# Understanding Our Service-Learning Community: An Exploratory Study of Parent, Teacher, and Student Perceptions About Childhood Obesity

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## Abstract

Childhood obesity has reached epidemic proportions in the U.S. University health and physical education programs have a unique opportunity to assist in childhood obesity prevention through service-learning programs. However, prior to the implementation of service-learning curricula, it is imperative to gain insight into the unique needs of the selected community. The purpose of this study was to understand a service-learning community through exploring parent, teacher, and student perceptions about healthy lifestyles, barriers to achieving healthy lifestyles, and what families and schools can do to help prevent childhood obesity. During the spring and summer of 2004, researchers conducted focus groups of children, parents, and teachers in a minority, low-income neighborhood located within a West Texas city. Results revealed that childhood obesity prevention was a challenge for the population in this study. The complex interplay between personal factors, environment and situations, and the underlying issue of poverty all interacted to influence behavior in a striking way. University service-learning programs can play a unique role in childhood obesity prevention through teaching university students how to develop essential cultural competencies and communication skills that can enhance relationships and strengthen family involvement in the health education process.

Childhood overweight and obesity have reached epidemic proportions and represent a major public health crisis (Centers for Disease Control and Prevention [CDC], 2004). An estimated nine million children over six years of age are now considered obese (Kaplan, Liverman, & Kraak, 2005). Childhood obesity is associated with numerous, preventable chronic health problems including asthma, insulin resistance and Type 2 diabetes, cardiovascular disease risk factors (e.g., high blood pressure, elevated cholesterol and triglyceride levels, and atherosclerosis),

pulmonary problems, gastrointestinal disorders, and orthopedic disorders (Daniels, 2006; Kaplan, Liverman, & Kraak, 2005; The Center for Health and Health Care in Schools, 2005). Obesity also is a risk factor for the onset of eating disorders (Fairburn, Welch, Doll, Davies, & O'Connor, 1997). In addition, children who are overweight and obese suffer from an array of psychological issues including low self-esteem, negative body image, shame, self-blame, depression, and social stigmatization (Daniels, 2006; Kaplan, Liverman, & Kraak, 2005). The health consequences associated with childhood overweight and obesity negatively impact the "whole" child and diminish children's health-related quality of life and school performance (Lumeng, Gannon, Cabral, Frank, & Zuckerman, 2004). Obese children also are at significant risk for obesity during adulthood (Anderson & Butcher, 2006; CDC, 2004; Daniels, 2006). Overweight and obese adults are at increased risk for chronic health conditions including cardiovascular disease, diabetes, cancers, gallbladder disease, osteoarthritis, as well as adult morbidity and mortality (Daniels, 2006; Must & Strauss, 1999). In addition, there are a host of obesity-related economic issues (related to both children and adults) that hold staggering implications for our nation's health care system and economic robustness (Daniels, 2006).

Children from minority and low-income families are at significantly higher risk for obesity and greater health care disparities compared to other youths (Kumanyika & Grier, 2006; Robert Wood Johnson Foundation, 2005). Nationwide, over 27 million children are growing up in low-income families. In the state of Texas, nearly 6 million (48%) children are being raised by families whose income is insufficient (National Center for Children in Poverty, 2004).

Complex interactions between genetic, environmental, and behavioral factors are evident in childhood obesity (American Academy of Pediatrics [AAP], 2003). Having overweight parents more than doubles a child's risk of being obese (Kaplan, Liverman, & Kraak, 2005), but genetics does not describe the total picture. Environmental risk factors for childhood obesity encompass multiple interacting dynamics within the family, school, and community. For example, limited financial resources often impact a low-income family's ability to provide healthy food choices. These same families also may reside in high-crime neighborhoods that limit children's opportunities to participate in outdoor physical activities after school (Lumeng, Appugliese, Cabral, Bradley & Zuckerman, 2006). Additionally, behavioral risk factors for childhood obesity behaviors are crucial and include unhealthy food choices combined with physical inactivity.

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Moreover, lifestyle habits that play a role in chronic disease usually begin in childhood, and most available treatments for childhood obesity have not produced effective results (Robinson & Killen, 2001). Therefore, primary prevention of childhood overweight and obesity should begin early.

Parents/other caregivers and schools play an integral role in preventing childhood obesity (AAP, 2003; Kaplan, Liverman, & Kraak, 2005; Lindsay, Sussner, Kim, & Gortmaker 2006; Story, Kaphingst, & French, 2006). For example, schools are a major medium for reaching our nation's children and youth. In 2000, 53.2 million U.S. students were enrolled in public and private elementary and secondary schools (Kaplan, Liverman, & Kraak, 2005). In terms of childhood obesity prevention, schools possess a ripe opportunity to foster healthy eating and physical activity behaviors and provide an environment supporting these efforts. The family's influence is essential as well because health behaviors are often established in childhood. A health-minded family that encourages and models healthy habits such as sound nutrition and regular physical activity can positively impact children's eating and exercise behaviors. Interventions that target preadolescents have the greatest potential to prevent childhood obesity that often tracks into adulthood (Robinson & Killen, 2001). Although other studies have explored parents' (Price, Desmond, Ruppert, & Sauder, 1992), principals' (Price, Desmond, & Stelzer, 1987), and school food-service directors' (Price & Telljohann, 1994) perceptions about childhood obesity, few studies have explored parent, teacher, and student perceptions of childhood obesity prevention through focus groups. There also are gaps in the literature regarding the perceptions of these three groups within minority, low-income neighborhoods.

Universities have the potential to be a thriving venue for change by participating in prevention-focused research that employs service-learning. Service-learning is a pedagogical strategy that provides multifaceted opportunities for students to engage in experiential learning while meeting community needs (Jacoby, 1996). Research examining the impact of student participation in service-learning programs has shown that students have demonstrated higher levels of academic achievement, heightened sense of civic responsibility, increased awareness of national and community problems, and enhanced critical-thinking skills and self-confidence (Astin & Sax, 1998). University health and physical education programs have a unique opportunity to assist in combating the growing epidemic of childhood obesity through the development of service-learning programs. However, prior to implementation of the service-learning curricula, it is imperative to gain insight into the unique needs of the selected community, which includes families and schools. The purpose of this study was to understand a service-learning community through exploring thoughts and perceptions about healthy lifestyles and childhood obesity prevention within a minority, low-income neighborhood.

## Methods

### Participants

The authors conducted focus groups with three different groups of participants—teachers, parents, and students—to explore knowledge and attitudes about healthy lifestyles, perceived barriers to achieving healthy lifestyles, and what families and schools can do to help prevent childhood obesity. The expressive data derived from this focus group research provided a deeper understanding and insight about individuals and their experiences and perceptions (Kreuger & Casey, 2000; Morgan, 1997) that would not have been completely understood by more direct, closed-ended questioning that is typical of traditional surveys. Furthermore, focus groups have been shown to provide a non-threatening atmosphere for marginalized participants (e.g., minority adults and children living in poverty) (Madriz, 2000).

Participants in this study were a convenience sample of parents, teachers, and students in a minority, low-income neighborhood within a mid-sized city located in West Texas. All of the participants taught at, attended, or were parents/caregivers of the children attending the neighborhood Title 1 school (K-2). Title I is a federal entitlement program that allocates resources to schools based on student enrollment and poverty census data (United States Department of Education, 2006). Title I funding supports school-wide programs to assist in helping students most at risk of academic failure on state assessments. Demographics of children who attended the school were as follows: 75% African-American, 20% Hispanic, and 5% Caucasian. This particular school was targeted due to the existing, positive partnership between the university and the school in facilitating the ongoing university service-learning programs. In addition, body mass index data collected via the school nurses revealed that over 25% of the children enrolled in this elementary school were at risk for overweight or obese. After receiving permission from the university human subjects committee and the school district's central office to conduct the study, researchers recruited participants.

### Procedure

The school principal and school nurse helped recruit teachers to participate in three separate focus groups (N = 8, 7, 7). Ethnic demographics of the 22 teachers were 20 Caucasian, 1 Hispanic, and 1 African-American. All teachers had taught at the school for a minimum of two years, and their participation was voluntary. Focus groups were organized around the teachers' group planning periods so they would not miss classroom instructional time. Each focus group interview took place in an available classroom and lasted approximately 30-40 minutes.

The recruitment of parents via informal verbal announcements at parent meetings, information sent home

by the school nurse, and flyers posted in prominent locations throughout the school proved to be unsuccessful. Therefore, with assistance from an African American graduate student who grew up in the neighborhood, researchers met a small group of parents on their "home turf"—a government housing apartment complex—to conduct a focus group. Meeting participants in their community has been successful in previous research examining urban parents' involvement in their children's education (McDermott & Rothenberg, 2004). African American mothers (N = 12) attended the focus group session, which lasted approximately 60 minutes.

The number of children who could be recruited for participation in the study was limited due to the school district's strict policy concerning the removal of children from the classroom for research purposes. With assistance from the school's physical education teacher, two groups of children (K-2) were recruited through their physical education classes to participate in the study. Each group consisted of 10 African American children (boys and girls), and each session lasted approximately 15-20 minutes.

The open-ended questions (including prompts) used for the focus group discussions are depicted in Figure 1. The questions were intentionally designed to be uncomplicated and straightforward. In addition, the moderator slightly modified the questions for the children's focus groups to better accommodate their age and development. The moderator verbally summarized the main points for each question to ensure that participants felt they had clearly expressed their views. To maintain consistency, the same researcher served as moderator for each focus group; and the other researcher (along with an assistant) served as co-moderators and recorded detailed notes throughout the interviews.

### Data Management and Analysis

Each focus group session was audio-taped and transcribed verbatim. Transcripts were carefully read and re-read numerous times independently by members of the research team. Constant comparative analyses were used to identify major themes (Patton, 2002). A master coding template was developed around the major themes, and a separate coding template was created for identifying statements and phrases that best represented each of the major themes. Each researcher participated in the content analysis process. Trustworthiness was established through member checks, confirmability audits, and triangulation (Patton, 2002).

### Results

[Questions 1 & 2] In terms of behaviors associated with a healthy lifestyle, all three groups identified healthy eating and physical activity as foundational for good health and childhood obesity prevention. Conversely, all three groups identified eating "junk food" and not exercising as behaviors associated with an unhealthy lifestyle and childhood obesity.

In addition, both students and teachers emphasized oral health as a behavioral factor in healthy and unhealthy lifestyles. For example, many of the children defined a healthy person as having "good teeth" (i.e., "you have no cavities"). When asked what people look like when they are not healthy, several students responded along these lines: "They have rotten teeth," "Half of their teeth will be gone," and "They will be fat." In describing poor oral health as a factor involved in unhealthy lifestyles, most of the teachers referred to several students as having "poor teeth" and not owning a toothbrush. Parents and teachers also addressed other issues associated with unhealthy lifestyle behaviors, including tobacco, alcohol, and other drug use; insufficient sleep; child abuse and neglect; low self-esteem, stress, anxiety, and depression.

[Question 4] Several perceived barriers to adopting healthy lifestyles emerged from the focus group discussions. First, parents/caregivers appeared deficient in their knowledge and skill base concerning childhood obesity prevention. Regarding this educational gap, both teachers and parents believed that "education is the key." Both groups indicated that parents need general parenting classes that cover important health-related topics, such as healthy lifestyles and healthy eating, menu planning, and how to make healthier food choices on a tight budget with food stamps. They also believed that if parents possessed more knowledge and skills to promote healthy eating, they would be more likely to reinforce and model those skills in the home. As one teacher summarized, "The majority of our parents are doing the best they can with what they've got. If we can give them more tools and offer them more encouragement . . . maybe put a little funding into a little resources, then we have to believe that they will do the right thing."

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1. Describe a healthy lifestyle.
   Probe: What behaviors are associated with a healthy lifestyle? [Behavior]
2. What health problems are associated with an unhealthy lifestyle?
   Probe: What behaviors are associated with an unhealthy lifestyle? [Behavior]
3. What can parents/caregivers do to help prevent children from becoming overweight or obese, or perhaps help overweight/obese children become healthier? [Personal Factors; Environment]
4. What barriers do you think prevent families from adopting healthy lifestyles? [Personal Factors; Environment]
5. How can schools help families adopt healthier lifestyles? [Environment & Situations]
6. What else would you like to add?

*Figure 1.* Focus Group Questions

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In addition, teachers expressed a great deal of concern about the psychosocial issues affecting their students. One teacher observed, "I have a lot of kids who are really stressed. I think they live a stressful lifestyle at home . . . just not knowing if their parents are there or where they're going when they get home. . . . I think the kids have tons more stress than we do . . . they have to deal with a lot more than most six year olds." Another teacher added, "A lot of that stress magnifies itself into depression. When you're depressed, you really don't want to do anything and [there is] lots of anger; and that's not healthy." As one teacher surmised, "They [students] worry daily about what they'll eat that night, where they'll sleep, how many people will be sleeping there. I have a student that has never slept in a bed, has never slept in a bed with a pillow and a blanket, sleeps on the floor every night, and he's six years old. That's just something I could never imagine until I'm here and it's here in my face every day . . . that survival mode." Another teacher added, "It's not unusual for them to have police come into a home in their neighborhood or into their own home and take someone away. . . . If you don't know if someone's gonna come and take away the adults in your home, it's very frightening as far as survival."

Environment and situations also surfaced as barriers to childhood obesity prevention from four primary fronts: family, neighborhood, school, and the underlying issue of poverty (Figure 2). The majority of the children in this study were from single-parent families. In addition to the apparent lack of health-related knowledge and insufficient role modeling by parents, children also dealt with a lack of supervision, safety, and security in the home. One teacher described a trip to a student's home: "There were cases of beer and wine . . . and there were bottles, and bottles, and bottles, and bottles all over the counter."

Furthermore, food insecurity emerged as a significant concern in the lives of the children. As one teacher explained, "Food is a big issue. As a classroom teacher, when you pass out food, there will be a knock-down, break-out fight if someone tries to take or touch their food because that food may go in their pocket [and] may be what they eat that night." Another teacher commented, "What is amazing to me is we have a snack in our classroom every day, and sometimes it's just plain crackers; but they will take those crackers and break them into little teeny tiny pieces. I can't get them to quit; I guess it just feels like more." One teacher agreed and added, "When I give my kids a snack, they eat a little and then they want to save it and take it home." Teachers also observed, " . . . a lot of our kids are on food stamps, so they [family] buy things that are cheap—macaroni and cheese, corn dogs, and lots of sweets—a diet that is not conducive to a very healthy lifestyle." In addition, several of the children mentioned they were on food stamps; and they viewed fruit—
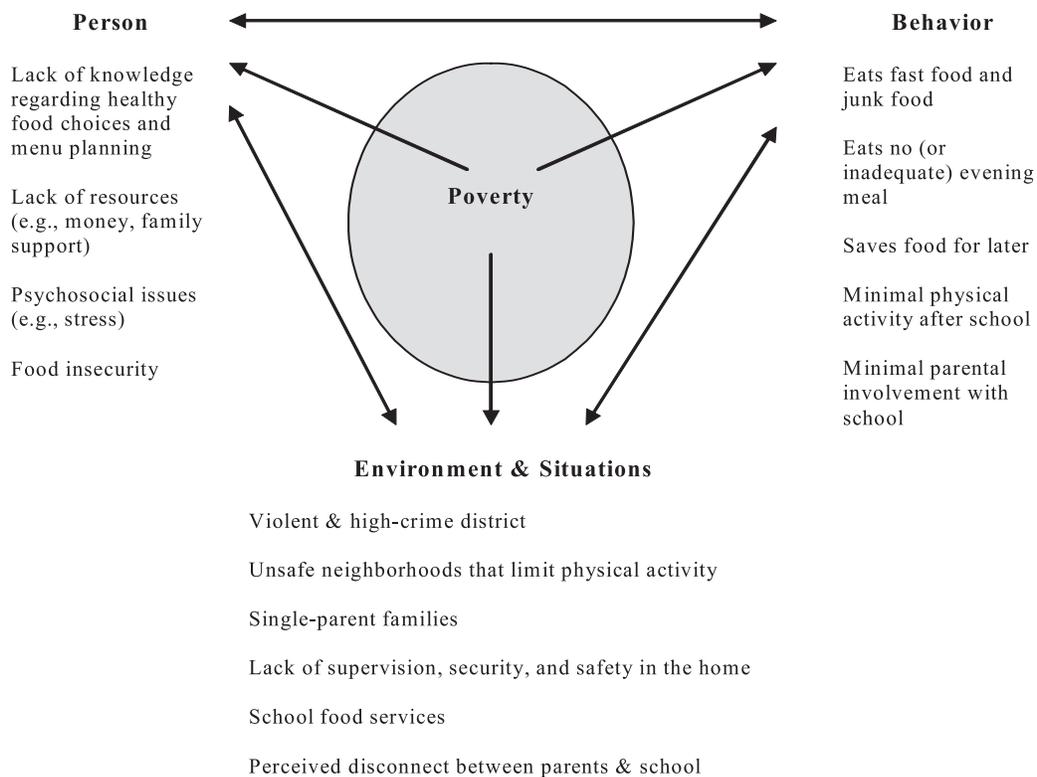


Figure 2. A Framework for Understanding Childhood Obesity in a Low-Income, Minority Service-Learning Community*

*Adapted from *Social Foundations of Thought and Action* (C) Pearson Education, Inc., NJ

particularly apples—as a very special and occasional treat. One girl stated that she likes to eat apples, but she didn't eat them often because "I don't have no money." Most of the children emphasized that they would eat more fruit if their families had the money to buy it.

Both teachers and parents expressed frustration that many parents do not take the time to prepare meals for their families, nor do they adequately supervise what their children eat at home. One parent stated that many of the parents who live in her apartment complex "don't put forth the effort to try and make or prepare a meal for them [children]." She identified the parents' lack of supervising what their children eat as a problem, stating that "I think they [children] are going in the cabinets and pulling out whatever is available." Teachers paralleled these thoughts: "We're looking at students who come to fend for themselves. . . . [They] are not sitting down at the table eating a meal where their parents are monitoring what they are eating. I think they are going in the cabinets and pulling out whatever is available. . . . Most of my students are not on a decent schedule." "Parents don't have structures, kids don't have structured times, and a lot of the meals are junk food and fast food." "I'll ask my second graders, 'What did you eat for supper last night?' And one girl said, 'We had a can of beanie weenies, potato chips, and a coke.' So what they do eat . . . is just unhealthy."

Another critical environmental barrier that surfaced during the interviews was the violent, high-crime district in which the children/families live. One teacher stated that it would be "meaningful if my students did not have gunfire every night once they go to bed." Another teacher agreed and said, "We have lots of students that witness violence, people being murdered or committing suicide in front of them. They have seen the violence . . . and they . . . are being desensitized to the violence because of what they have seen." (In fact, during the study, three children and their mother were brutally murdered in their apartment within this neighborhood.) According to the teachers, unsafe neighborhoods not only pose psychosocial health risks to children, they also limit opportunities for children to engage in outdoor physical activities—"We hardly ever see children outside playing."

Within the school environment, both parents and teachers identified school food services as a roadblock to healthy lifestyles. Both groups believed that school food services could offer more nutritious and appealing foods. Teachers were concerned about the school breakfast (often a small breakfast bar) in meeting nutritional needs of the children, particularly because they felt that many of their students did not have adequate nourishment from the previous evening. One teacher described a school situation where second graders could bring an extra 50 cents to school and buy "extras" such as "giant" cookies or cheese nachos. As one teacher exclaimed, "Oh, my gosh! I could not believe how much these kids could eat!" In addition, the parents mentioned the time period that students have to eat their lunch. From the parents' perspective, "They are not giving them enough time to eat their food. They just want them to gulp it down, and that's not healthy." Both groups believed that school lunches were not as nutritious as they should be, citing pizza, French fries, and chocolate cake as examples of how school lunches reinforce unhealthy eating patterns among children.

According to Social Cognitive Theory (Bandura, 1986), both environment and situation—a person's perception of the environment—provide a basis for better understanding behavior. In this study, the situation of perceived "disconnect" between parents and teachers/school emerged as a significant finding. This disconnect was exemplified through lack of relationship, communication, and trust between the two groups. As one parent lamented, "The biggest thing with me about __ISD and the community is that they do not have a relationship—none." Parents also expressed frustration and even anger regarding how they are treated when they visit the school. One of the parents admitted, "I hate to say it . . . in a black community, we do have a problem with being involved with our children in school and activity." When asked why they are not more involved in school activities, one parent commented, "They are very rude." Another parent added, "Some white people don't mean no harm and no disrespect, but some white people can make black people feel like dirt. They will look you up and down and then they will respond to you. Then the first thing they say is, 'What do you want?'" Another parent offered this insight: "The most reason why parents come to the schoolhouse is that they are either picking [children] up, dropping them off, or something's wrong."

Teachers were frustrated as well, stating that it was very difficult to get parents involved in school activities. One teacher commented, "We have offered parenting classes here and parents don't come. We provided a brown bag lunch for second grade parents and hardly had any come. . . . Then we offered the first grade parents pizza for lunch, and they were here." They seemed puzzled about what factors actually would draw parents into the school. One of the parents asserted that "if the parents wanna take the time and go, they'll make time to go if they actually wanna be involved." She went on to say, "If you're not interested, you're not gonna be bothered with it, you're not gonna go, and I don't think [offering people free food] will bring them in. I think that it has to come from the parent—the individual."

[Questions 3 & 5] In light of the multiple roadblocks that appeared to hinder childhood obesity prevention efforts in this neighborhood, the focus group participants had some key suggestions regarding what families and schools could do to improve the situation. The parents spoke about the need for parents/caregivers to buy and prepare healthier meals and supervise children's food choices (including snacks) and portion sizes. They also felt that parents/caregivers should limit the time children spend watching TV and encourage them to be more physically active. Their suggestions for how schools can help included the following points: offer parenting education that includes nutrition education, send home school newsletters, improve school

food services, offer family fun and fitness events, and make a concerted effort to involve parents/families. One parent commented, "I think teachers need to get to know you, the parent . . . really get to know the child and the parent."

Teachers suggested offering "family nights" to help parents learn how to reinforce nutrition and physical activity at home. They also mentioned parenting education that offered parents practical "tools for healthy lifestyles." They thought parenting education should begin in the area high school to "help break the cycle" of inadequate knowledge and skills for healthy living. In addition, teachers felt that their students needed cultural role models as well as university student mentors to guide them and set positive examples.

The children voiced the following tips to parents and schools: "Bring some fruit and vegetables," "give us some apples and oranges and milk," and let us "do some exercise" and "go outside longer."

## Discussion

This study was qualitative and served as a preliminary exploration that requires further research and validation. The study was limited to a small convenience sample that may not be representative of similar groups within the general population. Nevertheless, findings led to richer insight about a service-learning community and can be useful to other health and physical educators who engage in service-learning, particularly in minority, low-income neighborhoods.

Childhood obesity prevention appeared to be a challenge for the participants in this study. Drawing from Social Cognitive Theory (Bandura, 1986), Figure 2 presents a framework for understanding childhood obesity in a low-income, minority service-learning community. The framework classifies major themes derived from this investigation according to personal factors, environmental and situations, and the underlying issue of poverty. The complex interplay among these components influenced behavior in a striking way.

In this exploratory investigation, poverty was the distinguishing factor underlying the participants' perceptions about healthy lifestyles, barriers to achieving healthy lifestyles, and what families and schools can do to prevent childhood obesity. Poverty often superseded personal factors related to healthy food choices (e.g., knowledge and skills) and imposed environmental constraints (e.g., unsafe neighborhoods), thereby limiting positive health behaviors (e.g., engagement in physical activity). Although the purpose of this study was to understand a service-learning community through exploring thoughts and perceptions about healthy lifestyles and childhood obesity prevention, the participants revealed other pressing health issues that clearly competed for attention, such as psychosocial health, personal safety, and oral health. The situation of "perceived disconnect" between parents and teachers/school further complicated the picture. From a broad perspective, these factors are colossal in terms of

their perplexity and their negative impact on the health-related quality of life of children and their families. Through the lens of service-learning, they steal the focus from prevention efforts directed towards helping children develop knowledge and skills connected with a healthy lifestyle. For example, with regard to childhood obesity prevention, it is difficult for children to focus on healthy eating and physical activity when they are in the "survival mode" and contending with more urgent life issues such as where their next meal is coming from, where they are going to sleep at night, and how to cope with anger and chronic stress.

In spite of the enormous childhood obesity prevention roadblocks that emerged from the focus group interviews, there are ways to make progress and address some of these barriers through a university-based service-learning venue. First, family involvement must be an integral component of service-learning programs targeting children's health promotion because families are a major health and social influence in the lives of children and youth. Research has shown that family involvement plays a key role in a variety of school-based health promotion efforts targeting children and youth, including cardiovascular health promotion (Hopper, Munoz, Gruber, & Nguyen, 2005; Nader et al., 1996), fruit and vegetable consumption (Domel & Baranowski, 1993), and alcohol prevention (Perry et al., 1996). When families and schools form positive relationships and partner together to promote children's health, it is a win-win-win situation. Moreover, findings from this study suggest that there is a need for parent education classes/events that teach parents about basic nutrition concepts, menu planning, how to purchase healthy food on a limited income (e.g., with food stamps), and meal preparation. These classes could include experiential activities for skill development (e.g., role play) to hold more relevance for the target audience. Also, when working with low-income, minority parents, it is helpful to have someone from their community teach the classes. However, service-learning students can assume leadership roles and assist in meaningful ways, such as helping to plan, market, implement, and evaluate the health education classes/events.

Additionally, family involvement activities can be incorporated into service-learning activities that are designed to help the entire family develop healthier eating and physical activity lifestyle behaviors. For example, families can track their efforts by keeping a weekly score card (Hopper, et al., 2005) to track points in nutrition and physical activity. Similarly, family fun nights with a nutrition and physical activity theme can be fun and educational for both students and their families. They also can serve as non-threatening venues for families and school personnel to build relationships and partner to enhance children's health and wellness. Furthermore, service-learning projects with strong family involvement components can be expanded to include projects related to other pressing health issues identified through this study, such as oral health, psychosocial health (e.g., anger and stress management) and personal safety.

Second, enhancing the relationship between school personnel and parents/families warrants particular attention. The findings in this study concerning the gulf between families and the school mirror other studies (McDermott & Rothenberg, 2004) and reveal that cultural and communication chasms exist. In this study, fundamental differences between parents and school personnel appeared to play a role in parents' resistance to involvement in school-related activities, including this focus group study. Research suggests that family resistance to school involvement can be reversed when educators *intentionally* learn about children's cultural backgrounds and proactively collaborate with families. Pre-service educators must have multiple opportunities to develop cultural and communication competencies through service-learning and other field-based experiences in health, physical education, and other teacher preparation programs. A variety of active learning experiences can foster growth in these areas. For example, service-learning students can visit the neighborhoods/ communities in which they will be working to demonstrate interest in and respect for the children and their families. Through participating in service-learning curricula, students also should be able to demonstrate their ability to communicate effectively with families via channels such as newsletters, personal notes, and meaningful one-on-one conversations. In conjunction with supervisor evaluations, student portfolios with audio-visual materials can help students expound on their abilities in the areas of cultural competence, communication, and other relevant skills. In addition to these more formal types of educational experiences, it is up to the individual to purposefully embrace and practice cultural competence, which includes creating caring relationships with students and their families.

The hallmark of prevention is education, and service-learning is a valuable pedagogical method that can produce a positive, reciprocal relationship of learning for all the participants. In order for university-based service-learning projects targeting critical children's health issues to be successful and even life-changing, it is imperative that university faculty and students seek to understand their respective service-learning communities. The importance of building caring relationships and encouraging open lines of communication with students and their families should be strongly emphasized. Because low-income, minority families are often marginalized from schools by poverty and cultural differences (McDermott & Rothenberg, 2004; Payne, 1998), it is imperative that university students have multiple opportunities to assess and enhance their cultural competence. Then, as these students enter their careers as educators (or school nurses, school counselors, etc.), they will possess the self-efficacy to foster successful relationships with the students and families they serve. In turn, families and schools will be able to seize the opportunity to build bridges and partner to make a positive difference in notable children's health promotion efforts such as childhood obesity prevention.

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