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Municipal officials' perspectives on policymaking for addressing obesity and health equity

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Abstract

Background: Obesity evidence-based policies (EBPs) can make a lasting, positive impact on community health; however, policy development and enactment is complex and dependent on multiple forces.

Aims and objectives: This study investigated key factors affecting municipal officials' policymaking for obesity and related health disparities.

Methods: Semi-structured interviews were conducted with 20 local officials from a selection of municipalities with high obesity or related health disparities across the United States between December 2020 and April 2021.

Findings: Policymakers follow a general decision-making process with limited distinction between health and other policy areas. Factors affecting policymaking included: being informed about other local, state, and federal policy, conducting their own research using trustworthy sources, and seeking constituent and stakeholder perspectives. Key facilitators included the need

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The authors declare that there is no conflict of interest.

for timely, relevant local data, and seeing or hearing from those impacted. Key local policymaking barriers included constituent opposition, misinformation, controversial issues with contentious solutions, and limited understanding of the connection between issues and obesity/health. Policymakers had a range of understanding about causes of health disparities, including views of individual choices, environmental influences on behaviors, and structural factors impacting health. To address health disparities, municipal officials described: a variety of roles policymakers can take, limitations based on the scope of government, challenges with intergovernmental collaboration or across government levels, ability of policymakers and government employees to understand the problem, and the challenge of framing health disparities given the social-political context.

Discussion and conclusion: Understanding factors affecting the uptake of EBPs can inform local-level interventions that encourage EBP adoption.

Keywords

Local policy; evidence-based policymaking; obesity policy; health equity

Background

Obesity is a serious concern in the U.S. Almost half of adults (42.4%) are affected (Hales et al 2020), with higher prevalence among racial and ethnic minorities (Petersen et al 2019), and lower income populations (Zare et al 2021). Obesity is a leading cause of death (Remington et al 2016), and costs about $149.4 billion (US dollars) annually (Kim and Basu 2016).

Public health policy, in the form of laws, regulations, and guidelines, has a profound effect on health, including obesity (Brownson et al 2009, Gortmaker et al 2011). There are numerous effective or evidence-based policies (EBPs) to prevent obesity (Community Preventive Services Task Force, McKinnon et al 2016, University of Wisconsin Population Health Institute). Developing and implementing state and local-level EBPs is imperative (Brownson et al 2009, Institute of Medicine 2009, Mier et al 2013, Zaza et al 2005), considering policies often have a more sustained impact on health than individual-level interventions (Brownson et al 2006, Eyler et al 2016). Municipal and other local governments have unique roles in addressing obesity and shaping policies to support community health (Reeve et al 2015). Strategies such as enhancing access to healthy environments are operationalized locally through zoning and other land use ordinances, city or park master plans, food marketing, and transportation policies (Chriqui 2013, Lyn et al 2013).

However, formulating health policies is complex and depends on a variety of scientific, economic, social, and political forces (Spasoff 1999). Policies have greater odds of being adopted when the problem is clearly defined, potential solutions are identified, and politics and public opinion are supportive (Purtle et al 2023). This complexity underscores the need to understand how policymakers obtain, understand, use and disseminate evidence.

Local officials are often receptive to constituents and data about local issues (Yamey 2011) and local-level evidence can play an important role in policy (Fielding and Frieden 2004, Kneale et al 2017, Yost et al 2014). Additionally, relationships with key organizations in their community can impact the actions of local policymakers. Given the importance of local policy, it is imperative policymakers have access to high-quality research evidence, presented in a useful format and by opinion leaders. Yet, policymakers are often overwhelmed by the information they receive and prefer local data that are concise, visually appealing, current, and relevant (Bogenschneider and Corbett 2010, Oliver et al 2014, Tricco et al 2016).

Understanding policymakers' perceptions on issues has been important aspect in translation of research evidence into policymaking (Oliver et al 2014). Most research on public health and obesity policies has been conducted with state legislators (Dodson et al 2009, Dodson et al 2013, Killian et al 2020, Welch et al 2012), and much less scholarship among municipal officials. Given the influence local officials have on health policy (McCarty et al 2009), understanding municipal officials' perspectives on community health and the policies impacting it is vital to translating evidence to local policymakers and into policies that promote health (Bernier and Clavier 2011). This lends to conceptual use of research evidence, i.e., for enlightment or learning, introduced by Weiss (Weiss 1977), which aims to shift how policymakers or practitioners think about issues, problems or potential solutions.

To date, little attention has been paid to local policy approaches most useful for communities experiencing obesity disparities. There are pervasive disparities in obesity-related environments and policies that disadvantage low-income communities and racial minority populations (Ewart-Pierce et al 2016, Jones et al 2015, Lovasi et al 2009, Singleton et al 2016). The objective of this study was to understand the decision-making process for policies impacting obesity and community health, and perspectives on obesity and related health disparities among local policymakers from municipalities experiencing obesity disparities.

Methods

This qualitative study consisted of 20 semi-structured interviews with local elected and top-appointed officials from municipalities across the United States, conducted between December 2020 and April 2021. The Institutional Review Board of Washington University in St. Louis approved this study (#202001197).

Selecting Municipalities and Participants

The study team generated a purposive sample of municipal-level government officials from the Community Advisory Board (CAB) for the Prevention Research Center to pilot test the interview guide. The list of contacts was based on CAB members' professional connections, and the presence of obesity or related health disparities within the officials' municipalities. Then, the team selected 20 communities through a stratified sampling of 200 communities with a high prevalence of obesity (defined as within the highest prevalence quintile in their region according to the 500 Cities Project (Centers for Disease Control and Prevention) and US Diabetes Surveillance System (Centers for Disease Control and Prevention)), using

five geographic regions (USDA Agricultural Research Service regions: Midwest, Northeast, Pacific West, Plains, and Southeast) and two jurisdiction population size categories (US Census urban and rural classification; 50,000 or more, and 2,500-49,999); two communities per cell were randomly selected. The team developed the list of officials from the selected communities using the 2018 Municipal Yellow Book, a comprehensive source on local government personnel data, coupled with municipality website searches and phone calls to fill in contact information gaps.

Data collection

From December 2020 through April 2021, the researchers invited, via email, 165 elected and top-appointed officials from the pilot testing list and 20 municipalities to participate in the key-informant interviews. If necessary, up to six follow-up emails or phone calls were made. After obtaining consent, the study team scheduled and conducted audio-only interviews via virtual meeting technology. Interviews ranged from 24 to 73 minutes, and were conducted until thematic saturation was reached (Guest et al 2006, Padgett 2016).

Measures

The interview guide contained open-ended questions on the following topics: decision-making process for health policies, useful information for policymaking, perspective on health disparities and policymaker role in addressing them, collaborators for community health, and COVID-19's impact on health policies.

Data management and analyses

Each interview was audio-recorded, transcribed verbatim by Rev.com, and de-identified. Two coauthors developed and refined a codebook, and independently coded 20% of the transcripts using NVivo software (NVIVO 12 2020). When agreement was >95% and Kappa was >0.70, one coder coded the remaining transcripts (Saldana 2016). The team used a dual independent process to conduct content analysis (Miles 1994, Saldana 2016, Strauss 1997). For each domain, co-author pairs independently reviewed coded texts and made notes to identify themes, summarize content and identify illustrative quotes. They met and reached consensus on themes and subthemes. Data and supporting materials are available at https://doi.org/10.48765/9e7a-a026 (raw transcripts under restricted access) (Parks et al 2023).

Findings

Of 165 officials contacted, 20 (12%) agreed and participated. Two of the 22 consented contacts did not attend their scheduled interview or reschedule. Interviews were conducted with officials from 16 municipalities with an even split between council-manager and mayor-council governance types. Most participants were men (65%), elected officials (90%), aged ≥60 years (70%), and of liberal social ideology (60%). Table 1 provides additional participant and municipality background information. Interviewees varied according to position as an elected or appointed official. Primary responsibilities mentioned included passing and overseeing the budget, drafting and passing legislation, serving as ambassadors for the city, researching and meeting constituent needs, representing the people, and

engaging in committee work. Appointed officials mentioned running day-to-day operations of the city and acting as a conduit between staff and the council.

Themes and Subthemes

Health policy decision-making process—When asked about the process interviewees undergo when making a decision about a health-related policy, many participants indicated they follow a general policy decision-making process with no distinction between health and other policy areas.

> "So I think my initial scan would say, "Okay, who's engaged in this?" Secondly… so what exactly are we attempting to do with that policy? Is there actually any research or data that proves that the expected result is realistic, or comes from this implementation of a policy like that? And then the final, it's the constituent feedback. Are folks even paying attention to the issue and what might they think about the particular issue?"

Participants shared the importance of staying informed of other local, state, and federal policy. An aspect of this included understanding the limits on policy control or influence their municipality has,

> "Due to state preemption doctrine or governance type I read other ordinances, I read the legislation that's happening at the state level that has bearing on our city."

In addition, participants mentioned they look to other communities to see what they have done,

> "Major decisions I'll look at other communities and how they address the issue… not all communities are the same, so I might get information from a community that has the same type of issue. You know, we're a desert, inland, rural community compared to an urban community…I might look to other communities that are similar and see the success or failure based on a policy that they may have implemented."

The practice of conducting their own research using trustworthy sources to understand the policy issue was another theme (types of credible health-related information sources participants mentioned is provided in supporting materials, https://doi.org/10.48765/9e7a-a026) (Parks et al 2023). Background information and recommendations provided by municipal department heads or employees were cited as information sources. Some also mentioned they solicited information from department heads. Participants from smaller municipalities referenced contracting with experts for capability they do not have among their staff.

Another theme was seeking community, constituent, and stakeholder perspectives. Participants talked about the forums with which they engage with constituents and stakeholders, including informal and formal channels: knocking on doors, starting conversations at the grocery store, hosting regular virtual meetings, holding town halls, and forming advisory committees.

> "We've got a really good, engaged community, and I spend a lot of time talking to our residents, and learning with our residents. And I really rely on them bringing ideas as well… I'll ask people, "What do you think we can do?""

Policies to support community health—Participants were asked to provide a recent example of a health-related policy they proposed or championed. There were a range of policies mentioned (32) across ten domains (Table 2). Active transportation and COVID-19 related policies were referenced most frequently by officials from different municipalities. Later in the interview, participants were asked what they think is the single biggest policy change needed to make it easier for people to lead healthier lives in their community. Responses were grouped into eight categories, five of which overlapped with domains of the health-related policy examples (Table 2).

Health policymaking facilitators and challenges—Interview participants were probed on the impetus for pursuing the health-related policy example they provided. Three themes emerged: No other choice but to take action due to immediate public health threat or by mandate from a higher level of government, personally impacted by the issue (*"both my parents were returning citizens, so I saw how it impacted their lives."*), and seeing or hearing from those affected,

> "We had camp setting up on the riverbank, and it was a health hazard. It was filthy and disgusting…there were 200 people camped on the riverfront down there living in squalor…as I learned more about it, you realize those aren't outsiders. Those are our homeless people."

Table 3 outlines the themes and illustrative quotes for the facilitators and challenges to health-related policymaking efforts. Four facilitators emerged from participants' responses to what was most helpful in efforts for their stated health-related policy(ies): Working with community organizations, being able to address concerns or pushback with information, keeping community members informed of city policymaking, and willingness to compromise and have open-minded discussions. The three main challenges with policy efforts discussed by participants were: Local constituent opposition and misinformation, addressing a controversial issue with contentious solutions, and having a limited understanding of the connection of issues to health.

Perceptions of health disparities in their community—Participants were presented their community's data on obesity and related health disparities followed by the statement, "These types of health differences may result from some people not having the same opportunities, based on where they live, work, go to school, or their race or ethnicity, to make choices that would allow them to live a long, healthy life." Participants were asked how they view this issue, and several themes emerged from those responses.

Understanding of causes spans individual choices, environments, and structural factors: Some respondents viewed health behaviors as a matter of individual choice and personal responsibility, where their actions as a policymaker are limited to setting a good example to others, providing information and education, and improving the food and physical activity environment.

> "We could promote them [physical activity venues], we could provide them, we could make sure they're in proper working order, but like I said, you can lead a horse to water, but you can't make them drink."

Others identified factors that go beyond individual choices, such as affordability of food and income or the role of basic income and secure housing on the ability to benefit from healthy food environments.

> "I'm also not the biggest believer, just personally, in the idea that if you can just solve food deserts, that the issue is one of getting people more choices… behind it, is a far deeper issue which is simply having the economic ability. You know, having the base levels of income and secure enough housing that you can be in a position to make better choices…and be in a place that encourages you [to] make better choices about how you get around and what you eat."

One respondent described effects of interpersonal and institutional racism on ability to use physical activity spaces (e.g., race-based harassment by individuals or police can prevent someone from walking even when the infrastructure is there). When describing how it is difficult to make healthy choices in an unhealthy environment, one respondent highlighted that these ideological differences in how people view the problem creates a barrier to addressing it.

Economic and educational opportunities: Many participants brought up economic and educational issues in their community. These included lack of job opportunities, community economic stagnation, limited housing, difficulty attracting skilled professionals, education opportunities available and attained, poverty, and labor force decline due to shrinking population. Some mentioned the relationship with economic status and race or ethnicity.

> "[This municipality] has experienced population decline every year since at least 2000. And we are one of the top 10 fastest shrinking cities since 2010. Our labor force has declined even faster than our population has. Our median household income is below state national averages. Our unemployment rate is consistently higher than state and national averages. Our poverty rate is over 20% right now, above national averages. Our educational attainment rates at [municipality] public school systems are below state averages. You combine that with the low health metrics that you mentioned and others that I'm aware of, and it creates a very challenging situation for local government to navigate."

A problem of isolating parts of the community on the outskirts, away from resources: One respondent described how areas of low-income housing located on the outskirts of their municipality have less infrastructure for walking and biking and are isolated from resources.

> "We're trying to serve people better, but we're placing them on the outskirts of town, modern day lepers, and they're not well-served or well-connected to anything."

Another participant described how as a city grows economically, housing gets less affordable in walkable, central neighborhoods, and vulnerable groups are pushed out to less-walkable areas with fewer transit connections that are more affordable.

Recognition of the complexity of causal factors: Respondents stated limited job opportunities and limited wealth together with race and ethnicity compound and intersect to create disparities. They also commented that unemployment and unaffordability of childcare impact each other, economic stagnation results from multiple related causal factors, and multifactorial challenges that affect health need joint action across institutions.

> "When you're talking about multifactorial challenges, like chronic health, poverty, unemployment, these are not challenges that any one entity can solve. And it will take not only multiple entities solving it, but it's going to take individuals on the council…and the legislative body that has very different ideological values and getting everybody to work together for the common good. And that in it of itself is a challenging proposition."

Lack of a long-term, historical lens: The respondents almost exclusively used a short-term, present lens to describe the issue, with little historical analysis of health differences in the responses. One respondent noted historical planning and policy decisions that created present disparities.

> "[Being disconnected is]…maybe by design, by historic standards… A lot of our health resources have left downtown to go out into the outskirts and that now they're not as accessible to different communities."

Addressing health disparities—Interview participants also responded to the inquiry, "How do you view your role as a policymaker in solving this [health disparities]?" Several themes emerged from the responses.

Policymaker roles: One common response fell within the parameters of the policymaker's official responsibilities or the city's strategic goals, funding, and services. A council member responded by describing their 'technical role' on the city council that requires the council to take a specific action, in contrast to their broader community-based role. Another council member described a city's strategic planning, putting funding toward achieving strategic goals, providing program or services, or partnering with entities who are already doing the work.

> "And how we can do this, is by setting strategic goals that the City Council is willing to put funding towards… we need to do this. There's things that we can do on our own. And there are other things that we really need to either A) partner with other entities that already are doing them, or B) if there is no partner currently doing it, then we either need to find partners or maybe that's something that we need to work on as a city."

Another role is in community efforts outside of the direct influence they have on policymaking. A council member described a broader community-based role that is part of being on the council, which elevates issues and pushes for changes (e.g., securing funding,

pulling together resources, serving on committees). Other respondents referred to raising funds for community initiatives as part of their role as policymaker.

> "[T]here's this community component to being on it…that doesn't necessarily require the city council to take a specific action, but my involvement, or other council members involvement will elevate it and give a push to make change in other ways. And whether that's grant dollars or pulling together resources."

Limitations or challenges to what policymakers can do: Possible policy action is based on the level, type, goals, and revenue source of the government. One respondent said when the government's purpose is specifically defined, based on their mission and their source of revenue (e.g., type of taxes, recreation fees), some problems fit into that scope and some do not, requiring flexibility in government's mission. Another respondent shared that only certain policies can be implemented at the local level (e.g., food assistance is largely done at federal and state levels) and localities work with less funding. Several respondents mentioned that local government funding is an obstacle (i.e., funding for the short term to bring up economy in the long term).

> "All we can do is present and perfect an environment for the choices that are available…the policies that we make in terms of walkability…those are the kinds of things we struggle with because we simply don't have the resources… we're not a wealthy community at all at any level so it's always a struggle."

Difficulty of collaboration across silos that multifactorial problems require: A respondent highlighted that given the multifactorial nature of the problem (e.g., chronic disease, poverty, and unemployment), multiple governmental departments and entities are necessary to address it. This requires cooperation across silos, for which one needs good interpersonal relationships, potentially across ideological differences.

> "Sometimes it is cooperation amongst the people in government that makes a difference. And so personalities between decision makers, particularly, well, both within whatever that government body is, but also between government bodies, plays a significant role in the ability to advance some of these issues that are going to require multiple people working together."

Dependent on how policymakers view the scope of government's role in people's health: Several respondents described a limited role of government to affect people's health choices, one where the government's role is to shape the environment (e.g., recreation department providing opportunities to be active) and to promote health behaviors and services.

> "The city council here, we really don't get involved in developing policies on the personal health of the citizens… We can be a conduit to provide that. We do support our recreation department and we seek opportunities for mobility for our citizens and for the increased physical activity in our community."

Ability of policymakers and government officials to understand the problem (positionality): Participants mentioned that people who shape policies may not fully

understand how their identities or socioeconomic position shape their perspectives, part of the problem leading to inequities. One participant described issues of interpersonal or structural racism influencing the ability to use physical activity spaces, and how planners who are white may be unaware of these issues. This respondent also highlighted the importance of developing culturally-appropriate solutions to encourage physical activity (e.g., opening a swimming pool that is women-only in a Muslim community, constructing a cricket pitch in a community with a high Samoan population). Another made the point, when describing efforts to improve healthfulness of snacks for children, if policymakers do not include people directly impacted by health issues, arriving at the right solution is difficult.

Educating about and the framing of health disparities: A respondent described the educational process needed to get other council members to understand the cause of the disparities, to explain the connection of historical policies and municipal planning and design to present-day health disparities during discussions that might have another focus. Another respondent described a racial equity initiative that worked with multiple agencies in their government.

> "Race and social justice initiative in the city, which was working within every agency to try to help them work on that issue… it's a successful initiative in the sense that it's embedded within government, and it was embraced by the agencies."

One participant described the process of deciding how to talk about equity given the political climate and wanting a productive conversation. They decided framing the conversation around health and social determinants of health gets at the same goals as framing the conversation around addressing health disparities, and it's also better suited to the politically diverse community with which they are a part. Another respondent highlighted the importance of making an economic argument given the limited funding available.

> "[I]t's more so figuring out how we do it reasonably, too. Because one of the things is, [municipality] is unfortunately, and I hate to say this out loud, we are broke… Investments into certain issues can lead to savings over time for the government. So it's making the economic argument, because often I find that some of my colleagues are very economic based in terms of thinking."

Prioritizing or focusing on a specific area in the community: When talking about their role, participants mentioned focusing on specific areas of the community described as "the depressed or lower socioeconomic area," and "parts of the community that need attention." Some of the language respondents used painted the community area as 'the other' or disconnected, indicating engagement efforts with this segment and wanting all parts of the community to have "the same" as in "better subdivisions" of the community. On the other hand, sometimes a respondent described themselves as from the neighborhood and representing the specific part of the community or neighborhood.

> "There's a school board member of [municipality], has a similar story to me. Grew up in the neighborhood, we got elected at the same time, as part of a district election, so we're both very focused on supporting our particular area of

the city, which has long been underrepresented, and does suffer from more of these environmental and health burdens."

Discussion and conclusions

Policy action at the local level can greatly contribute to community health equity and address obesity (Gortmaker et al 2011, Kumanyika 2019, 2019). Findings from this qualitative study provide advocates and practitioners insights on factors affecting municipal officials' policymaking, and policies that have been adopted to address obesity, community health, and health equity. The study also highlights key takeaways about local officials' understanding of health disparities, such as the diversity in perceived causes of disparities and their limits on action, and the importance of working across disease and risk factor silos and ideological backgrounds.

Local officials in this study used a general approach when engaging in policy decision-making, whether the topic was health or another area. Similar to previous studies with state legislators (Ashcraft et al 2020, Dodson et al 2013, Purtle et al 2018), municipal officials value constituents' opinions. Since local policymakers may not be directly affected by some of the challenges faced by their constituents, it is critical to engage the community in the co-creation of policies (Walker et al 2022). Municipal officials interviewed conduct their own research, referring to "go-to" or trustworthy sources, and look to other communities to see what they have done and the impact of those policy actions. Exploring the relationship between the officials and their sources may be another step in understanding policy actions.

The connection with and input provided from community organizations and stakeholders on an issue and ways to address it are important in facilitating policymaking at the municipal level, emphasizing the key role some local organizations or groups play as policy intermediaries. There is a growing body of work on the role of brokers, intermediaries, and boundary spanners (BIBS) in addressing the challenges in transferring research evidence between research and policy or practice communities (Bullock et al 2021, Neal et al 2022). Strategies include facilitating relationships, disseminating evidence, finding alignment, capacity building, and advising on decisions (Neal et al 2021). Current findings suggest the importance of researchers or knowledge producers identifying and establishing relationships with key community organizations or groups with ties to local policy actors or key community members (i.e., intermediaries) to provide timely research evidence to build understanding and support with constituents (to indirectly influence policymaking) and local officials (directly).

Importantly, local officials did not make clear distinctions between health and other policy areas. For efforts to address obesity, much of the progress will come from sectors outside of health (e.g., agriculture, transportation, city planning) (Gortmaker et al 2011). Successful implementation of EBPs across these sectors requires finding common ground (e.g., equity) among a diverse set of organizations, often with missions that do not focus on health (Mazzucca et al 2021). This aligns with local-level policies that emphasize health in all policies or equity in all policies (Brownson et al 2021, Puska 2007).

Local leaders in our sample appeared to understand the importance of addressing disparities along with the complexity of intersecting causal factors, including lack of job opportunities, the wealth gap, and racism. Yet, elsewhere US mayors have reported they do not always perceive accountability for prevalent health concerns (e.g., obesity) (Godinez Puig et al 2021) and are often unaware of the policies to address health disparities (Purtle et al 2018). Respondents in our study reported challenges in collaborating across departments and levels of government (municipal and county), which is necessary for addressing complex, interconnected disparities. It is also critical to bring on new equity partners, share power and decision-making, and break down funding silos (Brownson et al 2021).

As in previous studies (Oliver et al 2014), we identified multiple barriers to policy action. It is useful to categorize these challenges across a continuum of modifiability. Several barriers to policy translation can be changed in a relatively short time period (e.g., timely access to relevant research evidence, skill-building among intermediaries). Other barriers to policy progress are much more difficult to change (e.g., political ideology). Our study and others emphasize the role of framing—how something is presented to the audience ("the frame") influences the choices people make about how to process information and act (Akl et al 2011, Rothman and Salovey 1997). In a review of effective advocacy for health equity, there is consensus on the need to frame messages to the political environment (Farrer et al 2015). Research in the US showed constituents of conservative ideology believe poor health results from "poor choices" and that messages should focus on how policies can help people make "positive choices," whereas words like "equality," "fairness," and other terms or concepts that appeal to more progressive voters should be avoided (Westen 2010). Future research should examine data by political party to consider how ideology influences the way issues are understood by local policymakers.

In conjunction with these barriers, we identified several key facilitators for local policy progress, including the need for timely, relevant, and actionable data. While it is well-documented that local policy officials seek out local data (Fielding and Frieden 2004, Kneale et al 2017, Yost et al 2014), information systems at the city and county level are much less developed than those at state and national levels (Chriqui 2013, Haire-Joshu et al 2010).There is a small, but expanding list of user-friendly local data resources for health, social and economic factors in the US (County Health Rankings & Roadmaps (University of Wisconsin Population Health Institute), City Health Dashboard (NYU Langone Health), PLACES: Local Data for Better Health (Centers for Disease Control and Prevention)). This is accompanied by the need to build awareness of these resources among organizations and their workforce's skills in accessing and using them. Our study illustrates the growing challenge of mis-information, though there are ways to address this seemingly insurmountable problem (e.g., providing accurate, engaging information that can be shared across multiple platforms) (Caulfield 2020, Office of the U.S. Surgeon General 2021). However, this requires substantial resources among already resource-scarce local organizations and government. Exploring the role of local thought leaders and organizations intervening in public opinion is an area for future research.

There are some limitations to our study. Our results reflect the perspectives and experiences of municipal officials in a selection of US municipalities with high rates of obesity or

related health disparities, some of which were randomly sampled, while other officials were selected purposively. Participants from the latter group may have been more receptive to community health issues. Our study does not represent all settings (e.g., urban, rural) and populations (e.g., racial/ethnic minority groups, low-income populations) across the US.

There is a growing number and range of EBP for addressing obesity disparities in communities in the US and globally (the “what” that needs to be put in place) (Kristensen et al 2014, Kumanyika 2019, Lyn et al 2013, McKinnon et al 2016). There is far less information on how to implement EBP within a particular context, including the process of policy adaptation (Brownson et al 2022). In addressing the “how,” policymakers typically make decisions across a wide array of issues and may lack a broad understanding of the relationship of obesity-relevant policies or their potential impact across sectors (e.g., transportation, housing, and health). They may lack skills on ways to collaborate with other policymakers to make comprehensive and systematic policy decisions to positively impact community health and health equity. Community organizations have a key role as intermediaries influencing local policymaking. Findings from our study provide leads on how to inform and accelerate local-level policy development, implementation, and evaluation.

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Key messages:

- Municipal officials value and seek input from constituents, community organizations and stakeholders on issues, emphasizing the key role some local organizations play as policy intermediaries.
- Local policymakers may have limited understanding of the relationship of obesity-relevant policies or their potential impact across sectors (e.g., transportation, housing, and health).
- There are challenges in collaborating across departments and levels of government (municipal and county).
- Access to timely, relevant research evidence and skill-building among intermediaries are key facilitators for local policy translation that are able to be addressed/changed in a relatively short time period.

Table 1.

Interviewee and municipality background information.

	% (n)
Interviewee (n=20)	
Position	
City manager or administrator (appointed)	10 (2)
Council member (elected)	65 (13)
Mayor (elected)[1]	25 (5)
Age	
30-39 years old	15 (3)
40-49	10 (2)
50-59	5 (1)
60-69	50 (10)
≥70	20 (4)
Gender	
Man	65 (13)
Woman	35 (7)
Years in local government (mean, range)	13.1 (1, 39)
Social ideology[2]	
Conservative	25 (5)
Moderate	5 (1)
Liberal	60 (12)
Other	10 (2)
Fiscal ideology[2]	
Conservative	35 (7)
Moderate	25 (5)
Liberal	30 (6)
Other	10 (2)
Municipality (n=16)	
Population	
2,500-49,999	56 (9)
≥50,000	44 (7)
Governance structure	
Council-manager	50 (8)
Mayor-council	50 (8)

[1] Depending on municipalities' charter or bylaws, the mayor may have been elected by constituents, or a council member voted into the mayor role for a term by fellow council members.

[2] Assessed using 7-point Likert scale, 1=extremely liberal to 7=extremely conservative. Combined response ratings of 1, 2 (liberal) and 3 (slightly liberal) for 'Liberal' category, and for 'Conservative,' combined 5 (slight conservative), 6 (conservative) and 7.

Table 2.

Policy actions to support community health discussed by interview participants.

Health-related policy proposed or championed by interviewees		Single biggest policy change needed to improve community health[1] (separate question and responses)
Domain	**Policy actions**	
Access to health care	*Representing 2 municipalities* • Levy supporting school health centers. • City funding to repair road ensuring access to hospital for segment of community.	
Access to healthy foods	*Representing 2 municipalities* • Supporting small businesses—helping immigrant markets meet requirements to sell fresh vegetables. • Supporting farm to school. • School summer meal program. • Healthy vending in parks and recreation facilities.	Policies increasing accessibility and affordability of healthy food (*2 participants*)
Active transportation	*Representing 5 municipalities* • Safe school routes. • New subdivision code requiring sidewalks. • Appealing to state to assess safety of state highway cutting through community. • Funding elements of active transportation plan. • Sidewalk repair program.	Designing cities for/ with active transportation options (*3 participants*)
Criminal justice	*Representing 1 municipality* • Funding an office for returning citizens.	
COVID-19 policies	*Representing 5 municipalities* • Shifting enforcement of penalties for bars/restaurants not complying with closing indoor dining from local health department (county-level) to city/municipality. • Requiring grocery stores to provide hazard pay to employees during pandemic/COVID-19. • Closing parks to mitigate spread. • Closing city hall and migrating to virtual meetings – requiring masks at public meetings, limited public attendance, virtual meeting for public engagement.	
Environmental health	*Representing 4 municipalities* • Banning storage of crude and shale oil. • Ensuring safe, lead-free tap water. • Smoke-free parks/public spaces. • Banning use of e-cigarettes/vaping in parks.	
General/ comprehensive plan for community health	*Representing 2 municipalities* • Land use and zoning.	Revising zoning policies (*2 participants*)

Health-related policy proposed or championed by interviewees		Single biggest policy change needed to improve community health[1] (separate question and responses)
Domain	**Policy actions**	
	• Updating city plans supporting health (housing affordability, community gardens and small commercial agriculture).	
Green spaces/parks and recreation	*Representing 3 municipalities* • Funding parks and recreation. • Repairing and operating swimming pool during summer. • Adding or enhancing recreational amenities (splash pad).	Providing resources that encourage physical activity (e.g., parks, trails, exercise facilities, wellness programs) (*6 participants*)
Housing – affordable, improved conditions, shelters for people unhoused	*Representing 3 municipalities* • Increasing affordable housing – multi-family units, maintain high standards. • Improving housing—landlord rental registration inspection. • Funding or support for shelter/tents for unhoused population. • Expanding the use of regulated tent encampments. • Supporting development of affordable housing. • Addressing vacant houses.	More affordable housing (*3 participants*)
Reducing alcohol or tobacco availability	*Representing 2 municipalities* • Increasing alcohol tax, funding programs for cessation and persons with developmental disabilities. • Banning the sale of tobacco products to those under 21.	

[1] Unique responses that did not fit within the above domains: Better income/wages (5 participants), accessible health insurance (4 participants), incentivizing businesses to promote employee and family health (1 participant), educating community about healthy behaviors (2 participants).

Table 3.

Facilitators and challenges to health-related policymaking.

Theme	Illustrative quote
Facilitators	
Received information from and worked with community organizations	*"It first got brought to us by a group of high school students working with a local nonprofit … they initially, came to the council and just through their efforts said, "We have seen this elsewhere and we think it makes sense for us to explore."*
Being able to address concerns/pushback with information/data	*"I had a lot of research on my side. So I was able to counter very quickly and say that driving is the number two killer of children. So the safest thing we can do for our community is to get people out of their cars." … when people come at you with safety concerns, for walking and biking, it's really helpful to have all that data"*
Keeping community members informed of policymaking	*"One of the techniques that I use in getting policies passed is to make sure that our citizens are aware of what is occurring in [municipality]'s governance process. And so me as an individual, for well over two years now, I have a website, Facebook page, LinkedIn account."*
Willingness to compromise and have open-minded discussions	*"I think the general perception on the council for me is that I am a swing vote. If you can prove me wrong or provide the facts that then enlighten me to change my vote, I'm willing to. As my colleagues say, I'm not closed-minded."*
Challenges	
Local constituent opposition and misinformation	*"Having to deal with the nay-sayers…no matter what you try to do. Try to institute a policy, "That'll never work." That's kind of a running joke that no matter what idea we come up with, there's always a Rolodex of excuses why it won't work."*
Controversial issue and solutions	*"And so you try and manage the problem, and then you create, the other half of the town is all up in arms that we're enabling people that should just go get a job. So it's been very difficult to communicate the complexity of the issue to our community because, well, we live in a time when people would rather jump up and down and holler about simplistic solutions that really aren't possible."*
Limited understanding of the connection of issues to health	*"Our streets and zoning codes are not viewed as a public health issue by the public. They are viewed as a transportation issue … In which elected officials should support the mode of transportation they believe is the best, and the mode of housing they believe is the best … it's not treated as a public health issue, in which we should create places in which everyone can have the opportunity to live a healthful life."*