

All Health Is Local: State and Local Planning for Physical Activity Promotion

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Context: Physical activity is a leading cause of death in the world. Although state and local public health planning is a useful strategy to address noncommunicable disease health concerns such as heart disease, diabetes, cancer, and obesity, physical activity frequently is subsumed in such disease-centric planning efforts. This strategy could dilute broader efforts to promote physical activity, create administrative silos that may be trying to accomplish similar goals, and weaken efforts to more collectively address a variety of noncommunicable diseases. Currently, few stand-alone state plans directed specifically at physical activity exist. The reasons and barriers for this situation are not understood. **Objective:** In 2011, we surveyed public health care practitioners to describe state and local efforts for physical activity planning. **Design:** Cross-sectional study. **Setting:** Survey of physical activity practitioners in the United States.

Participants: A total of 227 former or current members of the US National Society of Physical Activity Practitioners in Public Health who completed a survey. **Results:** Overall, 48.0% of respondents indicated that they were aware of public health plans for physical activity promotion in their state, whereas 36.6% indicated that they did not know. Respondents at the state level more frequently reported awareness of a plan (62.1%) than those with local-level (52.4%) or other job responsibilities (36.0%). A greater proportion of respondents reported that stand-alone physical activity plans existed in their state than actually did exist in the respective states. Integration with the National Physical Activity Plan was least often identified as a moderately or extremely relevant aspect of a state-level physical activity plan, although it was chosen at a high percentage (75.7%). Respondents identified financial support (88.0%) and

political will and support (54.6%) most frequently as very or somewhat difficult barriers to moving forward with state-level physical activity plans. **Conclusions:** These data suggest that despite efforts to increase development and use of stand-alone physical activity plans, most practitioners rely on existing chronic disease- or obesity-related plans to guide their efforts. Barriers to developing stand-alone physical activity plans must be addressed to develop such plans.

KEY WORDS: dissemination, evaluation, implementation, local planning, national plan, policy, public health practitioners, state planning, surveillance

Planning is a core function of public health, used in areas ranging from acute emergency response capabilities¹ to infectious disease outbreak prevention

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and management, and long-term approaches for chronic disease reduction and health promotion.² Public health plans take a structured approach that considers the health problem, target population, and prevention, treatment, and/or management strategies to address the problem. Moreover, public health plans can build capacity in a given area and assist in prioritizing resources to address the planned goals.

Physical inactivity is one area that could benefit from a public health planning approach. A major cause of global noncommunicable disease burden,³ physical inactivity accounts for an estimated 5 million deaths per year across the world. The burden, similar to that of cigarette smoking, suggests a need for urgent action and a public health approach to promoting physical activity.⁴

National planning for physical activity lags behind its importance as a leading cause of poor health. Moreover, physical activity frequently is subsumed in noncommunicable disease planning efforts that focus on specific disease outcomes, such as cardiovascular disease, diabetes mellitus, and obesity.⁵ Often, the goal of such plans is to use physical activity in addressing the noncommunicable disease of choice rather than to increase overall physical activity.

Upon the creation of the US Physical Activity Guidelines,⁶ the US National Physical Activity Plan was published in 2010.⁷ Led by a Coordinating Committee that included nonprofit organizations, academia, and government agencies, the process to develop the plan was collaborative in using a broad, trans-sectoral approach to address the problem of physical inactivity at the national level.⁸ The resulting national plan provides a framework for translating and mobilizing efforts at the state and local levels. As of January 2012, only one state plan that specifically targets physical inactivity had been created.⁹ The extent to which any additional mobilization in response to the US National Physical Activity Plan is happening is unclear, and the barriers to implementation are unknown.

Using data gathered from a survey of the National Society of Physical Activity Practitioners in Public Health (NSPAPPH), we sought to better understand state and local planning efforts targeted specifically to physical activity. The article aims to describe these survey results in the context of state and local efforts for physical activity planning.

● Methods

The NSPAPPH is a professional organization focused on increasing the capacity of physical activity practitioners in public health and elevating physical activity in public health practice at national, state, and lo-

cal levels through professional development (<http://www.nspapph.org/>). The membership includes practitioners whose jobs focus on physical activity at the national, state, and local levels, providing a range of perspectives.

Description of survey

The questionnaire was designed specifically for NSPAPPH members, including professionals with jobs focused on physical activity promotion at the national, state, or local levels. Expert review by academics and practitioners with expertise in the field was used to determine face and content validity. The questionnaire consisted of 34 items, some with multiple response options, and included information on the US National Physical Activity Plan as well as state physical activity planning, as described here. Details about the remaining portions of the survey can be found elsewhere.¹⁰ Respondents were assigned to 1 of 4 US census regions on the basis of their mailing address (Midwest, Northeast, South, and West) (http://www.census.gov/geo/www/us_regdiv.pdf).

The executive director of NSPAPPH introduced the survey to attendees at the organization's national conference in June 2011 and invited members to complete paper versions on-site. Subsequently, each member was e-mailed a link to the online survey (using Qualtrics: <http://www.qualtrics.com/>). Nonrespondents were sent an e-mail reminder and received up to 3 phone call attempts. We searched the Internet and placed calls to find replacement e-mail addresses and phone numbers for unreachable members. All surveys were completed in June-August 2011. The protocol was approved by the institutional review board at the University of North Carolina-Chapel Hill.

Response and statistical analysis

The NSPAPPH membership list included 653 names in total; we did not survey members living outside the United States ($n = 17$), student members ($n = 38$), or members involved with survey development ($n = 7$). Also excluded were 3 members who took the survey but were students and 99 members who could not be reached by e-mail or phone. Among the remaining 492 members, 291 responded to the survey (59%). If we include in the denominator the 99 members whose contact information could not be verified, the response rate was 49% (291/591). Respondents missing key survey item responses were removed ($n = 64$) for a final analytic sample of 227 respondents. Statistical testing was based on χ^2 analyses. All analyses were conducted using STATA version 10.1.

● Results

Descriptive characteristics of respondents are shown in Table 1. Experience varied, with 33.0% reporting not currently being employed as a physical activity practitioner and 26.2% reporting at least 10 years of experience as a physical activity practitioner. Most respondents (81.8%) had at least some graduate education. Job responsibilities of respondents were categorized as primarily state level (44.8%), local level (19.8%), or other (35.4%). Respondents represented 48 states, as well as Washington, DC, District of Columbia.

In response to the question “Does your state currently have a state public health plan for physical activity?” nearly half (48.0%) of survey respondents said that they were aware of a state-level public health plan for physical activity in their state and 36.6% said they did not know. However, responses varied by job type, with those who have job responsibilities at the state level more frequently reporting awareness (62.1%) than those with local-level (52.4%) or other job responsibilities (36.0%) ($P < .01$). A substantially higher percentage of those with responsibilities that were not at the state or local levels (52.0%) said that they did not know of a state public health physical activity plan in their state

TABLE 1 ● Descriptive Characteristics of Survey Respondents: NSPAPPH 2011 (N = 227)

Characteristic	n	%	Missing
Length of NSPAPPH membership			23
<1 y	101	49.5	
1-<2 y	54	26.5	
2-<3 y	18	8.8	
3+ y	31	15.2	
Experience as a physical activity practitioner			6
Not currently	73	33.0	
<1 y	2	1.0	
<3 y	30	13.6	
3-<5 y	20	9.0	
5-<10 y	38	17.2	
10+ y	58	26.2	
Highest level of formal education			6
Some college or technical school	3	1.4	
College graduate	37	16.7	
Some graduate school	16	7.2	
Master's degree	136	61.5	
Doctoral degree	29	13.1	
Primary job responsibility			15
State	95	44.8	
Local	42	19.8	
Other	75	35.4	

Abbreviation: NSPAPPH, National Society of Physical Activity Practitioners in Public Health.

compared with respondents with either state- (11.6%) or local-level (12.6%) job responsibilities.

Responses about awareness of various types of state public health plans are summarized in the Figure. Respondents were asked, “Does your state currently have a chronic disease plan, such as an obesity, heart disease, asthma, or diabetes state plan that includes physical activity as a key focal point?” A small proportion (2.2%) of respondents said that there was a state public health plan for physical activity but no chronic disease plan in their state. In comparison, a much larger percentage of respondents reported that their state had a public health plan for physical activity as well as a plan for addressing chronic diseases (39.2%).

Responses to questions about the components of a state public health plan for physical activity are summarized in Table 2. Respondents were asked to rate the importance of a having a local emphasis, a collaborative approach, setting goals and targets, using evidence-based strategies, conducting a needs assessment, prioritizing populations, evaluation of programs or initiatives, and integration with the National Physical Activity Plan. More than 75% of respondents ranked all components as moderately or extremely relevant to a state public health plan for physical activity. Integration with the National Physical Activity Plan was least frequently rated as moderately or extremely relevant, although it was still chosen at a high percentage (75.7%). The distributions of these responses did not vary by job type of the respondent (ie, state, local, other; data not shown).

Data in Table 3 summarize responses to the question “Please rate the difficulty with moving forward with a state public health plan for physical activity.” Perceived difficulty varied across potential barriers. Existence of community partners (53.3%), access to content expertise (50.4%), and access to state and local data on physical activity (50.0%) were the top-3 components rated *somewhat easy* or *easy to use* by respondents. On the contrary, financial support (88.0%), political will and

FIGURE ● Awareness of State Plans for Physical Activity and Chronic Disease: NSPAPPH 2011 (N = 227)

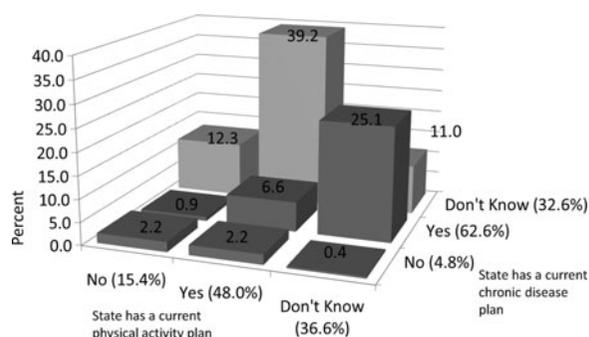


TABLE 2 ● Overall Responses to How Relevant Each Component Was to a State Public Health Plan for Physical Activity: NSPAPPH 2011 (N = 227)

Component	Not At All or Slightly Relevant		Neutral		Moderately or Extremely Relevant		Missing
	n	%	n	%	n	%	
Local (city, town, municipality) emphasis	12	5.3	11	4.8	204	89.9	0
Collaborative (multisector) approach	9	4.0	10	4.4	207	91.6	1
Setting goals and targets	12	5.3	15	6.6	199	88.0	1
Evidence-based strategies	7	3.1	18	8.0	200	88.9	2
Needs assessment	9	4.0	15	6.6	203	89.4	0
Prioritizing populations	15	6.6	30	13.2	182	80.2	0
Evaluating programs or initiatives	8	3.5	14	6.2	204	90.3	1
Integration with NPAP	13	5.7	42	18.6	171	75.7	1

Abbreviations: NPAP, National Physical Activity Plan; NSPAPPH, National Society of Physical Activity Practitioners in Public Health.

support (54.6%), developing a state public health plan for physical activity (53.7%), and having appropriately trained staff (51.1%) were most frequently cited as very difficult or somewhat difficult.

Data in Table 4 indicate the overall and job category-specific proportion of respondents reporting “very difficult” or “somewhat difficult” for each barrier. As with overall results from Table 3, financial support and political will and support were the components most commonly rated as very difficult or somewhat difficult. Although some consistency was observed across job category, differences did exist. For example, among those not employed in a state or local work role, 32.4% indicated difficulty with access to content expertise. This value was higher than that reported by respondents with either state (20.0%) or local (26.2%) job responsibilities.

● Discussion

The assumption that all health is local suggests that policies and programs must be articulated at the local level. Under this assumption, we sought to understand the degree to which practitioners working in physical activity and public health use physical activity plans to guide their actions. Furthermore, we sought to understand the barriers and plan components that may be important to success. Such data are critical for informing national-level action to effectively promote physical activity.

Survey results provide several important observations. First, physical activity practitioners believe that state public health plans for physical activity already exist, although the contrary often is true. Respondents likely confused physical activity-specific plans with

TABLE 3 ● Perceived Barriers to Developing and Implementing a State Public Health Plan for Physical Activity: NSPAPPH 2011 (N = 227)

Barrier	Very Difficult or Somewhat Difficult		Neither Difficult Nor Easy		Somewhat Easy or Easy		Missing
	n	%	n	%	n	%	
Developing a state public health plan for physical activity	122	53.7	71	31.3	34	15.0	0
Appropriately trained staff	115	51.1	56	24.9	54	24.0	2
Financial support	198	88.0	21	9.3	6	2.7	2
Access to physical activity content expertise	57	25.2	55	24.3	114	50.4	1
Political will and support from agency	144	54.6	54	24.2	25	11.2	4
Community partners and leaders in physical activity	53	23.6	52	23.1	120	53.3	2
Access to state and local data on physical activity	66	29.7	45	20.3	111	50.0	5

Abbreviation: NSPAPPH, National Society of Physical Activity Practitioners in Public Health.

TABLE 4 ● Proportion of Respondents Who Rated Barriers of a State Plan for Physical Activity as Very or Somewhat Difficult, Overall and by Job Type^a: NSPAPPH 2011 (N = 212)

Barrier	Job Type					
	State		Local		Other	
	n	%	n	%	n	%
Developing a state public health plan for physical activity	50	52.6	22	52.4	42	56.0
Appropriately trained staff	48	51.6	18	42.9	41	54.7
Financial support	83	89.2	38	90.5	65	86.7
Access to physical activity content expertise	19	20.0	11	26.2	24	32.4
Political will and support from agency	58	62.4	28	66.7	51	69.9
Community partners and leaders in physical activity	21	22.3	11	26.2	18	24.3
Access to state and local data on physical activity	33	35.9	9	21.4	24	32.9

Abbreviation: NSPAPPH, National Society of Physical Activity Practitioners in Public Health.

^aRespondents who did not indicate their job type were excluded (n = 15).

public health chronic disease plans that include physical activity as a secondary component. As of January 2012, we are aware of one state (Texas) that developed a stand-alone public health plan for physical activity promotion. Only 7 of the survey respondents indicated that they lived in Texas at the time of the survey (data not shown), thus making it unlikely that these respondents skewed any results. These data suggest that despite efforts to increase development and use of stand-alone physical activity plans,^{7,11} most practitioners are not aware of the distinction and rely on their state's chronic disease plans to guide their efforts.

In the United States, many state chronic disease plans and control efforts are funded through initiatives from the Centers for Disease Control and Prevention. This leadership not only has been useful in developing planning efforts but also has resulted in a silo approach where states develop separate plans for heart disease, cancers, diabetes, and obesity, among others. With a common risk factor such as physical activity, which is inversely associated with each of these outcomes (and others), such an approach is inefficient and incomplete. Examples abound of state public health plans to control tobacco use,¹² drug and alcohol consumption,¹³ and nutrition.¹⁴ Given the importance of physical activity both in multiple disease processes and in public health,³ state-based planning for physical activity promotion should be a stand-alone issue as with these other important risk factors. Furthermore, such public health planning tools should ideally include needs-assessment data, well-defined and specific population targets of influence, trans-sectoral approaches when appropriate, clearly stated goals, and evaluable objectives, as well as an evaluation plan.⁵

Across 8 selected components comprising a physical activity plan,¹⁵ most respondents rated as moderately or extremely all relevant components. Only integra-

tion with the National Physical Activity Plan received less than 80% of responses in these 2 categories. Although the reason for this is unclear, integration with the National Physical Activity Plan may be an important strategy for minimizing important barriers to state and local plan development, such as lack of funding and political support. Utilizing the national plan as a model, while relying on local realities and appropriate modifications, may reduce the effort and expenses of local plan development, making such plans a more palatable option for state and local leaders.

Regardless of respondent job category, the barriers most commonly rated as somewhat or very difficult to overcome were obtaining financial and political support from relevant parties or agencies. These concerns may be by-products of recent economic decline and slow recovery. The economic circumstances have been accompanied by decreased government revenues, budget cuts, and the prioritization of programs that stimulate economic growth. In this context, practitioners may need to frame physical activity promotion in terms of potential economic impact, including increased productivity, decreased absenteeism, and increased cost-effectiveness.¹⁶ Recent collaborative efforts such as the "Designed to Move"¹⁷ initiative may provide a useful guide in effective message framing.

These data are cross-sectional, but they can provide a baseline for further evaluation. To assess selection bias, respondents were compared with nonrespondents by US census region, with no significant differences found. It is not known whether there were important differences between respondents and nonrespondents on other factors, such as awareness of state plans, since these were not available on nonrespondents. Comments on the survey indicated that several members working at the national level had difficulty answering some questions. Future data collection efforts should

guide national members to answer by reflecting upon their own state.

Data from this survey suggest that despite efforts to increase development and use of stand-alone physical activity plans,^{7,11} most practitioners rely on chronic disease plans to guide their efforts. Compared with local-level practitioners, more state-level practitioners reported awareness of state-level public health plans to promote physical activity. However, the 2 groups are similar on a number of topics. Both groups commonly rate having to obtain financial and political support as key barriers to using physical activity plans. Similarly, in ranking by importance various aspects of state physical activity plans, the 2 groups both gave the lowest ranking to integration with the National Physical Activity Plan. These findings suggest that similar strategies could be appropriate in reaching state- and local-level practitioners with education about the plans. For example, there is an opportunity to correct misinformation about the existence of only a couple of state-level plans exclusively about physical activity. Perhaps, more important, there also is great need to educate practitioners at all levels about the benefits such a plan could bring and the type of messaging to use in advocating for state-level physical activity plans.

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