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Community stakeholders' perceptions of major factors influencing childhood obesity, the feasibility of programs addressing childhood obesity, and persisting gaps

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Abstract

Purpose: Prior research has identified numerous factors contributing to increased rates of childhood obesity. However, few studies have focused explicitly on the experience of community stakeholders in low-income communities. This study sought to capture the perspectives of these on-the-ground experts regarding major factors contributing to childhood obesity as well as gaps in current prevention and control efforts.

Methods: We conducted semi-structured interviews with 39 stakeholders from different community sectors (e.g., healthcare providers, childcare providers, teachers). Data were drawn

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The authors declare that they have no conflict of interest.

from the Massachusetts Childhood Obesity Research Demonstration (MA-CORD) project, a multi-level, multi-sector intervention designed to reduce childhood obesity being implemented in two low-income communities in Massachusetts. Interviews were conducted at baseline, transcribed, coded using grounded theory approach, and analyzed in NVivo 10.0.

Results: The vast majority of stakeholders had recently participated in obesity prevention strategies, and nearly all of them identified gaps in prevention efforts either within their organizations or in the broader community. In addition to factors previously identified in the literature, several themes emerged including the need to change policies to increase physical activity during school, offer healthier snacks in schools and afterschool programs, and increase communication and collaboration within the community in prevention efforts.

Conclusion: Community stakeholders can impact the success of interventions by bridging the gap between science and lived experience. The results of this study can guide future research by highlighting the importance of including stakeholders' frontline experiences with target populations, and using information on identified gaps to augment intervention planning efforts.

Keywords

Childhood obesity prevention; Qualitative research; Community stakeholder; Community health; Policy changes

Introduction

Despite increased efforts to prevent child overweight and obesity, obesity rates significantly decreased only in preschoolers [1]. Research has shown that overweight and obesity tend to be more prevalent among children with low socio-economic status and among racial/ethnic minorities, particularly Hispanics [2, 3]. To more effectively prevent and control overweight and obesity in these target groups, current prevention models increasingly emphasize multi-sectorial, multi-disciplinary, and culturally-relevant approaches [4–10] that change not only individual behavior but also the broader environment in which children and their families live.

The success of these new models is dependent on their ability to include and engage representatives from multiple sectors, e.g., healthcare practitioners, early care and education staff, teachers, and staff working with public health agencies and/or community programs [4, 11]. These stakeholders are well-positioned to influence both children's and their families' lifestyle choices and can significantly affect the outcomes of childhood obesity prevention programs and initiatives. Understanding these stakeholders' perspectives regarding childhood obesity prevention programs is therefore essential in the planning and implementation process [4].

However, while many childhood obesity interventions have been evaluated against child weight-related outcomes [12], stakeholders' opinions about these interventions have received little attention. The authors of a recent Cochrane review of childhood obesity interventions pointed to the need for qualitative research to provide a better understanding and view of stakeholders' and families' opinions regarding prevention programs that may be more or less successful in their communities [10]. Qualitative approaches add to existing

behavioral and epidemiological evidence as they open the possibility to tailor interventions to individual and community needs [13]. Yet, few studies have focused explicitly on the knowledge and experiences of diverse stakeholders, as well as the gaps in prevention that they identify within their communities. Moreover, stakeholders' perspectives on the feasibility of organization specific and community-wide strategies have not been widely addressed in prevention research.

To address this gap, we explore the perspectives of stakeholders from multiple community sectors (primary healthcare, schools, after school programs, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and early care and education) from two low-income communities implementing the Massachusetts Childhood Obesity Research Demonstration project (MA-CORD) [14, 15], a multi-level, multi-sector childhood obesity intervention. Interview questions solicited stakeholders' perspectives on: 1) major factors contributing to childhood obesity in these communities, 2) the feasibility of past obesity prevention strategies in their community; and 3) gaps in past and current childhood obesity prevention and control efforts.

Methods

Setting

The current study is nested within MA-CORD, which is described in detail elsewhere [14, 15]. Briefly, the MA-CORD project is a multi-level, multi-sector community-based intervention to prevent and control childhood obesity among underserved children aged 2–12 years. Interventions were implemented in two low-income, small- to mid-size (population 40,000–100,000) communities in Massachusetts. In both communities, the population is predominantly non-Hispanic white (~68%) and Hispanic (16–21%). The mean per capita income is $22,000, which is below the state average of $35,000, and the poverty rate is 23–27%, which is twice as high as the state-level poverty rate. The community sectors included in the MA-CORD project are: afterschool, school, WIC, primary healthcare, and early care and education (from now on referred to as healthcare and early education).

Participants

In both communities, eligible stakeholders were responsible for either leading (e.g., school principals, medical and program directors) or implementing (e.g., teachers, afterschool and early education staff) MA-CORD study components. At baseline, multiple introductory meetings were held to provide an overview of the MA-CORD project. Stakeholders who attended one of these meetings were invited to participate in a semi-structured interview. All stakeholders who agreed to be contacted were sent an email to schedule the interview (with up to two follow-up emails). Stakeholders who did not reply after a third reminder were counted as non-responders. In total, 63 of 108 stakeholders (58.3% of those eligible) agreed to be interviewed, and a total of 39 (61.9% of 63) participated in the interview.

Interview procedure

Stakeholders were interviewed between September 2012 and March 2013. Although some project participation training sessions had taken place by this time, the interviews were

conducted before any intervention components had been implemented. Two researchers (A.A., C.G.) conducted the interviews either in-person (n=8) or by phone (n=31). To ensure consistency, three interviews were conducted with both researchers present. Differences in interview style were discussed afterwards. To ensure standardization of interview procedure, a semi-structured interview guide was developed. Key topics included identifying: 1) the population(s) stakeholders work with; 2) major factors leading to childhood obesity in the community; 3) strategies for obesity prevention that stakeholders were already engaged in (prior to MA-CORD); 4) the most feasible of those strategies; and 5) strategies still needed, which stakeholders felt could be successful in their community. All participants reviewed the consent form and gave permission for audio recording. At the end of the interview, a brief survey was administered to collect demographic data (e.g. age, gender, race/ethnicity). The average time of the interviews was 24 minutes, with a range of 10 – 64 minutes. All procedures were reviewed and approved by the institutional review boards of Harvard T.H. Chan School of Public Health and San Diego State University. Stakeholders received a $10 gift card as compensation.

Data analysis

Interviews were audio recorded and transcribed. The transcripts were reviewed by study personnel (C.G., R.B.) for accuracy, and entered into NVivo QSR 10.0 (QSR International Pty Ltd., Doncaster, Victoria, Australia). A grounded theory approach was utilized to analyze the data [16]. The two interviewers (AA, CG) independently coded five randomly selected transcripts to document emergent categories and possible subcategories. Categories were discussed between the coders to develop a preliminary coding scheme. With this scheme, five more interviews were coded independently, and coding was discussed to resolve disagreements. A consensus meeting with a third investigator (KKD) was held to finalize the coding scheme, and all interviews were double coded with this scheme. Data analysis focused on stakeholders' perspectives about major factors contributing to childhood obesity in their community, the feasibility of past obesity prevention strategies implemented in their community, and gaps in current childhood obesity prevention and control efforts.

Results

Interviewed stakeholders (n=39) represented all sectors of MA-CORD. The majority of stakeholders were from schools (N=15). Stakeholders were also recruited from afterschool programs (N=8), primary healthcare (N=7), WIC (N=6), and early care and education centers (N=3). More detailed demographic information is presented in Table 1. Stakeholders reported a wide range of factors that they saw influencing childhood obesity in their communities, and provided suggestions for organization- and community-level strategies to prevent and control childhood obesity. Illustrative quotes are provided in Table 2.

Major factors influencing childhood obesity in the community

Stakeholders' reports included individual-and societal-level factors associated with high rates of childhood obesity in their community, which, overall were consistent with an ecological perspective on obesity prevention. The most frequently mentioned factors were a lack of physical activity (PA) and an increase in sedentary behaviors (62%) among children

and their families (quotes 1–3). Stakeholders from each sector cited low socio-economic status (54%) as a factor impacting the success of prevention efforts, and as contributing to low program attendance and a lack of healthy nutrition in families (quotes 4, 5). Almost half of all stakeholders (46%) named access to healthy and affordable food as a problem (quote 6), and 12 (31%) stakeholders, mostly from the school and healthcare sectors, mentioned lower education in families as a factor contributing to high childhood obesity rates (quote 7). Stakeholders from each sector also named a lack of community resources (28%), such as transportation and programming (quotes 8,9) and cultural influences (21%), particularly the food preferences and norms of Hispanic cultures, as factors that also lead to an increase of childhood obesity in their community (quotes 10, 11). Another important factor is a lack of neighborhood safety (quote 12), seen by several stakeholders (33%) as contributing to increased sedentary behaviors.

Strategies related to childhood obesity prevention and most feasible of these strategies

To determine the feasibility of strategies to prevent and control childhood obesity we targeted our questions to focus on programs implemented in the organization or community prior to the MA-CORD project. We then asked stakeholders which programs and strategies were most feasible. The majority of stakeholders cited nutrition- or PA-related strategies (54%) as being most feasible. Stakeholders from school, afterschool, and early education sectors found changing their organizations' policies around food to be the easiest strategy to catalyze change. For example, stakeholders described the transition to healthy lunches according to "My Plate" [17] as a very positive and successful change (quote 13). Furthermore, changes to school food policy, in particular banning unhealthy foods for classroom celebrations, switching from soda and chocolate milk to water, and eliminating the vending machines, were seen as successful, feasible, and easy to implement (quote 14–17). Stakeholders from schools, WIC, early education, and in particular afterschool (44%), had targeted increasing PA, for example through walking programs and the use of special fitness equipment (quotes 18–20). Stakeholders from the school and afterschool sectors mentioned that adding more activity into the school day and afterschool programs was another simple way to improve wellness, not only because the children had fun and enjoyed the chance to be active (quote 21), but also because no extra staff were needed to implement these changes (quote 22). More than half of the stakeholders (54%) across sectors tried to implement diverse strategies specifically to address parents, in order to communicate the importance of childhood obesity to parents (e.g., organized phone calls, sending home handouts and newsletters, quotes 23, 24). According to stakeholders, calling parents was not only an effective way to deliver information about school activities, but also to address diverse problems. Sending home handouts and newsletters was an easy way for stakeholders to communicate to parents although stakeholders were not sure how successful this strategy is when trying to reach out to parents.

Missing prevention strategies: Organizational level

When asked about organizational-level strategies that could be successful but were currently lacking, stakeholders across all sectors mentioned the importance of several specific PA (44%) and nutrition (44%) strategies. Specifically, stakeholders pointed to a need for increased PA during the school day, access to physical education (PE) classes, hiring more

PE teachers, and increasing activity options (e.g., recess, afterschool options, quotes 25–28). A few stakeholders from school, early education, and the clinic sector (13%) went so far as to suggest policy mandates around PA, specifically requiring recess and P.E., would be a much needed change (quotes 29–32). Stakeholders (44%) pointed to a need for increasing the offering of healthy foods both during school and afterschool (quote 33), and either removing vending machines, or replacing the typical snacks with healthy ones (quotes 34, 35). Across all sectors, stakeholders (21%) agreed on the importance of doing more to target parents; examples included offering parenting classes and home visitation programs (quotes 36–39).

Missing prevention strategies: Community level

When asked what may be missing from community-level prevention strategies, the approach mentioned most frequently by stakeholders (41%), was improved and increased cross-sector collaboration and communication in the community. Stakeholders saw the efforts of other organizations as opportunities for collaboration, rather than competition (quotes 40–42). Stakeholders from all sectors but WIC (28%) demanded the inclusion of the whole family and specifically mentioned increasing family-oriented outdoor programs to get children out of the house and away from watching television, educating and informing parents about wellness; and involving parents by bringing solutions into the families' homes (quotes 43–45). Stakeholders (16%), especially from schools also mentioned the need for more PA opportunities available to the larger community (e.g., offering safe routes to school or promoting newly cleaned local parks for outdoor activities, quote 46).

Differences by sector

Overall, there was general agreement across sectors on the major factors influencing childhood obesity in the community. Few differences were identified for stakeholders from different sectors regarding the most feasible obesity prevention strategy to implement. Of 21 stakeholders who identified nutrition- and PA-related strategies as most feasible to implement, the majority of stakeholders were from the school and afterschool sector (15 of 21, 71%). When asked about strategies that were still needed in their organization, mostly stakeholders from schools (67% versus ≤33% from other sectors) named PA-related strategies. In regard to missing strategies in their community, stakeholders from all sectors but WIC mentioned collaboration and communication and family-related programs as the most needed strategies. PA-related strategies in the community were mentioned by stakeholders from school, afterschool, and healthcare, but not by stakeholders from WIC and early education.

Discussion

Prevention interventions focused on childhood obesity rarely measure or explore stakeholders' opinions regarding strategies or the problem as it presents within their community. Qualitative research can help provide a better understanding of why prevention programs may or may not be successful [5, 10, 18]. The direct involvement of stakeholders *(i.e.,* teachers, afterschool teachers, early care and education staff, WIC staff, and healthcare staff) with children and their parents makes them key to provide practical evaluations of

program efforts, and highlights the importance of their experiences. This qualitative study is the first to interview on- the-ground-experts across different sectors about major factors contributing to childhood obesity, the feasibility of past childhood obesity prevention strategies, and persisting gaps in prevention efforts. The most noteworthy findings of this study were stakeholders' wish for nutrition and PA related policy changes as well as the call for more collaboration and communication across sectors when implementing strategies to combat childhood obesity. WIC was the only sector not asking for more cross-sector collaboration, which could be because WIC staff already works closely with other stakeholders, *i.e.,* hospitals and community centers [19]. Furthermore, stakeholders' named factors contributing to childhood obesity in their community which were consistent with previously published data [20–24].

Stakeholders, particularly from the afterschool and school sectors, found the reduction of PA time *(i.e.,* recess and PE classes) during the school day problematic. Stakeholders across sectors stated that more PA options during the day are greatly needed for children, despite the bureaucratic hurdles this might entail. Stakeholders agreed this would be an easy and feasible strategy since, in their experience, children generally "love to run around" and activities related to play and sport had high attendance. This finding supports prior research [25] which has shown that the most successful childhood obesity intervention strategies entailed some PA component. Stakeholders mentioned a general feeling within schools and afterschool that there just isn't enough time to include PA within the school day, often pointing to the need to spend that time studying to achieve higher test scores. But stakeholders from this study and others argue that a lack of PA actually decreases test scores [26]. Getting leadership on board when implementing intervention strategies, seems to be an important first approach to gain the necessary support to successfully increase PA options for children during the school day.

Stakeholder opinions about the feasibility of past and recent prevention strategies are an important finding that has rarely been described in previous literature. We found that making changes to food policy was one of the easiest strategies for stakeholders to implement, because it affects an entire organization or community at once; changes are easier to adapt when everyone is on board, and changes to policy have been shown to be sustainable [18]. As reported by stakeholders, it is important to consider not only the prohibition of unhealthy foods and drinks in policies, but also their replacement with healthier options. Substituting healthier options allows children and staff to become accustomed to the new options, and may encourage preference for the new choices over the old options *(i.e.,* water over chocolate milk and soda).

Stakeholders across all sectors also called for more communication and cross-sector collaboration. To our knowledge this is a novel finding that has not been reported in prior research. Stakeholders noted that although organizations typically work independently from each other, they are often trying to achieve the same goals. Stakeholders felt that successes could be increased through collaboration, and by learning from each other's experiences. This finding supports the call for coordinated multi-sector and multi-disciplinary approaches rather than implementing a series of solo interventions in different sectors [4, 18].

Strengths and limitations

Community stakeholders play an important role as on-the-ground-experts in multi-sector obesity interventions. Yet, their experiences and opinions have not been emphasized much in the literature. An important aspect of this study is the inclusion of stakeholders representing five community sectors. Additionally, the use of a qualitative approach provided the possibility to delve more deeply into stakeholders' views regarding reasons for the increase of childhood obesity in their community and strategies still needed. Interview questions were broad and open-ended, which gave stakeholders the opportunity to address every topic individually, and expound upon those important to them.

This study also has limitations which need to be considered when interpreting the results. Since this study was part of the MA-CORD project, stakeholders may have already had some interest in childhood obesity and consequently might not represent stakeholders in other low-income communities. Furthermore, the early education sector was underrepresented and therefore, study results may not fully represent the views of all stakeholders. Finally, this study focused on a specific low-income region in the north east of the U.S., and therefore results might not be applicable to other low-income communities.

Since there exist only a few effective strategies which help overweight and obese children and adults to lose weight and to maintain a healthier weight [20, 21], prevention strategies are still key. Our study results are encouraging because they show that some important strategies may already be in place to prevent and control childhood obesity. Resources may be more appropriately directed toward increasing policy changes and increasing cross-sector communication and collaboration, which could affect whole organizations and/or communities, helping community interventions to progress even further.

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Table 1:

Characteristics of participating stakeholders (N=39)

Stakeholder Demographics	**N (%)**
Community sector	
Primary health care	7 (17.9)
Special Supplemental Nutrition Program for Women, Infants and Children	6 (15.4)
School	15 (38.5)
Afterschool programs	8 (20.5)
Early care and education	3 (7.7)
Total	39 (100)
Organizational Role of Stakeholder	
Implementer	30 (76.9)
Program leader	9 (23.1)
Sex	
Female	36 (92.3)
Male	3 (7.7)
Age, years	
18 – 29 years	5 (12.8)
30 – 39 years	9 (23.0)
40 – 49 years	11 (28.2)
50 – 59 years	12 (30.8)
60 or older	2 (5.1)
Ethnicity	
Hispanic	5 (12.8)
Not Hispanic	34 (87.2)
Race	
White	33 (84.6)
Asian	2 (5.1)
African American	1 (2.6)
Unknown	3 (7.7)

Table 2:

Illustrative quotes from community stakeholders

Research aim	Community Stakeholder Sector	Quote
Major factors influencing childhood obesity in the community	School	1. “I’ve been teaching physical education for quite a long time and in 1995 when we removed the time mandate for physical education classes it allowed for local districts to start eliminating and greatly reducing the amount of PE [physical education]. So back in that time I knew that this [increasing prevalence of childhood obesity] would happen. So it was something that was very frustrating because they took physical education out of the occasion and went toward testing and became very rigorous to ELA [English, Language, Art] and math to the elimination of any sort of recess and any sort of physical education.”
	Early Care and Education	2. “Low income families can’t afford that [program attendance fees]. You’re looking to the school, and you’re looking to the early care and education program to facilitate the exercise. Kids coming home after school and they’re sitting in front of the TV, or they’re playing with their video games.”
	Afterschool	3. “It [high prevalence of childhood obesity in the community] makes me very sad because—I just notice when I drive around I don’t see kids playing outside like kids used to do a long time ago. Everybody is in the house playing video games, so we got try and change that.”
	School	4. “I think that in some ways, it has to do with the sociodemographics. It’s a lot less expensive to eat poorly than it is to eat well.”
	School	5. “Depending on where you live there may not be a place to go outside and play and depending on their economic status … you may not have a yard, or you may not be near a park.”
	Early Care and Education	6. “In [community name], we actually only have three grocery stores. For a large city that’s a very small number. But also, it’s those convenience stores that are on the corners and are near the housing. And you know, they’re offering candy and chips and everything else, and where are the fruits and the vegetables and everything else that we preach about? But, they [parents] don’t have the accessibility to find and eve n purchase some of those items.”
	School	7. “Well the first thing that comes to my mind is a real large lack of education, whether it be with the student or with the parents, but the adults in general are not aware of a lot of the things that they should be aware of.”
	School	8. “I’m not sure if there is a lot of organized activities and sports that happen for these children because of so much funding that has been cut. For example, at my own school, we used to be able to run afterschool intramural programs, and afterschool programs and pay the teachers to run these programs, but unfortunately many of those programs have been cut.”
	School	9. “So when we don’t have that sort of ability for transportation or financial support to be able to join the youth league and to be able to … cart them over to the youth league, the students in this area do not have a lot of external organized activities.”
	Primary Healthcare	10. “But I would say half of the community is Hispanic origin and they attend to eat the rice and the beans and things that are high in carbs, high in fat and not necessarily the healthiest choices, not a whole of vegetables… They [parents] wouldn’t think that they are doing anything wrong. They are just trying to feed their kids.”
	School	11. “I think … that we have a strong Hispanic culture and there is a very different attitude towards food and weight … and health.”
	WIC	12. “Not all of our neighborhoods are the safest neighborhoods, so … I’m sure people aren’t walking as much as they used to.”
Strategies related to childhood obesity prevention and most feasible of these strategies	School	13. “There is a program through the state where the cafeteria, the food service management, is responsible for preparing healthy lunches and make sure that they eat according to My Plate.”
	School	14. “In … our school wellness initiative we don’t allow parties that have unhealthy food. Like, we can’t bring cupcakes into the building. We can’t do bake sales and things like that. I think we’re ahead of the game when it comes to that initiative to try to promote healthier foods. We don’t use food as a reward for kids. I think we also have water available for kids if they need water.”

Research aim	Community Stakeholder Sector	Quote
	School	15. “The food [school lunch]. Because I mean that’s being done district wide.”
	Afterschool	16. “I think the most [feasible] was the water. Because when we were offering the water to the kids they kind of looked at us like they were crazy like, “You’re really offering us water?” Which we never did, and we keep cold water in the fridge. They seem like, they lean more towards, the water than the milk.”
	Afterschool	17. 17. “Well, we just actually—and our policy is that during school vacations they have to bring their lunch. We just made it a policy: no fast food, no juice. It has to be a healthy lunch. We send information regarding what healthy lunches and what healthy serving sizes are to them [parents].
	School	18. “We’re also gonna be doing a Walk Across America, so we’re getting some pedometers. The third, fourth and fifth grades when they come in at 8:00am they walk around the gym. We’re gonna start tracking how many miles they walk around the gym. We’re gonna actually put it up on the bulletin board so that the kids can see how far they’ve traveled.”
	Afterschool	19. “New Bedford Y is we have a youth circuit area within our Wellness Center so we have a line of equipment that’s designed specifically for kids. Actually, it’s great equipment and it uses the child’s body weight so it’s such great equipment that even our adults use it.”
	Early Care and Education	20. 20. We have access to a gym and so does in MOC [Montachusett Opportunity Council], and taking the kids to the gym to do some real movement out of the classroom is also good, too.
	Afterschool	21. 21. “The activity. The physical activity is very, very easy because you tell kids to put rollerblades on, and they love it…They have to jump around and they love that stuff… Our kids sit in the classroom for eight hours. They are so thrilled to be out and run around in the gym. They just love to run around. Oh, it was easy. It was very, very easy.”
	Afterschool	22. “The most feasible is probably the open gym time. Because it’s just entirely at our facility so it doesn’t require any of our. staff to take extra time, it’s already on our hours. It’s just at our site so it’s probably in terms of funds it’s the least expensive.”
	Afterschool	23. “We do a monthly newsletter that so that’s most of our communication to the parents. We try and always attach healthy, fun recipes.”
	Early Care and Education	24. “The family handouts. If you can provide family handouts to parents that’s the easiest way to get information [to them]. Or family activities. You know, offering stuff that they can to get, stuff the whole family can do.”
Needed and important strategies – organizational level	School	25. “So the kids are always complaining that they don’t get PE [physical education] enough because they only see me once every six days. So, I would say increasing PE.”
	School	26. “They desperately need to add more elementary physical education teachers.”
	School	27. “I definitely feel we should have gym, you know, physical education every day. Every day. I mean it’s ridiculous not to have that. I also think that we should have health classes. We don’t have health classes.”
	Early Care and Education	28. “I really wish physical activity and the health and nutrition was more applicable and also mandated so to speak. And um, maybe mandate is the wrong word. Maybe more utilized in the classroom.”
	School	29. “I do think that increasing phys ed [physical education] time and making sure that, you know, recess is mandatory. I think those would be helpful.”
	School	30. “I think they could do both [including physical activity and nutrition] you know. Bring it right in the curriculum. I haven’t seen that. And that’s too bad, but I think that it could happen. If they really tried, they could bring it in to the curriculum. Then it would be mandatory and the kids … the whole state of Massachusetts, the department of education could incorporate it. That should come from national, from the President as far as like incorporating something that’s mandatory in the curriculum where the children learn about nutrition.”
	Early Care and Education	31. “Get their school lunches healthier. I like that they can’t send in cupcakes and cookies anymore for school for the snacks and school parties. That makes me happy.”
	Afterschool	32. “I would like to see implemented a little bit better a snack or food and drink policy at our center. I think that we’ll be able to a better snack policy. So maybe only water can be allowed in certain areas and then as far as foods maybe we provide a better snack to them

Research aim	Community Stakeholder Sector	Quote
		[children]. Unfortunately right now we do not have a snack available for the kids and consequently kids are bringing in outside food and it's not always the best choices."
	School	33. "As far as the food goes, I do think that maybe giving them [the children] a few other options. I know that's difficult when you're feeding a mass amount of kids, but I think giving some healthy, additional healthy options, you know the kids maybe haven't been exposed to a lot of this food."
	Early Care and Education	34. "Probably one of the easiest things that can be done is to change their eating habits at school. You know, get the vending machines out of the schools. Um, changing the way the kids view their meals at school."
	School	35. "I can think they could do healthy snack machines, like vending machines."
	School	36. "We definitely could be taking far more aggressive action on getting to the homes through technology. It's amazing, they don't have food but they do have computers."
	Primary Healthcare	37. "But I feel that if you starting incorporating the homes that will work."
	WIC	38. "It is more the information part . more information, more ideas, what different things they [parents] can do with their kids."
	Afterschool	39. "Something that we could do—I don't know how possible it would be—but would be hosting nutrition/healthy-living classes for the parents."
Needed and important strategies – community level	Early Care and Education	40. "But instead of everybody just doing things separately, and if we're all typically working on the same goals, why don't we all work together? …. Let's share our resources, share our ideas and let's tag team this. Let's really work together and make a bigger team and a bigger trend throughout the community. So really, the collaboration piece is a huge piece."
	School	41. "I think every entity that has a direct public connection needs to incorporate a message to the whole community. It has to be consistent."
	Afterschool	42. "I would say town meetings, community meetings, events. Having flyers around letting them know, give a little bit brief information on it, some pamphlets. The spoken word, having the word out there and especially having a communication with the health centers which is important because a lot of people go there."
	Early Care and Education	43. "I think that probably offering more family oriented outdoor movement to get the kids away from the TV as much as possible."
	School	44. "Helping parents to understand, that … a cookie isn't a good snack."
	Afterschool	45. "I firmly believe that parent involvement and awareness and education are so important. So beginning that fight, so to speak, in the home is absolutely essential."
	School	46. "I think that we should be promoting our parks. A lot of these neighborhoods do have nice parks that kids can go to and I think we can talk about exercise, or taking a walk or you know doing something fun."