Public Perceptions of Childhood Obesity

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Background: Obesity has been identified as an epidemic by the Centers for Disease Control and Prevention. Rates of unhealthy body weight among children and adolescents have tripled since the 1980s to 15%. Media coverage of obesity has also increased, and the public is now highly aware of obesity-related health threats facing adults and children.

Methods: RTI International sponsored a representative survey of U.S. households ($n = 1047$) that included detailed questions about perceptions of the severity, causes, and public support for specific intervention strategies to combat childhood obesity. Logistic regressions were calculated to examine differences in support by sociodemographic characteristics.

Results: Respondents considered childhood obesity to be as serious as other major childhood health threats, such as tobacco use and violence, but not as serious as drug abuse. They supported most school-, community-, and media-based strategies that involved offering health information, limiting unhealthy food promotion, and increasing healthy nutrition and physical activity choices, but were generally opposed to regulatory and tax- or cost-based interventions. Logistic regressions revealed significantly greater support for some interventions among highly educated individuals and women, and lower support among parents with children at home.

Conclusions: This study demonstrates that there is strong public support for interventions aimed at reducing overweight and obesity among children and adolescents. It also shows specific school, community, and media interventions that the public supports and opposes, and what consequences the public will accept in combating childhood obesity. These findings can help policymakers and public health professionals design and implement appropriate interventions.

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Introduction

Obesity in the United States has been identified as an epidemic by the Centers for Disease Control and Prevention (CDC). The prevalence of obesity has doubled in the past 25 years; today, two thirds of adults are overweight. As a consequence, the incidence of obesity-attributable diseases, including diabetes, heart disease, cancer, musculoskeletal disorders, sleep apnea, and gallbladder disease continues to increase, as does obesity-attributable mortality and economic costs.

Poor diet and inactivity, the primary modifiable contributors to obesity, are estimated to be responsible for 400,000 deaths per year,[1] and it is expected that obesity will soon surpass smoking as the number one preventable killer in the United States. Finkelstein et al.[2] estimated that overweight and obesity-related U.S. medical expenditures are as much as $93 billion per year, or approximately 9% of total annual medical expenditures for adults. They also report that half of the costs of obesity are funded by taxpayers through the Medicare and Medicaid programs, providing a motivation for governments to implement strategies to reduce the economic burden of obesity.

The obesity epidemic is not restricted to adults. Today, 15% of children and adolescents are overweight.[3] The increase in child and adolescent overweight can be traced to the 1980s. In the time interval between the second National Health and Nutrition Examination Survey (NHANES II) (completed in 1980) and third survey (NHANES III) (completed in 1994), the prevalence of obesity increased from an estimated 7% to 11% among children aged 6 to 11 years and from 5% to 11% among adolescents aged 12 to 19 years. This trend suggests that a new generation of Americans will enter adulthood already obese or at risk for obesity, and will already have or be at risk of multiple related health conditions, such as diabetes and cardiovascular disease, unless actions are taken to reverse the epidemic.[3,4]

Over the past 20 years, the increase in news coverage for obesity and related topics has grown at least as quickly as the epidemic itself. Whereas 20 years ago, news coverage of obesity was virtually nonexistent, today stories related to the causes and consequences of obesity are featured almost daily throughout the media. Moreover, both state and federal governments have

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implemented health promotion campaigns aimed at obesity awareness and prevention.

Researchers have recently begun to measure public attention, awareness, and attitudes about obesity. Oliver and Lee[5] conducted what they describe as "the first study of public attitudes toward obesity and obesity policy" in spring 2001. Based on a nationally representative sample of U.S. households, they found that "contrary to the views of most health experts, most Americans are not seriously concerned with obesity, express relatively low support for obesity-targeted policies, and still view obesity as resulting from individual failure rather than environmental or genetic sources."[5]

More recent polls have documented a shift in the public's attitude concerning obesity. Two years after Oliver and Lee's data were collected, Harvard University sponsored a similar survey.[6] The Harvard study found that Americans consider obesity to be a major public health issue, comparable to smoking. Several more recent polls confirm these results. In spring 2003, the American Public Health Association commissioned a poll concerning Americans' attitudes about obesity.[7] This survey found that 82% and 74% of Americans, respectively, were concerned about childhood and adult obesity, and 89% and 83%, respectively, considered childhood and adult obesity to be a serious problem. In fall 2003, *The San Jose Mercury News* and the Henry J. Kaiser Family Foundation conducted a survey on childhood overweight,[8] and found similar results for youth. The differences between the results of Oliver and Lee[5] and those of the more recent surveys may indicate that public concern is growing in response to the increased media and government attention toward obesity.

For the most part, these surveys focus on attitudes and perceptions of obesity and prevention efforts in relatively broad terms. Although the surveys reveal that Americans recognize the problem of obesity, they also find that there is generally little support for obesity prevention efforts, with one notable exception. There is broad public support for government interventions aimed at preventing and reducing obesity among children and adolescents. Although this information is informative, the surveys provide little evidence concerning which childhood interventions are supported in light of competing demands for scarce public health resources.

This study seeks to investigate in more detail public perceptions concerning intervention strategies to combat childhood overweight and obesity. The main research questions are as follows: How serious does the U.S. public consider the problem of childhood overweight and obesity in comparison to other youth health threats? What specific interventions to control or prevent childhood overweight and obesity does the U.S. public support? To what extent does the public continue to support these interventions in light of potential consequences, such as increased government regulation or taxes? What sociodemographic characteristics are associated with support for specific childhood overweight and obesity interventions?

Methods

An instrument was developed designed to capture opinions on the seriousness of childhood overweight and obesity compared with other youth issues; support for specific interventions; and potential barriers to support, such as negative consequences or increased taxes. Also included were some questions about adult obesity and sociodemographic characteristics of respondents. The specific intervention questions were based on a review of childhood interventions that have recently been implemented or proposed. The questions were grouped into three domains: schools, media, and communities. These domains were selected not only because they represent areas in which promising interventions have already been developed and implemented in some communities, but because they are likely targets for future government and private funding. Within each domain, scales were created to rank possible interventions by degree of intensity or restrictiveness. The scales were designed to be ordinal, based on intensity.

The Odom Survey Research Institute at the University of North Carolina was selected to conduct the data collection on behalf of RTI. The study protocol was submitted to the RTI and Odom Internal Review Boards, and was approved by both boards in early January 2004.

Survey respondents were recruited using random-digit-dialing (RDD) methodology. Specifically, a single-stage, equal-probability selection method (EPSEM) sample of all residential telephone numbers (including listed, unlisted, and nonpublished numbers) in the defined sample frame was used. The sample frame consisted of the set of all telephone exchanges that met residential telephone-exchange geographic criteria. The resulting list covered an estimated 96.4% of all U.S. residential telephone numbers.

Genesys Sampling Systems, Inc. provided the sample. Based on the sample frame defined above, Genesys computed an interval such that the number of intervals was equivalent to the desired sample size. The interval was computed by dividing the total possible telephone numbers in the sample frame by the desired RDD sample size. Within each interval a single random number was generated between 1 and the interval size; the corresponding phone number within the interval was identified and added to the sample.

The result of this procedure was that every potential telephone number within the defined sample frame had a known and equal probability of selection. The sample was nationally representative according to American Association of Public Opinion Research standards.[9]

Interviewers screened each telephone number in the sample and identified whether it was a household or a business. Only households were eligible to complete the survey. Once a useable telephone number was identified, trained interviewers contacted and screened each household for an eligible participant. Screening was accomplished by asking if an adult aged ≥18 years was available to complete the survey. If more than one adult was available, the interviewer randomly selected from among all age-eligible adults in the household. Verbal consent was elicited from participants. The introduction of the survey reminded the participant of his or her

rights to privacy and confidentiality and provided a toll-free telephone number to verify the legitimacy of the study or to provide more information.

The survey was administered between January 17 and March 6, 2004. A total of 1010 interviews were completed (along with 37 partial completes) with respondents in all 50 states and the District of Columbia. Overall, the survey achieved a relatively low response rate of 30.1%. Although this is low by historical standards, it is consistent with recent results obtained for similar health-related surveys (e.g., the Behavioral Risk Factor Surveillance System [BRFSS] survey).[3]

Prior to analysis, Odum Institute and RTI analysts conducted extensive logic checks, data cleaning, and validation to ensure data quality. SAS software, version 8 for Windows (SAS Institute, Cary NC) was used for all data management and analysis. For all descriptive analyses, frequencies, percentages, cross-tabulations, and chi-square statistics were calculated (Tables 1 to 3).

To explore whether support for each of the 18 childhood overweight and obesity interventions systematically varied by specific sociodemographic characteristics, a series of logistic regression analyses were conducted. The dependent variable for each regression was coded as 0 for "oppose" or "strongly oppose" and 1 for "favor" or "strongly favor." Independent variables included education (0=less than high school, high school degree, or GED; and 1="some college, 2-year college degree, 4-year college degree, or postgraduate study"); gender (0="male and 1="female"), income (0="≥$50,000" and 1="<$50,000"); and children aged <18 living in the household (0 "none" and 1="one or more"). Table 4 reports odds ratios (ORs) and 95% confidence intervals (CIs) showing the relationship between each of these variables and support for specific interventions.

Results

Sample Characteristics

Table 1 presents sociodemographic characteristics of respondents. Nearly 60% of respondents were female, and roughly this same percentage attended at least some college and had incomes >$25,000. The self-reported percentage of overweight is similar to that from BRFSS; however, whereas BRFSS reports a self-reported nationwide obesity prevalence of 22% in 2002,[10] only 3% of respondents to this survey report being obese. This may be due to the fact that participants were aware of the nature of the survey prior to being asked the question concerning their weight. Of the 40% of respondents with children at home, 12% reported having at least one overweight or obese child. It is important to note that 18.7% of respondents either refused to report or did not know their household income. Cross-tabulation analyses were conducted to examine potential associations between demographic characteristics (i.e., gender and education) and those who reported their income versus those who did not report their income. No significant associations were found. Thus, the subsample of respondents who did not report their income was no different from the larger sample of respondents who did report their income.

Table 1. Sample characteristics

Demographic group	*n*	%
Overall	1047	100.0
Gender		
Female	596	59.0
Male	414	41.0
Education		
High school degree	77	7.6
High school graduate or GED	309	30.6
Some college or 2-year college degree	268	26.5
4-Year college degree	199	19.7
Postgraduate study	148	14.7
Refused/don't know	9	0.9
Income		
<$25,000	163	16.1
$25,000–$49,999	268	26.4
$50,000–$74,999	176	17.4
$75,000–$99,999	112	11.1
$100,000–$124,999	38	3.8
$125,000–$149,000	19	1.9
≥$150,000	46	4.6
Refused/don't know	149	18.7
Respondents' weight status		
Overweight	353	35.9
Obese	34	3.3
Has overweight or obese child		
Yes	47	4.5
No	352	33.6

Perceptions of Childhood Obesity

Results reveal that 41% of Americans perceived childhood overweight and obesity to be a serious problem, similar to tobacco use (42%) but not as serious as drug abuse (55%, $p<0.05$). The most significant contributors to childhood overweight were felt to be junk food (77%) and fast food (65%), followed closely by viewing ≥2 hours of television per day (57%). Nearly 91% of respondents considered parents to be the parties having the most responsibility for reducing childhood overweight; only about 16% thought the government was most responsible. These data are summarized in Table 2.

Childhood Obesity Interventions

Public support for specific childhood interventions is presented in Table 3. The "Percent in favor" column includes those who either "strongly support" or "support" the intervention. Most Americans favored restricting the availability of unhealthy foods in school vending machines (74% favor or strongly favor) and school cafeterias (75%), even if it would result in a loss of revenues, but fewer favored such strategies as raising the price of unhealthy foods (45% in cafeterias) or eliminating all vending machines (36%). Americans overwhelmingly favored requiring healthy eating and

Table 2. Perceptions of health threats and contributors to childhood obesity

	n	%
Believe that each of the following is a "very serious" problem		
Drug abuse among adolescents	571	54.5
Youth violence	528	50.4
Underage drinking	496	47.4
Teen sex	464	44.3
Underage smoking	444	42.4
Childhood obesity	432	41.3
Believe that the following factors have contributed "a significant amount" to increase in childhood obesity		
Watching ≥2 hours of TV per day	593	56.6
Fast food such as McDonalds	677	64.7
Junk food and sodas	806	77.0
Video games or the Internet	570	54.4
Lack of exercise in school	463	44.2
Lack of places to exercise	269	25.7
Crime	186	17.8
Believe that the following have "a lot of responsibility" to reduce childhood obesity		
Parents	950	90.7
TV advertising	469	44.8
Individual child	411	39.3
Food companies	339	32.4
Schools	314	30.0
Restaurants (fast food or others)	283	27.0
Healthcare providers or physicians	281	26.8
Government	176	16.8

exercise education in schools (94%), as well as requiring more time for physical education (82%).

Increasing the cost of unhealthy foods and other regulatory actions were not well supported, and were often opposed. For instance, 59% of respondents opposed increasing costs of fast food marketed to children and 61% opposed removing all school vending machines (data not shown in Table 3). Increasingly, availability of more nutritious foods and opportunities for exercise in schools were generally well supported. For example, 69% favored increased recess and intramural activities. Respondents strongly supported small ($25) tax increases to support childhood overweight and obesity interventions (71% favor); support dropped for costlier interventions ($100), yet remained favorable for 50% of respondents.

Logistic Regression Analyses

Logistic regressions revealed that support was statistically greater among more educated respondents for 8 of the 18 specific interventions in the survey. ORs for intervention support among this group ranged from 1.40 (increase cost of less healthy foods) to 2.14 (increase promotion of healthy foods). However, more educated respondents were significantly less likely to support weight evaluation in schools. Women were more likely to support the interventions than men. In 10 of the 18 regressions, the ORs were positive and statistically significant, ranging from 1.35 (restrict availability of less healthy food in vending machines) to 2.68 (restrict less healthy food ads during children's television programs). In no cases were women significantly less likely to support an intervention than men. Having a lower income did not have a strong effect on support for these interventions; the effect was significantly positive for only three interventions and significantly negative in one (increase promotion of less healthy foods). Consistent with the finding that more educated people were less likely to favor weight evaluation in schools, higher-income respondents were also less likely to support these intervention strategies. Where significant (7 of 18 interventions), those with children at home were less supportive of the interventions. These again include the three interventions that address weight evaluation in schools.

Discussion and Policy Implications

Consistent with other recent surveys, this study confirms that there is strong public support for interventions aimed at reducing overweight and obesity among children and adolescents. Additionally, this is the first survey to compare and contrast support for specific types of childhood interventions that have recently been implemented or proposed. Such data are likely to be of great interest to policymakers and others who might consider endorsing specific interventions.

Overall, the public favors most school-based interventions, such as restricting the availability of unhealthy foods in school vending machines and cafeterias, even if it means a loss of school revenue. The public also favors requiring healthy eating and exercise education in schools and increasing the amount of time spent on physical activity and health education, although support for these interventions drops sharply if they lead to reductions in basic education (e.g., language, math, science).

The public opposes most tax-based (e.g., raising the price of unhealthy foods) or regulatory (e.g., eliminating vending machines, standardizing restaurant portion sizes) strategies to reduce childhood overweight and obesity. This result may stem from a general discontent toward any policy that is seen as a tax. Results from prior surveys[6,11] show that the majority of Americans are against any sort of "fat tax." One explanation for this is that many Americans do not view government as the best or most responsible entity to solve many public problems. Evans et al. (2004) found that the U.S. public considered government to be the least responsible entity for addressing the problem of childhood obesity.[12] Public education may also be needed to illustrate the benefits of obesity prevention

Table 3. Support for childhood obesity intervention strategies

Intervention	*n*	Percent (%) in favor
School vending machines		
Increasing promotion and marketing of healthy foods and drinks in school vending machines	894	85.4
Restricting the availability of less healthy foods and drinks in school vending machines	767	73.6
Allowing only the sale of healthy foods and drinks in school vending machines	738	70.9
Increasing cost of less healthy foods and drinks in school vending machines	474	45.3
Removing all vending machines from schools	374	35.9
Still favor change in current vending practices in schools if it meant less money available to schools for other school activities	600	58.9
School cafeterias		
Restricting the availability of less healthy foods and drinks in school cafeterias	769	74.5
Allowing only the sale of healthy foods and drinks in school cafeterias	696	67.4
Removing all fast food and other less healthy foods and drinks from school cafeterias	634	61.4
Increasing the cost of less healthy foods and drinks in school cafeterias	455	44.0
Still favor changes in school cafeterias if it meant a loss of money available to schools	620	67.8
School curriculum		
Requiring schools to teach students healthy eating and exercise habits	963	93.9
Requiring more physical education classes in school	846	82.3
Requiring more recess and supervised intramural activities in school	708	68.9
Still favor changes in school curriculum if it meant less time for traditional academic courses such as math, science, English, and history	342	34.1
Evaluating children's weight in schools		
Providing students who are obese with weight loss and exercise programs in school	748	72.9
Sending parents a health report card of their children's weight on a regular basis	586	57.1
Recording students' weight on a regular basis	508	49.5
Still favor evaluation of students' health if it meant some students would be embarrassed by the results	407	49.0
Promotion of fast food and other less healthy food marketed to children		
Restricting the amount of fast food and less healthy food advertisements during children's television programs	770	75.3
Prohibiting the advertising and promotion of fast food and less healthy foods marketed to children	490	47.9
Increasing the tax on fast food and less healthy foods marketed to children	400	39.1
Still favor restrictions on fast food and less healthy foods if it meant the government would have more control on what foods are available to children	359	43.9
Still favor the above or other actions if it meant an increase of $25 a year in income taxes that you owe	**612**	**70.9**
Still favor the above or other actions if it meant an increase of $100 a year in income taxes that you owe	**305**	**49.8**

interventions, and the associated costs and need for funding, and thereby to justify tax increases.

Several key sociodemographic characteristics are associated with support for childhood overweight and obesity interventions. In general, more educated respondents and women are more supportive of the interventions. However, more educated respondents, those with greater incomes, and those with children at home were less likely to support weight evaluation in schools.

In constructing the survey, it was implicitly assumed that the public would perceive the interventions in the assigned rank order and that support for interventions would be inversely correlated with degree of intensity (i.e., there would be less support for more intensive interventions). This hypothesis was not confirmed. Some of the more restrictive interventions, such as allowing only the sale of healthy foods in school cafeterias, were highly supported, whereas presumably less restrictive interventions, such as increasing the cost of

Table 4. Support for childhood obesity interventions

Intervention	Demographics			
	Education (no college vs at least some college) OR (95% CI)	**Gender (female vs male) OR (95% CI)**	**Income (<$50,000 vs ≥$50,000) OR (95% CI)**	**Children aged <18 (none vs one or more) OR (95% CI)**
School vending machines				
Increase promotion of healthy foods	**0.47*** (0.32–0.68)	**1.69*** (1.16–2.47)	**0.58*** (0.38–0.88)	0.88 (0.60–1.28)
Increase cost of less healthy foods	**0.68*** (0.53–0.89)	**1.36*** (1.05–1.75)	0.94 (0.71–1.23)	0.85 (0.66–1.09)
Restrict availability of less healthy food	**0.54*** (0.40–0.73)	**1.35*** (1.10–1.81)	0.79 (0.57–1.09)	1.26 (0.95–1.68)
Allow only sale of healthy foods	1.15 (0.86–1.54)	**2.02*** (1.53–2.68)	1.30 (0.96–1.77)	**1.39*** (1.06–1.83)
Remove all vending machines from schools	1.21 (0.93–1.58)	1.20 (0.92–1.57)	1.21 (0.90–1.61)	**1.46*** (1.13–1.90)
School cafeterias				
Increase cost of less healthy foods	**0.72*** (0.55–0.93)	1.15 (0.89–1.48)	0.98 (0.74–1.30)	1.06 (0.82–1.36)
Restrict availability of less healthy food	**0.58*** (0.43–0.78)	**1.62*** (1.21–2.17)	0.73 (0.53–1.01)	1.22 (0.92–1.63)
Allow only the sale of healthy foods	1.14 (0.86–1.50)	**1.45*** (1.11–1.90)	1.28 (0.95–1.72)	**1.36*** (1.04–1.78)
Remove all less healthy foods	1.18 (0.90–1.54)	**1.37*** (1.05–1.78)	1.17 (0.88–1.56)	**1.41*** (1.09–1.82)
School curriculum				
Require more physical education	**0.68*** (0.49–0.96)	0.82 (0.58–1.16)	0.75 (0.51–1.10)	1.26 (0.90–1.76)
Require more recess and intramural activities	**0.54*** (0.41–0.71)	1.22 (0.93–1.62)	0.85 (0.62–1.15)	0.98 (0.74–1.29)
Require teaching of healthy eating and exercise	1.19 (0.67–2.11)	1.48 (0.86–2.54)	1.67 (0.92–3.04)	1.26 (0.74–2.14)
Weight evaluation in schools				
Recording weight on regular basis	**1.31*** (1.01–1.70)	0.84 (0.65–1.08)	**1.33*** (1.01–1.76)	**1.44*** (1.21–1.86)
Send parents a health report card of children's weight on regular basis	1.19 (0.92–1.55)	0.78 (0.60–1.01)	1.32 (1.00–1.76)	**1.31*** (1.02–1.69)
Provide obese students with weight loss and exercise programs	**1.41*** (1.04–1.92)	1.03 (0.77–1.38)	**1.47*** (1.07–2.03)	**1.47*** (1.10–1.95)
Marketing of less healthy foods				
Increase tax on less healthy foods marketed to kids	0.96 (0.74–1.25)	**1.55*** (1.19–2.01)	0.92 (0.69–1.22)	0.92 (0.71–1.20)
Restrict less healthy food ads during kids' TV programs	**0.69*** (0.52–0.93)	**2.68*** (1.99–3.62)	0.96 (0.70–1.33)	1.10 (0.82–1.48)
Prohibit less healthy food ads marketed to kids	1.08 (0.84–1.40)	**1.49*** (1.16–1.92)	**1.33*** (1.01–1.76)	1.15 (0.89–1.47)

Notes: Intervention items were coded 0=oppose and 1=support. Demographic characteristics were coded as follows: education: 0=some college, 2-year college degree, 4-year college degree, or postgraduate study, and 1=less than high school, high school degree, or GED; gender: 0=male and 1=female; income: 0=≥$50,000 and 1=<$50,000; and children aged <18: 0=none and 1=one or more. Thus, the ORs can be interpreted as the characteristic coded as 1 (the denominator) as compared to the characteristic coded as 0 (the numerator).
CI, confidence interval; DR, odds ratio.
*Odds ratio significantly different from 1 ($p<0.05$) (bolded).

less healthy foods sold in cafeterias, were opposed (see Evans et al.,[12] for more details). These seemingly inconsistent public opinions about obesity deserve further investigation.

The public clearly wants to reduce unhealthy, and increase healthy, food consumption among children and adolescents. However, they are wary about accomplishing these goals through intensive regulation or taxation. Interventions that have been implemented on a local level, such as restricting vending machine access or decreasing the amount of unhealthy food choices available in schools, have broad public support and should be further considered for implementation.

Although the public supports increased recess and health and physical education, the findings suggest that the public is not willing to have these increases come at a cost in the amount of time given to basic education. Given this reality, school policymakers may need to explore other strategies, such as decreasing elective time or combining health and physical education classes, to find time for increased physical and health education without decreasing time for standard subjects. Policymakers should also recognize the importance of nutrition and fitness in children's educational progress and achievement.[13,14] Education and health are not only compatible, but mutually reinforcing and essential to child and adolescent development.

Interestingly, unlike other forms of regulation, there was strong public support for restricting junk food/fast food advertising during children's television programming. These restrictions could include efforts to influence media buys (i.e., where and when firms buy advertising time) through regulation, self-regulation, or other means, such as providing a tax break for stations that advertise specific products only when children are unlikely to be watching.

This survey addressed public support for specific interventions aimed at reducing childhood overweight and obesity. It provided information concerning which interventions might be feasible from a public policy perspective. However, relatively little scientific information exists on which of these interventions are effective

What This Study Adds . . .

Rates of childhood overweight and obesity have tripled since the 1980s.

Childhood obesity interventions require public support to be feasible.

Recent studies show that the U.S. public considers childhood obesity to be a serious problem, but provide little information on what interventions the public supports, and what costs or consequences they will accept.

This study provides the most detailed data to date on public attitudes toward specific interventions, and differences in support among various sociodemographic subgroups.

in actual school, community, and media settings.[15] At the same time, it remains to be seen which interventions will prove to be both feasible and effective in reducing the epidemic of overweight and obesity among children and adolescents. Future intervention research should address this important issue.

Policymakers should play a lead role in helping to raise public awareness of the need for more prevention intervention research and help the public understand the complex nature of combating the obesity epidemic through multiple prevention and treatment strategies. Heightened public awareness will both raise public understanding of the health issues involved, and make it easier to obtain support for effective interventions. Researchers should continue in-depth research on public attitudes and the factors that influence it, as public support is a key to feasible implementation and sustainability of prevention interventions.

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