Child care providers’ use of role modeling to promote healthy eating

Child care providers play an important role in helping preschool-aged children develop healthy eating habits, food preferences, and dietary intake. Most US preschoolers spend time in non-parental care each week (National Center for Education Statistics, 2015) and many eat half or more of their meals in these settings (US Department of Education, 2006). However, little is known about how child care providers approach feeding young children.

One strategy child care providers can use to promote healthy eating is role modeling. Role modeling is most effective when adults eat the same healthy foods as children (Addessi, et al., 2005), avoid consuming unhealthy foods in front of children (Palfreyman, et al., 2014), and talk enthusiastically about their preference for healthy foods (Hendy & Raudenbush, 2000).

This poster presents findings from a mixed methods study exploring child care providers’ understanding and use of role modeling. First I present a quantitative description of providers’ use of five role modeling behaviors – consuming snack foods, sweets, or soda in front of children, eating the same food as children, and enthusiastically role modeling healthy eating – and explore differences by facility type (Head Start, center-based care, and home-based care). I then present qualitative data exploring providers’ understanding of role modeling and the perceived barriers to role modeling.

Three hundred and forty-three center-based child care providers, Head Start teachers and home-based child care providers completed a 10 page and 95 item survey and a sub-sample of 50 providers completed in-depth phone interviews. Five items from the Nutrition and Physical Activity Self-Assessment for Child Care were used to assess providers’ use of role modeling (Ammerman, et al., 2007). Frequencies and logistic regression models that were adjusted for provider age, race, education, and years employed as a child care provider were used to analyze the quantitative data. Qualitative analysis consisted of moving through the six stages of thematic analysis (Braun & Clark, 2006).

More than 80% of providers in all three facility types reported never consuming snack foods, sweets, or soda in front of the children they cared for and there were no statistically significant differences by facility type. Less than half of the full sample reported always eating the same foods as children and enthusiastically role modeling eating healthy foods. Providers in home-based facilities were statistically significantly less likely to report eating the same foods as children or enthusiastically role modeling healthy eating than providers in center-based facilities or Head Start centers.

Findings from the qualitative interviews suggest that while providers saw eating the same food as children as part of role modeling they did not see enthusiastically talking about a preference for healthy foods as an important component of role modeling. Providers also reported struggling to role model foods that they did not enjoy eating and in some settings limited resources meant providers had to choose between eating the same food as the children and making sure all children had enough food at mealtimes. Implications for future research as well as the development of provider training will be discussed.
References


