This paper is the companion to “Assessment of Information on Public Health Law Best Practices for Obesity Prevention and Control,” and the fourth of four action papers produced as part of the National Summit on Legal Preparedness for Obesity Prevention and Control, convened June 2008 by the Centers for Disease Control and Prevention, the Robert Wood Johnson Foundation, and the American Society for Law, Medicine & Ethics. The four action papers present options to address gaps in the four core elements of public health legal preparedness as outlined in the relevant companion papers. The four core elements are: (1) laws and legal authorities; (2) legal competencies for public health professionals to apply those laws and authorities; (3) coordination of law-based efforts across jurisdictions and sectors, and (4) information on public health law best practices. While its companion paper addresses who the stakeholders are and what information they need, this paper addresses the gaps in dissemination strategies, including identification and assessment of effective legal-based efforts, and proposes actions public health professionals can take to improve their access to the information they need to develop, adapt, or implement effective programs.

The national obesity epidemic is a problem of population health, and must be addressed at the population, not individual level. Six target areas have been identified as relevant to the obesity epidemic:

- Reduce consumption of sugar-sweetened beverages;
- Reduce consumption of energy-dense foods;
- Increase consumption of fruits and vegetables;
- Increase physical activity;
- Reduce television viewing; and
- Increase the initiation and duration of breastfeeding.

Changing collective behavior requires changing the environment in which those behaviors occur; possible legal-based efforts include both policy and environmental strategies. Improving public health by changing our social and physical environment through law-based efforts is not a new approach. In an examination of the 10 greatest achievements in public health, laws and regulations played a major role in 9 of them. Effective law-based action for obesity prevention and control may mean using a systems approach, rather than following a paradigm of linear cause and effect. A systems approach would emphasize the importance of relationships, especially coordination and partnership development among multiple stakeholders. The multiple stakeholders will typically form an interlooping spider web: “a complex adaptive system with multiple components, where results are often greater than the sum of their parts.” Recognizing that everything is interlocked and that nothing should be considered in

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isolation can help minimize unintended consequences and maximize the cumulative effect of interventions.

**Who Are the Stakeholders, and What Information Do They Need?**

Before one can partner with other stakeholders, one needs to identify them. Some stakeholders may be obvious (e.g., state chronic disease directors) while others may be more obscure (e.g., the state demographer). Table 1 gives examples of some of the stakeholders, considered in terms of both settings (e.g., schools, workplaces) and sectors (e.g., the insurance industry and governmental agencies). Any large stakeholder is not only a potential intervention tool but also a potential target for intervention: for instance, local and state governments are themselves large employers. Trade and professional associations often have great influence on their members; such groups can be invaluable in developing and implementing policy and environmental change strategies. Thus, a setting or sector can serve both as an intervention site and as a fulcrum for policy leverage.

**Scope and Types of Population Health Information**

Population health information is needed to inform the laws and legal authorities developed to address the obesity epidemic. The relevant population health information, as discussed here, is the collective knowledge needed for public health legal preparedness regarding obesity prevention and control. This information is vast in scope, encompassing many sectors, categories, sources, and subjects. The information should be easily accessible, transparent, easy to use, relevant, and available to all stakeholders. Most stakeholders need to be educated on the importance and rationale of emphasizing population-based approaches rather than “personal responsibility.” Summit participants discussed the need for surveillance and monitoring, the need for the information on which legal best practices could be grounded — the evidence base — as well as the need to know what constitutes legal best practice.

**Surveillance and Monitoring**

One type of information needed is basic epidemiologic and surveillance data about the obesity epidemic and its effect on quality of life, health, communities, the workplace, education, health care, industry, society, and the economy. Decision makers need accurate information about the extent of the obesity epidemic and its medical, social, and economic consequences. They also need data as to the effectiveness of strategically targeting obesity in order to decrease the prevalence of other chronic diseases.

Surveillance and monitoring efforts are critical, as they help to identify high-risk populations, identify risk factors, and monitor progress in reducing the prevalence of obesity. Some surveillance systems are already in place at the national, state, and regional levels (see Table 2), as is at least one longitudinal study, Healthy Passages. Such longitudinal studies are particularly useful in examining behavioral, social, and environmental risk factors. At the state level, some states are using electronic health records to track health information, particularly among children. Such records can be set up to allow for epidemiological analysis and population-level surveillance of overweight and obesity. Regional and local governments are also attempting to accumulate the needed data. However, many of the existing surveillance and monitoring efforts and ongoing longitudinal studies are threatened by funding cuts.

As both a surveillance technique and an intervention, some states have enacted legislation requiring at least some schools to measure each child’s BMI and give the information to parents in a “health report card.” Arkansas was the first to pass such legislation, in 2003, and saw its escalating childhood obesity rate level off in three years. However, school administrators protested the time involved, and parents became increasingly concerned. As a result, an amendment in 2007 eliminated BMI assessments for high school seniors and children in odd-numbered grades; parents can choose to have their child excluded in the other grades. Several other states have instituted programs for selected grades, many on a pilot basis. In New York, the data will be used by the Department of Education to create a profile of the state’s childhood obesity and obesity-related diseases. In Houston, administrators report that parents welcome having their child’s BMI included on report cards (private communication).

**Knowledge Base**

The knowledge base of effective law-based interventions is still nascent, and creating the evidence base upon which good decisions can be made, and supported, is critical to effectively combating this epidemic. The Robert Wood Johnson Foundation annually reports the various law-based actions each state (and some cities) has taken to promote nutrition, increase physical activity, and prevent obesity. It is unlikely that any single one of these interventions will by itself reduce a state population’s rates of obesity. While they may not be sufficient, many of these approaches may be necessary. Noticeable population-level change is likely
to require comprehensive, coordinated efforts across jurisdictions, settings, and sectors.

Many of the strategies which have brought a large number of stakeholders to the table have relied on voluntary cooperation rather than on law-based actions. While such agreements can be difficult to enforce, they may prove the most fruitful approach. Examples include the memoranda of understanding (MOU) brokered by the Alliance for a Healthier Generation, which is a joint initiative of the William J. Clinton Foundation and the American Heart Association. In the first MOU, the American Beverage Association, Cadbury-Schweppes, Coca-Cola, and PepsiCo voluntarily agreed to new nationwide guidelines for school beverages, including calorie density, portion size, calorie counts, and sweetening levels. Under this MOU, the results will be evaluated with an annual analysis by a named third party; this data can then become an important part of the evidence base for policymakers. A second MOU with different partners addressed competing foods sold to school children.

Finding the needed information and evaluating the relative effectiveness of different approaches can be a challenge; some basic information sources on the Web are listed in Appendix A. Summit participants suggested the creation of an information clearinghouse on best available and promising practices, not simply “best practices.” Policymakers need data on the effectiveness of laws and policies as well as their social and economic costs and benefits. Multiple toolkits have been developed to aid in particular objectives (see Appendix A), but there is no one, central “go to” Web site. Existing Web sites are for the most part targeted at a specific sector or setting. For example, the National Governors Association (NGA) Center for Best Practices has developed Shaping a Healthy America, a Decision Making Guide. The NGA Center evaluates public policy innovations and ensures that all governors are aware of these advances. Similarly, the Robert Wood Johnson Foundation’s Active Living Research initiative seeks to identify environmental factors and policies that influence physical activity for children and families and to use this information to inform effective prevention strategies. Each sector needs to know what others have already recommended. For instance, the Institute of Medicine, the American Academy of Pediatrics, and the American Academy of Family Practitioners, among others, have issued recommendations for one or more of the six identified areas of behavior relevant to fighting the obesity epidemic. Summit participants strongly suggested informing public health practitioners and other stakeholders of these recommendations.

Web sites are excellent ways to ensure stakeholders have the information they need. Summit participants identified two gaps:

- There is no easily accessible Web portal that identifies best practices and resources available across sectors and settings.
- Information about what does not work is usually not reported.

To promote sustainability, expediency, and efficacy, and to avoid reinventing the wheel at the micro level, Summit participants identified the following informational action items that could be implemented by agencies of the federal government:

- Develop a Web portal that is devoted to legal and policy practices, both what has worked and what has not. “What works” is not necessarily aimed at obesity prevention and control; the law of unintended consequences (in a complex system, you can never change just one thing) sometimes carries bonuses. For instance, teen physical activity programs may result in a decrease in teen pregnancy rates.
- Detail how policy strategies can have a positive economic impact and how some strategies can have positive effects on other health and social outcomes.
- Document also how not acting can have negative economic effects. While some consider “anecdotal evidence” an oxymoron, such real-world tales can sometimes convey a point more quickly and persuasively than any number of statistics. An example from the conference: a large employer decided not to build a factory in a major city because of the population’s third-grade obesity rates. Off the record, the CEO explained that he did not want to be hiring that many employees that would not be packing up to leave the city in 20 years, because he did not want to be dealing with their retiree medical costs in 50 years. Policymakers need to be similarly long-sighted in implementing measures that promote health rather than fostering obesogenic environments.
- Create a central listing of funding sources and resources.
- Collect and improve the research base of what programs work, under what circumstances, and what approaches appear not to have worked in what circumstances.
- Develop tools and tool kits to assist decision makers in implementing strategies. Tools needed include:
### Table 2

#### Existing National Surveillance Systems

**Population-based.** NHANES: National Health and Nutrition Examination Survey. Updated annually since the early 1960s by CDC, it provides population-based data derived from private interviews and extensive non-invasive individual health exams. U.S. national obesity prevalence rates are based on NHANES data. [http://www.cdc.gov/nchs/nhanes.htm](http://www.cdc.gov/nchs/nhanes.htm)

**State-based.** BRFSS: Behavioral Risk Factor Surveillance System. Conducted by CDC since 1984, it is the world's largest on-going telephone health survey system. Monthly data collection allows each state to closely monitor trends in its population. Data include health risk behaviors, preventive health practices, health care access, and health conditions. [http://www.cdc.gov/BRFSS/](http://www.cdc.gov/BRFSS/)

**School-based policies.** SHPPS ("ships"): School Health Policies and Programs Study. This national survey is done at six-year intervals (most recently in 2006) to assess school health policies and practices at all levels (state, district, school, and classroom). Data include physical education, food services, and health service policies. [http://www.cdc.gov/HealthyYouth/shpps/index.htm](http://www.cdc.gov/HealthyYouth/shpps/index.htm)

**High school students.** YRBSS: Youth Risk Behavior Surveillance System, which uses the YRBS (Youth Risk Behavior Survey, conducted by CDC) to monitor priority health-risk behaviors, such as obesity, and asthma among high school students. Data include nutrition and physical activity. [http://www.cdc.gov/HealthyYouth/yrbs/index.htm](http://www.cdc.gov/HealthyYouth/yrbs/index.htm)

**Infants and young children.** PedNSS: Pediatric Nutrition Surveillance System and its companion the PNSS (Pregnancy Nutrition Surveillance System) monitor the nutritional status of the women, infants, and children up to age 5 in federally funded maternal and child health programs. Data describe prevalence and trends of nutrition, health, and behavioral indicators. [http://www.cdc.gov/pednss/](http://www.cdc.gov/pednss/)

**Longitudinal study of adolescents.** Healthy Passages: A 10-year community-based longitudinal study of adolescent health (beginning in fifth grade, roughly age 10) being conducted with over five thousand children and their parents in Birmingham, Houston, and Los Angeles. Data will allow identification of behavioral, social, and environmental risk factors. Funded by CDC and other Federal agencies. [www.healthypassages.org](http://www.healthypassages.org)
• Model legislation, policies, and agreements; and
• How best to work with legislative committees.

Setting-Specific Actions
Many of the information action items identified by Summit participants are for specific settings (see Table 1). For clarity, these will be discussed by setting.

School Settings
The school setting can be used to affect obesity rates for both school-aged youth and adults (parents, teachers, and school staff). In 2006, over 54 million children were enrolled in some type of school setting, and school systems are some of the larger employers in many states. Unfortunately, many schools often have poor food environments and limited time for physical activity. A variety of stakeholders have already taken the lead in implementing promising strategies such as school nutrition, physical activity, and nutrition education programs and policies. Informational issues for schools include the need to:

• Explore the implications of providing to students, parents, or both student health evaluations that include BMI or height/weight evaluations.
• Consider pilot programs to provide parents and communities with school health reports, on an aggregate school- or district-wide basis.
• Address the issues raised by FERPA (Family Educational Rights and Privacy Act) as it relates to using school health records for public health surveillance purposes.
• Increase schools’ knowledge of federal reimbursement regulations with respect to school meal programs, to maximize school reimbursement while improving student nutrition.
• Mandate calorie labeling on school menus and in school cafeterias; provide this information to parents and parent-teacher associations as well.
• Develop model programs to improve standards in school nutrition programs.
• Share such programs as have been developed. For instance, the Houston Independent School District (HISD) has created “CHOMP, Choosing Healthy Options Means Power: Houston ISD’s Plan for Nutrition and Wellness Leadership.” The plan includes a five-year strategy and timeline for completely revising the school menus and the foods available a la carte, and a comprehensive strategy to communicate with, solicit input from, and educate the community (private communication). Each aspect of the plan has a vision, a goal, the actionable items required, and a timeline of evaluable benchmarks. However, perhaps because parts of the plan are still being drafted, there is no access to these documents over the Web.
• Create model vending machine contracts, using the beverage and food industries’ voluntary guidelines as a floor (not a ceiling) and incorporating the recommendations of the American Academy of Pediatrics with other school districts across the country.
• Establish physical activity and education requirements (e.g., intensity and duration) and physical education requirements (e.g., motor skills and movement patterns) for all ages, and determine the effect of implementing such requirements on various measures of academic achievement and school attendance.
• Evaluate the effectiveness of worksite wellness programs for teachers and staff.
• Investigate existing programs for improving how the built environment supports physical activity for both students and their parents by, e.g., working with local community groups to turn school grounds into neighborhood parks (the SPARK school park program in Houston, Texas), implementing the Safe Routes to School program, or adopting the Kids Walk-to-School campaign from CDC’s ACES (Active Community Environments Initiative).

Medical and Clinical Settings
While medical and clinical settings are an obvious intervention point, not only for patients but for their own employees, there are also many informational issues that need to be resolved:

• Assess what would be necessary to ensure full coverage of EPSDT (the early periodic screening, diagnostic, and testing program), along with appropriate counseling services under each state’s children’s health insurance program (CHIP).
• Clarify coverage for prevention, screening, counseling, and treatment of overweight and obesity under federal and state laws, e.g., ERISA (the Employee Retirement Income Security Act of 1974), the Social Security Act, and the Americans with Disabilities Act.
• Investigate reimbursement options under Medicaid, Medicare, and commercial insurance plans for obesity prevention, screening, counseling, and treatment.
• Evaluate the cost, if coverage for medical treatment of morbid obesity is mandated; consider requiring coverage of behavioral and nutritional counseling and prescription medications whether or not bariatric surgery is performed, in alignment with the current clinical practice guidelines.24
• Explore legal approaches to removing barriers to accessing care for those who are obese or at risk of being obese (e.g., few health care providers have scales — or waiting room chairs — that can accommodate patients over 300 pounds).
• Update and make available clinical practice guidelines for obesity prevention and treatment.
• Review the extent to which accreditation, accountability, and licensure processes promote provision of obesity prevention and reduction services by health care providers to their employees.
• Consider adding a measure to HEDIS (Health-care Effectiveness Data and Information Set, from the National Committee for Quality Assurance) that encourages health care practitioners to address weight-related issues with overweight or obese patients.

Worksite Settings
Many employers have implemented highly effective worksite health programs and have realized great economic benefits25 as well as the potential returns in greater productivity and employee morale. Several health insurance companies and some state governments have taken a “walk the talk” approach, insisting that their employees meet certain health standards or face financial penalties.26 Such tactics are punitive and regressive. Instead, best practices need to be developed and disseminated, as the Partnership for Prevention’s Worksite Health Web site is doing (see Appendix A):

• Educate employers how they can use positive incentives to support obesity prevention and control.
• Analyze the costs vs. benefits of requiring health plans to cover enumerated services.
• Propagate access to such tools as the National Business Group on Health’s A Purchaser’s Guide to Clinical Preventive Services: Moving Science into Coverage.27
• Catalog incentives and benefits employees can take advantage of through their health plan or human resources department that encourage obesity prevention, diagnosis, counseling, and treatment.

• Elucidate how employers can use non-punitive incentives, such as changes in co-payments or premiums, to promote employees’ achieving health goals, while maintaining both privacy and nondiscrimination. Suggest they consider incentives for incremental goals, rather than taking an “all or nothing” approach: loss of 10% of body weight carries with it significant health gains, even if the person is still obese.28
• Develop and share tax incentives (property, business, and other) and awards programs for employers that offer worksite wellness programs; provide onsite gyms, showers, or exercise facilities (e.g., a running track around the parking lot); subsidize use of exercise facilities by their employees; or provide access to fresh fruits and vegetables in the workplace.
• Build the consensus necessary to amend the 2012 editions of the International Building Code and the Comprehensive Consensus Codes to encourage inclusion of shower facilities in office buildings and to foster access to and use of stairwells.

Community Settings
Land-use planning commissions and zoning laws have a great effect on the built environment, and the built environment in turn can have a significant influence on the physical activity habits of residents. Neighborhood associations, tax increment finance districts (TIFs), and other groups can influence the built environment in more localized areas. Transit-oriented development (TOD, also known as transit-oriented design) takes advantage of mass transit and alternative transit (walking, biking) to create more compact, “livable” communities, often as part of an effort to revitalize an urban core. However, neighborhood-oriented solutions are not “one size fits all.” Conference attendees urged those wishing to use the built environment to encourage physical activity to:

• Elucidate the different relevant facets of the built environment for rural, suburban, and urban communities.
• Investigate existing and needed legal and regulatory approaches for tribal health.
• Communicate to taxpayers and legislators how policies and laws affect obesity prevention and control, how they positively and negatively impact the liberties, entitled services, and lifestyle of those who are obese, and illustrate the need for concerted action across settings and sectors.
• Use participatory action approaches to partner with community groups, residents, and government entities.
• Identify and implement effective policies and practices for the built environment that can increase physical activity and appropriate changes in diet.
• Educate community decision-makers on their authority to take health effects into consideration in land-use planning, permit processes, et al., and on the tools available to assist them in doing so. (See the tools available from the National Association of County and City Health Officials, Appendix A).
• Set up a clearinghouse or other shared access for model legislation, codes, ordinances, and neighborhood/community association bylaws that would allow food gardens on private, public, and school property; permit farmers markets, encourage the presence of grocery stores; foster transit-oriented design; and promote “walkable” neighborhoods with bike and pedestrian paths.

**Sector-Specific Actions: Government**
The law can do many things: it can enable, it can encourage, it can require consideration, and it can enforce action. Law-based actions to prevent obesity can take place at local, county, state, tribal, or federal levels, and can take many forms, e.g., statute law, administrative regulations, or tax or health code provisions. A fundamental concern for government sectors at all levels is pre-emption by the federal government; this issue is addressed in depth in the laws and legal authorities papers. An appropriate attorney should always be consulted to determine the feasibility and authority for any law-based action.

To bring multiple stakeholders together, or to allow new criteria to be considered in a regulatory process, frequently requires special enabling legislation. For example, the end-of-year 2007 *Balance* report notes such actions as “specifies that the department may collaborate with” and “requires that an interagency coordination council be established.” Facilitating farmers markets may require legislation specifically exempting them from the definitions of “food establishment” and their employees from the definition of “food handler,” or allowing them to operate on government-owned property. Other legislation may be needed to allow or require consideration of health effects in permit processes, or to earmark a portion of mass transit funds for bicycle and pedestrian paths. Regulations may be needed to clarify calculations of “pedestrian” or “recreational” space: a tree-planted median does not give vital shade to pedestrians on sidewalks, and a golf course is a limited-use facility unless it is encircled with shaded pedestrian and bicycle paths. The appropriate level of policy- or law-making body will vary by state and locality. However, incentives, particularly tax incentives, can often be offered at a lower governmental level — though even that may require enabling state legislation.

Summit attendees suggested the following informational action items for specific levels of government:

**Federal Government**
- Increase the resources available to communities to find, tailor, implement, and evaluate evidence-based practices to prevent and control obesity (e.g., CDC’s STEPS program).
- Make needed nutrition information more understandable and usable for the average consumer, e.g., by adopting an easier-to-use food labeling system such as the one developed in the United Kingdom.

**State Government**
- Collect information, perhaps through the state demographer, that is germane to the prevention of obesity and the promotion of physical activity and healthy eating.
- Create a forum for state attorneys general and other government attorneys to discuss public health law initiatives, such as menu labeling policies.

**Local Government**
- Governments at all levels can lead by appropriate encouragement of healthy eating and physical activity by their own employees. The *Balance* reports include many city-based initiatives, including use of health codes, building codes, planning commissions, and various tax incentives to foster physical activity and healthy eating.
- Foster inter-sector cooperation and education. For instance, the Harris County (Texas) Public Health and Environmental Services department has set up a “School Health Leadership Group.” Each independent school district in the county is invited to send up to three people to meetings three times a year; most districts send their School Health Coordinator, Child Nutrition Director, and District Health/PE Coordinator.
- Set up inter-agency task forces to pool information, share agendas, and coordinate efforts to promote physical activity and reduce caloric intake.
Conclusion
Evaluation of the long-term impact of legal-based efforts to combat the obesity epidemic is still needed, and so “best practices” are still in the exploratory stage. However, there are promising and best-available practices which can be implemented now. Acknowledging the problem and making small, incremental changes in the built and food environments are steps that can be taken at almost any level of policymaking and government. Both creativity and patience will be required. It has taken us more than three decades to create the problem; the solution will not come overnight, but reversing the epidemic is possible. Disseminating the information necessary to do so is the first step.

Appendix A: Selected Information Sources

**NATIONAL**

Action for Healthy Kids (Campaign for School Wellness program): http://www.actionforhealthykids.org/
- AHK State Teams (includes state profiles): http://www.actionforhealthykids.org/state.php
- Resources and links (submissions welcome): http://www.actionforhealthykids.org/resources.php

Agency for Healthcare Research and Quality (AHRQ)
- **National Guideline Clearinghouse**: http://www.guidelines.gov/; search “obesity”
- **Screening and Interventions to Prevent Obesity in Adults** (U.S. Preventive Services Task Force): http://www.ahrq.gov/clinic/uspstf/uspsobes.htm

Alliance for a Healthier Generation (a partnership of the American Heart Association and the William J. Clinton Foundation): http://www.healthiergeneration.org/

Association for Supervision and Curriculum Development: http://www.ascd.org

Center for Science in the Public Interest: http://www.cspinet.org

- **National Alliance for Nutrition and Activity**: http://www.cspinet.org/nutritionpolicy/nana.html; Includes Model School Wellness Policies and selected resources for developing, implementing, and monitoring/reviewing of local wellness policies.

- **ACES: Active Community Environments** promotes walking, bicycling, and the development of accessible recreation facilities: http://www.cdc.gov/nccdphp/dnpa/physical/health_professionals/active_environments/aces.htm
- **Kids Walk-to-School**: http://www.cdc.gov/nccdphp/dnpa/kidswalk/

- **The Nutrition, Physical Activity, and Obesity Program (NPAO)** is implementing a social-ecological model in 23 states, and provides numerous tools and resources: http://www.cdc.gov/nccdphp/dnpa/obesity/state_programs/index.htm
- **Steps Program** (cooperative agreement that provides funding for evidence-based community interventions): http://www.cdc.gov/steps/

Council of Better Business Bureaus (CBBR); National Advertising Division and Children’s Advertising Review Unit (both overseen by the National Advertising Review Council) and the Children’s Food and Beverage Advertising Initiative: http://us.bbb.org, click BBB for Businesses, click Advertising Review Services. All of these are voluntary self-regulation programs.

Food and Food Marketing Policy Centers
• Agricultural and Food Policy Center, Texas A&M University: http://www.afpc.tamu.edu
• Food Marketing Policy Center, University of Connecticut: http://www.fmpec.uconn.edu/
• Rudd Center for Food Policy and Obesity, Yale University: http://www.yaleruddcenter.org

Institute of Medicine (IOM): http://www.iom.edu/
• Standing Committee on Childhood Obesity Prevention: http://iom.edu/CMS/3788/51730.aspx, which has links to the IOM reports on
  • Preventing Childhood Obesity: Health in the Balance (2004)
  • Food Marketing to Children and Youth: Threat or Opportunity? (2005)
  (see also the 2008 report released from the Federal Trade Commission)
  • Progress in Preventing Childhood Obesity: How Do We Measure Up? (2006)

Kaiser Family Foundation: http://www.kff.org/
• Study of Media and Health: http://www.kff.org/entmedia/index.cfm
  • First Analysis of Online Food Advertising Targeting Children
  • the annual Sex on TV reports
  • a research brief on how children’s media use may create sleep problems (in turn linked to obesity)

Keystone Center: Center for Science and Public Policy: http://www.keystone.org/
• Health Policy section (http://www.keystone.org/spp/health-practice.html) with links to:
  • Keystone Forum on Away-from-Home Foods: Opportunities for Preventing Overweight and Obesity
  • Youth Policy Summit on Child and Adolescent Nutrition in America
  • Keystone National Policy Dialogue on Food, Nutrition, and Health

National Association of State Boards of Education: http://www.nasbe.org/, particularly the
• Center for Safe and Healthy Schools: http://www.nasbe.org/index.php/shs a partnership of NASBE and DASH (CDC's Division of Adolescent and School Health).

National Association of County and City Health Officials (NACCHO)
• Healthy Development Measurement Tool: http://www.thedhmt.org/
• The Built Environment and Health (Websites and articles): http://www.thedhmt.org/built_environment.php
• National Connection for Local Public Health: Toolbox: http://www.naccho.org/toolbox

National Governors Association, Center for Best Practices
• Shaping a Healthy America: A Decision-Making Guide: http://www.subnet.nga.org/healthyamerica/guide/

Partnership for Prevention:
• Worksite Health: http://www.prevent.org/content/view/29/40/
  • Leading by Example Reports
  • Evidence Base for Worksite Health
  • Policy and Advocacy on Obesity, Activity, and Nutrition
  • Policy and Advocacy on Worksite Health
  • Effective strategies

• Menulabeling ordinances from around the country: http://www.phlpnet.org/ords.html
• Planning for Healthy Places: http://www.healthypreplanning.org/ land use, economic development, other built environment policy strategies (formerly the Land Use and Health Program)
• School Health Law Project: http://www.schoolhealthlaw.org/

Robert Wood Johnson Foundation: http://www.rwjf.org Publications, research, issues, policy briefs:
• Childhood Obesity: http://www.rwjf.org/childhoodobesity/
• Obesity: http://www.rwjf.org/pr/topic.jsp?topicid=1024
• Physical Activity: http://www.rwjf.org/pr/topic.jsp?topicid=1067
• Reports on State Action... (“Balance” Reports): http://www.rwjf.org/childhoodobesity/search.jsp and refine by searching for “Balance”
Programs:

- **Active Living by Design:** Increasing physical activity through community design: [http://www.activelivingbydesign.org/](http://www.activelivingbydesign.org/)

- **Leadership for Healthy Communities:** Advancing Policies to Support Healthy Eating and Active Living: [http://leadershipforhealthycommunities.org/](http://leadershipforhealthycommunities.org/)

- **Fact sheets, policy briefs, reports, profiles, toolkits, and numerous other resources.**


Trust for America’s Health: [http://healthyamericans.org](http://healthyamericans.org)

Annual *F as in Fat: How Obesity Policies Are Failing In America* report (2004), which includes the interactive map at [http://healthyamericans.org/reports/obesity2008/](http://healthyamericans.org/reports/obesity2008/)

U.S. Department of Agriculture, Food and Nutrition Service


- **Senior Farmers’ Market Nutrition Program:** [http://www.fns.usda.gov/wic/SeniorFMNP/SFMNPMenu.htm](http://www.fns.usda.gov/wic/SeniorFMNP/SFMNPMenu.htm)

U.S. Department of Health and Human Services


See particularly the *Farm Bill and Food and Nutrition* sections

STATE AND LOCAL

Arkansas Center for Health Improvement: [http://www.achi.net/index.asp](http://www.achi.net/index.asp)


References


19. See Alliance for a Healthier Generation, supra note 13 and 14.


31. See supra note 10.