MEETING SUMMARY
National Collaborative on Childhood Obesity Research (NCCOR)
Member Meeting

Wednesday, September 20, 2023
1:00–3:30 p.m. ET
Livestream recording

PARTICIPANTS (n= 21)

CDC: L. Kettel Khan	**USDA:** A. Amico, M. Abley
NIH: D. Berrigan, A. Brown, S. Czajkowski, B. Kowtha, L. Nebeling, M. Shams-White	**RWJF:**
Coordinating Center (CC): K. Deuman, M. Din, R. Grimsland, D. Hatfield, K. Hilyard, T. Phillips, M. Van Orman	**Other Virtual Attendees:** A. Yaroch, *Gretchen Swanson Center for Nutrition*

Speakers (in order of appearance)

- L. Duane House, PhD, *CDC*
- Laura Davis, MA, *Advocates for Youth*
- Karen Torres, *Advocates for Youth*
- Sally Herndon, MPH, *Tobacco Prevention and Control Branch, Division of Public Health, NC Department of Health and Human Services*
- Jessica Rath, PhD, MPH, CHES, *Truth Initiative*
- Elizabeth C. Hair, PhD, MS, *Truth Initiative*
- Tamara Dubowitz, ScD, SM, MSc, *Pardee RAND Graduate School*

Welcome and Highlights of NCCOR's Recent Accomplishments

Karen Hilyard, PhD, *NCCOR Coordinating Center*

K. Hilyard welcomed participants, reviewed the agenda, introduced the presenters, highlighted the primary purpose of the meeting—*to explore how lessons learned from public health interventions can be applied to childhood obesity research*—and provided highlights of recent NCCOR accomplishments and activities (pages 4–8 of the Member Meeting Binder).

NCCOR's accomplishments:

- Established a new work group: *Policy Lessons Learned for Healthy Childhood Development*
- Published two journal articles
  - *Count Every Bite to Make "Every Bite Count": Measurement Gaps and Future Directions for Assessing Diet from Birth to 24 Months (JAND)*
  - *National Collaborative on Childhood Obesity Research Efforts to Advance Childhood Obesity Research: Progress and Next Steps (AJPM)*
- Hosted a webinar, *Measuring Diet Quality Across the Lifespan: Introducing the New Healthy Eating Index-Toddlers-2020 and Healthy Eating Index-2020*, and published an HEI fact sheet in collaboration with NCI and USDA colleagues

Discussion: What are Some Similarities Between Childhood Obesity, Tobacco, and Teen Pregnancy?
moderated by Karen Hilyard, PhD, *NCCOR Coordinating Center*

K. Hilyard introduced the discussion topic—*similarities and differences between childhood obesity, tobacco, and teen pregnancy*—and provided the following prompts for member discussion:

Discussion prompt: What is on your mind as we compare tobacco use, teen pregnancy, and childhood obesity and their possible solutions?

- B. Kowtha (chat): All three may be connected with behavior modification and involve environmental factors.
- D. Berrigan: They seem to differ in dimensionality. Two seem to involve corporate interests, and one not as much. My initial thought was that childhood obesity has hundreds of determinants and maybe tobacco use has fewer and teen pregnancy fewer, but I'm not sure if that's necessarily true. The dimensionality is sort of "how do you pick out what to address through a policy or program," and somehow it seems more straightforward with tobacco than with food, although both have a lot of determinants. In addition, the direct harms are simpler to understand for tobacco than obesity. (Via chat – Another dimension is the moral/ethical/component, which perhaps looms largest in discussions of pregnancy.)
- A. Yaroch: In terms of similarities, tobacco taxes paved the way for what was done with sugar-sweetened beverage taxes.
- S. Herndon: It could be a social environment that is at play or it could be the physical environment in terms of what smoke-free zones people have access to, what healthy food zones people have access to, what the environment is in terms of being able to get healthy and safe; and what norms are in one's community about those types of things.
- T. Dubowitz (chat): The "language" around obesity as well as for teen pregnancy (now referred to more often as sexual health) is probably important.

Panel: Applying Successful Tobacco and Teen Pregnancy Interventions to Childhood Obesity
moderated by Karen Hilyard, PhD, *NCCOR Coordinating Center*

Preventing Teen Pregnancy through Community-Wide Initiatives: Implementation from a 5-Year Project in 10 Communities with High Teen Birth Rates – L. Duane House, *CDC*

L.D. House explained why adolescent reproductive health continues to be a public health priority by highlighting the disparities in U.S. teen birth rates and describing a community-wide initiative (CWI) to prevent teen pregnancy, implemented between 2010–2015.

- Disparities in U.S. teen birth rates
    - Teen childbearing has long-term economic and social consequences for teen parents and their children.
    - The United States continues to have the highest teen birth rates among high-income countries, with disparities listed below:
        - Racial/ethnic disparities: American Indian/Alaska Native, Hispanic, Non-Hispanic Black, and Native Hawaiian/Pacific Islander have the highest rates.
        - Geographic disparities: South and Southeastern regions highest

        - Socioeconomic disparities: Counties with higher unemployment, lower educational attainment, and family income had highest rates
- Community-wide teen pregnancy prevention initiative (CWI) – This partnership between CDC, Office of Adolescent Health, and Office of Population Affairs aimed to implement innovative, multi-component, community-wide initiatives to reduce teen pregnancies and births in communities with the highest rates, with a focus on reaching African American and Latino/Hispanic youth ages 15–19.
    - Goals:
        1. Increase youth access to high-quality reproductive health services
        2. Increase youth access to evidence-based prevention interventions
        3. Reduce rates of pregnancies and births to youth in intervention communities
    - Program model:
        - National organizations provide training and technical assistance to state and community-based organizations
        - State and community-based organizations provide training and technical assistance to youth-serving organizations, health centers, and local partners
        - Health center partners and youth-serving organization partners plan, implement, and evaluate
    - Five components of the model:
        1. Community mobilization: Support the sustainability of teen pregnancy prevention efforts by empowering community members and groups, including youth leaders, to take action to facilitate change.
        2. Stakeholder education: Support informed decision-making regarding strategies for teen pregnancy prevention by improving stakeholder (e.g., community members, civic leaders, parents) access to data and resources on teen pregnancy prevention and evidence-based prevention strategies.
        3. Working with diverse communities: Raise awareness among community partners about the link between teen pregnancy and social determinants of health, ensure that culturally and linguistically appropriate programs and reproductive health care services are available to young people, and ensure diverse youth and community partner engagement in initiative planning and delivery.
        4. Evidence-based programs: Provide teens with evidence-based teen pregnancy prevention programs; provide training and technical assistance to grantees to support intervention implementation.
        5. Reproductive health services: Increase youth access to quality reproductive health care services
    - Reproductive health services reach
        - CWI serves 48,000 unduplicated adolescent clients annually.
        - >219,000 reproductive health visits
        - Most clients were female (69%), African American (54%), and aged 15–17 (43%)
        - Increases in adolescent patient volume served by health centers ranged from +130 to +1,600 youth.
    - Training and technical assistance (TTA)
        - National organizations provided a total of 2,400 hours of TTA to grantees.
        - Grantees provided a total of 713 hours of training and 1,422 hours of technical assistance to partners.
        - Total TTA hours were associated with higher levels of contraceptive coverage by health centers.

- Key takeaways
    - Comprehensive, multi-level, multi-component approaches are needed to achieve change.
    - Strong community-clinic linkages and community engagement appeared to be important for increasing adolescent access to health centers.
    - Strong support systems that can provide quality training and technical assistance are important to improve adolescent health care and provide evidence-based sexual health interventions to youth.
    - Quality implementation was critical to effectiveness.
- Resource: CWI Project Tools for Components are available on the Division of Reproductive Health website

Preventing Teen Pregnancy through Community-Wide Initiatives: Community Mobilization and Youth Engagement – Laura Davis and Karen Torres, *Advocates for Youth*

L. Davis described the vision, mission, and goals of Advocates for Health; their role in the CWI from 2010–2015; the theoretical frameworks that informed their work; and best practices and lessons learned. K. Torres shared a case study, The Reproductive Health Access Project (RHAP) in Tucson, AZ from 2017–2019.

Advocates for Youth envisions a society in which all young people are valued, respected, and treated with dignity; sexuality is accepted as a healthy part of being human; and youth sexual development is normalized and embraced. A significant aspect of the work focuses on engaging young people as activists, advocates, and leaders to build their power to help shift our cultural paradigm around youth sexual development.

- Advocates for Youth's role in the CWI: Provided capacity-building support to nine state and community-based organizations through training and workshops, technical support and coaching, tools and resources, and networking opportunities
- CWI was grounded in the Socioecological Model, following three frameworks:
    1. Community Pathways Model, which includes a focus on:
        - **Individual changes** among teens such as changes in knowledge, attitudes, and behaviors related to sexual health and sexual activity
        - **Social changes** including increased public will, greater community leadership capacity, increased and high-quality youth and community participation, and supportive social norms
        - **Structural changes** including policy and practice changes and greater coordination of health, education, and social services
    2. Youth-Adult Partnership Approach: Youth are seen as a partner in the work, rather than simply recipients of it
    3. Collective Impact Approach, which posits that communities are likely to sustain initiatives and be most effective when five pre-conditions are in place: common agenda, shared measurement, mutually reinforcing activities, continuous communication, and presence of a backbone organization
- Core strategies that supported community mobilization and youth engagement
    1. Each community:
        - Secured strong leadership and developed a formal infrastructure
        - Engaged the entire community and sought authentic participation
        - Mobilized young people to engage in meaningful and productive roles

        - Developed shared visions grounded in data, evidence-based practices, and locally defined needs and capacities
        - Developed and implemented a strategic action plan with mutually reinforcing strategies
        - Evaluated interventions and implementation processes using shared measures
        - Created long-term sustainability plans
- Lessons learned
    1. Sustainability depends on mobilizing the entire community and is likely to happen when young people are engaged, encouraged, and provided with tools and resources to take ownership of programs and strategies.
    2. Youth leadership and community buy-in are essential.
    3. Creating formal partnership between health centers and social service agencies is critical.
    4. Systems-level change is time-consuming and expensive but has huge payoffs.
    5. Teens want, and have the right to be, engaged in all aspects of programming.
    6. Teens are fully capable of serving as providers of care and should be compensated for their work.
- Case study: Reproductive Health Access Project (RHAP), Advocates for Youth and El Rio Health Center, Tucson, AZ
    1. Strategy 1: Secure strong leadership and develop a formal infrastructure.
    2. Strategy 2: Engage the community (paid youth leaders played multiple roles).
    3. Strategy 3: Create a shared vision grounded in data, evidence-based practices, and locally defined needs and capacities. Teens worked in partnership with adults to review evidence-based guidelines and practices; assess county and health center data; conduct surveys, interviews, and focus groups; interpret, analyze, and utilize results; and create a shared vision for change.
    4. Strategy 4: Develop and implement a strategic action plan with mutually reinforcing strategies.
    5. Strategy 5: Evaluate outcomes: Interventions and implementation processes
    6. Key outcomes:
        - RHAP contributed to a significant increase in the number of youths who received health care at El Rio
        - In 2019, El Rio provided health services to 11,883 youth ages 14–24, an increase of 60% (n=4,444) from baseline (2015/16)
        - In 2019, 3,543 teens received family planning services, an increase of 49% (n=1,165) from baseline
    7. Strategy 6: Sustain the success!

NCI Project Assist - Sally Herndon, MPH, *Tobacco Prevention and Control Branch, Division of Public Health, NC Department of Health and Human Services*

S. Herndon described the historical context of National Cancer Institute (NCI) Project ASSIST (American Stop Smoking Intervention Study for Cancer Prevention). This three-pronged intervention used policy development, mass media and media advocacy, and program services and included the National Cancer Institute's Five Phases of Cancer Control Research (slide 78), conceptual frameworks, and the tobacco industry's challenges to public health policies.

- State health agencies in collaboration with American Cancer Society state-level affiliates were funded in 17 states, which facilitated both advocacy and education efforts.

- Policy priorities included eliminating exposure to environmental tobacco smoke, promoting higher taxes for tobacco, limiting tobacco advertising and promotions, and reducing minors' access to tobacco products.
- The tobacco industry's challenges to public health policies included discrediting the science, promoting ineffective alternatives, and introducing pre-emptive statewide legislation.
- Success was due to ASSIST's infrastructure, ongoing training and technical assistance, and strong internal and external partnerships.
- Conceptual frameworks:
    - The ASSIST Conceptual Framework: Goal was to create a paradigm shift in the United States to move from education and behavior modification interventions that targeted at-risk populations to a more varied set of interventions that included media, policy, and program services
    - The Public Health Model: Goal was to build support for tobacco control policy by clearly communicating that the tobacco industry was the enemy, or the "agent"
- What works: A combination of strategies such as tobacco price increases, cessation access, media campaigns, and smoke and tobacco-free policies were enhanced by point-of-sale interventions such as reducing availability, increasing price and promotion, advertising and display bans, and raising the age of sale to 21.
- Resource: [ASSIST: Shaping the Future of Tobacco Prevention and Control]()

The truth® Tobacco Prevention Campaign - Jessica Rath, PhD, MPH, CHES and Elizabeth C. Hair, PhD, MS, Truth Initiative

J. Rath provided an overview of the truth® Tobacco Prevention Campaign, insights from the truth combustible campaign, and a description of how its messaging has evolved. The Truth Initiative conducts groundbreaking research and policy studies; gives young people the facts about smoking, vaping, nicotine and the tobacco industry; engages individuals and groups to make change in their communities; innovates new ways to end tobacco use; and joins forces with collaborators committed to making tobacco use and nicotine addiction a thing of the past.

- Insights from the truth Tobacco Prevention Campaign
    - Show respect and empathy for the audience
    - Don't tell young people what to do
    - Health effects alone don't penetrate the invincible shield of youth
    - Make it personal
    - Appeal to their desire for fairness
    - Build a brand
- Tactics to learn about knowledge, attitudes, beliefs, behaviors to inform campaign
    - Expert interviews
    - Research (surveillance studies, attitudinal items, constructs testing)
    - Facts testing through surveys and in-person focus groups for the ability to capture attention, convey new info, and motivate action
    - Qualitative and quantitative testing of approaches and messaging
    - Pre-market testing of near-final versions of ads to optimize prior to airing
- Evaluation of campaign
    - Formative: audience research, message development, pre-market studies
    - Implementation: in-market studies (continuous tracking)
    - Outcome: longitudinal cohort studies
- Evolution of messaging strategy over time, e.g., switch of focus from combustibles to vaping

    - Early 2000's: 23% smoking prevalence in teens; smoking was a rebellious act; target age 12–17 years; delivery method was TV ads
    - 2014: 9% smoking prevalence in teens; smoking was a social act; target age 15–21 years; delivery methods were TV ads, digital ads, and social media
    - 2018 (vape prevention): 4.6% smoking prevalence in teens, 20% vaping prevalence in teens; target age 15–24 years; delivery methods were tv ads, digital ads, and social media
- Vaping campaign objectives
    - Increase campaign-related knowledge, attitudes, and beliefs
    - Reduce intentions to use all tobacco products (e.g., nicotine-containing cigarettes, cigars, e-cigarettes, etc.)
    - Reduce initiation of tobacco use
    - Reduce progression to established tobacco use
- Vaping campaign techniques
    - Ads: Breath of Stress Air
    - Influencers: Join McCall
    - Quit program: This is Quitting

Q&A with Panelists

K Hilyard: What advice do you have when the topic is considered sensitive, and how direct can we be? How did you cope with opposing viewpoints or sensitivities around these topics?

- D. House: Sex was a focus because we were really trying to target sexually active youth. It was controversial, which was a major challenge. We were mostly in the Southeast where rates were the highest and where it's more controversial to talk about sex and access to services. For that reason, the mobilization, education components, and technical assistance were important. We had to meet the community where they were, such as finding common ground and speaking to the facts of science, and [we had to] build strong relationships and find champions in the community. We found some success in engaging non-traditional partners like faith-based organizations.
- L. Davis: We did a lot of controversy management training with our communities. Engaging young people and having their voices be front and center was critical, as well as using local data and having spokespeople from the community represent the data.
- K. Torres: Young people really appreciate honesty from adults and will be more trusting of adults and institutions and organizations that are honest with them. Parents are often interested in these topics and don't know how to bring them up, so engaging parents in how to talk to young people about these topics is very important.
- E. Hair: Our biggest controversy in tobacco was between messaging to kids on how to not initiate and at the same time messaging to adults about not using cigarettes. In our testing, we look at the unintended consequences of our messaging. We make sure we are using influencers across different groups, especially the vulnerable groups that are most likely to use these products. We make sure those groups are represented, and we have people from those populations on social media. Allowing youth to use their authentic voice has helped with some of those controversies, although sometimes their authentic voice is not always totally accurate.

K Hilyard: Can you share your experiences working with youth to reduce stigma?

- S. Herndon: We did a lot in North Carolina to build youth advocates. It is a great investment because it builds strong advocates for your issue as well as strong citizens and small "d" democracy. When things are politically controversial, having youth and people with lived

experience to speak truth to power is really very powerful. In NC, youth influenced the governor to pursue tobacco-free schools. Their voices gave the governor the backbone to act.

D. Berrigan (chat):

- Work seems to be emerging about how to talk to parents and kids about obesity, so I see parallels.
- Coming back to the icebreaker about similarities and differences between these three public health challenges, I wonder if a key difference is that we must eat to live but we can live without tobacco and adolescent sex - this fact must influence the behavior change context.

T. Dubowitz (chat): I was curious from Jessica's presentation/truth campaign if you expanded from tobacco to other substances like cannabis with the landscape change to vaping/e-cigs.

- E. Hair: Truth is not currently messaging on cannabis in our public education campaign but may in the future. We are currently creating modules about cannabis and vaping to include in our school-based curriculum, Vaping: Know the Truth, which is offered through the EVERFI/Blackbaud platform to schools to use for free. These modules should be available early in 2024.
- S. Herndon: States that have legalized recreational cannabis have merged their programs in some places. In NC, intoxicating hemp products are everywhere and totally unregulated.

Discussion: How can lessons learned from tobacco or teen pregnancy interventions be applied to childhood obesity research?

moderated by Tamara Dubowitz, ScD, SM, MSc, Pardee RAND Graduate School

T. Dubowitz led a discussion on how lessons learned from tobacco or teen pregnancy interventions can be applied to childhood obesity research.

Bringing it all together: What can childhood obesity prevention learn from work in the tobacco and teen pregnancy space?

- Similarities
  - Inequities/disparities
  - Multilevel – Grassroots to policy; homes and families; schools and communities
  - Multisectoral – Industry, community, schools
  - Controversy (for example, adolescent sexual reproductive health, obesity and body shaming)
- Differences
  - Is the "endpoint" different? Is the focus on childhood obesity inherently more difficult than an "endpoint" of smoking/vaping and/or sexual and reproductive health?
  - Is childhood obesity inherently broader, given that determinants range from food industry and environment to socioeconomic conditions?
  - Are messages different in the childhood obesity world? (i.e., what is "healthy" food and do you need more than a healthy diet?)
- Learning through questions
  - Are there processes specific to tobacco or adolescent sexual health that might be transferable to childhood obesity?
  - Are there processes that are non-transferrable?
  - Understanding the history and landscape of these domains might also assist with next steps.

Discussion prompt: How can lessons learned from tobacco or teen pregnancy prevention be applied to childhood obesity?

D. Berrigan (chat): I'm wondering about the relationship between the prevalence of these different behaviors, interventions, and social and secular changes in society and how those three things are interrelated. Is it really the interventions? Is it secular and social changes? Or is it some interaction between what we do in public health and what is happening in society that leads to changing for the better or for the worse?

- S. Herndon: My quick answer is that media and policy change norms, and that changes the environment.
- E. Hair: I agree with Sally. I think there is a big difference between what happened with tobacco and what we're seeing with obesity, but also even with teen pregnancy prevention. We had the master settlement agreement. We had this moment in time that allowed all the stakeholders to come together to put policies in place. National public education was put into place, and treatment is real. I think what is not happening with obesity is that there is not really a national public education campaign. There aren't policies in place, and there is still a belief that obesity is a choice. Weight management is not necessarily covered by our insurance and our medical care. In tobacco control, all three pillars have to be in place, like a three-legged stool. If one of those legs is not functioning well, it teeters, which is why we are seeing a massive increase in vaping. They found a way to get nicotine back in front of kids. The question is, how do you put those pillars in place for obesity?

K. Hilyard: What lessons have you heard here today from tobacco or teen pregnancy prevention that you think could be applied to childhood obesity?

- A. Brown: What stood out to me in Tamara's comments and questions was how similar or different is obesity prevention in comparison with the other behaviors and issues? Thinking about obesity, the multiple behaviors that are linked to it could include nutrition, physical activity, sleep patterns, [and] other social determinants of health. I think the learning is about engaging industry partners to find common ground where possible. The White House Conference on Hunger, Nutrition, and Health had some success engaging a variety of stakeholders, but I'm not quite certain that there is sufficient movement in the food industry or by other key stakeholders.

K. Hilyard: How can we implement grassroots efforts that could support top-down policy initiatives?

- L. Davis: Another lesson learned from our field is that we have just recently brought the birth control pill over the counter, and there have been some technological innovations in our field that have offset some of the more restrictive policies related to abortion access. This can be considered a mediating factor not necessarily related to interventions themselves.
- D. House: As a Federal agency, there are limitations around grassroots advocacy, for good reason. We tried to navigate and let the communities sort those things out.

K. Hilyard: What ideas do you have for how youth could drive momentum on reducing and preventing childhood obesity? What would not only be feasible and possible, but what would be ideal?

- T. Dubowitz: I'm curious about what kind of language has been used that has been successful? When I think about obesity, I want to veer away from saying, "let's empower youth to confront childhood obesity." I want to say, "let's empower youth to really define health." What does it mean to be healthy—and that would encompass healthy eating, sleeping, activity, and more. What kind of language has been used in the tobacco and reproductive health world?

- L. Davis: Many have stopped using the term "teen pregnancy prevention." The question is, how do you let communities define the way that they want to approach the issue? When we prevent something that is negative that hasn't even happened or problematize a behavior or consequence of a behavior that is so much bigger than an individual's choice, we lock ourselves in, in that the solutions are defined by the way we define that problem. The way we have shifted is to think about adolescent sexual health and development as a normal part of being human and that our goal is to promote healthy relationships, intended pregnancy, and family formation where it makes sense, vs. talking about out of wedlock births or non-marital births. If we talk to young parents, we don't use the term "teen parents" because it has been so stigmatized.
- K. Torres: Recommend shifting framing from "what is wrong with you" to "what is right with you" and asking what support they need from adults. This can give young people the knowledge to know when things are wrong and the language to know how to ask for help to change.
- S. Herndon: Big corporations market junk food and make sure the items are identifiable and appealing to young people. We are using youth leadership to do counteradvertising by working with a group called Counter Tools to do store assessments to see where the vape products are advertised on the store front. Engaging kids to document what is going on in their communities is very powerful, [as is] having them speak about it to leadership. Kids were brought together for a Youth Summit in February. They are engaged in keeping their friends healthy by bringing awareness to leaders. In North Carolina, oftentimes our local decision makers such as school resource offices are the ones that can communicate with state leaders to help make those things happen, and they are listening to young people.
- J. Rath: I love the examples that have already been provided about how to reframe these things. For example, "vaping" is an industry-developed word that we have to say so that youth know what we're talking about, but in our publications, we use "e-cigarettes." Another industry word is "habit." Back in the day, they talked about smoking as a habit as a way to make it sound very easy to change. A habit doesn't seem like a problem or an addiction. Finally, the word "novel products"—this is a way that products are described which makes them sound very friendly and usable. When we talk about the products available in the larger tobacco landscape, we are careful with the language we use to describe the product.

K. Hilyard: For both teen pregnancy and tobacco use, are there any kinds of glossaries or guides available that talk about some of these language differences, and how you have shifted and tried to reframe using more accurate language?

- J. Rath: We have some internally, but I am not aware of anything external. There is this fear—because we are always being watched—that putting these kinds of things out there will make them multiply. But it's really just calling out the industry for what they are doing, which is making a product that is very harmful sound not harmful.
- E. Hair: Joanna Cohen at Johns Hopkins has a video on her tobacco control page highlighting these issues. It isn't a lexicon, but more just being careful and monitoring because the industry is good at coming up with phrases that make products seem enticing. When we talk to kids, we have to use the language they are speaking.
- J. Rath: Teaching kids that industry does this for a reason and does this to target you is part of our messaging.
- E. Hair: We have testimonials. We also use influencers. We have a whole activism group as well. We bring in youth as ambassadors. We can't lobby, but we can send youth to go talk to different state and national representatives about why legislation needs to be passed. They create projects in their own communities and sometimes end up collaborating on national efforts.
- K. Deuman (chat): On the topic of counteradvertising/messaging, there is a campaign called "truth about fruit drinks" which is a social marketing countermarketing campaign to reduce fruit

drink purchases. I believe that Jim Krieger leads this work: https://www.truthaboutfruitdrinks.com/

- A. Brown (chat): Operation Good Food and Beverage is an example of a youth-driven initiative to encourage the restaurant industry to provide more healthy meals. It was launched by the Council on Black Health.
- S. Herndon (chat): Tobacco disparities messaging: Tobacco Disparities Messaging Project - Google Drive

Discussion prompt: How can NCCOR members strategically leverage partnerships? Who are the key players that we should be partnering with to build a shared mission?

- S. Herndon: In government, sometimes we need partners who do work that we cannot do. We can lobby upline in our executive branches, but we cannot cross that line and lobby for legislation. One of the brilliant things about Project ASSIST is that it was a partnership with the American Cancer Society who could do things that we could not. Our role was to be the subject matter experts who laid out the facts, and our external partners advocated.
- E. Hair: We also align ourselves with other national groups that can lobby. On the public education side, we partner with groups that kids are already aligning themselves with, e.g., Vans shoes and the video gaming industry. We try to go to where the kids are instead of making the kids come to us.
- J. Rath: We also need to make sure partners understand why they would want to partner with us. We need to make sure both sides are getting something out of the partnership, making sure that partners understand what we bring to the table.
- D. House: Partners that can provide training and technical assistance at the national, regional, or local level.
- S. Herndon: The folks that I work with who are working on childhood obesity are jealous of the sound science we have in tobacco and the very specific focus on what policy actions work. They wish they had five things that they should be doing.

Wrap-Up and Closing – Karen Hilyard, PhD*, NCCOR Coordinating Center*

NCCOR updates:

- NCCOR member survey will be sent in October by A. Yaroch at the Gretchen Swanson Center for Nutrition.
- NCCOR Coordinating Center will be at the American Public Health Association's Annual Meeting & Expo on November 12–15 in Atlanta (booth #520).
- NEW: NCCOR’s Catalogue of Surveillance Systems has been updated with sleep variables.
- Next member meeting: Tentatively February 2024