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Perspectives of Community Health Advocates: Barriers to Healthy Family Eating Patterns

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INTRODUCTION

Risk factors for diet-related diseases including obesity are more prevalent in low-income areas and minority populations.¹ The increasing rates of obesity have challenged researchers to identify contributing behaviors to this epidemic such as poor nutrition. Changes in diet to include healthier food can modify one's risk of developing chronic diseases. The promotion of family meals has been suggested as a possible protective factor for obesity because of the positive associations with healthful food intake.²⁻³ Studies have found that adolescents who participate in family meals have greater intakes of nutrients, grains, fruits, vegetables, and lower amounts of fried foods and soft drinks.⁴ One additional reason why the family meal has an impact on the quality of nutritious food is that approximately 68% of the total calories consumed are from foods prepared at home.⁵ A few studies that have examined the

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frequency of family meals by ethnicity/race suggest that African Americans (AAs) as a group tend to have a lower frequency of family meals compared to other ethnic groups.⁶⁻¹⁰ An understanding of the root causes of health disparities as related to eating habits as well as the factors that shape eating behavior is needed.¹¹

Improving health through nutritional diets is addressed in Healthy People 2020.¹²⁻¹³ The national overarching goals of Healthy People 2020 include eliminating health disparities among different ethnic groups in the population, and creating social and physical environments that promote good health for all.¹² It also encourages healthy behaviors across all life spans. Encouraging healthy eating with minority and disadvantaged populations through frequent family meals is an attempt to address the overarching goals of Healthy People 2020.¹³

Focus groups are a useful qualitative method to identify cultural beliefs and perceptions of a group prior to designing and launching an intervention program.¹⁴ Fulkerson, et al.¹¹ used focus groups to identify perceptions of parents on the barriers of family meals prior to organizing interventions to overcome those barriers and promote healthful eating at home. The purpose of this paper is to characterize findings from a focus group conducted to be used as a formative evaluation in planning a program centered around healthy eating, family meals, meal planning, food preparation, and communication around the table. The focus group was comprised of Community Health Advocates (CHAs) who live and work with families in identified health disparity zip codes.¹⁵

Family Systems Theory

Family members influence the actions of one another. When parents participate in routines such as planning meals and communicating at mealtime, they serve as examples to their children; and parents' behaviors are often replicated by their children.¹⁶ Family systems theory has been effectively used to look at health behavior.¹⁷ Researchers selected the theory to guide the understanding of healthy eating and family communication in this study.

Specific Aims

The specific aims of this study are to assess CHAs' beliefs and perceptions about barriers related to eating healthy family meals, meal planning, and communication around the table.

METHODS

Participants

The participants consisted of CHAs. They were recruited for this study because they live, worship, work, and/or were raised in the communities of interest and have experience working with those who live in health disparity zip codes. These CHAs were a unique cohort of key informants with deep ties within the minority community. Developed and maintained within the catchment area over the past six years as part of a larger community engagement program focused on eliminating health disparities, the CHA program is a unique opportunity for community stakeholders to become involved in community based participatory research.

All CHAs who are active in the program participated in this focus group. CHAs are involved in planning, interpreting, recruiting, advising, implementing, reporting, and a variety of other roles regarding consumer advocacy, disease prevention, and program evaluation. The only requirements for "active" status as a CHA are completion of an online curriculum program and implementation of disparity-focused programs within designated zip codes. The curriculum was developed to ensure CHAs were well-equipped with the tools and

knowledge to respond to basic health issues and disease-specific questions and to provide CHAs with information needed to identify health disparities prevalent within their communities. The CHA program helps to maintain consistency of information disseminated to the general public through these means as well as other formalized training and workshops. The CHAs were the group selected for the focus group due to their knowledge of the population and their potential involvement in the future by bringing this information to families. Also, their practices, perceptions, and views are reflective of the community in which they live and serve.

The study received Institutional Review Board approval. The focus group participants were recruited through e-mail invitations to CHAs living in the area who participate in monthly CHA meetings. Written consent to participate in the study was obtained from them. This exploratory pilot project was undertaken to understand beliefs and barriers to eating healthy family meals, meal planning, and communication around the table.

The ultimate goal of this project is to improve the health of minority populations through the promotion of frequent, healthy family meals.

Setting

The CHAs live and work in the specified health disparity zip codes. The health disparity zip codes identified in this research project were selected because greater than 30% of the individuals in these zip codes were living below the poverty line and 92% of population was AA. Individuals from these health disparity zip codes have higher rates of mortality from cancer and cardiovascular disease.¹⁵

Data Collection

The focus group was conducted using established methodology.¹⁸ The research team drafted the semi-structured interview guide, which included open-ended questions related to beliefs about and barriers to frequent, healthy family meals, meal planning, and communication around the table. The questions were reviewed for content and readability (see Table 1).

The focus group session lasted about 90 minutes. The investigator first greeted the CHAs and obtained their informed consent with assurance of the confidentiality of responses. The CHAs who agreed to participate responded to open-ended questions posed by the researcher. The focus group session was recorded using an audio tape. A second researcher took notes of participants' comments as well nonverbal behavior. At the end of each question the PI verified the discussion points, summarized responses using themes identified throughout the discussion, and welcomed input from participants on any missed points.

Participants of this focus group were not compensated but were requested to keep all discussions confidential. Later, one researcher transcribed the recordings, and the second researcher reviewed the transcript for accuracy. Audio tape recordings, notes, and transcripts were stored in locked cabinets.

Data analysis involved examining, categorizing, tabulating, mapping, and interpreting the transcripts. The research team carefully reviewed the focus group transcript for general themes in the discussion. The analysis involved separating the transcript into different discrete idea units. Then each idea unit was entered as a distinct line item in a spreadsheet and the units were sorted into categories. The larger categories were formed by grouping similar idea units together, and they were sorted to create distinctions among them. The researchers reviewed the themes independently and mutually agreed upon the recurring consensus themes.

RESULTS

Participants

All participating CHAs in the focus group were female ($n = 18$). Eighty-one percent of them were AA, 7% white, and 11% Hispanic. Eighty-five percent of participants had earned either a bachelor's degree or a master's degree. The largest age group of participants was 51-65 years old (22%), followed by 41-50 year olds (19%) and 31-40 year olds (19%). Sixteen or greater, and 9% to 30 years old.

Data Analysis

The three main topics regarding beliefs and barriers that were discussed in the focus groups were: (1) barriers to frequent, healthy family meals; (2) meal planning; and (3) communication around the table. Table 1 lists questions used when interviewing CHAs regarding barriers to healthy eating and frequent, healthy family meals within their own families and the families that they serve. The following themes were identified by the CHAs as beliefs and barriers.

A. Beliefs and Barriers to Frequent, Healthy Family Meals

- **Busy schedules:** A familiar theme that surfaced from the focus group sessions was busy schedules. According to one participant, "It is so difficult to plan meals because everyone is on a different schedule. One child is at soccer practice and one is at football."
- **Insufficient space for the whole family to gather at the same time:** One participant commented on how everyone eating together around a table is difficult at dinnertime: "It seems like everyone is eating at the same time but in different parts of the home. They don't all eat together in one place. This is not good." A simple reason for this occurrence was offered by one participant: "Oftentimes there is not enough room for everyone to sit at the table at the same time. We often sit in other areas of the house."
- **Picky eaters:** According to one CHA, "I have very picky eaters, and it is hard to find a meal that they both like." She stated, "We all ate what my mom cooked; children should not have so many choices."
- **Socioeconomic factors:** CHAs indicated that a significant challenge of individuals in low income areas is their inability to buy healthy food that is more expensive compared to less healthful food that is typically inexpensive.
- **Need to educate:** CHAs acknowledged the perception that healthy foods taste bad, and they voiced the need to teach people that healthy food can taste good too. "We need to educate the population about what foods are healthy. Young people do not know what healthy foods are." Lack of cooking skills was indicated as another contributing factor to lack of healthy family meals. "Young people need cooking classes."
- **Availability of markets:** Many participants indicated that supermarkets with healthy food items are not located in their zip code areas, but convenience stores and fast food restaurants are plentiful.

B. Meal Planning

One CHA shared that many people do not know how to plan meals and prepare food. Several identified that the individuals with whom they work do not frequently observe pre-

planning meals. While one participant admitted that she could seldom plan for a week at a time, another said she based her menu on what was on sale at the grocery store.

C. Barriers to Communicating around the Table

- **Modern electronics:** Modern electronics are one of the leading causes of barriers to family meals. If everyone is watching TV while eating, then there is no intention of carrying on a meaningful conversation with the other family members in the same room. "I feel like one of the greatest barriers to family meals is all the distractions such as TV, cell phones, and texting. It seems like everyone likes to eat in the living room around the television. The TV has become the center of our homes."
- **Generational differences:** Generational differences were also considered an obstacle to communication at mealtime and continued conversation because the older generation was perceived as having trouble understanding the slang of the younger generation. One CHA expressed concern that due to infrequent family meals and reduced communication, families are no longer sharing stories. She said that stories about family history have always been part of AA culture and used as an effective tool to teach the next generation. As a strategy to promote mealtime conversations, she recommended that older family members should share stories about their lives with the younger family members. Narratives about the importance of graduating and working to buy a new car can communicate valuable lessons to the younger generation.
- **Financial stress:** The final barrier discussed was the effects of the current economy on family budgets. The tight economic conditions and uncertainties associated with them are adding to the stress and causing family members to avoid talking with each other.

DISCUSSION

Education was cited as an important method to help this community learn cooking skills and identify healthy vs. unhealthy foods. Requests were made for cooking demonstrations that would include preparing healthy foods with flavor and taste testing. Meal planning was identified as another important area to be included in a family meal intervention class. Participants stated that such a class should include education on preparing healthy meals ahead of time that can be frozen and cooked at a later date. A genuine interest was expressed in learning creative ways to make frequent family meals a reality. Many participants viewed meal planning as an important skill related to the frequency of family meals, which corresponds with the results described in the literature. Women who plan meals ahead of time were twice as likely to eat more vegetable servings each day.¹⁹⁻²⁰ Research has also shown that individuals who pre-plan their meals eat healthier diets compared to those who buy food or meals on impulse.¹⁹⁻²⁰

Communication around the table was identified as a high priority. CHAs expressed regret that families now watch television during mealtime and no longer enjoy conversations at the table as they once did. Many participants believed that the stories told around the table help with teaching values to the younger generation. This corresponds with the literature that has identified that families who consistently celebrate life together at the dinner table create deeper relational bonds.²¹ Fulkerson, et al.²² observed racially diverse, low-income urban youth over a 3.5-year period (6th grade to 8th grade) to examine the link between the frequency of family meals and the frequency of parent-child communication. Fifty-one percent of participants in this study were black youth. Results indicated that the impact of

family meal frequency on adolescent perception of parent-child communication was highest for AA youth compared to Latino and white youth. Also, researchers found that the communication level, as measured by scaled scores, was positively related to the frequency of family meals.²² This study identified that evidence-based interventions regarding effective communication at meals is warranted.

The Family systems theory (FST) is a framework that helps identify the influence of the family system on health behaviors. The FST postulates that functional families manage day-to-day life through supportive family interactions.²³ FST identifies the importance of establishing and participating in routines such as planning meals and communicating at mealtime, and how these activities are modeled and passed down to the next generation.¹⁶

Many participants indicated that supermarkets with healthy food items are not located in their zip code areas, but convenience stores and fast food restaurants are plentiful. This is consistent with the literature that has identified that local and large chain grocery stores have been replaced by convenience stores in low income areas.²⁴ Researchers have also associated a relationship between healthy food intake and access to supermarkets.²⁵⁻²⁶ Studies have shown that adolescents whose families had access to chain supermarkets had lower BMIs, whereas teens whose families lived close to convenience stores had higher BMIs.²⁷ One researcher found that if AA families had an additional supermarket for grocery shopping in their community, their fruit and vegetable intake increased by 32%.²⁶ Resources that list the closest supermarkets, fruit stands, and farmers' markets are necessary tools to include in a family meal intervention program. This topic needs to be further explored.

As described earlier, the purpose of this study was to characterize findings from a focus group to identify beliefs and barriers to frequent, healthy family meals to aid in the crafting of a framework for a relevant, culturally sensitive, healthful eating, family meal intervention program. Findings from the focus group identified specific topics for such a framework.

LIMITATIONS

The generalizability of these results is limited due to the sample size of this study and the specific geographical location. This study did provide some insights about beliefs and barriers to frequent, healthy family meals at the table of households located in health disparity areas, but further research is needed in this area.

CLINICAL IMPLICATIONS AND CONCLUSIONS

Health care providers could utilize the findings from this study to raise awareness of the many challenges families residing in health disparity zip codes face regarding meal planning, preparing food, and communicating around the table. Education is needed in the area of planning, purchasing, and preparing low cost, healthy meals that are tasty. Families may benefit from cooking classes and having the opportunity to be involved in the process of preparing and tasting meals.

Encouraging families to communicate through story telling was identified as a helpful means of communication in this population. Encouraging families to turn off cell phones and the TV during mealtime to reduce distractions would be one strategy to help them share stories around the table. Researchers could further explore beliefs and barriers to identify effective strategies to encourage healthy eating patterns for families who reside in health disparity zip codes.

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Table 1**Semi-Structured Interview Guide**

Beliefs of and barriers to healthy eating and frequent, healthy family meals in the population that the CHAs serve:

1. What do you feel are the greatest barriers to frequent family meals?
2. What do you feel are the greatest barriers to healthy family meals?
3. How often do you feel that a busy schedule prevents you from preparing frequent family meals?
4. Do you feel lack of cooking skills contributes to not having frequent family meals? If so, how often?
5. How do you make your family meals healthy?
6. In your opinion, what has been the most helpful strategy to make family meals a reality?

Meal planning in the lives of CHAs:

7. How often do you pre-plan your meals (i.e. you know by 9 a.m. what you plan to eat for dinner)?
8. How often do you plan a menu for 2-3 days at a time?
9. How often do you plan a menu for a week at a time?
10. Do you shop for groceries with a list of ingredients needed for specific meals?

Communication around the table in the lives of CHAs and the population that they serve:

11. What strategies have you used that encourage conversations around the table?
 12. In your opinion, what are the greatest barriers to communication around the table?
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