American Reinvestment & Recovery Act: Component I
Tobacco & Obesity Policy Project
Focus Group & Key Informant Interviews
At-A-Glance Findings

Background

In May 2010, the Tobacco Prevention and Control Program (TPCP) and the Obesity Prevention Program (OPP) with New Hampshire Department of Health and Human Services (NHDHHS) contracted with the Community Health Institute (CHI) to assess the feasibility of implementing voluntary policies that would increase food, nutrition and physical activity standards and, decrease screen time and exposure to secondhand smoke in licensed childcare settings, decrease access to competitive foods in public schools and allow municipalities the opportunity to enact stricter regulations around tobacco use if they so desired.

The first course of action for CHI was to conduct an assessment of the challenges and difficulties that child care providers encounter in both licensed centers and family-based programs in providing better nutrition, increasing opportunities for physical activity, decreasing the amount of time children spend in front of a screen such as TV or computer and decreasing children's exposure to secondhand smoke and contaminants from smoking. The assessment consisted of three components 1) focus groups, 2) key informant interviews, and 3) a survey of all licensed child care providers. This report is a summary of this three-part assessment of child care programs. The findings from this assessment will be used to inform the development of strategies to create healthier environments where children learn and play in their formative years.

Sample & Methodology

A six-member CHI team worked with OPP and TPCP to develop the scope of the assessment and the research questions. CHI staff reviewed previous assessment tools and surveys to draft the qualitative scripts and surveys. Together OPP, TPCP and CHI identified strategies for recruiting focus group participants, identified individuals for key informant interviews and the strategies for disseminating the survey. CHI developed a fact sheet of *Frequently Asked Questions* to answer anticipated questions from the participants. The final focus group, interview scripts, and recruitment strategies were approved by OPP and TPCP, and the final survey was approved by the Director of the NH Division of Public Health Services.

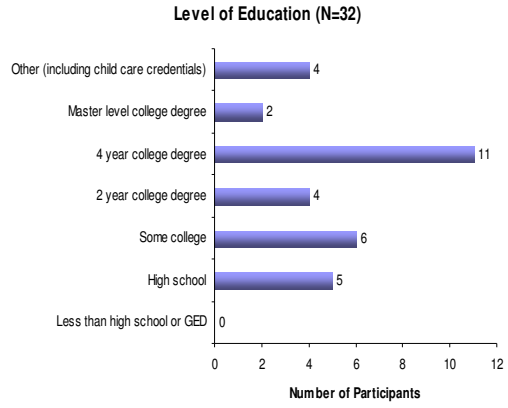
FOCUS GROUPS

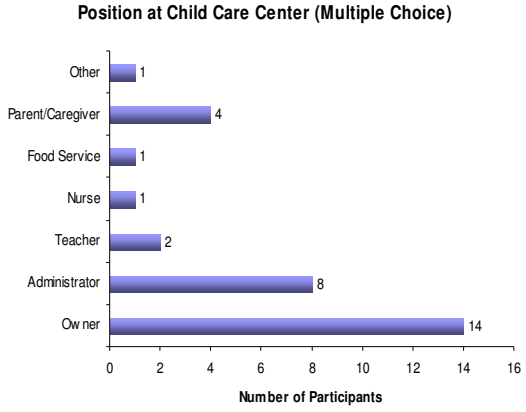
CHI staff conducted a total of five focus groups lasting approximately two hours each. The focus groups were comprised of the following participants: two focus groups representing programs enrolled in the Child and Adult Care Food Program (CACFP) as a center or family-based program, two center and family-based programs that do not participate in CACFP; and one group of parents who send their children to a licensed child care program. The Resource and Referral program assisted CHI in recruiting the participants for all the focus groups and hosted the discussion. For their assistance they each received a stipend for $250. Participants of the focus group received a $50 Wal-Mart gift card. The recruitment of the focus group participants was not randomized. A note taker documented the major themes and points of discussion in each group. The purpose of the notes was to summarize key concepts expressed and not to transcribe verbatim what was said. The following table is a summary of the focus groups.

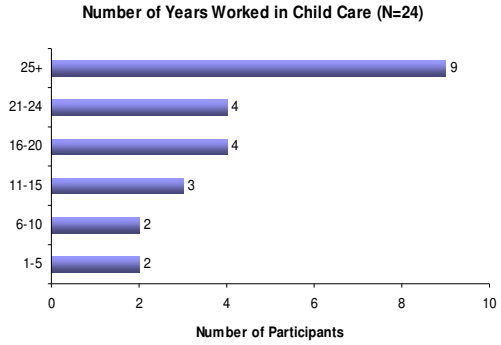
TABLE A: Focus Group Participants

Type of Program Represented	# of Individuals	Location	Date
CACFP Participating Family-Based	9	Salem	10/15/10
CAPFP Participating Centers	7	Dover	10/27/10
Non-CACFP Family-Based	8	Laconia	11/17/10
Non-CACFP Centers	2	Littleton	12/14/10
Family Members/Care Givers	10	Concord	11/30/10

Each participant completed a demographic survey, which is highlighted by the following graphs. There were a total of 28 females and four males representing a range of ages who participated in the focus groups. All participants finished high school with the majority having some college and 13 percent with a four-year degree or higher. Also, over one third of the participants reported working in the field for more 25 years, while only two reporting between 1 – 5 years of experience.







FOCUS Groups: Summary of Findings

Non-CACFP Center & Family

- Selected policies are reasonable.
- Quality of food sent by families is challenging.
- Most participants are adhering to the selected standards, i.e. serving 100% juice, whole grain products, teaching children about nutrition.
- More challenging to increase physical activity levels because of staff attitude towards vigorous activity and education.
- Staff find it difficult to talk with parents and communicate about these topics & need assistance to educate them.

CACFP Center & Family

- Selected policies are reasonable.
- Most participants are adhering to the selected standards, i.e. serving 100% juice, whole grain products, teaching children about nutrition, but there is room for improvement. Food is high calorie.
- Difficult to find nutritious snacks.
- CACFP identified as helping to increase knowledge about nutrition, menu planning and budgeting.
- Celebrations such as birthdays and holidays are challenging.
- More challenging to increase physical activity levels because of staff attitude towards vigorous activity and education.
- Children's' clothing impacts their ability to be active.

Tobacco Exposure

- Most programs do not have smoke-free campuses.
- Most staff support the regulations.
- Programs do not find the current policy onerous and would support a policy to ban smoking 24/7.
- Few programs have staff who smoke.
- Parental smoking is a challenge.
- Parent communication & education is challenging.

Screen Time

- Most programs do not provide computers or TVs in the classrooms, and if they do, they use age-appropriate software/filters.
- Programs report very little TV use.

- Family-based programs report showing movies and PBS shows more frequently than centers.

Parent Focus Group

- All the participants supported the selected standards and many recommended stricter standards.
- Parents supported a policy to ban smoking 24/7.
- Smoking policy would impact their decision of where to send child.
- Parents reported more screen time for children attending after school programs.

KEY INFORMANT INTERVIEWS (KII)

CHI was tasked with conducting seven key informant interviews with people considered leaders or key stakeholders in the field of early childhood education with a unique perspective of the community. They were selected because they had experience in early childhood education that provided them a 360 degree view of the field and its challenges. Using the *Community Readiness Model* (www.TriEthnicCenter.org, 2010), CHI interviewed seven professionals considered experts in the field of child care. The *Community Readiness Model* is an assessment tool that measures the degree of readiness that a community possesses to engage in change across six different dimensions. The dimensions are: community efforts, community knowledge of the efforts, leadership, community climate, community knowledge about the issue and resources related to the issue.

Sectors Represented by Key Informant Interviewees
NH Childcare Licensing
Merrimack/Belknap County Community Action Program, Head start
Child Care Center Administrators
Early Learning NH
Child & Adult Care Food Program
Healthy Child Care Initiative
NH Legislature
Childcare Resource & Referral Networks

CHI used the short version of the interview script to interview participants about the topics of obesity prevention and tobacco exposure. Each interview transcript was reviewed and scored by two CHI staff members and given a score for each dimension between one and nine. "One" represents no awareness about the issue and "9" represents a high level of community ownership around the issue. The community's readiness to change score for childhood obesity is 4.33. The community's readiness to change score for tobacco exposure is 3.27. According to the model, interventions should focus on strategies that increase awareness about the issue and its impact on the population and developing tangible strategies that community members can engage in. The following table is a summary of the final community readiness scores for each respondent for each topic.

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Community Readiness Score for Obesity Prevention

	Respondent							
Dimension	1	2	3	4	5	6	7	Total Score
A	3.50	6.50	4.50	7.00	3.00	4.00	6.50	5.00
B	3.00	5.00	3.00	4.00	2.00	3.50	4.50	3.57
C	4.00	6.00	4.00	6.00	3.00	6.50	5.00	4.93
D	2.50	7.00	4.50	5.00	3.50	4.00	4.50	4.43
E	3.50	4.50	3.00	5.00	2.50	3.50	4.00	3.71
F	3.50	5.00	4.00	5.50	3.50	3.50	5.00	4.29
TOTAL	4.00	5.67	3.83	5.42	2.92	4.17	4.92	4.33

Community Readiness Score for Tobacco Exposure

	Respondent							
Dimension	1	2	3	4	5	6	7	Total Score
A	3.00	3.50	6.00	6.00	2.50	n/a	2.50	3.92
B	4.00	2.00	3.50	3.00	n/a	n/a	1.00	2.70
C	2.50	2.00	2.00	3.00	2.50	n/a	1.50	2.25
D	7.00	7.00	3.50	2.00	7.00	n/a	3.50	5.00
E	4.00	3.00	3.00	3.00	2.50	n/a	3.00	3.08
F	3.50	1.50	3.00	2.00	3.50	n/a	2.50	2.67
TOTAL	4.00	3.17	3.50	3.17	3.60	n/a	4.92	3.27

KEY INFORMANT INTERVIEWS: Summary of Findings

- The community is invested in the healthy growth and development of the children they serve. They are eager to provide proper nutrition for the children under their care.
- Most in the community do not see childhood obesity as a public health problem. They do not see it as a priority issue to address. They see it through the lens of a family or individual problem.
- Most in the community lack the knowledge of the risk factors and causes of childhood obesity. Therefore, they do not have an understanding of prevention strategies that impact the environment.
- There is increased awareness about the intervention *I am Moving; I am Learning* and the *NAP SACC* program.
- Conversely, the community sees tobacco exposure as harmful to the health of children and accepts they cannot smoke around children. They support the current regulation and are supportive of stricter regulation that would prohibit tobacco use 24/7 across the campus.
- The community is unaware of broader public health efforts to address tobacco exposure.
- The community needs tools and resources to educate and refer family members and care givers when they intervene with a family.

Score	Stage of Readiness	Goal of Stage
1	No Awareness	Raise awareness of the issue(s)
2	Denial/Resistance	Acknowledge existence of issue(s)
3	Vague Awareness	Increase believe that community can make positive change
4	Preplanning	Develop concrete strategies
5	Preparation	Gather pertinent information
6	Initiation	Initiate action
7	Stabilization	Stabilize efforts
8	Confirmation/Expansion	Expand and enhance services
9	High Level of Community Ownership	Maintain momentum, grow and use what you have learned

Stage of Community Readiness	
No Awareness	No identification of the issue as a problem. "It's just the way things are." Community climate may unknowingly encourage the behaviors although the behavior may be expected of one group and not another.
Denial	Recognition of the issue as a problem, but no ownership of it as a local problem. If there is some idea that it is a local problem, there is a feeling that nothing needs to be done about it locally. "It's not our problem." "It's just those people who do that." "We can't do anything about it."
Vague Awareness	Beginning of recognition that it is a local problem, but no motivation to do anything about it. Ideas about why the problem occurs and who has the problem tend to be stereotyped and or vague. No identifiable leadership exists or leadership lacks energy or motivation for dealing with it.
Pre-Planning	Clear recognition of the issue as a problem that needs to addressed. Discussion is beginning, but no real action planning. Community climate is beginning to acknowledge the necessity of dealing with the problem.
Pre-Preparation	Planning on how to address the issue is underway and decisions are being made on strategy and who will do it. There is general information about local problems and about the pros and cons of prevention activites, actions, or policies, but it may not be based on formally collected data.
Initiation	An activity or action has been started and is ongoing, but it is still viewed as a new effort. There may be great enthusiasm among the leaders because limitations and problems have not yet been experienced.