

# Preventing Childhood Obesity through State Policy: Qualitative Assessment of Enablers and Barriers

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## ABSTRACT

As the prevalence of obesity rapidly climbs among youth in the United States, public health practitioners and policymakers seek effective means of slowing and reversing these trends. Recently, many state laws and regulations addressing childhood obesity have been introduced and enacted. Understanding determinants of such legislation may inform the development and passage of future policies. For this study, key-informant interviews were conducted with 16 legislators and staffers from 11 states in 2005–2006 to examine qualitative factors that enable and impede state-level childhood obesity prevention legislation. Commonly cited factors positively influencing the passage of childhood obesity prevention legislation included national media exposure, introduction of the policy by senior legislators, and gaining the support of key players including parents, physicians, and schools. Noteworthy



barriers included powerful lobbyists of companies that produce unhealthy foods and misconceptions about legislating foods at schools. Although the total number of informants was modest, their valuable insights provide policymakers and practitioners with a set of enablers and barriers to be considered when pursuing state-level policy.

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#### INTRODUCTION

The prevalence of overweight and obesity in children is rapidly increasing in the United States. Recent estimates suggest that 17% of children aged 2–19 years are overweight (defined by having a body mass index at or above the 95th percentile for US children of same sex and age) (1). As childhood obesity continues to climb, researchers, public health practitioners, and policymakers seek effective means of improving energy balance (i.e., calories consumed equal to calories expended) and reducing the prevalence of obesity among youth in the United States. Although solutions are multifaceted, the utility of policy interventions to address rising obesity trends is widely touted by researchers (2–4). In particular, policies hold potential because of their ability to expand upon individual effects to influence entire populations. In this way, they might offer one of the most efficient means of improving and protecting public health (3,5,6).

Individual states retain much of the power to influence policies and regulations in the United States (7). Through legislative and regulatory actions, state governments are able to wield substantial power over specific actions that affect public health (7). In recent years, many state laws and regulations focusing on childhood obesity have been introduced. For example, between 2003 and 2005, over 230 pieces of legislation addressing school nutrition standards and vending machines, and over 190 addressing physical education and physical activity, were introduced at the state level (8). Table 1 provides a sample typology of common types of state legislation related to childhood obesity that have been recently introduced.

Table 1: Common childhood obesity prevention legislation topic areas and potential stakeholders\*

<i>Topic area</i>	<i>Description</i>	<i>Examples of potential stakeholders</i>
<i>Nutrition</i>		
School nutrition and vending standards	Provide students with nutritional food and beverage items. Restrict access to vending machines and competitive foods. Regulate marketing of foods and beverages with minimal nutritional value. Report nutritional information and vending machine revenue.	School boards and administrators Parents Teachers Vendors School cafeteria/food services
Farmers' markets	Support and make appropriations for farmer's market initiatives. Promote the use of locally grown nutritious foods in school systems.	Neighborhood associations Community residents Parents Teachers Agriculture departments
Soda and snack tax	Increase or establish a tax on snack and soft drink items. May use revenue to promote nutrition and health in schools.	School boards and administrators Vendors School groups Parents Local city officials
Restaurant menu and product labeling	Regulates the labeling of nutrition content on food items. Requires restaurants to post nutritional information on menus/boards.	Business owners Restaurant associations Patrons Local health department leaders Tourist bureaus

Table 1 (continued)

<i>Topic area</i>	<i>Description</i>	<i>Examples of potential stakeholders</i>
<i>Physical activity</i>		
Physical education and physical activity	Ensure schools have a physical education program. Set time and frequency requirements for physical education classes. Restrict substitutions and waivers for physical education. Promote physical activity in other classes.	School boards and administrators Parents Teachers Coaches
Curriculum for health and physical education classes	Govern changes to the state's curriculum relating to health, nutrition, and physical education. Require set amount of physical education per week. Establish graduation requirements.	School boards and administration Parents Teachers Public health professionals Doctors/nurses
Safe routes to school	Provide bicycle facilities (such as paths), sidewalks, crossing guards, and traffic-calming measures to enable children to bicycle or walk safely to school.	City planners Transportation departments School administrators Parents Local police department Community residents
Walking and biking paths	Support physical activity (through appropriation and regulations) by creating or maintaining bicycle trails, walking paths, and sidewalks. Promote bicycle and pedestrian safety.	City planners Community residents Business owners Land use and transportation planners Local police departments

\* Adapted from Boehmer *et al* (8).

In 2006, Schmid *et al.* proposed a framework for physical activity policy research that provides a useful means of conceptualizing policy research in general (4). Specifically, the framework suggests that researchers (1) identify policies, (2) examine determinants of policies, (3) study the development and implementation of policies, and (4) evaluate outcomes of policies. Previous work, which addressed the first two phases of this framework, described patterns in childhood obesity prevention legislation and used quantitative methods to identify several determinants of enacting legislation, such as bipartisan sponsorship, introduction in the senate, and amendments to existing bills, as well as state-level factors such as a 2-year legislative session and Democratic control of both legislative chambers (8,9). Building on those efforts, this paper focuses on the second and third phases of the framework and relies upon qualitative research methods to further explore the determinants and development of legislation to prevent childhood obesity.

The process of policy formation is complex and poorly understood by researchers (10,11). Because of this gap and the rich information about the political process potentially available through conversations with policymakers, this study utilized key-informant interviews (12). Key informants included both legislators and staffers. Legislative staffers often have a great deal of influence in forming the priorities of an elected official. This influence is observed in three key, interrelated areas: gathering information, setting the agenda, and crafting the specific legislative proposals (13). According to Kingdon, the policy process comprises three primary streams: problems, policies, and politics (14). The study of these streams and their participants may help researchers understand, communicate, and collaborate with policymakers.

This study sought to use lessons learned from state policymakers to improve understanding of the link between public health research and policy, and to inform the development and passage of future policies aiming to reduce the prevalence of childhood obesity.

#### METHODS

The research team conducted key-informant interviews among state-level policymakers representing a variety of political climates.

States were selected with consideration of geographic location, adult obesity prevalence, and dominant political party during 2003–2005. Within states, leaders in obesity policy were identified by their history of introducing or sponsoring legislation related to childhood obesity prevention. A goal of 10–20 completed interviews was set to achieve content saturation (i.e., when similar comments are consistently repeated by key informants).

Trained interviewers conducted key-informant interviews by initially contacting legislators' staff via telephone, explaining the research project, and requesting an appointment during which the interviewer might speak with the legislator or staffer for approximately 20 min. Interviewers made at least three attempts to reach each participant. The purpose of a key-informant interview is to obtain descriptive data in an informal manner, often through a conversation between one respondent and one interviewer. The respondent typically has special knowledge or insight that may assist researchers in understanding information or observations in unfamiliar settings. Frequently, respondents are expected to respond to previously determined, structured, open-ended questions (15). The interviewers used a script to conduct one-on-one, semi-structured telephone interviews that included three demographic questions regarding the legislators' educational backgrounds and legislative responsibilities, followed by eight open-ended questions regarding their experience with childhood obesity legislation (16). The research team designed and revised the interview questions to meet the study objectives.

Interviews were completed between December 2005 and April 2006. Interviewers received oral consent from participants to tape record all interviews. The average interview administration time was 26 min (range, 17–60 min). All tape recordings were transcribed verbatim. Two independent coders then systematically analyzed the transcripts using focused coding qualitative techniques (17). This use of focused coding enabled coders to analyze transcripts using the same set of thematic categories (Table 2). The research team predetermined these categories in accordance with primary research aims. To ensure accuracy, a subsample of coding was conducted in duplicate ( $n = 6$ ). Only minimal discrepancies in coding were discovered; these were easily resolved, resulting in high inter-rater agreement (86%) (18).

Table 2: In the words of policymakers: Primary factors affecting the passage of state-level legislation to prevent childhood obesity

# Times cited	Thematic categories	Policymaker/staffer remarks
<i>“In your view, what factors support or facilitate the introduction and adoption of childhood obesity prevention legislation?”</i>		
16	Gaining support or involvement of key players	“It’s easier to pass if you’ve had a broad group of individuals working on the actual language of the bill, what needs to be included in the bill, rather than someone saying, ‘Oh, this is a great idea. Let me sit down and write a bill about it.’ But the more people you involve, the more buy-in that you get, the stronger the coalition that you have supporting it, certainly the easier it’s going to be to pass it.”
6	National media exposure	“Well I think, I guess I would say that there’s been much more in the media about the need to rethink ... obesity and what we need to be doing, particularly for children, because there is this tremendous increase in obesity. And so I think that there’s been much more attention through the media so that I think people are beginning to rethink what they’re doing. So I think that’s been helpful, though it seems to come in waves so it’s not always consistent. But I do think that the more we see of that in the media and the more we understand the need to be addressing this issue that, I think, can be very helpful in pushing legislation forward.” “[Which bills pass] depends on what makes it into the media.”
4	Political climate	“The politics were working against us in those early years. And the politics were working against us even in a Democratic-controlled legislature, in which the Assembly Health Committee was, for a period of time, the greatest challenge to good health policy ... And then a couple of years later, all of those legislators embarked upon their own [health] initiatives as a result of the political wake-up call in their district.”

Table 2 (continued)

# Times cited	Thematic categories	Policymaker/staffer remarks
3	Introduction by senior legislators and those with strong personal interest	“We said that we need to do something about the obesity issue instead of just inform the public ... We just did basic fundamental thinking of, what can we do to help? And then: what can we do that will pass?”
<i>“In your view, what factors oppose or inhibit the introduction and adoption of childhood obesity prevention legislation?”</i>		
9	Lobbyists for manufacturers of unhealthy foods and beverages*	“You can’t blindside the lobbyists ... I had this one ... bill, we had as many lobbyists in the room as legislators ... Lobbyists are there. They get paid and they can watch things a lot more carefully than public interest groups, which are not as well-funded.”
9	Misconceptions about the problem and proposed solutions*	“Representatives who voted no [on school junk food bill indicated] that their schools had encouraged them to vote no. Some of them implied that soft drink companies had put pressure on them as well. But most of them, even the ones who said they got pressure from the soda companies, all of them mentioned pressures from their school districts they represented, saying that their school districts feared they would lose money.”
6	Program costs	“Always, in any legislative meeting, there’s always somebody that will pop up and say, ‘What’s this going to cost us?’ ... So I think that the monetary issue is the most important to some people and the medical issue is the most important to other people. And in this instance [policy to reduce childhood obesity] both groups can benefit.”

\* Specific to childhood obesity.

## RESULTS

Of 48 interview attempts, 16 were successfully completed with policymakers representing 11 states (Arkansas, California, Connecticut, Illinois, Maine, Massachusetts, Nevada, New Hampshire, South Carolina, Texas, and Washington). As designed, the states varied by political party (six Democratic, three Republican, and three split party), obesity prevalence (four low, four mid, and three high by tertiles), and geographic region (three West, one Midwest, three South, and four Northeast). Among the 16 participants, there were six staffers and 10 legislators; 80% were members of the Democratic Party. Approximately 20% of participants reported a formal health-related educational background; law and education were the most common. Participants reported working in or with the state legislature for a median of 12 years (range, 4–21 years).

Participants described a variety of legislative responsibilities and committee affiliations. Six participants indicated service with Health and Human Service Committees, and four legislators reported serving as Chair of this committee in their states. Three participants served on Public Health committees, one of whom was Chair. Two participants served on Judiciary Committees, and six reported service to various education committees, including several K-12 subcommittees.

The following results of the focused coding analysis are organized according to the primary themes of the key-informant interviews. Even with a modest number of informants, the responses were sufficient to identify common themes, which are presented in order of the frequency with which they were mentioned. Quotations from participants are also included where appropriate (Table 2).

*Enablers*

To introduce a discussion about enablers, participants were asked, “In your view, what factors support or facilitate the introduction and adoption of childhood obesity prevention legislation?” All 16 participants cited gaining the support or involvement of stakeholders to participate in the process of considering, drafting, and adopting childhood obesity prevention legislation as a significant enabler (Table 2). Specifically, participants described working with parents,

physicians, schools, community members, and health departments to address childhood obesity successfully through legislation.

The next most commonly cited enabler was national media exposure of the issue. This was closely followed by the importance of timing in the introduction of legislation. Specifically, many cited the considerable role of the political climate (e.g., majority party, committee assignment, legislature's relationship with state agencies) in determining how legislative efforts are received by governing bodies. Finally, three participants mentioned the advantages that accompany childhood obesity prevention legislation when it is introduced by senior legislators, as well as by legislators with a strong personal interest who are willing to work creatively to address the problem of childhood obesity.

### *Barriers*

Similarly, participants were invited to discuss barriers with the question, "In your view, what factors oppose or inhibit the introduction and adoption of childhood obesity prevention legislation?" Over half of participants discussed the difficulties posed by powerful lobbyists representing manufacturers of unhealthy foods and beverages (Table 2). The second most commonly cited barrier was misinformed constituents. Specifically, participants discussed the pervasive fears and misconceptions in many schools regarding negative outcomes of legislating school foods and altering school vending machine practices. Many participants described the importance of educating constituents about the benefits of legislation designed to prevent or reduce childhood obesity. Six participants also named cost as a barrier, referring specifically to costs related to school and community programs. However, one respondent noted that in the case of childhood obesity prevention, all concerned parties stand to gain when successful measures are taken.

### *Incremental vs. comprehensive bills*

Another question posed to key informants was, "Do you think obesity legislation is more likely to progress through (1) a series of several incremental bills or (2) a few comprehensive bills?" Of those who answered this question, 73% stated their belief that legislation

is much more likely to pass through incremental efforts. One respondent noted, “I think incrementalism is the name of the game here in the legislature, given our fiscal constraints.” Only a few interviewees answered in favor of comprehensive bills, and of these, most described a comprehensive bill that provided for an incremental phase-in of proposed changes.

#### DISCUSSION

This paper describes factors commonly cited by legislators and staffers that enable or impede the enactment of childhood obesity prevention legislation at the state level. Some identified factors are familiar and can be applied to legislative efforts on a variety of issues (Table 1). For example, it is already known that cost is a concern prevalent in most legislative decision making, that garnering stakeholder support for new initiatives is vital for long-term success and sustainability, and that the political climate is important but often not modifiable (3,8). However, some factors presented are unique to legislative efforts related to childhood obesity prevention. Moreover, some of these factors are modifiable and thus present clear opportunities for intervention. The qualitative data presented in this paper are useful in “triangulation” of findings (i.e., accumulation of evidence from a variety of sources to gain insight into a particular topic) from two previous quantitative studies (8,9).

After lobbyists, the most commonly cited barrier to passing childhood obesity prevention legislation in states was the problem of misinformed constituents. Legislators and staffers repeatedly described how parents and school administrators opposed initiatives involving school vending machines. They explained how concerned citizens could inadvertently oppose promising legislation due to a poor understanding of the issues, the persuasive arguments of lobbyists, and fears of how local schools could suffer. Improving public education about such topics can both help constituents become informed voters as well as positively influence the public will (19). This, in turn, can dramatically affect political will and policy decisions. Therefore, efforts should be aimed at debunking myths and educating constituents, schools, and stakeholders about the problem of childhood obesity and possible policy solutions.

Other opportunities to conquer barriers and build upon those existing enablers mentioned by study participants include training community advocates to use the media, utilizing well-respected champions of the cause, advocating for issues incrementally, and learning from other areas that have seen success through policy interventions (e.g., tobacco policy) (3,20–22). Because of the vital role of an integrated media campaign in any social change movement, childhood obesity prevention efforts must include building media coverage, especially at the local level (20). Similar to media exposure, having a well-respected individual advocate for childhood obesity prevention legislation can raise awareness about the issue and elicit support from a variety of people. Such individuals can be highly committed legislators (as mentioned by study participants), celebrities, or local leaders. In combination with these efforts, policymakers and advocates should remember the advantages of introducing policy changes incrementally, perhaps through budget bills or as amendments (9). Finally, successful policy movements, such as those addressing tobacco use, should be scrutinized for methods that can be applied to childhood obesity prevention efforts (21,22).

Two study limitations deserve mention. Although the research team sought political and geographic diversity in states selected for study, coverage was not complete. Thus, the generalizability (i.e., external validity) of these findings and recommendations are limited to states with similar political climates. This is a general weakness in the childhood obesity literature (23). Also, the political climate is different in each state, and is ever-changing, depending on current local, state, national, and international events. Therefore, application of study findings should consider state-specific characteristics.

Within states, legislators and staffers were selected because of their prior work in childhood obesity prevention. This resulted in a majority of participants representing the Democratic Party. Further, the research team did not solicit information from legislators with opposing views or from key stakeholders (e.g., school administrators, parents, food vendors) affected by policy implementation. Thus, a broader perspective of viewpoints should be addressed in future studies.

Important next steps in the arena of childhood obesity prevention include building the evidence base for childhood obesity policy (24),

and developing and understanding existing practice-based evidence. Researchers should use prospective studies to examine the effects of specific types of bills and content areas that actually affect population health when implemented appropriately (9). Surveillance systems should be developed to facilitate identification, monitoring, and evaluation of relevant policies. Finally, researchers should note that many legislators serving as Chairs of Health and Human Service Committees commonly lack formal public health or scientific training (backgrounds in law and education were most commonly cited in this study). Thus, concerted efforts should be made to translate relevant scientific evidence clearly for policy-makers.

State-level policy holds promise in childhood obesity prevention. This study provides policymakers and practitioners with a set of enablers and barriers that should be considered when pursuing state-level policy enactment. In conclusion, it draws on relevant policy literature to suggest specific recommendations for those considering the introduction of childhood obesity prevention legislation (Table 3).

Table 3: Recommendations for addressing childhood obesity through policy\* (3,25–27)

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- Clearly define goals of policy
  - Identify potential stakeholders<sup>†</sup>
  - Form coalitions and traditional and/or nontraditional partnerships
  - Develop a common language to build consensus and understanding
  - Describe how diverse interests could be supported through policy action
  - Strive for a neutral forum for discussion, a fair process, and clear facilitation
  - Study examples from other states, understand your own state contexts, and adapt examples appropriately
  - Engage local media
  - Educate the public about misconceptions regarding proposed policy
  - Allocate resources to support implementation, enforcement, and evaluation of policy
  - Utilize sanctions or incentives to encourage compliance
- 

\* Based on findings in the following sources: Brownson *et al* (3); Kumanyika and Brownson (25); Schilling and Keyes (26); Clark (27).

<sup>†</sup> See Table 1.

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