Joe Lombardo
Governor

Laura Rich
Director

DEPARTMENT OF HUMAN SERVICES

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

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March 11 , 2026

Roger Wilkerson, Acting Director
Legislative Counsel Bureau
401 South Carson Street
Carson City, Nevada 89701

Dear Director Wilkerson,

Please see the attached 2025 Obesity Annual Report for your review, which is due to the Director of the Legislative Counsel Bureau (LCB) for transmittal to the Joint Interim Standing Committee on Health and Human Services during even-numbered years on or before March 15, in accordance with the Nevada Revised Statutes (NRS) 439.521.

Per NRS 439.521, the Division of Public and Behavioral Health (DPBH) shall prepare and submit a written annual report on obesity to the Director of the LCB, which includes the current obesity rates in the State; obesity concerning specific demographics; actions taken by the DPBH regarding obesity; and the State's goals regarding obesity rates.

The 2025 Obesity Annual Report is also submitted to Clark and Washoe County Superintendents and the Chief Medical Officer within DBPH since height and weight are collected and measured every other year per NRS 392.420 (11).

Please refer any questions or concerns to Lori Taylor at l.taylor@health.nv.gov .

Sincerely,

Andrea R. Rivers, MS
Administrator
Division of Public and Behavioral Health

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

Nevada Obesity

2025 Annual Report



Nevada Department of Human Services

Chronic Disease Prevention and Health Promotion

Wellness and Prevention Program

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GOVERNOR OF THE STATE OF NEVADA

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ACKNOWLEDGMENTS

This report was developed by the Nevada Department of Human Services (DHS), Division of Public and Behavioral Health (DPBH), with contributions from the Chronic Disease Prevention and Health Promotion (CDPHP) Section and the Nevada Health Authority Office of Analytics (OOA).

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EXECUTIVE SUMMARY

The 2025 Nevada Annual Obesity Report prepared in accordance with Nevada Revised Statutes (NRS) 439.521 and NRS 392.420, provides a comprehensive overview of obesity across the state of Nevada. This report draws on multiple data sources including the National and Nutrition Examination Survey (NNES), Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavior Surveillance System (YRBSS), National Center for Health Statistics (NCHS), state level data and Women, Infants, and Children (WIC), and the Kindergarten Health Survey. The data collected and analyzed from these sources are used to inform evidence-based policy and program development across the state.

Key Findings:

- Adults
  - Nevada adult obesity rates reached 34.3% in 2024, surpassing the national average of 34.2% for the first time in a decade (Figure 2 and Table S2).
  - In 2024, Hispanic adults had the highest rates of obesity (40.4%) (Figure 6 and Table S6).
  - Rural areas exhibited the highest prevalence of obesity in 2024 (37.9%) (Figure 3 and Table S3).
- Youth
  - Among 14–18-year-olds, Native Hawaiian/Pacific Islanders exhibited the highest obesity rate at 40.4% (Figure 15 and Table S15).
  - 30% of Clark and 27% of Washoe County school district students were overweight and obese (Figure 16, Table S16, Figure 20 and Table S20).
- Chronic Disease
  - 49.1% of diabetics and 40.4% of individuals with coronary heart disease are obese (Figure 30 and Table S30).

DPBH Actions

- Continued statewide promotion and outreach for the Nevada 5-2-1-0 Program to encourage healthy eating, physical activity, and reduced screen time among children and families.
- Administered the Fund for a Healthy Nevada, hunger funds, to support initiatives that enhance food security and improve nutrition quality for Nevada residents.
- Leveraged the Preventive Health and Health Services Block Grant and Centers for Disease Control and Prevention (CDC) funding to collaborate with local partners on initiatives that increase awareness and improve prevention efforts for obesity, diabetes, and cardiovascular disease.

DPBH Recommendations

- Prioritize focused interventions for rural communities, low-income populations, and groups with highest burden of disease to address health disparities.
- Increase public awareness and engagement in physical activity, nutrition education, and obesity prevention programs through coordinated outreach and communication strategies.
- Advance policies that improve the food environment, including adequate access to healthy and affordable options.

- Promote evidence-based practices to reduce obesity-related stigma, ensuring messaging and programs are culturally sensitive and supportive.

STATUTE REQUIREMENTS

The Division of Public and Behavioral Health (DPBH) compiles and submits an annual Obesity Report in accordance with NRS 439.521.[1] This statute mandates the annual reporting of obesity statistics, demographic information, actions undertaken by DPBH to combat obesity, and any accomplishments. Additionally, DPBH is obligated to report on the collection of height and weight data from school districts with enrollments exceeding 100,000 students as stipulated by NRS 392.420.[2] At present, Clark and Washoe counties are the only two districts that meet this criterion, while participation from other districts remains voluntary. The collection of height and weight data is completed biennially among 4th and 7th graders.[2] The information provided in this report may aid statewide initiatives, local health authorities, state programs, and private organizations in fulfilling their federal grant obligations and in obtaining funding. Collectively, NRS 439.521 and NRS 392.420 facilitate the integration of statewide obesity data into a comprehensive report that assists in shaping evidence-based policy decisions, bolsters public health initiatives, and addresses health disparities across the state.[1-2]

DATA OVERVIEW

The 2025 Annual Obesity Report utilizes various data sources from national, state, and local levels to deliver a thorough overview of obesity prevalence in Nevada. The data in this report is intended to illustrate at least five (5) years of obesity trends to enable a comprehensive analysis. The sources used to collect, review, and analyze the data are as follows:

National Health and Nutrition Examination Survey (NHANES)

NHANES is an annual survey that collects health information through physical examinations, laboratory tests, and interviews from adults and children across the United States (U.S.).[3] The analysis of this data provides a nationally representative sample of the overall health of the U.S. population and is the source of national level data in this report.[3]

Limitations: Cross-sectional study design and self-reported health information.

Behavioral Risk Factor Surveillance System (BRFSS)

BRFSS is a telephone-based health survey that collects state-level information about "health-related risk behaviors, chronic health conditions, health-care access, and the use of preventative services".[4]

Limitations: The data is self-reported and may contain participation, coverage, or recall bias.

Youth Risk Behavior Surveillance System (YRBSS)

YRBSS is a randomized school-based survey that collects health behavior information in public and private schools among children in 9th to 12th grade.[5]

Limitations: Information collected is self-reported including height and weight data. The survey is limited to students who attend school, excluding youth who are homeschooled or not enrolled.

NRS 392.420 Height and Weight Data Collection

NRS 392.420 is a legislative mandate that requires the collection of height and weight from 4th and 7th grade students in counties with greater than 100,000 enrollments, which is currently Clark and Washoe counties and includes those charter schools within these counties.[2] Additional counties may voluntarily provide height and weight data and are encouraged to use the same process for collection and reporting as identified in the NRS.[2]

Limitations: Data collection depends on trained staff and the standardization and calibration of equipment. A holistic analysis of the state is dependent on all counties reporting and not mandatory by the NRS.

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

WIC collects state level data among participants including children under the age of five (5).[6] Reported data includes program participation and eligibility, nutritional risk factors, breastfeeding, and obesity rates.[6]

Limitations: Data is available among children who participate in the WIC program and excludes those eligible, but who do not participate, resulting in participation bias. Due to ongoing COVID-19 waivers, some WIC height and weight measurements were self-reported, which may introduce inaccuracies in BMI calculations.

Nevada Kindergarten Health Survey (KHS)

The KHS collects sociodemographic and health information annually to assess student health among Nevada's kindergartners.[7]

Limitations: Data is self-reported by parents or guardians. It also includes only children who attend a public kindergarten, excluding children attending private schools, who are home schooled, or who or not enrolled in school. This leads to participation, recall, and/or response bias.

Nevada Office of Vital Statistics (NOVS)

NOVS collects and records birth, death, marriage, divorce, and adoption data for the state of Nevada.[8] NOVS works with hospitals, funeral homes, and medical certifiers for the collection of information.[8]

Limitations: Data's completeness and accuracy is limited to what is collected by the reporting party and may cause inconsistencies, influencing interpretation.

National Center for Health Statistics (NCHS)

NCHS collects and analyzes health data that includes birth/death records, medical records, interviews, physical examinations, and laboratory testing.[9] This information is used and shared to improve the overall health of the U.S. population.[9]

Limitations: Variations in cause-of-death reporting and the underreporting of obesity as a contributing factor to mortality influences data reliability.

BACKGROUND

History of Obesity

The prevention of obesity is a multifaceted issue. In Nevada, obesity is defined as, "a chronic disease characterized by an abnormal and unhealthy accumulation of body fat which, statistically, correlates with premature mortality, hypertension, heart disease, diabetes, cancer, and other health conditions."[10] Early writings described obesity as, "a disorder of metabolism characterized by excessive deposit of fat in the body," and as a "common condition which may be a source of great bodily and mental distress."[11] In 1948, the World Health Organization (WHO) recognized obesity as a disease in the International Classification of Diseases (ICD).[12] It wasn't until 1977 that the government began to tackle obesity-related issues by releasing the dietary guidelines for Americans.[13] In 2004, the Centers for Medicare and Medicaid chose to exclude obesity from the Coverage Issue Manual (CIM), explaining that "the Coverage Issue Manual is intended to address the coverage of particular care and services, rather than the definition of illness, we do not believe it is appropriate for the manual to address this issue."[14] The American Medical Association (AMA) didn't recognize obesity as a disease until 2013.[15]

Body Mass Index (BMI)

To assess obesity status among adults and children, medical professionals use body mass index, which is a measure of height and weight.[16] How to calculate BMI and classification categories may be found in Table 1 and Table 2. Body mass index is a widely used tool in obesity evaluation because it is simple to complete and is non-invasive (Table 3). In addition, it has been established through research as a reliable measurement of obesity status, which may be associated with body fat and chronic disease risk.[16,19] However, BMI has limitations that must be considered (Table 3), meaning it should be used as a tracking and or identification tool for weight related concerns.[16,19] If an individual is categorized as obese, they need to work with their healthcare provider to determine if further steps and or diagnostics are needed. This is one reason states like Nevada collect information about chronic disease prevalence and mortality to analyze their correlation with obesity status.

Table 1. Adult body mass index definition and classifications.

BMI for adults is calculated by dividing a person's weight into kilograms by the square of their height in meters (kg/m2).

Underweight	Less than 18.5 kg/m^2
Healthy weight	18.5 to less than 25 kg/m^2
Overweight	25 to less than 30kg/m^2
Class 1 Obesity	30 to less than 35 kg/m^2
Class 2 Obesity	35 to less than 40 kg/m^2
Class 3 Obesity	40 kg/m^2 or greater

Source: Centers for Disease Control and Prevention[16-17]

Table 2. Child body mass index definition and classifications.

BMI is determined through "BMI-for-age percentiles", which means values are compared to other children who are the same age and gender.

Underweight	Less than the 5th percentile
Healthy weight	5th to less than the 85th percentile
Overweight	85th to less than the 95th percentile
Obesity	95th percentile or greater
Severe Obesity	120% of the 95th percentile or greater or 35 kg/m^2 or greater

Source: Centers for Disease Control and Prevention[18]

Table 3. Body Mass Index Strength and Weaknesses

Strengths

- Simple and cost effective: only requires height and weight.
- Non-invasive
- Standardized: allows for comparison across populations.

Weaknesses

- Does not distinguish between fat, muscle, and bone mass.
- Does not account for fat distribution or metabolic health.

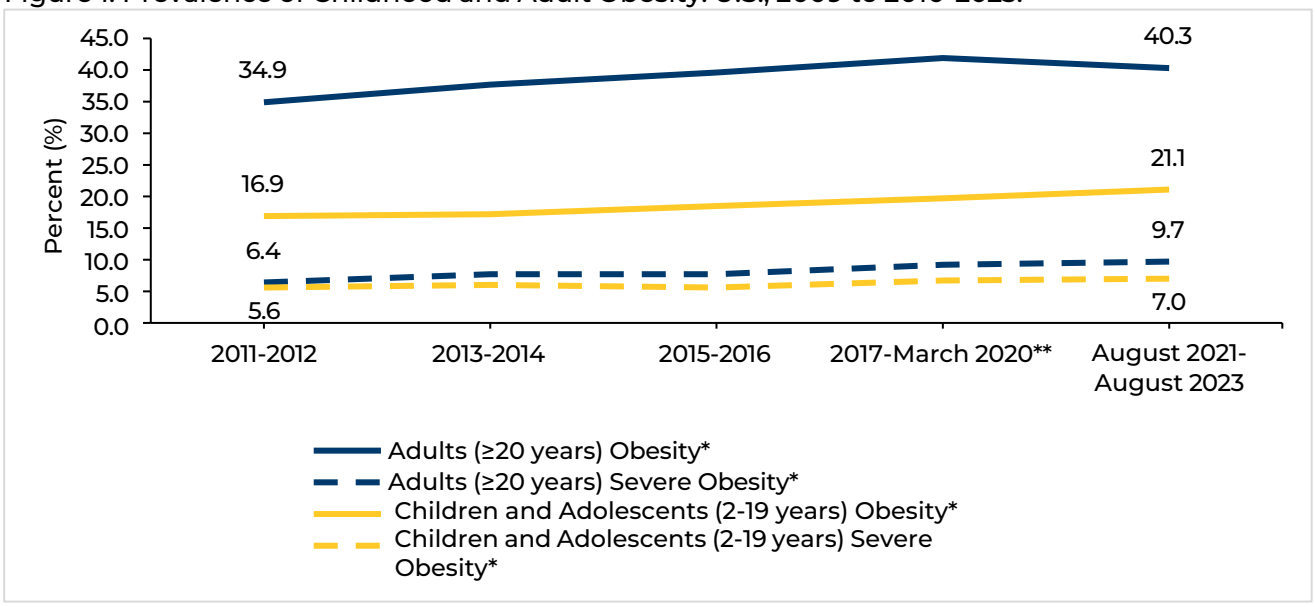
Source: Centers for Disease Control and Prevention[16,19]

OBESITY FINDINGS

Adult and Childhood Obesity in the United States

Obesity is a significant obstacle the U.S. must overcome, and obesity rates are anticipated to rise escalating the public health issue. For example, obesity related medical costs are estimated to be $173 billion for adults and $1.32 billion for children.[20] These figures are expected to rise in light of the projected prevalence of obesity by 2050, which anticipates an increase of 41.4 million adults and 6.74 million.[20] Also by 2050, the majority of states will have one (1) in three (3) adolescents and two (2) in three (3) adults identified as obese.[21] NHANES data from 2011-2023 indicated a steady increase in obesity rates among adults and children. The adult obesity rose from 34.9% to 40.3% and severe obesity from 6.4% to 9.7% (Figure 1 and Table S1). Childhood obesity increased from 16.9% to 21.1% and severe obesity from 5.6% to 7.0% (Figure 1 and Table S1).

Figure 1. Prevalence of Childhood and Adult Obesity: U.S., 2009 to 2010-2023.

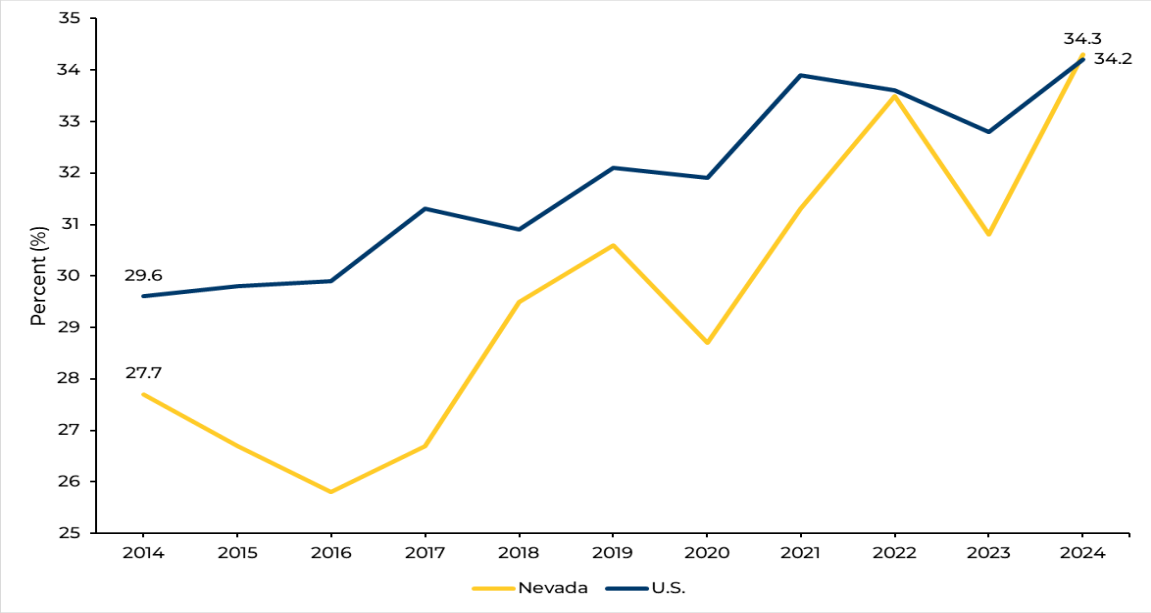


Source: National Health and Nutrition Examination Survey
*Age-adjusted.
**Data from the partial 2019–2020 cycle (March 2020) were combined with 2017–2018 data for nationally representative estimates.

Adult Obesity in Nevada

In the United States, during 2014. obesity was on the rise, increasing from 30% to 33% (Figure 2 and Table S2). Between 2014-2024, Nevada had the lowest rate of obesity and in 2016, whereas the prevalence rate was 25.8% (Figure 2 and Table S2). Nevada consistently remained below the national average until 2024 when it reached 34.3%, slightly surpassing the national average of 34.2% (Figure 2 and Table S2). Nevada saw the highest prevalence of obesity during the most recent reporting year of 2024 at 34.3%, which is the highest among the reporting periods (Figure 2 and Table S2).

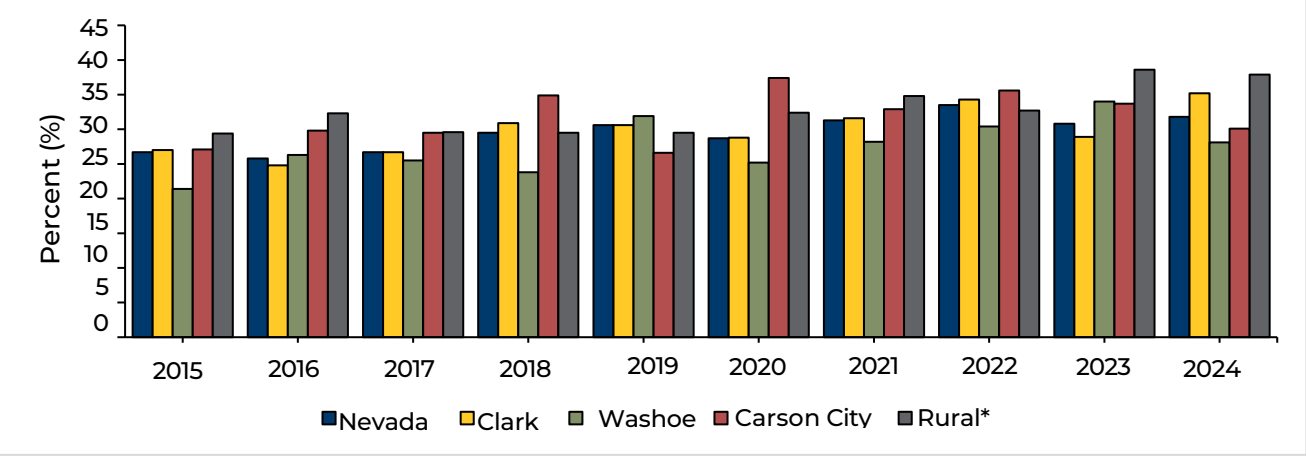
Figure 2. Prevalence of Adult Obesity: Nevada and the United States, 2014–2024.



Source: Behavioral Risk Factor Surveillance System
Abbreviations: U.S. (United States)

The highest prevalence of obesity for six (6) out of the ten (10) years analyzed was among rural counties (Figure 3 and Table S3). In 2024, Washoe County had the lowest prevalence of obesity at 28% and on average the lowest between 2014-2024 (Figure 3 and Table S3). Between counties, Clark saw the biggest increase of obesity at around 6% from 2023-2024 (Figure 3 and Table S3).

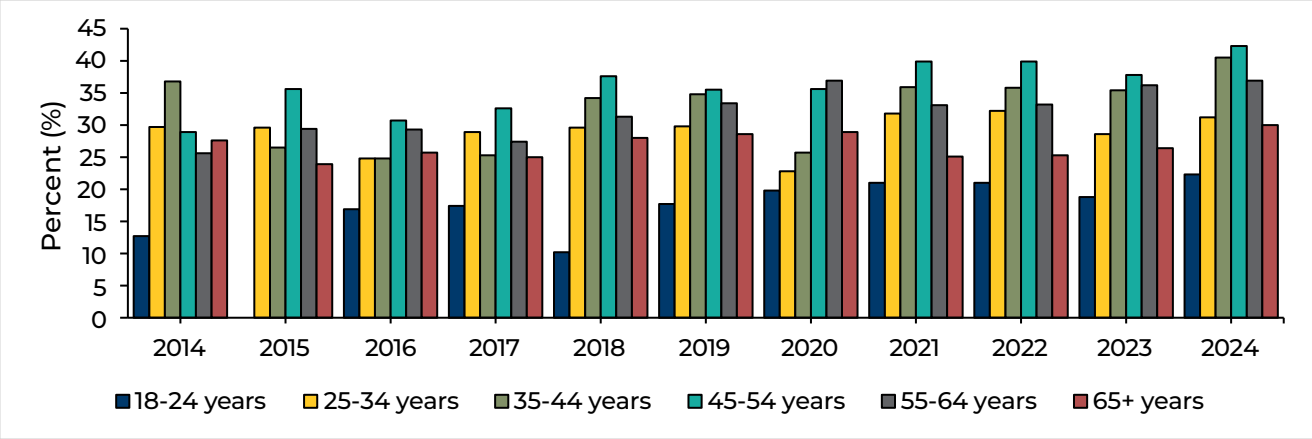
Figure 3. Prevalence of Adult Obesity, by Region: NV, 2015 – 2024.



Source: Behavioral Risk Factor Surveillance System
*Rural area defined as Elko, Nye, Lyon, Douglas, Churchill, Humboldt, White Pine, Pershing, Lander, Mineral, Lincoln, Storey, Eureka, and Esmeralda.

The prevalence of adult obesity rose among all age categories from 2023 to 2024 (Figure 4 and Table S4). The largest prevalence of obesity was seen among 45-54 years at 42.3% in 2024 (Figure 4 and Table S4). The lowest prevalence of obesity was 18-25 at 22.3% followed by 65+ years at 30% (Figure 4 and Table S4). The highest prevalence of obesity for any year was seen in 2024 for 18-24 years (22.3%), 35-44 years (40.5%), 45-54 years (42.3%), and 65+ years (30%). During 2022, 25-34 years was highest at 32.2% and 55-64 years in 2024 tied with 2020 at 36.9 (Figure 4 and Table S4).

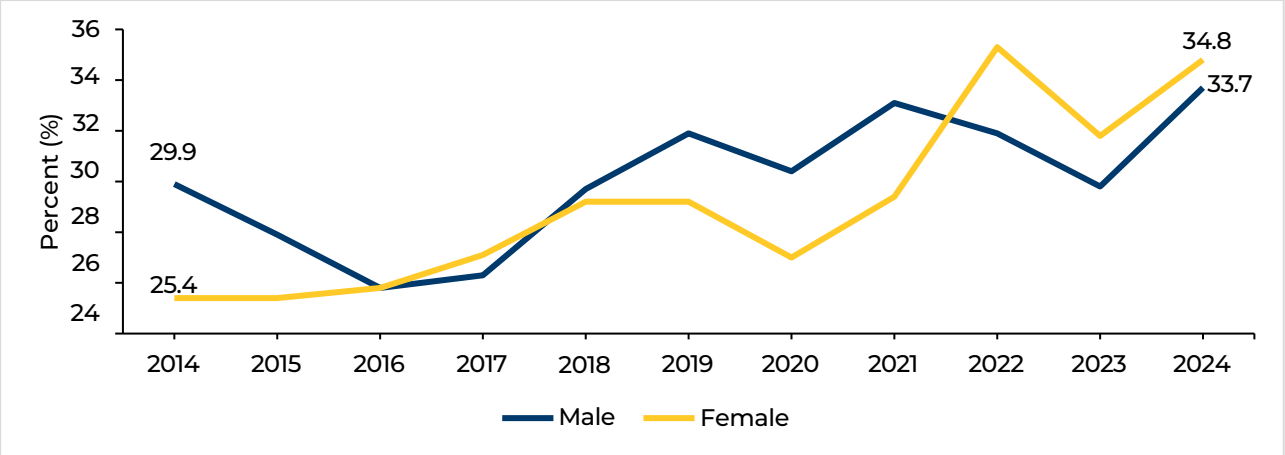
Figure 4. Prevalence of Adult Obesity, by Age Group: NV, 2014 – 2024.



Source: Behavioral Risk Factor Surveillance System
Missing bars indicate data not available.

In 2024, females had a roughly 1% higher prevalence of obesity compared to males (Figure 5 and Table S5). Females saw the largest change of obesity increase from 25.4% in 2014 to 34.8 in 2024 (Figure 5 and Table S5). This is a 37% increase compared to the 13% increase in males. The highest prevalence of obesity in women occurred in 2022, whereas in men it was during 2024 (Figure 5 and Table S5).

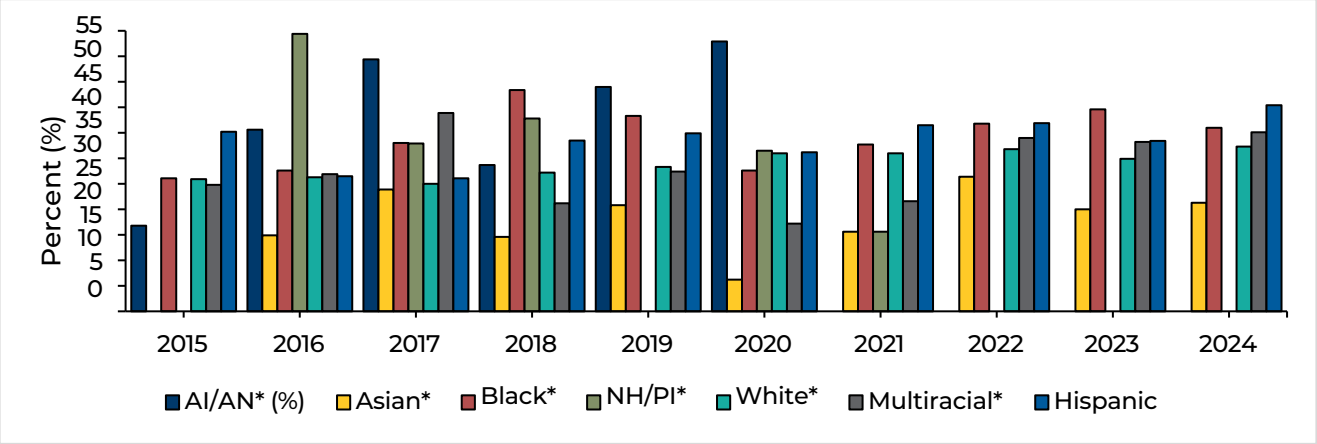
Figure 5. Prevalence of Adult Obesity, by Sex: NV, 2014 – 2024.



Source: Behavioral Risk Factor Surveillance System

During 2024, Hispanics had highest prevalence of obesity at 40.4% with the lowest being non-Hispanic Asians at 21.3% (Figure 6 and Table S6). The examination of 2023 and 2024 indicates all racial groups increased their prevalence of obesity except non-Hispanic blacks who saw an almost 4% decrease (Figure 6 and Table S6). Based on available data from 2014-2024, the highest median prevalence of obesity was among American Indian/Alaska Native at 39.8% (Figure 6 and Table S6).

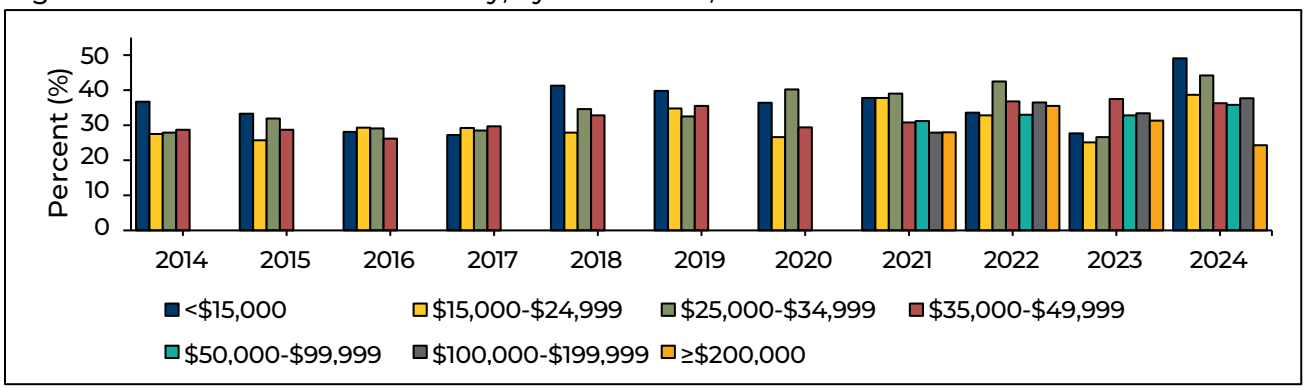
Figure 6. Prevalence of Adult Obesity, by Race/Ethnicity: NV, 2015 – 2024.



Source: Behavioral Risk Factor Surveillance System
Abbreviation: AI/AN (American Indian/Alaska Native), NHPI (Native Hawaiian/Pacific Islander)
*Non-Hispanic
Note: Missing bars indicate values were suppressed due to small sample sizes.

Compared to the previous year, 2024 saw a large increase in obesity prevalence for incomes below $35,000 (Figure 7 and Table S7). For instance, individuals earning less than $15,000 saw a 21.4% increase, $15,000-$24,999 saw a 13.6% increase, and $25,000-$34,999 saw a 17.6% increase (Figure 7 and Table S7). This is an estimated 77%, 54%, and 66% change from 2023-2024 (Figure 7 and Table S7). Those earning greater than 200,000 were least likely to be obese at 24.3% (Figure 7 and Table S7).

Figure 7. Prevalence of Adult Obesity, by Income: NV, 2014–2024.

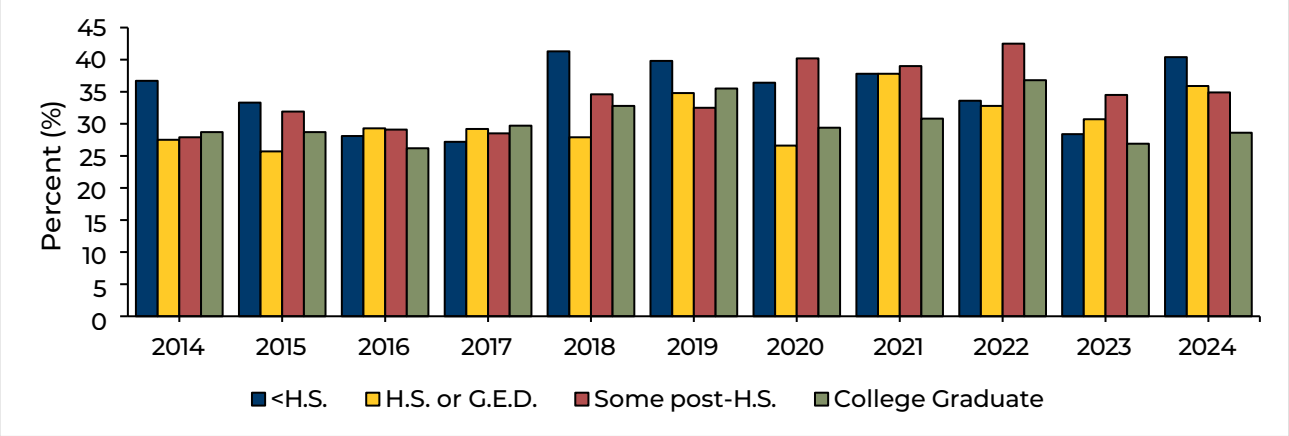


Source: Behavioral Risk Factor Surveillance System

Note: Missing bars indicate values were suppressed due to small sample sizes.

Between 2014 and 2024, the average obesity rate among college graduates was the lowest at 30% and individuals with less than a high school diploma was the highest at 35% (Figure 8 and Table S8). Figure 8 and Table S8 indicate that the prevalence of obesity rate decreases as education increases. It is noteworthy to mention that college graduate students, during 2018, had the highest prevalence of obesity between all educational levels at almost 30% (Figure 8 and Table S8).

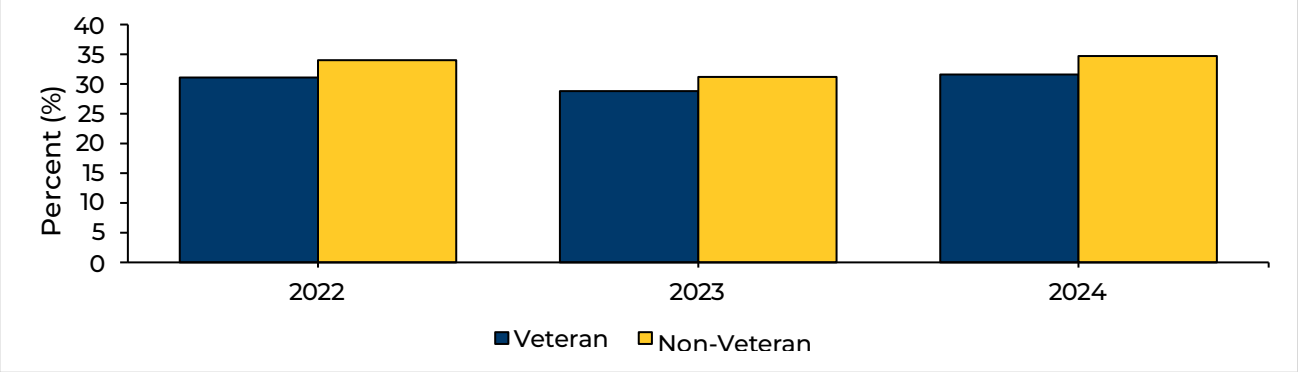
Figure 8. Prevalence of Adult Obesity, by Education: NV, 2014– 2024.



Source: Behavioral Risk Factor Surveillance System
Abbreviation: H.S. (High School), G.E.D. (General Education Development)

An analysis of veteran status indicates that non-veterans were more likely to be obese than veterans from 2022-2024 (Figure 9 and Table S9). In 2023, both groups saw a slight decrease in prevalence to 28.8% in veterans and 31.2% in non-veterans (Figure 9 and Table S9).

Figure 9. Prevalence of Adult Obesity, by Veteran Status: NV, 2022 and 2024.

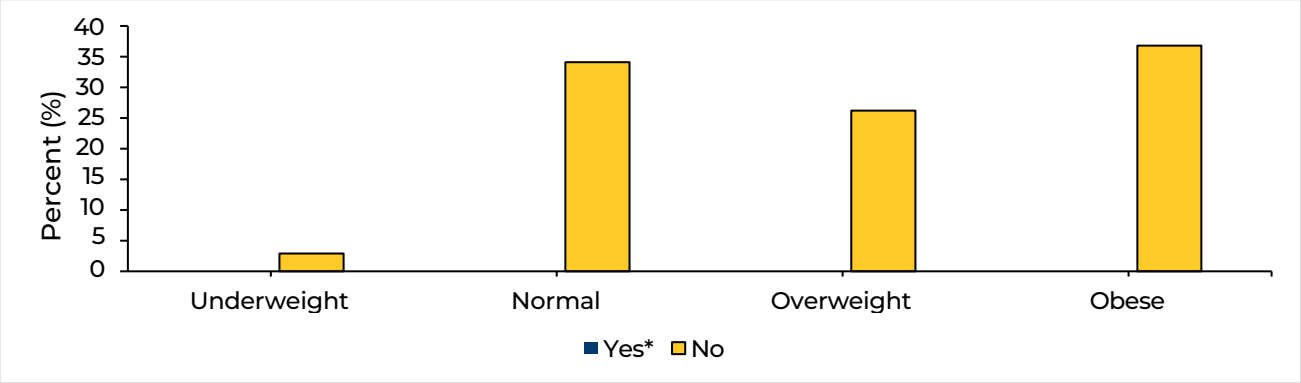


Source: Behavioral Risk Factor Surveillance System

Of the individuals who reported not being pregnant, 36.8% were categorized as obese and 63% were overweight or obese (Figure 10 and Table S10). The next highest category was normal at 34.1% (Figure 10). Overall, 59.5% of the pre-pregnancy population was overweight or obese (Figure 11 and Table S11). The county with the highest prevalence of pre-pregnancy obesity was Lyon at 37.1% followed by Nye at 36.9% (Figure 11 and Table S11). Clark County had the lowest prevalence

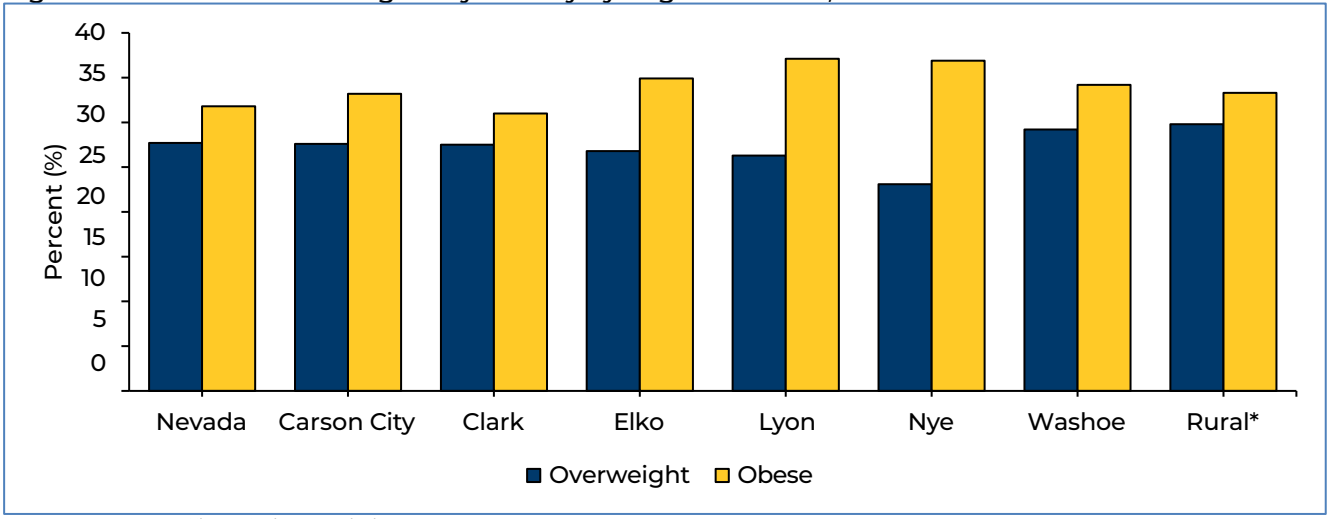
of pre-pregnancy obesity at 31.0% (Figure 11 and Table S11).

Figure 10. Distribution of BMI by Maternal Status: Nevada, 2024.



Source: Behavioral Risk Factor Surveillance System
Maternal Status refers to whether an individual was pregnant or not at the time of the survey.
*Insufficient responses for statistical analysis.

Figure 11. Prevalence Pre-Pregnancy Obesity by Region: Nevada, 2024.

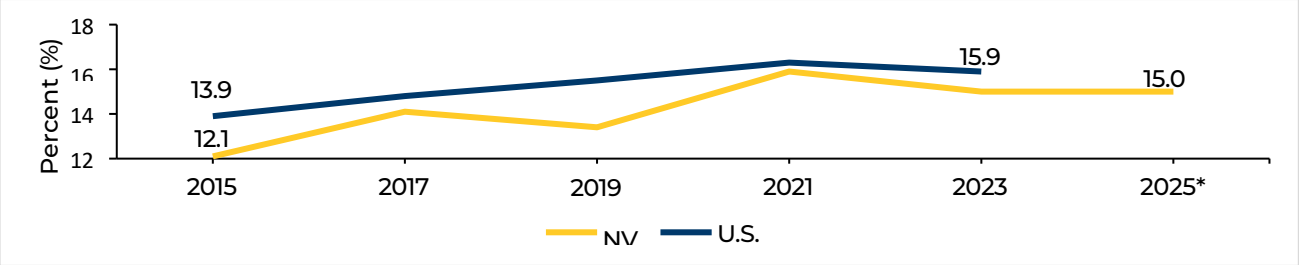


Source: Nevada Office of Vital Statistics
Pre-Pregnancy is all births in the state of Nevada where the mother is a Nevada resident.
*Rural is defined as Churchill, Douglas, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Mineral, Storey, and White Pine

Youth Obesity in Nevada

Since 2015, the percentage of Nevada youth with obesity has risen from 12% to 15%, with the highest prevalence during 2021 at almost 16% (Figure 12 and Table S12). In 2023 there was a slight decrease to 15%, which remained unchanged in 2025 (Figure 12 and Table S12). Nevada consistently remains below the national average for obesity among youth aged 14-18 (Figure 12 and Table S12).

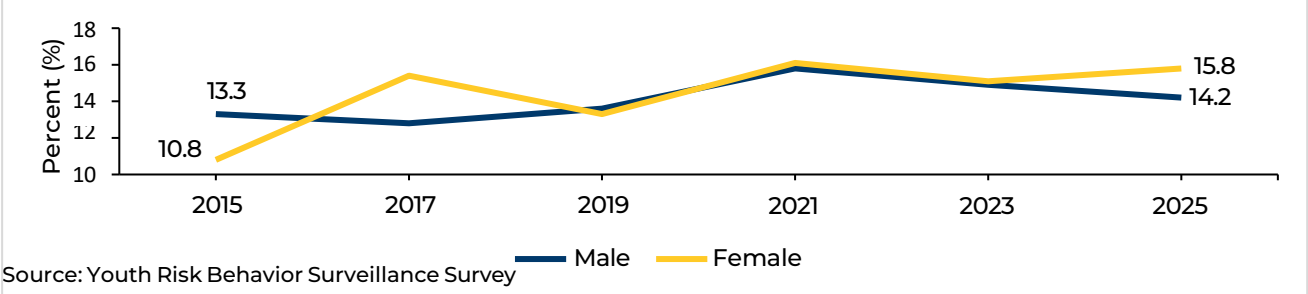
Figure 12. Prevalence of Obesity in Youth Aged 14 to 18: Nevada and United States, 2015-2025.



Source: Youth Risk Behavior Surveillance Survey
Abbreviation: NV (Nevada), U.S. (United States)
*2025 data for the entire U.S. population is not currently available.

The prevalence of obesity among young females rose from 6% to 16%, an increase of 46% and young males decreased to 14% (Figure 13 and Table S13). Since 2019 rates of obesity between males and females remained similar with a slight deviation appearing in 2025 (Figure 13 and Table S13).

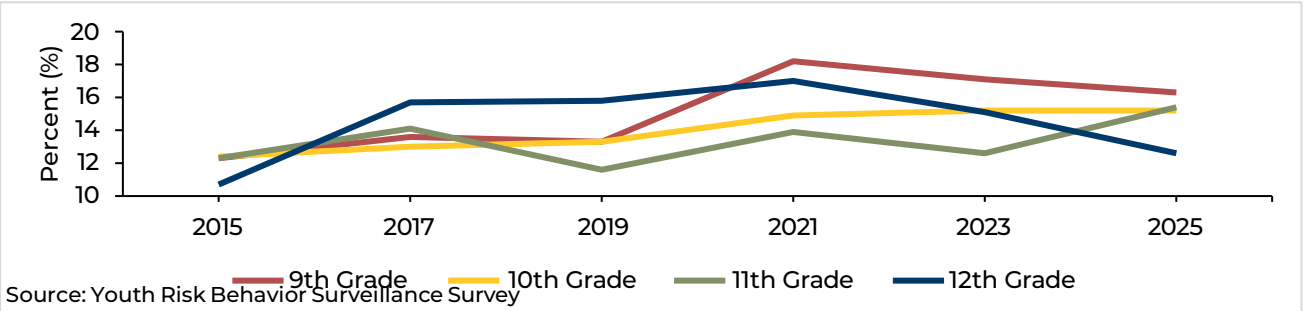
Figure 13. Prevalence of Obesity in Youth Aged 14 to 18, by Sex: Nevada, 2015-2025.



Source: Youth Risk Behavior Surveillance Survey

During 2021, the state of Nevada saw the highest average prevalence of obesity among all years and the highest percentage of obesity at 18% for 9th graders (Figure 14 and Table S14). In 2025, 9th graders had the highest rates of obesity at 16.3% and 12th graders with the least at 12.6% (Figure 14 and Table S14).

Figure 14. Prevalence of Youth Obesity, by Grade Level: Nevada, 2015-2025.

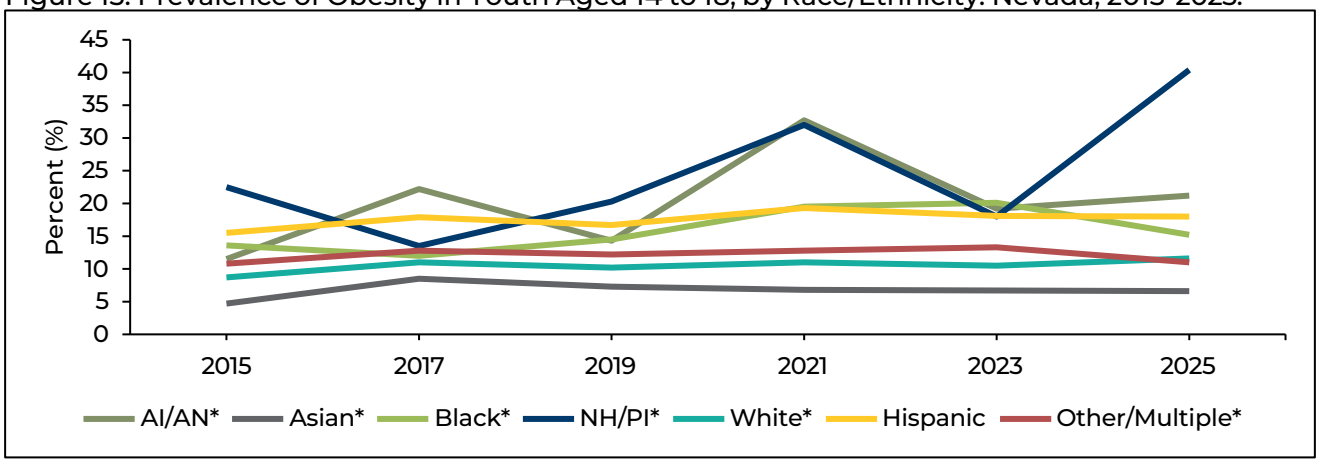


Source: Youth Risk Behavior Surveillance Survey

On average and across all years, non-Hispanic Asians and Whites had the lowest rates of obesity (Figure 15 and Table S15). In 2025, the group with the highest prevalence of obesity was non-Hispanic Native Hawaiians and Pacific Islanders followed by non-Hispanic American Indians and

Alaska Natives (Figure 15 and Table S15). The group with the lowest rates of obesity was non-Hispanic Asians (Figure 15 and Table S15).

Figure 15. Prevalence of Obesity in Youth Aged 14 to 18, by Race/Ethnicity: Nevada, 2015-2025.



Source: Youth Risk Behavior Surveillance Survey
Abbreviation: AI/AN (American Indian/Alaska Native), NHPI (Native Hawaiian/Pacific Islander)
*non-Hispanic

Youth Obesity in Schools (Height and Weight Data Collection)

Obesity rates in schools are collected as identified on page 4 of this report under statute requirements. Table 4 details the mandated and voluntary collection periods, along with the relevant Obesity Annual Reports when data is examined. This report includes the analysis of school year 2023 from August 2023 to June 2024 due to reporting timeframes and report deadlines. For a visualization of school and height data refer to the Nevada Office of Analytics Dashboard.

Table 4. Height and Weight Data Collection Periods Requirements

School Year	Timeline	Collection Period?	Year of Annual Obesity Report
2022	August 2022-June 2023	No	Data provided voluntarily may be analyzed in 2023 and/or 2024 report
2023	August 2023-June 2024	Yes	2025
2024	August 2024-June 2025	No	Data provided voluntarily may be analyzed in 2026 and/or 2027 report
2025	August 2025-June 2026	Yes	2027
2026	August 2026-June 2027	No	Data provided voluntarily may be analyzed in 2028 and/or 2029 report
2027	August 2027-June 2028	Yes	2029

Table 5. Number of Students Surveyed for Height and Weight during the 2023 school year (August 2023 to June 2024).

Category	4th Grade	7th Grade	10th Grade
Clark County	18,987	19,122	77
Washoe County	253	51	44

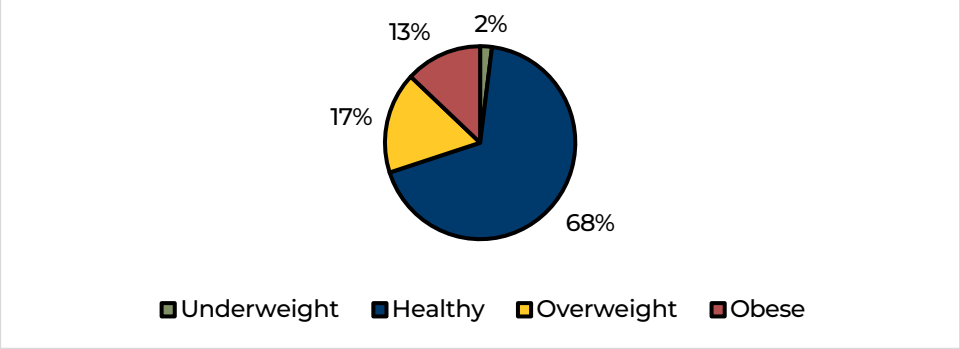
Source: Clark County and Washoe County School District

The data collected among 10th graders in Clark County School District as well as 4th, 7th, and 10th graders in Washoe County School District should be interpreted with caution due to the small sample size (Table 5).

Clark County School District (CCSD)

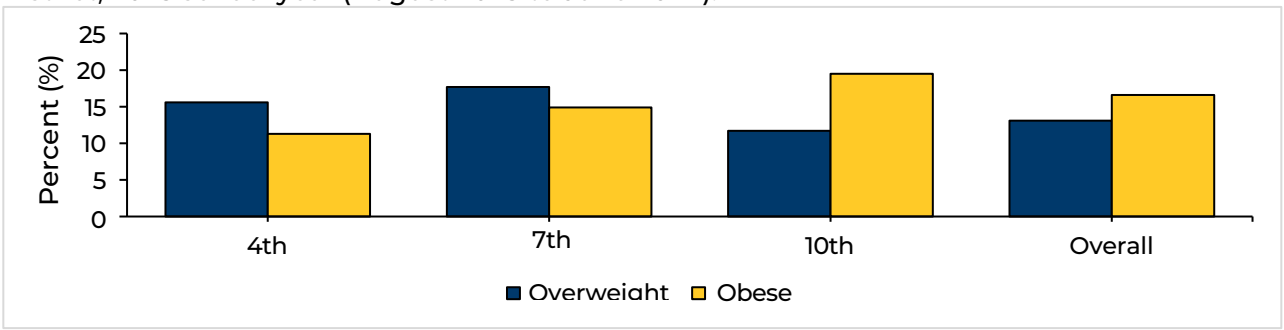
Most children (68%) in Clark County were considered healthy weight (Figure 16). Of the students surveyed, 17% were considered overweight and 13% obese (Figure 16). In comparison of 4th and 7th grade it was identified both grades have higher numbers of students overweight than obese (Figure 17). The 7th grade students have higher rates of being overweight (17.7%) and obese (14.9%) compared to the 4th graders (Figure 17). Analysis of all grades finds 10th graders to have the highest obese population at 19.5% (Figure 17).

Figure 16. Distribution of Body Mass Index Categories Among Youth in Grades 4th, 7th, and 10th: Clark County School District, 2023 school year (August 2023 to June 2024).



Source: Clark County School District

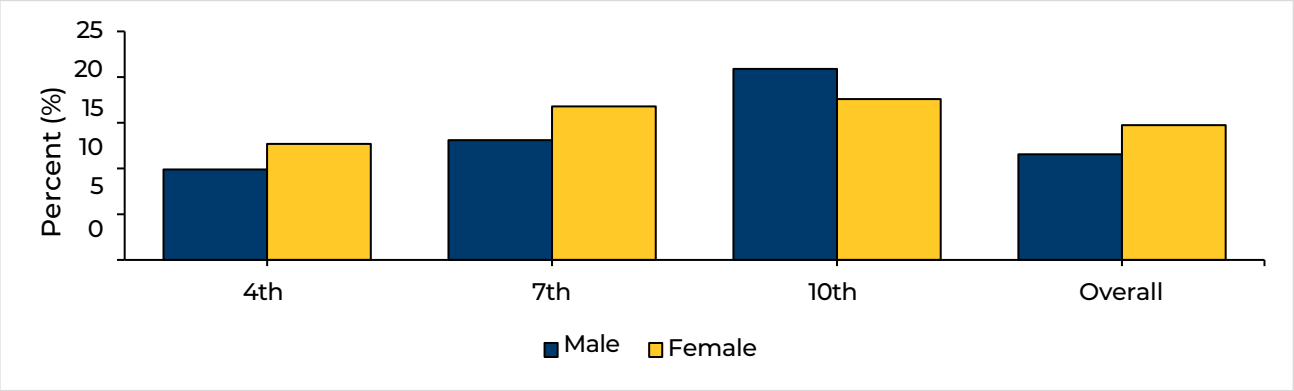
Figure 17. Prevalence of Overweight and Obesity Among Youth by Grade: Clark County School District, 2023 school year (August 2023 to June 2024).



Source: Clark County School District

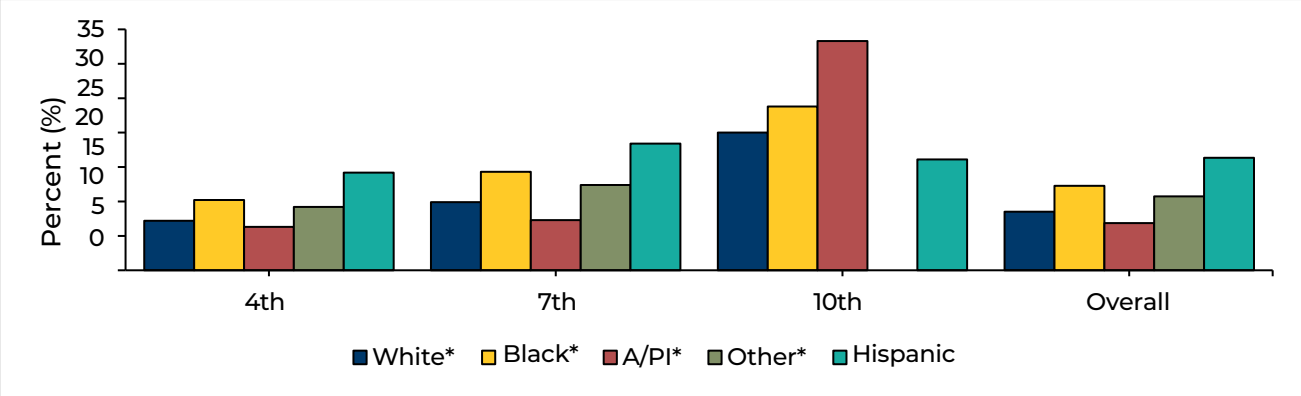
During the August 2023 - June 2024 school year, females had higher prevalence of obesity compared to males among the 4th and 7th grade students (Figure 18). The 10th grader males had a higher prevalence of obesity at 20.9% (Figure 18). Analysis of race/ethnicity between 4th and 7th grade students found 7th graders have a higher prevalence of obesity among all categories (Figure 19). Hispanic 4th graders at 14.2% and 7th graders at 18.4% had the highest rates of obesity of any race/ethnicity category (Figure 19).

Figure 18. Prevalence of Obesity Among Youth in Grades 4th, 7th, and 10th by Sex: Clark County School District, 2023 school year (August 2023 to June 2024).



Source: Clark County School District

Figure 19. Prevalence of Obesity Among Youth in Grades 4th, 7th, and 10th by Race/Ethnicity: Clark County School District, 2023 school year (August 2023 to June 2024).



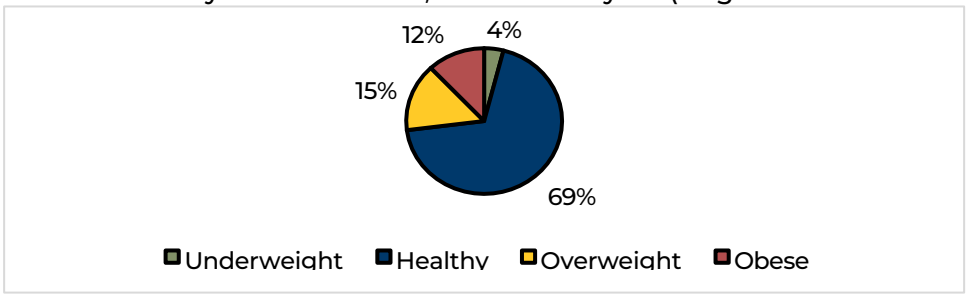
Source: Clark County School District
Abbreviation: A/PI (Asian/Pacific Islander)
Missing bars indicate missing data.
*non-Hispanic

Washoe County School District (WCSD)

Washoe County data indicates 69% of students have a healthy weight with 12% being obese (Figure 20). 10th graders have a higher prevalence of obesity (22.7%) compared to 4th and 7th

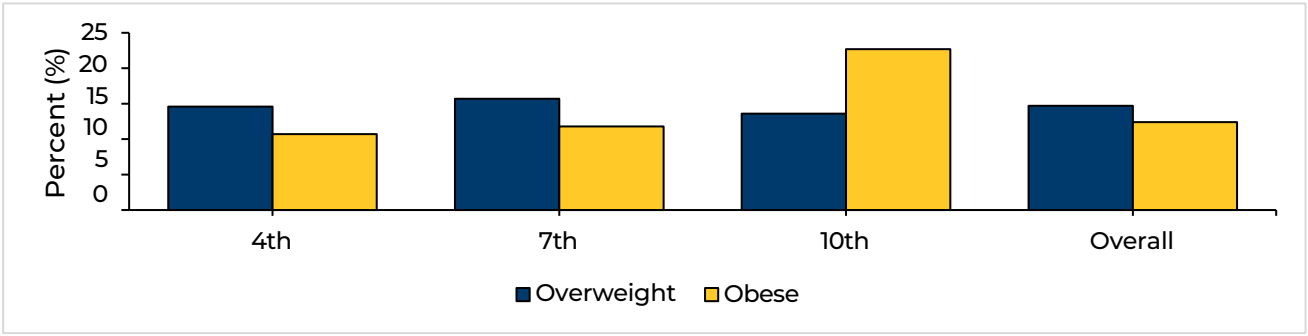
graders (Figure 21). When examining overweight status, 4th and 7th graders had higher rates compared to 10th graders with 7th graders having the highest prevalence at 15.7% (Figure 21).

Figure 20. Distribution of Body Mass Index Categories Among Youth in Grades 4th, 7th, and 10th: Washoe County School District, 2023 school year (August 2023 to June 2024).



Source: Washoe County School District

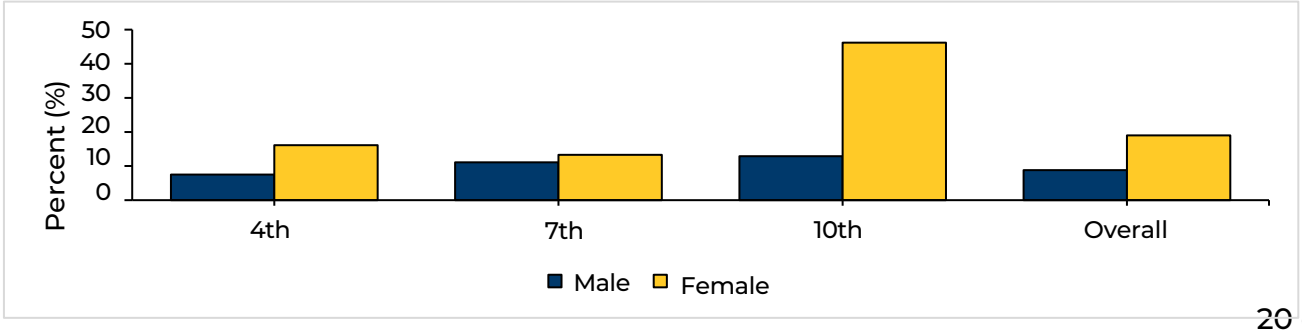
Figure 21. Prevalence of Overweight and Obesity Among Youth by Grade: Washoe County School District, 2023 school year (August 2023 to June 2024).



Source: Washoe County School District

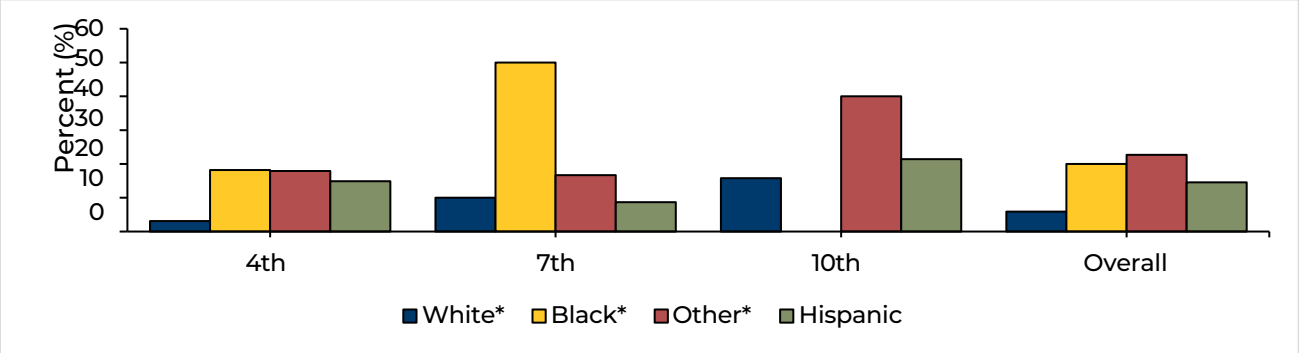
Females had higher rates of obesity compared to males in all grades (Figure 22). Of the 10th grade females surveyed, 46.2% were obese (Figure 22). Fourth grade male students had the lowest prevalence of obesity at 7.5% (Figure 22). Overall analysis of race/ethnicity shows the other category (22.7%) has the highest prevalence of obesity (Figure 23). The 4th and 7th graders who were Black had the highest prevalence at 18.2% and 50% (Figure 23). The lowest obesity prevalence was 3.1%, seen among white 4th graders (Figure 23).

Figure 22. Prevalence of Obesity Among Youth in Grades 4th, 7th, and 10th by Sex: Washoe County School District, 2023 school year (August 2023 to June 2024).



Source: Washoe County School District

Figure 23. Prevalence of Obesity Among Youth in Grades 4th, 7th, and 10th by Race/Ethnicity: Washoe County School District, 2023 school year (August 2023 to June 2024).



Source: Washoe County School District
Missing bars indicate missing data.
*non-Hispanic

Childhood Obesity in Nevada

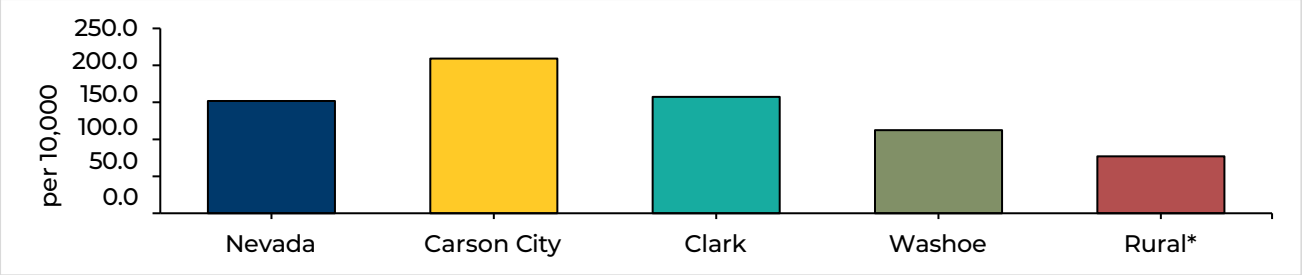
Women, Infants, and Children (WIC)

Height and weight data is also collected from Nevada children participating in WIC, which is a program that assists low-income pregnant, post-partum and breastfeeding women and families with children under five (5) years with nutrition education, breastfeeding education and supplies, healthcare referrals, and nutritious supplemental foods. The preferred method for evaluating weight status among children less than the age of two (2) years is weight-for-length with any child greater than two (2) years evaluated by BMI.[22] Although WIC data does not include all children aged 0–5 in Nevada, it serves as a dependable indicator of obesity trends among those participating in supplemental nutrition programs. Since the 2024 Obesity Annual Report, the methodology for calculating obesity prevalence among WIC-enrolled children analyzes obesity using Risk Codes 113 and 115, which flag participants based on BMI-for-age and weight-for-length percentiles. Due to this change, direct comparisons can vary.

- Risk Code 113: Obese Children 2-5 Years of Age: ≥ 24 months and ≥ 95th percentile BMI
- Risk Code 115: High Weight-for-Length: Birth – 24 months ≥ 98th percentile

In 2024, Carson City had the highest prevalence of children with a BMI ≥ the 95th percentile at 209.2 per 10,000, followed by Clark County at 157.4 per 10,000 (Figure 24 and Table S24). Rural counties at 77.0 per 10,000 had around two to three times less children with a BMI in the ≥ 95th percentile than the state, Carson City, Washoe and Clark counties (Figure 24 and Table S24).

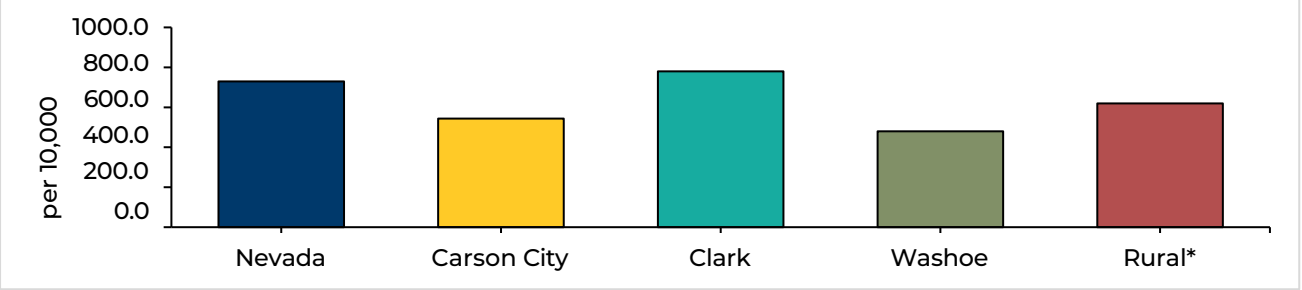
Figure 24. Prevalence of Obesity Among WIC Enrolled Children Aged 2 to 5 Years (Risk Code 113) by Region: Nevada, 2024-2025.



Source: Women, Infants, and Children
*Rural is defined as Churchill, Douglas, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Storey, and White Pine

Among children aged 2 to 5 years, Washoe County had the lowest prevalence of obesity at 543.9 per 10,000 with Clark County having the highest at 780.0 per 10,000 (Figure 25 and Table S25). The overall prevalence among all Nevadans was 729.6 per 10,000 (Figure 25 and Table S25)

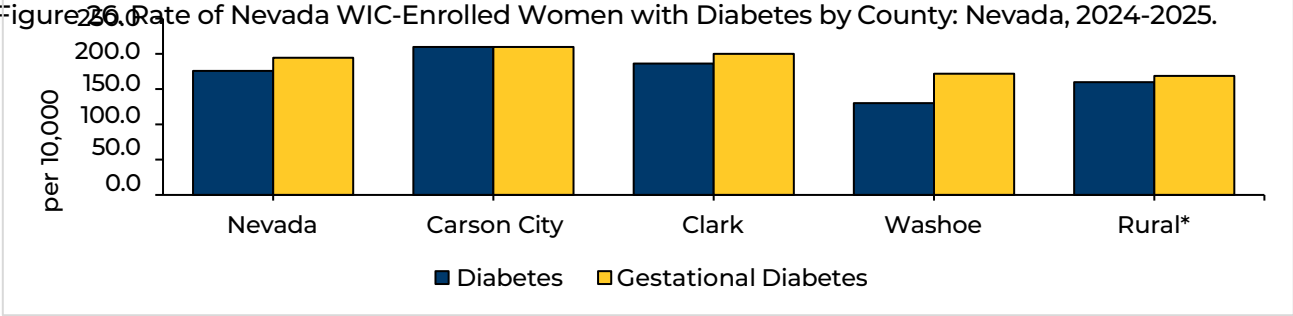
Figure 25. Prevalence of High Weight for Length WIC-Enrolled Children Aged 0-24 Months (Risk Code 115) by County: Nevada, 2024-2025.



Source: Women, Infants, and Children
*Rural is defined as Churchill, Douglas, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Storey, and White Pine

Carson City had the highest prevalence of diabetes and gestational diabetes among WIC-enrolled women compared to all counties at 209.8 per 10,000 for both categories (Figure 26 and Table S26). Washoe County WIC adult women had the lowest diabetes prevalence at 130.1 per 10,000 whereas rural counties had the lowest prevalence of gestational diabetes (Figure 26 and Table S26).

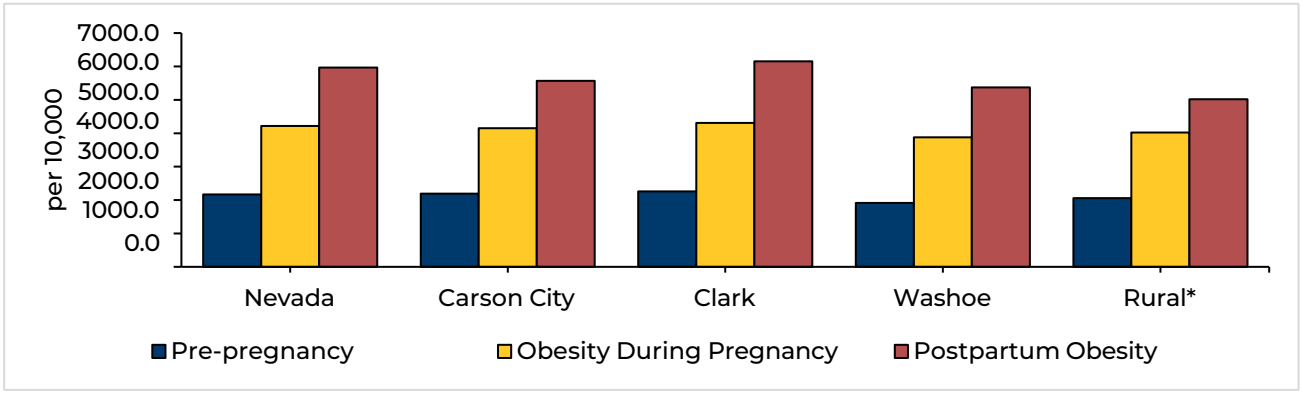
Figure 26. Rate of Nevada WIC-Enrolled Women with Diabetes by County: Nevada, 2024-2025.



Source: Women, Infants, and Children
*Rural is defined as Churchill, Douglas, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Storey, and White Pine.

From 2024-2025, Washoe County had the lowest rates of pre-pregnancy obesity among WIC-enrolled pregnant women at 1,912.6 per 10,000 and obesity during pregnancy at 3,879.8 compared to all other counties (Figure 27 and Table S27). Rural counties had the lowest rate of postpartum obesity at 5,020.0 per 10,000 (Figure 27 and Table S27). Clark County had the highest rates of obesity for all categories at 2,259.1, 4,309.7, and 6,155.0 per 10,000 (Figure 27 and Table S27). Obesity rates consistently rose from pre-pregnancy all the way to post-partum (Figure 27 and Table S27).

Figure 27. Rate of Nevada WIC-Enrolled Women with Obesity by County: Nevada, 2024-2025.



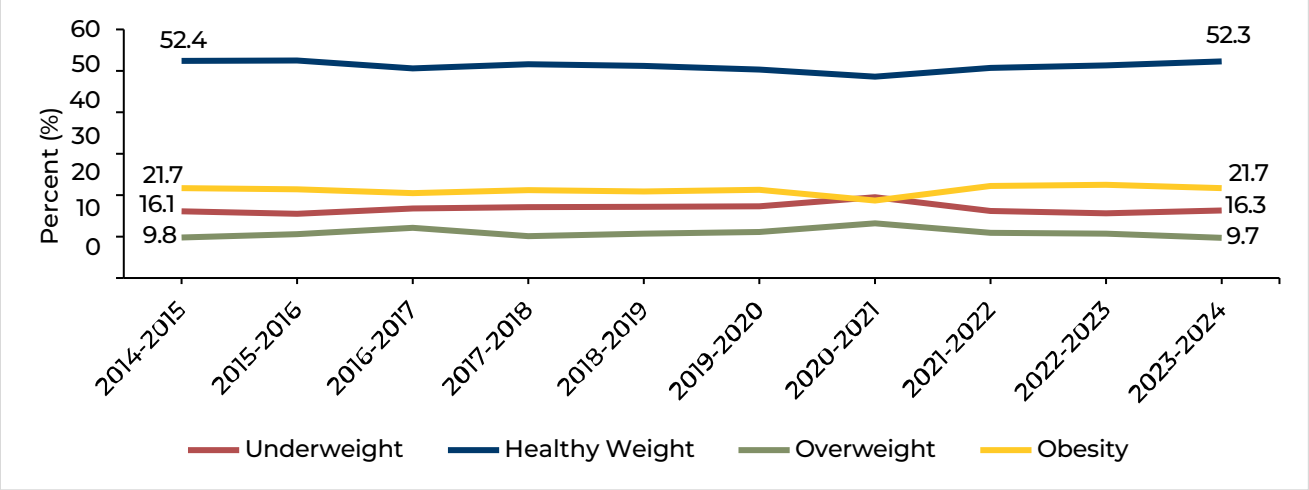
Source: Women, Infants, and Children
*Rural is defined as Churchill, Douglas, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Storey, and White Pine

Kindergarten Health Survey (KHS)

The KHS is conducted annually to assess the weight status and overall health of kindergarten students in Nevada. The data aids statewide public health efforts to reduce obesity and improve overall health. Although the KHS data does not encompass all kindergarten-aged children in Nevada, as it is restricted to public school students, it acts as an indicator of obesity rates among young children beginning their education.

Overall, BMI categories are largely consistent since 2014. However, exploration of the data shows a slight variation year by year with differences ranging from one (1) to two (2) percentage points (Figure 28 and Table S28). The most recent school year data shows the majority (52.3%) of children are of healthy weight and about a quarter (21.7%) are categorized as obese (Figure 28 and Table S28). In addition, 9.7% of kindergartners are classified as overweight (Figure 28 and Table S28). These trends differ from the national and state obesity trends, which have seen a steady increase overtime (Figures 1 and Table S1).

Figure 28. Distribution of Body Mass Index Categories Among Kindergartners: NV, 2014-2024.

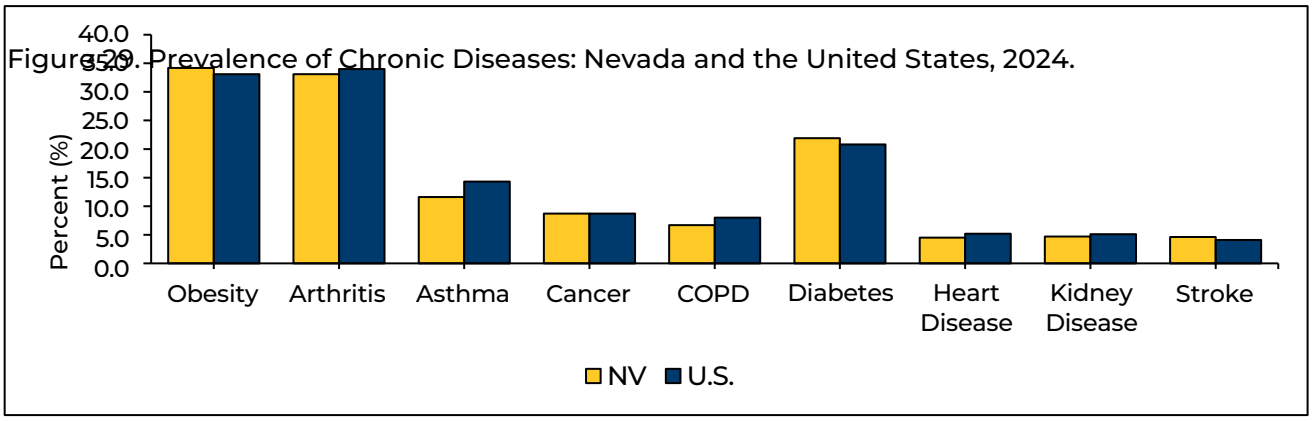


Source: Nevada Institute for Children Research & Policy: Kindergarten Health Survey

Obesity and Chronic Diseases

Obesity is a risk factor for various chronic illnesses, such as heart disease, type 2 diabetes, and some cancers. It is estimated that 60% of young adults (18-34 years) and almost 80% of mid-life adults (25-64 years) have at least one chronic disease.[23] Young adults (18-34 years) had a 5.2 million increase of individuals with chronic disease from 2013-2023.[23] In 2022, eight out of the ten leading causes of death in the U.S. were chronic diseases.[24] Tackling obesity through public health initiatives is essential for enhancing overall health outcomes in Nevada. In 2024, the chronic disease with the highest prevalence nationally was arthritis at 34% (Figure 29 and Table S29). In Nevada, obesity held the top stop at 34.2% (Figure 29 and Table S29). The disease with the lowest prevalence in the U.S. was stroke at 4.1% whereas in Nevada, heart disease was the lowest at 4.5% (Figure 29 and Table S29). High obesity rates continue to support the need for DPBH to continue integrating obesity prevention programs within the Chronic Disease Prevention and Health Promotion Section.

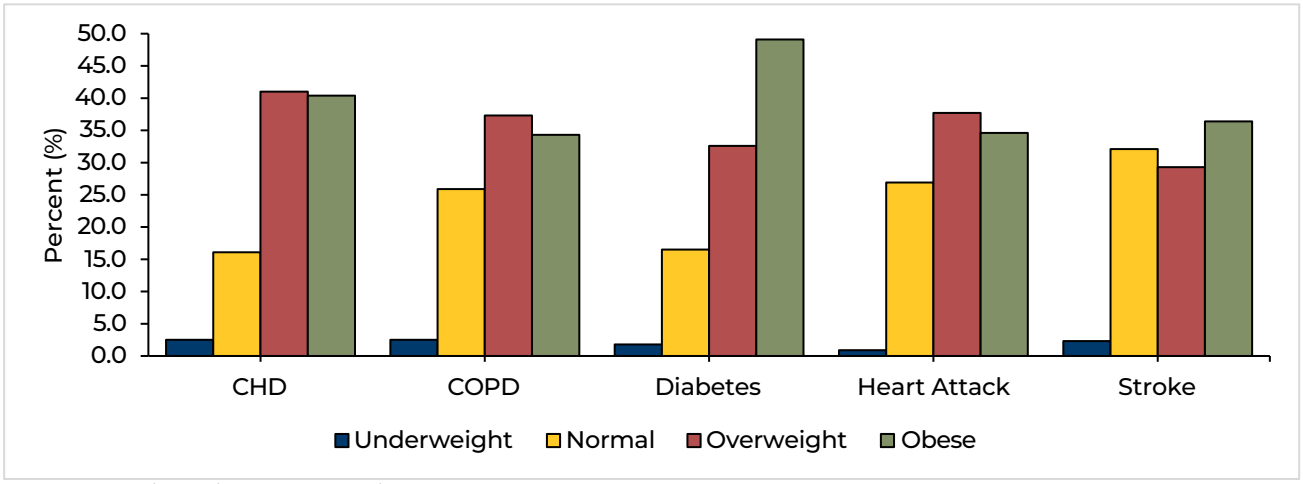
Figure 29. Prevalence of Chronic Diseases: Nevada and the United States, 2024.



Source: Behavioral Risk Factor Surveillance Survey
Abbreviation: NV (Nevada), U.S. (United States), COPD (Chronic Obstructive Pulmonary Disorder)

The diabetes category had the largest number of individuals classified as obese at 49.1% (Figure 30 and Table S30). The overweight classification was highest among coronary heart disease at 41% (Figure 30 and Table S30). Stroke was higher among normal BMI at 32.1 compared to underweight at 2.3% and overweight at 29.3% (Figure 30 and Table S30).

Figure 30. Body Mass Index Distribution of Chronic Diseases: Nevada, 2024.

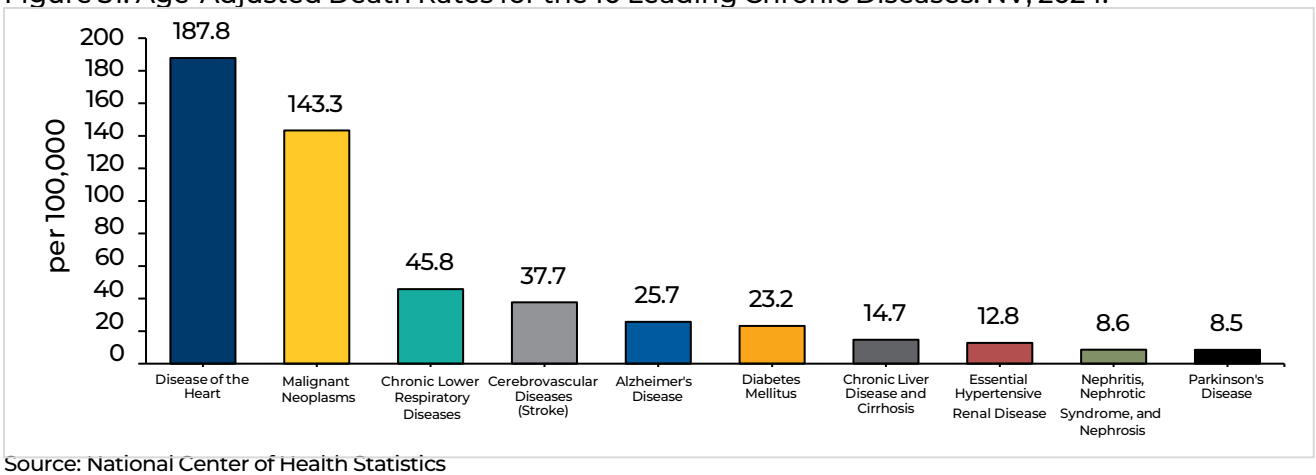


Source: Behavioral Risk Factor Surveillance System
Abbreviation: COPD (Chronic Obstructive Pulmonary Disorder), CHD (Coronary Heart Disease).

Chronic Disease Mortality

The two chronic diseases with the largest death rates are disease of the heart at 187.8 per 100,000 and malignant neoplasms at 143.3 per 100,000 (Figure 31 and Table S31). Diabetes was the 6th leading cause of death with 23.2 per 100,000 (Figure 31 and Table S31). Parkinson's disease had the lowest rates of death among the leading chronic diseases in Nevada at 8.5 per 100,000 (Figure 31 and Table S31).

Figure 31. Age-Adjusted Death Rates for the 10 Leading Chronic Diseases: NV, 2024.



Source: National Center of Health Statistics

FINDINGS and RECOMMENDATIONS

Annually, the Wellness and Prevention Program (WPP) gathers data on obesity and contributes to the comprehensive analysis of obesity rates in Nevada to comply with the regulatory requirements outlined in NRS 439.521. This report disseminates obesity statistics to the community and legislative bodies, including demographic details and the measures taken by DPBH to address obesity in Nevada, as well as the achievements made. WPP is responsible for reporting the collection of height and weight data from school districts in accordance with NRS 392.420. The limitations of the data used in this report are outlined on pages 5 and 6 to provide guidance for its independent use and application in other contexts. The prioritization of findings and recommendations is context-dependent and may vary based on a program's individual priorities.

Summary of Adult Obesity

- In 2024, Nevada surpassed the national average of 34.2% to 34.3% (Figure 2 and Table S2).
- Rural counties (Churchill, Douglas, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Pershing, Storey, and White Pine) have the highest prevalence of obesity at 37.9% (Figure 3 and Table S3).
- Since 2022, females are more likely to be obese than males (Figure 5).
- Among racial and ethnic categories, adult Hispanic (40.4%) and non-Hispanic Black (36.0%) experience the highest levels of obesity (Figure 6 and Table S6).
- The lowest three income categories ($0-$34,999) carried the highest prevalence of obesity (Figure 7 and Table S7).
- 49.1% of diabetics and 40.4% of individuals with coronary heart disease are obese. (Figure 30 and Table S30).

Summary of Youth Obesity

- 14–18-year-old females are more likely to be obese than males (Figure 13 and Table S13).
- 16.3% of 9th grade students were obese, which was the highest among all grades (Figure 14 and Table S14).
- Examination of racial/ethnicity categories found 40.4% of Native Hawaiian/Pacific

Islanders and 21.2% of American Indian/Alaska Natives to be obese (Figure 15 and Table S15).
- 30% of Clark and 27% of Washoe County school district students were overweight and obese (Figure 16, Table S16, Figure 20, and Table S20).
- Among WIC children, Carson City (209.2 per 10,000) saw the highest rates of obesity among children 2-5 years, whereas Clark County (780.0 per 10,000) saw the highest rates among 0–24-month-old children (Figure 24, Table S24, Figure 25, and Table S25).
- During the 2023-2024 school year, 9.7% of kindergartners were overweight and 21.7% were obese (Figure 28 and Table S28).

DPBH Activities

In 2025, DPBH partnered with various community organizations to create more effective programs and strategies promoting a healthy lifestyle.

- Conducted community outreach to build awareness of the Supplemental Nutrition Assistance Program Education (SNAP-Ed) and Women, Infants, and Children (WIC) programs.
- Collaborated with local health districts, partners, and experts in obesity prevention to promote Healthy Eating Active Living Nevada's (HealNV) 5-2-1-0 Program. This program emphasizes the importance of consuming five (5) or more servings of fruits and vegetables, limiting recreational screen time to two (2) hours or less, engaging in one (1) hour or more of physical activity, and avoiding sugary drinks altogether (0). In 2025, the primary focus was to incorporate 5-2-1-0 messaging within healthcare settings, ensuring respectful discussions regarding weight status and behaviors related to chronic disease prevention would be integrated into clinical practice. DPBH continued its initiatives to improve public awareness and outreach by refreshing the HealNV website and enhancing social media presence through YouTube, LinkedIn, Instagram, and Facebook.
- Managed state funds aimed at bolstering statewide food security strategies that enhance participation in state nutrition programs, improve access to nutrition programs and resources, and advance data collection for enhancing food security across Nevada.
- Engaged in the enhancement of the Standard Operating Procedures (SOP) for Collecting and Reporting Students' Height and Weight in Nevada Schools in collaboration with the Department of Education, Office of Analytics, and school nursing staff. The SOP assists school nurses, teachers, and licensed educational personnel in measuring student height and weight consistently.
- Collaborated with the University of Nevada, Reno – Extension and the statewide Early Childhood Education (ECE) providers to increase awareness of obesity prevention efforts and to enhance tools and resources to develop and install fruit and vegetable gardens. The goal is to give Nevada children access to programs/activities that teach and promote healthy behaviors, such as gardening and cooking.
- Partnered with the Nevada Institute for Children's Research and Policy's (NICRP) Early Childhood Health Lifestyle Workgroup, which is a statewide working group of community members whose singular goal is to reduce obesity and related comorbidities.
- Partnered with Health Districts in Nevada to support the development of obesity prevention programs.
    - The Northern Nevada Public Health District (NNPH) conducts health promotion activities

and conducts a walking school bus, a bike month, and senior physical activity program.
    - The Nevada Institute for Children's Research and Policy (NICRP) works to improve Caring for Our Children (CFOC) standards related to physical activity, nutrition, and breastfeeding as well as the creation and distribution of childhood obesity prevention materials.
    - The Southern Nevada Health District (SNHD) conducts diabetes referrals, prevention campaigns, and holds English and Spanish diabetes self-management education and support classes.
- The DPBH Cardiovascular Health Program contributed to obesity prevention through promoting the American Heart Association's "Life's Essential 8" framework, which includes key components directly related to healthy weight maintenance such as healthy diet, physical activity, and overall cardiovascular wellness. Through cardiovascular focused initiatives, program partners delivered nutrition and healthy eating education along with Dietary Approaches to Stop Hypertension (DASH) consultations. The program takes a comprehensive, evidence-based approach to supporting individuals in achieving and maintaining a healthy weight.
- The DPBH Diabetes Program coordinates several programs that help to manage diabetes symptoms and provide education for maintaining a healthy lifestyle. Sandford Center for Aging (SCA), Dignity Health, Carson Tahoe Health, and Roseman offer Diabetes Self-Management Education and Support (DSMES) programs and Diabetes Prevention Program (DPP) workshops. These programs provide support to people living with diabetes through healthy lifestyle education and diabetes management.

DPBH Recommendations

Demographics, environmental factors (healthy and affordable food, healthcare, housing, transportation, and economic stability) and health behaviors (lack of physical activity, improper diet, poor sleep, food access, medications, and stress) are all risk factors for obesity.[25] Once an individual becomes obese, risk of developing high blood pressure, type two (2) diabetes, breathing problems, osteoarthritis, gallstones, high cholesterol, heart disease, cancer, and mortality increases.[26]

General Recommendations

To bolster prevention, awareness, and management strategies, several recommendations are identified for Nevada to mitigate the effects of obesity and address the root cause.

- BMI Tools: The BMI method is an effective resource for organizations of all sizes to adequately use to evaluate obesity prevalence and risk of chronic diseases. Despite the tool not giving the complete understanding of obesity, it can assist in treatment plans, identifying the root cause, and develop prevention programs.
- Understanding Comprehensive Obesity Data: There is need for more comprehensive data in Nevada encompassing sociodemographic factors, waist circumference, blood tests, dietary logs, blood pressure, muscle mass assessments, and medical history. This approach may be advantageous as it will enable agencies to tailor preventive programs according to the primary causes of obesity within the population.
- Improving the food environment: Food deserts, food swamps, and food insecurity may increase the likelihood of obesity.[27-29] In Nevada, 15% of people do not have enough food, and 40 of its census areas are labeled as food deserts. [30-31] Thirty percent (30%) of the

population in Washoe County and 19% in Clark County have limited access to grocery stores.[32] Washoe County has 383 (0.80 per 1,000 people) fast food restaurants while Clark County has 2,065 (0.89 per 1,000 people) and in the U.S. 1 out of 3 individuals eat fast food on any day.[33-34]

- Policy Research: Given the negative impact of food swamps (areas with high densities of fast food compared to supermarkets), it's necessary to conduct ongoing research to identify policy solutions. Promoting dietary guidelines and knowledge is crucial, but due to the low consumption of essential foods, the barriers to meeting dietary recommendations in Nevada needs to be further explored. For instance, only 16% of total grain consumption comes from whole grains, and the U.S. population is only reaching about 80% of the recommended vegetable and 40% of fruit intake.[35-36]
- Physical Exercise: Participating in physical exercise is a crucial element in combating obesity. Estimates indicate that merely 26% of adolescents fulfill the aerobic activity recommendations, whereas only 24% of adults comply with the guidelines for physical activity and muscle strengthening.[37] In Nevada, 26% of the population claims to be inactive, slightly exceeding the national average.[38] Continuing efforts to create and maintain educational programs that emphasize the value of physical activity is crucial. Providing tips and maps to locate parks, trails, or other exercise areas can be an effective approach. Additionally, enhancing access to recreational facilities, parks, and trails has proven to boost overall physical activity.[39]
- Reducing Stigma: Stigmatization is associated with negative health outcomes. The reduction or elimination of stigma may help individuals with obesity attend preventative care, discuss the issues they are facing, and participate in physical activity. In the U.S., 52% of overweight individuals felt stigmatized by their doctor.[40] Individuals who face weight bias are at increased risk of weight gain and experiencing disordered eating.[41-42] Additionally, obesity stigmatization is associated with an 60% increased risk of mortality.[43] Of the general population, 68% do not consider obesity as a disease and 49% said genetics plays a role in obesity.[44] In the media, around 72% of the top teen shows included weight teasing and 57% of tweets with the word fat were negative. [45]
- Increase Nutrition Education for Supplemental Nutrition Assistance Program (SNAP) Participants: SNAP is focused on helping low-income individuals and households purchase food. SNAP improves access to affordable food, improves health, and decreases healthcare costs compared to eligible non-participants.[46] SNAP found participants to have lower healthy eating index scores, consume fewer fruits and vegetables, have a higher sugar intake, and experience more cases of diabetes and obesity.[47] Therefore, SNAP participation needs more awareness built around physical activity, nutrient dense foods, and how to prepare/cook healthy meals.
- Increase awareness of the Women, Infants, and Children (WIC) Program: WIC supports low-income pregnant, postpartum, and breastfeeding women, infants, and children up to age 5.[48] WIC improves birth outcomes, infant mortality, cognitive development, and overall diet.[49-50]

Specific Recommendations

- For the first time in a decade, Nevada adult obesity rates reached 34.3%, surpassing the national average of 34.2% suggesting the need for a more robust obesity prevention strategy across the state. Further assessments may be needed to understand what has changed and resource allocation.

- In Nevada, for the last two years, rural counties have led the state with the highest prevalence of obesity, demonstrating the need for improved obesity prevention strategies in rural communities. This may include policy development to enhance the food environment and improve access to healthy and nutritious food.
- Comparison of obesity by sex found both female adults and children to have higher rates of obesity compared to their male counterparts. To further comprehend this difference, a more complex data analysis will need to be conducted to understand the reasons behind this difference, which may include hormonal changes, weight stigma, and/or body composition. Based on these results, educational materials may need to be geared towards females.
- Examination of race and ethnicity found adult Hispanics to have the highest rates of obesity at 40.4% followed by African Americans at 36%. Among children aged 14-18 years old, Native Hawaiian/Pacific Islander were the highest at 40.4% and American Indian/Alaska Natives at 21.2%. This shows a necessity for greater obesity prevention strategies among minority populations and may require agencies and organizations to develop programs based on cultural relevance.
- In Nevada, individuals earning less than $35,000 have the highest rates of obesity. In addition, those with less than a high school diploma (40.4%) is more likely to be obese than college graduates (28.6%). This conveys the need for improved nutritional education at a younger age and the potential for a policy solution to reduce food costs, which may include sourcing food locally.
- Most individuals with coronary heart disease, chronic obstructive pulmonary disease, diabetes, heart attacks, and strokes are overweight or obese. This may indicate the need for the integration of obesity prevention and management into chronic disease management programs.
- The Maternal Mortality Review Committee (MMRC) analyzed data from 2022-2023 and found 33.1% of severe maternal mortality cases were obese and 23.9% were overweight.[51] Furthermore, four (4) of the thirty-nine (39) deaths analyzed by the committee were attributed to obesity an additional three (3) as probable.[51] Based on these results and statewide obesity rates, the committee recommended the following:
    - “Health systems and payers should be incentivized to address upstream determinants of poor outcomes, such as extreme morbid obesity.”
    - “Providers and facilities should ensure that obese patients are counseled about weight management, risk of morbid obesity, and available treatment modalities, and these be documented in the medical record.”
    - “Providers should diagnose and treat medical conditions in obese individuals, rather than attributing all symptoms/signs to obesity and provide training for providers in motivational interviewing.”

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APPENDIX

Supplementary Tables

Table S1, related to Figure 1. Prevalence of Childhood (2-19 years) and Adult (≥20 years) Obesity: United States, 2011-2012 to August 2021-2023.

Year	Adult Obesity* (%)	Adult Severe Obesity* (%)	Childhood Obesity * (%)	Childhood Severe Obesity* (%)
2011-2012	**34.9**	**6.4**	**16.9**	**5.6**
2013-2014	**37.7**	**7.7**	**17.2**	**6.0**
2015-2016	**39.6**	**7.7**	**18.5**	**5.6**
2017-March 2020**	**41.9**	**9.2**	**19.7**	**6.7**
August 2021-August 2023	**40.3**	**9.7**	**21.1**	**7.0**

Source: National Health and Nutrition Examination Survey
*Values are age-adjusted
**Data from the partial 2019–2020 cycle (March 2020) were combined with 2017–2018 data for nationally representative estimates.

Table S2, related to Figure 2. Prevalence of Adult Obesity: Nevada and the United States, 2014–2024.

Year	Nevada (%)	U.S. (%)
2014	27.7	29.6
2015	26.7	29.8
2016	25.8	29.9
2017	26.7	31.3
2018	29.5	30.9
2019	30.6	32.1
2020	28.7	31.9
2021	31.3	33.9
2022	33.5	33.6
2023	30.8	32.8
2024	34.2	33.1

Source: Behavioral Risk Factor Surveillance System
Abbreviation: U.S. (United States)

Table S3, related to Figure 3. Prevalence of Adult Obesity, by Nevada Region: 2015–2024.

Year	Nevada (%)	Clark (%)	Washoe (%)	Carson City (%)	Rural (%) *
2015	26.7	27.0	21.4	27.1	29.4
2016	25.8	24.8	26.3	29.8	32.3
2017	26.7	26.7	25.5	29.5	29.6
2018	29.5	30.9	23.8	34.9	29.5
2019	30.6	30.6	31.9	26.6	29.5
2020	28.7	28.8	25.2	37.4	32.4
2021	31.3	31.6	28.2	32.9	34.8
2022	33.5	34.3	30.4	35.6	32.7
2023	30.8	28.9	34.0	33.7	38.6
2024	31.8	35.2	28.1	30.1	37.9

Source: Behavioral Risk Factor Surveillance System
*Rural area defined as Churchill, Douglas, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Pershing, Storey, and White Pine.

Table S4, related to Figure 4. Prevalence of Adult Obesity, by Age Group: NV, 2014 – 2024.

Year	18-24 years	25-34 years	35-44 years	45-54 years	55-64 years	65+ years
2014	12.7	29.7	36.8	28.9	25.6	27.6
2015	–	29.6	26.5	35.6	29.4	23.9
2016	16.9	24.8	24.8	30.7	29.3	25.7
2017	17.4	28.9	25.3	32.6	27.4	25.0
2018	10.2	29.6	34.2	37.6	31.3	28.0
2019	17.7	29.8	34.8	35.5	33.4	28.6
2020	19.8	22.8	25.7	35.6	36.9	28.9
2021	21.0	31.8	35.9	39.9	33.1	25.1
2022	21.0	32.2	35.8	39.9	33.2	25.3
2023	18.8	28.6	35.4	37.8	36.2	26.4
2024	22.3	31.2	40.5	42.3	36.9	30.0

Source: Behavioral Risk Factor Surveillance System
-Data not available

Table S5, related to Figure 5. Prevalence of Adult Obesity, by Sex: NV, 2014-2024.

Year	Male (%)	Female (%)
2014	29.9	25.4
2015	27.9	25.4
2016	25.8	25.8
2017	26.3	27.1
2018	29.7	29.2
2019	31.9	29.2
2020	30.4	27.0
2021	33.1	29.4
2022	31.9	35.3
2023	29.8	31.8
2024	33.7	34.8

Source: Behavioral Risk Factor Surveillance System

Table S6, related to Figure 6. Prevalence of Adult Obesity, by Race/Ethnicity: NV, 2015–2024.

Year	AI/AN* (%)	Asian* (%)	Black* (%)	Multiracial* (%)	NHPI* (%)	White* (%)	Hispanic (%)
2015	16.8	-	26.1	24.8	-	25.9	35.2
2016	35.6	14.9	27.6	26.9	54.4	26.3	26.5
2017	49.4	23.9	33.0	38.9	32.9	25.0	26.1
2018	28.7	14.6	43.4	21.2	37.8	27.2	33.5
2019	44.0	20.8	38.3	27.4	-	28.3	34.9
2020	52.9	6.2	27.6	17.2	31.5	31.0	31.2
2021	-	15.6	32.7	21.6	15.6	31.0	36.5
2022	-	26.4	36.8	34.0	-	31.8	36.9
2023	-	20.0	39.6	33.2	-	29.9	33.4
2024	-	21.3	36.0	35.1	-	32.3	40.4

Source: Behavioral Risk Factor Surveillance System
Abbreviations: AI/AN (American Indian/Alaska Native), NH/PI (Native Hawaiian/Pacific Islander)
*non-Hispanic
-Indicates values suppressed due to small sample sizes.

Table S7, related to Figure 7. Prevalence of Adult Obesity, by Income: NV, 2014 – 2024.

Year	<$15,000 (%)	$15,000-$24,999 (%)	$25,000-$34,999 (%)	$35,000-$49,999 (%)	$50,000-$99,999 (%)	$100,000-$199,999 (%)	≥$200,000 (%)
2014	36.7	27.5	27.9	28.7	-	-	-
2015	33.3	25.7	31.9	28.7	-	-	-
2016	28.1	29.3	29.1	26.2	-	-	-
2017	27.2	29.2	28.5	29.7	-	-	-
2018	41.3	27.9	34.6	32.8	-	-	-
2019	39.8	34.8	32.5	35.5	-	-	-
2020	36.4	26.6	40.2	29.4	-	-	-
2021	37.8	37.8	39.0	30.8	31.2	27.9	28.0
2022	33.6	32.8	42.5	36.8	33.0	36.5	35.5
2023	27.7	25.1	26.6	37.5	32.8	33.4	31.3
2024	49.1	38.7	44.2	36.3	35.8	37.7	24.3

Source: Behavioral Risk Factor Surveillance System
-Missing values are due to a change in reporting after the 2020 cycle.

Table S8, related to Figure 8. Prevalence of Adult Obesity, by Education: NV, 2014–2024.

Year	<H.S. (%)	H.S. or G.E.D. (%)	Some post-H.S. (%)	College Graduate (%)
2014	36.7	27.5	27.9	28.7
2015	33.3	25.7	31.9	28.7
2016	28.1	29.3	29.1	26.2
2017	27.2	29.2	28.5	29.7
2018	41.3	27.9	34.6	32.8
2019	39.8	34.8	32.5	35.5
2020	36.4	26.6	40.2	29.4
2021	37.8	37.8	39.0	30.8
2022	33.6	32.8	42.5	36.8
2023	28.4	30.7	34.5	26.9
2024	40.4	35.9	34.9	28.6

Source: Behavioral Risk Factor Surveillance System
Abbreviations: H.S. (High School), G.E.D. (General Education Development)

Table S9, related to Figure 9. Distribution of BMI by Maternity Status: Nevada, 2024.

Year	Veteran (%)	Non-Veteran (%)
2022	31.1	34.0
2023	28.8	31.2
2024	31.6	34.7

Source: Behavioral Risk Factor Surveillance System

Table S10, related to Figure 10. Distribution of BMI by Maternity Status: Nevada, 2024.

Response	Underweight (%)	Normal (%)	Overweight (%)	Obese (%)
Yes*	-	-	-	-
No	2.9	34.1	26.2	36.8

Source: Behavioral Risk Factor Surveillance System
*Insufficient responses for statistical analysis.

Table S11, related to Figure 11. Prevalence of Pre-Pregnancy Obesity by Region: Nevada, 2024.

Region	Overweight (%)	Obese (%)
Nevada	27.7	31.8
Carson City	27.6	33.2
Clark	27.5	31.0
Elko	26.8	34.9
Lyon	26.3	37.1
Nye	23.1	36.9
Washoe	29.2	34.2
Rural*	29.8	33.3

Source: Nevada Office of Vital Statistics
*Rural area defined as Churchill, Douglas, Esmeralda, Eureka, Humbolt, Lander, Lincoln, Mineral, Pershing, Storey, and White Pine.

Table S12, related to Figure 12. Prevalence of Obesity in Youth Aged 14 to 18: Nevada and United States, 2015-2025.

Year	NV (%)	U.S. (%)
2015	12.1	13.9
2017	14.1	14.8
2019	13.4	15.5
2021	15.9	16.3
2023	15.0	15.9
2025	15.0	-

Source: Youth Risk Behavior Surveillance System
Abbreviation: NV (Nevada), U.S. (United States)
-2025 data for the entire U.S. population is currently unavailable.

Table S13, related to Figure 13. Prevalence of Youth Obesity, Age 14 to 18, by Sex: Nevada, 2015-2025.

Year	Male (%)	Female (%)
2015	13.3	10.8
2017	12.8	15.4
2019	13.6	13.3
2021	15.8	16.1
2023	14.9	15.1
2025	14.2	15.8

Source: Youth Risk Behavior Surveillance System

Table S14, related to Figure 14. Prevalence of Youth Obesity, by Grade Level: Nevada, 2015-2025.

Year	9th Grade (%)	10th Grade (%)	11th Grade (%)	12th Grade (%)
2015	12.3	12.4	12.3	10.7
2017	13.6	13.0	14.1	15.7
2019	13.3	13.3	11.6	15.8
2021	18.2	14.9	13.9	17.0
2023	17.1	15.2	12.6	15.1
2025	16.3	15.2	15.4	12.6

Source: Youth Risk Behavior Surveillance System

Table S15, related to Figure 15. Prevalence of Obesity in Youth Aged 14-18, by Race/Ethnicity: Nevada, 2015-2025.

Year	AI/AN* (%)	Asian* (%)	Black* (%)	NH/PI* (%)	White* (%)	Hispanic (%)	Other/Multiple* (%)
2015	11.5	4.7	13.6	22.5	8.7	15.5	10.8
2017	22.2	8.5	12.0	13.5	11.0	17.9	12.8
2019	14.3	7.3	14.5	20.3	10.2	16.7	12.2
2021	32.7	6.8	19.5	32.0	11.0	19.3	12.8
2023	19.2	6.7	20.1	18.0	10.5	18.1	13.3
2025	21.2	6.6	15.2	40.4	11.6	18.0	11.0

Source: Youth Risk Behavior Surveillance System
Abbreviation: AI/AN (American Indian/Alaska Native), NH/PI (Native Hawaiian/Pacific Islander)
*non-Hispanic

Table S16, related to Figure 16. Distribution of Body Mass Index Categories Among Youth in Grades 4th, 7th, and 10th: Clark County School District, August 2023-June 2024 School Year

Underweight (%)	Healthy (%)	Overweight (%)	Obese (%)
2	68	17	13

Source: Clark County School District

Table S17, related to Figure 17. Prevalence of Overweight and Obesity Among Youth by Grade: Clark County School District, August 2023-June 2024 School Year.

Categories	4th (%)	7th (%)	10th (%)	Overall (%)
Overweight	15.6	17.7	11.7	16.6
Obese	11.3	14.9	19.5	13.1

Source: Clark County School District

Table S18, related to Figure 18. Prevalence of Obesity Among Youth in Grades 4th, 7th, and 10th, by Sex: Clark County School District, August 2023-June 2024 School Year.

Sex	4th (%)	7th (%)	10th (%)	Overall (%)
Male	9.9	13.1	20.9	11.56
Female	12.7	16.8	17.6	14.75

Source: Clark County School District

Table S19, related to Figure 19. Prevalence of Obesity Among Youth in Grades 4th, 7th, and 10th by Race: Clark County School District, August 2023-June 2024 School Year.

Race/Ethnicity	4th (%)	7th (%)	10th (%)	Overall (%)
White*	7.2	9.9	20	8.5
Black*	10.2	14.3	23.8	12.28
A/PI*	6.3	7.3	33.3	6.85
Other*	9.2	12.4	-	10.73
Hispanic	14.2	18.4	16.1	16.35

Source: Clark County School District
Abbreviation: A/PI (Asian/Pacific Islander)
Missing bars indicate data not available.
*non-Hispanic

Table S20, related to Figure 20. Distribution of Body Mass Index Categories Among Youth in Grades 4th, 7th, and 10th: Washoe County School District, August 2023-June 2024 School Year.

Underweight (%)	Healthy (%)	Overweight (%)	Obese (%)
4%	69%	15%	12%

Source: Washoe County School District

Table S21, related to Figure 21. Prevalence of Overweight and Obesity Among Youth by Grade: Washoe County School District, August 2023-June 2024 School Year.

Categories	4th (%)	7th (%)	10th (%)	Overall (%)
Overweight	14.6	15.7	13.6	14.7
Obese	10.7	11.8	22.7	12.4

Source: Washoe County School District

Table S22, related to Figure 22. Prevalence of Obesity Among Youth in Grades 4th, 7th, and 10th, by Sex: Washoe County School District, August 2023-June 2024 School Year.

Sex	4th (%)	7th (%)	10th (%)	Overall (%)
Male	7.5	11.1	12.9	8.81
Female	16.1	13.3	46.2	19.01

Source: Washoe County School District

Table S23, related to Figure 23. Prevalence of Obesity Among Youth in Grades 4th, 7th, and 10th, by Race/Ethnicity: Washoe County School District, August 2023-June 2024 School Year.

Race/Ethnicity	4th (%)	7th (%)	10th (%)	Overall (%)
White*	3.1	10	15.8	5.88
Black*	18.2	50	-	20
AP/PI*	-	-	-	-
Other*	17.9	16.7	40	22.7
Hispanic	14.9	8.7	21.4	14.57

Source: Washoe County School District
Missing bars indicate data not available.
*non-Hispanic

Table S24, related to Figure 24. Prevalence of Obesity Among WIC-Enrolled Children Aged 2 to 5 Years (Risk Code 115) by County: Nevada, 2024-2025.

Region	Risk Code 113 (per 10,000)
Nevada	151.9
Carson City	209.2
Clark	157.4
Washoe	112.4
Rural*	77.0

Source: Women Infants, and Children
*Rural area defined as Churchill, Douglas, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Pershing, Storey, and White Pine.

Table S25, related to Figure 25. Prevalence of High Weight for Length WIC-Enrolled Children Aged 0-24 Months (Risk Code 115) by County: Nevada, 2024-2025.

Region	Risk Code 115 (per 10,000)
Nevada	729.6
Carson City	543.9
Clark	780.0
Washoe	479.9
Rural*	619.5

Source: Women, Infants, and Children
*Rural area defined as Churchill, Douglas, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Pershing, Storey, and White Pine.

Table S26, related to Figure 26. Rate of Nevada WIC-Enrolled Adult Women with Diabetes by County: Nevada, 2024-2025.

Region	Diabetes (per 10,000)	Gestational Diabetes (per 10,000)
Nevada	175.7	194.4
Carson City	209.8	209.8
Clark	186.3	199.9
Washoe	130.1	171.7
Rural*	159.8	168.7

Source: Women, Infants, and Children
*Rural area defined as Churchill, Douglas, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Pershing, Storey, and White Pine.

Table S27, related to Figure 27. Rate of Nevada WIC-Enrolled Adult Women with Obesity by County: Nevada, 2024-2025.

Region	Pre-pregnancy Obesity (per 10,000)	Obesity During Pregnancy (per 10,000)	Postpartum Obesity (per 10,000)
Nevada	2166.3	4219.3	5968.5
Carson City	2191.1	4149.2	5571.1
Clark	2259.1	4309.7	6155.0
Washoe	1912.6	3879.8	5373.4
Rural*	2059.5	4021.3	5020.0

Source: Women, Infants, and Children
*Rural area defined as Churchill, Douglas, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Pershing, Storey, and White Pine.

Table S28, related to Figure 28. Distribution of Body Mass Index Categories Among Kindergartners: NV, 2014-2023.

School Year	Underweight (%)	Healthy Weight (%)	Overweight (%)	Obesity (%)
2014-2015	16.1	52.4	9.8	21.7
2015-2016	15.5	52.5	10.6	21.4
2016-2017	16.8	50.6	12.1	20.5
2017-2018	17.1	51.6	10.1	21.2
2018-2019	17.2	51.2	10.7	20.9
2019-2020	17.3	50.3	11.1	21.3
2020-2021	19.5	48.6	13.2	18.7
2021-2022	16.2	50.7	10.9	22.2
2022-2023	15.6	51.3	10.7	22.5
2023-2024	16.3	52.3	9.7	21.7

Source: Nevada Institute for Children's Research and Policy: Kindergarten Health Survey

Table S29, related to Figure 29. Prevalence of Chronic Disease: Nevada and the United States, 2024.

Disease	Nevada (%)	U.S. (%)
Obesity	34.2	33.1
Arthritis	33.1	34.0
Asthma	11.6	14.3
Cancer	8.7	8.7
COPD	6.7	8.0
Diabetes	21.9	20.8
Heart Disease	4.5	5.2
Kidney Disease	4.7	5.1
Stroke	4.6	4.1

Source: Behavioral Risk Factor Surveillance System
Abbreviation: U.S. (United States)

Table S30, related to Figure 30. BMI Distribution of Chronic Disease: Nevada, 2024.

Disease	Underweight (%)	Normal (%)	Overweight (%)	Obese (%)
CHD	2.5	16.1	41.0	40.4
COPD	2.5	25.9	37.3	34.3
Diabetes	1.8	16.5	32.6	49.1
Heart Attack	0.9	26.9	37.7	34.6
Stroke	2.3	32.1	29.3	36.4

Source: Behavioral Risk Factor Surveillance System
Abbreviation: CHD (coronary heart disease), COPD (Chronic Obstructive Pulmonary Disease)

Table S31, related to Figure 31. Age-Adjusted Death Rates for the 10 Leading Chronic Diseases: Nevada, 2024.

Chronic Disease	Deaths per 100,000
Disease of the Heart	187.8
Malignant Neoplasms	143.3
Chronic Lower Respiratory Diseases	45.8
Cerebrovascular Diseases (Stroke)	37.7
Alzheimer's Disease	25.7
Diabetes Mellitus	23.2
Chronic Liver Disease and Cirrhosis	14.7
Essential Hypertensive Renal Disease	12.8
Nephritis, Nephrotic Syndrome, and Nephrosis	8.6
Parkinson's Disease	8.5

Source: National Center for Health Statistics