



Research report

Qualitative study of influences on food store choice ☆

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ABSTRACT

Previous research indicates food store choice influences dietary intake and may contribute to health disparities. However, there is limited knowledge about the reasons which prompt the choice of a primary food store, particularly among populations vulnerable to obesity and chronic diseases (e.g., individuals living in rural locations and African-Americans). Purposive sampling was used to select rural and urban communities (three African-American and two Caucasian focus groups; $n = 48$) in Arkansas from June to November 2010, allowing examination of potential racial or rurality differences. Primary household food shoppers ($n = 48$) (96% female, 63% African-American, mean age = 48.1 ± 13.9 years old, mean BMI = 30.5 ± 7.8) discussed reasons for choosing their primary store. Qualitative analysis techniques—content analysis and constant comparison—were used to identify themes. Four themes emerged: proximity to home or work, financial considerations and strategies, availability/quality of fruits, vegetables, and meat, and store characteristics (e.g., safety, cleanliness/smell, customer service, non-food merchandise availability, and brand availability). While there were persistent rurality differences, the relevant factors were similar between African-American and Caucasian participants. These findings have important implications for future policies and programs promoting environmental changes related to dietary intake and obesity, particularly in rural areas that appear to have significant challenges in food store choice.

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Introduction

Environmental aspects of dietary intake (e.g., food stores, restaurants) have emerged as a key consideration in risk for chronic diseases, as these environments may broadly impact health (Popkin, Duffey, & Gordon-Laren, 2005). Research has illuminated significant disparities in access to nutritious dietary options, particularly among racial minority and rural populations. In the United States, nutritious foods (e.g., fruit, low-fat milk) tend to be less available in areas with a higher proportion of African-Americans (Baker, Schootman, Barnidge, & Kelly, 2006; Hosler, Varadarajulu, Ronsani, Fredrick, & Fischer, 2006) and in rural communities (Dean & Sharkey, 2011; Sharkey, Horel, & Dean, 2010), and nutritious food availability is associated with dietary intake (Cheadle et al., 1991, 1993; Fisher & Strogatz, 1999). A significant determinant in nutritious food availability is the accessibility of supermarkets (Block & Kouba, 2006; Chung & Myers, 1999;

Connell et al., 2007; Jetter & Cassady, 2006; Liese, Weis, Pluto, Smith, & Lawson, 2007; Sallis, Nader, Rupp, Atkins, & Wilson, 1986); yet, supermarkets are less frequently located in communities with a high proportion of African-American residents (Baker et al., 2006; Liese et al., 2007; Moore & Diez Roux, 2006; Morland, Wing, Diez Roux, & Poole, 2002; Powell, Slater, Mirtcheva, & Chaloupka, 2007) and in rural areas (Connell et al., 2007; Powell et al., 2007). Therefore, racial minority and rural populations that are at greater risk for obesity (Flegal, Carroll, Ogden, & Curtin, 2010; Wang & Beydoun, 2007), and diet-related chronic diseases (Banks, Marmot, Oldfield, & Smith, 2006) may find availability of nutritious foods is a major obstacle to consuming a health-promoting diet.

Although the availability of nutritious foods is plainly a significant influence on dietary intake, the accessibility of nutritious foods is likely driven by other factors, including price and quality (i.e., freshness). Specifically, many nutritious foods are more expensive than less nutritious items (Jetter & Cassady, 2006; Liese et al., 2007). In addition, supermarkets (which are not as frequently located in locations with a high proportion of racial/ethnic minority residents, with a lower average socioeconomic status, or in rural areas) have been shown to have lower overall prices than grocery or convenience stores (Chung & Myers, 1999; Liese et al., 2007). Finally, research has demonstrated that store size is also associated with food quality (Connell et al., 2007).

Thus, emerging research supports the importance of availability, pricing, and quality of foods and store type/size in relation to

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the consumption of these foods; however, previous research has largely not examined the reasons for food store choice. The few studies that have reported on reasons for food store choice have focused on low-income residents (D'Angelo, Suratkar, Song, Stauffer, & Gittelsohn, 2011; Wang et al., 2008; Wiig & Smith, 2009) and Latinas (Ayala, Mueller, Lopez-Madurga, Campbell, & Elder, 2005); however, reasons for food store choice in a broader sample of individuals have not yet been examined. In addition, the questionnaires used in these studies were limited in scope and the degree to which they were developed based on community input is unclear, so it is uncertain as to whether they accurately represent the diversity of community perceptions.

Qualitative methods, including focus groups, are considered an important approach to gain an in-depth understanding of community perceptions (Speziale & Carpenter, 2007) and for informing quantitative assessments of relationships between complex conditions and subjective responses (Hsieh & Shannon, 2005). The purpose of this study, which used focus group methodology, was to gain an in-depth understanding of the reasons for choosing their primary food store and examine potential racial or rurality differences in these reasons.

Methods

Setting

The site for this study was purposively selected because of the mix of urban and rural areas and the proportion of African Americans in Arkansas (16% African American (United States Census Bureau, 2010)). The majority of the population lives in a rural area, with 55 of 75 counties classified as non-metropolitan (Rural Policy Research Institute, 2006), based on the definition that all counties not part of a metropolitan area are considered rural (Office of Rural Health Policy, 2009). The study included five focus groups conducted with individuals who resided in four Arkansas communities (two focus groups were conducted in one community), that represented diverse perspectives.

The five focus group can be described as:

- *Rural African American focus group*: This rural town has approximately 1200 people, who are predominately identified as African American (63% African American, 37% Caucasian) (United States Census Bureau, 2010).
- *Rural Caucasian focus group*: This rural town has approximately 600 people, who are predominately identified as Caucasian (70% Caucasian, 30% African American).
- *Urban African American & Urban Caucasian focus groups (two separate groups)*: This metropolitan area is the largest city in the state, with approximately 193,000 people and with substantial populations of both African American and Caucasians (43% African American and 50% Caucasian).
- *Small City African American focus group*: This small city has approximately 49,000 people, who are predominately identified as African American (76% African American, 23% Caucasian).

Participant recruitment

Participants were recruited through established networks of community organizations across the state, facilitated by the inclusion of a community liaison in every stage of this research. We employed a multi-component recruitment approach, including: (1) direct, community-based efforts using small media (e.g., posters in local businesses, notices in churches or newsletters); and (2) targeted invitations to known community gatekeepers likely to know potentially eligible participants. Interested individuals were in-

vited to call the research team to learn more about the focus groups and to complete a phone screener to determine eligibility. To be eligible to participate, an individual had to be: (a) at least 18 years old, (b) the primary food shopper for a household with a minimum of two individuals, and (c) not following a particular diet requiring shopping at a particular store (e.g., gluten intolerance). Only one member of a household could participate. Consistent with recommendations for the planning of focus groups (Morgan, 1997), participants were recruited into focus groups that were homogeneous for race (i.e., each focus group was designated as recruiting African Americans or Caucasians) and rurality (i.e., each focus group was designated as being located in a specific community).

Data collection

After informed consent was reviewed orally (with opportunity for questions) and obtained in writing, the focus group was conducted and sociodemographic data were collected through questionnaires. Measured body weight and self-reported height were collected on all focus group participants, and body mass index (BMI; weight [kg]/height [m²]) was calculated. The focus group guide was developed by the first author; it was reviewed by the other members of the research team and revised. Following the focus group guide, participants were asked a series of semi-structured, open-ended questions such as "How do you go about choosing where you typically buy your food?" Probe questions were used to expand discussion. Focus groups took place in community locations convenient for participants (i.e., churches and community centers). All focus groups were scheduled in the evening hours, for the convenience of the participants. The focus groups ranged in length from 61 to 96 min, and all study participants received a \$20 gift card for participation.

All focus groups were conducted by an experienced African American or Caucasian facilitator, depending upon who was the race-concordant individual. The investigator who was not facilitating the focus group assisted by observing and taking notes during the focus group. All focus groups were digitally recorded and the study was approved by the institutional review board at the University of Arkansas for Medical Sciences.

Data analysis

Digitally recorded sessions were transcribed verbatim, by an experienced transcriber; transcripts were then reviewed with the digital recording to ensure accuracy. Five coders who were members of the research team (one of whom was also a focus group facilitator) read the initial focus group transcript to develop codes based on repeated themes. The final codebook included 10 themes and operational definitions. The second focus group transcript was then read and coded independently by the same five coders, who then met to discuss discrepancies in coding and reach consensus on coding decisions. The remaining three focus group transcripts were then coded by the first author, based on the codebook.

The investigators employed the qualitative techniques of content analysis and constant comparison (Hsieh & Shannon, 2005; Speziale & Carpenter, 2007). Once code words were assigned to pertinent sections of data according to line number (content analysis), these were entered into Ethnograph v6 qualitative data management software (Qualis Research, Denver, CO), which allows data to be segregated according to code words to assist with analysis. Findings were compared across interviews to determine differences and similarities in the data (constant comparison). Similar coded segments were aggregated into larger blocks of data and then into themes reflecting data reported by

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