Barriers and Supports to Implementing a Nutrition and Physical Activity Intervention in Child Care: Directors' Perspectives

Rodney Lyn, PhD[1]; Sarah Evers, MPH[1]; Justin Davis, MPH[1]; Joyce Maalouf, MS, MPH[1]; Monica Griffin, MS, RD, LD[2]

ABSTRACT

Objective: To explore the experiences of child care centers implementing a nutrition and physical activity (PA) program and identify supports and barriers as reported by center directors.

Design: Semi-structured interviews with 20 child care center directors following program implementation.

Setting: Twenty-two child care centers serving low-income children in Georgia.

Participants: Twenty child care center directors who led program implementation at their respective centers.

Intervention: The program focused on introducing wellness policies to centers and on providing training and technical assistance to support implementation.

Phenomenon of Interest: Center directors' perceptions, attitudes, and reflections on the process of implementing changes to nutrition and PA practices.

Analysis: Qualitative analysis of interview transcripts was conducted using NVivo 9 software. Researchers employed 2 levels of coding; 4 predominant themes emerged.

Results: Directors' insights included the importance of hands-on activities and printable materials to engage children in nutrition and PA education and healthy behaviors; challenges and supports to engaging parents in child wellness; recognition that children readily accept nutrition and PA changes; and the need for program implementation efforts to prioritize the provision of support for directors and staff in modifying nutrition and PA practices.

Conclusion and Implications: Directors consider nutrition and PA policy changes to be beneficial to the child care environment. This study highlights important considerations for efforts to promote healthy weight environments in the early care setting.

Key Words: child care, wellness, policies, nutrition, physical activity (*J Nutr Educ Behav*. 2014;46:171-180.)

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INTRODUCTION

Obesity is the most common chronic pediatric disease.[1] Since 1980, the obesity rate for children ages 2–5 has more than doubled; currently, more than 20% of the nation's preschool-age children are overweight or obese.[2] During the preschool years, children develop dietary and physical activity behaviors that are important to their healthy development. Practices within child care facilities can improve children's nutrition and levels of physical activity.[3] Because nearly 75% of children under 5 years of age now spend at least part of their day in child care, this environment has been identified as critical for promoting behaviors that prevent childhood obesity.[4]

A number of obesity prevention programs in child care centers have yielded positive results to the dietary and physical activity environment of centers and even reduced body mass index in children.[1,5,6] Qualitative research has identified several barriers to good nutrition in child care centers, including children's dislike of some healthy foods, staff perception of parents as a barrier to children's healthy habits and the serving of unhealthy foods at home, staff practices around food service being different from recommendations, and perceptions of healthy foods not being available in the child care center.[7,8] Barriers to implementing recommended amounts of physical activity in child care (and family child care) centers include the need for more staff support and training for structured physical activities with children, indoor and outdoor environments that are not suitable for physical activity (including inclement weather), parental attitudes and behaviors, and a lack of a variety of age-appropriate physical activity equipment.[9-11] Research examining

[1]School of Public Health, Georgia State University, Atlanta, GA
[2]Nutrition Services Division, Bright From the Start: Georgia Department of Early Care and Learning, Atlanta, GA
Address for correspondence: Rodney Lyn, PhD, School of Public Health, Georgia State University, 856 Urban Life, Atlanta, GA; Phone: (404) 413-1133; Fax: (404) 413-1140; E-mail: rlyn1@gsu.edu
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child care centers as a setting for promoting health has identified the lack of resources and technical assistance as a barrier.[12] Other research suggests that when implementing nutrition training with child care providers, particular attention should be paid to providers' beliefs and attitudes toward healthy eating because they can affect practices in the center.[13] More research is needed to identify strategies that are effective in improving nutrition and physical activity in child care centers. To build effective and sustainable programs aimed at mitigating childhood obesity, an understanding of the facilitators and barriers to implementation of nutrition and physical activity programs and policies is critical.

In 2011, 13% of low-income preschool children in Georgia were obese.[14] In an effort to improve physical activity and nutrition in child care centers in Georgia, a 1-year pilot program (spring, 2010 to spring, 2011) was implemented by the Georgia Department of Early Care and Learning (DECAL). In winter, 2010, DECAL issued an abbreviated request for applications (RFA) to centers, held a pre-application conference to introduce centers to the program, and distributed previously developed nutrition and physical activity materials and curricula. Interested centers were asked to respond to the RFA by submitting a self-assessment to help identify areas related to nutrition and physical activity that needed improvement, 6 self-selected wellness policies that corresponded to areas in need of improvement, and proposed activities related to implementation of policies.

A total of 24 child care centers applied and were enrolled in the program. Wellness policy implementation began in May, 2010 and continued for 1 year. A DECAL staff member provided technical assistance on an ongoing basis to help centers achieve the implementation of wellness policies (Table 1) and any goals indicated in their proposal. An expert on physical activity provided input on the development, implementation, and evaluation of program activities related to physical activity. Centers were provided with up to $2,000 to support improved healthy snacks, education materials, and physical activity equipment. Center directors and staff were required to participate in quarterly trainings on nutrition and physical activity, menu planning, food safety, and healthy habits consistent with the wellness policies. The objectives of the program were to: (1) introduce child care providers to the concept of a wellness policy; (2) help child care providers select 6 relevant wellness policies related to nutrition and physical activity and a practical plan for implementation; (3) support centers through training, technical assistance, and funding to implement policies; and (4) evaluate the impact of a wellness policy on children and staff. Table 1 presents wellness policy options and their respective components.

Center directors were responsible for implementing policy changes, and thus were vital to the success of the program. At the conclusion of the study, interviews were conducted with directors to capture their overall perceptions, attitudes, and experiences with the program. Other components of the program evaluation included assessments of menu and physical activity changes, staff surveys, observations, and interviews. The aims of this qualitative study were to explore the experiences of child care directors while implementing a nutrition and physical activity program; and to gain an understanding of barriers and facilitators for implementing policy changes to nutrition and physical activity.

METHODS

Setting

The southwest region of the state of Georgia experiences many health disparities, high rates of poverty and adult obesity, and low high school graduation rates. The Georgia DECAL selected this region for program implementation given its need for support. To participate in the program, centers were required to be licensed by the state and not be located in an elementary school. The program included 58% (n = 14) for-profit and 42% (n = 10) nonprofit centers. Four centers offered the Head Start program and only 1 maintained accreditation by the National Association for the Education of Young Children. A total of 55% of child care centers were located in cities with populations over 50,000. The mean population size of cities where centers were located was 99,056 (minimum, 981; maximum, 194,107). The centers served a total of 2,042 children between the ages of 2 and 5, with a range of 40–245 children during the time of the program. There was an average of 6 lead teachers (minimum, 1; maximum, 14) and an average of 4 assistant teachers (minimum, 0; maximum, 11) employed in centers during the time of the program. All centers provided full-day programs and were a part of the Child and Adult Care Food Program.

Interviews

Center directors were invited to participate in an in-depth interview at the conclusion of the program in spring, 2011. Researchers at Georgia State University who led this study developed an interview protocol including questions to solicit directors' overall experiences and perceptions of the program, the processes they used to make changes to nutrition and physical activity, and any barriers they experienced (Table 2). Program staff from DECAL reviewed the protocol. Their feedback was incorporated into the final protocol. The Georgia State University Institutional Review Board approved the study and all participants provided written informed consent.

Of the 22 child care centers that completed the program, 20 were available for a final interview because 2 centers closed during the summer months. The research team contacted directors by phone to arrange a convenient time to meet in their respective centers during a regular work day. Interviews were conducted in person; however, because of scheduling conflicts, 5 centers participated via phone. The principal investigator and 3 research team members, organized as 2 pairs, conducted interviews, which lasted 60 minutes on average. The primary interviewer was responsible for following a semi-structured interview guide with the participant, whereas the secondary interviewer took down notes about key

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