Engaging Caregivers in School-Based Obesity Prevention Initiatives in a Predominantly Latino Immigrant Community: A Qualitative Analysis

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ABSTRACT

Objectives: To explore caregiver perceptions of, and barriers and facilitators to, their involvement in school-based obesity prevention programs in underserved Latino immigrant communities.

Methods: Focus groups discussions were conducted with caregivers (n = 42) at 7 elementary schools with an academic partnership-based obesity prevention program. Thematic analysis was used to identify key findings in the data.

Results: Caregivers described their role as (1) learners of new and often complex health information using their children as primary messengers and (2) champions within their homes in which healthier choices are assimilated. Barriers to involvement included lack of time, financial pressures, unhealthy family practices, and concern that attempts to engage peers would be perceived as intrusive. Facilitators included assurance that stigmatizing health issues would be addressed with sensitivity.

Conclusions and Implications: Caregiver involvement in obesity prevention may be fostered by transmitting information through children, addressing cultural barriers, and avoiding potentially stigmatizing approaches to delivering health messages.

Key Words: school, health promotion, obesity, Latino immigrant, caregiver (*J Nutr Educ Behav*. 2017;49:53-59.)

Accepted August 8, 2016. Published online September 28, 2016.

INTRODUCTION

Immigrant minority children in underserved urban areas are disproportionately affected by obesity and its associated health-related consequences. The prevalence of childhood overweight and obesity approaches 50% in New York City communities such as Washington Heights, whose inhabitants are predominantly immigrant and Latino, compared with 20% for New York City as a whole.[1] Environmental factors in such communities, such as poor access to affordable nutritious foods, combined with underlying social determinants such as poverty, create a "perfect storm" of vulnerability for this health epidemic.[2]

Family and culture (defined as shared characteristics among a group or community) also play complex but important roles in the obesity epidemic. Studies have explored the complex relationship between cultural traditions, perceptions, behaviors, and higher rates of obesity in various Latino groups, including first- and second-generation immigrant groups.[3,4] In many first-generation immigrant Latino communities (defined as those who have moved to another country to take up permanent residence), traditional beliefs about feeding, such as the belief that providing an abundance of food is an indicator of good parenting, can promote obesity.[5,6] In some Latino communities, the perception that a heavier child is a "healthier child" may lead to less engagement with prevention or treatment efforts for obesity.[7] The relationship between culture and obesity is complex and ever-changing as culture shapes health behaviors and experiences while at the time becoming shaped by health outcomes and experiences of groups and communities over time. The effect of acculturation on obesity in immigrant communities has also been documented.[8] Length of stay in the US, family dynamics, and neighborhood factors have all been implicated in the relationship between acculturation and obesity.[9] Whether or not acculturation increases or decreases obesity continues to be investigated.

Obesity prevention initiatives with the greatest potential impact are those

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http://dx.doi.org/10.1016/j.jneb.2016.08.004

based on a social-ecological framework that addresses individual, family, and community factors that influence child behavior.[10-13] Community-academic partnerships,[14,15] such as those that integrate such efforts from academic medical centers with schools in the community, are beginning to have an impact, although engaging caregivers (such as parents and other guardians) in these settings continues to be a challenge. Social marketing techniques have been used as a strategy to promote caregiver involvement in school-based settings.[16] Still, the most effective engagement methods to use in underserved communities with immigrant families remain uncertain. Immigrant caregivers may feel inhibited from involvement in school activities, believing that it is the teacher's job to educate a student and that their participation could be considered an intrusion into the teacher's territory of expertise.[17-19] In immigrant households in which family members are undocumented, fear of deportation may prevent parents from communicating with official institutions such as schools.[20] Finally, caregiver involvement that relies on the passive exchange of written information home may be inaccessible for those with low English literacy levels.[21]

Founded in 1999, *Choosing Healthy and Active Lifestyles for Kids* (CHALK) is a school-based wellness program based onthe social-ecological model for behavior change.[22-24] Its primary goal is to collaborate with schools and the community to promote healthy behaviors and lifestyles. A social marketing campaign is promoted through weekly newsletters and postings, nutrition lessons, school-wide nutrition fairs, school farmer's markets, and provision of fitness programs in the schools. Specific interventions are geared toward the children as well as the influential adults in their lives. Environmental-level programs and policies aim to address availability of healthy foods offered in the cafeterias, vending machines, and local food retail stores around the school community and to promote instituting the 120 minutes of physical activity per week required by New York State's Education Department.

At the time of this study, CHALK served 7 elementary schools in New York's Harlem, Washington Heights, and Inwood communities, including more than 5,000 children in grades Kindergarten through 5th grade. A part-time Family Care Worker (FCW) and program manager were employed in each school. Community members and caregivers themselves, FCWs assisted with the implementation of social marketing activities and events, reached out to caregivers to invite them to activities, served as liaisons between families and school or CHALK staff, and provided interpretation services (English/Spanish) when needed.

In an effort to explore caregiver involvement in obesity prevention programs in schools, FCWs conducted focus groups with caregivers from participating schools to (1) explore how caregivers define and perceive their involvement in school-based health promotion programs and, in particular, obesity prevention programs such as those supported by CHALK and (2) determine barriers to and facilitators of caregiver involvement in these health promotion efforts.

METHODS

Caregivers from all 7 CHALK schools were recruited through the use of a convenience sampling approach. Signs were posted in English and Spanish throughout each school, inviting caregivers to attend a focus group. At caregiver meetings held in the month before the focus groups, FCWs at each school announced plans to convene these groups. The first 10 caregivers responding from each school were invited to participate. No caregivers volunteering to participate in focus groups chose later to opt out. On average, 6 caregivers, (range, 4–11) attended on the day the groups met. Institutional Review Board approval was obtained from both Columbia University Medical Center and the New York City Department of Education before the study was conducted.

Questions for discussion in focus group meetings were developed by the investigators and CHALK staff and reviewed and edited by content experts at Columbia University Medical Center (Table 1). The questions were directed at gaining a better understanding of (1) caregivers' opinions regarding health programs in schools; (2) caregivers' specific roles in health promotion inside and outside of school; (3) barriers to caregivers' involvement; and (4) ideas for extending their involvement in promoting their children's health.

Table 1. Focus Group Questions Assessing Caregiver Perceptions, Barriers, and Facilitators to Their Involvement in School-Based Health Education Programs

Parent perceptions and roles in health promotion/obesity prevention

1. What do you think about health programs in schools?
2. What is their purpose?
3. What do you feel about your children learning health information in school (as compared with non-health curricula such as math and science)?
4. How can parents be involved in the health promotion of their child in school?
5. What about outside of school?
6. What sorts of things have you done to participate in health promotion for your child?
7. What programs have you participated in?
8. What about changing the routines that you have at home?
9. What about changing what you buy at the store?
10. What about talking to your kids about what they have learned?
11. How important or unimportant is this role that you play in helping your kids to change?
12. Who else do you think should be involved in the health promotion of your child?
13. How should they be involved?

Barriers and facilitators to parent involvement

1. What are some barriers that make it hard for you to do these things?
2. What are some things that make it easier for you to get involved?
3. What kinds of changes would you like the program to do in order to help you become involved in the health promotion of your child?