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It's All in the Lens: Differences in Views on Obesity Prevention between Advocates and Policy Makers

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Abstract

Background: Intervention strategies to reduce obesity include policy and environmental changes that are designed to provide opportunities, support, and cues to help people develop healthier behaviors. Policy changes at the state level are one way to influence access, social norms, and opportunities for better nutrition and increased physical activity among the population.

Methods: Ten states were selected for a broad variance in obesity rates and number of enacted obesity prevention policies during the years of 2006–2009. Within the selected states, a purely qualitative study of attitudes of childhood obesity policy using semistructured telephone interviews was conducted. Interviews were conducted with state policy makers who serve on public health committees. A set of six states that had more than eight childhood obesity policies enacted were selected for subsequent qualitative interviews with a convenience sample of well-established advocates.

Results: Policy makers in states where there was more childhood obesity policy action believed in the evidence behind obesity policy proposals. Policy makers also varied in the perception of obesity as a constituent priority. The major differences between advocates and policy makers included a disconnect in information dissemination, opposition, and effectiveness of these policies.

Conclusions: The findings from this study show differences in perceptions among policy makers in states with a greater number of obesity prevention bills enacted. There are differences among policy makers and advocates regarding the role and effectiveness of state policy on obesity prevention. This presents an opportunity for researchers and practitioners to improve communication and translation of evidence to policy makers, particularly in states with low legislation.

Introduction

The increase in the prevalence of obesity in the United States is well documented.^{1,2} It is estimated that almost 34% of American adults³ and 17% of children and adolescents aged 2–19 are obese.⁴ Long-term outcomes of the obesity epidemic include predictions of a decline in population health and substantial societal and economic costs.⁵ In response to the obesity epidemic, there is a focus on identifying effective interventions to reverse trends in the next decade.^{6–8} These intervention strategies include policy and environmental changes that are designed to provide opportunities, support, and cues to help people develop healthier behaviors.⁹

Policy changes, particularly at the state level, are one way to influence access, social norms, and opportunities

for better nutrition and increased physical activity among the population.¹⁰ Obesity prevention policies may include the mandate of quality physical education programs in schools as well as transportation policies that facilitate walking, or reduce automobile/cycling conflicts and result in increased cycling.¹¹

Shaping health policy is one core function of public health professionals.¹² To influence policy, there is a need to understand the policy process. Unfortunately, these processes are complex and rarely linear or logical.¹³ Kingdon¹⁴ describes a framework that depicts the policy process and argues that policies move forward when elements of three “streams” come together. In Kingdon’s model, three distinct streams must “coincide” in a fluid process that results in concrete policy developed from proposals or ideas. The first of these streams is the

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definition of the problem (e.g., high rates of obesity). The second is the development of potential policies to solve that problem (e.g., major influence of advocacy agencies on policy makers about the problem via information). Finally, there is the role of politics and public opinion (e.g., interest groups supporting or opposing the policies). Policy change occurs when a “window of opportunity” opens and the three streams push policy change through.¹⁴ The third element of interest groups, including leaders, is an especially important factor in the development of obesity prevention legislation. In an effort to gain insight into state obesity prevention policy and the processes involved, this study explores the views of both legislators and obesity prevention advocates.

This study is the qualitative, exploratory part of a project on childhood obesity prevention legislation, the State Childhood Obesity Policy Evaluation (SCOPE). The overall aim of SCOPE is to examine patterns and predictors of childhood obesity legislation at the state level through both qualitative investigation and quantitative bill content analysis.

Methods

State Selection

A sample of states was chosen for study by placement in a 2×2 table with both prevalence of childhood obesity and the level of enacted bills related to childhood obesity prevention. Enacted bills were chosen as the focus of analysis because they represent successful efforts within the state. State childhood obesity rates were taken from the National Survey of Children’s Health conducted by the Child and Adolescent Health Measurement Initiative supported by the Maternal and Child Health Bureau of the U.S. Department of Health and Human Services.^{15,16} The states were rank-ordered by obesity prevalence and divided into tertiles. Because we wanted to obtain information from a broad range of states, we only used the states that ranked consistently in the highest and lowest tertiles for placement in the table. For an assessment of the level of state childhood obesity policy enactment within states, an online legislative database was used.¹⁷ State legislation, defined as bills (not including resolutions) introduced in the state’s House of Representatives, Senate, or Legislative chamber, from 2006 to 2009 on 19 topic areas that have the potential to positively influence childhood obesity was analyzed. These topic areas were based on previous research^{18–21} and included nutrition and vending standards, health and physical education, BMI reporting, safe routes to school, local authority, model school policies, taskforces, farmer’s markets, Farm to School programs, walking and biking trails, menu and product labeling, soda and snack taxes, and child care physical activity and nutrition standards. Each state was ranked by the total number of bills enacted within these categories. The states at the high (high policy action) and low (low policy action) ends of the enacted bills range (0–30) were

Table 1. States Selected for Inclusion in Sample

	Low obesity	High obesity
Low policy action	South Dakota Montana	Arizona Kansas
High policy action	Washington Maine <i>Colorado</i>	Louisiana New York <i>Oklahoma</i>

Note: States in *italic* were only included in advocacy interviews.

selected. We chose to use the total number of bills enacted as a measure of broad obesity prevention efforts within the state, with the 19 different bill topics being of equal importance. Low-policy-action states had three or less bills enacted and high-policy-action states had eight or more bills enacted and were placed within quadrants in the 2×2 table (see Table 1). We chose two to three states in each quadrant for our study.

Using this information, we conducted a purely qualitative study of attitudes about childhood obesity policy using semistructured telephone interviews with state policy makers and advocates. For policy maker interviews, states within each quadrant were chosen to get the most representative geographically and politically diverse sample (see Table 1 for selected states). Because we wanted to gain information from advocates in states with significant policy action, only states in the high-policy-action quadrants—those with eight or more childhood obesity bills passed (2006–2009)—were included in the sample. Of the 15 states that met these criteria, six were selected for geographic representation.

Question Development

The research team developed a semistructured, open-ended interview tool based on contextual influences on policy enactment. These influences were drawn from Kingdon’s model as well as practical experience with legislators and advocates. Categories of questions included knowledge and awareness of obesity prevention efforts within states, level of support, perceptions of constituent concern, and barriers to relevant policy enactment. Questions were tailored to both policy makers and advocates. Three interviewers were trained to conduct the interviews by telephone. The questions were pilot tested on four policy makers and minor changes made. The interview guides are available at <http://prcstl.wustl.edu/research/Pages/SCOPE.aspx/>.

Recruitment

The project goal was to conduct 20 interviews with policy makers and 20 interviews with advocates. Policy makers for this study were drawn from a list of state legislators who serve on public health committees within selected states. This list ($n = 160$) was populated with assistance from the National Association of Chronic Disease Directors (NACDD). Advocates were considered

state or local individuals working in the area of health policy related to obesity prevention. Contacts for advocates were recommended by Directors of Health Promotion and Education (DHPE) and members of NACDD whose positions gave them first-hand knowledge of individuals engaged in advocacy for childhood obesity policy within their states. We asked DHPE and NACDD representatives for the top two advocates within each state selected. Additionally, names were added if mentioned in the policy maker interviews or from snowball sampling during advocate interviews. These recommendations resulted in a convenience sample ($n = 24$) of advocates to recruit for interviews.

This study was approved by the Institutional Review Board at Washington University in St. Louis.

Data Collection

Demographic information was collected from internet websites for respondents in both the legislative and advocate groups prior to interviews. Interviews with legislators were conducted between October, 2009, and December, 2009. Calls were made in the order of leadership within the public health committees (*e.g.*, Chair, Vice-Chair, and Member). Three attempts were made to reach the policy maker before moving on to the next name on the list. The average length of interview was 21 minutes. Seventeen interviews were completed by telephone with legislators themselves, three with legislative staff assigned to a health committee member, and three with legislative staff assigned to a public health or appropriations committee. Demographics for staff assigned to committees were not included in the results, making the total demographic response $N = 20$. Fifteen respondents were white, three were black, and two were Hispanic. Nine were male and 11 were female. Half were Republicans (10) and half Democrats (10). Six were committee chairs, two were vice chairs, and twelve were health committee members. The average tenure as a legislator was 12.1 years for high-policy states and 10.5 years for low-policy states. Three of the states studied were led by Republican governors and five were led by Democrats.

Seventeen telephone interviews with advocates were conducted in June and July of 2010. Three attempts were made to contact before moving to the next person on the list. The average length of interview was 26 minutes. Between two and four advocates interviewed for each of the six states were selected for study. No interviews were conducted with advocates from the same organization. Ten respondents were male and seven were female. Fifteen were white and two were Hispanic. The participants in this study averaged 8.2 years working in obesity advocacy. The data-gathering process for both policy makers and advocates concluded when the categories under review ceased to yield new information. The interviews had reached theoretical saturation, producing as much variability in responses as could be expected.

Data Analysis

Each interview was conducted by telephone, and responses were written verbatim. The transcripts of the conversations were read in aggregate to facilitate formation of general thematic categories within the framework used. A constant comparative methodology was used to analyze results and open coding was used to identify common themes. Quotes were coded by theme and by the contextual categories of policy enactment. Comparisons and contrasts among policy makers and advocates across the four quadrants were identified.

Results

The first part of our analysis focused on differences and similarities among state policy makers' demographics and perceptions in states with a high number of childhood obesity bills passed (≥ 8) and low number of childhood obesity bills passed (≤ 3) and high and low obesity rates. More legislators in high-policy states were Democrats, in session longer, and served in the legislature for more time than in low-policy states. The high-policy-action states had more Republican-led Senates, but little variance in governor's party or house leadership.

Perception of Problem, Evidence, and Priority

More differences were noted among high/low-policy-action states than high/low-obesity rates. States in quadrants with a high number of legislative bills passed held different perceptions than policy makers in low-legislation states. These legislators believed the evidence or science behind obesity policy proposals was strong and well communicated, unlike legislators in low-legislation states where communication of evidence is perceived as lacking (Table 2).

“In the past 10 years, much has been done... the medical evidence is good.”

“Legislators want to see a proven, scientific model before they fund anything. So far, there is nothing out there.”

In general, policy makers from high-legislation states perceived obesity as an issue of moderate to high importance to the public, whereas legislators in low-legislation states were uncertain of the importance of the issue to constituents. Funding for state obesity efforts was a topic that elicited similar responses from policy makers in all quadrants studied. The legislators noted that cost in implementing a new policy on obesity prevention is a major barrier.

Advocacy and Opposition

Legislators in high-legislation states were able to name groups or individuals who support and/or oppose the adoption of childhood obesity legislation in their state. Legislators in low-policy states were not able to recall

any “champions” for obesity policy. Yet policy makers had mixed perceptions of the effectiveness of advocacy efforts in their states. Legislators from both high- and low-obesity states regarded messages about obesity in the media as confusing and not tied to specific actions.

“I’ve seen a few things in the media—broccoli leaves dancing, telling you to eat healthy. Another is a ‘get off the couch’ message.”

Advocates Versus Legislators

The second part of our analysis was a comparison of policy makers and advocates. We found they had differing views on several important issues relevant to childhood obesity prevention (Table 3).

Perception of Problem, Evidence, and Priority

First, the perception of obesity as a problem or a priority within the state varied between these two groups. Although both were aware of obesity rates and were familiar with health and social implications, legislators did not perceive any consensus among constituents about the severity of the problem. Furthermore, interviews revealed that obesity prevention policies were not tied to current legislative priorities. Conversely, advocates considered obesity prevention a high legislative priority for both the public and policy makers.

“I don’t believe the public values obesity policy. Most would rank concern (1) economy, (2) jobs, and (3) housing market.” —Legislator

“The importance of obesity to the public is growing. We (advocates) have done a good job raising the profile of the related issues—we make sure that the stakeholders get the best information....” —Advocate

Use of Policy To Prevent Obesity

Second, no consensus emerged among policy makers with regard to the role of the state legislature in addressing policies to reduce obesity. Policy makers felt that messages in the media were inconsistent and that they had not been convinced that policy approaches would impact obesity rates. Legislators did not perceive that their involvement in policy actions would be viewed favorably by constituents. On the other hand, advocates were well versed in evidence-based policy approaches to obesity prevention for children and adults. Advocates were able to cite presentations and reports that had been shared with policy makers regarding obesity policy.

“There is only a basic or general understanding (in the legislature) that it is more effective to prevent obesity because of the medical costs associated with the effects on the back end...” —Legislator

“There is support for prevention but not for legislation.” —Legislator

“We set a policy agenda for obesity each year. Priorities are based on evidence and follow areas where we’ve had success.” —Advocate

Table 2. Response Summary from Legislators in States with High and Low Policy Action for Obesity Prevention

High-policy state legislators ^a	Low-policy state legislators ^a
• Believe in evidence related to obesity policy proposals	• Described how evidence was lacking
• Able to name groups or individuals within states who support or oppose these efforts	• Not able to recall champions in state for this cause
• Perceived obesity as moderate to high importance to public	• Uncertain of public perception of priority of obesity as a problem
• Messaging about obesity is confusing	
• Cost is a major barrier to obesity prevention legislation	

^aHigh policy action was defined as a state having enacted eight or more obesity prevention bills between 2006 and 2009. Low policy action was defined as having three or fewer obesity prevention bills during the same study period.

Table 3. Comparison of Responses from Legislators and Advocates for Obesity Prevention

Legislators	Advocates
• No consensus on perception of level of concern about obesity among constituents	• Thought of obesity as a high priority for both legislators and public
• Obesity not a high legislative priority	
• Uncertain of role of policy makers in obesity prevention	• Articulated the importance of policy in these efforts
• Perceived opposition as strong	• Believed opposition was addressable
• Confident in positive changes made through past state policy efforts	• Pointed to the shortcomings of existing legislation

Perception of Opposition

Another difference that emerged between legislators and advocates had to do with opposition. Perceived opposition was mentioned by a majority of legislators. In states where organized opposition to childhood obesity legislation or issues like beverage tax, zoning, and revenue had been recently debated, policy makers were articulate about potential political cost of obesity policy. Advocates viewed opposition as addressable. Supporters for obesity policy were recalled by legislators, especially if it came from former legislators or individuals familiar to the policy makers. If the committee chair, governor, or party leaders had endorsed obesity policy actions, it was articulated as a high priority for legislators. Advocates mentioned public health, research and medical leaders who had testified on behalf of childhood obesity legislation.

“Our legislature passed a soda tax with revenues to go toward a state health care program. Later, the beverage industry started a ‘fed up with taxes’ effort that led to a repeal. The legislature was afraid. It was a sick day. I was devastated.” —Legislator

“It takes persistence—let the public attention and concern catch up to you. Be there and continue to be there.” —Advocate

Perception of Effectiveness of State Efforts to Prevent Obesity

Legislators were confident that changes made in recent years, especially related to school food service and school vending, were being implemented successfully and demonstrated a responsibility of the legislature. In one state, the formation of a state-level council was mentioned. Advocates pointed out shortcomings in legislation, additional areas for policy improvement (*e.g.*, complete streets, access to healthy foods), and the need to address obesity policy beyond the school level. Engagement of public health and education agencies was mentioned sometimes as a facilitator to policy and sometimes as a barrier.

“Our obesity efforts have been very effective—especially around diabetes and nutrition.” —Legislator

“We haven’t passed any obesity laws yet. We tried in the past to remove sodas and candy from schools. The schools were afraid of lost income and fought the policies.” —Advocate

Last, the effectiveness of policy was discussed on different levels. Both groups of respondents shared perceptions of the overall effectiveness of policy in addressing childhood obesity. They also shared insights about success of policies in their own states. Legislators indicated uncertainty of effectiveness for policies to impact child-

hood obesity, while advocates expressed optimism in the impact of these policy changes. Legislators mentioned that current policies were adequate to address public needs. Advocates were sophisticated in their understanding of the evidence base for a variety of policy approaches and the need to link formal policy with community activities that support obesity prevention.

“Can you legislate obesity?” —Legislator

“Having a statewide coalition has been a huge breakthrough. The coalition makes sure that stakeholders get information they need to advocate and are all on the same page.” —Advocate

Discussion

Our findings provide insight on the varied perceptions regarding state obesity prevention legislation from two important groups. Even though we interviewed policy makers from states varying on level of policy and childhood obesity rates, more differences were apparent when comparing high- versus low-legislation states than in states with high versus low childhood obesity rates. In states where many policies have been enacted, the policy makers were aware of initiatives and champions for obesity prevention and thought evidence about obesity prevention was well-communicated. In low-policy states, the policy makers could not identify champions for the cause within their state or recall communication on the evidence of obesity prevention. Communicating the issue of obesity relates to the first “stream” in Kingdon’s framework.¹⁴ Research shows that policy-relevant issues must be clearly defined and communicated to policy makers to be effective.^{22,23} This presents an opportunity for researchers and practitioners to improve communication and translation of evidence to policy makers, particularly in states with low levels of obesity legislation.

Another difference among high/low-legislation states was the perception of constituents’ view of the obesity problem. Policy makers and advocates in high-policy states thought of obesity as an important public health issue. Competing economic priorities may have overshadowed obesity as perceived constituent concerns in the low-legislation states.

Several key contrasts between the legislators and advocates emerged from this qualitative research. The influence of advocacy groups on policy relates to Kingdon’s second stream.¹⁴ There were differences in how each group views the problem of obesity, the role of the legislature in obesity policy, support and opposition, current policy, and overall use of policy as a tool to prevent childhood obesity. Previous research has explored differences in decision making among public health practitioners and policy makers and found a similar disconnect.^{22,24} Much of this disconnect relates to information transfer from research to policy practice. Brownson and Jones conclud-

ed that there is a need for making research and information more accessible to policy audiences.²⁴ Not only does the information have to be more accessible, our findings suggest that the information must include specific recommended policy actions. Our results concur with a study by Dodson et al., who found the need for information to be translated into specific recommendations for legislators considering obesity legislation.²²

Also important is the need to tailor advocacy efforts by topic, by session, and by state context. It seems as if childhood obesity policies are more likely to be considered independently and incrementally. Policy makers who find they can champion one policy approach (e.g., school nutrition) may find it difficult to support other evidence-based approaches (e.g., soda tax). Advocacy plans that endorse incremental approaches may find more robust support from a critical mass of policy makers. Assessing efforts for each legislative session may also be more effective than a general approach. In this way, individuals who champion specific policy actions can be identified and messages will be more likely to resonate with individual legislators, staff and the state legislature as a whole. Generalized approaches at the state level are not likely to achieve this.

There also seems to be a lack of understanding of how evidence can be used to inform policy. Although the advocates understood the link between evidence-based policy and effectiveness, the legislators were unsure of the connection. This finding is similar to other studies that show a need for a system to articulate evidence.^{12,14,25} Advocates must become more skilled at translation of childhood obesity policy evidence to state policy makers in light of current priorities, actors, and barriers to policy enactment. However, evidence alone is not sufficient; it must complement the political will of constituents and policy makers. Promoting the cause to constituents (Kingdon's third stream)¹⁴ by including constituents in visits to state policy makers will improve the perception of the importance of obesity to the general public.

Another theme that emerged from this research is the need for a collective and persistent effort in a state's fight against childhood obesity. The need for constant reminders to the policy makers about obesity prevention policies and persistence by the advocates promoting those policies were identified as necessary steps toward effectiveness. Additionally, sharing policy success needs to occur in multidisciplinary settings. Getting information to policy makers from a wide range of stakeholders strengthens the effort. Most state-level public health committee members do not attend regional or national meetings where obesity policy is discussed. Inclusion of obesity policy approaches in state and local discussions through forums for elected officials, planning meetings, briefings, and targeted local news can help increase support for policy as a tool to address childhood obesity.

Because of the need for a strong and collective effort, state advocacy efforts to reduce childhood obesity should

consider pooled resources for state-level policy actions. Pooling of resources, including staff, funds, printing, and media contracts enables groups with small budgets to design and carry out sophisticated advocacy plans. Many advocates interviewed were salaried through a patchwork of funds that allow lobbying and facilitate the actualization of coalition and council priorities in the state house.

There was a clear sentiment by policy makers about financial priorities and budget constraints as a barrier to obesity-prevention policy enactment. Bills with associated high or uncertain costs may be less likely to be supported. Advocates need to be realistic in promoting bills that align with budget priorities. For example, pushing for a bill that would expand physical education requirements to middle and high schools would involve significant financial resources. However, advocating for a bill that would not allow physical education exemption for middle and high school is a less costly alternative and can be effective at maintaining existing curriculum. Being realistic and sensitive to the state's current economic climate is important.

Limitations and Strengths

Limitations and strengths of this study warrant mention. First, we only used enacted legislation as a measure of successful policy action. Introduced legislation at varying stages within the legislative process might also be a measure of policy action and should be considered for future study. Additionally, without studying the process of the legislation being enacted, the level of influence of advocacy on specific bills cannot be made. Even though our sampling plan was developed to get a range of policy makers and advocates from states with varying levels of policy and obesity, our sample only included 10 states. We saw little variability among interviews in high- and low-obesity states. A larger sample size might have resulted in greater differences among the policy makers and advocates in all four quadrants. Findings are also limited by the convenience sample of advocates. Although state directors were confident in providing names of obesity prevention advocates within the states, some may have been missed. Also, the research team did not solicit information from opponents of legislation to prevent childhood obesity or from other key stakeholders (e.g., school administrators, industry, other state-level personnel) affected by policy implementation. In spite of these limitations, this is a unique study that contributes to the literature on how to influence state level policy to prevent obesity.

Implications for Practitioners

Information from this study identifies gaps and opportunities for promoting state legislation on obesity prevention. Practitioners can play a vital role by taking advantage of these opportunities in several ways.

- *Improve communication on topic, evidence, and effectiveness.* Both legislators and advocates cited the

unclear and inconsistent messaging. Effective communication can be enhanced by making research more accessible to policy audiences. Evidence becomes more relevant to policy makers when it involves a local example and when the effects are framed in terms of its direct impact on one's local community, family, or constituents.²⁶ In the policy arena, decision makers indicate that relevance to current debates is a critical factor in determining which research will be used and which proposals will be considered.²⁷ Research on contextual issues and the importance of narrative communication is beginning to present data in the form of a story that helps to personalize an issue.²⁸ Communication can also be enhanced by building relationships with state policy makers and their staff. Getting to know their preferences can also help tailor information to their needs.²⁶ Building these connections can help facilitate "champions" for the cause.^{29,30}

- *Learn from successful efforts and apply effective strategies.* In states where many positive obesity prevention policies were enacted, advocacy organizations and practitioners seemed to excel at raising awareness about childhood obesity policy. We can learn from this by looking to states with high levels of obesity prevention legislation as models. A lot can be learned from states that have been successful in getting legislation passed. Information on the persistent and consistent messaging, how to seize "windows of opportunity," and learning patience can be gleaned from advocates in these states. Connecting with practitioners and advocates with a similar cause in these states may provide insight into the process of facilitating bill introduction and enactment.¹³ Looking to states that are federally funded to prevent obesity and their successes in enactment is one potential strategy.³¹
- *Be aware of political context of state.* Knowing what is happening politically and economically within a state is important to timing of efforts. In particular, be sensitive to perception of cost of prevention efforts. With state budgetary constraints, new and costly programs are less likely to be supported. Working with advocates to develop legislation that clearly outlines costs and benefits might be an effective strategy in state obesity prevention.¹³

Conclusions

The findings from this study show that there are differences in perceptions among policy makers in states with a greater number of obesity prevention bills enacted. They seem to be aware of evidence and are better connected to advocacy in their states. There also seem to be differences among policy makers and advocates about both the role and potential effectiveness of state policy in preventing childhood obesity. A model that considers nonmodifiable factors, such as the extent of the problem and evidence-

based policy approaches, as well as modifiable factors such as local context and political, will facilitate policy change. Many opportunities exist for practitioners, advocates, and researchers to influence childhood obesity policy through dissemination of successful models.

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