

Georgia Collaborative Task Force - Data and Evaluation Workgroup
Social Marketing Plan
July 24, 2004

CDCynergy, is a social marketing tool developed by the CDC that is used to guide organizations step by step through the process of social marketing and intervention development, implementation and evaluation. The following is Phase I and Phase II of the CDCynergy tool.

Phase 1 – Problem Description

1.1 Problem Statement

Nationally, the percentage of overweight children and adolescents has more than doubled in the past two decades, from 7% in 1980 to 15% in 2000. African American and Hispanic children and youth are disproportionately affected with 21.5% and 21.8% respectively classified as overweight compared to 12.3% of non-Hispanic white children. In Georgia during the 2001 school year, 13% of middle school children were overweight, and 16% of middle school children were at risk for overweight (Georgia Youth Tobacco Survey). In May of 2003, a sample of Georgia 4th graders showed that 24.8% of 4th graders were overweight, and 41.6% were at risk for overweight (Georgia Childhood Overweight Prevalence Survey). In 2002, the following percent of 2-5 year old children were overweight by race: 17% Hispanic, 15% White, 13%Black, and 12%Asian. An alarming fact also realized by this research is the percent of children 2-5 that were at risk for overweight: 17% Hispanic, 11% White, 11% Asian, and 10% Black (Georgia Pediatric Nutrition Surveillance).

Georgia is divided into urban, suburban, rural growth, and rural decline. The highest prevalence of overweight and at risk for overweight occurs in areas of rural decline (65.7%). Rural growth areas have a prevalence of overweight/at risk for overweight of 51.4%. Urban and Suburban areas have the lowest rates of overweight/at risk for overweight (suburban 54.9%, urban 49.8%.)****

Obesity has become an increasingly important medical problem in children and adolescents, and is associated with risk factors for cardiovascular disease, type 2 diabetes, pulmonary complications, growth acceleration, dyslipidemia, musculoskeletal problems and psychosocial programs (*Ebbeling et al., 2002*). This is likely to cause more chronic health problems, and more severe disparities between minority youth and the general population. Children and adolescents who are overweight are more likely to be overweight or obese as adults (Casey et al., 1992; Guo et al., 1994; Ferraro et al., 2003). Overweight adults are at increased risk for heart disease, high blood pressure, stroke, diabetes, some types of cancer, and gallbladder disease (PHS, 1988).

****Data provided by Georgia Childhood Overweight Prevalence Survey: The Four Georgias, May 2003

1.2 Causes of the health problem and identify potential audiences

Contributing behavioral factors:

GENETIC/BIOLOGICAL

- Genetic predisposition.
- Physiological response to energy dense, high fat foods (Pediatrics, 1998)

BEHAVIORAL

- Behavioral choice
- **Family meal patterns; including increase food consumption outside the home**
- Family food choices
- Portion control and portion size
- Fat intake
- **Sugar beverages (CDC, 2004)**
- Increase in sedentary behaviors
- **Increased television viewing (CDC, 2004)**
- **Low fruit and vegetable intake (CDC, 2004) (Pediatrics, 1998)**
- Preference for fruit and vegetables, learned behavior (Baranowski et al., 1998)
- Decrease in liquid milk consumption (CDC, 2004)
- Meal skipping (CDC, 2004)
- Snack food consumption (CDC, 2004)
- Breastfeeding/Bottle feeding (Pediatrics, 1998)
- **Poor parental modeling**
- Lack of physical activity (YRBSS, 2003)
- Parental education; greater than 13 years of education improves child's nutrition (Pediatrics, 1998)

PHYSICAL ENVIRONMENT

- **School food service (NICHS, 2003)**
- **Food availability/access**
- Multitude of nutrition products (overwhelming, what works?)
- Lack of sidewalks/Inability to walk to school
- **Unsafe neighborhoods and parks**
- Built environment resulting in increase motor vehicle use
- Increased use of Technology
- Neighborhood planning and zoning, including clusters of fast food outlets near schools
- Strict parental control of diet
- **Lack of structured physical activity during the school day (YRBSS, 2003)**
- **Media exposure (advertising) (Center for Weight and Health, 2001)**
- Lack of access to physical activity centers (Pediatrics, 1998)

SOCIAL ENVIRONMENT

- Super-sizing
- Lack of value placed on health, nutrition and physical education in schools
- **State educational policies not support recess and daily PE in schools**
- Cafeterias as profit centers in schools
- Competitive foods policies
- Vending policies
- Peer modeling
- **TV viewing while eating (Ebbeling et al., 2002)**
- Increased pressure surrounding test scores
- Lack of parental support for physical activity (Pediatrics, 1998)
- **Need to learn about social networks.**

- Need to learn about culture of target audience.
- Does discrimination against healthy eating occur?
- What are the living conditions of our target audience?
- Does our target audience have different segments/neighborhoods?
- Education of audience.
- Income of audience.
- Social norms of audience.
- Social capital of audience.
- Need to learn about attitude of audience.
- Need to learn perceptions of audience.
- Need to learn preferred information channels of audience.
- Who are the community members/organizations that will be important to the intervention?

Risk Factor	Direct Contributing Factors	Indirect Contributing Factors
Unhealthy eating	<ul style="list-style-type: none"> ➤ Lack of availability of healthy choices ➤ Cultural Background ➤ Low SES ➤ Competitive unhealthy foods ➤ Increased accessibility to fast food ➤ Unhealthy food environment ➤ Vending machine choices ➤ Lack of family mealtime ➤ Increased portion size ➤ Lack of parental modeling ➤ Personal choice issues ➤ Increased consumption of sweetened beverage ➤ Emotional issues 	<ul style="list-style-type: none"> ➤ <i>Marketing</i> ➤ Financial incentive ➤ Lack of nutrition labeling at fast food outlets ➤ Societal shift in habits ➤ Lack of income ➤ Economics – working parents ➤ Over scheduling of activities ➤ Culture ➤ Lack of parenting skills around feeding ➤ Crazy nutrition media messages ➤ Lack of social support ➤ Societal norms ➤ Perceived cost
Decreased physical activity	<ul style="list-style-type: none"> ➤ Increased screen time ➤ Poorly planned environment - built environment not conducive to walking/biking ➤ Increased TV viewing/screen time ➤ Increased computer time ➤ No PE/Recess in schools ➤ Parental modeling/support ➤ Personal choice issues ➤ Social/emotional issues related to food 	<ul style="list-style-type: none"> ➤ Lack of parental guidance ➤ Increased technology – Internet ➤ Programming ➤ TV as babysitter – latch key kids ➤ Zoning laws ➤ Greed of economic development ➤ Traffic ➤ Predators ➤ Lack of Public Funding for community facilities program ➤ Lack of knowledge on part of planners ➤ DOT policies favoring auto for highways do not support Marta ➤ Societal norms
Protective Factors	Direct Contributing Factors	Indirect Contributing Factors
Improved Nutrition	<ul style="list-style-type: none"> ➤ Increased education ➤ Healthy home cooking ➤ Access to affordable and healthy food choices ➤ Access to drinking water ➤ Availability of appetizing F&V at school, home and stores ➤ Absence of bad food choices ➤ Parenting Role Models ➤ Genetics ➤ Healthy eating ➤ Personal choice factors 	<ul style="list-style-type: none"> ➤ Mental Health

Increased physical activity	<ul style="list-style-type: none"> ➤ Increased education ➤ Decreased inactivity (less sedentary) ➤ Environment that makes PA safe, easy and accessible ➤ Activities to support moderate PA – 60 mins a day, structured and free ➤ Increased access to programs/facilities ➤ Improved environmental design ➤ Parental modeling of physical activity ➤ Promotion of PA by gender 	<ul style="list-style-type: none"> ➤ Mental Health ➤ Eating a healthy diet
------------------------------------	--	--

Existing supports to prevent or solve the problem (behavioral, environmental):

Existing supports:

- State partners from private and public sectors
- Beginnings of state legislation (physical education/recess)
- Local and state coalitions (advocacy and education)
- State PTA
- GPAN
- GCORD
- Training programs already in place for school personnel
- QCC requirements for 4th grade students in Georgia
- Many after school programs already exist
- School nurse program
- Georgia learning connection website
- Local school board policies re: nutrition/vending and physical education/activity
- Intervention programs (in school and after school)
- Chronic Disease coordinators by public health district
- Statewide Safe Kids
- Health promotion messaging – Take Charge of Your Health
- Parks and Recreation programs (Hearts n’ Parks)
- Statewide cardiovascular disease prevention initiative
- PATHs, Silver Comet trail, community bike paths and walkways
- School gyms and grounds
- Training of school health personnel (PADRES, School Health Manual)

Audiences to target and rationale:

Primary: Children, ages 5-11 yrs, Kindergarten through 5th grade

Secondary: Parents, children, school cafeteria, school physical education, and after school programs

Who is most affected?

Hispanic and African American children.

Who is most likely to change behavior?

Young children, still developing food preferences.

Who is able to shape circumstances relevant to the problem?

Parents	Schools-after	Clinicians	School lunch
Children	Advertising	Recreation programs	
Community	Restaurants	School PE	

Elementary schools, the environment in which American children spend the largest portion of their waking hours, are powerfully positioned to reach children on a regular basis and foster changes in health-related behaviors. In the past, schools provided many opportunities for children to be physically active, including recess, free play periods, and physical education classes. Additionally, the opportunity for students to receive a variety of healthy foods through school breakfast and school lunch programs has expanded considerably. Over the past decade, schools have felt increasing pressure to improve the academic performance of students, the principle measure of school success. This intervention will contribute to the body of knowledge about health and learning in young people, key factors in achieving positive educational outcomes. Schools can promote academic learning while encouraging physical activity and healthful nutrition that are associated with broad-based health benefits. Data shows successful behavior change occurs in students participating in school programs that involve influential adults including teachers, administrators and parents.

1.3 Identify models of behavior change and best practices.

Applicable behavior change models and determinants of behavior:

The Health Belief Model (HBM) was designed in the 1950's by a group of scientists working at the US Public Health Services. The theory is driven by the idea that people engage or do not engage in behaviors due to the consequences of the behavior. People participate in health programs if the benefit they will receive is large, or they are highly at risk. The HBM consists of weighing the odds, what are the perceived barriers and the perceived benefits. The HBM has six key concepts:

Health Belief Model

Perceived Susceptibility	An individual's belief of the chance of them personally getting a condition. <i>Ie. Does the individual think they may become obese?</i>
Perceived Severity	One's belief on how acute the consequences are. <i>Ie. What will happen if I am obese? Low self – esteem or heart disease?</i>
Perceived Benefits	One's belief in the ability of the action to reduce or alleviate the consequences. <i>Ie. If I follow this plan, will I lose weight? Will eating healthy protect me from heart disease?</i>
Perceived Barriers	One's belief about the costs of the action and the personal factors that will prevent them from being able to follow the action. <i>Ie. The school cafeteria food is not healthy and I don't have time or money to pack my own lunch.</i>
Cues to Action	Tactics/events that prepare the individual for action. <i>Ie. My parents are obese and I don't want to be that way.</i>
Self – efficacy	An individual's confidence in his/her ability to take action. <i>Ie. I believe that I can be active 30 minutes a day because my teacher taught me many ways to be active.</i>

The HBM is critiqued for failing to take into account environmental or social factors. The theory assumes that an individual's behaviors are controlled at the individual level and he/she has complete autonomy over his/her actions. The goal of the theory is to modify beliefs about an action and therefore to change the behavior. Changing a person's attitude may not be enough to change the behavior

The **Transtheoretical/Stages of Change Model (TTM)**, was designed from a complete analysis of psychotherapy and behavior change theories. The model described the new concept that people use multiple theories to make decisions. The

theory states that individuals progress through stages before taking action and maintaining behaviors. The stages of the TTM are:

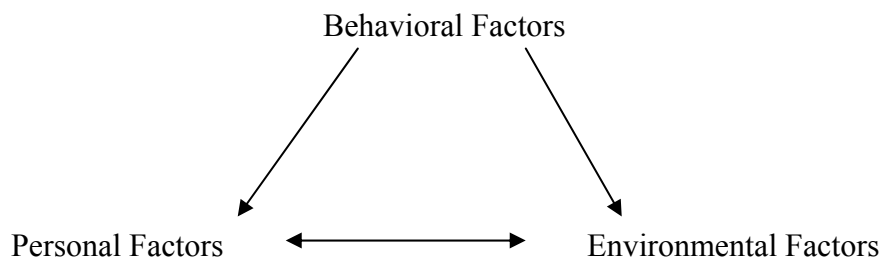
Precontemplation	Has no plans to take action, may not know problem exists.
Contemplation	Thinking of taking action.
Preparation	Has begun to take steps towards action.
Action	Has changed behavior for less than 6 months.
Maintenance	Has maintained behavior for greater than 6 months

The goals of interventions designed from the TTM theory are to help people progress through stages gradually. Programs work to move people forward through the stages by increasing the perceptions of the pros of the behavior and decreasing the perceptions of the cons of the behavior. The processes of change occur through 10 constructs. The constructs of the TTM are:

- | | |
|--------------------------------------|--|
| 1. <u>Consciousness raising</u> | Learning about the healthy behavior. |
| 2. <u>Dramatic relief</u> | Experiencing fear and anxiety over the risks of the unhealthy behavior. |
| 3. <u>Self – reevaluation</u> | Taking ownership of need for behavior change. |
| 4. <u>Environmental reevaluation</u> | Realizing the impact of the behavior on his/her physical and social environment. |
| 5. <u>Self-liberation</u> | Committing to change. |

At the interpersonal level, the dominant theory is the Social Cognitive Theory (SCT). SCT was developed by Bandura in 1986. The theory describes a dependent relationship between three constructs; the environment, personal factors, and the behavior. This is the triadic reciprocal model, if you change one of the constructs you then change the ability to perform the behavior.

Triadic Reciprocal Model or Social Cognitive Theory (SCT)



SCT describes the health behavior as being dynamic and dependent on the environment and the person. These three constructs constantly influence one another to form reciprocal determinism. SCT does not clearly describe how the interaction occurs between the three constructs. The environment includes families, peers, institutions, and media. The environment also includes the person’s reaction to the environment, this is called the situation. Situation includes place, time, and person’s role in the environment. Environment can also include access to tangible goods and limitations. One key component of the environment is observational learning. People learn by watching others in their environment, this is how norms are developed.

SCT describes behavior as a learned operation that in order to change one must know the specific behavior and have the skills to perform the behavior. This is known as behavioral capability, which specifies the difference between learning a behavior and performing a behavior. SCT stresses that interventions must be very clear about the particular behavior to be changed and increase the individual’s self efficacy to perform the behavior.

Behavior is reinforced three different ways in SCT.

- Direct reinforcement
- Vicarious reinforcement (observational learning)
- Self-reinforcement

Intrinsic or self-reinforcement has been shown to be a strong predictor of behavior change.

SCT is composed of numerous constructs that are important to the triadic model of reciprocal determinism. Unfortunately, interventions are often designed that use only a few of the constructs of SCT. Interventions that do not use all of the constructs often lead to an oversimplification of the theory. The following table summarizes SCT.

Major Concepts In Social Cognitive Theory and Implications for Intervention

(The table is from Health Behavior and Health Education, 3rd Edition)

Concept	Definition	Implications
Environment	Factors physically external to the person	Provide opportunities and social support
Situation	Person's perception of the environment	Correct misperceptions and promote healthful norms
Behavioral Capability	Knowledge and skill to perform a given behavior	Promote mastery learning through skill training
Expectations	Anticipatory outcome of a behavior	Model positive outcomes of healthful behavior
Expectancies	The values that the person places on a given outcome; incentives	Present outcomes of change that have functional meaning
Self – Control	Personal regulation of goal directed behavior or performance	Provide opportunities for decision making, self monitoring, goal setting, problem solving, and self-reward
Observational Learning	Behavioral acquisition that occurs by watching the actions and outcomes of others' behavior	Include credible role models of the target behavior
Reinforcements	Responses to a person's behavior that increase or decrease the likelihood of reoccurrence	Promote self initiated rewards and incentives
Self-efficacy	The person's confidence in performing a particular behavior and in overcoming barriers to that behavior	Approach behavior change in small steps to ensure success; seek specificity about the change sought
Emotional coping responses	Strategies or tactics that are used by a person to deal with emotional stimuli	Provide training in problem solving and stress management; include opportunities to practice skills in emotionally arousing situations
Reciprocal Determinism	The dynamic interaction of the person, behavior, and the environment in which the behavior is performed	Consider multiple avenues to behavioral change including environmental, skill, and personal change

Ecological Models of health behavior acknowledge that multiple levels of influence work together to determine health behaviors. Ecological models look at five levels of influence; intrapersonal factors, interpersonal processes and primary groups, institutional factors, community factors, and public policy. Ecological models function on four basic assumptions:

- Health is influenced by physical and social environments
- Environments are multi-dimensional and dynamic
- People interact with the environment at different levels; family work, culture, communities, and populations
- People influence the environment, and then environmental changes alter health behaviors

Currently, research is underway to determine what environmental constructs predict positive health behavior change. The following are proposed environmental constructs to guide interventions:

1. availability of healthy or unhealthy consumer products
2. physical structures
3. policy and social environments
4. media and culture

The campaign to increase the rate of seat belt use employed an ecological model. The campaign involved policy change, mass media, and the use of coalitions. Ecological models work on the framework that one level of change is not enough to change behavior. For example, if sidewalks are added to a community, there also must be a campaign to promote use of the sidewalks. Adding the physical structure to the environment is not enough.

Ecological models do have many challenges. The primary challenge is time, ecological models take years to implement. Funding is also an important consideration. Results are often not seen for years and often funding is dependent on results. Coalition building can be difficult, especially when community members have different knowledge levels. Evaluation is not a one-time process; it must be ongoing to ensure the intervention is on target. Despite all of these challenges, obesity is an issue that has several levels of influence and fits well within the scope of the ecological model.

Summary Table

Theory/Model	Summary	Key Concepts
Individual Level		
Health belief model	For people to adopt recommended physical activity behaviors, their perceived threat of disease (and its severity) and benefits of action must outweigh their perceived barriers to action.	Perceived susceptibility Perceived severity Perceived benefits of action Perceived barriers to action Cues to action Self-efficacy
Stages of change (transtheoretical model)	In adopting healthy behaviors (e.g., regular physical activity) or eliminating unhealthy ones (e.g., watching television), people progress through five levels related to their readiness to change—precontemplation, contemplation, preparation, action, and maintenance. At each stage, different intervention strategies will	Precontemplation Contemplation Preparation Action Maintenance

Theory/Model	Summary	Key Concepts
	help people progress to the next stage.	
Relapse prevention	Persons who are beginning regular physical activity programs might be aided by interventions that help them anticipate barriers or factors that can contribute to relapse.	Skills training Cognitive reframing Lifestyle rebalancing
Information-processing paradigm	The impact of persuasive communication, which can be part of a social marketing campaign to increase physical activity, is mediated by three phases of message processing—attention to the message, comprehension of the content, and acceptance of the content.	Exposure Attention Liking/interest Comprehension Skill acquisition Yielding Memory storage Information search and retrieval Decision Behavior Reinforcement Post behavior consolidation
Interpersonal Level		
Social learning/social cognitive theory	Health behavioral change is the result of reciprocal relationships among the environment, personal factors, and attributes of the behavior itself. Self-efficacy is one of the most important characteristics that determine behavioral change.	Self-efficacy Reciprocal determinism Behavioral capability Outcome expectations Observational learning
Theory of reasoned action	For behaviors that are within a person's control, behavioral intentions predict actual behavior. Intentions are determined by two factors—attitude toward the behavior and beliefs regarding others people's support of the behavior.	Attitude toward the behavior • Outcome expectations • Value of outcome expectations Subjective norms • Beliefs of others • Desire to comply with others
Theory of planned behavior	People's perceived control over the opportunities, resources, and skills needed to perform a behavior affect behavioral intentions, as do the two factors in the theory of reasoned action.	Attitude toward the behavior • Outcome expectations • Value of outcome expectations Subjective norms • Beliefs of others • Desire to comply with others Perceived behavioral control

Theory/Model	Summary	Key Concepts
Social support	Often incorporated into interventions to promote physical activity, social support can be instrumental, informational, emotional, or appraising (providing feedback and reinforcement of new behavior).	Instrumental support Informational support Emotional support Appraisal support
Community Level		
Community organization model	Public health workers help communities identify health and social problems, and they plan and implement strategies to address these problems. Active community participation is essential.	Social planning Locality development Social action
Ecological approaches	Effective interventions must influence multiple levels because health is shaped by many environmental subsystems, including family, community, workplace, beliefs and traditions, economics, and the physical and social environments.	Multiple levels of influence <ul style="list-style-type: none"> • Intrapersonal • Interpersonal • Institutional • Community • Public policy
Organizational change theory	Certain processes and strategies might increase the chances that healthy policies and programs will be adopted and maintained in formal organizations.	Definition of problem (awareness stage) Initiation of action (adoption stage) Implementation of change Institutionalization of change
Diffusion of innovations theory	People, organizations, or societies adopt new ideas, products, or behaviors at different rates, and the rate of adoption is affected by some predictable factors.	Relative advantage Compatibility Complexity Triability Observability

Sources

1. Alcala R, Bell RA. *Promoting Nutrition and Physical Activity Through Social Marketing: Current Practices and Recommendations*. Davis, CA: Center for Advanced Studies in Nutrition and Social Marketing, University of California, Davis;2000.
2. National Institutes of Health. *Theory at a Glance: A Guide for Health Promotion Practice*. Bethesda, MD: National Institutes of Health, National Cancer Institute;1995.
3. US Department of Health and Human Services. *Physical Activity and Health: A Report of the Surgeon General*. Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.

Best practices/lessons learned from other programs:

From Robert Wood Johnson Foundation Report* – *Healthy Schools for Healthy Kids*

<http://www.rwjf.org/publications/publicationsPdfs/healthySchools.pdf>

In-school Programs - Key Findings:

- Physical activity and nutrition programs in schools alone cannot solve the childhood obesity epidemic. But such programs can foster long-term healthy habits in children and contribute significantly to prevention.
- Programs need time to succeed.
- Training is critical to successful program implementation.
- “New P.E.,” which emphasizes personal fitness and lifelong activities over team sports, is beginning to receive recognition as an effective alternative to traditional P.E. classes.
- Providing kids with a sense of program ownership increases learning and participation and helps maximize the success of in-school programs.
- Teacher buy-in is increased when programs incorporate academics.
- District-level support significantly increases teacher buy-in.
- Children take healthy behaviors home to their families.
- Schools without a strong program leader or cohesive planning team have greater problems with implementation.
- Program implementation is hindered by the increased emphasis on academics and testing.
- Many schools lack funding for equipment, in-class materials or additional training needed for successful implementation.
- Many program providers lack the capacity to provide implementation training and guidance to the growing number of inquiring schools.

After-school Programs - Key Findings:

- There is no broad-reaching infrastructure to both disseminate and ensure implementation of after-school programs.
- Most after-school programs do not address physical activity and healthy eating.
- Many after-school programs are led by untrained staff.
- The frequency and duration of after-school programs are highly variable.
- Inconsistent attendance is an issue for many programs.
- Most after-school programs are not based on any model and are developed for and adapted to the communities in which they are implemented.

RECOMMENDATIONS

Pyramid’s research on policies, programs and efforts to increase physical activity and healthy eating in schools revealed that change is slowly taking place and gaining momentum. For every school to become a healthy school, a number of steps must be taken. These are encompassed in our recommendations.

- Provide 30 minutes of P.E. for every child, every day in every grade.
- Implement “new P.E.” programs.
- Conduct regular physical fitness testing in schools.
- Convert the contents of school vending machines to healthy foods and beverages.
- Improve school lunches.
- Strengthen competitive food standards.
- Interventions should also educate children about physiological factors and health risks of obesity, establishing possible future consequences of their present actions.

*(RWJF Report was produced by Pyramid Communications)

Social Marketing Strategies

Numerous social marketing strategies have been employed to increase physical activity, and fruit and vegetable consumption. These campaigns use traditional marketing strategies to target an audience and develop materials to encourage certain behaviors. The 1% milk campaign in public schools is an example of a social marketing strategy. The intervention focused on one behavior and the target audience was low-income public schools in urban communities (Center for Weight and Health, 2001). The marketing campaign was designed using the PRECEED-PROCEED model. Some tools used were celebrity endorsement, product positioning, advertising, product trials, and the use of entertainment. The campaign increased low fat milk consumption in intervention schools by 28%. Social marketing is an important strategy for interventions although it is often best used in

combination with other interventions, particularly if the goal of the program is a complex behavior (Center for Weight and Health, 2003).

Lessons learned from clinical based interventions (NICHS, 2003)

1. Emotional/psychological counseling is effective
2. Increase self-esteem
3. Increase self efficacy
4. Individual attention is necessary
5. Rely on professionals

- Community partner involvement is key in making the population-based communication strategies more personal to individuals, ultimately making efforts more effective (Center for Weight and Health, 2001).
- In the development of communication strategies, marketing campaign designs should be driven by applying behavioral theories. Goals of the communication efforts should be specific, realistic, and measurable (such as “Be physically active for 30 minutes, 3 days a week”). Short-term goals should be directed at increasing physical activity and nutritious eating habits, and long-term goals should be focused on maintaining these behaviors (Center for Weight and Health, 2001).

Behavior Changes	School Environment	Community Environment	Home environment
Regular meal patterns	Improve school food	Access to quick healthy food	Reduce TV viewing
Portion control	Modeling	Healthy dine out options	Eat as a family
Breastfeeding	Remove vending and a la carte items	Accessible fruits and vegetables	Modeling good nutrition and PA
Teach importance of a varied diet at a young age	Health fundraising	Reduce food advertising targeting children	Increase access to health foods
Teach hunger and satiability	Legislation mandating PE	Encourage females to be physically active	Create rewards for PA and healthy eating
Learn skills to cope with emotional/psychological issues	Make public connection between test scores and physical activity	Create rewards for PA and healthy eating	Prepare healthy meals ahead of time
	Create a training program for the “new PE”	Teach physiological importance of nutrition and physical activity	Make family physical activity events
	Focus on physical activity, not competition in PE	Improve access to PA	

1.4 Form your strategy team

This section included names of individuals associated with this particular project. While those names have been removed, it may be helpful to know that the strategy team had members with expertise in the following areas:

- Surveillance
- Marketing research and analysis
- Expertise in interventions and best practices
- Program development
- Social marketing and health communication
- Evaluation

Members also represented a wide group of partners.

Future members to bring on board from intervention community:

1. Teachers
2. School Board Members
3. PTA
4. Community Leaders
5. Local Business
6. Local health centers
7. Local medical practitioners
8. Students
9. After school personnel
10. Faith based leaders
11. Cafeteria personnel

Structure for communications, decision-making

The team will be broken up into two focuses. One team will primarily work on the state wide obesity plan development. The other team will work on and make decisions specifically regarding the pilot intervention. The meetings for the workgroups occur on Tuesdays from 1pm to 4pm at the Loudermilk Center. The groups need to further segment for efficiency. Decisions are made via consensus and if not able to achieve consensus then by majority rule vote. Workgroups follow the larger Task Force Terms of Reference/Operating Guidelines

1.5 Conduct a SWOT analysis

SWOT analysis was conducted on June 8, 2004 in Atlanta with Data and Evaluation workgroup representatives and representatives from schools (state and local), teachers, community organizations (eg Parks and Recreation). The results are as follows:

Strengths:

- Partnerships – State and local
 - Public Health Departments, Professional Associations, Community Groups
 - Health and Social Coalitions, Non profit organizations
- Existing infrastructure
- Philanthropic Collaborative Funding to GPAN and GCORD is committed for childhood obesity policy/prevention activities
- Training programs exist for school and school nutrition staff

- Existing documents/presentations re: nutrition, PA and academic achievement
- Model programs exist (Planet Health, TAKE 10!®, CATCH, SPARK, Kids on the Move)
- Awareness exists; obesity is a “hot topic”
 - Media attention to obesity, PA, and nutrition
 - Federal and State attention to obesity and related chronic diseases
- GA Legislation regarding nutrition and PA was introduced in the past 12 months
- Existing Board of Education/QCC requirements exists for fitness testing in 4th grade and development of an individual fitness plan
- School’s accessibility – able to reach majority of children
- Extended day programs already exist
- School nurse program already exists
- GA learning connection is an on-line resource within the Dept of Education website:
 - Click on educators and curriculum instruction
 - Information re: nutrition and school nurses
 - Contains instructional standards and sample lesson plans

Weaknesses:

- Lack of coordination/communication between partners
- Leadership at state level (lack of PE coordinator with Dept of Education)
- Lack of understanding about the issue
- Parents’ knowledge – PA, eating, maternal perceptions about overweight
- The “New PE” is not understood
- QCC - State requirements vs. actual implementation
- Lack of resources - financials and staffing
- Lack of direct programming re: PA/Nutrition
- Lack of enforcement of policies (existing)
- Environment (no sidewalks to school, accessibility to parks and safe places, transportation to programs)
- Parent involvement is lacking or minimal
- Parent behavior – lack of role modeling and poor purchasing behaviors
- School as a financial model vs. children’s health as a priority - PTA fundraisers include food (high fat, high sugar), cafeteria as a profit center, etc., vending
- Local and state accountability structure missing PA/Nut components
- Staff turnover (school) impacts:
 - Program sustainability
 - Policy and Procedure implementation and maintenance
- Turf issues result in barriers to action (gov’t, school, parents)
- Lack of focus/awareness/support, political will by key audiences
 - Superintendents
 - District level administration
 - Principals
 - Curriculum specialists
 - Policy makers
- There is no “testing” relative to the health of children, only academic
- Lack of health data for 6-11 year olds
- Lack of nursing coverage in schools

Opportunities:

- Developing functioning school councils or advisory committees to include health, PA/Nutrition concerns, etc.
- Partnering with PTA (health community)

- Training of school staff (SDLPs re: PA, nutrition and health)
- School-based improvement plans are required, but PA and Nutrition are missing
 - Establish links to academic achievement
 - Identify top school level committees
 - Develop action plans
 - Formulate evaluations
- Consider whether the intervention should be age-focused vs. geographic focused: Which has the greatest impact? Which is easiest to coordinate and evaluate?
- More curriculum integration needed – PA/NUT and health with core subjects
- Take advantage of the fact that this is a hot topic.
- Take advantage of the fact that this is an election year – more advocacy
- More partnership building is taking place
- Use existing infrastructure to take action
- Parent involvement/empowerment – help parents, principals and others become champions
- Vending contracts – encourage healthier choices, create “business partners” for project
- Consider existing community, faith-based, after-school etc. programs
- Consider need for adaptive programs (adaptive PE or classroom activities)
- GRPA, DFACS, - participant cost based on a “sliding scale” and scholarship program
- Recognition/incentives to key leaders, superintendents or principals that take action

Threats:

- School accessibility is difficult – “getting in” to schools
- Health is not a high priority to school officials compared to test scores
- Lack of accountability for “health” performance in schools
- Competing for financial resources among partners on the project
- Time is limited– parents, teachers, school day
- Fad diet info and bad nutrition info
- “Blaming” or finger pointing at certain organizations or activities (potential partners?) rather than focus on solutions
- Funding limitations
- Lack of policy to support or require a sustained program
- System fit vs. system change and program sustainability
- Spreading ourselves too thin to successfully execute the intervention
- Parent/teacher – often don’t believe health and learning or achievement are linked
- Too many choices
- Too many QCC’s to cover already
- Extreme behaviors/reactions
- Promotion or products - marketing to kids