Missouri State Representative, District #63; Dr. Ingrid Taylor, MD; Ms. Serena Muhammad, Chair and Director of Healthy Youth Partnership; and Darlynn Bosley, Educator for their participation in the panel discussion and Dr. Denise Hooks-Anderson for her unwavering commitment and dedication to this effort. The participation of these entities and individuals was essential in evaluating ways to eliminate obesity among Missouri children and adolescents.

Report writers: Mavis Thompson and Yuri Walker

Cover adopted by <http://www.cdc.gov/HealthyYouth/KeyStrategies>

Findings and Recommendations

TABLE OF CONTENTS

Foreword	
MCBA President Pamela Meanes.....	8
Healthcare Chair Mavis Thompson .	9
Executive Summary	10
Commission Findings	15
National Trends	
Missouri Overview	
St. Louis Public Schools Healthcare Initiatives	
St. Louis City Public Schools	
St Louis County Public Schools	
Recommendations.....	32
Conclusion	
Addendum:	36
Survey Cover Letter	
Healthcare Commission Survey.....	46

HEALTHCARE PANEL DISCUSSION



Panelists: Ms. Ingrid Taylor, MD; Ms. Serena Muhammad, Chair and Director of Healthy Youth Partnership; The Honorable Robin Wright-Jones, Missouri State Representative, District #63; and Darlynn Bosley, Educator

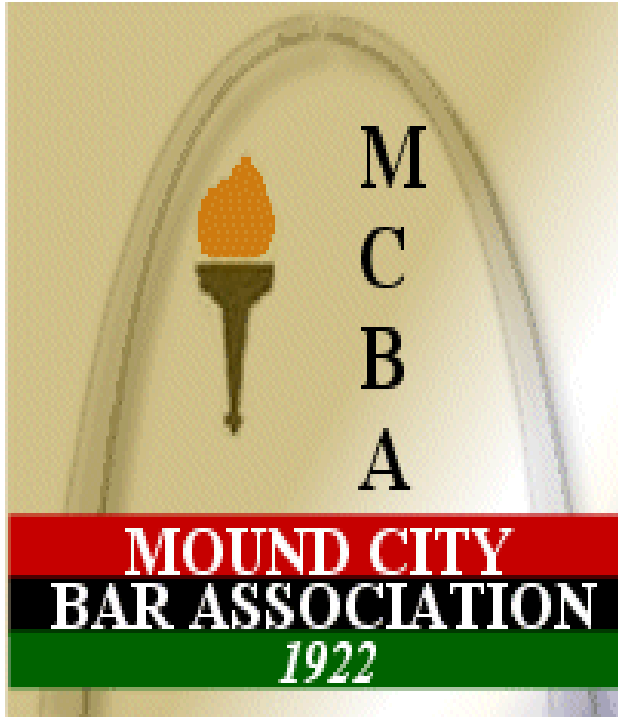


Moderator: Mavis Thompson



February 28, 2007

Foreword



Mound City Bar Association President

Diversity is one of the most critical issues facing America and the legal profession today. To that end, rarely can one find an institution, business, or establishment which has not implemented a diversity initiative or program. Although most applaud these efforts, when confronted with their results, many have questioned whether said initiatives have created diversity or simply an appearance of it. Confronted with this critical question, in July 2006, the Mound City Bar Association (“MCBA”) decided to test the diversity initiatives of certain entities in the following four disciplines: 1) education, 2) social; 3) healthcare; and 4) employment. To accomplish this goal, a Commission was established for each discipline. Each Commission was charged with: 1) researching and surveying its particular entity; 2) conducting a panel discussion with the leaders of said entities at the MCBA general body meeting; and 3) drafting a Report which would be published in various media outlets.

In January 2007, the MCBA Healthcare Commission, led by Chairwoman Mavis Thompson, undertook the task of examining the healthcare initiatives of St. Louis City and St. Louis County public schools to determine: 1) whether said initiatives contributed to the amelioration or proliferation of obesity among children and adolescence; and 2) whether disparities exist between St. Louis City and St. Louis County public schools.

According to the US Department of Health and Human Services, since 1980, the percentage of overweight children has more than doubled, while rates among adolescents have more than tripled. With respect to African Americans, studies have revealed that obesity occurs at higher rates than with whites. To that end, diseases such as diabetes mellitus and certain other obesity-related conditions occur to a markedly greater than average extent in many minority populations. Thus, special attention must be given to it as it occurs in and affects ethnic minorities in America.¹

This Report provides a critical analysis of the existing healthcare initiatives of the St. Louis Metropolitan public schools and outlines findings and recommendations gathered from various sources. The motivating factor behind this Report arises from MCBA’s desire to join the fight to eliminate obesity in children and adolescents.

I encourage MCBA, Missouri legislators, and healthcare providers to utilize this Report to raise public awareness and to win the battle against obesity.

2006-2007 MCBA President
Pamela J. Meanes

¹ See Special Issues Regarding Obesity in Minority Populations at www.ncbi.nlm.nih.gov.

MCBA Healthcare Commission Chair

When Madame President Pamela Meanes asked me to chair the MCBA Healthcare Commission, I had no idea that we would work so hard or learn so much about the problems of overweight and obesity in youth attending the St. Louis metropolitan area public schools. WOW! We have an epidemic on our hands. I thank President Meanes for her vision to have lawyers join doctors, teachers, parents and legislators in crafting solutions to this increasing public health problem.

Overweight and obesity is a chronic disease involving social, cultural, genetic, physical and psychological components. The Center for Disease Control states that, "Since 1980 the percentage of children who are overweight has more than doubled and the rate for adolescents has tripled."

We should have known that the lack of physical activity, accessibility of high caloric fast food joints, lack of accessibility and the high cost of organic fruits and vegetables, lack of safe places for children to recreate, excessive television watching, excessive computer usage, excessive video gaming, overweight parents as role models, etc., etc. would lead to overweight and obesity in children.

We should have known that sooner or later children would resort to methods primarily reserved for adults trying to lose weight. Fad Diets, use of enemas and diuretics, starvation, and recent media reports of parents consenting to gastric bypass surgery for their children.

At least a dozen states have enacted legislation pertaining to childhood overweight prevention and some type of school intervention or school study, including Arkansas, California, Colorado, and Illinois. Missouri's response has been minimal; to date legislative action has been limited requiring students to earn an additional one-half unit in health education prior to graduation, effective 2010. This dismal response to an epidemic is our call-to-action.

The MCBA Healthcare Commission was charged with examining this critical issue of overweight and obesity in youth and determining whether: 1) any disparities existed in the physical education curriculum, health education programs, and/or facilities while presenting an illusion of equity; and 2) if there were legislative options that needed to be considered to ensure inclusion among various ethnic and socioeconomic groups. Accordingly, we submit this report for your review.

I wish to extend special thanks to Commissioner Yuri Walker, BSN, MPH, JD for the tremendous amount of work she put into this assignment. Working with Yuri was a pleasure and I have made a friend for life. Additionally, I thank Dr. Denise Hooks-Anderson for serving as our liaison to the Mound City Medical Association, throughout the later months of her pregnancy.

Let's go to work people. This issue is effecting our children, our future leaders. They are looking to us for solutions.

Mavis Thompson, BSN, JD
Chair, MCBA Healthcare Commission

Executive Summary



¹ Picture adopted by: <http://www.cdc.gov/HealthyYouth/KeyStrategies>

Race-based disparities are a distressing reality in America. Over the past decade, medical research has proven that said disparities are prevalent in the healthcare profession. For instance, research has revealed that racial and ethnic disparities are evident in cardiovascular and cancer treatments. For instance, studies have found that minorities are less likely to receive appropriate: 1) cardiac medications or to undergo bypass surgery; and 2) cancer diagnostic tests and treatments. Moreover, although African Americans suffer strokes at a higher rate than whites, several studies have shown that minorities are less likely to receive major diagnostic and therapeutic interventions. In addition, minorities are less likely to: 1) be placed on waiting lists for kidney transplants or to receive kidney dialysis or transplants; 2) receive various state of the art treatments, which could forestall the onset of AIDS; and 3) receive appropriate medications to manage chronic Asthmatic symptoms. Finally, although minorities have a higher rate of death and illness from diabetes, this disease is poorly managed among minority patients. In a study of nearly 1,400 Medicare patients, diabetic African Americans were found less likely to receive key diagnostic tests. Furthermore, minorities were also more likely to receive certain less-desirable procedures, such as lower limb amputations for diabetes and other conditions.²

According to the American Obesity Association, many of these diseases are linked to obesity. For instance, “obesity appears to contribute to the higher risk of pancreatic cancer among African Americans than among whites, particularly for women. With respect to heart disease among African Americans, the high prevalence of obesity and obesity-related conditions such as hypertension and type 2 diabetes are factors reported to contribute to their high death rate from coronary heart disease. Finally, the high prevalence of obesity is reported to be a

² See “Unequal Treatment Confronting Racial Ethnic Disparities in Health Care,” Institute of Medicine at www.iom.edu, Released March 20, 2002.

contributing factor to the high prevalence of hypertension in minority populations, especially among African Americans who have an earlier onset and run a more severe course of hypertension.”³

Frightfully, more revealing is that these diseases which were once more common among adults have now become more customary among African American children and adolescence.⁴ The reason for this phenomena is the increase in childhood obesity. Childhood obesity is a disease similar to a plague of epic proportions,⁵ and its impact on African American children is alarming.⁶ For instance, obesity rates for African American children are ten (10) to twelve (12) percent higher than for white children.⁷ In light of these startling statistics, Mound City Bar Association (“MCBA”) decided to explore the impact of childhood obesity on African American children who live in Missouri.

Mission

The MCBA Healthcare Commission (“Commission”) was initially charged with examining the healthcare initiatives of St. Louis City and St. Louis County public schools to determine whether: 1) said initiatives led to the amelioration or proliferation of obesity in children and adolescents; and 2) disparities exist between St. Louis City and St. Louis County

³ See AOA Fact Sheet Obesity In Minority Populations, American Obesity Association at www.obesity.org, (Last Update May 2, 2005).

⁴ *Id.*

⁵ U.S. Department of Health and Human Services, The Surgeon General’s Call to Action to Prevent and Decrease Overweight and Obesity (Rockville, MD: U.S. Dept. of Health and Human Services, Public Health Service, Office of the Surgeon General, 2001).

⁶ See AOA Fact Obesity in Youth, American Obesity Association at www.obesity.org, (Last update May 2, 2005) .

⁷ See Introduction to article entitled, “Targeting Intervention for Ethnic Minority and Low-Income Population,” by Skiriki Kumanyika and Sonya Gier at www.futureofchildren.org

public schools, and if so, to propose legislation. To accomplish these goals, this Commission: 1) researched and analyzed the Missouri educational and legislative systems' commitment to the elimination of obesity; 2) drafted and distributed a questionnaire survey to the St. Louis Metropolitan schools; 3) moderated a panel discussion with distinguished legislative, medical, and educational experts; and 4) drafted its findings and recommendations ("Report").

The Findings

Although there exists enormous evidence and literature to substantiate the devastating effects of childhood obesity and its impact on the African American community, nominal research exists regarding healthcare disparities in the St. Louis public school system. Thus, to conduct a comparative analysis of St. Louis City and St. Louis County schools and propose legislation, this Commission intended to utilize the survey results it received from these schools. However, the Commission's ability to accomplish this task was hindered by the limited responses it received from St. Louis City public schools. Although the Commission sent a survey to all of the City schools, it only received eight (8) responses.

With respect to St. Louis County, for management purposes, the Commission sent a survey to each school district. Of the twenty one (21) districts surveyed, the Commission received eight (8) responses. While the number of responses appear equivalent to the number received from City schools, they are not. Unlike the City, the County responses were representative of all the schools located in the responding district. Thus, the responding population was significantly larger than the City. A summary of the City and County's responses are included in this Report.

In light of the above, this Report only provides an analysis of Missouri's educational and legislative commitment to the amelioration of overweight and obese children. To that end, this

Commission’s findings and recommendations are derived from independent research and recommendations it received from a panel discussion of local experts. The panelists for that discussion included the Honorable Robin Wright-Jones, Missouri State Representative, District #63; Dr. Ingrid Taylor, MD, Physician certified in Family Medicine; Ms. Serena Muhammad, Chair and Director of Healthy Youth Partnership; and Ms. Darlynn Bosley, Educator, Riverview Gardens School District and former Missouri Teacher of the Year.

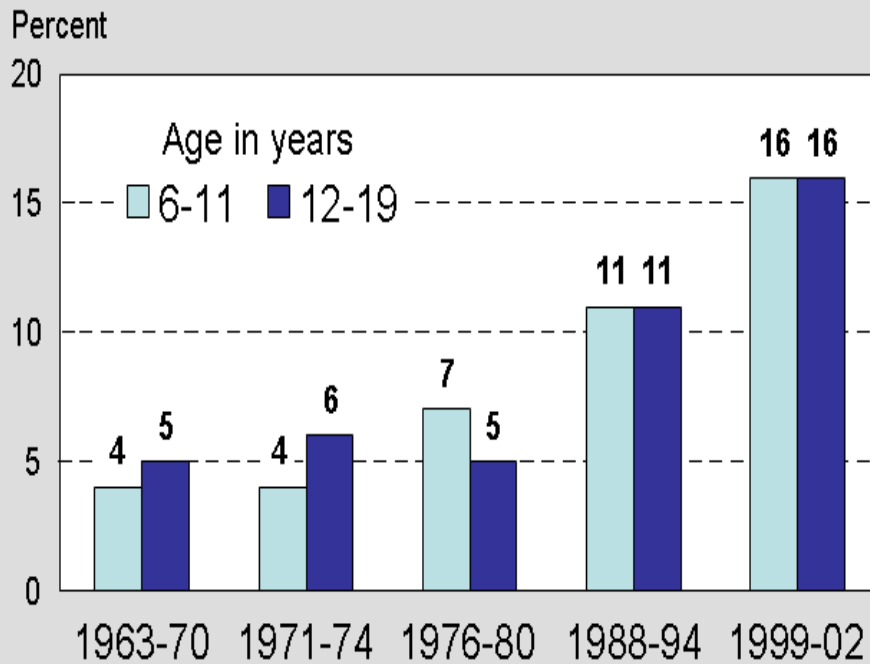
Based on this Commission’s research, childhood obesity in Missouri has reached epidemic proportions, and its impact is dramatically higher in the African American community. Many scholars have attributed this disparity to: 1) the existence of certain socioeconomic and environmental factors which may not be prevalent in the white community; and 2) the failure of intervention and treatment programs to take these differences into consideration.⁸ Since obesity is the second leading cause of unnecessary deaths and has been linked to numerous diseases which are more prevalent among African Americans, this illness demands immediate attention and action from the African American community.

⁸ See “Targeting Intervention for Ethnic Minority and Low-Income Population,” by Skiriki Kumanyika and Sonya Gier at www.futureofchildren.org

Commission

Findings and Results

Figure 1. Prevalence of overweight among children and adolescents ages 6-19 years



NOTE: Excludes pregnant women starting with 1971-74. Pregnancy status not available for 1963-65 and 1966-70. Data for 1963-65 are for children 6-11 years of age; data for 1966-70 are for adolescents 12-17 years of age, not 12-19 years.
SOURCE: CDC/NCHS, NHES and NHANES

9

⁹ Figure 1 adopted by: <http://www.cdc.gov/nchs/products/pubs/pubd/hestats/overwght99.htm>

NATIONAL TRENDS

The U.S. Surgeon General identified the obesity epidemic as one of the greatest public health problems facing the nation.¹⁰ Obesity is a chronic disease involving social, dietetic, cultural, genetic, physical, and psychological components. Children who are overweight have a much greater likelihood of becoming obese as adults than children who are of normal weight.¹¹ Approximately 30.3 percent of children (ages 6 to 11) are overweight and 15.3 percent are obese.¹² For adolescents, 30.4 are overweight and 15.4 percent are obese.¹³ Overweight and obesity for children and adolescents are defined as being at or above the 85th and 95th percentile of Body Mass Index (BMI) scale, a measurement of the proportion of an individual's weight relative to their height.¹⁴ Since 1980, the percentage of children who are overweight has more than doubled; the rate for adolescents has tripled.¹⁵

Although obesity rates have increased among children, “they have increased more for African American and Mexican American children. By 1999–2002, obesity rates were higher for both of these two groups than for white children within each age and gender group. In some cases, obesity rates for ethnic minority children exceeded rates for white children by 10 to 12 percentage points. For boys of both age groups, the obesity rate among Mexican Americans exceeded that among African Americans. For example, nearly a quarter of Mexican American adolescent boys were obese in 1999–2002, as against 19 percent of African Americans and 15

¹⁰ U.S. Department of Health and Human Services, *The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity* (Rockville, MD: U.S. Dept. of Health and Human Services, Public Health Service, Office of the Surgeon General, 2001).

¹¹ *Id.*

¹² *See*, Obesity in Youth, American Obesity Association @ <http://obesity1.tempdomainname.com> (Last reviewed 10/18/06)

¹³ *Id.*

¹⁴ Body Mass Index (BMI) is a mathematical calculation used to determine whether a person is overweight. BMI, is calculated by dividing a person's body weight in kilograms by their height in meters squared. The Centers for Disease Control (CDC) and the American Academy of Pediatrics (AAP) recommend the use of BMI to screen for overweight children and adolescents.

¹⁵ Centers for Disease Control, *Healthy Youth! Make a Difference at Your School*, at <http://www.cdc.gov/HealthyYouth>.

percent of whites. This pattern differs for girls, with the highest obesity rates found among African American girls. For example, among adolescent girls, 24 percent of African Americans, 20 percent of Mexican Americans, and 13 percent of whites were obese.”¹⁶

RACIAL BREAKDOWN¹⁷

Children (Ages 6 to 11) Prevalence (%)		Adolescents (Ages 12 to 19) Prevalence (%)		
Race	Overweight	Obesity	Overweight	Obesity
Black (Non-Hispanic)	35.9	19.5	40.4	23.6
Mexican American	39.3	23.7	43.8	23.4
White (Non-Hispanic)	26.2	11.8	26.5	12.7

Source: CDC, National Center for Health Statistics, National Health and Nutrition Examination Survey. Ogden et. al. JAMA. 2002;288:1728-1732.

More alarming are the adverse health effects associated with overweight and obesity in children and adolescents.¹⁸ For instance, “overweight during childhood and particularly adolescence is related to increased morbidity and mortality in later life.”¹⁹ To that end, obesity is linked to asthma, diabetes (Type 2), hypertension, orthopedic complications, psychosocial effects and stigma, sleep apnea in children. According to the American Obesity Association, these health effects are dramatically higher for African American and Mexican American children.²⁰

¹⁶ See Introduction to article entitled, “Targeting Intervention for Ethnic Minority and Low-Income Population,” by Skiriki Kumanyika and Sonya Gier at www.futureofchildren.org

¹⁷ See AOA Fact Obesity in Youth, American Obesity Association at www.obesity.org, (Last Update May 2, 2005).

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ *Id.*

Contributing Factors

There are many factors that contribute to overweight and obesity.²¹ While many point to genetic determinants as the underlying cause of obesity, research reveals the substantial increase in overweight children is primarily due to non-genetic factors.²² For instance, the following factors have been linked to an increase in obese and overweight children and adolescents: 1) a lack of disciplined physical activity and exercise; 2) unhealthy eating habits; 3) sedentary behaviors evidenced by a high frequency of television, computer, and video game usage; 4) socioeconomic status; and/or 5) a combination of any of the above.²³ According to scholars, these factors are influenced by many sectors of society, including families, community organizations, healthcare providers, faith-based institutions, businesses, government agencies, the media, as well as schools.²⁴

With respect to minority children, some have concluded that obesity occurs at a higher rate in minority communities because of the presence of certain socioeconomic and environmental factors which may not be as prevalent in white communities. For instance, low-income and minority children watch more television than white children. Thus, potentially minorities are more exposed to commercials advertising high-calorie, low-nutrient food. Moreover, minorities are more likely to live in neighborhoods which typically have more fast-food restaurants and fewer vendors of healthful foods. Furthermore, unlike their white

²¹ U.S. Department of Health and Human Services at 1.

²² Hill, J.O. and Trowbridge, F.L., Childhood obesity: future directions and research priorities, *Pediatrics*, 1998; Supplement: 571.

²³ See Childhood Obesity, American Obesity Association at <http://obesity1.temdomainname.com> (Last reviewed 10/18/06).

²⁴ Wechsler, Howell et al, *The Role of School in Preventing Childhood Obesity*, National Association of State Boards of Education: The State Education Standard, (2004).

counterparts, minority children’s ability to engage in physical activity may be impeded by the presence of unsafe streets, dilapidated parks, and lack of facilities.²⁵

In addition to the above, the MCBA panelists also indicated that Missouri children may be at risk because: 1) they no longer walk to schools (due in large part to the fact that they do not attend neighborhood schools); 2) there is lack of healthy and organic foods not accessible or cost prohibitive; 3) few meals are cooked at home because parents are working more than one job; and 4) there is a presence of overweight parents as role models.

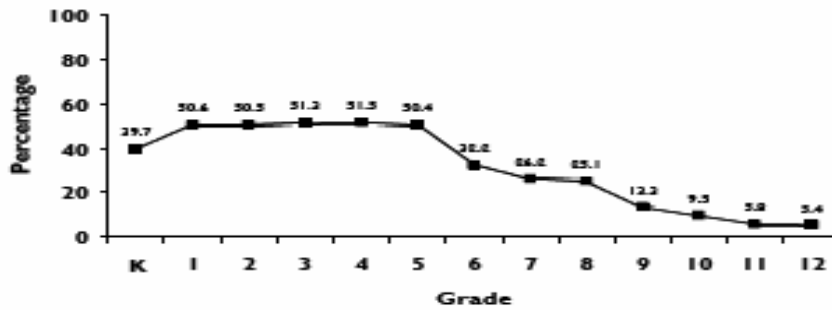
Educational Involvement

While few would classify obesity as an education problem, many have suggested that the educational system has contributed to the epidemic and thus has an obligation to help eliminate it. According to the American Obesity Association, “today's youth are considered the most inactive generation in history caused in part by reductions in school physical education programs”²⁶

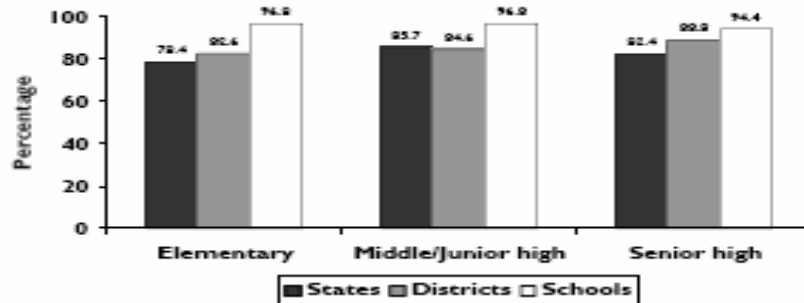
²⁵ See “Targeting Intervention for Ethnic Minority and Low-Income Population,” by Skiriki Kumanyika and Sonya Gier at www.futureofchildren.org

²⁶ See American Obesity Association AOA Fact Sheet at <http://obesity1.temdomainname.com> (Last reviewed 10/18/06).

Percentage of Schools that Require Physical Education, by Grade



27



28

In light of disturbing statistics regarding overweight and obese children, one may naturally question why the educational system has reduced instead of increased healthcare programs.

There are various reasons why the education system has not placed an importance on healthcare programs. One of the most predominate reasons is because educators, school administrators, and school boards are under increasing pressure from legislators and parents to focus on increasing standardized test scores, graduation rates, and college admissions. For instance, the federal No Child Left Behind (NCLB) law holds public schools accountable for

²⁷ Graph adopted by: <http://www.cdc.gov/HealthyYouth/shpps/factsheets/pdf/pe.pdf>

²⁸ *Id.*

student standardized test scores. Accordingly, a student’s performance on these tests has a direct correlation to funding, faculty tenure, and state accreditation. To that end, monetary and other penalties are imposed when performance targets are unmet. Thus, this pressure creates a competition between the need to focus on academic subjects which are tested versus non-academic subjects, such as health education and physical education, which are not tested.²⁹ However, research has revealed that failure to effectively address healthcare issues may have an impact on the ability of a school to teach and a child to learn. To that end, the National Association of State Boards of Education (“NASBE”) stated: “[h]ealth and success in school are interrelated. Schools cannot achieve their primary mission of education if students and staff are not healthy and fit physically, mentally, and socially.”³⁰

In addition to the above, lack of resources may also prohibit a school from implementing certain healthcare programs. According to NASBE, declining resources often creates barriers to implementing policies, programs for quality physical education and health education instruction, adequate recess time, after school physical activity programs, and healthy meals and snacks, all of which contribute to improved student health.³¹

SAINT LOUIS CITY AND COUNTY PUBLIC SCHOOLS

In an effort to assess overweight and obese children in Missouri public schools, this Commission surveyed local St. Louis City and St. Louis County public schools. The

²⁹ Missouri Department of Health and Senior Services (DHSS), *Overweight Among School-Age Youth: Challenges and Opportunities for Missouri Schools*, DHSS Policy Brief #1, January 2006.

³⁰ National Association of State Boards of Education, *Fit, Healthy, and Ready to Learn: Part 1: Physical Activity, Healthy Eating, and Tobacco-Use Prevention* (Alexandria, VA: National Association of State Boards of Education, 2000).

³¹ Missouri Department of Health and Senior Services (DHSS) at 2.

Commission’s survey was modeled after a nationwide obesity study conducted by the Schaefer Center for Public Policy. Although questionnaire surveys were sent to all St. Louis City public schools, only eight schools responded. A summary of the City’s responses is set forth below.

Demographic Summary

School/Grades	# of Students	% Black/White	% Male/Female
Bunche Intl Studies MS/6-8	260	60/20	55/45
Cole e-MINTS Academy/ PreK – 7	317	100	65/35
Cote Brilliante Elem/ PreK-7	305	100	Not reported
Gundlach Elem/ PreK-7	304	100	50/50
Nottingham CAJT HS/9-12	130	90/9	100/0
Stevens Middle CEC/ 6-8	318	98/1	55/45
Wilkinson Early Childhood Ctr/ PreK – 2	197	55/40	50/50
Williams Ninth Grade Academy	220	100%	47/53

Health Education

School/Grades	% Federally Subsidized	Health Educ Required	Grades Required	Topics Include Nutrition
Bunche Intl Studies MS	50-75%	Yes	6-8	Yes
Cole e-MINTS Academy	Greater than 75%	Yes	4-6	Yes
Cote Brilliante Elementary	Greater than 75%	Yes	Kg – 6	Yes
Gundlach Elementary	Greater than 75%	Yes	Kg – 7	Yes
Nottingham CAJT HS	50-75%	Yes	Not reported	Yes
Stevens Middle CEC	Greater than 75%	Yes	6-8	Yes
Wilkinson Early Childhood Ctr	50 – 75%	Yes	Not reported	Not reported
Williams Ninth Grade Academy	25-50%	Yes	9	Yes

Nutrition

School/Grades	Vending Machines	Fruits / Vegetables	Fruit juices/ bottled water	Junk food (sodas, chips)
Bunche Intl Studies MS	Yes	Not reported	Yes	Yes
Cole e-MINTS Academy	No	No	No	No
Cote Brilliante Elementary	No	No	No	No
Gundlach Elementary	No	No	No	No
Nottingham CAJT HS	Yes	Not reported	Yes	Yes
Stevens Middle CEC	Yes	Not reported	Yes	Yes
Wilkinson Early Childhood Ctr	No	No	No	No
Williams Ninth Grade Academy	Yes	No	Yes	Yes

Physical Education

School/Grades	Phys Educ Required	Grades Required	Intramural Activities	Exercise tng/ Weight room
Bunche Intl Studies MS	Yes	6-8	No	No
Cole e-MINTS Academy	Yes	5-7	Yes	No
Cote Brilliante Elementary	Yes	PreK – 6	No	No
Gundlach Elementary	Yes	Kg – 7	No	No
Nottingham CAJT HS	Yes	9 – 12	Yes	No
Stevens Middle CEC	Yes	6 – 8	Yes	No
Wilkinson Early Childhood Ctr	Yes	PreK – 2	No	No
Williams Ninth Grade Academy	Yes	9	Yes	Yes (minimal)

Healthy Initiatives

School/Grades	Routine Health Screening	% Students Overweight (est.)	Special Initiatives
Bunche Intl Studies MS	Yes	26 – 50%	None reported
Cole e-MINTS Academy	Yes	26 – 50%	None reported
Cote Brilliante Elementary	Yes	10 – 25%	None reported
Gundlach Elementary	Yes	26 – 50%	None reported
Nottingham CAJT HS	Yes	10 – 25%	Limited
Stevens Middle CEC	Yes	26 – 50%	None reported
Wilkinson Early Childhood Ctr	Yes	Less than 10%	Nutritionist; nutritional program
Williams Ninth Grade Academy	No	Not reported	None reported

With respect to St. Louis County, of the twenty one (21) school districts surveyed, the Commission received eight responses. Below is a summary of the responses received.

District	Elementary # of Students	Middle School # of Students	High School # of Students	Total # of Students
Affton	1,075	577	855	2,507
Brentwood	335	211	259	805
Clayton	1,064	559	906	2,529
Ferguson- Florissant	6,077	2,075	4,079	12,231
Maplewood- Richmond Hgts	536	161	316	1,013
Ritenour	2,841	1,485	1,896	6,222
Rockwood	9,634	5,332	7,248	22,214
Valley Park	545	234	254	1,033

Demographics

District	Male/ Female	% Black/ African- American	% White/ Caucasian	%Hispanic /Latino	% Asian /Pacific Islander	% Other
Affton	1,270/1,237	10.8	84.8	1.5	2.7	0.2
Brentwood	421/384	29	64	2	5	0
Clayton	1,290/1,239	22.3	67.4	1.8	8.4	0
Ferguson- Florissant	6,255/5,976	75.6	22	1.3	1	0.1
Maplewood - Richmond Hgts	564/529	39.2	55.4	3.3	1.8	0
Ritenour	3,206/3,016	37	50	10	3	0
Rockwood	11,273/10,941	11	82.7	1.6	4.3	0.2
Valley Park	527/506	26	65	4	4.5	0.5

Health Education

District	% Eligible for Federal Subsidy	Health Educ Required	Grades Required	Topics include Nutrition
Affton	25-50%	Yes	Kg – 12	Yes
Brentwood	Less than 25%	Yes	Kg – 9	Yes
Clayton	15.3%	Yes	Kg – 10	Yes
Ferguson- Florissant	50-75%	Yes	Kg – 9	Yes
Maplewood- Richmond Hgts	50-75%	Yes	Kg - 9	Yes
Ritenour	More than 75%	Yes	Kg – 9	Yes
Rockwood	Less than 25%	Yes	Kg – 9	Yes
Valley Park	25-50%	Yes	Kg – 12	Yes

Nutrition

District	Vending Machines	Fruits / Vegetables	Fruit juices/ bottled water	Junk food (sodas, chips)
Affton	Yes	Yes	Yes	No
Brentwood	Yes	Yes	Yes	No (exc. Elem)
Clayton	Yes	Yes	Yes	Yes
Ferguson- Florissant	Yes	Yes	Yes	Yes
Maplewood- Richmond Hgts	Yes	Yes	Yes	Yes (limited)
Ritenour	Yes	Yes	Yes	No
Rockwood	Yes	Yes	Yes	Yes
Valley Park	Yes	Yes	Yes	Yes

Physical Education

District	Phys Educ Required	Grades Required	Intramural Activities	Exercise tng/ Weight room
Affton	Yes	Kg – 12	Yes	Yes
Brentwood	Yes	Kg – 12	Yes	Yes
Clayton	Yes	Kg-11	Yes	Yes
Ferguson-Florissant	Yes	Kg – 12	Yes	Yes
Maplewood-Richmond Hgts	Yes	Kg – 9	Yes	Yes
Ritenour	Yes	Kg – 12	Yes	Yes
Rockwood	Yes	Kg – 9	Yes	Yes
Valley Park	Yes	Kg – 12	Yes	Yes

Healthy Initiatives

District	Annual Health Screening	% Students Overweight (est.)	Special Initiatives
Affton	Yes	Not reported	Wellness Board Policy; Wellness Committee
Brentwood	Yes	12.8% (High School)	Wellness Committee
Clayton	Yes (Kg, 1,3,5,7,9)	10-25% (High school)	Parent’s group
Ferguson-Florissant	Yes	13.7% (elementary)	Wellness Plan
Maplewood-Richmond Hgts	Yes	10-25%	Wellness Committee
Ritenour	Yes (Kg – 8)	Not reported	None reported
Rockwood	Yes	Not reported	Wellness Committee; community education classes
Valley Park	Yes (elementary)	Not reported	Wellness Policy

Based on the responses, all of the above schools have a physical education program and some variation of a Wellness Committee. Accordingly, one might logically assume that: 1) these schools are taking necessary steps to address and combat obesity; and 2) if other Missouri

schools have similar programs than Missouri is winning the fight against obesity. On the contrary, research reveals that Missouri is losing the battle.³²

According to the data, one in five Missourian adults are obese, and more than half of adults are overweight.³³ Consistent with national trends, the current rate of obesity in Missouri adults represents a 95 percent increase since 1980.³⁴ Studies involving Missouri children also mirror the national trends. To that end, some of the troubling findings identified by the State of Missouri indicate that: 1) only 27.4 percent of middle school and 17.5 percent of high school students have daily physical education classes; 2) nearly 23 percent of elementary school students participating in the Missouri school-aged children health service program are overweight; 3) 14.5 percent of middle school students and 13.6 percent of high school students are overweight, less than 25 percent of Missouri high school students eat the recommended servings of fruits and vegetables – five or more servings per day; 4) while 25.3 percent of middle school students and 31 percent of high school students drank two or more glasses of sweetened beverages each day, only 22.3 percent of middle school students and 15.9 percent of high school students consume the ADA recommended 3 or more glasses of milk each day; and 5) excessive television viewing contributes to the sedentary lifestyle: 40.4 percent of middle school students and 35.1 percent of high school students reported watching TV for three or more hours on an average school day.^{35/36}

³² Mississippi ranks first with the country's highest obesity rate; Colorado ranked 50th with the country's lowest obesity rate.

³³ Missouri Department of Health and Senior Services (DHSS), *Missouri's Nutrition and Physical Activity Plan*, 2005, available at www.dhss.mo.gov/Obesity/index.html.

³⁴ Missouri Department of Health and Senior Services (DHSS), *Obesity State: A Closer Look at Obesity in Missouri*, available at www.dhss.mo.gov/Obesity/index.html. (In 1986, less than 10 percent of Missouri adults were obese).

³⁵ Missouri Department of Health and Senior Services (DHSS). *Dietary Intake and Physical Activity Summary Report*. The Missouri School-Age Children's Health Services Program School Year 2002-2003.

When faced with similar statistics, the following states enacted preventive legislation:^{37/38}

1. Arkansas – Bill created a child health advisory committee; prohibits vending machine access
2. California – Childhood Obesity Prevention Act set explicit nutritional standards for vending machines
3. Colorado – Bill sets forth nutritional guidelines for food and beverages that are offered in vending machines
4. Illinois – Bill to conduct a sugar consumption study aimed at determining the effects of sugar consumption on the health of school children
5. Maine³⁹ – Healthy Maine Partnership (funded largely by the tobacco Master Settlement agreement); bans on sale of soda and candy during school day in all schools; leveraged grants and local funds to support physical education
6. Michigan⁴⁰ - Board of Education policy recommending 150 minutes per week of physical education for elementary school students; 225 minutes per week for middle and high school students
7. New Mexico – Passed resolution requesting a childhood obesity study of nutrition/physical activity; impact of foods/beverages on public school students
8. West Virginia – Resolution requesting government committee to study childhood obesity epidemic in the state.

³⁶ Missouri Department of Health and Senior Services (DHSS). 2005. Youth Tobacco Survey.

³⁷ States that have passed relevant legislation since 2003 include Colorado, California, Arkansas, Kentucky, Washington, and Texas.

³⁸ Missouri Department of Health and Senior Services (DHSS), *Overweight Among School-Age Youth: Healthy Foods and Beverages in Schools*, DHSS Policy Brief #2, January 2006.

³⁹ Kohl, HW and Hobbs, KE, Development of physical activity behaviors among children and adolescents, *Pediatrics*, 101: 549-554 (1998).

⁴⁰ Taras, H., Nutrition and Student Performance at School, *Journal of School Health*, 75 (6), 199 (August 2005).

By comparison, the legislative response in Missouri has been minimal. For instance, the Missouri Board of Education (“Board”) increased high school graduation requirements effective 2010. To that end, one of the Board’s changes will require students to earn one-half unit in health education prior to graduation in addition to the one unit (or one year) of physical education that continues to be required.⁴¹

Moreover, in a nationwide obesity survey conducted by the Schaefer Center for Public Policy, Missouri did not fair well. This study evaluated the presence and absence of eight types of legislations⁴² relating to the management of obesity that have either been introduced or passed. Each state was given a letter grade of A, B, C, D, or F and a ranking (between 1 – 50) of obesity prevalence. The state of Missouri received a letter grade of D⁴³ and was ranked with the country’s tenth highest obesity rate.⁴⁴ Thus, while this Commission applauds the Board’s effort, it contends that more must be done. Accordingly, this Commission would encourage the Board to lobby the State to enact preventive obesity legislation.

Finally, this Commission would encourage the Board to seriously consider the recommendations offered by the MCBA panelists. According to the panelists, if Missourians

⁴¹ Missouri Department of Health and Senior Services (DHSS) at 2.

⁴² The Schaefer Center for Public Policy evaluated the presence of the following types of legislation: 1) vending machine usage (prohibiting types of foods and beverages sold in school and prohibiting access to vending machines at certain times); 2) body mass index (BMI) measurements being taken in school; 3) Recess and Physical Education – State mandated additional recess and physical education time; 4) obesity Programs and Education – Programs established as part of curriculum 5) obesity Research – Legislature directed other institutions or groups to study obesity; 6) obesity Treatment in Health Insurance – Expanding health insurance to cover obesity treatment where applicable. See Obesity Commissions – Legislature established commissions designed to study obesity Available @ <http://www.ubalt.edu/experts/obesity/states.html>. (Last reviewed 10/18/06)

⁴³ No state received an “A”; Connecticut and Arkansas received a grade of “B”.

⁴⁴ Mississippi ranks first with the country’s highest obesity rate; Colorado ranked 50th with the country’s lowest obesity rate.

have any hope of eliminating this epidemic, everyone must assume responsibility for the solution. For instance, the government and schools must explore creative options such as subsidized neighborhood Farmer's Markets to make fruits and vegetables more accessible. In addition, school districts must increase its lunch periods and offer some form of exercise at lunch. More importantly, parents and children must take an active role. Finally, legislators must address the problem by providing more oversight of cafeteria food plans and the content of vending machines in schools.

RECOMMENDATIONS

During the last three years, over 40 partner organizations, including the Missouri Department of Elementary and Secondary Education, collaborated to develop the Missouri Wellness Policy and Procedures aimed at decreasing overweight and obesity among children, youth, and adults. The state plan includes strategies and actions to improve access to healthy food choices and opportunities for physical activity in schools and child care facilities.

The Commission endorses the following recommendations for policy action that has been identified, but to date not legislated, in Missouri's Nutrition and Physical Activity Plan –

- 1) Increase school physical education requirements
 - Elementary school – A minimum of 30 minutes of physical education/day
 - Middle school – A minimum of 45 minutes of physical education/day
 - High school – Increase requirement from one to two credits of physical education for graduation.
- 2) Support opportunities for physical activity in addition to that provided in the physical education program
 - Elementary schools – A minimum of one supervised recess period for students each day
 - Increased funding for before and after school physical activity programs.
- 3) Require nutrition be taught as part of the school health education curriculum
 - Include in required content for elementary, middle, and high school health education requirements

- 4) Require assessment of student performance in physical fitness and health education
 - Conduct routine testing of children in health education and physical fitness using The Missouri Assessment Program (MAP)
- 5) Establish state requirements for healthy food choices in Missouri schools
 - Require schools to follow recommendations established in the “Missouri Eat Smart” nutrition standards eliminating the sale and marketing of unhealthy foods and beverages

In addition, the Commission recommends that a’ la carte, vending machine foods and beverages as well as food and beverages sold at fundraisers also meet the “Missouri Eat Smart” nutrition guidelines.

CONCLUSION

America is in the mist of a healthcare crisis and if we all do not strive to find solutions nationally and in Missouri, the epidemic of overweight and obesity in youth will continue to escalate. Since obesity is the second leading cause of unnecessary deaths, the disparity in services and attention necessitates our immediate response and action despite assistance from the government, healthcare profession and other industries.

Missouri legislators should follow the lead of their colleagues in other states in providing legal oversight to this problem. A promising first step is the introduction of two pieces of legislation co-sponsored by Representative Connie Johnson, introduced this 2006-2007 legislative session:

- 1) Establishes curriculum requirements for physical education classes for students in grades six through twelve. These classes shall include at least 225 minutes of movement each week, consistent with the “Healthy People by 2010” initiative undertaken by the U.S. Department of Health and Human Services and the recommendations of the National Association of Sport and Physical Education as approved by the American Heart Association.

This legislation also requires that each child shall have the opportunity to participate in learning individual health assessment skills and participate in programs that demonstrate the effects of consistent good choices such as exercise or food selection.

- 2) Establishes curriculum requirements for physical education classes for students from kindergarten to fifth grade. These classes shall include at

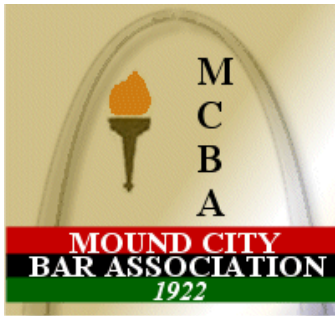
least 150 minutes of movement each week, consistent with the “Healthy People by 2010” initiative undertaken by the U.S. Department of Health and Human Services and the recommendations of the National Association of Sport and Physical Education as approved by the American Heart Association.

This legislation also requires that each child shall have the opportunity to participate in learning individual health assessment skills and participate in programs that demonstrate the effects of consistent good choices such as exercise or food selection.

In conclusion, the Mound City Bar Association has pledged to review the status of this problem in one year and report the progress that has been made toward its resolution.

APPENDIX

CORRESPONDENCE



Mound City Bar Association

P.O. Box 1543

St. Louis, MO 63188

Tel: (314) 552.6349

E-mail: pmeanes@thompsoncoburn.com

January 4, 2007

Ms. Amy Phillips
Williams 9th Grade Academy
3955 St. Ferdinand Avenue
St. Louis, MO 63113

Dear Ms. Phillips:

This letter is written on behalf of the Mound City Bar Association (“MCBA”) Healthcare Commission. MCBA is one of the oldest black bar associations west of the Mississippi River. The organization’s objectives are to advance the professional interest and professional development of its’ members; promote the administration of justice; uphold the honor of the legal profession, and provide service to the community. Currently, MCBA is researching, examining and analyzing the diversity initiatives of various establishments in the following four disciplines: 1) Education; 2) Health care, 3) Bar Association and 4) Employment.

With respect to health care, a Commission has been established. The Commission’s primary responsibility is to examine the problem of obesity in the St. Louis Metropolitan school districts to determine whether: 1) there are any legislative options that should be considered to address this issue; and 2) if any disparities exist in the type of physical education programs and/or facilities which are available at schools located in the St. Louis Metropolitan school districts. To that end, this Commission will: 1) research the need for physical education in the Missouri Public School system; 2) distribute survey to said schools; 3) facilitate a meeting with various healthcare providers, legislators and educators on February 28, 2007; and 4) draft a report setting forth its findings and recommendations (“Commission Report”).

According to the US Department of Health and Human Services, since 1980 the percentage of children who are overweight has more than doubled, while rates among adolescents have more than tripled.

Pamela J. Meanes
President

Rufus J. Tate, Jr.
President-Elect

Annette Slack
Vice-President

Paul A. Randolph
Treasurer

Carla Allen
Corresponding
Secretary

Kemba Logan
Recording Secretary

Joan K. Miller
Member-At-Large

Rolanda Johnson
Member-At-Large

Robert Kenney
Parliamentarian

Celestine Dotson
Historian

Hon. Marvin O. Teer
Immediate Past
President

Obesity in children and adolescents is a serious issue with many health and social consequences that often continue into adulthood. Implementing prevention programs and getting a better understanding of treatment for adolescents is important to controlling the obesity epidemic.

The 2005 Youth Risk Behavior Survey conducted by the Centers for Disease Control and Prevention ("CDC") indicates that among Missouri high school students, 14% are overweight and 16% are at risk for becoming overweight. Accordingly, practical solutions should include better health education, more physical education, physical activity and healthier school environments.

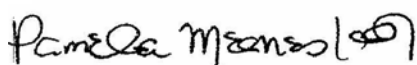
The education system cannot solve the obesity epidemic on its own, but it is unlikely to be halted without strong school-based policies and programs. However, we believe that schools play an especially important role because:

- 1) Over 95% of young people are enrolled in schools;
- 2) Promotion of physical activity and healthy eating have long been a fundamental component of the American educational experience, so schools are not being asked to assume new responsibilities;
- 3) Research has shown that well-designed, well-implemented school programs can effectively promote physical activity, healthy eating, and reductions in television viewing time; and
- 4) Emerging research documents the connections between physical activity, good nutrition, physical education programs and academic performance.

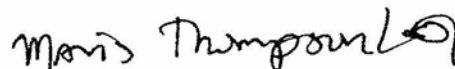
Most importantly, schools can help students adopt and maintain healthy eating and physical activity behaviors. The CDC has published guidelines that identify school policies and practices most likely to be effective in promoting life-long physical activity and healthy eating. The guidelines which are based on comprehensive reviews of the research literature and extensive input from academic experts and school health practitioners contain many different recommendations; however, the MCBA Healthcare Commission will focus on assisting schools through legislative action to strengthen schools' physical activity policies.

We appreciate your assistance in this matter. Please find attached a survey regarding Childhood Obesity. We request that you complete the survey and mail it to Mavis Thompson, at 3510 Dodier Street. St. Louis, MO 63107, no **later than January 26, 2007**. Thank you for your cooperation and we look forward to working with you to combat the obesity epidemic that is plaguing our youth.

Sincerely,



Pamela Meanes



Mavis Thompson

Pamela J. Meanes
President

Rufus J. Tate, Jr.
President-Elect

Annette Slack
Vice-President

Paul A. Randolph
Treasurer

Carla Allen
Corresponding
Secretary

Kemba Logan
Recording Secretary

Joan K. Miller
Member-At-Large

Rolanda Johnson
Member-At-Large

Robert Kenney
Parliamentarian

Celestine Dotson
Historian

Hon. Marvin O. Teer
Immediate Past
President

President, Mound City Bar Association

Chair, MCBA Healthcare Commission

Adams Elementary School
1311 Tower Grove Ave
St. Louis, MO 63110
Phone: 535-3910
Fax: 535-3949
Principal: Jeanetta Stegall
Email: Jeanetta.Stegall@slps.org

Ames VPA School
2900 Hadley St
St. Louis, MO 63107
Phone: 241-7165
Fax: 231-1607
Principal: Javetta Parks
Email: Javetta.Parks@slps.org

Ashland Elementary School
3921 N Newstead Ave
St. Louis, MO 63115
Phone: 385-4767
Fax: 385-6129
Principal: Shonta Smith
Email: Shonta.Smith@slps.org

Baden Elementary School
8724 Halls Ferry Rd
St. Louis, MO 63147
Phone: 388-2477
Fax: 388-9931
Principal: Alila Barr
Email: Alila.Barr@slps.org

Bryan Hill Elementary School
4342 Aldine
St. Louis, MO 63107
Phone: 534-0370
Fax: 535-7864
Principal: Carole Johnson
Email: Carole.Johnson@slps.org

Buder Elementary School
5319 Lansdowne Ave
St. Louis, MO 63109
Phone: 352-4343
Fax: 352-3150
Principal: Monica Hudson
Email: Monica.Hudson@slps.org

Clark Elementary School
1020 N Union Blvd
St. Louis, MO 63113
Phone: 367-1505
Fax: 367-3624
Principal: Cynthia Warren
Email: Cynthia.Warren@slps.org

Clay Elementary School
3820 N 14th St
St. Louis, MO 63107
Phone: 231-9608
Fax: 231-1660
Principal: Donna Owens
Email: Donna.Owens@slps.org

Cole Elementary School
3935 Enright Ave
St. Louis, MO 63108
Phone: 533-0894
Fax: 533-4509
Principal: Stella Erondu
Email: Stella.Erondu@slps.org

Columbia Elementary CEC School
3120 Saint Louis Ave
St. Louis, MO 63106
Phone: 533-2750
Fax: 534-0452
Principal: Judith Durham
Email: Judith.Durham@slps.org

Cote Brilliante Elementary School
2616 Cora Ave
St. Louis, MO 63113
Phone: 531-8680
Fax: 531-7910
Principal: Karen Jones
Email: Karen.Jones@slps.org

Dewey IS Elementary School
6746 Clayton Ave
St. Louis, MO 63139
Phone: 645-4845
Fax: 645-5926
Principal: Dr. Ann Russek
Email: Ann.Russek@slps.org

Dunbar Elementary School
1415 N Garrison Ave
St. Louis, MO 63106
Phone: 533-2526
Fax: 533-0269
Principal: Carla Cunigan
Email: Carla.Cunigan@slps.org

Euclid Montessori Elementary School
1131 N Euclid Ave
St. Louis, MO 63113
Phone: 367-4385
Fax: 367-8541
Principal: DeAdrienne Torrey
Email: DeAdrienne.Torrey@slps.org

Farragut Elementary School
4025 Sullivan Ave
St. Louis, MO 63107
Phone: 531-1198
Fax: 531-5356
Principal: Joyce Wilks-Love
Email: Joyce.Wilks-Love@slps.org

Ford Elementary School
1383 Clara Ave
St. Louis, MO 63112
Phone: 383-0836
Fax: 383-0887
Principal: Denise Segers
Email: Denise.Segers@slps.org

Froebel Elementary School
3709 Nebraska Ave
St. Louis, MO 63118
Phone: 771-3533
Fax: 771-3590
Principal: Mamie Womack
Email: Mamie.Womack@slps.org

Gateway Elementary School
4 Gateway Dr
St. Louis, MO 63106
Phone: 241-8255
Fax: 241-3159
Principal: Richard Sirna
Email: Richard.Sirna@slps.org

Gundlach Elementary School
2931 Arlington Ave
St. Louis, MO 63120
Phone: 383-0913
Fax: 383-6883
Principal: Mary Jensen
Email: Mary.Jensen@slps.org

Hamilton Elementary CEC School
5819 Westminster Pl
St. Louis, MO 63112
Phone: 367-0552
Fax: 367-2392
Principal: Glenda Bryant
Email: Glenda.Bryant@slps.org

Henry Elementary School
1220 N 10th St
St. Louis, MO 63106
Phone: 231-7284
Fax: 621-6013
Principal: Myrtle Reed
Email: Myrtle.Reed@slps.org

Herzog Elementary School
5831 Pamplin Pl
St. Louis, MO 63147
Phone: 385-2212
Fax: 385-1925
Principal: Deirdre Jackson
Email: Deidre.Jackson@slps.org

Hickey Elementary School
3111 Cora Ave
St. Louis, MO 63115
Phone: 383-2550
Fax: 383-5164
Principal: Peggy Starks
Email: Peggy.Starks@slps.org

Hodgen Elementary School
1616 California
St. Louis, MO 63104
Phone: 771-2539
Fax: 771-2418
Principal: Vasilika Tschlis
Email: Vasilika.Tschlis@slps.org

Jefferson Elementary School
1301 Hogan St
St. Louis, MO 63106
Phone: 231-2459
Fax: 231-2905
Principal: Roger Brock
Email: Roger.Brock@slps.org

Kennard CJA Elementary School
5031 Potomac St
St. Louis, MO 63139
Phone: 353-8875
Fax: 351-0441
Principal: Merry Denny
Email: Merry.Denny@slps.org

Kottmeyer ECC Elementary School
1530 S Grand
St. Louis, MO 63104
Phone: 865-2600
Fax: 664-1237
Principal: Sally Bloom
Email: Sally.Bloom@slps.org

Laclede Elementary School
5821 Kennerly Ave
St. Louis, MO 63112
Phone: 385-0546
Fax: 385-7294
Principal: Sandy Wiley
Email: Sandy.Wiley@slps.org

Lexington Elementary School
5030 Lexington Ave
St. Louis, MO 63115
Phone: 385-2522
Fax: 385-4158
Principal: Barbara Anderson
Email: Barbara.Anderson@slps.org

Lyon ABI Elementary School
7417 Vermont Ave
St. Louis, MO 63111
Phone: 353-1353
Fax: 481-8625
Principal: Donald Nabors
Email: Donald.Nabors@slps.org

Mallinckrodt ABI Elementary School
6020 Pernod Ave
St. Louis, MO 63139
Phone: 352-9212
Fax: 352-3142
Principal: Betty Blanchard
Email: Betty.Blanchard@slps.org

Mann Elementary School
4047 Juniata St
St. Louis, MO 63116
Phone: 772-4545
Fax: 772-6348
Principal: Brian Zimmerman
Email: Brian.Zimmerman@slps.org

Mark Twain Elementary School
5316 Ruskin Ave
St. Louis, MO 63115
Phone: 381-1616
Fax: 381-6926
Principal: Arthelda Busch
Email: Arthelda.Busch@slps.org

Mason Elementary School
6031 Southwest Ave
St. Louis, MO 63139
Phone: 645-1201
Fax: 645-0884
Principal: Curtis Wright
Email: Curtis.Wright@slps.org

Meramec Elementary School
2745 Meramec St
St. Louis, MO 63118
Phone: 353-7145
Fax: 353-6783
Principal: Jerome Woodson
Email: Jerome.Woodson@slps.org

Mitchell Elementary School
955 Arcade Ave
St. Louis, MO 63112
Phone: 367-0930
Fax: 367-1007
Principal: Carol H. Powell
Email: Carol.Henderson@slps.org

Monroe Elementary School
3641 Missouri Ave
St. Louis, MO 63118
Phone: 776-7315
Fax: 776-7339
Principal: Gerald Arbini
Email: Gerald.Arbini@slps.org

Mullanphy ILC Elementary School
4221 Shaw Ave
St. Louis, MO 63110
Phone: 772-0994
Fax: 865-3759
Principal: Kenneth Blanton
Email: Kenneth.Blanton@slps.org

Nance Elementary School
8959 Riverview Boulevard
St. Louis, MO 63147
Phone: 867-0634
Fax: 867-1006
Principal: Emma Cannon
Email: Emma.Cannon@slps.org

Oak Hill Elementary School
4300 Morganford Rd
St. Louis, MO 63116
Phone: 481-0420
Fax: 481-2371
Principal: Wanda LeFlore
Email: Wanda.LeFlore@slps.org

Peabody Elementary School
1224 S 14th St
St. Louis, MO 63104
Phone: 241-1533
Fax: 241-2805
Principal: Chereyl Spann
Email: Chereyl.Spann@slps.org

Scruggs Elementary School
4611 S Grand Blvd
St. Louis, MO 63111
Phone: 752-0604
Fax: 752-3887
Principal: Beverly Phillips
Email: Beverly.Phillips@slps.org

Shaw VPA Elementary CEC School
5329 Columbia Ave
St. Louis, MO 63139
Phone: 776-5091
Fax: 776-5124
Principal: Deborah Leto
Email: Deborah.Leto@slps.org

Shenandoah Elementary School
3412 Shenandoah Ave
St. Louis, MO 63104
Phone: 772-7544
Fax: 772-8581
Principal: Sonya Wayne
Email: Sonya.Wayne@slps.org

Shepard Elementary School
3450 Wisconsin Ave
St. Louis, MO 63118
Phone: 776-3664
Fax: 664-3708
Principal: Carol Hall
Email: Carol.Hall@slps.org

Sherman Elementary CEC School
3942 Flad Ave
St. Louis, MO 63110
Phone: 776-2626
Fax: 776-3978
Principal: Rosemary Howard
Email: Rosemary.Howard@slps.org

Sigel Elementary CEC School
2050 Allen Ave
St. Louis, MO 63104
Phone: 771-0010
Fax: 771-4527
Principal: Christine Martchink
Email: Christine.Martchink@slps.org

Simmons/Marshall Mega Magnet
Elementary School
4318 St. Louis Ave
St. Louis, MO 63115
Phone: 535-5844
Fax: 535-0827
Principal: Carey Cunningham
Email: Carey.Cunningham@slps.org

Stix ECC Elementary School
647 Tower Grove Ave
St. Louis, MO 63110
Phone: 533-0874
Fax: 533-8262
Principal: Florence Flieg
Email: Florence.Flieg@slps.org

Walbridge Elementary CEC School
5000 Davison Ave
St. Louis, MO 63120
Phone: 383-1829
Fax: 383-2292
Principal: Ruth Banks
Email: Ruth.Banks@slps.org

Washington Montessori Elementary
School
1130 N Euclid Av
St. Louis, MO 63113
Phone: 361-0432
Fax: 361-2760
Principal: DeAdrienne Torrey
Email: DeAdrienne.Torrey@slps.org

Wilkinson ECC Elementary School
7212 Arsenal St
St. Louis, MO 63143
Phone: 645-1202
Fax: 645-2618
Principal: Rosalyn Mason
Email: Rosalyn.Mason@slps.org

Woerner Elementary School
6131 Leona St
St. Louis, MO 63116
Phone: 481-8585
Fax: 351-2272
Principal: George Taubenheim
Email: George.Taubenheim@slps.org

Woodward Elementary School
725 Bellerive Blvd
St. Louis, MO 63111
Phone: 353-1346
Fax: 353-5768
Principal: Nathaniel Watlington
Email: Nathaniel.Watlington@slps.org

Wyman Elementary School
1547 S Theresa Ave
St. Louis, MO 63104
Phone: 772-9328
Fax: 772-3636
Principal: Gloria Shelton
Email: Gloria.Shelton@slps.org

Blewett Middle School
1927 Cass Ave
St. Louis, MO 63106
Phone: 231-7738
Fax: 231-0073
Principal: Annie Chambers
Email: Annie.Chambers@slps.org

Blow Middle CEC School
516 Loughborough Ave
St. Louis, MO 63111
Phone: 353-1349
Fax: 353-9048
Principal: Gregory Cosby
Email: Gregory.Cosby@slps.org

Bunche International Studies Middle
School
3125 S Kingshighway
St. Louis, MO 63139
Phone: 772-1779
Fax: 772-1715
Principal: Carol J Howard
Email: Carol.Howard@slps.org

Busch AAA Middle School
5910 Clifton Ave
St. Louis, MO 63109
Phone: 352-1043
Fax: 352-3685
Principal: Robert Lescher
Email: Robert.Lescher@slps.org

Carr Lane VPA Middle School
1004 N Jefferson Ave
St. Louis, MO 63106
Phone: 231-0413
Fax: 241-1213
Principal: Melba Davis
Email: Melba.Davis@slps.org

Compton-Drew ILC Middle School
5130 Oakland Ave
St. Louis, MO 63110
Phone: 652-9282
Fax: 652-9371
Principal: Andrea Walker
Email: Andrea.Walker@slps.org

Fanning Middle CEC School
3417 Grace Ave
St. Louis, MO 63116
Phone: 772-1038
Fax: 772-0427
Principal: Verona Bowers
Email: Verona.Bowers@slps.org

Gateway Middle School
1200 N Jefferson Ave
St. Louis, MO 63106
Phone: 241-2295
Fax: 241-7698
Principal: Vickie Rogers
Email: Vickie.Rogers@slps.org

Humboldt Middle School
2516 S 9th St
St. Louis, MO 63104
Phone: 772-5566
Fax: 772-3180
Principal: Georgia Calhoun-Green
Email: Georgia.Calhoun-Green@slps.org

L'Ouverture Middle School
3021 Hickory St
St. Louis, MO 63104
Phone: 664-3579
Fax: 664-7955
Principal: Juanita Jones
Email: Juanita.Jones@slps.org

Langston Middle School
5511 Wabada Ave
St. Louis, MO 63112
Phone: 383-2908
Fax: 385-4632
Principal: Carol Barnes
Email: Carol.Barnes@slps.org

Long Middle CEC School
5028 Morganford Rd
St. Louis, MO 63116
Phone: 481-3440
Fax: 481-7329
Principal: Alva Blue
Email: Alva.Blue@slps.org

McKinley CJA Middle School
2156 Russell Blvd
St. Louis, MO 63104
Phone: 773-0027
Fax: 771-9749
Principal: Brenda Smith
Email: Brenda.Smith@slps.org

Northwest Accelerated Middle School
5140 Riverview Blvd
St. Louis, MO 63120
Phone: 385-4774
Fax: 389-3566
Principal: Valerie Carter-Thomas
Email: Valerie.Carter-Thomas@slps.org

Stevens Middle CEC
1033 N Whittier St
St. Louis, MO 63113
Phone: 533-8550
Fax: 533-0306
Principal: Larry W. Schleicher
Email: Larry.Schleicher@slps.org

Stowe Middle School
5750 Lotus Ave
St. Louis, MO 63112
Phone: 382-7310
Fax: 382-4277
Principal: Vernice Hicks
Email: Vernice.Hicks@slps.org

Webster Middle School
2127 N 11th Street
St. Louis, MO 63106
Phone: 231-9196
Fax: 231-3927
Principal: Rosemary Johnson
Email: Rosemary.Johnson@slps.org

Yeatman Middle CEC School
4265 Athlone Ave
St. Louis, MO 63115
Phone: 261-8132
Fax: 389-4613
Principal: Valerie Taylor
Email: Valerie.Taylor@slps.org

Beaumont High School
3836 Natural Bridge Ave
St. Louis, MO 63107
Phone: 533-2410
Fax: 535-0786
Principal: Travis Brown
Email: Travis.Brown@slps.org

Career Academy High School
1000 N Grand
St. Louis, MO 63106
Phone: 371-0394
Fax: 371-1311
General Email: millerca@millerca.org
Principal: Steve Warmack
Email: Stephen.Warmacksr@slps.org

Mel Carnahan High School
4041 S. BROADWAY
ST. LOUIS, MO 63118
Phone: 314-457-0582
Fax: 314-457-9482
Principal: Dr. Alice Roach

Central VPA High School
3125 S Kingshighway
St. Louis, MO 63139
Phone: 771-2772
Fax: 771-0135
Principal: Dr. Stanley Engram
Email: Stanley.Engram@slps.org

Cleveland NJROTC School at Pruitt
1212 N. 22 nd Street
St. Louis, MO 63106
Phone: 231-1443
Fax: 231-4895
Principal: Sherman Curtis
Email: Sherman.Curtis@slps.org

Gateway IT High School
5101 McRee Ave
St. Louis, MO 63110
Phone: 776-3300
Fax: 776-8267
Principal: Kathryn Piller
Email: Kathryn.Piller@slps.org

Lafayette 9th Grade Center
815 Ann Ave
St. Louis, MO 63104
Phone: 762-0252
Fax: 762-0252
Principal: Sylvia Shead
Email: Sylvia.Shead@slps.org

Madison Alternative
1118 S 7th Street
St. Louis, MO 63104
Phone: 588-8750
Fax: 588-1510
Principal: Donnie Hollins
Email: Donnie.Hollins@slps.org

Meda P. Washington Education Center
2030 S Vandeventer Ave
St. Louis, MO 63110
Phone: 771-4041
Fax: 771-4053
Principal: Marlene Davidson
Email: Marlene.Davidson@slps.org

Metro Academic and Classical High School
4015 McPherson Ave
St. Louis, MO 63108
Phone: 534-3894
Fax: 531-4894
Principal: Wilfred Moore
Email: Wilfred.Moore@slps.org

Nottingham CAJT
4915 Donovan Ave
St. Louis, MO 63109
Phone: 481-4095
Fax: 481-4095
Administrator: Roland Werner
Email: Roland.Werner@slps.org

Roosevelt High School
3230 Hartford St
St. Louis, MO 63118
Phone: 776-6040
Fax: 776-0152
Principal: Terry Houston
Email: Terry.Houston@slps.org

Soldan IS High School
918 N Union Blvd
St. Louis, MO 63108
Phone: 367-9222
Fax: 367-1898
Principal: Thomas Cason
Email: Thomas.Cason@slps.org

Sumner MEGA High School
4248 Cottage Ave
St. Louis, MO 63113
Phone: 371-1048
Fax: 531-9852
Principal: Randolph Spencer
Email: Randolph.Spencer@slps.org

Trans
5140 Riverview Blvd
St. Louis, MO 63120
Phone: 385-4774
Fax: 389-3566
Principal: Valerie Carter-Thomas
Email: Valerie.Carter-Thomas@slps.org

Turner 9th Grade Center
2615 N Billups Ave
St. Louis, MO 63113
Phone: 535-8482
Fax: 535-0196
Principal: Annette Hayes
Email: Annette.Hayes@slps.org

Vashon High School
3035 Cass
St. Louis, MO 63106
Phone: 533-9487
Fax: 533-7540
Principal: Barbara Sharp
Email: Barbara.Sharp@slps.org

Williams 9th Grade Academy
3955 St. Ferdinand Ave
St. Louis, MO 63113
Phone: 533-0201
Fax: 531-1789
Principal: Amy Phillips
Email: Amy.Phillips@slps.org

**Mound City Bar Association
St. Louis City Public School Survey
Childhood Obesity**

1. School Name/Address Bunche ISMS
3125 Kingshighway
2. Type of school:
a. Elementary: Grades _____
b. Middle: Grades 6-8
c. High School: Grades _____
3. Number of students enrolled 260
4. What is the racial composition (%) of your student body?
a. Asian/Pacific Islander 5%
b. Black/African-American 60%
c. Hispanic/Latino 15%
d. White/Caucasian 20%
e. Other _____
5. What is the gender distribution of your student body?
a. Male 55
b. Female 45
6. What % of your student body is eligible for federally subsidized nutrition programs?
a. Less than 25% _____
b. 25 – 50% _____
c. 50 – 75% √
d. Greater than 75% _____
7. Are your students required to participate in a health education course?
a. Yes √ No _____
b. If YES,
i. What grades are required to have this course? 6-8
ii. Does the course include instruction on nutrition and dietary topics?
Yes √ No _____
8. Do you allow students to purchase snack foods or beverages from vending machines, a school store, canteen or snack bar?
a. Yes √ No _____
b. If YES,
i. Are fruits and vegetables available for purchase?
ii. Are 100% fruit juices available for purchase?
Yes √ No _____

- iii. Is bottled water available for purchase?
 Yes No
- iv. Are students allowed to purchase candy, soft drinks, sport drinks, or high fat snacks, e.g. potato chips during school lunch periods?
 Yes No
9. Are students required to participate in physical education activities or courses?
 a. Yes No
 b. If YES,
 i. What grades have this requirement? 6-8
 ii. How many days/week? 2/4
 iii. How many hours/week? 2/4 hrs
 iv. Courses taught Phys Ed
 v. Sports available No
10. Does your school offer intramural activities or physical activity clubs for students?
 a. Yes No
11. Does your school have an exercise training or weight room?
 a. Yes No
 b. If YES,
 i. What type of equipment? _____

12. Do you routinely complete health screenings on your students which include height and weight measurements?
 a. Yes No
13. What % (estimate) of your student body is overweight (calculation of height and weight based on Body Mass Index (BMI) > 95th percentile)?
 a. Less than 10% _____
 b. 10 – 25% _____
 c. 26 – 50% _____
 d. 51 – 75% _____
 e. Greater than 75% _____
 f. Don't know _____
14. Comments _____

Thank you for taking the time to complete this survey. If you have any questions, please contact the MCBA Healthcare Commission chairperson, Ms. Mavis Thompson at 314-652-7314.

**Mound City Bar Association
St. Louis City Public School Survey
Childhood Obesity**

1. School Name/Address Cole eMINTS Academy
3935 Enright Avenue
St. Louis, MO 63108
2. Type of school:
a. Elementary: Grades Preschool – 5th
b. Middle: Grades 6th, 7th
c. High School: Grades _____
3. Number of students enrolled 315
4. What is the racial composition (%) of your student body?
a. Asian/Pacific Islander _____
b. Black/African-American √
c. Hispanic/Latino _____
d. White/Caucasian _____
e. Other Caucasian/Black
5. What is the gender distribution of your student body?
a. Male 208
b. Female 109
6. What % of your student body is eligible for federally subsidized nutrition programs?
a. Less than 25% _____
b. 25 – 50% _____
c. 50 – 75% _____
d. Greater than 75% √
7. Are your students required to participate in a health education course?
a. Yes √ No _____
b. If YES,
i. What grades are required to have this course? 4, 5, 6
ii. Does the course include instruction on nutrition and dietary topics?
Yes √ No _____
8. Do you allow students to purchase snack foods or beverages from vending machines, a school store, canteen or snack bar?
a. Yes _____ No √
b. If YES,
i. Are fruits and vegetables available for purchase?
ii. Are 100% fruit juices available for purchase?
Yes _____ No √

- iii. Is bottled water available for purchase?
 Yes _____ No
- iv. Are students allowed to purchase candy, soft drinks, sport drinks, or high fat snacks, e.g. potato chips during school lunch periods?
 Yes _____ No
9. Are students required to participate in physical education activities or courses?
 a. Yes No _____
 b. If YES,
 i. What grades have this requirement? 5 – 7th
 ii. How many days/week? 2
 iii. How many hours/week? 100 minutes/week
 iv. Courses taught Exercise/Health
 v. Sports available Soccer, Football, Basketball
10. Does your school offer intramural activities or physical activity clubs for students?
 a. Yes No _____
11. Does your school have an exercise training or weight room?
 a. Yes _____ No
 b. If YES,
 i. What type of equipment? _____

12. Do you routinely complete health screenings on your students which include height and weight measurements?
 a. Yes No _____
13. What % (estimate) of your student body is overweight (calculation of height and weight based on Body Mass Index (BMI) > 95th percentile)?
 a. Less than 10% _____
 b. 10 – 25% _____
 c. 26 – 50%
 d. 51 – 75% _____
 e. Greater than 75% _____
 f. Don't know _____
14. Comments _____

Thank you for taking the time to complete this survey. If you have any questions, please contact the MCBA Healthcare Commission chairperson, Ms. Mavis Thompson at 314-652-7314.

**Mound City Bar Association
St. Louis City Public School Survey
Childhood Obesity**

1. School Name/Address Cote Brilliante
4908 Cote Brilliante Ave.
St. Louis, MO 63113
2. Type of school:
 - a. Elementary: Grades Pre K - 6
 - b. Middle: Grades _____
 - c. High School: Grades _____
3. Number of students enrolled 305
4. What is the racial composition (%) of your student body?
 - a. Asian/Pacific Islander _____
 - b. Black/African-American 100%
 - c. Hispanic/Latino _____
 - d. White/Caucasian _____
 - e. Other _____
5. What is the gender distribution of your student body?
 - a. Male _____
 - b. Female _____
6. What % of your student body is eligible for federally subsidized nutrition programs?
 - a. Less than 25% _____
 - b. 25 – 50% _____
 - c. 50 – 75% _____
 - d. Greater than 75% √
7. Are your students required to participate in a health education course?
 - a. Yes √ No _____
 - b. If YES,
 - i. What grades are required to have this course? Kg - 6
 - ii. Does the course include instruction on nutrition and dietary topics?
Yes √ No _____
8. Do you allow students to purchase snack foods or beverages from vending machines, a school store, canteen or snack bar?
 - a. Yes _____ No √
 - b. If YES,
 - i. Are fruits and vegetables available for purchase?
 - ii. Are 100% fruit juices available for purchase?
Yes _____ No _____

- iii. Is bottled water available for purchase?
 Yes _____ No _____
- iv. Are students allowed to purchase candy, soft drinks, sport drinks, or high fat snacks, e.g. potato chips during school lunch periods?
 Yes _____ No
9. Are students required to participate in physical education activities or courses?
 a. Yes No _____
 b. If YES,
 i. What grades have this requirement? Pre K - 6
 ii. How many days/week? 2
 iii. How many hours/week? 90 minutes
 iv. Courses taught _____
 v. Sports available _____
10. Does your school offer intramural activities or physical activity clubs for students?
 a. Yes _____ No
11. Does your school have an exercise training or weight room?
 a. Yes _____ No
 b. If YES,
 i. What type of equipment? _____

12. Do you routinely complete health screenings on your students which include height and weight measurements?
 a. Yes No _____
13. What % (estimate) of your student body is overweight (calculation of height and weight based on Body Mass Index (BMI) > 95th percentile)?
 a. Less than 10% _____
 b. 10 – 25%
 c. 26 – 50% _____
 d. 51 – 75% _____
 e. Greater than 75% _____
 f. Don't know _____
14. Comments _____

Thank you for taking the time to complete this survey. If you have any questions, please contact the MCBA Healthcare Commission chairperson, Ms. Mavis Thompson at 314-652-7314.

**Mound City Bar Association
St. Louis City Public School Survey
Childhood Obesity**

1. School Name/Address Gundlach School
3931 Arlington Ave.
St. Louis, MO 63120
2. Type of school:
 - a. Elementary: Grades Pre-K to 7th
 - b. Middle: Grades _____
 - c. High School: Grades _____
3. Number of students enrolled 304
4. What is the racial composition (%) of your student body?
 - a. Asian/Pacific Islander _____
 - b. Black/African-American 100%
 - c. Hispanic/Latino _____
 - d. White/Caucasian _____
 - e. Other _____
5. What is the gender distribution of your student body?
 - a. Male 50%
 - b. Female 50%
6. What % of your student body is eligible for federally subsidized nutrition programs?
 - a. Less than 25% _____
 - b. 25 – 50% _____
 - c. 50 – 75% _____
 - d. Greater than 75% √
7. Are your students required to participate in a health education course?
 - a. Yes √ No _____
 - b. If YES,
 - i. What grades are required to have this course? Kg. – 7th
 - ii. Does the course include instruction on nutrition and dietary topics?
Yes √ No _____
8. Do you allow students to purchase snack foods or beverages from vending machines, a school store, canteen or snack bar?
 - a. Yes _____ No √
 - b. If YES,
 - i. Are fruits and vegetables available for purchase?
 - ii. Are 100% fruit juices available for purchase?
Yes _____ No _____

- iii. Is bottled water available for purchase?
 Yes _____ No _____
- iv. Are students allowed to purchase candy, soft drinks, sport drinks, or high fat snacks, e.g. potato chips during school lunch periods?
 Yes _____ No
9. Are students required to participate in physical education activities or courses?
 a. Yes No _____
 b. If YES,
 i. What grades have this requirement? Kg – 7th
 ii. How many days/week? 2 days/week
 iii. How many hours/week? 1½ hours/week
 iv. Courses taught -
 v. Sports available not at an organized level
10. Does your school offer intramural activities or physical activity clubs for students?
 a. Yes _____ No
11. Does your school have an exercise training or weight room?
 a. Yes _____ No
 b. If YES,
 i. What type of equipment? _____

12. Do you routinely complete health screenings on your students which include height and weight measurements?
 a. Yes No _____
13. What % (estimate) of your student body is overweight (calculation of height and weight based on Body Mass Index (BMI) > 95th percentile)?
 a. Less than 10% _____
 b. 10 – 25% _____
 c. 26 – 50%
 d. 51 – 75% _____
 e. Greater than 75% _____
 f. Don't know _____
14. Comments _____

Thank you for taking the time to complete this survey. If you have any questions, please contact the MCBA Healthcare Commission chairperson, Ms. Mavis Thompson at 314-652-7314.

**Mound City Bar Association
St. Louis City Public School Survey
Childhood Obesity**

1. School Name/Address Nottingham CAST H.S.
4915 Donovan Ave.
St. Louis, MO 63109

2. Type of school:
 - a. Elementary: Grades _____
 - b. Middle: Grades _____
 - c. High School: Grades 9, 10, 11, 12 [all students developmentally disabled moderate/severe]

3. Number of students enrolled 130

4. What is the racial composition (%) of your student body?
 - a. Asian/Pacific Islander _____
 - b. Black/African-American 90%
 - c. Hispanic/Latino 1%
 - d. White/Caucasian 9%
 - e. Other _____

5. What is the gender distribution of your student body?
 - a. Male √
 - b. Female _____

6. What % of your student body is eligible for federally subsidized nutrition programs?
 - a. Less than 25% _____
 - b. 25 – 50% _____
 - c. 50 – 75% √
 - d. Greater than 75% _____

7. Are your students required to participate in a health education course?
 - a. Yes √ No _____
 - b. If YES,
 - i. What grades are required to have this course? _____
 - ii. Does the course include instruction on nutrition and dietary topics?
Yes √ No _____

8. Do you allow students to purchase snack foods or beverages from vending machines, a school store, canteen or snack bar?
 - a. Yes √ No _____
 - b. If YES,
 - i. Are fruits and vegetables available for purchase?
 - ii. Are 100% fruit juices available for purchase?
Yes √ No _____

- iii. Is bottled water available for purchase?
 Yes No _____
- iv. Are students allowed to purchase candy, soft drinks, sport drinks, or high fat snacks, e.g. potato chips during school lunch periods?
 Yes No _____
9. Are students required to participate in physical education activities or courses?
 a. Yes No _____
 b. If YES,
 i. What grades have this requirement? All
 ii. How many days/week? 2
 iii. How many hours/week? 1/2
 iv. Courses taught _____
 v. Sports available
10. Does your school offer intramural activities or physical activity clubs for students?
 a. Yes No _____
11. Does your school have an exercise training or weight room?
 a. Yes _____ No
 b. If YES,
 i. What type of equipment? None

12. Do you routinely complete health screenings on your students which include height and weight measurements?
 a. Yes No _____
13. What % (estimate) of your student body is overweight (calculation of height and weight based on Body Mass Index (BMI) > 95th percentile)?
 a. Less than 10% _____
 b. 10 – 25%
 c. 26 – 50% _____
 d. 51 – 75% _____
 e. Greater than 75% _____
 f. Don't know _____
14. Comments Our school population as a whole is working toward combating obesity epidemic by better nutrition and exercise, food choice and being better informed.

Thank you for taking the time to complete this survey. If you have any questions, please contact the MCBA Healthcare Commission chairperson, Ms. Mavis Thompson at 314-652-7314.

Mound City Bar Association
St. Louis City Public School Survey
Childhood Obesity

1. School Name/Address Stevens Middle CEC School
1033 N. Whittier Street
St. Louis, MO 63113

2. Type of school:
 - a. Elementary: Grades
 - b. Middle: Grades 6, 7 & 8
 - c. High School: Grades

3. Number of students enrolled 318

4. What is the racial composition (%) of your student body?
 - a. Asian/Pacific Islander
 - b. Black/African-American 98%
 - c. Hispanic/Latino 1%
 - d. White/Caucasian 1%
 - e. Other

5. What is the gender distribution of your student body?
 - a. Male 174
 - b. Female 144

6. What % of your student body is eligible for federally subsidized nutrition programs?
 - a. Less than 25%
 - b. 25 – 50%
 - c. 50 – 75%
 - d. Greater than 75% √

7. Are your students required to participate in a health education course?
 - a. Yes √ No
 - b. If YES,
 - i. What grades are required to have this course? 6, 7 & 8
 - ii. Does the course include instruction on nutrition and dietary topics?
Yes √ No

8. Do you allow students to purchase snack foods or beverages from vending machines, a school store, canteen or snack bar?
 - a. Yes √ No
 - b. If YES,
 - i. Are fruits and vegetables available for purchase?
 - ii. Are 100% fruit juices available for purchase?
Yes √ No

- iii. Is bottled water available for purchase?
 Yes No
- iv. Are students allowed to purchase candy, soft drinks, sport drinks, or high fat snacks, e.g. potato chips during school lunch periods?
 Yes No
9. Are students required to participate in physical education activities or courses?
 a. Yes No
 b. If YES,
 i. What grades have this requirement? 6, 7 & 8
 ii. How many days/week? daily
 iii. How many hours/week? 50 min.
 iv. Courses taught _____
 v. Sports available _____
10. Does your school offer intramural activities or physical activity clubs for students?
 a. Yes No
11. Does your school have an exercise training or weight room?
 a. Yes No
 b. If YES,
 i. What type of equipment? _____

12. Do you routinely complete health screenings on your students which include height and weight measurements?
 a. Yes No
13. What % (estimate) of your student body is overweight (calculation of height and weight based on Body Mass Index (BMI) > 95th percentile)?
 a. Less than 10% _____
 b. 10 – 25% _____
 c. 26 – 50% _____
 d. 51 – 75% _____
 e. Greater than 75% _____
 f. Don't know _____
14. Comments _____

Thank you for taking the time to complete this survey. If you have any questions, please contact the MCBA Healthcare Commission chairperson, Ms. Mavis Thompson at 314-652-7314.

**Mound City Bar Association
St. Louis City Public School Survey
Childhood Obesity**

1. School Name/Address Wilkinson E.C.C.
7212 Arsenal Street
St. Louis, MO 63143

2. Type of school:
 - a. Elementary: Grades Pre-K – 2nd (Early Childhood Center)
 - b. Middle: Grades _____
 - c. High School: Grades _____

3. Number of students enrolled 197

4. What is the racial composition (%) of your student body?
 - a. Asian/Pacific Islander 1%
 - b. Black/African-American 55%
 - c. Hispanic/Latino 50%
 - d. White/Caucasian 40%
 - e. Other _____

5. What is the gender distribution of your student body?
 - a. Male 50%
 - b. Female 50%

6. What % of your student body is eligible for federally subsidized nutrition programs?
 - a. Less than 25% _____
 - b. 25 – 50% _____
 - c. 50 – 75% √
 - d. Greater than 75% _____

7. Are your students required to participate in a health education course?
 - a. Yes _____ No √
 - b. If YES,
 - i. What grades are required to have this course? _____
 - ii. Does the course include instruction on nutrition and dietary topics?
Yes _____ No _____

8. Do you allow students to purchase snack foods or beverages from vending machines, a school store, canteen or snack bar?
 - a. Yes _____ No √
 - b. If YES,
 - i. Are fruits and vegetables available for purchase?
 - ii. Are 100% fruit juices available for purchase?
Yes _____ No _____

- iii. Is bottled water available for purchase?
 Yes _____ No _____
- iv. Are students allowed to purchase candy, soft drinks, sport drinks, or high fat snacks, e.g. potato chips during school lunch periods?
 Yes _____ No _____
9. Are students required to participate in physical education activities or courses?
 a. Yes No _____
 b. If YES,
 i. What grades have this requirement? Pre-K – 2nd
 ii. How many days/week? One-two days per week
 iii. How many hours/week? One-two hrs. a wk.
 iv. Courses taught _____
 v. Sports available _____
10. Does your school offer intramural activities or physical activity clubs for students?
 a. Yes _____ No
11. Does your school have an exercise training or weight room?
 a. Yes _____ No
 b. If YES,
 i. What type of equipment? _____

12. Do you routinely complete health screenings on your students which include height and weight measurements?
 a. Yes No _____
13. What % (estimate) of your student body is overweight (calculation of height and weight based on Body Mass Index (BMI) > 95th percentile)?
 a. Less than 10%
 b. 10 – 25% _____
 c. 26 – 50% _____
 d. 51 – 75% _____
 e. Greater than 75% _____
 f. Don't know _____
14. Comments Our dietary nutritional program is calculated by a nutritionist who closely monitors the total caloric intake which promotes low caloric intake.

Thank you for taking the time to complete this survey. If you have any questions, please contact the MCBA Healthcare Commission chairperson, Ms. Mavis Thompson at 314-652-7314.

**Mound City Bar Association
St. Louis City Public School Survey
Childhood Obesity**

1. School Name/Address Williams Ninth Grade Academy
3955 St. Ferdinand Ave.
St. Louis, MO 63113
2. Type of school:
 - a. Elementary: Grades _____
 - b. Middle: Grades _____
 - c. High School: Grades 9
3. Number of students enrolled 220
4. What is the racial composition (%) of your student body?
 - a. Asian/Pacific Islander _____
 - b. Black/African-American 100%
 - c. Hispanic/Latino _____
 - d. White/Caucasian _____
 - e. Other _____
5. What is the gender distribution of your student body?
 - a. Male 47%
 - b. Female 53%
6. What % of your student body is eligible for federally subsidized nutrition programs?
 - a. Less than 25% _____
 - b. 25 – 50% √
 - c. 50 – 75% _____
 - d. Greater than 75% _____
7. Are your students required to participate in a health education course?
 - a. Yes √ No _____
 - b. If YES,
 - i. What grades are required to have this course? 9
 - ii. Does the course include instruction on nutrition and dietary topics?
Yes √ No _____
8. Do you allow students to purchase snack foods or beverages from vending machines, a school store, canteen or snack bar?
 - a. Yes √ No _____
 - b. If YES,
 - i. Are fruits and vegetables available for purchase? No.
 - ii. Are 100% fruit juices available for purchase?
Yes √ No _____

iii. Is bottled water available for purchase?

Yes No

iv. Are students allowed to purchase candy, soft drinks, sport drinks, or high fat snacks, e.g. potato chips during school lunch periods?

Yes No

9. Are students required to participate in physical education activities or courses?

a. Yes No

b. If YES,

i. What grades have this requirement? 9

ii. How many days/week? 5

iii. How many hours/week? 5

iv. Courses taught PE

v. Sports available none

10. Does your school offer intramural activities or physical activity clubs for students?

a. Yes No

11. Does your school have an exercise training or weight room?

a. Yes No

b. If YES,

i. What type of equipment? minimal

12. Do you routinely complete health screenings on your students which include height and weight measurements?

a. Yes No

13. What % (estimate) of your student body is overweight (calculation of height and weight based on Body Mass Index (BMI) > 95th percentile)?

a. Less than 10%

b. 10 – 25%

c. 26 – 50%

d. 51 – 75%

e. Greater than 75%

f. Don't know

14. Comments _____

Thank you for taking the time to complete this survey. If you have any questions, please contact the MCBA Healthcare Commission chairperson, Ms. Mavis Thompson at 314-652-7314.



Mound City Bar Association

P.O. Box 1543

St. Louis, MO 63188

Tel: (314) 552.6349

E-mail: pmeanes@thompsoncoburn.com

Pamela J. Meanes
President

Rufus J. Tate, Jr.
President-Elect

Annette Slack
Vice-President

Paul A. Randolph
Treasurer

Carla Allen
Corresponding
Secretary

Kemba Logan
Recording Secretary

Joan K. Miller
Member-At-Large

Rolanda Johnson
Member-At-Large

Robert Kenney
Parliamentarian

Celestine Dotson
Historian

Hon. Marvin O. Teer
Immediate Past
President

February 22, 2007

Dr. Diana Bourisaw
Superintendent of St. Louis Public Schools
801 N. 11th Street
St. Louis, MO 63101

Dear Dr. Bourisaw:

This letter is written on behalf of the Mound City Bar Association (“MCBA”) Healthcare Commission. Currently, MCBA is researching, examining and analyzing the diversity initiatives of various establishments in the following four disciplines: 1) Education; 2) Health care, 3) Bar Association and 4) Employment.

With respect to health care, a Commission has been established. The Commission’s primary responsibility is to examine the problem of obesity in the St. Louis Metropolitan school districts to determine whether: 1) there are any legislative options that should be considered to address this issue; and 2) if any disparities exist in the type of physical education programs and/or facilities which are available at schools located in the St. Louis Metropolitan school districts. To that end, this Commission will: 1) research the need for physical education in the Missouri Public School system; 2) distribute survey to said schools; 3) facilitate a meeting with various healthcare providers, legislators and educators on February 28, 2007; and 4) draft a report setting forth its findings and recommendations (“Commission Report”).

On or about January 4, 2007, MCBA sent a survey to all the principals of the St. Louis Public Schools. A list of the schools that received the survey is attached hereto. Of these schools, MCBA received responses from the following: 1) Bunche International Studies Middle School; 2) Cole Elementary School; 3) Cote Brilliante Elementary School; 4) Gundlach Elementary School; 5) Nottingham CAJT High School; 6) Stevens Middle CEC; 7) Wilkinson Early Childhood Center; and 8) Williams Ninth Grade Academy.

Pamela J. Meanes
President

Rufus J. Tate, Jr.
President-Elect

Annette Slack
Vice-President

Paul A. Randolph
Treasurer

Carla Allen
Corresponding
Secretary

Kemba Logan
Recording Secretary

Joan K. Miller
Member-At-Large

Rolanda Johnson
Member-At-Large

Robert Kenney
Parliamentarian

Celestine Dotson
Historian

Hon. Marvin O. Teer
Immediate Past
President

In addition to the St. Public Schools, MCBA also sent the survey to the Superintendents of the St. Louis County School Districts. To that end, MCBA received a favorable response from the St. Louis County School Districts. In light of the few responses that we received from the St. Louis City Public Schools, I have enclosed a copy of the sample cover letter and survey in hopes that you complete it on behalf of the School District.

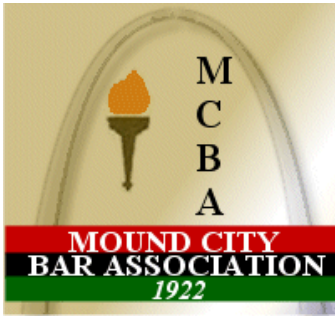
We appreciate your assistance in this matter. Please complete the survey and mail it to Mavis Thompson, at 3510 Dodier Street, St. Louis, MO 63107, no **later than March 10, 2007**. Thank you for your cooperation and we look forward to working with you to combat the obesity epidemic that is plaguing our youth.

Sincerely,



Pamela Meanes
President, Mound City Bar Association

cc: Mavis Thompson



Mound City Bar Association

P.O. Box 1543

St. Louis, MO 63188

Tel: (314) 552.6349

E-mail: pmeanes@thompsoncoburn.com

Pamela J. Meanes
President

Rufus J. Tate, Jr.
President-Elect

Annette Slack
Vice-President

Paul A. Randolph
Treasurer

Carla Allen
Corresponding
Secretary

Kemba Logan
Recording Secretary

Joan K. Miller
Member-At-Large

Rolanda Johnson
Member-At-Large

Robert Kenney
Parliamentarian

Celestine Dotson
Historian

Hon. Marvin O. Teer
Immediate Past
President

January 4, 2007

Dr. Charles Penberthy
90 Yorkshire Lane
Brentwood, MO 63144

Dear Dr. Penberthy:

This letter is written on behalf of the Mound City Bar Association (“MCBA”) Healthcare Commission. MCBA is one of the oldest black bar associations west of the Mississippi River. The organization’s objectives are to advance the professional interest and professional development of its’ members; promote the administration of justice; uphold the honor of the legal profession, and provide service to the community. Currently, MCBA is researching, examining and analyzing the diversity initiatives of various establishments in the following four disciplines: 1) Education; 2) Health care, 3) Bar Association and 4) Employment.

With respect to health care, a Commission has been established. The Commission’s primary responsibility is to examine the problem of obesity in the St. Louis Metropolitan school districts to determine whether: 1) there are any legislative options that should be considered to address this issue; and 2) if any disparities exist in the type of physical education programs and/or facilities which are available at schools located in the St. Louis Metropolitan school districts. To that end, this Commission will: 1) research the need for physical education in the Missouri Public School system; 2) distribute survey to said schools; 3) facilitate a meeting with various healthcare providers, legislators and educators on February 28, 2007; and 4) draft a report setting forth its findings and recommendations (“Commission Report”).

According to the US Department of Health and Human Services, since 1980 the percentage of children who are overweight has more than doubled, while rates among adolescents have more than tripled.

Pamela J. Meanes
President

Rufus J. Tate, Jr.
President-Elect

Annette Slack
Vice-President

Paul A. Randolph
Treasurer

Carla Allen
Corresponding
Secretary

Kemba Logan
Recording Secretary

Joan K. Miller
Member-At-Large

Rolanda Johnson
Member-At-Large

Robert Kenney
Parliamentarian

Celestine Dotson
Historian

Hon. Marvin O. Teer
Immediate Past
President

Obesity in children and adolescents is a serious issue with many health and social consequences that often continue into adulthood. Implementing prevention programs and getting a better understanding of treatment for adolescents is important to controlling the obesity epidemic.

The 2005 Youth Risk Behavior Survey conducted by the Centers for Disease Control and Prevention ("CDC") indicates that among Missouri high school students, 14% are overweight and 16% are at risk for becoming overweight. Accordingly, practical solutions should include better health education, more physical education, physical activity and healthier school environments.

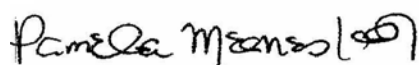
The education system cannot solve the obesity epidemic on its own, but it is unlikely to be halted without strong school-based policies and programs. However, we believe that schools play an especially important role because:

- 1) Over 95% of young people are enrolled in schools;
- 2) Promotion of physical activity and healthy eating have long been a fundamental component of the American educational experience, so schools are not being asked to assume new responsibilities;
- 3) Research has shown that well-designed, well-implemented school programs can effectively promote physical activity, healthy eating, and reductions in television viewing time; and
- 4) Emerging research documents the connections between physical activity, good nutrition, physical education programs and academic performance.

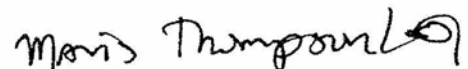
Most importantly, schools can help students adopt and maintain healthy eating and physical activity behaviors. The CDC has published guidelines that identify school policies and practices most likely to be effective in promoting life-long physical activity and healthy eating. The guidelines which are based on comprehensive reviews of the research literature and extensive input from academic experts and school health practitioners contain many different recommendations; however, the MCBA Healthcare Commission will focus on assisting schools through legislative action to strengthen schools' physical activity policies.

We appreciate your assistance in this matter. Please find attached a survey regarding Childhood Obesity. We request that you complete the survey and mail it to Mavis Thompson, at 3510 Dodier Street. St. Louis, MO 63107, no **later than January 26, 2007**. Thank you for your cooperation and we look forward to working with you to combat the obesity epidemic that is plaguing our youth.

Sincerely,



Pamela Meanes



Mavis Thompson

Pamela J. Meanes
President

Rufus J. Tate, Jr.
President-Elect

Annette Slack
Vice-President

Paul A. Randolph
Treasurer

Carla Allen
Corresponding
Secretary

Kemba Logan
Recording Secretary

Joan K. Miller
Member-At-Large

Rolanda Johnson
Member-At-Large

Robert Kenney
Parliamentarian

Celestine Dotson
Historian

Hon. Marvin O. Teer
Immediate Past
President

President, Mound City Bar Association

Chair, MCBA Healthcare Commission

Affton

Don Francis
8701 Mackenzie Road
Saint Louis, MO 63123
Phone: (314) 638-8770
Fax: (314) 631-2548

Bayless

Dr. Maureen Clancy-May
4530 Weber Road
St. Louis, MO 63123
(314) 631-2244 phone
(314) 544-6315 fax

Brentwood

Dr. Charles Penberthy
90 Yorkshire Lane,
Brentwood, Missouri 63144
Phone: 314-962-4507 Fax: 314-962-7302

Ferguson-Florissant

Jeffrey R. Spiegel
Ferguson-Florissant School District
Office of Public Information
Phone (314) 506-9037
Fax (314) 506-9146
e-mail commrel@fergflor.k12.mo.us

Hancock Place

Stewart, Edward
9101 South Broadway
Saint Louis, MO 63125
Phone: (314) 544-1300
Fax: (314) 631-3752

Kirkwood

Dr. David Damerall
11289 Manchester Rd
Kirkwood Mo 63122
314.213.6100
Fax 314.984.0002

Ladue

Dr. David L. Benson, Ph.D.
9703 Conway Road
St. Louis, MO 63124
314.994.7080

Lindbergh

James A. Sandfort
4900 South Lindbergh Boulevard
St. Louis MO 63126
(314) 729-2480
Fax: 729-2482

Maplewood-Richmond Heights

Linda Henke, PhD
7539 Manchester Rd
Maplewood, Missouri 63143
Phone Number: 3146444401

Mehlville

Dr. Jerry Chambers,
3120 Lemay Ferry Rd,
St. Louis, MO 63125
467-5001

Neuwoehner School (Clayton)

Don Senti
#2 Mark Twain Circle
Clayton, MO 63105
(314) 854-6000

Normandy

CONNIE KENNEDY CALLOWAY, Ph.D.
3855 Lucas & Hunt Rd.
St. Louis, MO 63121
(314) 493-0402

Parkway

Dr. Robert Malito
455 North Woods Mill Rd.
Chesterfield, MO 63017
314-415-8002
314-415-8013 Fax

Pattonville

Hugh A. Kinney, Ed.D.
11097 St. Charles Rock Rd.
St. Ann, MO 63074

Ritenour

Dr. Cheryl Compton
2420 Woodson Road,
St. Louis, MO 63114-5499
314-493-6050

Riverview Gardens

Henry P. Williams, Ed.D.
1370 Northumberland Drive
St. Louis, MO 63137-1413
Voice: (314) 869-2505
Fax: (314) 869-6354
E-mail: hpwilliams@rgsd.org

Rockwood

Craig H. Larson, Ed.D
111 East North Street
Eureka, MO 63025-1229
938-2200

Special School District ***University City**

Dr. James M. Victory
8136 Groby Road,
University City, Missouri 63130
(314) 290-4000

Valley Park

Laura Kinder
One Main Street,
Valley Park, MO 63088
Phone: 636.923.3500
Fax: 636.861.1002

Webster Groves

Dr. Brent Underwood
ext. 10008
e-mail: underwood.brent@mail.webster.k12.mo.us
400 East Lockwood
Webster Groves, Mo. 63119
Phone: (314) 961-1233
Fax: (314) 963-6411

Wellston

Charles R. Brown, Ph.D.
6574 St. Louis Ave
St. Louis MO 63121
314-290-7900
Fax: 314-290-7905

Mound City Bar Association
St. Louis County Public School Survey
Childhood Obesity

1. School District Affton
 Address 8701 Mackenzie Road
St. Louis, MO 63123
2. Type/Number of schools in district:

a. Elementary:	# of schools <u>2</u>	Grades <u>(K-3) (3-5)</u>
b. Middle:	# of schools <u>1</u>	Grades <u>6-8</u>
c. High School:	# of schools <u>1</u>	Grades <u>9-12</u>
3. Total number of students enrolled –

a. Elementary:	<u>1075</u>
b. Middle:	<u>577</u>
c. High School:	<u>855</u>
4. What is the racial composition (%) of your student body?

a. Asian/Pacific Islander	<u>2.7</u>
b. Black/African-American	<u>10.8</u>
c. Hispanic/Latino	<u>1.5</u>
d. White/Caucasian	<u>84.8</u>
e. Other	<u>0.2</u>
5. What is the gender distribution of your student body?

a. Male	<u>1270</u>
b. Female	<u>1237</u>
6. What % of the students in your school district are eligible for federally subsidized nutrition programs?

a. Less than 25%	<u> </u>
b. 25 – 50%	<u> </u> ✓
c. 50 – 75%	<u> </u>
d. Greater than 75%	<u> </u>
7. Are the students in your district required to participate in a health education course?

a. Yes	<u> </u> ✓	No	<u> </u>
b. If YES,			
i. What grades are required to have this course?	<u> K-12 </u>		
ii. Does the course include instruction on nutrition and dietary topics?			
Yes	<u> </u> ✓	No	<u> </u>
8. Do you allow students in your school district to purchase snack foods or beverages from vending machines, a school store, canteen or snack bar?

a. Yes	<u> </u> ✓ (Healthy)	No	<u> </u>
--------	-------------------------------	----	-----------------------------

- b. If YES,
- i. Grade levels (check all that apply)
 1. Elementary _____
 2. Middle school √
 3. High school √
 - ii. Are fruits and vegetables available for purchase?
Yes √ No _____
 - iii. Are 100% fruit juices available for purchase?
Yes √ No _____
 - iv. Is bottled water available for purchase?
Yes √ No _____
 - v. Are students allowed to purchase candy, soft drinks, sport drinks, or high fat snacks, e.g. potato chips during school lunch periods?
Yes _____ No √
9. Are students required to participate in physical education activities or courses?
- a. Yes √ No _____
 - b. If YES,
 - i. What grades have this requirement? K-12
 - ii. How many days/week? 2-3
 - iii. How many hours/week? 35 min to 60 min per day
 - iv. Courses taught Physical Ed./Health
 - v. Sports available –
 1. Boys Yes
 2. Girls Yes
10. Does your school district offer intramural activities or physical activity clubs for students?
- a. Yes √ No _____
 - b. If YES,
 - i. Grade levels –
 1. Elementary schools _____
 2. Middle schools √
 3. High schools _____
 - ii. Sports available –
 1. Boys Yes
 2. Girls Yes
11. Do any schools in your district have an exercise training or weight room?
- a. Yes √ No _____
 - b. If YES,
 - i. How many schools –
 1. Elementary schools _____
 2. Middle schools √
 3. High schools √

ii. What type of equipment? Weights/nautilus/stationary bicycles

12. Do you routinely (annually) complete health screenings on your students which include height and weight measurements?

a. Yes No

b. If YES,

i. What grades –

1. Elementary schools

2. Middle schools

3. High schools

ii. Are any services, e.g., nutrition counseling, physician referral, offered for students who are overweight?

1. Yes No

2. Describe services offered Health/Family and Consumer Science

13. What % (estimate) of the students in your district are overweight (calculation of height and weight based on Body Mass Index (BMI) > 95th percentile)?

	Elementary	Middle School	High School
Less than 10%			
10 – 25%			
26 – 50%			
51 – 75%			
Greater than 75%			
Don't know			

14. Are there currently any special initiatives underway in your school district targeting prevention and/or management of childhood obesity?

a. Yes No

b. If Yes, describe. Wellness Board Policy/Wellness Committee in District

15. Comments

Thank you for taking the time to complete this survey. If you have any questions, please contact the MCBA Healthcare Commission chairperson, Ms. Mavis Thompson at 314-652-7314.

**Mound City Bar Association
St. Louis County Public School Survey
Childhood Obesity**

1. School District Brentwood School District
Address 90 Yorkshire Lane
Brentwood, MO 63144
2. Type/Number of schools in district:
 - a. Elementary: # of schools 2 Grades K-5
 - b. Middle: # of schools 1 Grades 6-8
 - c. High School: # of schools 1 Grades 9-12
3. Total number of students enrolled –
 - a. Elementary: 335
 - b. Middle: 211
 - c. High School: 259
4. What is the racial composition (%) of your student body?
 - a. Asian/Pacific Islander 5%
 - b. Black/African-American 29%
 - c. Hispanic/Latino 2%
 - d. White/Caucasian 64%
 - e. Other none
5. What is the gender distribution of your student body?
 - a. Male 421
 - b. Female 384
6. What % of the students in your school district are eligible for federally subsidized nutrition programs?
 - a. Less than 25% √
 - b. 25 – 50% _____
 - c. 50 – 75% _____
 - d. Greater than 75% _____
7. Are the students in your district required to participate in a health education course?
 - a. Yes √ No _____
 - b. If YES,
 - i. What grades are required to have this course? K-5 it is incorporated with PE class and also taught in a classroom setting. At the middle school it is taught in 6th grade health class and in PE class in 8th grade. At the high school it is taught in 9th grade health class.
 - ii. Does the course include instruction on nutrition and dietary topics?
Yes √ No _____

8. Do you allow students in your school district to purchase snack foods or beverages from vending machines, a school store, canteen or snack bar?

a. Yes No

b. If YES,

i. Grade levels (check all that apply)

1. Elementary

2. Middle school

3. High school

ii. Are fruits and vegetables available for purchase?

Yes No

iii. Are 100% fruit juices available for purchase?

Yes No

iv. Is bottled water available for purchase?

Yes No (elementary)

v. Are students allowed to purchase candy, soft drinks, sport drinks, or high fat snacks, e.g. potato chips during school lunch periods?

Yes (elementary) No

9. Are students required to participate in physical education activities or courses?

a. Yes No

b. If YES,

i. What grades have this requirement? K-12

ii. How many days/week? 3 at elementary; 5 days per week for 2 weeks at the high school.

iii. How many hours/week? 1½ hrs/week at elementary; 7½ per week for 2 weeks at the high school.

iv. Courses taught PE methods and fitness training at the high school.

v. Sports available -

1. Boys Individual and team sports

2. Girls Individual and team sports

10. Does your school district offer intramural activities or physical activity clubs for students?

a. Yes No

b. If YES,

i. Grade levels –

1. Elementary schools No

2. Middle schools Yes

3. High schools Yes

ii. Sports available –

1. Boys Fitness, volleyball, flag football, soccer, ping pong, basketball

2. Girls Same

11. Do any schools in your district have an exercise training or weight room?
 a. Yes √ No _____
 b. If YES,
 i. How many schools –
 1) Elementary schools No
 2) Middle schools 1
 3) High schools 1
 ii. What type of equipment? Cardio, weight machines, free weights
12. Do you routinely (annually) complete health screenings on your students which include height and weight measurements?
 a. Yes √ No _____
 b. If YES,
 i. What grades –
 1. Elementary schools K-5 with fitness assessment
 2. Middle schools 7th grade
 3. High schools 9th and 11th
 ii. Are any services, e.g., nutrition counseling, physician referral, offered for students who are overweight?
 1. Yes √ No _____
 2. Describe services offered Referrals to pediatrician for BMI > 95%.

13. What % (estimate) of the students in your district are overweight (calculation of height and weight based on Body Mass Index (BMI) > 95th percentile)?

	Elementary	Middle School	High School
Less than 10%			
10 – 25%			
26 – 50%			
51 – 75%			
Greater than 75%			12.8%
Don't know			

14. Are there currently any special initiatives underway in your school district targeting prevention and/or management of childhood obesity?
 a. Yes √ No _____
 b. If Yes, describe. The topic is discussed. Also, a Wellness Committee was established

15. Comments In 2005-06 school year, the Brentwood School District adopted the Wellness Committee which followed the state guidelines provided and made many positive changes in nutrition, education and activities.

Thank you for taking the time to complete this survey. If you have any questions, please contact the MCBA Healthcare Commission chairperson, Ms. Mavis Thompson at 314-652-7314.

Mound City Bar Association
St. Louis County Public School Survey
Childhood Obesity

1. School District School District of Clayton
 Address #2 Mark Twain Circle
Clayton, MO 63105
2. Type/Number of schools in district:
 - a. Elementary: # of schools 3 Grades K-5
 - b. Middle: # of schools 1 Grades 6-8
 - c. High School: # of schools 1 Grades 9-12
3. Total number of students enrolled – 2529
 - a. Elementary: 1,064
 - b. Middle: 559
 - c. High School: 906
4. What is the racial composition (%) of your student body?
 - a. Asian/Pacific Islander 8.40%
 - b. Black/African-American 22.30%
 - c. Hispanic/Latino 1.80%
 - d. White/Caucasian 67.40%
 - e. Other _____
5. What is the gender distribution of your student body?
 - a. Male 51%
 - b. Female 49%
6. What % of the students in your school district are eligible for federally subsidized nutrition programs?
 - a. Less than 25% 15.30%
 - b. 25 – 50% _____
 - c. 50 – 75% _____
 - d. Greater than 75% _____
7. Are the students in your district required to participate in a health education course?
 - a. Yes √ No _____
 - b. If YES,
 - i. What grades are required to have this course? K-10
 - ii. Does the course include instruction on nutrition and dietary topics?
 Yes √ No _____
8. Do you allow students in your school district to purchase snack foods or beverages from vending machines, a school store, canteen or snack bar?
 - a. Yes √ No _____

- b. If YES,
- i. Grade levels (check all that apply)
 1. Elementary _____
 2. Middle school _____
 3. High school _____
 - ii. Are fruits and vegetables available for purchase?
Yes No _____
 - iii. Are 100% fruit juices available for purchase?
Yes No _____
 - iv. Is bottled water available for purchase?
Yes No _____
 - v. Are students allowed to purchase candy, soft drinks, sport drinks, or high fat snacks, e.g. potato chips during school lunch periods?
Yes No _____
9. Are students required to participate in physical education activities or courses?
- a. Yes No _____
 - b. If YES,
 - i. What grades have this requirement? K-11
 - ii. How many days/week? K-5: 5; 6-8: 3; 9-11: 2½
 - iii. How many hours/week? K-5: 2½; 6-8: 4; 9-11: 1½ - 2
 - iv. Courses taught K-5: Health units; 6-8 quarter course; 9-11: quarter courses
 - v. Sports available –
 1. Boys Football, basketball soccer, golf, etc.
 2. Girls Basketball, volleyball, track, etc.
10. Does your school district offer intramural activities or physical activity clubs for students?
- a. Yes No _____
 - b. If YES,
 - i. Grade levels –
 1. Elementary schools _____
 2. Middle schools _____
 3. High schools _____
 - ii. Sports available –
 1. Boys Many choices
 2. Girls Many choices
11. Do any schools in your district have an exercise training or weight room?
- a. Yes No _____
 - b. If YES,
 - i. How many schools –
 1. Elementary schools _____
 2. Middle schools _____

3. High schools √
 ii. What type of equipment? Bikes, treadmills, elliptical, climbing wall, pool, courts

12. Do you routinely (annually) complete health screenings on your students which include height and weight measurements?
 a. Yes √ No _____
 b. If YES,
 i. What grades –
 1. Elementary schools K, 1, 3, 5
 2. Middle schools 7
 3. High schools 9
 ii. Are any services, e.g., nutrition counseling, physician referral, offered for students who are overweight?
 1. Yes √ No _____
 2. Describe services offered Students are referred to their physicians for follow-up.

13. What % (estimate) of the students in your district are overweight (calculation of height and weight based on Body Mass Index (BMI) > 95th percentile)?

	Elementary	Middle School	High School
Less than 10%			<u> √ </u>
10 – 25%			
26 – 50%			
51 – 75%			
Greater than 75%			
Don't know	<u> √ </u>	<u> √ </u>	

14. Are there currently any special initiatives underway in your school district targeting prevention and/or management of childhood obesity?
 a. Yes √ No _____
 b. If Yes, describe. We are working with a parent group to address an adequate but sensitive referral process – will then work on specific referrals to community resources with physician's approval.
-
15. Comments All screenings in our district that show abnormal results are referred to student's physician by way of letter to the student's family.

Thank you for taking the time to complete this survey. If you have any questions, please contact the MCBA Healthcare Commission chairperson, Ms. Mavis Thompson at 314-652-7314.

Mound City Bar Association
St. Louis County Public School Survey
Childhood Obesity

1. School District Ferguson-Florissant
 Address 1005 Waterford Drive
Florissant, MO 63033

2. Type/Number of schools in district:
 - a. Elementary: # of schools 17 Grades K-6
 - b. Middle: # of schools 3 Grades 7-8
 - c. High School: # of schools 3 Grades 9-12

3. Total number of students enrolled –
 - a. Elementary: 6,077
 - b. Middle: 2,075
 - c. High School: 4,079

4. What is the racial composition (%) of your student body?
 - a. Asian/Pacific Islander 1.0%
 - b. Black/African-American 75.6%
 - c. Hispanic/Latino 1.3%
 - d. White/Caucasian 22.0%
 - e. Other 0.1%

5. What is the gender distribution of your student body?
 - a. Male 6,255
 - b. Female 5,976

6. What % of the students in your school district are eligible for federally subsidized nutrition programs?
 - a. Less than 25% _____
 - b. 25 – 50% _____
 - c. 50 – 75% √
 - d. Greater than 75% _____

7. Are the students in your district required to participate in a health education course?
 - a. Yes √ No _____
 - b. If YES,
 - i. What grades are required to have this course? K-9
 - ii. Does the course include instruction on nutrition and dietary topics?
 Yes √ No _____

8. Do you allow students in your school district to purchase snack foods or beverages from vending machines, a school store, canteen or snack bar?
- a. Yes No
- b. If YES,
- Grade levels (check all that apply)
 - Elementary
 - Middle school
 - High school
 - Are fruits and vegetables available for purchase?
Yes No
 - Are 100% fruit juices available for purchase?
Yes No
 - Is bottled water available for purchase?
Yes No
 - Are students allowed to purchase candy, soft drinks, sport drinks, or high fat snacks, e.g. potato chips during school lunch periods?
Yes No
(By school operations only in some schools)

9. Are students required to participate in physical education activities or courses?
- a. Yes No
- b. If YES,
- What grades have this requirement? Grades K-9 then 1 other credit (10-12 grades)
 - How many days/week? Elementary/60 min., 3-6/90 min. K-2
 - How many hours/week? M.S. varies/H.S. varies (Middle School 110-225 min. a week; High School 240-330 min. a week)
 - Courses taught Personal Fitness
 - Sports available – Soccer; Swimming; Ice Hockey
 - Boys Basketball; Track; Cross Country; Wrestling; Football; Baseball
 - Girls Basketball; Track; Volleyball; Softball; Soccer; Cross Country; Swimming
(Sports are open to both genders)

10. Does your school district offer intramural activities or physical activity clubs for students?
- a. Yes No
(All activities funded by outside sources)
- b. If YES,
- Grade levels –
 - Elementary schools A few elementary school offer them-most do not.
 - Middle schools One M.S. has several physical activity clubs. The other 2 M.S. have few to none.

- 3. High schools H.S. only have sports teams-no physical activity clubs or intramurals.
- ii. Sports available –
 - 1. Boys (See question #9)
 - 2. Girls (See question #9)
(Activities vary in middle schools) _____

11. Do any schools in your district have an exercise training or weight room?

- a. Yes √ No _____
- b. If YES,
 - i. How many schools –
 - 1. Elementary schools 0
 - 2. Middle schools 3- one M.S. suffers in equipment items.
 - 3. High schools 3
 - ii. What type of equipment? Equipment varies at each site. Stability balls; treadmills; wt. training items.

12. Do you routinely (annually) complete health screenings on your students which include height and weight measurements?

- a. Yes √ No _____
- b. If YES,
 - i. What grades –
 - 1. Elementary schools √
 - 2. Middle schools √
 - 3. High schools √
 - ii. Are any services, e.g., nutrition counseling, physician referral, offered for students who are overweight?
 - 1. Yes _____ No √
 - 2. Describe services offered _____

13. What % (estimate) of the students in your district are overweight (calculation of height and weight based on Body Mass Index (BMI) > 95th percentile)?

	Elementary (<u>3-6th grade</u>)	Middle School	High School
Less than 10%			
10 – 25%	13.7%		
26 – 50%			
51 – 75%			
Greater than 75%			
Don't know		√	√ (Data sill being compiled)

14. Are there currently any special initiatives underway in your school district targeting prevention and/or management of childhood obesity?
- a. Yes No
- b. If Yes, describe. We have adopted a Wellness Plan. We are collecting data on school strengths and weaknesses. We are tracking progress on action plans in Wellness Plan.
-
15. Comments _____
-
-
-

Thank you for taking the time to complete this survey. If you have any questions, please contact the MCBA Healthcare Commission chairperson, Ms. Mavis Thompson at 314-652-7314.

**Mound City Bar Association
St. Louis County Public School Survey
Childhood Obesity**

1. School District Maplewood Richmond Heights
Address 7539 Manchester
Maplewood, MO 63143
2. Type/Number of schools in district:
a. Elementary: # of schools 2 Grades Pre K-6th
b. Middle: # of schools 2 Grades 7-8
c. High School: # of schools 1 Grades 9-12
3. Total number of students enrolled – Pre-80
a. Elementary: 536 K-6
b. Middle: 161
c. High School: 316
4. What is the racial composition (%) of your student body?
a. Asian/Pacific Islander 1.8%
b. Black/African-American 39.2%
c. Hispanic/Latino 3.3%
d. White/Caucasian 55.4%
e. Other 0%
5. What is the gender distribution of your student body?
a. Male 564
b. Female 529
6. What % of the students in your school district are eligible for federally subsidized nutrition programs?
a. Less than 25% _____
b. 25 – 50% _____
c. 50 – 75% √ _____
d. Greater than 75% _____
7. Are the students in your district required to participate in a health education course?
a. Yes √ No _____
b. If YES,
i. What grades are required to have this course? K-9
ii. Does the course include instruction on nutrition and dietary topics?
Yes √ No _____

8. Do you allow students in your school district to purchase snack foods or beverages from vending machines, a school store, canteen or snack bar?

a. Yes No

b. If YES,

i. Grade levels (check all that apply)

1. Elementary

2. Middle school

3. High school

ii. Are fruits and vegetables available for purchase?

Yes No

iii. Are 100% fruit juices available for purchase?

Yes No

iv. Is bottled water available for purchase?

Yes No

v. Are students allowed to purchase ~~candy, soft drinks, sport drinks, or high fat snacks, e.g. baked~~ potato chips during school lunch periods?

Yes No

9. Are students required to participate in physical education activities or courses?

a. Yes No

b. If YES,

i. What grades have this requirement? K-9

ii. How many days/week? 5

iii. How many hours/week? 45 min.

iv. Courses taught One in conjunction with Health Nutrition, Heart Smart

v. Sports available –

1. Boys

2. Girls

10. Does your school district offer intramural activities or physical activity clubs for students?

a. Yes No

b. If YES,

i. Grade levels –

1. Elementary schools

2. Middle schools

3. High schools

ii. Sports available –

1. Boys

2. Girls

11. Do any schools in your district have an exercise training or weight room?
 a. Yes No _____
 b. If YES,
 i. How many schools –
 1. Elementary schools _____
 2. Middle schools
 3. High schools
 ii. What type of equipment? Free wt. and adolescent strength training machines.

12. Do you routinely (annually) complete health screenings on your students which include height and weight measurements?
 a. Yes No _____
 b. If YES,
 i. What grades –
 1. Elementary schools
 2. Middle schools
 3. High schools
 ii. Are any services, e.g., nutrition counseling, physician referral, offered for students who are overweight?
 1. Yes No _____
 2. Describe services offered Nutrition counseling done - by school nurse & taught in Health classes. Special referrals to pediatricians through parents who were at risk of hypertension, Type II diabetes, overweight.

13. What % (estimate) of the students in your district are overweight (calculation of height and weight based on Body Mass Index (BMI) > 95th percentile)?

	Elementary	Middle School	High School
Less than 10%			
10 – 25%	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
26 – 50%			
51 – 75%			
Greater than 75%			
Don't know			

14. Are there currently any special initiatives underway in your school district targeting prevention and/or management of childhood obesity?
 a. Yes No _____
 b. If Yes, describe. Our wellness committee is addressing this from a nutrition, seed to table and activity schedule. We are eliminating junk food and soda from the choices.

15. Comments Low fat alternatives offered in the high school/middle school lunchroom begin in early childhood center with the seed to table program.
-
-

Thank you for taking the time to complete this survey. If you have any questions, please contact the MCBA Healthcare Commission chairperson, Ms. Mavis Thompson at 314-652-7314.

**Mound City Bar Association
St. Louis County Public School Survey
Childhood Obesity**

1. School District Ritenour School District
Address 2420 Woodson Road
St. Louis, MO 63114
2. Type/Number of schools in district:
 a. Elementary: # of schools 6 Grades K-5
 b. Middle: # of schools 2 Grades 6-8
 c. High School: # of schools 1 Grades 9-12
3. Total number of students enrolled –
 a. Elementary: 2,841
 b. Middle: 1,485
 c. High School: 1,896
4. What is the racial composition (%) of your student body?
 a. Asian/Pacific Islander 3%
 b. Black/African-American 37%
 c. Hispanic/Latino 10%
 d. White/Caucasian 50%
 e. Other _____
5. What is the gender distribution of your student body?
 a. Male 3,206
 b. Female 3,016
6. What % of the students in your school district are eligible for federally subsidized nutrition programs?
 a. Less than 25% _____
 b. 25 – 50% _____
 c. 50 – 75% _____
 d. Greater than 75% √
7. Are the students in your district required to participate in a health education course?
 a. Yes √ No _____
 b. If YES,
 i. What grades are required to have this course? K-8
 ii. Does the course include instruction on nutrition and dietary topics?
 Yes √ No _____
8. Do you allow students in your school district to purchase snack foods or beverages from vending machines, a school store, canteen or snack bar?
 a. Yes √ No _____

- b. If YES,
- i. Grade levels (check all that apply)
 1. Elementary _____
 2. Middle school _____
 3. High school _____
 - ii. Are fruits and vegetables available for purchase?
Yes No _____
 - iii. Are 100% fruit juices available for purchase?
Yes No _____
 - iv. Is bottled water available for purchase?
Yes No _____
 - v. Are students allowed to purchase candy, soft drinks, sport drinks, or high fat snacks, e.g. potato chips during school lunch periods?
Yes _____ No
9. Are students required to participate in physical education activities or courses?
- a. Yes No _____
 - b. If YES,
 - i. What grades have this requirement? K-12
 - ii. How many days/week? K-5 3; 6-8 5; 9-12 3
 - iii. How many hours/week? K-5 1.5; 6-8 3.75; 9-12 3-4.5
 - iv. Courses taught PE & Health
 - v. Sports available –
 1. Boys See Attachment 1
 2. Girls See Attachment 1
10. Does your school district offer intramural activities or physical activity clubs for students?
- a. Yes No _____
 - b. If YES,
 - i. Grade levels –
 1. Elementary schools _____
 2. Middle schools _____
 3. High schools _____
 - ii. Sports available –
 1. Boys See Attachments
 2. Girls See Attachments
11. Do any schools in your district have an exercise training or weight room?
- a. Yes No _____
 - b. If YES,
 - i. How many schools –
 1. Elementary schools 0
 2. Middle schools 2
 3. High schools 1

ii. What type of equipment? Free weights, weight machines, treadmill.

12. Do you routinely (annually) complete health screenings on your students which include height and weight measurements?

a. Yes No

b. If YES,

i. What grades –

1. Elementary schools K-5

2. Middle schools 6-8

3. High schools --

ii. Are any services, e.g., nutrition counseling, physician referral, offered for students who are overweight?

1. Yes No

2. Describe services offered _____

13. What % (estimate) of the students in your district are overweight (calculation of height and weight based on Body Mass Index (BMI) > 95th percentile)?

	Elementary	Middle School	High School
Less than 10%			
10 – 25%			
26 – 50%			
51 – 75%			
Greater than 75%			
Don't know	√	√	√

14. Are there currently any special initiatives underway in your school district targeting prevention and/or management of childhood obesity?

a. Yes No

b. If Yes, describe. _____

15. Comments _____

Thank you for taking the time to complete this survey. If you have any questions, please contact the MCBA Healthcare Commission chairperson, Ms. Mavis Thompson at 314-652-7314.

**Mount City Bar Association
St. Louis County Public School district Survey
Childhood Obesity
Attachment 1**

Question 9.v.

Sports Available	
Boys	Girls
Cross Country	Cross Country
Football	Tennis
Soccer	Volleyball
Swimming	Basketball
Softball	Swimming
Basketball	Soccer
Wrestling	Track
Baseball	
Golf	
Tennis	
Track	
Volleyball	

Question 10.vii:

Sports Available (Grades 6-8)	
Boys	Girls
Hockey	Hockey
Basketball	Basketball
Fleetball	Volleyball
	Spirit club
See attached for grades 9-12	



ATTACHMENT 2

NEW STUDENT ATHLETICS/ACTIVITIES FORM

All students should participate in at least two extracurricular activities. Please circle the activities that interest you, and these coaches or sponsors will contact you.

NAME: _____

FALL SPORTS	WINTER SPORTS	SPRING SPORTS
Cross Country (B/G)	Basketball (B)	Baseball
Football	Basketball (G)	Golf
Soccer (B)	Swimming (G)	Soccer (G)
Swimming (B)	Wrestling	Tennis (B)
Softball		Track (B)
Tennis (G)		Track (G)
Volleyball (G)		Volleyball (B)

YEAR LONG COMPETITIVE TEAMS

Cheerleading Rhythmettes Speech and Debate Strength and Conditioning

Clubs and Organizations

AFS AYF Band Band Auxiliary (Color Guard) Big Brothers/Big Sisters

Choir DECA Dramatics FBLA FCCLA French Club German Club

German Honor Society Gay/Straight Alliance Jazz Band KRHS

La Sociedad Honoraria Hispánica La Société Honoraire de Français Mock Trial

Mu Alpha Theta National Honor Society Orchestra Pepper Box

Plays (Fall and Spring) Reflections Ritenour Cardinal Ordinates (RCO)

Scribblers (Art Club) Spanish Club Student Council Teenage Health Consultants

Yearbook/Melaureus

Please return form to your grade level office or to the Activities/Athletic office.



Growing Together,
Learning for Life

Administrative Center

111 East North Street
Eureka, MO 63025-1229

636.938.2205
636.938.2251 Fax
larsoncraig@rockwood.k12.mo.us

Craig H. Larson, Ed.D.
Superintendent of Schools

January 26, 2007

Pamela Meanes, President
Mound City Bar Association
P.O. Box 1543
St. Louis, MO 63188

Dear Ms. Meanes:

Attached please find our response to your survey. You may notice that we did not complete the BMI portion of the questionnaire. While we do measure height and weight on students semi-annually, we report those numbers to parents; we do not convert to BMI.

We also have multiple opportunities for children to become involved in athletics throughout the district and at all grade levels. We offer community education classes before and after school, many of which have a physical activity as the focus, such as Karate, or Pom and Cheer, and as the children move into middle school, intramurals are offered. These run the gamut from bowling to ping-pong to track and field. Of course we also have opportunities for many of the typical sports such as basketball, football, volleyball, swimming and wrestling. I hope you find the information provided useful. Thank you for giving us the opportunity to participate.

Sincerely,


Craig H. Larson, Ed.D.
Superintendent


Amy Wehr RN, BSN, NCSN
Supervisor of Health and Wellness

- b. If YES,
- i. Grade levels (check all that apply)
 1. Elementary _____
 2. Middle school √
 3. High school √
 - ii. Are fruits and vegetables available for purchase?
Yes √ No _____
 - iii. Are 100% fruit juices available for purchase?
Yes √ No _____
 - iv. Is bottled water available for purchase?
Yes √ No _____
 - v. Are students allowed to purchase candy, soft drinks, sport drinks, or high fat snacks, e.g. potato chips during school lunch periods?
Yes √ No _____
9. Are students required to participate in physical education activities or courses?
- a. Yes √ No _____
 - b. If YES,
 - i. What grades have this requirement? K-9
 - ii. How many days/week? Daily or daily equivalent in block scheduling
 - iii. How many hours/week? K-5 = 2.5; 6-8 = 3.75; 9 = 4.6
 - iv. Courses taught health and physical education
 - v. Sports available –
 1. Boys multiple
 2. Girls multiple
10. Does your school district offer intramural activities or physical activity clubs for students?
- a. Yes √ No _____
 - b. If YES,
 - i. Grade levels
 1. Elementary schools K-5
 2. Middle schools 6-8
 3. High schools _____
 - ii Sports available –
 1. Boys multiple
 2. Girls multiple
11. Do any schools in your district have an exercise training or weight room?
- a. Yes √ No _____
 - b. If YES,
 - i. How many schools –
 1. Elementary schools _____
 2. Middle schools 6
 3. High schools 4

ii. What type of equipment? Free weights, machines, fitness appreciation

12. Do you routinely (annually) complete health screenings on your students which include height and weight measurements?
- a. Yes No
- b. If YES,
- i. What grades –
1. Elementary schools 3-5
 2. Middle schools 6-8
 3. High schools 9
- ii. Are any services, e.g., nutrition counseling, physician referral, offered for students who are overweight?
1. Yes No
 2. Describe services offered _____
-

13. What % (estimate) of the students in your district are overweight (calculation of height and weight based on Body Mass Index (BMI) > 95th percentile)?

We do not calculate BMI

	Elementary	Middle School	High School
Less than 10%			
10 – 25%			
26 – 50%			
51 – 75%			
Greater than 75%			
Don't know			

14. Are there currently any special initiatives underway in your school district targeting prevention and/or management of childhood obesity?
- a. Yes No
- b. If Yes, describe. District-wide wellness committee, including parents, students, administration and teachers to increase physical activity and improve nutritional offerings in school stores, vending machines, classroom rewards, fund raising.
-
15. Comments _____
-
-

Thank you for taking the time to complete this survey. If you have any questions, please contact the MCBA Healthcare Commission chairperson, Ms. Mavis Thompson at 314-652-7314.

**Mound City Bar Association
St. Louis County Public School Survey
Childhood Obesity**

1. School District Valley Park School District
Address One Main Street
Valley Park, MO 63088
2. Type/Number of schools in district:
 - a. Elementary: # of schools 1 Grades PK-5
 - b. Middle: # of schools 1 Grades 6-8
 - c. High School: # of schools 1 Grades 9-12
3. Total number of students enrolled –
 - a. Elementary: 545
 - b. Middle: 234
 - c. High School: 254
4. What is the racial composition (%) of your student body?
 - a. Asian/Pacific Islander 4.5%
 - b. Black/African-American 26%
 - c. Hispanic/Latino 4%
 - d. White/Caucasian 65%
 - e. Other 0.5%
5. What is the gender distribution of your student body?
 - a. Male 51%
 - b. Female 49%
6. What % of the students in your school district are eligible for federally subsidized nutrition programs?
 - a. Less than 25% _____
 - b. 25 – 50% √
 - c. 50 – 75% _____
 - d. Greater than 75% _____
7. Are the students in your district required to participate in a health education course?
 - a. Yes √ No _____
 - b. If YES,
 - i. What grades are required to have this course? K-12
 - ii. Does the course include instruction on nutrition and dietary topics?
Yes √ No _____
8. Do you allow students in your school district to purchase snack foods or beverages from vending machines, a school store, canteen or snack bar?
 - a. Yes √ No _____

- b. If YES,
- i. Grade levels (check all that apply)
 1. Elementary _____
 2. Middle school _____
 3. High school _____
 - ii. Are fruits and vegetables available for purchase?
Yes No _____
 - iii. Are 100% fruit juices available for purchase?
Yes No _____
 - iv. Is bottled water available for purchase?
Yes No _____
 - v. Are students allowed to purchase candy, soft drinks, sport drinks, or high fat snacks, e.g. potato chips during school lunch periods?
Yes (high school) No _____
9. Are students required to participate in physical education activities or courses?
- a. Yes No _____
 - b. If YES,
 - i. What grades have this requirement? K-12
 - ii. How many days/week? _____
 - iii. How many hours/week? _____
 - iv. Courses taught _____
 - v. Sports available –
 1. Boys _____
 2. Girls _____
10. Does your school district offer intramural activities or physical activity clubs for students?
- a. Yes No _____
 - b. If YES,
 - i. Grade levels
 1. Elementary schools _____
 2. Middle schools _____
 3. High schools _____
 - ii Sports available –
 1. Boys _____
 2. Girls _____
11. Do any schools in your district have an exercise training or weight room?
- a. Yes No _____
 - b. If YES,
 - i. How many schools –
 1. Elementary schools _____
 2. Middle schools _____
 3. High schools _____

ii. What type of equipment? _____

12. Do you routinely (annually) complete health screenings on your students which include height and weight measurements?

a. Yes No _____

b. If YES,

i. What grades –

1. Elementary schools

2. Middle schools _____

3. High schools _____

ii. Are any services, e.g., nutrition counseling, physician referral, offered for students who are overweight?

1. Yes * No _____

2. Describe services offered _____ *if parent asks

13. What % (estimate) of the students in your district are overweight (calculation of height and weight based on Body Mass Index (BMI) > 95th percentile)?

	Elementary	Middle School	High School
Less than 10%			
10 – 25%			
26 – 50%			
51 – 75%			
Greater than 75%			
Don't know			

14. Are there currently any special initiatives underway in your school district targeting prevention and/or management of childhood obesity?

a. Yes No _____

b. If Yes, describe. The district has incorporated a “Wellness Policy” to promote healthier food choices and increased physical activity.

15. Comments _____

Thank you for taking the time to complete this survey. If you have any questions, please contact the MCBA Healthcare Commission chairperson, Ms. Mavis Thompson at 314-652-7314.

PANEL DISCUSSION

QUESTIONS FOR MCBA HEALTHCARE COMMISSION PANEL

FEBRUARY 28, 2007

STATEMENT OF ISSUE

MAVIS THOMPSON

Upon taking office in 2006 MCBA President Pamela Meanes established 4 Commissions to examine, evaluate and analyze the diversity efforts in four disciplines: Education, Professional Bar Associations, Employment and Healthcare. Specifically, related to healthcare our charge was to examine the problem of obesity in youth attending public schools in the St. Louis Metropolitan area and determine whether:

1. any disparities exist in the type of physical education /health education/ an/or nutrition programs,
2. there are any legislative options that should be considered to address this issue, and
3. to facilitate a discussion around this issue with various healthcare providers, legislators and educators.

I wish to thank President Meanes for her foresight and council, Dr. Denise Hooks Anderson for serving as our MCMA liaison and particular and special thanks go to Commissioner Yuri Walker met with me on a regular basis and perform a yuleman's share of work on this commission.

Heartfelt thanks are extended to our panelists:

Honorable Robin Wright-Jones, State Representative and former Vice Chairperson of the STL School's Chairperson's Council

Dr. Ingrid Taylor

Christine Shannon, Director, Medical and Healthy Youth in Partnership

Darlynn Bosley, educator Riverview Gardens School District and former Missouri Teacher of the Year

Steve Warmack, Principal Clyde C. Miller Career Academy and member of the NBA/MCBA MLK Advocacy Competition Committee

LOGISTICS

The panel discussion will last no longer than 1 hour.

Each panelist is asked to give a 3 minute opening statement regarding obesity in youth from the viewpoint of their particular discipline.

The moderator poses a series of questions to the panelists either individually or collectively and each panelist is asked to respond in 3-5 minutes.

Each panelist is asked to give a 3-minute summation.

QUESTIONS

1. What is different in society now that contributes to obesity in youth that wasn't there a generation ago?
2. Are Race and Gender factors that contribute to disparities?
3. Has commercialization contributed to this issue?
4. How do we enhance the partnership with schools and parents to promote healthy eating and physical education?
5. How do schools balance the need to generate revenue from the vending machines with encouraging healthy nutrition?
6. Whose problem is it? Government? Parents? Vendors? Schools?
7. What is your vision on resolving the issue?

PANELIST SUMMATIONS

(Limited to 3 minutes each)

CLOSING REMARKS

Mavis Thompson

PANELIST:

Honorable Robin Wright-Jones. Missouri State Representative, District 63.
Utilized statistics from Missouri's Nutrition and Physical Activity Plan
(www.dhss.mo.gov/obesity/index.html)

Dr. Ingrid Taylor, certified in Family Medicine
Has her own web site: www.alliesinhealth.com
Utilized a pamphlet: What works for Obesity? Produced by the BMJ Publishing Group in 2004.

Serena Muhammad, Chair and Director of Healthy Youth Partnership
Utilized pamphlet: Overweight Among School-Age Youth; Challenges and Opportunities for Missouri Schools. A Policy Brief published by the Missouri Department of Health and Senior Services, Jan. 2006.

Darlynn Bosley, educator Riverview Gardens School District and former Missouri Teacher of the Year
Utilized data from the American Obesity Association: Childhood Obesity

QUESTIONS:

1. What is different in society now that contributes to obesity in youth that wasn't there a generation ago?
2. Has commercialization contributed to this issue?
3. Are Race and Gender factors that contribute to disparities?
4. How do we enhance the partnership with schools and parents to promote healthy eating and physical education?
5. How do schools balance the need to generate revenue from the vending machines with encouraging healthy nutrition?
6. Whose problem is it? Government? Parents? Vendors? Schools? All of the above?
7. What is your vision on resolving the issue?

PANELISTS RESPONSES

OPENING STATEMENTS

Correct terminology is "overweight" not obesity. Obesity carries a negative connotation.

Missouri has a Governor's Counsel on Physical Fitness and Health.

Missouri requires only 1 unit of Physical Education to graduate from High School.

Children are using adult methods to deal with overweight issues. Diet. Enemas. Pills.

Overweight causes many health issues: Diabetes, Asthma, Cardiac problems

Overweight impacts Academic Achievement

Missouri is at the bottom of poor statistics regarding overweight youth

Pattonville School District has a great Wellness program

MO legislation requires SLPS to follow a Wellness Program. However, the legislation is not enforced.

Look at the 10 steps from the CDC to promote healthy choices

QUESTION 1

Overweight because lack of Physical Education, Accessibility of Fast Foods, Over-saturation of Fast Foods in Black communities, no longer walking to school b/c do not attend schools in the neighborhood, healthy and organic foods not accessible and too expensive, parents working 2 jobs, decreased accessibility to parks, parks unsafe, overweight parents as role models, computers, video games, television commercials, growth hormones used to breed animals and other food additives.

QUESTION 2

MO has abolished Women's Health Department???? When women cannot access resources they can not take care of the family and the family unit falls apart.

QUESTION 3

Commercialization of food has an impact on obesity. The more fun the product the more likely it is high caloric, high in carbohydrates and sugar. Eating healthy can be made as attractive as poor food choices. Must take a look at how we advertise food. Must revisit the basic Food Pyramid.

QUESTION 4

Schools need to take a more active role in combating the problem

Look at the CDC's 10 steps to promote healthy living

Go back to the using the "Fitness Report Card"

We must educate children regarding the problems of overweight and use them as role models for the parents. Same as we did for smoking and drugs. (D.A.R.E.)

QUESTION 5

Research indicates there is no loss revenue when vending machines change to healthy choices.

Don't just look at vending machines. Must also look at cafeteria food plans. We must revisit the basic food pyramid?

QUESTION 6

Shared responsibility. Government should re-initiate President Kennedy's fitness Program. It must start at the White House-State House-City Hall.

QUESTION 7

Empower youth to take control of their health

Physical Education as a mandate to graduate

Push for healthy choices in vending machines

Subsidized neighborhood Farmers Markets. Make fresh fruits and vegetables accessible.

More safe places to play and recreate

BJC Wellness Policies which motivate employees to lose weight. Also, make apply for reduced insurance rates.

Encourage schools to participate in the State Wellness Program

Tax Credits for Healthy Living Programs

Give Time off to exercise, same as breaks for smokers

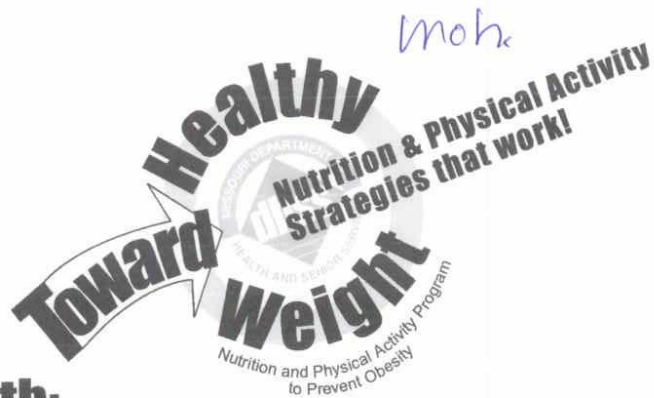
It take at least 20 minutes to digest food. Lunch periods much be longer and need to exercise after lunch.

Get back to families eating together at home

Stop using Fast Food as a reward

Turn off the TV and get active outside

DHSS Policy Brief #1
January 2006



Overweight Among School-Age Youth; Challenges and Opportunities for Missouri Schools

Acknowledgement

The Missouri Department of Health and Senior Services (DHSS), in partnership with the Obesity Prevention Center of the St. Louis University School of Public Health, prepared this policy brief to call attention to the challenges facing schools today that are created by the competing demands of increasing student academic achievement and the need to address student health issues, including an increasingly serious problem—overweight. This brief presents the challenges and offers policy recommendations for addressing the problem of overweight among school-age children that also supports the academic mission of schools. The recommendations provide sound policy options to debate, modify if needed, and adopt to support the education and health of school-age youth in mutually beneficial ways. A special thanks is extended to Chris Fleming of St. Louis University for his work in preparing this paper.

Introduction

The obesity epidemic in America is not a passing trend – 65 percent of adults age 20 years and older in the United States are either overweight or obese, and the percentage of young people who are overweight has more than tripled since 1980.¹ Overweight in children is defined similarly to obesity in adults. The increase in overweight among young children is alarming and will have serious social and economic consequences if not addressed. Schools are often called upon to help address health problems impacting students. The rise in overweight among children and adolescents is no exception. Schools are also faced with increased pressure to improve student academic performance to meet and exceed state and national standards. Such pressure creates competition for instructional time among subjects for which academic testing is conducted and those that may not be tested, such as health education and physical education. Additionally, shrinking resources may create barriers to implementing policies, programs and services such as quality physical education and health education instruction, adequate recess time, after school physical activity programs, and healthy meals and snacks, all of which can improve and support the health of students. This paper offers recommendations for actions that can be taken to support Missouri's schools in providing increased opportunities for student access to physical activity and healthy nutritional choices.

Specifically, this paper will:

- Discuss the relationship between childhood physical activity and dietary intake to childhood overweight;
- Highlight the pressures on schools to meet academic standards;
- Detail existing evidence demonstrating positive links between increased physical activity and improved nutrition with health and academic achievement;
- Present examples that schools and states throughout the nation have taken to increase physical activity and improve nutritional choices within schools; and
- Offer recommendations for state-level policy action in Missouri.

(Continued, next page)

Prevalence, Consequences and Contributing Factors of Childhood Overweight

Traditional measures for overweight and obesity utilize the Body Mass Index (BMI) scale, which is a measurement of the proportion of an individual's weight relative to that individual's height. Because children's and teens' body fat changes as they grow, BMI is used to assess underweight, at risk for overweight, and overweight.² Known as BMI-for-age, it is a gender-specific measurement basing overweight or at risk for overweight status on percentiles – children and teens with a BMI that falls between the 85th and 95th percentile for a gender and age specific population are considered at risk for overweight, while having a BMI in the 95th percentile or higher places children and teens in the overweight category.

These distinctions are important, because evidence has shown that the children who are overweight or at risk for overweight have a much better chance of being obese as an adult than children who are of normal weight. For instance, one study found that for children aged 10 to 15 years, 75 percent of the children who were at risk for overweight were obese adults at age 25, while 83 percent of the overweight children in this age

group were obese by the age of 25.³

Increases in the prevalence of overweight in both children and adult populations are having and will continue to have enormous economic consequences in terms of health care spending on obesity-related conditions. A 2002 study of multiyear National Hospital Discharge Survey data revealed that for children 6-17 years old, discharges of diabetes nearly doubled, obesity and gallbladder diseases tripled, and sleep apnea increased five-fold. Annual hospital costs associated with obesity in these children increased three times to \$127 million during 1997-1999 (in 2001 dollars).⁴ It has been estimated that direct medical costs attributable to adult overweight and obesity have reached \$75 billion per year (in 2003 inflation-adjusted dollars).⁵ In Missouri in 1998, health care costs attributed to adult obesity alone totaled \$1.6 billion (in 2003 dollars).⁵

The prevalence of overweight children has tripled since 1980, and while obesity has genetic determinants, the genetic composition of the population does not change rapidly, meaning that the large increase in childhood overweight is due to non-genetic factors.⁶ It has become clear that dietary intake⁷ and physical activity⁸ patterns developed among children and adolescents play an integral role in the increase of overweight children and adolescents.

Children and adolescents are eating too much of the wrong kinds of foods and are not getting enough physical activity. Providing environments that encourage healthy food consumption and physical activity is crucial in addressing the problem of childhood overweight.^{8,9}

In Missouri, the evidence confirms that there is a rising percentage of children who are overweight and at risk for overweight. In 1999, the Missouri Department of Health and Senior Services (DHSS) found that 18.6 percent of Missouri children aged 12-19 years who were screened were overweight, compared to the national average of 14 percent for the same age group.⁹ The percent of overweight appears to be increasing among students aged 5-11, as 19.4 percent of Missouri students in the population screened were overweight in 1999, while in the 2000-2001 school year, 21.5 percent of the population was overweight.⁹

The problems related to childhood overweight are not simply cosmetic; there are profound health problems associated with excess weight. The American Heart Association (AHA) stresses the importance of increasing childhood physical activity and decreasing childhood obesity as two important factors in the primary prevention of atherosclerotic cardiovascular

(Continued, next page)

disease (“clogged” arteries).¹⁰ Post mortem studies following unexpected deaths have marked the presence of atherosclerosis in children and young adults – these studies have shown a positive and significant correlation with established risk factors (low-density lipoprotein cholesterol, triglycerides, systolic and diastolic blood pressure, BMI, and presence of cigarette smoking) for cardiovascular disease.¹⁰

Much scientific evidence has shown that many of the risk factors for cardiovascular disease are exacerbated by physical inactivity. Indeed, the AHA noted that, based on evidence from the well-documented and extensive Bogalusa Heart study, as the number of cardiovascular risk factors increases, so does the pathological evidence of atherosclerosis in the aorta and coronary arteries beginning in early childhood.¹⁰⁻¹¹

In addition to evidence of early atherosclerosis among children and young adults, clinic-based reports and regional studies are consistently finding increases in the prevalence rates of children with type 2 diabetes mellitus.¹² These rates have increased as much as 10-fold over the past two decades, and there is “broad consensus” that the increasing prevalence of overweight in children has played a major role in the recent increase in pediatric type 2 diabetes.¹² Virtually all published studies have found that mean BMI among children with type 2 diabetes mellitus is above the 95th percentile for age.¹²

Challenges and Opportunities for Physical Activity in Schools

School Physical Education Programs

Given the importance of physical activity among children and adolescents in preventing and controlling overweight, ensuring adequate amounts of quality physical education is a priority. However, the presence of physical education in our nation’s schools is currently inadequate. Nationwide, just 8 percent of elementary schools, only 6.4 percent of middle/junior high schools, and a mere 5.8 percent of senior high schools provide daily physical education or its equivalent for the entire school year for students in all grades in the school.¹³ Furthermore, in 2003, according to the CDC only 39.2 percent of high school students nationwide were physically active 20 or more minutes during physical education class on three to five days per week, a possible indication of the quality of instruction provided.¹⁴

Participation rates relative to physical education classes are also quite low among Missouri schoolchildren. Based on data from the 2003 Youth Risk Behavior Survey (YRBS) results, 66.8 percent of Missouri high school students did not attend daily physical education class, while 49.4 percent reported not being enrolled in a physical education class at all during the school

year.¹⁵ Indeed, 72 percent of Missouri high school students reported participating in insufficient moderate physical activity, both inside and outside of school.¹⁶ More recently, according to the 2005 Youth Tobacco Survey conducted by Missouri DHSS, only 27.4 percent of middle school students and 17.5 percent of high school students reported attending a physical education class daily.¹⁶

Barriers to Opportunities for Physical Activity in Schools

Providing adequate opportunities for physical activity during the school day through physical education classes and recess time is often difficult because of competition for instructional time needed to meet the demands created by state and national academic standards. The federal No Child Left Behind (NCLB) law holds schools accountable for poor standardized test scores among students. NCLB has added four additional reading tests for grades 3-8, four additional math tests for grades 3-8, and three new science tests for grade spans 3-5, 6-9, and 10-12. The increased number of tests coupled with the monetary and other penalties imposed for not meeting certain test score standards has prompted many school districts and local education agencies to divert resources away from subject areas such as physical education instruction to the core, “tested” courses.¹⁷ In an effort to conserve resources and boost time spent on

(Continued, next page)

Challenges and Opportunities for Healthy Foods in Schools

A Healthy School Nutritional Environment

Most schools have recognized the role school meals play in providing adequate nutrition during the school day. The federal government, specifically USDA, has been subsidizing this component since 1946 for National School Lunch and 1975 for National School Breakfast. Availability of healthy food options and consistent, accurate nutritional information with frequent opportunities to use that information is the foundation of a healthy school nutritional environment.²⁴ Messages about healthy eating and physical activity should be consistent, accurate, clear and applicable wherever students go in a school—classrooms, dining room, gym, etc.²⁴ Wherever students go, they should be able to choose healthy food options—whether in the lunchroom, the classroom, at parties or at sports events.²⁴ Another component of the healthy school nutritional environment is adults modeling healthy eating and physical activity behaviors in the school setting.

Barriers to Healthy food Choices in Schools

Children face many eating opportunities while in school. Some opportunities support healthy choices while many others

undermine a healthy diet. In Missouri, over 500 public and private school districts participate in the National School Breakfast Program and over 700 public and private districts participate in the National School Lunch Program. These programs address problems of hunger, food insecurity and poor nutrition by providing nutritious meals that meet specific dietary guidelines for children. Yet a recent report from the U.S. Government Accountability Office (GAO) indicates that nationally, nearly 9 out of 10 schools sell competitive foods—foods that compete with the sale of federally reimbursable school meals.²⁵ Foods sold in vending machines, school stores, snack bars, for fundraisers and as a la carte in the cafeteria are all considered competitive foods. The nutritional value of competitive foods is largely unregulated and typically poor—consisting of high sugar, fat and calorie foods, such as candy and baked goods.²⁶ In addition to the school meals and competitive foods, children also frequently receive food at school parties and in the classroom as rewards or incentives for desired behaviors. Again, these foods are often high in sugar, fat and calories and low in nutrients.

The overwhelming presence of less nutritious foods in schools can significantly compromise the nutritional health of children. First, it sends children conflicting messages about acceptable dietary behaviors. In the classroom children learn about the importance of practicing moderation and consuming adequate

quantities of fruits, vegetables, low-fat milk and whole grains. Yet the opportunities for children to select these healthy foods are limited to reimbursable meals while the opportunities to select less nutritious foods abound. In some schools healthy eating messages are further compromised by noncash goods and services, such as scoreboards, cups and coolers provided through exclusive beverage contracts. These items typical bear the logo and promotional message of less nutritious beverages and their presence serves as a silent endorsement of these products by the school.²⁵ Second, research indicates that the total food environment influences students' food choices. The simple availability of healthful foods such as fruits and vegetables may not be sufficient to prompt the selection of these items when other food items of high-palatability (often high fat and sugar items) are easily accessible, especially those that are heavily marketed to youth.²⁶

The primary barrier to improving healthy choices in schools is financial concerns, but several other barriers also exist. The sale of competitive foods generates substantial revenues for schools to support the food service operations and other school groups such as athletic teams. According to a 2005 GAO report the potential loss of revenue to support a variety of projects at the school level is a key reason school officials oppose changes to competitive foods practices.

(Continued, next page)

School officials have also cited a lack of clear standards defining healthy and less nutritious foods, an uncertainty of the full extent of competitive foods sales in their schools and the need to continually monitor implementation of competitive foods policies as obstacles to change. In addition, finding healthy, affordable and available foods that appeal to the students has also been identified as a barrier.

Nutrition and Academic Achievement

Malnutrition can be found in many different forms. In the United States the most common forms of malnutrition are linked to inadequate intake of individual nutrients, as with iron deficiency anemia and dietary excess, as is the case with overweight and obesity. Both of these forms of malnutrition are associated with compromised academic achievement. Conversely, healthy nutrition behaviors have been found to have a positive impact on academic success.

The importance of various nutrients, breakfast and food sufficiency (the availability of nutritionally adequate and safe foods) to cognition or academic performance has been shown in a number of studies. The nutrients studied since 1980 because they have been consumed at lower than recommended levels include iron, zinc and iodine. While deficiency of zinc and iodine is not a concern in the United States, iron deficiency is still a problem. Children with iron deficiency

anemia who do not receive treatment can experience impaired cognitive functioning and memory as well as decreased school performance.²⁷ Although the evidence that food insufficiency negatively affects cognition or academic achievement is limited (three studies in the United States), the results of these studies indicate an association between food insufficiency and poorer cognitive functioning, decreased school attendance or diminished academic achievement.²⁸ These results point to the need to ascertain the presence of food insufficiency among schoolchildren and to address that need, if found.

While nutritional intake is important, the weight status of children also affects cognition or academic achievement. In a review of 10 articles published in peer review journals related to children and school performance over the last 10 years, Tares et al found that there were consistent findings that school performance was not as high among children who are at risk of overweight or overweight.²⁹ Overweight children were more likely to have lower IQs, lower test scores, and miss more days of school. One study found that overweight girls were more likely to be held back a grade and consider themselves poor students; overweight boys were more likely to consider themselves poor students and expect to quit school.

The Institute of Medicine states that children obtain about one-third of their total daily energy

requirement from school lunch and “should expend about 50 percent of their daily energy expenditure while at school.”²⁶ Further, students who eat breakfast at school possibly consume as much as “58 percent of their total daily energy requirement at school.”²³ These percentages speak to the importance schools must attach to their student meal programs, especially in the context of the epidemic increase in childhood overweight. Implementing sound school nutrition policies should be a priority not only for the health implications, but also due to the presence of positive links between adequate nutrition and cognition and academic achievement among children (as detailed in a collection of resources put together by the Food and Nutrition Information Center at the United States Department of Agriculture’s National Agricultural Library).³⁰

Sufficient nutrition has also been shown to have positive effects on not only academic achievement but also behavioral functioning. Brandeis University’s Center on Hunger and Poverty has pointed to research that shows the benefits for the cognitive development of children resulting from initiatives such as the federal School Breakfast Program.²⁷ Such benefits include:

- Higher performance on standardized tests;
- Better school attendance;
- Lowered incidence of anemia;
- Reduced need for costly special education.²⁷

(Continued, next page)

A three-year study of a universal breakfast pilot program in Minnesota elementary schools yielded positive results relative to student behavior and academic performance. Breakfast was integrated into the educational schedule of all students, and parents, teachers, and school administrators reported many positive results:

- Increased student attention - teachers reported that students are more energetic at the start of the day, and complaints about mid-morning hunger “have noticeably decreased”.³¹
- Improved student behavior - administrators acknowledged 40-50 percent declines in discipline referrals.³¹
- Reduced nurse visits – school nurses reported a significant decline in morning visits to their offices due to minor headaches and stomachaches.³¹
- Improved test scores – there was a general increase in composite math and reading percentile scores when comparing the test scores of third graders before the universal school breakfast program with their scores as sixth graders after experiencing the program for three years.³¹

The placement of and amount of time devoted to school lunches have also been shown to have positive effects on student behavior, consumption of nutrients, and willingness to learn. Pilot studies at seven schools in Washington State and Montana placed recess before lunch and produced promising results.^{32,33} The Washington study found that consumption of vitamins and minerals,

especially calcium intake, was “significantly higher in the schools with recess before lunch and represented a 35 percent increase in intake.”³² The Montana study also found that milk consumption increased among students eating lunch after recess, and administrators and teachers commented that, among students eating lunch after recess, behavior during lunch, at recess, and in the classroom noticeably improved.³³ Both studies found significant decreases in food waste among students eating lunch after recess, and the Washington study found that the intake of macronutrients and amounts of calcium and vitamin A consumed were significantly greater among students given 30 minutes versus 20 minutes to eat lunch.^{32,33}

Responses to Childhood Overweight Across the Nation

Federal Legislative Requirement for Local Wellness Policies

In 2004, Congress passed Public Law 108-265 requiring each school district participating in the National School Lunch and/or National School Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year. The goals of the law are to promote sound nutrition and establish a healthy school environment in order to enhance student health and reduce childhood

overweight. The law requires districts to set goals for nutrition education, physical activity and other school based activities designed to promote student wellness. In addition, schools must include in their policy nutrition guidelines for all foods available on the school campus during the school day. The development of the local policy must be completed by a broad group of individuals, and a strategy for monitoring the plan must be implemented.

State Legislative Actions

In 2005, there has been a substantial increase in the number of bills introduced addressing the availability of physical and health education classes in addition to nutritional standards and access issues in schools. Forty states introduced approximately 200 bills providing some form of nutritional guidance, while 48 bills advocating health education were introduced in 24 states.³⁴ Regarding physical education, 43 states have introduced measures that would implement or enhance physical education or activity standards, while 18 of these states have adopted such legislation.³⁴ Notable bills include:

- South Carolina H.B. 3499 – mandates 150 minutes per week of physical education and physical activity for students in kindergarten through grade 5 beginning in the 2006-07 academic year.
- Kentucky S.B. 172 – allows for 150 minutes per week to be part of the instructional day at schools with grades K to 5.

(Continued, next page)

- Washington S.B. 5186 – charges the superintendent of public instruction to promote the adoption of curricula and policies that provide quality, daily physical education for all students.

Other states have passed legislation, implemented agency-driven plans, or used a combination of such actions in bringing about important policy changes affecting schools. To view noteworthy actions taking place in several states, please see Appendix I.1. Additionally, for a more thorough discussion on state activities relative to nutritional choices in schools, please see Policy Brief #2 issued by DHSS entitled “Overweight Among School-Age Youth: Healthy Foods and Beverages in Schools.”

Missouri’s Response to Childhood Overweight

New High School Graduation Requirement for Health Education

The Missouri Board of Education increased high school graduation requirements in October 2005 that will become effective in 2010. One of the changes made is to require students to earn one-half unit in health education to graduate in addition to one unit of credit, or one year, of physical education credit that continues to be required. The total number of credits to be earned for graduation increased from 22 to 24. Four units of communication arts

and three each of math, science and social studies are required.

Local Wellness Policies

Professionals representing several Missouri organizations were convened to prepare a coordinated approach for assisting schools in meeting the Federal Local Wellness Policy requirements. The Missouri Department of Elementary and Secondary Education, the Missouri Department of Health and Senior Services, the Missouri School Boards’ Association, University of Missouri Extension, the American Heart Association, and the Dairy Council collaborated to develop a model Missouri Wellness Policy and Procedures. The state team provided the policies, procedures, and other resources for a cadre of individuals from throughout the state during a workshop in fall 2005. The purpose of the workshop was to prepare the cadre of individuals to help schools in their communities with developing local wellness policies. In addition, members of the state team conducted numerous presentations on the Missouri Model Local Wellness Policy at several statewide conferences including the Missouri School Boards’ Association annual meeting and the Coordinated School Health Conference.

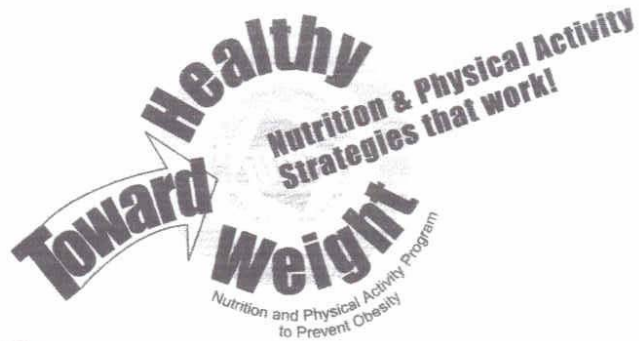
Preventing Obesity and Other Chronic Diseases – Missouri’s Nutrition and Physical Activity Plan

During the last two years over 40 partner organizations and 300

individuals helped craft Missouri’s plan to decrease overweight and obesity among children, youth and adults. The state plan includes strategies and actions to improve access to healthy food choices and opportunities for physical activity in schools and child care facilities, workplaces, homes and communities. Strategies are also outlined for developing and delivering consistent messages about how to safely and effectively improve nutrition and physical activity practices, to enhance the ability of health care providers and systems to prevent, treat and manage patients’ weight, and increase state-level policies that promote physical activity and healthy nutritional habits.

This paper is a first step toward addressing state-level policy that will support school-age youth in adopting healthy physical activity and nutritional habits to prevent and control overweight.

(Continued, next page)



Overweight Among School-Age Youth; Healthy Foods and Beverages in Schools

Acknowledgement

The Missouri Department of Health and Senior Services (DHSS), in partnership with the Obesity Prevention Center of the St. Louis University School of Public Health, prepared this policy brief to inform recommendations for action. A special thanks is extended to Chris Fleming of St. Louis University for his work in preparing this paper.

Introduction

The rising tide of obesity in Missouri is not a simple problem. To stem the tide, careful analysis of the factors that contribute to this health hazard and strategic thinking to identify effective ways to control and reverse the problem must occur. During the past two years more than 40 partner organizations and 300 individuals helped to craft Missouri's plan to decrease overweight among children, youth and adults across a broad spectrum of influences. One of the four goals defined in the plan is to increase state-level public policies that promote physical activity and nutritional habits to prevent obesity and chronic diseases and one of the strategy focus areas is schools. The purpose of this paper is to provide Missouri policymakers with critical information about the policy and legislative steps that other states have taken and offer recommendations for state level policy action in Missouri.

Background

Traditional measures for overweight and obesity utilize the Body Mass Index (BMI) scale, which is a measurement of the proportion of an individual's weight relative to that individual's height. Because children's and teens' body fat changes as they grow, BMI is used to assess underweight, overweight, and at risk for overweight.¹ Known as BMI-for-age, it is a gender-specific measurement basing overweight or at risk for over-

weight status on percentiles—children and teens with a BMI that falls between the 85th and 95th percentile for a gender and age specific population are considered at risk for overweight, while having a BMI in the 95th percentile or higher places children and teens in the overweight category.

These distinctions are important, because evidence has shown that the children who are overweight or at risk for overweight

have a much better chance of being obese as an adult than children who are of normal weight. For instance, one study found that for children aged 10 to 15 years, 75 percent of the children who were at risk for overweight were obese adults at age 25, while 83 percent of the overweight children in this age group were obese by the age of 25.² Multiple studies indicate that

(Continued, next page)

the prevalence of childhood obesity has steadily increased over the last twenty to thirty years. The National Health and Nutrition Examination Survey taken from 1971 to 1974 found that 4 percent of children aged 6-11 years were overweight. In 2002, 16 percent of children in this category were overweight. For adolescents aged 12-19 years, 6 percent were overweight in 1974 while 16 percent were overweight in 2002.³ Public health officials are concerned with the dramatic rise in type-2 diabetes among children and adolescents. Type-2 diabetes was previously considered an adult disease, and it is closely linked with overweight and obesity.² The National Hospital Discharge from 1979 to 1999 found that the hospital costs associated with obesity-related diagnoses of diabetes, obesity, sleep apnea, and gallbladder disease among youth aged 6 to 17 years of age more than tripled, from \$35 million in 1979-81 to \$127 million in 1997-99.⁵ In Missouri, 18.6 percent of adolescents screened were overweight, compared to the national average of 14 percent overweight adolescents aged 12-19 in 1999, and the percent of overweight appears to be increasing among students aged 5-11, as 19.4 percent of Missouri students in the population screened were overweight, while in the 2000-2001 school year, the percentage increased to 21.5 percent.⁶

Targeting children is viewed by many as a preventive measure to control health care costs not only for overweight children, but also for chronic diseases that later

develop due, in large part, to causally related conditions such as overweight and obesity. Most recognize overweight and obesity as a serious health problem, but this recognition may decrease as media coverage on the topic decreases over time. Legislation introduced on the federal level has been sparse, and this speaks to the difficulty in gaining consensus on the means by which to attack the problem. At the state, and even the local level, many pieces of legislation aiming to combat the problem of childhood overweight have been passed, as consensus may be more viable. State policies are relatively new, so data examining the effectiveness of certain policies are lacking. This being the case, it is essential that state policymakers assess the political climate and take into account all potential stakeholders when crafting policy.

State Policies

The primary goal of policy proposals relating to childhood overweight is to reduce and prevent the prevalence of the problem. A significant number of state policies aim to increase the nutritional value of foods available to students, while oftentimes decreasing the amount of foods the United States Department of Agriculture ("USDA") deems to be "foods of minimal nutritional value" ("FMNV") available to students. Many policies set specific standards defining nutritional parameters. This state policy overview examines the common goal of allowing local school districts a voice in the implementation process. During

the past couple of years, approximately 40 states have introduced over 200 bills related to improving the nutritional intake of children with the purpose of decreasing the prevalence of childhood overweight.⁷ Since 2003, a number of bills pertaining to childhood overweight prevention and some type of school intervention or school study have been signed into law. Following the final page of this document, **Table 1.2** highlights and briefly explains several of the bills that have been passed since 2003.

Highlights of Select State Policies Enacted

Colorado

In 2004, Colorado Senate Bill 04-103 was signed into law. The bill's intent is that:

1. "School districts work with contractors to increase over time the nutritional value of foods offered to students in school vending machines and to phase in higher nutritional standards as vendor contracts are renewed," and

2. The language of the bill sets forth the nutritional guidelines for the food and beverages that are to be offered in the vending machines, and

3. School districts are to adopt a policy providing "that, by the 2006-2007 school year, at least 50 percent of all items offered in each vending machine or adjoining set of vending machines located in each school of the school district shall meet the criteria set forth" in the bill.

(Continued, next page)

California

In addition to providing healthful alternatives in school vending machines, many states also have enacted policies regulating the nutritional attributes of foods sold in competition with the National School Breakfast, Lunch, and After School Snack Programs. For instance, in 2003 California enacted Senate Bill 677, which stipulates that “the sale of all foods on school grounds shall be approved for compliance with the nutrition standards” set forth within the bill. These nutrition standards are similar to standards enacted in Colorado, Connecticut and Tennessee, which contain at least one of the following components:

1. An individual food item may not derive more than 35 percent of its total calories from fat (in some instances, this does not apply to nuts or seeds);

2. Not more than 10 percent of a food item’s total calories shall be from saturated fat;

3. Not more than 35 percent of a food item’s total weight shall be composed of sugar (in some cases this does not apply to the sale of fruits or vegetables); and

4. Beverages sold on school grounds often must consist of one or a combination of the following criteria:

- Acceptable beverages may include milk, as that term is defined in section 25-5.5-101, C.R.S., including chocolate milk, soy beverage, rice beverage, and other similar dairy or non-dairy beverages;

- One hundred percent fruit juices or fruit-based drinks composed of no less than 50

percent juice, without additional sweeteners, may be made available; and

- An electrolyte replacement beverage that contains 42 grams or fewer of additional sweetener per 20-ounce serving may be sold on school grounds.

Arkansas

In 2003, Arkansas passed into law House Bill 1583. Key provisions of the bill included:

1. The legislation provides for the creation of a 15-member Child Health Advisory Committee (“Committee”), requiring the Committee to develop nutrition and physical activity standards and policy recommendations for Arkansas schools;

2. The bill earmarked up to 5 percent of Health Master Settlement Agreement funds for model or pilot programs created under the Act.

3. The bill prohibits food and beverage vending machine access for elementary students. The bill requires schools “to include as part of the student report card to parents an annual body mass index percentile by age for each student”.

In 2004, the Arkansas Committee released its nutrition and physical activity standards. While setting forth specific guidelines, the Committee mandated that each school district convene a School Nutrition and Physical Activity Advisory Committee responsible for implementing nutrition and physical activity standards. Among the guidelines, the Committee mandates that the local school district committees maintain minimal nutritional

standards, and maintain and update annually a list of recommended locally available healthier options for food and beverage sales venues.

The Arkansas case is significant in that policy is essentially being implemented by local school districts, which in some cases may be a more politically feasible option. Also important to note is that the legislation stipulates at least partial funding for the programs created by the Act.

Kentucky

Kentucky recently put into law (KRS Chapter 158, Sections 2-5), via Senate Bill 172, policy similar to the Arkansas legislation in that the state designates the Kentucky Board of Education as the agency responsible for promulgating:

1. “An administrative regulation...to specify the minimum nutritional standards for all foods and beverages that are sold outside the National School Lunch programs, whether in vending machines, school stores, canteens, or a la carte cafeteria sales.

2. “Minimal nutritional standards shall be based on the most recent edition of the [USDA’s] Dietary Guidelines for Americans.

3. “The administrative regulation shall address serving size, sugar, and fat content of the foods and beverages.

4. “School districts may impose more stringent standards than those implemented under the administrative regulation.”⁸

(Continued, next page)

While the Kentucky statute does not provide specific funding that may be necessary in compensating school districts that may lose revenue as a result of policy implementation, the legislation does impose fines on schools that fail to comply with the nutritional requirements set forth in the bill. Revenue created as a result of fines will be transferred to the local school district's school food service fund.

Washington

Some states employ commissions, committees or task forces to set all guidelines for nutrition and/or physical activity requirements, potentially creating a more politically feasible atmosphere under which childhood overweight prevention legislation may be passed. The Washington state legislature in 2004 enacted Senate Bill 5436, which directs the Washington state school directors association to "convene an advisory committee to develop a model policy regarding access to nutritious foods, opportunities for developmentally appropriate exercise, and accurate information related to these topics." The bill is similar to those passed in Arkansas and Kentucky, yet it does not specify any nutritional guidelines to be met. The school directors association made an assessment and, at the beginning of 2005, submitted a model policy. The law requires that each district's board of directors establish its own policy by August 1, 2005.

Texas

In the absence of legislation targeting childhood overweight, some state agencies have distributed to schools policy recommendations regarding nutritional and physical activity guidelines to promote healthier school environments. The Texas Department of Agriculture, in March 2004, issued the Texas Public School Nutrition Policy, which outlined recommendations for minimal nutrition standards, maximum portion sizes, and making fresh fruits and vegetables available daily at all points of services, among other suggestions. This kind of departmental initiative may depend on availability of funds, which may depend on the availability of political support for such expenditures.

Funding

Pouring Contracts

Many school districts earn significant amounts of revenue from vending machines, and school districts often use that revenue to fund extracurricular activities. This fact alone discourages much legislation from gaining support, and it is an issue for which policymakers must account when establishing childhood overweight prevention initiatives in most schools, especially secondary schools. Many state legislative initiatives propose vending machine policies effective only at the elementary, middle, or junior high school levels.

The problem of losing revenue through vending machine restrictions was apparent in an initiative

enacted by the Chicago Board of Education. Chicago's Board of Education accepted a new contract with the American Bottling Company that replaced Coca-Cola products with pure juices, sports drinks, and water; the decision resulted in a new contract that guarantees \$6.4 million to the schools in revenue and sales while the Coca-Cola contract guaranteed \$8.6 million.⁹ As mentioned above, it is crucial for school districts to work with contractors as directed in the Colorado bill. In many cases, school districts may be able to work with existing contractors, as soft drink giants such as Coca-Cola and PepsiCo possess product lines that may meet many nutritional standards.

Taxes – Revenue Source & Consumption Impacts

There are currently taxes on such products as soft drinks and snack foods in place in many states and municipalities, and most of these tax revenues are earmarked for general funds.¹⁰ For instance, Arkansas taxes \$0.21 per gallon of liquid soft drink and \$2 per gallon of soft drink syrups, generating about \$40.4 million dollars in annual income.¹¹ This income is actually designated for a specific program: it funds Arkansas' Medicaid program. There are some other states that have rather hefty sales taxes on soft drinks and snack foods. California has a 7.25 percent sales tax on soft drinks, and this produces an estimated \$218 million in annual income for

(Continued, next page)

the state, which is deposited into general funds.¹² Indiana taxes candy, gum, soft drinks, bottled water, and dietary supplements at a rate of 5 percent; this tax raises \$43 million in annual revenue, and this money is designated for general funds.¹³ Before it was repealed, Missouri levied a tax of \$0.003 per gallon on soft drinks produced in the state, creating between \$400,000 and \$500,000 per year, which was used for health department inspections of bottling plants.¹⁴

Even though such taxes exist, redirecting funds or creating new taxes will inevitably meet substantial opposition. It is important to note, however, that small taxes on various food and beverage products have been found to have little effect on overall consump-

tion. Researchers with the USDA's Food and Rural Economics Division, Economic Research Service, found that a 1 percent tax on potato chips alone would reduce annual household purchases (average of 156.28 ounces) by 0.71 ounces, equivalent to 0.28 ounces per person per year, or 42 calories per person.¹⁵ The researchers also found that a tax on potato chips as high as 20 percent reduces purchases by 5.54 ounces per person per year, or 830 calories per person.¹⁶ The revenue-raising potential for even smaller taxes is impressive: national taxes between 1 percent and 20 percent on potato chips alone could generate revenue in the range of \$27 million to \$501 million.¹⁷ This type of tax could be intended

to fund various programs aimed at reducing childhood overweight, as the study displayed the minimal effect on snack food consumption.

Available Evidence

The Centers for Disease Control and Prevention (CDC) in 1996 made recommendations based on available scientific literature and national nutrition policy documents for "ensuring a quality nutrition program within a comprehensive school health program".¹⁸ Schools have consulted these recommendations in creating health programs addressing healthy eating. Schools that have adopted health programs based on the CDC's recommendations have been used

(Continued, next page)

CDC Recommendations for School Health Programs Promoting Healthy Eating¹⁸

Recommendations	Description
1. Formulate Policy	Adopt a coordinated school policy promoting healthy eating in both the classroom and the overall school environment.
2. Develop Curriculum for Nutrition Education	Implement sequential, comprehensive nutrition education from preschool through secondary school.
3. Choose Relevant Instruction Methods	Provide education that is developmentally appropriate, culturally relevant, fun, participatory and involves social learning strategies.
4. Integrate School Food Service and Nutrition Education	Coordinate the school food service with aspects of nutrition education.
5. Train School Staff	Train all staff involved with nutrition education, focusing on teaching strategies for behavioral change.
6. Involve Family & Community	Involve family members and the community in reinforcing nutrition education.
7. Evaluate the Program	Regularly evaluate the effectiveness of the program in promoting healthy eating, and make changes as appropriate.

as control groups in several studies. The CDC's recommendations are listed in the table on the preceding page.

While there has been significant media coverage of the obesity epidemic, and the problem has gathered political steam, there is not a stockpile of data on the effectiveness of interventions such as the ones discussed in this brief. There is some evidence, however, that speaks to the possibility for positive outcomes resulting from certain state policies. A study was conducted in the Canadian province of Nova Scotia examining the effects of school nutrition programs on rates of overweight among approximately 5,000 fifth graders. The study compared excess body weight, diet, and physical activity across schools with and without nutrition programs. There were three control groups: a group of schools reporting that they had policies or practices in place to offer healthy menu alternatives; a second group included seven schools that are part of a coordinated program incorporating aspects of each of the CDC recommendations for school-based healthy eating programs; and a third group of schools did not have any nutrition policies in

place.²⁰ The study found that the schools incorporating aspects of the CDC programs had significantly lower rates of overweight than schools both with and without reported nutrition programs.²¹

Several studies are available indicating the potential of nutrition intervention programs as they relate to soda consumption and vending machine choices. A study conducted in Britain examined the effects of a school-based educational program aimed at reducing the consumption of carbonated drinks to prevent excessive weight gain in children aged 7-11 years.²² The program encouraged children to drink more water and less "fizzy" drinks. After 12 months, soda consumption decreased in the intervention group compared with the control group, and the intervention group saw decreases in the rates of prevalence of overweight children upon completion of the study.²³

Policies limiting or restricting vending machine access are fairly common pieces of state legislation, and there is evidence that being creative with such policies can be effective in positively altering the diets of school-age children. In attempting to alter consumption patterns at a point of

sale such as a vending machine, it is important to take into account the effect such an intervention will have on revenue. A vending machine experiment showed strong pricing effects for low-fat vending snack purchases: sales of low-fat snacks increased by 80 percent during a three-week period when low-fat snack prices were reduced by 50 percent, while the average profit per machine per week was reduced to \$66 from \$116.²⁴ Similarly, in a high school cafeteria, sales increased two-fold to four-fold when prices for fresh fruit and baby carrots were reduced by 50 percent.²⁵ Still another study, titled the Changing Individuals' Purchase of Snacks ("CHIPS") explored pricing and promotion strategies (including promotional signage) for influencing low-fat food choices at diverse community sites, including 12 schools in the Minneapolis-St. Paul area. The study found that price reductions of 50 percent, 25 percent, and 10 percent were associated with increases in low-fat snack sales of 93 percent, 39 percent, and 9 percent, respectively.²⁶

(Continued, next page)

Summary

There is much evidence substantiating the fact that childhood overweight and obesity is increasing among America's schoolchildren. A review of existing state policies and available evidence on the effectiveness of interventions in improving healthy food choices in schools points to several factors to consider in adopting policy:

- Adopted policies need to be broad in scope.
- Advisory groups offer necessary guidance in crafting the appropriate scope of policy and legislation.
- It is helpful to provide for local flexibility in administering a plan while mandating adherence to basic levels of nutritional standards.
- An assessment of the prevailing political climate is necessary in crafting policy for legislative passage, which also means evaluating the political viability of various funding mechanisms.
- It is important to realistically address revenue issues and attempt to provide alternatives to offset any potential losses resulting from new policies or mandates.

For a sampling of adopted state legislation that corresponds to several of the aforementioned points see Table 1.1.

Recommendations for Policy Action in Missouri

■ Develop minimum standards for a la carte and vending food and beverage options. Schools provide significant amounts of foods to children, and assist them in learning good nutritional habits. Messages received throughout the school setting should be consistent. Foods available at school should reflect messages provided in classroom instruction.

■ It is recommended that a la carte and vending food and beverage options and food and beverages sold as fundraisers meet the "Missouri Eat Smart" nutrition guidelines.²⁷

■ Develop minimum standards for foods and beverages sold as fundraisers. Many schools conduct fundraising activities to support athletics, student clubs and other specific events. Other than selling foods or beverages, funds could be raised by selling non-food items, students assisting community residents with various chores (such as spring cleaning), selling bricks in a walkway or plaques for walls (with donor names engraved), etc.

■ It is recommended that foods and beverages sold as fundraisers meet the "Missouri Eat Smart" nutrition guidelines.

■ Eliminate the sale and marketing of unhealthy foods and beverages. Marketing is targeted at children through a variety of mechanisms; the two most frequent are television and in-school marketing.²⁸ Marketing toward youth occurs for a variety of reasons: they have money, they influence family spending, and they are future customers. Children have been found to be affected by marketing.

■ It is recommended that sale and marketing of unhealthy foods and beverages that do not meet the "Missouri Eat Smart" nutrition guidelines be eliminated from the school environment.

Table 1.1 – Recommendations in Action

Recommendation	State Bills Adopting Similar Recommendations	Discussion
Adopt policies broad in scope	Kentucky 2005 SB172; Arkansas 2003 HB1503	Both bills broadly address childhood obesity by providing for the maintenance of physical activity and nutritional standards, among other provisions.
Convene an advisory committee	Kentucky 2005 SB172; Arkansas 2003 HB1503; Washington 2004 SB5436	Committees vary from state to state; some are independent, appointed committees, while other legislation appoints the board of education.
Allow local flexibility in administering programs	Kentucky 2005 SB172; Colorado 2004 SB103 & 2005 SB81; Arkansas 2003 HB1503	These bills allow school districts/schools to adopt school-specific policies, while requiring adherence to legislated nutrition and physical activity standards. CO SB81 does not mandate standards.
Address revenue issues	Colorado 2004 SB103; Arkansas 2003 HB1503	CO SB103 allows schools to work with existing contractors and provides for gradual phase-out of unhealthy vending items. AR HB1503 earmarked up to 5 percent of Health Master Settlement Agreement.

**Table 1.2 — Childhood Obesity Prevention in the Schools
Highlighted State Legislation Enacted 2003-2005**

State, Year Enacted	Bill Name/Number	Description
Arkansas, 2003	A bill to create a child health advisory committee; HB 1583	Develops physical activity & nutrition standards; prohibits vending machine access; BMI reporting; earmarks funds
California, 2003	Childhood Obesity Prevention Act; SB 677	Sets explicit nutritional standards for vending machines
Colorado, 2004	Concerning policies to increase the inclusion of nutritious choices in school vending machines; SB 103	Aims to increase nutritional standards for vending machine foods; sets strict nutritional standards
Connecticut, 2004	A bill concerning childhood nutrition in schools, recess and lunch; HB 5344	Sets standards for school nutrition and physical activity
Illinois, 2003	A bill to conduct a sugar consumption study; HR 147	Aims to determine the effects of sugar consumption on health of school children
Kentucky, 2005	A bill relating to health and nutrition in schools; SB 172	Board of Education to develop nutritional standards for competitive foods
Louisiana, 2004	A bill to amend and re-enact R.S. 17:17, and to enact R.S. 17:17.1, 17.2, and 17.3; SB 871	Broad program to reward schools, commence studies, develop pilot programs
Louisiana, 2004	A bill requesting Dept. of Education to develop school menus, HR 20	Encourages creation of healthy school menus, especially foods containing marine-source long chain Omega-3 fatty acids
Maine, 2003	The Commission to study Public Health was created by Resolve 2003, chapter 95	Appoints commission to study the obesity epidemic and make recommendations
New Mexico, 2004	A resolution requesting a childhood obesity study; HM 28	Requests committee to study nutrition/physical activity; impact of foods/beverages on public school students
Tennessee, 2004	Amends Tennessee Code Annotated, SB 2743	Sets nutritional standards for K-8 schools
Washington, 2004	A bill relating to the sales of competitive foods and other issues; SB 5436	Requires state school directors association/local school districts to develop policies
West Virginia, 2004	A resolution requesting a childhood obesity study; HCR 8	Requests government committee to study childhood obesity epidemic in West Virginia

References

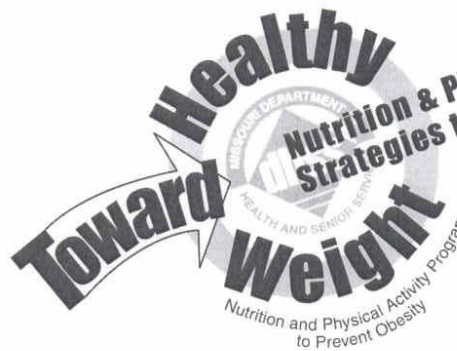
- ¹ Centers for Disease Control and Prevention. Body mass index: BMI for children and teens. Available at: http://www.cdc.gov/nccd/dnpa/bmi/bmi_for_children_and_teens.htm.
- ² Whitaker RC, et al. Predicting obesity in young adulthood from childhood and parental obesity. *N Engl J Med* 1997;337(13):869-873.
- ³ 1999-2002 National Health & Nutrition Examination Survey. Centers for Disease Control and Prevention.
- ⁴ 2001 Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity.
- ⁵ Obesity: Facts, Figures, Guidelines. West Virginia Department of Health and Human Resources, December 2002. Downloaded 03/22/2005 at: <http://www.wvdhhr.org/bph/oehp/obesity/contents.htm>.
- ⁶ Childhood Overweight. Missouri Department of Health and Senior Services web site. Downloaded 03/22/2005 at: <http://www.dhss.mo.gov/Obesity/Childhood.html>.
- ⁷ Health Policy Tracking Service, A Thomson West Business. *State Actions to Promote Nutrition, Increased Physical Activity and Prevent Obesity: A Legislative Overview*. 2005.
- ⁸ Kentucky Revised Statutes: Chapter 158, Section 4.
- ⁹ Cline KP, Spradlin TE, Plucker JA. Center for Evaluation & Educational Policy. Child Obesity in Indiana: A Growing Public Policy Concern. *Education Policy Brief*: Vol 3, No. 1, Winter 2005.
- ¹⁰ Jacobson MF, Brownell KD. Small Taxes on Soft Drinks and Snack Foods to Promote Health. *American Journal of Public Health*. 2000;90:854-857.
- ¹¹ Id.
- ¹² Id.
- ¹³ Id.
- ¹⁴ Id.
- ¹⁵ Kuchler F, Tegene A, Harris JM. Taxing Snack Foods: Manipulating Diet Quality or Financing Information Programs? *Review of Agricultural Economics*: Vol. 27;No. 1;4-20.
- ¹⁶ Id.
- ¹⁷ Id.
- ¹⁸ Centers for Disease Control and Prevention. Guidelines for school health programs to promote life-long healthy eating. *MMWR Recomm Rep*. 1996;45(RR-9):1-41.
- ¹⁹ Id.
- ²⁰ Veugeler PJ, Fitzgerald AL. Effectiveness of School Programs in Preventing Childhood Obesity: A Multilevel Comparison. *American Journal of Public Health*: March 2005, Vol. 95, No. 3.
- ²¹ Id.
- ²² James J, Thomas P, Cavan D, Kerr D. Preventing childhood obesity by reducing consumption of carbonated drinks: cluster randomized controlled trial. *British Medical Journal*: 2004; 328; 1237-; originally published online 23 Apr 2004. Downloaded 03/30/2005 at: <http://bmi.bmjournals.com>.
- ²³ Id.
- ²⁴ French SA, Jeffery RW, Story M, Hannan P, Snyder MP. A pricing strategy to promote low-fat snack choices through vending machines. *American Journal of Public Health*. 1997;87:849-851.
- ²⁵ French SA, Story M, Jeffery RW, et al. Pricing strategy to promote fruit and vegetable purchase in high school cafeterias. *J Am Diet Assoc*. 1997;97:1008-1010.
- ²⁶ French SA, Jeffery RW, Story M, Breitlow KK, Baxter JS, Hannan P, Snyder MP. Pricing and Promotion Effects on Low-Fat Vending Snack Purchases: The CHIPS Study. *American Journal of Public Health*. 2001;91:112-117.
- ²⁷ Missouri Eat Smart Guidelines, Missouri School Board Association web site at http://www.msbanet.org/pdf/wellness/Missouri_Eat_Smart.pdf.
- ²⁸ Food Marketing and Advertising Directed at Children and Adolescents: Implications for Child Overweight. November 18, 2003; American Public Health Association Policy Statement; <http://apha.org>.

This document was supported by Grant/Cooperative Agreement Number U58/CCU722795-02 from the Centers for Disease Control and Prevention. Contents are solely the responsibility of the authors and do not necessarily represent the views of the Centers for Disease Control and Prevention.

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER
Services provided on a nondiscriminatory basis

Alternate forms of this publication for persons with disabilities may be obtained
by contacting the Missouri Department of Health and Senior Services.
Hearing and speech impaired citizens telephone 1-800-735-2966. VOICE 1-800-735-2466.

**Preventing Obesity
and Other Chronic
Diseases**



*Miss.
Congresswoman*

Missouri Facts About Overweight and Obesity

Overweight among Missouri Children and Adolescents:

- 12.0% of the children participating in the WIC Program are overweight¹
- 22.8% of the elementary school students participating in the Missouri School-aged Children Health Service Program are overweight²
- 14.5% of middle school students are overweight³
- 13.6% of high school students are overweight³

Obesity among Missouri Adults:

- 23.6% of adults are obese⁴

Related Behaviors:

Fruit and Vegetable Consumption

- 16.0% of middle school students ate 5 servings of fruits and vegetables daily³
- 14.6% of high school students ate 5 servings of fruits and vegetables daily³
- 20.2% of adults ate 5 servings of fruits and vegetables daily⁴

Breastfeeding

Initiation Rate

- 63.9% of new mothers began breastfeeding⁵

Rate of Breastfeeding at 6 Months of Age

- 30.3% of mothers continued breastfeeding 6 months or more⁵

Sweetened Beverage Consumption

- 25.3% of middle school students drank 2 or more glasses of sweetened beverages a day³
- 31.0% of high school students drank 2 or more glasses of sweetened beverages a day³

(Continued, next page)

Calcium and Dairy Consumption

- 22.3% of middle school students drank 3 or more glasses of milk every day³
- 15.9% of high school students drank 3 or more glasses of milk every day³

Moderate or Vigorous Physical Activity

- 78.3% of middle school students met physical activity recommendations^{3*}
- 71.7% of high school students met physical activity recommendations^{3*}
- 45.1% of adults met physical activity recommendations⁴

Physical Education

- 27.4% of middle school students participated in daily physical education classes³
- 17.5% of high school students participated in daily physical education classes³

TV Viewing

- 40.4% of middle school students watched TV for 3 or more hours on an average school day³
- 35.1% of high school students watched TV for 3 or more hours on an average school day³

- ★ *These survey participants met CDC recommendations of 20 minutes vigorous physical activity for at least 3 days per week or 30 minutes of moderate activity for at least 5 days per week or a combination of vigorous and moderate physical activity for at least 5 days per week.*

References:

1. Centers for Disease Control and Prevention. 2003. Pediatric Nutrition Surveillance System Reports.
2. Missouri Department of Health and Senior Services. Dietary Intake and Physical Activity Summary Report. The Missouri School-Age Children's Health Services Program School Year 2002-2003.
3. Missouri Department of Health and Senior Services. 2005. Youth Tobacco Survey.
4. Centers for Disease Control and Prevention. 2003. Behavioral Risk Factor Surveillance System.
5. Ross Products Division of Abbott Laboratories. 2003. Mother's Survey.

This document was supported by Grant/Cooperative Agreement Number U58/CCU722795-02 from the Centers for Disease Control and Prevention. Contents are solely the responsibility of the authors and do not necessarily represent the views of the Centers for Disease Control and Prevention.

Alternate forms of this publication for persons with disabilities may be obtained by contacting the Missouri Department of Health and Senior Services, Division of Community and Public Health, Health Promotion Unit, PO Box 570, Jefferson City, MO 65102
573-522-2806

Hearing and speech impaired citizens telephone 1-800-735-2966. VOICE 1-800-735-2466.

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER
Services provided on a nondiscriminatory basis.

Preventing Obesity and Other Chronic Diseases

Missouri's Nutrition and Physical Activity Plan

2005



The Problem

Obesity is one of the most serious health issues facing society today. Obesity has grown at such an alarming rate during the past two decades, it is considered a national epidemic. In Missouri, more than one in five adults are obese, and more than half of adults are overweight, which can lead to obesity. In 2002, more than 23 percent of Missourians over the age of 18 were obese, an increase of 95 percent since 1990 (Figure 1).

Obesity attacks the well-being of millions of people every year. It is a contributing factor in some of the most devastating and disabling diseases – diabetes, heart disease, arthritis and several types of cancer. Obesity is a leading cause of preventable death in the United States. Nationwide, an estimated 112,000 premature deaths a year may be attributed to obesity. The stark reality is excess weight means an increase in the risk of early death.

Obesity is a complex problem with numerous causes and consequences:

- **It is an expensive epidemic.** Obesity costs Missouri thousands of lives and well over a billion dollars every year. In 1998, direct health care costs attributed to adult obesity totaled \$1.6 billion.
- **It contributes to many illnesses.** People who are overweight or obese are frequently plagued by serious and long-lasting health concerns. Both physical and mental health are affected.
- **It can decrease quality of life.** In some cases, overweight and obese people have a diminished quality of life due to health concerns, discrimination and difficulty or inability to participate in certain activities.
- **It is often misunderstood.** Overweight and obesity are not simply a result of eating too much, although poor eating habits are often a contributing factor. The problems are caused by a number of factors that are often interrelated. According to the American Obesity Association, behavior, environment and genetics are all part of the overweight and obesity equation.

"Overweight and obesity must be approached as preventable and treatable problems with realistic and exciting opportunities to improve health and save lives." – U.S. Surgeon General, 2001

(over)

The Plan

Missourians live in an environment that promotes poor eating habits and discourages physical activity in daily routines.

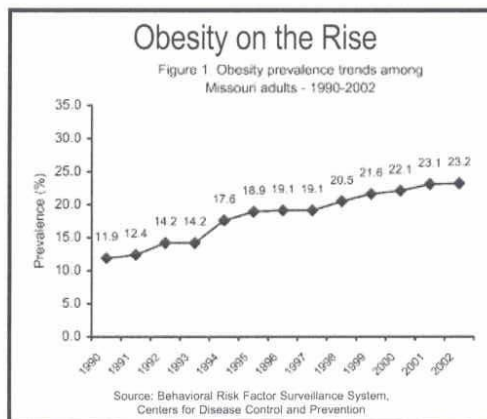
Because obesity is one of the most serious health problems facing society today, all Missourians must take action to help end this epidemic.

To guide this effort, Missouri has developed a strategic plan to combat the state's obesity problem. The plan was created by the Missouri Council on the Prevention and Management of Overweight and Obesity with input from Missouri residents who attended six public meetings held throughout the state and commented via the Internet. The Missouri Department of Health and Senior Services is facilitating the development and implementation of the plan.

The plan addresses the need to increase physical activity levels, improve dietary intake, increase the effectiveness of the health care system in obesity prevention and treatment and strengthen health-related policies in Missouri.

The framework of the plan is based on approaches defined by the Centers for Disease Control and Prevention (CDC) as essential to winning the battle against obesity. The CDC encourages promoting activities found to be effective in all areas that influence people's behaviors, including environmental and policy changes.

The plan includes goals, strategies and actions that Missouri can use to improve the health of its residents. The plan focuses on five main areas: families, communities, schools, health care services and public policy.



Within those areas, some of the specific actions include:

- Support family-focused community activities that provide healthy nutrition and physical activity opportunities.
- Help schools and child care facilities identify resources to assist families with children at risk for obesity.
- Recognize successful approaches used by employers that enable employees to improve nutrition, physical activity and breastfeeding practices.
- Provide training, resources and assistance to schools, child care facilities, families, communities and employers.
- Provide supports for primary health care settings to address obesity risks in early stages.
- Inform public officials about the health and economic costs of obesity.

The goals, strategies and actions detailed in Missouri's plan have been developed to ease the burden of obesity and help Missourians lead longer, healthier lives.

The complete plan, *Preventing Obesity and Other Chronic Diseases: Missouri's Nutrition and Physical Activity Plan*, can be found at: www.dhss.mo.gov



Missouri Department of Health
and Senior Services
Health Promotion Unit
P.O. Box 570
Jefferson City, MO 65102
1-573-522-2820

Alternate forms of this publication for persons with disabilities may be obtained by contacting DHSS: Hearing impaired citizens telephone 1-800-735-2966.

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER
Services provided on a nondiscriminatory basis

This document was supported by Grant/Cooperative Agreement Number US8/CCU 722795-02 from the CDC. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the CDC.

Obesity State

A Closer Look at Obesity in Missouri

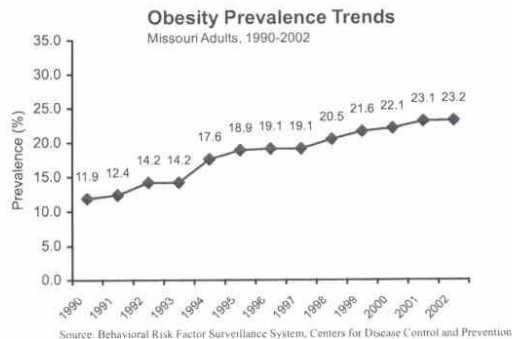
A special publication from:
Missouri Department of Health and Senior Services
Bureau of Health Promotion
573-522-2820

Obesity is on the rise in Missouri

The obesity epidemic is one of the most important health challenges facing Missouri and the entire nation.

Obesity rates are increasing.

- More than half of all Missouri adults are overweight and more than 23 percent are obese.^{1,2}
- In 1986, less than 10 percent of Missouri adults were obese. In 2004, close to one in four were obese. These rates are likely to be underestimated since height and weight, which are used to calculate obesity, are "self-reported."



Obesity is associated with an increased risk of:

- Premature death
- Type 2 diabetes
- Heart disease
- Stroke
- Hypertension
- Gallbladder disease
- Osteoarthritis (degeneration of cartilage and bone in joints)
- Sleep apnea
- Asthma
- Breathing problems
- Cancer (endometrial, colon, kidney, gallbladder and postmenopausal breast cancer)
- High blood cholesterol
- Complications of pregnancy
- Menstrual irregularities
- Hirsutism (presence of excess body and facial hair)
- Stress incontinence (urine leakage caused by weak pelvic-floor muscles)
- Increase surgical risk
- Psychological disorders such as depression
- Psychological difficulties due to social stigmatization

Adapted from www.niddk.nih.gov/statistics/index.htm.

Obesity is costly.

Obesity reduces economic productivity, increases the risk for chronic disease and premature death and drives up medical expenses. Everyone pays the price:

- Total annual health care costs attributed to adult obesity in Missouri are estimated at \$1.6 billion!
- More than half of these costs are paid by Medicare (\$454 million) and Medicaid (\$413 million).³
- People who are obese spend 36 percent more on medical expenses each year compared to adults with a healthy weight.¹

Obesity can lead to illness.

Obese people are more likely report poor physical and mental health.^{1,4}

- More than 30 medical conditions are associated with overweight and obesity.⁴
- Between 1988 and 2002, diagnosed diabetes jumped from 4.9 to 7.3 percent; more than 80 percent of people with diabetes are overweight.⁴
- For every two pound increase in weight, the risk of developing arthritis increases by nine to 13 percent.⁴
- Obese women are more likely to have health problems during pregnancy, labor and delivery.⁴

Overweight Children Could Face Lifelong Health Problems

Overweight is now the most common medical condition of childhood.⁵

Children are in danger of serious long-term conditions.

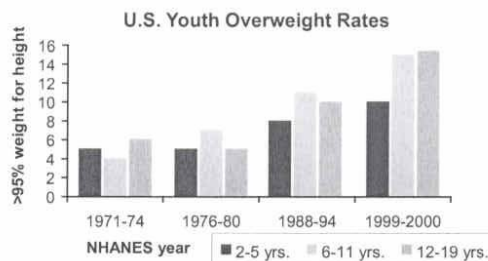
- Over the past several decades, the number of overweight children has quadrupled among 6 to 11 year olds and tripled among 12 to 19 year olds.⁶
- The number of overweight preschoolers, ages 2 to 5, has doubled since 1970.⁷
- All children are at risk, but minority children are at greatest risk. African American and Hispanic children are most likely to be overweight.^{1,8}
- Overweight children are more likely to have high cholesterol and high blood pressure - risk factors for heart disease. They are also more likely to develop Type 2 diabetes, which previously had only been seen in overweight adults.⁴

If obesity persists:

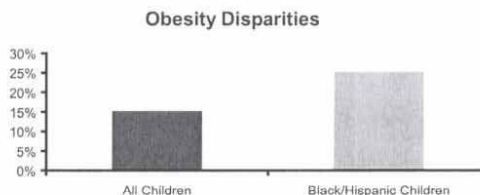
- Overweight children are more likely to be obese adults.⁹
- Obese teens have a 70 to 80 percent chance of remaining obese into adulthood.⁹

If trends do not change:

- One in three children born in the United States in 2000 will have diabetes at some time in their lives; the resulting medical problems will be of most concern for minorities and those with low incomes who have limited access to health care.¹⁰
- The lifetime costs of these diseases are staggering.
- Increases in obesity may result in a shorter life expectancy for youth today as compared to their parents.¹¹



Source: JAMA 288 (14), Oct. 9, 2002



Prevalence of obesity among American Indian Children: 30% of 7 year olds.

Source: Am. J. Clin Nutr. 2003; NIH, National Inst. of Env. Health Sciences, U.S. Dept. HHS

<h2>What is Missouri Doing to Battle its Obesity Problem?</h2>	<p>The Missouri Department of Health and Senior Services is dedicated to easing the burden of obesity to improve quality of life and reduce health care costs. The Missouri Council on Activity and Nutrition (MoCAN) has developed the <i>Healthy Missourians Initiative: Missouri's Nutrition and Physical Activity Plan</i> to address this vital health issue.</p> <p>The overall goal of the plan is to decrease obesity among children, youth and adults. The plan recommends:</p> <ul style="list-style-type: none"> ▫ Increasing opportunities to adopt physical activity and nutritional habits that promote good health. ▫ Increasing the effectiveness of messages that result in the public improving nutritional habits and increasing physical activity. ▫ Increasing support for health care systems to promote physical activity and nutritional habits that prevent and control obesity and chronic disease. ▫ Increasing state-level public policies that promote physical activity and nutritional habits to prevent obesity and chronic disease.
--	--

Many Factors Can Contribute to Obesity

Obesity is complex – although genetics can predispose some individuals to overweight and obesity, environment and behavioral factors also play a critical role.^{1,12} Key factors that lead to weight gain include:

Community environment

- The environment is more conducive to obesity than to healthy weight. For example, a person may choose not to walk to work because of a lack of sidewalks. Another example is eating establishments serving larger portion sizes than are needed by most people.

Too few babies breastfed

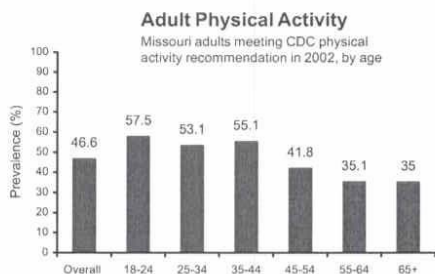
- Research shows that breastfeeding offers babies protection against childhood obesity and related chronic diseases.
- At 62.4 percent, Missouri is far below the Healthy People 2010 recommended breastfeeding rate of 75 percent for newborns.

Too much screen time

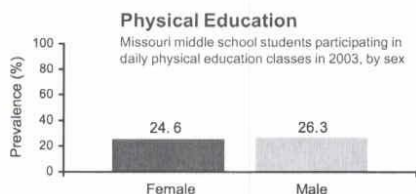
- National surveys have shown a positive association between the number of hours children watch television and prevalence of overweight.^{5,13}

Not enough physical activity

- Being physically active reduces the risk of obesity; it is a proven way to maintain a healthy weight and reduce risk for chronic diseases, such as heart disease, diabetes and cancer.¹
- Less than half of Missouri adults meet the recommended level of physical activity of moderate intensity for at least 30 minutes on five or more days of the week or physical activity of vigorous intensity for 20 minutes or more on three or more days per week.¹
- Physical education classes are ideal for teaching students about how to be physically active for life. But only about one third of Missouri students have daily physical education classes.¹



Source: Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention



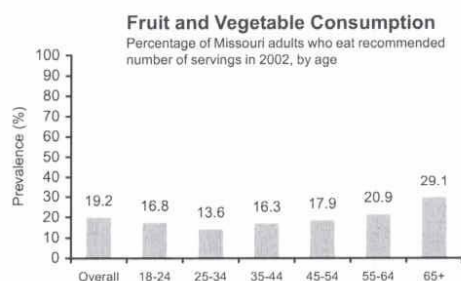
Source: Youth Tobacco Survey, Missouri Department of Health and Senior Services

Too many calories

- Portion sizes have increased over the past several decades; when more is served, more is consumed.^{1,17,18}
- Sweetened beverages - including soft drinks, fruit drinks and sport drinks - contribute to children and adults becoming overweight.^{1,19,20} Each 12-ounce sugared soft drink consumed daily has been associated with a 60 percent increase in a child's risk of obesity.²⁰

Too few fruits and vegetables

- Less than 20 percent of Missouri adults and fewer than 25 percent of Missouri high school students eat the recommended servings of fruits and vegetables - five or more servings per day.^{1,15}
- The high cost of fruits and vegetables is related to excessive weight gain by elementary-age children.¹⁶



Source: Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention

Reducing the Risk

To reduce the risk of obesity, the Centers for Disease Control and Prevention recommends impacting all levels of social structure that influence people's behavior. Five primary levels of social structure and examples of impact include:

1. **Public policy:** Laws, policies and regulations that fund alternative transportation or subsidize farmers' markets.
2. **Community:** Access to safe sidewalks and green space.
3. **Institutions and organizations:** Workplace wellness programs.
4. **Interpersonal:** Family and peer support and encouragement for a healthier lifestyle.
5. **Individual:** Personal understanding of the benefits of a healthy lifestyle.

Public Policy is Essential

Policy makers have an important role in Missouri's fight against obesity by supporting policies that provide for improved physical activity and nutrition environments for all Missourians. This support is essential to the success of Missouri's Nutrition and Physical Activity Plan. Examples of this type of support include:

- Strengthen state policies that support opportunities for children and youth to develop healthy nutrition and physical activity practices such as **increasing state requirements for physical education, providing adequate recess time and decreasing access to nutrient-poor, high-calorie vending and ala carte foods in schools.**
- Promote state policies and support for healthy nutrition and physical activity practices such as **tax incentives for communities and employers that increase support for physical activity; support for Medicaid coverage of prevention and treatment of obesity; and subsidizing farmers' markets.**

Conclusion

Overweight and obesity are serious and growing burdens for individuals, the health care system and society. Implementing Missouri's Nutrition and Physical Activity Plan is essential to reduce the obesity epidemic and its associated costs for all Missourians.

References:

1. Preventing Obesity and Other Chronic Diseases; Missouri's Nutrition and Physical Activity Plan, 2005.
2. Overweight and Obesity: Obesity Trends: U.S. Obesity Trends 1985-2004, BRFSS, Centers for Disease Control and Prevention; <http://www.cdc.gov/nccdphp/dnpa/obesity/trend/maps/>.
3. Finkelstein EA, Fiebelkorn IC, Wang G. "State-level estimates of annual medical expenditures attributable to obesity." *Obesity Research*. 2004; 12 (1): 18-24.
4. The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity, 2001. <http://www.surgeongeneral.gov/topics/obesity/calltoaction/toc.htm>.
5. American Academy of Pediatrics, Committee on Nutrition. "Prevention of pediatric overweight and obesity." *Pediatrics*. 2003; 112:424. <http://aappolicy.aappublications.org/cgi/content/full/pediatrics; 112/2/424>.
6. "Prevalence of overweight among children and adolescents ages 6-19 years." Centers for Disease Control and Prevention/National Center for Health Statistics, NHES and NHANES.
7. "U.S. Youth Overweight Rates," *Journal of the American Medical Association* 288 (14); Oct. 9, 2002.
8. "Obesity and the Environment." National Institute of Environmental Health Sciences, July 2005. <http://www.niehs.nih.gov/oc/factsheets/pdf/obesity.pdf>.
9. Whitaker, R.C., et al. "Predicting Obesity in Young Adulthood from Childhood and Parental Obesity;" *New England Journal of Medicine*. 1997; 337: 869-873.
10. Proceedings of the Roundtable on Understanding the Paradox of Hunger and Obesity, Food Research and Action Center, November 22, 2004; <http://www.frac.org/pdf/proceedings05.pdf>.
11. Olshansky, S.J., et al. "A potential decline in life expectancy in the United States in the 21st century;" *New England Journal of Medicine*; 2005; 352: 1138-1145.
12. Swinburn, B.S., et al. "Diet, nutrition and the prevention of excess weight gain and obesity;" *Public Health Nutrition*. 2004; 7 (1A):123-46.
13. Anderson, R. et al. "Relationship of physical activity and TV watching with body weight and level of fatness among children: Results from the Third National Health and Nutrition Examination Survey." *Journal of the American Medical Association*. 1998; 279 (12): 938-942.
14. Jeffery, R.W., and Utter, J. "The Changing Environment and Population Obesity in the United States." *Obesity Research*, 2003; 11:12S-22S. http://www.obesityresearch.org/cgi/content/full/11/suppl_1/12S.
15. "Percentage of high school students who ate five or more servings of fruits and vegetables per day during the seven days preceding the survey - Missouri and United States, 1995-2003." Missouri Department of Elementary and Secondary Education: Youth Risk Behavior Survey, 1995-2003.
16. Metropolitan Area Food Prices and Children's Weight Gain. Economic Research Service, USDA; Friday, December 30, 2005. <http://www.ers.usda.gov/Publications/CCR14/>.
17. Portion Distortion! Do You Know How Food Portions Have Changed in 20 Years? National Heart, Lung and Blood Institute, Department of Health and Human Services, National Institutes of Health, 2003, 2004. <http://hin.nhlbi.nih.gov/portion/>.
18. Rolls, B.J. et al. "Portion size of food affects energy intake in normal-weight and overweight men and women." *American Journal of Clinical Nutrition*. 2002; 76 (6): 1207-13.
19. Kearsst D.R. and Hoerr, S.L. "Beverage choices related to U.S. adult obesity," NHANES III. The Fourth International Conference on Dietary Assessment Methods. H.2.2.26.2000.
20. Ludwig D.S., et al. "Relation between consumption of sugar-sweetened drinks and childhood obesity." *Lancet*. 2001; 357:505-8.

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER Services provided on a nondiscriminatory basis.

Missouri's Nutrition and Physical Activity Plan can be found at: www.dhss.mo.gov/Obesity/index.html.



Finally A Cure for Obesity!

American Obesity Association

Search

AOA Career Center About AOA Our Sponsors Press Room Contact Us

Education

Research

Prevention

Treatment

Consumer Protection

Discrimination

- ▶ Home
- ▶ Welcome
- ▶ Advocacy Updates
- ▶ Childhood Obesity
- ▶ Contacting Congress
- ▶ Consumer Alert
- ▶ Tax Breaks
- ▶ Disability Due to Obesity
- ▶ Community Action
- ▶ My Story
- ▶ AOA Conference
- ▶ AOA Research Foundation: Finding a Cure for Obesity
- ▶ AOA Professional Members Directory
- ▶ Fast Facts
- ▶ Editorial
- ▶ News
- ▶ Membership

Childhood Obesity

▶ Prevalence and Identification

About 15.5 percent of adolescents (ages 12 to 19) and 15.3 percent of children (ages 6 to 11) are obese. The increase in obesity among American youth over the past two decades is dramatic, as shown in the tables below.

Year	Prevalence
1999 to 2000	15.3%
1988 to 1994	11%
1976 to 1980	7%

Year	Prevalence
1999 to 2000	15.5%
1988 to 1994	11%
1976 to 1980	5%

A measurement called percentile of Body Mass Index (BMI) is used to identify overweight and obesity in children and adolescents. The Centers for Disease Control (CDC), the supplier of national growth charts and prevalence data, avoids using the word "obesity" for children and adolescents. Instead, they suggest two levels of overweight: 1) the 85th percentile, an "at risk" level, and 2) the 95th percentile, the more severe level.

The American Obesity Association uses the 85th percentile of BMI as a reference point for overweight and the 95th percentile for obesity.

We do so, because the 95th percentile:

- corresponds to a BMI of 30, which is the marker for obesity in adults. The 85th percentile corresponds to the overweight reference point for adults, which is a BMI of 25.
- is recommended as a marker for children and adolescents to have an in-depth medical assessment.
- identifies children that are very likely to have obesity persist into adulthood.
- is associated with elevated blood pressure and lipids in older adolescents, and increases their risk of diseases.
- is a criteria for more aggressive treatment.
- is a criteria in clinical research trials of childhood obesity treatments.

Growth Charts - Identifying Obesity in Your Child

Parents and healthcare professionals in the U.S. have used growth charts since the late 1970's to follow the progress in physical growth of infants, children and adolescents. In May 2001, the CDC developed new growth charts to include BMI.

Healthy Weight for Children Tops AOA's Goals to Build a Healthy Tomorrow

The AOA's focus on childhood obesity has involved lobbying Congress to provide more funding for prevention programs, collecting research for further understanding, and convening experts at our conference to explore questions and seek answers.

Lobbying Congress

The AOA has lobbied Congress to pass the First Senate Bill (S. 2686) and secure funds for a Childhood Obesity Prevention Grant, and a bill to regulate the sale of non-nutritional foods in schools, introduced by Senators Leahy, Jeffords, Feingold, Bingaman and Wellstone.

AOA Survey on Parental Perceptions about their Children's Weight

The majority of parents in the U.S. (78 percent) believe that physical education or recess should not be reduced or replaced with academic classes.

- Read more results from this survey in the Childhood Obesity / Prevention and Families section of our website.
- Read the Executive Summary of the survey.

AOA Conference

- Take a look at some childhood obesity topics from our past conferences.

Related Articles and Links on the Prevalence of Childhood Obesity:

- Read more about prevalence and trends in the AOA Fact Sheet *Obesity in Youth*.
- Read the CDC's *Prevalence of Overweight among Children and Adolescents: United States, 1999*.
- Read the CDC Press

CLICK HERE TO
join
AOA

American Obesity Association

Search

Education

- ▶ Home
- ▶ Welcome
- ▶ Advocacy Updates
- ▶ Childhood Obesity
- ▶ Contacting Congress
- ▶ Consumer Alert
- ▶ Tax Breaks
- ▶ Disability Due to Obesity
- ▶ Community Action
- ▶ My Story
- ▶ AOA Conference
- ▶ AOA Research Foundation: Finding a Cure for Obesity
- ▶ AOA Professional Members Directory
- ▶ Fast Facts
- ▶ Editorial
- ▶ News
- ▶ Membership

Finally A Cure for Obesity!

AOA Career Center About AOA Our Sponsors Press Room Contact Us

Research Prevention Treatment Consumer Protection Discrimination

Childhood Obesity

▶ **Causes**

There are many factors that contribute to causing child and adolescent obesity - some are modifiable and others are not.

Modifiable causes include:

- Physical Activity - Lack of regular exercise.
- Sedentary behavior - High frequency of television viewing, computer usage, and similar behavior that takes up time that can be used for physical activity.
- Socioeconomic Status - Low family incomes and non-working parents.
- Eating Habits - Over-consumption of high-calorie foods. Some eating patterns that have been associated with this behavior are eating when not hungry, eating while watching TV or doing homework.
- Environment - Some factors are over-exposure to advertising of foods that promote high-calorie foods and lack of recreational facilities.

Non-changeable causes include:

- Genetics - Greater risk of obesity has been found in children of obese and overweight parents.

Related Articles and Links on Causes of Childhood Obesity

- *Television Viewing and Childhood Obesity* Robinson TN
- *Influence of the Home Environment on the Development of Obesity in Children* Strauss RS and Knight J.
- *Children, Adolescents, and Advertising* American Academy of Pediatrics
- *Child to adult body mass index in the 1958 British birth cohort: associations with parental obesity* Lake JK, Power C, Cole TJ.
- *Childhood obesity: the genetic-environmental interface* Maffei C

American Obesity Association
Copyright © 2002. All rights reserved.
[Terms of Service](#)
This web site was last updated on May 2, 2005



Finally A Cure for Obesity!

American Obesity Association

Search

AOA Career Center About AOA Our Sponsors Press Room Contact Us

Education

Research

Prevention

Treatment

Consumer Protection

Discrimination

- ▶ Home
- ▶ Welcome
- ▶ Advocacy Updates
- ▶ Childhood Obesity
- ▶ Contacting Congress
- ▶ Consumer Alert
- ▶ Tax Breaks
- ▶ Disability Due to Obesity
- ▶ Community Action
- ▶ My Story
- ▶ AOA Conference
- ▶ AOA Research Foundation: Finding a Cure for Obesity
- ▶ AOA Professional Members Directory
- ▶ Fast Facts
- ▶ Editorial
- ▶ News
- ▶ Membership

Childhood Obesity

▶ Prevention

Teaching healthy behaviors at a young age is important since change becomes more difficult with age. Behaviors involving physical activity and nutrition are the cornerstone of preventing obesity in children and adolescents. Families and schools are the two most critical links in providing the foundation for those behaviors.

Families

Parents are the most important role models for children. Results from an American Obesity Association survey show that:

- The majority of parents in the U.S. (78 percent) believe that physical education or recess should not be reduced or replaced with academic classes.
- Almost 30 percent of parents said that they are "somewhat" or "very" concerned about their children's weight.
- 12 percent of parents considered their child overweight.
- Comparing their own childhood health habits to their children's, 27 percent of parents said their children eat less nutritiously, and 24 percent said their children are less physically active.
- 35 percent of parents rated their children's school programs for teaching good patterns of eating and physical activity to prevent obesity as "poor," "non-existent," or "don't know."
- Among six choices of what they believed to be the greatest risk to their children's long-term health and quality of life, 5.6 percent of parents chose "being overweight or obese." More parents selected other choices as the greatest risk: alcohol (6.1 percent), sexually transmitted disease (10 percent), smoking (13.3 percent), violence (20.3 percent), and illegal drugs (24 percent).
- In terms of their own behavior, 61 percent of parents said that it would be either "not very difficult" or "not at all difficult" to change their eating and/or physical activity patterns if it would help prevent obesity in any of their children.

The AOA's survey results indicate that parents understand the importance of regular physical education for their children. Their unfamiliarity or inadequate rating of their children's school obesity prevention program is likely due to the lack of programs across the nation.

Parents appear to underestimate the health risk of excess weight to their children, and the difficulty in achieving and maintaining behavioral changes associated with obesity prevention. Additional studies are needed to develop appropriate public health programs to better educate parents in identifying and understanding changes in their children's weight, to incorporate the family in prevention efforts, and to improve school-based obesity prevention programs that include increasing physical education classes.

- For more details on AOA's survey, read the Executive Summary.

Here are some ways that parents can establish a lifetime of healthy

Related Articles and Links on Families and Childhood Obesity:

- How to help your kids live a healthy, active life
- Pathways family intervention for third-grade American Indian children
Teufel NJ, Perry CL, Story M, Flint-Wagner HG, Levin S, Clay TE, Davis SM, Gittelsohn J, Atlanta J, Pablo JT.
- Parental eating attitudes and the development of obesity in children. *The Framingham Children's Study*. Hood MY, Moore LL, Sundarajan-Ramamurti A, Singer M, Cupples LA, Ellison RC.
- The American Academy of Family Physicians' *Helping Your Child Keep A Healthy Weight*
- Parents' Guide to Children's Eating Problems, from the Children's Hospital of Iowa
- U.S. Department of Agriculture, *USDA for Kids*
- USDA's *Childcare Nutrition Resource System*.

Related Articles and Links on Schools, Nutrition and Childhood Obesity:

- *Promoting Healthy Eating Behaviors: The Role of School Environments*. A Speech by Ann Gallagher, President of the American Dietetic Association
- USDA Report to Congress, *Foods Sold in Competition with USDA School Meal Programs*
- CDC's Guidelines for School and Community Health Programs, *Promoting Lifelong Healthy Eating*.
- Team Nutrition *USDA - Healthy School Meals Resource System*

habits for their family:

Create an Active Environment:

- Make time for the entire family to participate in regular physical activities that everyone enjoys. Try walking, bicycling or rollerblading.
- Plan special active family-outings such as a hiking or ski trip.
- Start an active neighborhood program. Join together with other families for group activities like touch-football, basketball, tag or hide-and-seek.
- Assign active chores to every family member such as vacuuming, washing the car or mowing the lawn. Rotate the schedule of chores to avoid boredom from routine.
- Enroll your child in a structured activity that he or she enjoys, such as tennis, gymnastics, martial arts, etc.
- Instill an interest in your child to try a new sport by joining a team at school or in your community.
- Limit the amount of TV watching.

Create a Healthy Eating Environment:

- Implement the same healthy diet (rich in fruits, vegetables and grains) for your entire family, not just for select individuals.
- Plan times when you prepare foods together. Children enjoy participating and can learn about healthy cooking and food preparation.
- Eat meals together at the dinner table at regular times.
- Avoid rushing to finish meals. Eating too quickly does not allow enough time to digest and to feel a sense of fullness.
- Avoid other activities during mealtimes such as watching TV.
- Avoid foods that are high in calories, fat or sugar.
- Have snack foods available that are low-calorie and nutritious. Fruit, vegetables and yogurt are some examples.
- Avoid serving portions that are too large.
- Avoid forcing your child to eat if he/she is not hungry. If your child shows atypical signs of not eating, consult a healthcare professional.
- Limit the frequency of fast-food eating to no more than once per week.
- Avoid using food as a reward or the lack of food as punishment.

Schools

Outside of the home, children and adolescents spend the majority of their time in school. So, it makes sense that schools provide an environment that promotes healthy nutrition and physical activity habits. Only a few creative programs are being tested in schools across the country.

Overweight and Obesity

Results of a 1999 national survey showed that 16 percent of high school students were overweight (Body Mass Index (BMI) greater than the 85th percentile and below the 95th percentile) and nearly 10 percent were obese (BMI more than or equal to the 95th percentile). Self-reported height and weight was used. The survey, called the Youth Risk Behavioral Surveillance System (YRBSS), is conducted by the Centers for Disease Control and Prevention (CDC), and uses a nationally representative sample of students in grades 9 to 12.

Here are more results from the 1999 YRBSS:

- More male students (17 percent) were overweight than female students (14 percent), and obese (12 percent of males and 8 percent of females).

- [The American School Food Service Association](#)
- [Results From The USDA's 1994-96 Continuing Survey Of Food Intakes By Individuals](#)

Related Articles and Links on Schools, Physical Activity and Childhood Obesity:

- [PE Links 4 U](#)
- [CDC's Promoting Better Health for Young People Through Physical Activity and Sports](#)
- [Project Spark](#)
- [KaBOOM!](#)

Related Articles on Prevention of Childhood Obesity:

- [Preventing Obesity in Children and Adolescents](#) Dietz WH, Gortmaker SL
- [Prevention of Obesity--More than an Intention Concept and First Results of the Kiel Obesity Prevention Study \(KOPS\)](#) Muller MJ, Asbeck I, Mast M, Langnase K, Grund A
- [National Institute of Child Health and Human Development's Prevention of Chronic Disease](#)
- [Recommendations from overweight youth regarding school-based weight control programs](#) Neumark-Sztainer D, Story M
- [School-based programs for obesity prevention: what do adolescents recommend?](#) Neumark-Sztainer D, Martin SL, Story M

- More black students (22 percent) were overweight than white students (14 percent).
- More black and Hispanic female students (23 and 18 percent, respectively) were overweight than white female students (12 percent).

Self-Perception of Weight

- When asked to describe their weight, 30 percent of students thought of themselves as overweight.
- More female students (36 percent) than male students (24 percent) considered themselves overweight.
- More Hispanic students (37 percent) than white and black students (29 and 25 percent, respectively) considered themselves overweight.

Weight Loss Attempts

- 43 percent of students reported that they were trying to lose weight.
- More female students (59 percent) than male students (26 percent) reported that they were trying to lose weight.
- More Hispanic students (51 percent) reported that they were trying to lose weight than white students (43 percent) and black students (36 percent).

Methods of Weight Loss:

Exercise

- More than half (58 percent) of students reported the use of exercise (during the 30 days before the survey) to lose weight or to avoid gaining weight.
- More female students (67 percent) reported the use of exercise for weight loss or maintenance than male students (49 percent). More white female students (70 percent) reported the use of exercise for weight loss or maintenance than black female students (59 percent).

Change of Eating Behaviors

- 40 percent of students reported that they ate less food, fewer calories, or foods low in fat (during the 30 days before the survey) to lose weight or to avoid gaining weight.
- More female students (56 percent) reported that they ate less food, fewer calories, or foods low in fat than male students (25 percent) to lose weight or to avoid gaining weight.
- More white students (42 percent) reported that they ate less food, fewer calories, or foods low in fat than black students (34 percent) to lose weight or to avoid gaining weight.
- More white female students (60 percent) reported that they ate less food, fewer calories, or foods low in fat than Hispanic female students (51 percent) and black female students (43 percent) to lose weight or to avoid gaining weight.

Fasting

- 13 percent of students reported fasting ("without eating for 24 hours or more") to lose weight or to avoid gaining weight.
- More female students (19 percent) reported fasting than male students (6 percent) to lose weight or to avoid

gaining weight

Use of Dietary Supplements

- 8 percent of students reported taking diet pills, powders, or liquids without a doctor's advice to lose weight or to avoid gaining weight.
- More female students (11 percent) reported taking diet pills, powders, or liquids without a doctor's advice than male students (4 percent) to lose weight or to avoid gaining weight.
- More white female students (12 percent) reported taking diet pills, powders, or liquids without a doctor's advice than black female students (6.9 percent) to lose weight or to avoid gaining weight.

Purging / Laxative Use

- 5 percent of students reported vomiting or taking laxatives to lose weight or to avoid gaining weight.
 - More female students (7 percent) reported vomiting or taking laxatives than male students (2 percent) to lose weight or to avoid gaining weight.
- Find more 1999 YRBSS results from the CDC's *Morbidity and Mortality Weekly Report* and from the CDC's *Youth '99 Online Analysis*.

Creating a Healthy Eating Environment in Schools

Recommended daily servings of fruits and vegetables are not being met by today's youth. According to the Centers for Disease Control and Prevention, "51 percent of children and adolescents eat less than one serving a day of fruit, and 29 percent eat less than one serving a day of vegetables that are not fried."

According to the U.S. Department of Agriculture (USDA), children drink 16 percent less milk now than in the late 1970's, and 16 percent more of carbonated soft drinks. The consumption of non-citrus juices such as grape and apple mixtures increased by 280 percent.

A coalition of five medical associations and the USDA proposed a "Prescription for Change: Ten Keys to Promote Healthy Eating in Schools" to be used for guidance in school nutrition programs. Their prescription is:

1. Students, parents, food service staff, educators and community leaders will be involved in assessing the school's eating environment, developing a shared vision and an action plan to achieve it.
2. Adequate funds will be provided by local, state and federal sources to ensure that the total school environment supports the development of healthy eating patterns.
3. Behavior-focused nutrition education will be integrated into the curriculum from pre-K through grade 12. Staff who provide nutrition education will have appropriate training.
4. School meals will meet the USDA nutrition standards as well as provide sufficient choices, including new foods and foods prepared in new ways, to meet the taste preferences of diverse student populations.
5. All students will have designated lunch periods of sufficient length to enjoy eating healthy foods with friends. These lunch periods will be scheduled as near the middle of the school day as possible.
6. Schools will provide enough serving areas to ensure student access to school meals with a minimum of wait time.
7. Space that is adequate to accommodate all students and pleasant surroundings that reflect the value of the social aspects of eating will be provided.
8. Students, teachers and community volunteers who practice healthy eating will be encouraged to serve as role models in the

- school dining areas.
9. If foods are sold in addition to National School Lunch Program meals, they will be from the five major food groups of the Food Guide Pyramid. This practice will foster healthy eating patterns.
 10. Decisions regarding the sale of foods in addition to the National School Lunch Program meals will be based on nutrition goals, not on profit making.

- Read more recommendations from this coalition of medical associations and the USDA in, *Healthy School Nutrition Environments: Promoting Healthy Eating Behaviors*.

Creating an Active Environment in Schools

Nationwide in 1999, approximately 56 percent of high school students were enrolled in a physical education (PE) class and only 29 percent attended PE class daily, according to the Center for Disease Control and Prevention's (CDC) Youth Behavioral Risk Factor Surveillance System (YRBSS). Participation in high school sports was 55 percent, with a higher participation rate from male students (62 percent) than females (48 percent).

The CDC partnered with experts from other federal agencies, state agencies, universities, voluntary organizations, and professional associations to develop *Guidelines for School and Community Programs to Promote Lifelong Physical Activity Among Young People*. The 10 recommendations in the guidelines are:

1. Policy

Establish policies that promote enjoyable, lifelong physical activity.

- Schools should require daily physical education and comprehensive health education (including lessons on physical activity) in grades K-12.
- Schools and community organizations should provide adequate funding, equipment, and supervision for programs that meet the needs and interests of all students.

2. Environment

Provide physical and social environments that encourage and enable young people to engage in safe and enjoyable physical activity.

- Provide access to safe spaces and facilities and implement measures to prevent activity-related injuries and illnesses.
- Provide school time, such as recess, for unstructured physical activity, such as jumping rope.
- Discourage the use or withholding of physical activity as punishment.
- Provide health promotion programs for school faculty and staff.

3. Physical Education Curricula and Instruction

Implement sequential physical education curricula and instruction in grades K-12 that

- Emphasize enjoyable participation in lifetime physical activities such as walking and dancing, not just competitive sports.
- Help students develop the knowledge, attitudes, and skills they need to adopt and maintain a physically active lifestyle.
- Follow the National Standards for Physical Education.
- Keep students active for most of class time.

4. Health Education Curricula and Instruction

Implement health education curricula and instruction that

- Feature active learning strategies and follow the National Health Education Standards.
- Help students develop the knowledge, attitudes, and skills they need to adopt and maintain a healthy lifestyle.

5. Extracurricular Activities

Provide extracurricular physical activity programs that offer diverse, developmentally appropriate activities both noncompetitive and competitive for all students.

6. Family Involvement

Encourage parents and guardians to support their children's participation in physical activity, to be physically active role models, and to include physical activity in family events.

7. Training

Provide training to enable teachers, coaches, recreation and health care staff, and other school and community personnel to promote enjoyable, lifelong physical activity among young people.

8. Health Services

Assess the physical activity patterns of young people, refer them to appropriate physical activity programs, and advocate for physical activity instruction and programs for young people.

9. Community Programs

Provide a range of developmentally appropriate community sports and recreation programs that are attractive to all young people.

10. Evaluation

Regularly evaluate physical activity instruction, programs, and facilities.

American Obesity Association
Copyright © 2002. All rights reserved.
[Terms of Service](#)

This web site was last updated on May 2, 2005.



Finally A Cure for Obesity!

American Obesity Association

Search

[AOA Career Center](#) [About AOA](#) [Our Sponsors](#) [Press Room](#) [Contact Us](#)

[Education](#)

[Research](#)

[Prevention](#)

[Treatment](#)

[Consumer Protection](#)

[Discrimination](#)

- ▶ Home
- ▶ Welcome
- ▶ Advocacy Updates
- ▶ Childhood Obesity
- ▶ Contacting Congress
- ▶ Consumer Alert
- ▶ Tax Breaks
- ▶ Disability Due to Obesity
- ▶ Community Action
- ▶ My Story
- ▶ AOA Conference
- ▶ AOA Research Foundation: Finding a Cure for Obesity
- ▶ AOA Professional Members Directory
- ▶ Fast Facts
- ▶ Editorial
- ▶ News
- ▶ Membership

Childhood Obesity

▶ Health Risks, Diagnosis and Treatment

Determining if a child or adolescent has a weight problem can be challenging. How do you know if the excess weight your child has is part of the natural growth process, and will your child just "grow out of it?" How do you know if your child's weight may be negatively affecting his or her health?

Health Risks

Along with the rise in childhood obesity, there has been an increase in the incidence and prevalence of medical conditions in children and adolescents that had been rare in the past. Pediatricians and childhood obesity researchers are reporting more frequent cases of obesity-related diseases such as type 2 diabetes, asthma and hypertension that once were considered adult conditions.

- Read more about obesity-related health risks for children and adolescents in the AOA Fact Sheet, *Obesity in Youth*.
- Read about the relationship of obesity and type 2 diabetes in children at the CDC's *Children and Diabetes* web page.

Diagnosis

There are some signs that may help you determine if your child has or is at risk for childhood obesity, such as:

- Family history of obesity.
- Family history of obesity-related health risks such as early cardiovascular disease, high cholesterol, high blood pressure levels, type 2 diabetes.
- Family history of cigarette smoking and sedentary behaviors.
- Signs in the child of obesity-related health risks from a pediatrician's evaluation including:
 - Cardiac Risk Factors. Studies of children with obesity show higher than average blood pressure, heart rate and cardiac output when compared to children without obesity.
 - Type 2 Diabetes Risk Factors. This involves glucose intolerance and insulin levels that are higher than average.
 - Orthopedic Problems. Some symptoms include weight stress in the joints of the lower limbs, tibial torsion and bowed legs, and slipped capital femoral epiphysis (especially in boys).
 - Skin disorders. Some are heat rash, intertrigo, monilial dermatitis and acanthosis nigricans.
 - Psychological / Psychiatric Issues. Poor self-esteem, negative self-image, depression, and withdrawal from peers have been associated with obesity.
- Patterns of sedentary behavior (such as too much television viewing) and low physical activity levels.

Related Articles on Treatment of Childhood Obesity:

- *Evaluation and Treatment of Childhood Obesity* Moran R.
- The Weight-control Information Network's *Helping your Overweight Child*.

Related Links on Dietary Recommendations for Children and Adolescents:

- USDA's Food Guide Pyramid for Young Children
- USDA's *Dietary Guidelines for Americans*.
- USDA's Food and Nutrition Information Center.

Related Links on Physical Activity Recommendations for Children and Adolescents:

- Surgeon General's *Report on Physical Activity and Health*.
- President's Council on Physical Fitness and Sports
- National Association for Sports and Physical Education

- Taller height - children with obesity are often above the 50th percentile in height.
- Smoking initiation. Research studies show that youngsters use smoking as a method of weight control. Parents, pediatricians and schools should work together to discourage smoking as a weight control behavior for three main reasons: a) smoking is not likely to be successful in controlling weight, b) smoking is itself harmful, and c) smoking is associated with a decrease in sound nutrition and physical activity patterns.
 - Read the abstract about this study, *Smoking and weight loss attempts in overweight and normal-weight adolescents*. Strauss RS, Mir HM.
 - Read the abstract about this study, *Weight concerns, weight control behaviors, and smoking initiation*. Tomeo CA, Field AE, Berkey CS, Colditz GA, Frazier AL.

Treatment

An important part of treating obesity among children and adolescents is for parents and healthcare professionals to be sensitive to the youngsters and focus on the positive. Small and achievable weight loss goals should be set to avoid discouragement and to allow for the normal growth process.

Involvement of the entire family is also a motivating factor. Weight control programs that involve both parents and the child have shown improvement in long-term effectiveness compared to directing the program only to the child.

There are some structured weight loss programs such as Weight Watchers and Jenny Craig that allow older children and adolescents to participate with parental and medical permission.

Once the need for obesity treatment has been identified, your medical professional may suggest one or more options.

- Read *Obesity Evaluation and Treatment: Expert Committee Recommendations*, guidelines established for healthcare professionals by a committee of pediatric obesity experts brought together by The Maternal and Child Health Bureau, Health Resources and Services Administration, the Department of Health and Human Services.

1. Dietary Therapy

According to the U.S. Department of Agriculture (USDA), there is a steady decline in the diet quality of children and adolescents as they get older.

Consultation with a dietitian / nutritionist that specializes in children's needs is often a valuable part of obesity treatment. Nutrition consultants can outline specific and appropriate nutritional needs for healthy growth.

As with adults, a nutrition consultant may or may not recommend reducing the number of calories the child eats and implementing strategies like learning to read nutrition labels and the food guide pyramid, selecting proper portion sizes, and prepared foods. Some eating behaviors that nutrition consultants typically encourage include taking smaller bites, chewing food longer, and to avoid eating too quickly by putting the utensil down between bites.

2. Physical Activity

The U.S. Surgeon General recommends moderate physical activity for children every day for at least 60 minutes. If a child is unable to meet that goal, than an individualized program should be designed according to fitness level, using the general guideline as an ultimate goal.

3. Behavior Therapy

Behavior therapy involves changes in diet and physical activity habits.

to one that promote a healthy weight. Some behavioral therapy strategies for children and adolescents should include parent and family involvement.

Some behavioral therapy strategies for children are to:

- Record diet and exercise patterns in a diary to keep track of types and amount of foods eaten and exercise performed as well as the location and time that foods are eaten and exercise takes place. The diary useful to determine any problem areas in eating and exercise behavior.
 - Use the *National Heart, Lung and Blood Institute's Daily Food and Activity Diary*.
- Identify high-risk situations (such as having too many high-calorie foods in the house), and consciously avoid them. Watching TV during meal times is another high-risk situation that encourages eating every time the TV is on.
- Reward specific positive actions. Examples of such actions include meeting an exercise duration goal or eating less of a certain type of food.
- Rewards for achieving goals can be decided by children and parents together, and should revolve around something that encourages positive behavior. For example, giving sporting equipment as a reward may encourage more physically active behavior.
- Avoid using food as a reward, especially high-calories foods. Making them a reward may only make them more desirable. Parents and health professionals should regularly use verbal praise.
- Change unrealistic goals and false beliefs about weight loss and body image to realistic and positive ones.
- The family can work as a team to set weekly activity goals. Making a contract and having every family member sign it encourages commitment to a goal. Parents can also help a child adopt or maintain a positive attitude about new behaviors in addition to helping the child cope with any negative remarks from peers.
- Develop a social support network (family, friends or neighbors) that can encourage weight loss in a positive and motivating manner.

4. Drug Treatment

The U.S. Food and Drug Administration has not yet approved the use of any drugs to treat obesity in children. However, clinical trials are under way.

- For information on clinical drug trials to treat obesity in children, search the ClinicalTrials.gov website.

5. Surgery

Surgical procedures such as gastric bypass have been performed successfully on adolescents. However surgery for adolescents is usually considered only when severe medical conditions are present that can improve with the surgery.

American Obesity Association
Copyright © 2007. All rights reserved.
[Terms of Service](#)

This web site was last updated on May 2, 2005



Finally A Cure for Obesity!

American Obesity Association

Search

[AOA Career Center](#) [About AOA](#) [Our Sponsors](#) [Press Room](#) [Contact Us](#)

[Education](#)

[Research](#)

[Prevention](#)

[Treatment](#)

[Consumer Protection](#)

[Discrimination](#)

- ▶ [Home](#)
- ▶ [Welcome](#)
- ▶ [Advocacy Updates](#)
- ▶ [Childhood Obesity](#)
- ▶ [Contacting Congress](#)
- ▶ [Consumer Alert](#)
- ▶ [Tax Breaks](#)
- ▶ [Disability Due to Obesity](#)
- ▶ [Community Action](#)
- ▶ [My Story](#)
- ▶ [AOA Conference](#)
- ▶ [AOA Research Foundation: Finding a Cure for Obesity](#)
- ▶ [AOA Professional Members Directory](#)
- ▶ [Fast Facts](#)
- ▶ [Editorial](#)
- ▶ [News](#)
- ▶ [Membership](#)

Community Action

▶ Community Programs

Communities have begun to implement creative strategies to confront the obesity epidemic directly. Here are some examples:

- [The Philadelphia FitnessAge Challenge](#)
- [Sisters Together \(Boston\)](#)

If your community has a program, write to us so that we can share it with others.

State Programs

- [California's Project Lean](#)
- Find a list of nutrition and physical activity programs developed in some U.S. State health departments to prevent chronic diseases including obesity at the Centers for Disease Control and Prevention (CDC) website.
- Find out if your state legislature has been active in attempting to pass laws to prevent or manage obesity. Search the website of the National Conference of State Legislatures.

Health Communication Regarding Obesity

There are many challenges in communicating messages to the public about obesity, including the clutter of multiple messages, skepticism about experts, negativity surrounding weight management, and public confusion and misunderstandings about scientific results.

Creating partnerships between communities and primary care physicians, clinics, hospitals, government health departments (federal, state, local), health organizations, and businesses can be useful for developing messages that are consistent with scientific evidence, and for providing an effective network to distribute messages.

Data Tracking - Measurement of Obesity

Data on overweight and obesity prevalence are collected nationally, and have been useful in alerting public health officials to the state of obesity as an epidemic. Only a few local communities collect data on overweight and obesity.

According to the U.S. Department of Health and Human Services' Healthy People 2010, the benefits of documenting progress through data collection in communities are to:

- see real changes that result from the actions of a community program.
- create interest in people who have any doubts or are unfamiliar with the actions of a community program.
- demonstrate effectiveness to funders of a program.

AOA Contributes to Community Action

The AOA developed *Healthy Weight 2010* as a toolbox for the public health system. The importance of a healthy community is a part of the document.

- Read Section 4 of *Healthy Weight 2010: Integrating Obesity Management into the Public Health Infrastructure*.

Related Article:

- Read the abstract about this study: *Consumer preferences in format and type of community-based weight control programs*: Sherwood NE, Morton N, Jeffery RW, French SA, Neumark-Sztainer D, Falkner NH

- For more information on tracking progress and outcomes in communities, read *Healthy People in Healthy Communities: A Community Planning Guide Using Healthy People 2010*.

American Obesity Association
Copyright © 2002. All rights reserved.
[Terms of Service](#)
This web site was last updated on May 2, 2005.



Finally A Cure for Obesity!

American Obesity Association

Search

AOA Career Center About AOA Our Sponsors Press Room Contact Us

Education Research Prevention Treatment Consumer Protection Discrimination

- Home
- Welcome
- Advocacy Update
- Childhood Obesity
- Contacting Congress
- Consumer Alert
- Tax Breaks
- Disability Due to Obesity
- Community Action
- My Story
- AOA Conference
- AOA Research Foundation: Finding a Cure for Obesity
- AOA Professional Members Directory
- Fast Facts
- Editorial
- News
- Membership

Community Action

Creating a Healthy Environment

Promoting healthy lifestyles to prevent obesity in a community involves the creation of a healthy environment. The first step is to become aware of the environmental causes of obesity, some of which are listed in the table below.

Location or Type of Activity	Effect of Modernization	Impact on Obesity
Transportation	<ul style="list-style-type: none"> • Rise in car ownership. • Increase in driving shorter distances. 	<ul style="list-style-type: none"> • Decrease in walking or cycling
At Home	<ul style="list-style-type: none"> • Increase in the use of modern appliances (e.g. microwaves, dishwashers, washing machines, vacuum cleaners). • Increase in ready-made foods and ingredients for cooking. • Increase in television viewing, and computer and video game use. 	<ul style="list-style-type: none"> • Decrease in manual labor • Increase in consumption of convenience foods that contribute to obesity. • Decrease in time spent on more active recreational pursuits.
In the Work Place	<ul style="list-style-type: none"> • Increase in sedentary occupational lifestyles due to technology - increase in computerization 	<ul style="list-style-type: none"> • Decrease in physically demanding manual labor.
Public Places	<ul style="list-style-type: none"> • Increase in the use of elevators, escalators and automatic doors. 	<ul style="list-style-type: none"> • Decrease in daily physical activity patterns such as climbing stairs.
Urban Residency	<ul style="list-style-type: none"> • Fear of crime in urban areas. 	<ul style="list-style-type: none"> • Deters outdoor exercise and leisure activities

Strategies for Integrating Obesity Management into Communities

A community is maintained by its people and their ability to SIFT through the issues.

Speak Out: If you have an idea or a comment about obesity and creating a healthy community, then speak out.
Inform Others: If your community is unaware of the facts, then take the initiative to inform others.
Find Out: If you don't know where to speak out or how to take action, then find out.
Take the lead: If there is no leadership in your community on this issue, then take the lead or start a group to take action.

Here are some strategies for integrating an obesity action program into your community:

1. Form a community coalition or neighborhood association. Look for volunteers that can share their skills and resources.
 - o Learn how to build and run a healthy community coalition from the U.S. Department of Health's *Healthy People in Healthy Communities*.
 - o Find out how a coalition was formed in a Florida community from the Healthy Community Initiative of Greater Orlando.
 - o Learn how to start a neighborhood association from The Council of Albany Neighborhood Associations.
 - o Read the Centers for Disease Control's *Planned Approach to Community Health*.

2. Evaluate the infrastructure of your community. Find out where improvements can be made to reduce the prevalence of obesity and make it healthier.

Suburban sprawl has created communities with fewer sidewalks, and where schools, shopping, and recreational areas are no longer in walking distance. People rely more on driving cars than walking.

- o Read an article on how *Suburban Sprawl is Inducing a Sedentary Lifestyle* from Smart Growth Online.
- o Read *Healthy Places, Healthy People: Promoting Public Health & Physical Activity through Community Design* from the Robert Wood Johnson Foundation.
- o Learn about the Northwest Obesity Prevention Project's *The Interface of Urban Design, Public Health and Physical Activity in Preventing Obesity*.

In some parts of the country, neighborhoods, parks and recreational areas are considered unsafe. In low-income areas, the lack of neighborhood safety is a significant barrier to physical activity, as is the lack of recreational opportunities.

Learn about the Rebuilding Communities Initiative, that has helped to turn troubled, low-income neighborhoods into safe, supportive and productive environments.

- a. Transportation - Re-designing the layout of a community can promote physical activity by reducing dependence on driving cars.
 - Learn about SMARTRAQ, a transportation and land use research project being conducted by Georgia Tech for the Atlanta metropolitan area.
 - America Walks
 - The Pedestrian and Bicycle Information Center
 - Walkable Communities Inc.
 - b. Parks, Recreation Areas and Sidewalks - Re-zoning or planning cities with parks, recreation areas, and sidewalks can provide opportunities for physical activity.
 - Active Community Environments (ACEs) is a CDC-sponsored initiative to promote walking, bicycling, and the development of accessible recreation facilities.
3. Determine the important issues, and back them up with facts to give to a policy maker that supports your case.
 - Find helpful abstracts from research studies on various health-related topics at the National Library's PubMed.
 - Search a database of articles on various topics at Find Articles.com.
 4. Partnerships - Developing partnerships with local businesses can create important resources to minimize cost and open lines of communication to the community. Hospitals, media (newspaper, TV and radio stations), and various government agencies are some examples of potential partners.
 - Sustainable Communities Network "Linking citizens to resources and to one another to create healthy, vital, sustainable communities."
 - Read the Healthy People 2010 State Toolkit, *A Free Guide to Health Planning: Identifying and Engaging Community Partners*.
 5. Bring your case to the city council. Find out of what is happening in city council committees (such as land use committees) that are important to helping your community to prevent and manage obesity.
 - Read about how a youngster made a case for building a skate park in his Michigan community.
 6. Publicize your activities and information in the newspaper, on TV, and radio.
 - Learn about public service announcements and how the Ad Council may be able to help you promote your campaign.
 7. Create a website for your coalition to keep the community informed about your activities and to solicit volunteers and partners.

American Obesity Association
Copyright © 2002. All rights reserved.
Terms of Service
This web site was last updated on May 7, 2005.



Mound City Bar Association
P.O. Box 1543
St. Louis, MO 63188
Tel: (314) 552-6349