EXECUTIVE SUMMARY
Fit WIC Project Evaluation - Staff Focus Groups
Prepared by Mary Anne Wichroski, PhD
February, 2008

As part of the evaluation of the State of New Hampshire Fit WIC Project, focus groups were conducted with 31 staff from the five participating WIC agencies. Focus groups were conducted in late January, 2008, in Concord, Littleton, Exeter, and Manchester.

The purpose of the focus groups was to assess: (a) how Fit WIC staff perceived their skill levels and the effectiveness of staff training; (b) Fit WIC staff's acceptance of Fit WIC nutrition and physical activity messages; and (c) Fit WIC staff perception of their ability to effect change in participant behavior regarding nutrition and physical activity. Findings will be used to improve Fit WIC staff training.

Findings

(a) Participants seemed very knowledgeable about the causes and risks of overweight in preschool children, as well as what interventions could help mitigate it. They discussed the physical, psychological, and social effects of overweight and recognized the barriers, both internal and external, to its prevention. While internal factors were parent-centered, external barriers included the stress of working, lack of time to plan healthy meals, the cost of healthy foods, unsafe play areas, lack of control over the food given by child care providers, and counterproductive cultural messages.

(b) Overall, the staff demonstrated their acceptance of nutrition and physical activity messages, offering sound suggestions about what parents could do, but with an awareness of the obstacles parents face. In one group there appeared to be less empathy towards parents and a higher level of frustration towards their behavior, but most seemed to understand these difficulties. Urban and rural differences were noted, in terms of levels of physical activity due to living conditions and other environmental factors.

(c) Staff expressed caution about their ability to effect change in parent behavior. While confident in their abilities, knowledge, resources, and counseling skills, they did not have as much confidence in parent willingness to change. Some felt they could be a resource but not the direct agents of change. On the other hand, many had a variety of strategies for approaching parents about overweight, including a sensitive approach, client-driven assessment (VENA), objectivity, stressing weight as a health issue, using charts and other visual aids, building rapport with clients, avoiding offensive terminology, encouraging small, incremental changes/attainable goals, and offering on-going reinforcement and support. Many staff have used their personal experiences and problems as a "point of connection" with parents.

(d) Staff suggestions included having more time with clients, seeing the same client consistently, having on-going training and feedback, more staff, more space, and consistent funding. The staff would also like to see consistent messages about overweight from physicians and other health care providers.

Recommendations

- Provide on-going training and support.
- Arrange seminars on how to open a dialogue with parents, perhaps having the more experienced nutritionists work with those who are less trained.
- Provide parenting training and interactive skill training with children's groups.
- Provide materials in other languages (Manchester).
- Recommend to the State more fruits and vegetables and less cheese.
- Recommend the State provide nutrition and physical activity messages with issuance of Food Stamps.
- Clarify travel reimbursement for staff.
- Develop experiential learning techniques for parents.
- Provide incentives for parents to participate in the program.
- Investigate how time could be used more effectively or how more time could be allowed clients who are willing to work on their weight and the weight of their children.
- Investigate feasibility of client seeing the same nutritionist each time.
- Create partnerships with doctors and health care professionals to reinforce Fit WIC message.

Fit WIC Project Evaluation
Staff Focus Groups
Prepared by Mary Anne Wichroski, PhD
February, 2008

As part of the Evaluation Plan for the State of New Hampshire Fit WIC Project, focus groups were conducted with staff from the five WIC agencies representing the five intervention groups participating in the program. These focus groups were conducted in late January, 2008, in Concord, Littleton, Exeter, and Manchester.

The purpose of the focus groups was to "assess: (a) how Fit WIC staff perceived their skill levels and the effectiveness of staff training; (b) Fit WIC staff's acceptance of Fit WIC nutrition and physical activity messages; and (c) Fit WIC staff perception of their ability to effect change in participant behavior regarding nutrition and physical activity. Information from the groups will be used by Fit WIC leadership to improve staff training so that staff needs are continuously met in a timely manner and to improve Fit WIC messaging." (Fit WIC Evaluation Plan)

Method and Sample

Four focus groups were conducted with staff from the five WIC agencies: Community Action Program Belknap/Merrimack Counties; Ammonoosuc Community Health Services; Coos County Family Health Services; Rockingham Community Action; and Southern NH Services. (Staff from Ammonoosuc Community Health Services and Coos County Family Health Services met in one group). Each session was attended by between four and eleven participants. The sample included all five Program Directors, a Program Coordinator, eleven nutritionists, eight nutrition assistants, and other staff, such as health technicians, a breast feeding coordinator, a case manager, an educator, and an occupational therapist, for a total of 31 participants. About half of the sample had had at least ten years of experience. Over 30% had more than 15 years in the field. About ¾ of the sample had children of their own.

Each session was conducted by a trained facilitator and lasted between one and one and one half hours each. A note taker was present and all sessions were audio taped (with permission from the participants) for any additional information that could be added to the notes. Notes were then forwarded to the evaluator for independent review and analysis. Participants were informed of the purpose of the focus groups, assured of anonymity and confidentiality, and were encouraged to speak openly. Efforts were made to gather input from all of those attending.

Questions were framed in order to assess staff comfort with their knowledge and rationale for overweight causes, risks, and interventions; comfort with physical activity and play skill knowledge; comfort with talking to parents about overweight; comfort with changing the behavior of others; and comfort with their own weight and physical activity management. At the end of each session, participants were asked what additional resources they would need and what suggestions they might have for improvements in

the program. (See Appendices I, J, and K of the NH Fit WIC Evaluation Plan for focus group guidelines, questions, and protocol.)

Results

Comfort with knowledge and rationale for overweight causes, risks, and interventions

Causes of Overweight. Much of the discussion around what causes overweight in children centered around the behavior of parents. The most frequently mentioned reasons were poor modeling, lack of education, poor food choices (especially a lack of fruits and vegetables), bottle feeding for too long, too much juice and other sugary drinks, using food as a reward, a sedentary lifestyle as learned behavior - then transmitted to children, buying foods on the run, and being unwilling to sacrifice. Genetics was also mentioned as a primary cause. Responses to the question of what causes overweight in preschool children illustrate a combination of internal and external factors. While parents and their behaviors were brought up frequently, many of these behaviors could be the result of the influence of social and cultural forces, especially socioeconomic ones. For example, many brought up the higher cost of healthier foods like fruits and vegetables. Others mentioned the problems of working mothers who provide food to keep their children content or snacks because they are on the run. Many participants mentioned the relationship between television and food. One interesting point made was the "open kitchen" concept which is popular today but means there is more access to food at non-meal times. The popularity of snacking, fast food, processed food, and large portion sizes, often promoted by ads, is a problem. Lack of outdoor play and general inactivity, including less recess time in schools, were also cited as contributors to overweight. Finally, lack of pediatrician intervention was mentioned as a factor.

Risks of Overweight. The general consensus among all staff was that overall wellness in children was dependent upon a healthy weight. The majority of participants mentioned physical problems as a major risk, including diabetes, asthma, high blood pressure, heart disease, and eating disorders. Some mentioned that normal physical development could be hindered and that children could develop hyperactivity or ADHD as a result of a poor diet. Three out of four groups discussed the social stigma of being overweight and how that affects self esteem, social skills, self-confidence, and overall mental health. Overweight children may also learn to use food as a comfort if isolated and stigmatized and develop poor eating habits that they retain into adulthood.

What Can a Parent Do? Most participants emphasized that parents must take responsibility by modeling proper eating habits and exercise themselves. They should try to reduce their own stress, avoid fast food, and get educated on nutrition and exercise. Food should not be given in the car, nor should it be used as a reward. Healthy foods should be introduced when children are very young. Parents should not be afraid to say "no" to their children. One group mentioned how bottle feeding can lead to overfeeding. Another suggestion was for parents to monitor what their children are being fed at day care and that parents should take the time to plan healthy meals. Some discussed that parents blamed genetics and explained how cheaper foods, while less healthy, have a

longer shelf life. While most of the emphasis was on eating habits, three groups mentioned that parents needed to provide more physical activity for their children. Finally, it was suggested that parents seek advice on weight and diet from pediatricians.

Comfort with physical activity and play skills knowledge

Beneficial Effects of Play. Three out of four groups agreed that one hour per day was the government recommendation for the time children should play, but two groups mentioned that it depended upon the child and that more was always better. All of the groups brought up the physical, psychological, and social benefits of play for children. All of them brought up increased self-esteem and a sense of mastery as a result of physical activity. In addition to controlling weight, other physical benefits included more energy, better sleep patterns, better motor development, muscle strength, and coordination. All four groups brought up increased creativity and/or a willingness to try different things in other areas, and the ability to focus better on other activities. More physical activity leaves less time for television, videogames, and other sedentary activities. Television was cited as a major problem, especially because of ads that promote unhealthy foods. More physical activity could help children develop healthier patterns for later life. Finally, the social benefits of play were brought up often; for example, learning to play well with others (perhaps leading to team sports later), creating bonds with friends and family, overcoming shyness, promoting acceptance, and enhancing physical appearance.

Appropriate Physical Activities and Skills. There were some differences between groups on the types of physical activities they would recommend. Some believed that the basics were best, such as running, swinging, jumping, crawling, using little things to step on and playground equipment. Pretend play, such as imitating animals, and using simple tools such as trucks and shovels were mentioned. These things can be done anywhere and allow the child to use his/her imagination. Others emphasized group activities, such as kickball, and still others recommended more formal activities, such as badminton, karate, and dance. Some recommended family activities as a good idea. These differences may be attributable to the age of the child.

With regard to skills that were appropriate, cooperation through group play was mentioned, as well as gross and fine motor development enhancing coordination. Creativity could be developed through imaginative activities.

Barriers to Children's Physical Activity. In all four groups, the issue of lack of time and other demands came up as reported to them by parents, particularly working parents. Being tired and inactive themselves or brought up with exercise as a low priority was cited often as a reason given by parents. Three out of four groups discussed television as a problem, especially when used as a babysitter. Parents see this but they also wanted to get things done. Caregivers, especially grandparents, may use television or DVDs as a way to keep kids content. Some parents say they don't want to go outside with their children if they have other things to do. One person mentioned a handicapped parent who may not be physically able to go out with their children.

There were some differences between urban and rural sites on this question. Urban parents complain about not having a place to play; for example, if living in a small apartment, they are afraid to let their children make too much noise. Safety is also an issue; one person mentioned a park in the city frequented by prostitutes. Rural parents may have more outdoor space, but may also have transportation problems that prevent them from taking their children to parks or other organized activities.

The New England weather was mentioned in all four discussions as a barrier to outdoor activities. Other problems staff have heard from parents were the expense and lack of proper equipment, environmental deficiencies, such as lack of bike paths and sidewalks, fear of kids getting hurt, lack of ideas, and tending to occupy children with DVDs or other sedentary activities.

Comfort with talking to parents about overweight

All participants agreed that approaching a parent about an overweight child was up to nutritionists. While most felt confident with their counseling skills, many expressed caution about approaching parents on this subject. The consensus among all groups was that they test for receptivity first to avoid a defensive reaction. Eye contact and body language are noted. This is a difficult topic for parents, especially if they are overweight themselves. Because of this, sensitivity is required. Some mentioned that they present the topic as objectively as possible by showing the whole growth chart and emphasizing weight as a matter of health. Building rapport with parents was seen as essential if they are going to listen, make changes, and continue to come back. Some mentioned that a parent should see the same person consistently for trust to be established. Handouts, articles, and recipes helped to inform parents, a "softer," less direct approach.

Doctors were mentioned in three out of four groups. Sometimes parents feel there is no problem if doctors have not mentioned it. Participants said they might ask first if a doctor has made any recommendations. They feel that parents believe doctors first.

Finally, one group discussed "Value Enhanced Nutrition Assessment," a new style of counseling which is client-driven, meaning the client must <u>want</u> to address an issue. This is consistent with what was discussed above. Two of the groups mentioned time constraints and seeing clients only every three to six months.

What makes the conversation easier? In addition to parent interest and willingness to take advice, weight is easier to discuss if a parent has a medical problem in the family, such as diabetes, and is concerned about health. Other suggestions by participants for easing the process were to: take a constructive approach; not laying it all out right away but encouraging small steps to try; asking what a parent thinks they can reasonably do; using physical aids; having a goal calendar; promoting a good feeling in parents by encouraging them and recognizing the positive things they are doing.

What makes the conversation more difficult? In addition to lack of parent interest or a defensive attitude, other roadblocks included fear of alienating the parent, inconsistencies among health care providers, especially doctors, and being seen by parents as a

"necessary evil" to get the WIC voucher. In one group, terminology and labeling were mentioned as being offensive.

Facilitators. The process of approaching a parent about overweight children could be facilitated by having more time (they report they only have 15 minutes per family and they need a half hour); having one child at a time; seeing the same client consistently; getting more doctors involved in weight management; lower caseloads; more money; and more staff. One person suggested parenting training for WIC staff.

Comfort in changing others' behaviors

Overall, the participants expressed confidence about changing behaviors in that they had the knowledge, experience, information, and resources to effect change. Only one group seemed less optimistic about client willingness to change (unless there was a medical crisis that forced them to change) and more people in that group felt they could only be a resource, especially if they did not have more time with clients.

What works. What would work best is to have a solid knowledge of human behavior, to provide adequate support for clients, help them to implement small, incremental changes (for example, going from whole milk to skim) which are attainable, and emphasize the positive. Parents may need help learning how to talk to significant others and/or grandparents who may have different perspectives on eating. This can also be a problem for split families. They would emphasize to parents the importance of learning healthy habits young and not to panic when children don't want to eat.

Again participants mentioned seeing the same client consistently as important to offer them support and reinforcement. VENA came up again as a good assessment style. They would also like to see all health care professionals "on the same page," especially doctors. A community-wide effort to raise awareness about overweight and working with good partners on this would help, such as Head Start and the UNH Cooperative Extension Nutrition Connections program. Understanding the differences between rural and urban problems is important when talking to a client.

What does not work. To effect behavior change, it does not help to tell the parent what to do or to insult their parenting skills. One problem mentioned was that food stamps have no restrictions on what you can buy and that media can be a deterrent with promise of magic pills and conflicting advice about how to lose weight. School lunches and shorter recess times were mentioned also. Unhealthy patterns parents have used with other children are hard to break. Some parents use the wrong foods to keep their children happy. Some feel countermanded by doctors who do not suggest diet changes. Time constraints and not seeing the same person consistently were mentioned again and fear of failure and/or losing people if they become offended.

Comfort with staff's own weight and physical activity management

All four groups mentioned that they can often find a point of connection with clients based on their own experiences. It may help to share certain things with clients if you show you can relate to overweight as a common problem and give personal examples. Practicing what you preach can help to convince a client that you are not superior to them or judging them.

There was not much discussion about the participants' own difficulties or experience with their own behavior change. They mentioned that sharing experiences may be useful in building rapport, but often they are rushed and that may prevent a person from opening up to the nutritionist. However, many did say they could understand the problems people face and had difficulties themselves or within their families that helped them to be more empathetic with clients. Only one person said she did not feel empathetic and felt parents needed to sacrifice more for their children.

Additional Resources Requested and Comments

While many said that they understood Fit WIC and its goals and saw this as a priority, there were some concerns about administrative problems and how the program is being implemented. In one group, they wanted the program to be more clearly defined with more guidelines and felt it was over-burdening the staff. Getting parents involved, some who come only to get their vouchers, could be a problem. Other resources they felt were needed were: on-going training, including parenting (especially since problems emerged after the initial training), travel reimbursement (some travel up to an hour away); more space; more staff; more ways to interact with children, especially in groups (problem of the "technical vs. interactive nutritionist"); experiential learning techniques for parents; materials in other languages; offering fruits and vegetables and less cheese. One person asked if the State could be approached to include non-two and three –year olds in the clinic play groups. Bigger beach balls were requested. Giving children something to do while parents were meeting with adults was seen as a positive. Finally, funding was an issue and whether it would be provided and continued.

Conclusions

Participants seemed very knowledgeable about the causes and risks of overweight in preschool children, as well as what interventions could help mitigate it. They brought up the physical, psychological, and social effects of overweight and discussed at length the barriers faced by parents as well as health care professionals in addressing the problem. These barriers could be categorized as both internal and external; that is, much of the discussion centered around parent responsibility and their failure to provide a healthy diet and an appropriate amount of physical activity for their children, but they also discussed the many factors working against parents, such as the stress of working, lack of time to plan healthy meals, the cost of healthy foods, unsafe play areas, lack of control over the food given by child care providers, and counterproductive cultural messages.

Overall, the staff demonstrated their acceptance of nutrition and physical activity messages, offering sound suggestions about what parents could do, but with an awareness of the obstacles parents face. In one group there appeared to be less empathy towards parents and a higher level of frustration towards their behavior, but most seemed to understand the difficulties many face. Urban and rural differences were noted, in terms of levels of physical activity due to living conditions and other environmental factors.

On the staff's perception of their ability to effect change in parent behavior, almost all participants expressed a fair degree of caution. While they expressed confidence in their abilities and felt they had the knowledge, information, resources, and counseling skills to do the job, they did not have as much confidence in a parent's willingness to change. Some felt they could only be a resource and not the direct agents of change. On the other hand, many had a variety of strategies for approaching parents about overweight, including a sensitive approach, client-driven assessment (VENA), objectivity, stressing weight as a health issue, using charts and other visual aids, building rapport with clients, avoiding offensive terminology, encouraging small, incremental changes or attainable goals, and offering on-going reinforcement and support. While there was not as much discussion around their own behavior change, many staff have used their personal experiences and problems as a "point of connection" with parents.

The staff had several suggestions for improving the program, including having more time with clients, seeing the same client consistently, having on-going training and feedback (one group needed more guidelines and specifics), more staff, and in some cases, more space. The staff would also like to see consistent messages about overweight from physicians and other health care professionals and/or agencies who could reinforce Fit WIC messages on nutrition and physical activity. Finally, some wanted to be reassured about funding.

Recommendations

- Provide on-going training and support.
- Arrange seminars on how to open a dialogue with parents, perhaps having the more experienced nutritionists work with those who are less trained.
- Provide parenting training and interactive skill training with children's groups.
- Provide materials in other languages (Manchester).
- Recommend that the State provide more fruits and vegetables and less cheese.
- Recommend that the State provide nutrition and physical activity messages with issuance of Food Stamps.
- Clarify travel reimbursement for staff.
- Develop experiential learning techniques for parents.
- Provide incentives for parents to participate in the program.
- Investigate how time could be used more effectively or how more time could be allowed clients who are willing to work on overweight.
- Investigate feasibility of client seeing the same nutritionist each time.
- Create partnerships with doctors and other health care professionals to help reinforce Fit WIC messages.