



Exploring Family Child Care as a Context For Physical Activity

Exploration de l'activité physique dans les garderies en milieu familial

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Emerging evidence suggests that young children are very inactive during child care. Our aim was to increase our understanding of the family child care environment as it relates to the promotion of physical activity and motor skill development for young children. A survey of care providers' perceptions of predisposing, enabling, and reinforcing factors for physical activity was completed by 138 respondents; additionally four focus group interviews were conducted. Care providers were positively predisposed toward physical activity, yet they encountered barriers associated with the unique circumstance of family child care, including: the diversity of children in care, licensing safety regulations, rules for play indoors, and the size of indoor spaces for play. Care providers felt that resources providing 'how to' ideas that appreciated the distinctive nature of family child care would be useful.

De nouvelles données portent à croire que les jeunes enfants qui fréquentent les garderies en milieu familial tendent à être très inactifs physiquement. Les auteurs ont cherché à comprendre le contexte particulier des services de garde d'enfants en milieu familial dans l'optique de promouvoir l'activité physique et l'acquisition des habiletés motrices chez les jeunes enfants. Un sondage a été mené auprès de 138 gardiennes pour cerner les facteurs de prédisposition, d'encouragement et de renforcement pouvant favoriser l'activité physique. Quatre séances ont aussi été organisées avec des groupes de consultation. Il en ressort que les gardiennes sont favorablement prédisposées envers l'activité physique, mais se heurtent à des obstacles uniques aux garderies en milieu familial, soit la diversité des enfants desservis, les questions de sécurité liées à l'octroi des permis, les règles des jeux intérieurs et la grosseur de l'aire de jeu à l'intérieur. Les gardiennes étaient d'avis qu'il serait utile de produire des ressources pour leur fournir des trucs et des idées qui tiennent compte de la nature particulière des garderies en milieu familial.

Introduction

The 2010 Active Healthy Kids Canada Report Card on Physical Activity for Children and Youth (Active Healthy Kids Canada, 2010) is a call to action for early childhood policy makers, administrators, educators and assistants; health care professionals; recreation leaders; and parents. Rising levels of screen time and obesity among the very young, combined with concerns about physical inactivity and the lack of investment in early childhood has put the early years at the forefront of the 2010 report. A growing body of evidence from Canada and abroad suggests that young children are very inactive during preschool and child care (Brown et al., 2009; Pate, McIver, Dowda, Brown, & Addy, 2008; Pfeiffer, Dowda, McIver, & Pate, 2009; Temple, Naylor, Rhodes, & Wharf Higgins, 2009; Williams et al., 2008) and that opportunities for motor skill development may not be optimal (O'Connor & Temple, 2005; Taggart & Keegan, 1997; Temple & O'Connor, 2004; Trost, Messner, Fitzgerald, & Roths, 2009). The available evidence also demonstrates that the policies and practices of child care centres and preschools strongly influence children's opportunities for physical activity (Bower et al., 2008; Finn, Johannsen, & Specker, 2002; Pate, Pfeiffer, Trost, Ziegler, & Dowda, 2004). Pate and colleagues found that among nine preschools, the preschool attended by the child accounted for 43% of the variability in physical activity.

Given the strength of the relationship between child care centres and physical activity levels, some attempts have been made to understand how child care environments and policies influence physical activity. Recently, Bower et al. (2008) found that the children in centres more supportive of physical activity engaged in higher levels of moderate-vigorous physical activity and spent less time in sedentary behaviour than less supportive centres. The strongest correlate of physical activity and negative correlate of sedentary behaviour was Active Opportunities; which included: occasions of structured physical activity, occasions of outdoor play, and total minutes of opportunities provided. Additionally, the provision of portable play equipment (e.g. balls, hula hoops, and riding toys) and a lack of fixed play equipment were significant predictors of participation. These findings are supported by other studies that report that provision of portable play equipment (i.e. objects and balls) and access to open space (outdoor activity) are associated with physical activity among preschoolers (Brown et al., 2009; Hannon & Brown, 2008). Interestingly, Brown and colleagues found that teacher arranged physical activities indoors (e.g. dancing) were uncommon, but when implemented were associated with relatively high levels of physical activity.

Family child care occurs in a home setting where typically one adult cares for seven or less children (age range 0 to 12 years) at one time. In Canada, approximately 56% of children under age 6, and 51% of those aged 6 to 11 who received non-relative out-of-home care are in a family child care home (Doherty, Lero, Goelman, Tougas, & LaGrange, 2000). This form of child care has been associated with varied provision of physical activity opportunities connected with differences in: adequacy of space for play (O'Connor & Temple, 2005; Temple & O'Connor, 2004; Trost et al., 2009), lack of training (Trost et al.), time spent watching TV and videos (Trost et al.), lack of outdoors time and restrictive rules for play (O'Connor & Temple; Temple & O'Connor), and care providers'

attitudes toward physical activity (O'Connor & Temple; Temple & O'Connor; Trost et al.).

International studies suggest that opportunities for physical activity in family child care may not be optimal (O'Connor & Temple, 2005; Temple & O'Connor, 2004; Trost et al., 2009) and preliminary Canadian data are consistent with these findings (Temple et al., 2009). Using motion sensors (accelerometers) that continuously measured physical activity, Temple and colleagues found that children in family child care spent only 1.8 minutes per hour (or 14 minutes across a typical child care day) in moderate-to-vigorous physical activity; and that sedentary behaviour was high. These findings support Canadian parents' perceptions that group day care centres offer higher quality, more structured, and routine physical activity experiences than home day care settings (Irwin, He, Sangster Bouck, Tucker, & Pollett, 2005). In light of this evidence and in keeping with a settings-based approach to health promotion that acknowledges the influence of place on behaviour (Dooris et al., 2007); our aim was to examine factors within the physical and social context of family child care that may support or hinder children's opportunities for physical activity and motor skill development.

Method

A pragmatic sequential mixed-methods design was used (Mertens, 2005). Administration of a questionnaire (quantitative data) was followed-up with focus group interviews. The aim of both data collection techniques was to explore factors within the physical and social environment of family child care that may predispose, enable, or reinforce children's participation in physical activity and activities to enhance gross motor skill development.

Theoretical framework

This project was guided by the Precede/Proceed model for health promotion planning (Figure 1, Green & Kreuter, 2005). As a planning framework, Precede/Proceed draws on several health promotion and education theories (e.g. health belief model, social learning theory) but is best described as ecological. An ecological model is one that considers multiple level influences on behaviour including intrapersonal (e.g. confidence, self-efficacy), interpersonal (e.g. social support), and community and policy determinants to understand the interrelationships between personal behaviour and environmental conditions for health. This study focused on the education and organizational diagnosis phase of the model which is concerned with identifying predisposing, enabling, and reinforcing factors that affect individual or collective behaviour. In relation to participation in physical activity, these factors can be defined as follows:

- ◆ Predisposing factors are characteristics of an individual, a community, or environment that influences behaviour or conditions related to physical activity participation.
- ◆ Enabling factors are characteristics of an individual, group or environment that facilitate or hinder physical activity participation, including skills or resources.
- ◆ Reinforcing factors are reward, negative effect, or feedback following or anticipated as a consequence of promoting or participating in physical activity.

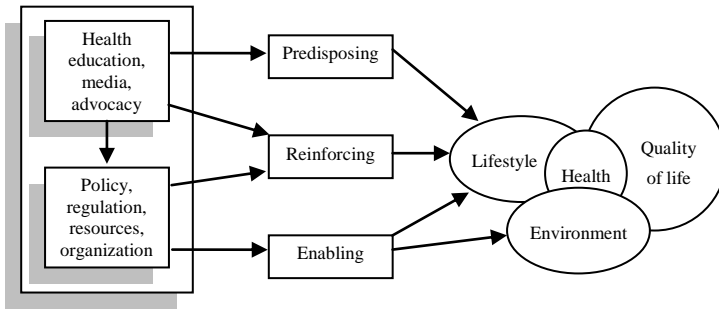


Figure 1. The Precede-Proceed Model for health promotion planning (Green & Kreuter, 2005, p.137).

These factors influence the behaviour differently, however often all three types of factors “are needed in some combination to motivate, facilitate, and sustain behavioural change” (Green & Kreuter, 2005, p.147). Factors identified using this process can be targets for change and/or provide objectives for programs (Green & Kreuter, 2005).

Participants

The sampling frame for this study was family child care providers registered with the Childcare Licensing Branches residing in the Vancouver Island and Interior Health Authority regions in British Columbia ($N = 329$). Questionnaires were sent to all those in the sampling frame and responses were received from 138 care providers (42% response). Focus group participants were those who volunteered for follow-up; four focus group interviews involving 19 participants in total were conducted.

Data collection methods

The care provider questionnaire examined predisposing, enabling, and reinforcing factors and had been previously used to explore the family child care context (O'Connor & Temple, 2005); we also asked care providers to complete the International Physical Activity Questionnaire [IPAQ] (Craig et al., 2003). Questionnaire sections were: 1) Demographic Information, 2) Typical Day Schedule of Activities (indoor and outdoor play - structured and unstructured, travel, screen viewing, naps, and meals), 3) Community Environment (access to parks, playgrounds, and walking; and barriers to physical activity), 4) Spaces and Rules for Play, 5) Equipment Use, and 6) About You (care provider knowledge and care provider physical activity via the IPAQ). Content validity and reliability of the questionnaire (excluding the IPAQ) had been previously established (Temple & O'Connor, 2004) with alpha coefficients for time spent in different contexts ranging from .82 to .96, and percent agreement for activities and equipment ranged from 55% to 79%. Focus group interviews were designed to elicit the care providers’ point of view about their role in promoting physical activity, and facilitators, barriers, and required supports to enhance children’s participation (see Appendix 1).

Procedures

University and health authority ethics approval was obtained and questionnaires were coded and distributed with an informed consent and postage paid envelope to registered family child care providers in the respective health regions. Follow-up questionnaires were mailed to non-respondents four weeks after the initial mail out. Questionnaire respondents who agreed to a follow-up focus group interview were contacted by telephone and invited to an interview.

Data analysis

Questionnaire. The open-ended question related to equipment use was coded using a scheme adapted from the Affordances in the Home Environment for Motor Development questionnaire (Rodrigues, Saraiva, & Gabbard, 2005). Equipment available for physical play was categorized as affording opportunities for fine motor play or gross motor play: body exploration materials, locomotor materials, manipulative materials, musical materials, general physical activity (e.g. ride on bicycles/tricycles), or other. Care provider physical activity level was scored categorically (low, medium, and high) and continuously in metabolic equivalents using the IPAQ scoring protocol (IPAQ, 2005). Descriptive statistics were computed for all variables and associations between variables were explored using Pearson Product Moment correlations.

Focus group interviews. The authors served as the moderator and note taker for the interviews. Audiotapes were subsequently transcribed verbatim by a research assistant. Using a data analysis approach described by Rabiee (2004), each author read the transcripts and observational notes several times to immerse themselves in the detail as well as to gain a sense of the whole. Using an inductive data-driven approach, transcripts were first coded openly, then revisited using axial coding and memoing (Miles & Huberman, 1994) to develop categories, identify relationships, and composite themes and related critical issues. Additionally, we coded the transcripts using a deductive a priori template of codes approach (Crabtree & Miller, 1999). The codebook template was developed a priori, based on the research questions and the theoretical framework. Specifically, the codebook included codes for positive and negative predisposing, enabling, and reinforcing factors. Our framework for interpreting both sets of codes (inductive and deductive) consisted of joint (VT and PJN) consideration of the actual words and their meaning, the context, the frequency and extensiveness of comments, the intensity, internal consistency, and specificity of responses, and larger trends (or big ideas) within these data.

Results

Questionnaire findings

Characteristics of child care providers. Respondents ranged in age from 21 to 66 years (Mean = 42 ± 10 years), and years worked as a care provider ranged from 6 months to 38 years (Mean = 13 ± 8 years). Forty-six percent of the participants engaged in high levels of physical activity per week and a further 42% in moderate levels of physical activity. Six percent of care providers cared for babies (≤ 6 months) and 37% cared for children aged 7 to 12 months. Care providers cared for between 3 and 8 children per week. On average children

spent 8.9 (\pm 1.5) hours per day in care and a ‘typical’ day is summarized in Table 1.

Table 1

‘Typical’ daily activities as a percentage of total hours in care

Activity	Mean (%)	SD
Indoor free play	17.8	11.1
Sleeping	17.1	11.0
Outdoor free play	16.5	9.4
Eating	11.6	5.4
Indoor structured play/activities	10.1	8.6
Quiet time	9.4	7.0
Screen time	6.1	5.8
Outdoor structured play	4.6	4.0
Travel time walking	4.5	4.1
Travel time vehicle	2.3	3.2
Total time in care	100.0	

Knowledge. A majority of care providers (79%) indicated they had quite a bit or a lot of knowledge about physical activity and movement skills. Knowledge gaps reported by some care providers related to facilitating vigorous activity (25%), enriching environments to facilitate movement experiences (17%), and catching and striking skills (11% and 12%, respectively). Almost all (> 95%) rated their knowledge of exploration/ free play and locomotor activities as adequate. Care provider confidence in facilitating physical activity was related to knowledge ($r = .40$, $p < .001$) and perceived barriers ($r = -.25$, $p = .005$); and outdoor play time was associated with care provider physical activity levels ($r = .35$, $p < .001$).

Type of play. The ratio between free play and structured play outdoors was 4:1 and 23% of respondents did not structure outdoor play. Indoor play involved only fine motor or cognitive activities (e.g. puzzles) for one third of participants ($n = 60$). Dance and body exploration activities were rarely mentioned.

Child care environment and equipment. Walking was a relatively uncommon activity, but when mentioned, minutes of walking was associated with number of playgrounds ($r = .24$, $p = .007$) and parks ($r = .48$, $p < .001$) within walking distance and their perceived accessibility ($r = .29$, $p = .001$). Equipment available for gross motor play outdoors was double that available indoors, see Table 2. Care providers also listed the natural environment like rocks and trees as ‘equipment’ for physical activity. The weather was an influential environmental factor; with over half of all survey comments indicating that outdoor play was weather dependent.

Table 2

Proportion of care providers who report having particular types of equipment available for indoor and outdoor physical play

Equipment type	Indoors	Outdoors
	%	%
Body exploration	58.0	93.1
General physical activity	76.3	90.8
Locomotor	53.4	74.0
Manipulative	64.9	89.3
Musical	77.9	----

Rules for play. Mean scores for indoor and outdoor rules for play are presented in Table 3. Use of ride-on-toys, and most manipulative skills and locomotor skills were unacceptable indoors; while dancing, creative play, and throwing soft objects were acceptable. Twelve percent of care providers indicated that striking games were not acceptable in either space.

Table 3

Acceptability of particular movement skills indoors and outdoors

Note. Measured on a five-point scale (1 = not acceptable at all, 5 = very acceptable)

	Indoors		Outdoors	
	Mean	SD	Mean	SD
Running	1.6	1.0	4.9	0.5
Dancing/moving	4.9	0.3	4.9	0.3
Skipping	3.0	1.4	4.9	0.3
Throwing a ball	2.0	1.2	4.9	0.4
Throwing a paper ball	4.0	1.3	4.8	0.7
Jumping	3.7	1.2	4.9	0.5
Creative play	4.9	0.6	4.9	0.3
Hitting a ball	1.4	1.0	4.9	0.6
Obstacle courses	3.6	1.2	4.9	0.4
Bicycles/tricycles	1.4	1.0	4.8	0.9
Bat and ball games	1.2	0.7	4.6	1.0
Kicking a ball	1.5	1.0	4.9	0.5
Other	3.5	1.9	5.0	0.0

Focus group interview results

Table 4 displays key themes that emerged from the inductive and deductive analyses of the focus group interviews. Participants uniformly understood the benefits of physical activity to health, to cognitive development, and for burning off childhood energy. Physical activity and the outdoors were referred to synonymously. Care providers believed strongly that free play outside was essential for development of social and cognitive skills (like sharing, cooperation, and exploration) and also indicated that outdoor play provided a necessary break from structure for both child and care provider. Facilitators of physical activity included the facility/setting, preparation, routine, and having the right attitude. Challenges included the loss of equipment due to regulation changes, caring for a broad age range of children, poor weather, and limitations related to spaces for play.

Table 4

Key themes and exemplary quotes from focus group interviews

	Themes	Quotes
Predisposing	Positive attitudes toward physical activity	<i>“I think physical activity is essential. Kids are such physical beings at that age”</i>
	Knowledge of the importance of physical activity and movement skills	<i>“I know it’s on its way out butto be able to climb trees and swing from things. Builds muscles”</i> <i>I think monkey bars and climbing works towards learning how to print. It develops the kids grasp”</i>
	Physical activity as a routine part of the day	<i>“we go out rain or shine... well we have a mission, we have to get [name] from the bus”</i> <i>“we are in such a routine that we are out early, we head out for a walk, we walk our road and then another road... to the park”</i>
	Preparation	<i>“...for weather, notify the families, lots of gear, songs etc.”</i> <i>“I give them all umbrellas while we are walking”</i>
	Attitude toward structured and unstructured activity	<i>“I believe in the philosophy of providing the equipment and ... let them run with it”</i> <i>“not necessarily led by me but providing the tools that they need.. using their physical abilities... to do what they can”</i>
Enabling	Weather	<i>“Until the [survey] I was a fair weather care provider”</i> <i>“.. there are some days when it is raining so hard that .. [we don’t go out]”</i>
	Concerns about equipment safety regulations	<i>“I guess I will have to get really creative, but there won’t be things that they can climb on because I can’t afford to change my backyard that much”</i>

		<p><i>“just being able to have climbing structures or slides or that kind of thing, with all the new regulation changes I have to get rid of all my equipment”</i></p> <p><i>“children need far more adult facilitation now / hands on”</i></p>
	Facility/setting	<p><i>“I think spaces are a really big factor... I changed my scenario about 6 years ago but not everyone can change their scenario....we renovated our whole house and added an upstairs</i></p> <p><i>“you have to have the right setting for a child to get their physical activity, you have to figure out how to use your yard or whatever to get it”</i></p> <p><i>“we are in a limited space inside and not really safe to play”</i></p>
	The daycare is also my home	<p><i>“some decisions are kind of a compromise on both parts... the daycare needs and my family needs...”</i></p>
	Age spread of children in care	<p><i>“and it is sometimes hard to play those games because you have a seven year old and a two year old that want to play duck duck goose.”</i></p> <p><i>“you can’t really go anywhere with a group when you have six children your whole week.... There is no way you can go walking at the edge of a road ... with two one-year olds and a 2-year old...”</i></p>
Reinforcing	Outdoors as respite from facilitating activities	<p><i>“ I enjoy having a little bit of unstructured play time outside just to be able to, kind of [relax], I have a very structured day with art and circle and taking children to school and lunches..”</i></p> <p><i>“a mini coffee break” “but you do kind of look forward to the outside time as the down time... people in family care are working 8,9,10 hours by themselves...”</i></p>
	Burning off energy helps children relax and assists with management	<p><i>“physical activity burns some steam off for them”</i></p> <p><i>“my primary goal outside is to get them exhausted. It’s good for them”</i></p> <p><i>“it is the best thing that could ever happen to my kids because I keep them so active. They are so stimulated and so relaxed by the afternoon”</i></p>

Discussion

Our aim was to investigate care providers' perceptions of the physical and social environment of family child care as it relates to the provision of physical activity. Specifically, we asked care providers to reflect upon factors that may predispose, enable, or reinforce opportunities for physical activity and motor skill development for children in their care.

Predisposing factors

Care providers were active, confident in their ability to promote physical activity, and they felt their knowledge was adequate. Articulated benefits of physical activity were limited to strengthening muscles, using energy, and settling children. Structured play outdoors was not a priority and appeared to be in conflict with a value system (belief in the social benefits of unstructured play) and context (outdoors is seen as a break from facilitation) that predisposes care providers to free play. This is consistent with parents' perceptions (Irwin et al., 2005) and the views of Australian family child care providers (O'Connor & Temple, 2005). It is also problematic because research demonstrates that time spent outdoors and the presence of equipment does not assure participation in physical activity or engagement in a broad range of activities (Kelly, Dagger, & Walkley, 1989; Taggart & Keegan, 1997; Temple et al., 2009). Rather, research evidence (DeBord, Hestenes, Moore, Cosco, & McGinnis, 2002; Taggart & Keegan, 1997) and expert consensus (National Association for Sport and Physical Education, 2009; Timmons, Naylor, & Pfeiffer, 2007) suggest that facilitation by care providers is an important mediator of engagement and learning. Some balance between child-initiated and care provider facilitated play would help to ensure that a wide range of movement activities were experienced regularly by children; as well as provide some breathing space for care providers who, as one focus group participant indicated "...are working 8, 9, 10 hours by themselves."

Care providers in this study had moderate or high levels of physical activity and this appears to be both predisposing and enabling. Total minutes of physical activity provided for children were associated with care provider physical activity levels. Active care providers may provide more opportunities for children or conversely, an active child care may provide health benefits for care providers. The potential benefits of child targeted health promotion strategies on the adult intermediary should be further explored.

Enabling factors

Space for physical activity and issues related to the interactions between space, rules for play, equipment, and the weather were evident in both the questionnaire responses and focus group interviews. Although children tend to be more active outdoors (cf. Brown et al., 2009), when time spent outdoors is low, little physical activity will be accrued. The 2010 Active Healthy Kids Canada Report Card on Physical Activity for Children and Youth identified the weather as "A Truly 'Canadian' Barrier to Physical Activity" (Active Healthy Kids Canada, 2010, p.15). Consistent with this sentiment, care providers in this study indicated that the weather influenced activity selection across the day, decreasing outdoor play in bad weather. In poor weather the opportunities for physical play and development of a broad spectrum of movement patterns were limited as children largely engaged in fine motor activity indoors, plus the rules and

equipment for play were more restrictive. In contrast, outdoor play had less restrictive rules for play, more equipment for a greater range of activities, and included excursions to neighbourhood parks. The proximity of parks and playgrounds to the home as well as the presence of safe sidewalks were also enabling. Care providers also indicated that many gross motor activities (dancing, jumping, obstacle courses, and tossing paper balls) would be acceptable indoors (see Table 3). This finding is consistent with previous research (cf. Temple & O'Connor, 2004) and indicative of the care setting also being the care providers' home.

Two themes arising from the focus group interviews that were not apparent from the questionnaire responses were the effect of safety regulations (Community Care and Assisted Living Act, 2007) and challenges associated with caring for children of different ages. Care providers' were concerned that the relatively new safety regulations would impact their ability to provide fixed play equipment (e.g. climbing structures). This was a concern to many care providers because renovations to their yard would be expensive and they felt that removal of climbing equipment would require the provision of alternative activities for the children outdoors. As one care provider said "... *I will have to get really creative, but there won't be things that they can climb on*". Care providers also indicated that the range of ages of children in care made facilitating physical activity more difficult. This consistent with previous research in family child care contexts (O'Connor & Temple, 2005; Temple & O'Connor, 2004) and unlike group child care where the children tend to be cared for in more discrete developmental grouping (i.e. infants, toddlers, preschoolers). Care providers reported that the implications of having a wide age range of children in care were: a greater need to stay inside more so that younger children could sleep, walking to the neighbourhood facilities was more difficult, and care providers felt there were safety concerns associated with some play equipment e.g. having balls hit a younger child.

Reinforcing factors

Reinforcing factors are rewards, negative effect, or feedback following an action. Many care providers found outside free play time reinforcing because it was a break from facilitating activities and because the children were more settled when they went inside. As mentioned earlier, family child care providers typically work alone and care for children all day. Therefore these findings are not surprising, however the low levels of facilitation reported may reduce levels of physical activity as well as the range of motor skills experienced by the children. Care providers also found that changes in equipment safety regulations were inhibiting children's typical activities outdoors, and this was placing pressure on care providers to facilitate activities outdoors.

There are limitations of this study which should be acknowledged. Firstly, our survey response rate was 42% and on the whole these respondents were moderately or highly active. These levels of physical activity are higher than the majority of Canadian adults (Public Health Agency of Canada, 2003) and it is likely that our respondents were more predisposed toward physical activity than non-respondents. Being personally predisposed toward physical activity may influence the care providers' practices, and therefore our results may reflect more favourable settings for physical activity. Secondly, our approach has been to

consider care providers' perceptions of the influences on children's physical activity rather than directly measuring children's physical activity as well as aspects of the physical and social setting. Future research would benefit from incorporating more direct measures of children's physical activity as an outcome measure.

The findings from this study suggest that care providers are generally positively predisposed to toward unstructured physical activity; but less inclined to structure outdoor physical activity. Our findings also suggest that constraints within the physical and social environment may limit physical activity opportunities and the range of movement skills experienced by the children, particularly in poor weather. Care providers indicated that the vast majority of time was spent indoors where gross motor play was inhibited by rules for play and a lack of space and equipment. Care providers also believed that changes to equipment safety regulations would require an increased level of adult engagement to facilitate physical activity.

Caregivers such as parents, care providers and preschool teachers are the gatekeepers of opportunities for physical activity and motor skill development of young children. The available evidence suggests that during formal care children are insufficiently active and that motor skill development opportunities are not optimal. Care providers in this study indicated they were positively predisposed toward physical activity. However, they also said they experience unique barriers to optimizing physical activity and motor skill development. Although the care providers felt that resources to help foster physical activity may be useful, they also felt that any resources developed would need to consider and respect the unique circumstance of family child care context, including: the diversity of children in care, licensing safety regulations, rules for play indoors, the size of indoor spaces for play, and that the care environment is also the care providers' home.

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Appendix 1

Focus group interview schedule

Define physical activity for the participants:

Physical activity is where most of the body is moving for example: riding a tricycle, running, or helping in the garden. It would not include quiet play such as puzzles or drawing.

1. What role does physical activity play in the development of preschool aged children?
 2. How much physical activity do children participate in during family child care?
 3. What kinds of physical activities should children participate in? (e.g. informal play; activities structured so that children develop / learn new skills; activities that make them huff and puff).
 4. How would you describe the care providers' role as it relates to providing physical activity for the children in care?
 5. What do care providers provide in the way of physical activity during a typical day?
 6. What are the things that make providing physical activity for the children in care difficult?
 7. What are the things that make it easy to provide physical activity opportunities easier?
 8. What would help care providers provide physical activity opportunities?
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