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A Qualitative Study of Acculturation and Diabetes Risk among Urban, Immigrant Latinas: Implications for Diabetes Prevention Efforts

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Abstract

Purpose—The purpose of this qualitative study was to understand how acculturation influences diabetes risk among urban, immigrant Latinas (Hispanic women).

Methods—Five focus groups were conducted with 26 urban, immigrant Latinas who were at high clinical risk for developing diabetes. The focus group sessions were audiotaped and transcribed verbatim. The authors independently analyzed transcripts using an inductive method of open coding, and themes were established by consensus among authors.

Results—All of the participants were foreign-born and had low levels of acculturation. During the acculturation process, they noted changes in their lifestyle behaviors and the family context in which those behaviors are shaped. They reported that since living in the U.S., their improved economic circumstances led to increased consumption of less healthy foods and beverages and a more sedentary lifestyle. They also described changing family roles and responsibilities, including working outside the home, which constrained healthy food choices. However, they perceived that their position of influence within the family offered opportunities to help family members prevent diabetes.

Conclusions—Lifestyle interventions to prevent diabetes in Latinas should address their acculturation experiences, which impact family functioning and health behaviors related to diabetes risk. For example, given the perceived link between Latinas' improved economic circumstances and their diabetes risk, prevention programs should incorporate strategies to help Latinas avoid adopting less healthy lifestyle behaviors that become affordable during the acculturation process.

Keywords

acculturation; diabetes mellitus; diabetes prevention; obesity; Hispanic Americans

Latinos represent the nation's largest and fastest growing minority group,¹ and they also have a high prevalence of diabetes. The estimated prevalence of diabetes among Mexican-American adults—the largest subgroup of U.S. Latinos—is 20.1%, compared to 11.0% for non-Hispanic whites and 18.7% for non-Hispanic blacks.² Recent data from a diverse national cohort of Latino adults demonstrated a similar burden of diabetes among Mexican-Americans (19%) and all Latino subgroups combined (17%).³ Among Latinos, women (hereafter called Latinas) have a higher risk of developing diabetes than men.⁴ In fact, the same study found that Latinas' lifetime risk of diabetes (53%) was higher than that of any other demographic group, illustrating the need to focus diabetes prevention efforts on Latinas.

Large randomized trials have shown that lifestyle interventions are effective at preventing diabetes.^{5–7} One of these trials, the Diabetes Prevention Program (DPP), demonstrated a 58% reduction in diabetes incidence among high-risk individuals randomized to an intensive lifestyle intervention.⁷ While many groups have subsequently adapted this intervention program and offered it in diverse settings and populations, few of these programs have reached Latinas.⁸ Motivating lifestyle changes through such programs requires knowledge of the social and cultural contexts that surround lifestyle behaviors in the target population. Understanding sociocultural influences on Latinas' health behaviors and resulting diabetes risk could provide a relevant framework for adapting lifestyle programs like the DPP to improve their effectiveness in this high-risk population.

Acculturation—the process by which immigrants adopt the prevailing attitudes, behaviors, and values of a new culture⁹—has a pervasive influence on the health of U.S. Latinos. Most research suggests that as they become more acculturated, Latinos adopt less healthy diets and become more sedentary,¹⁰ which puts them at higher risk for obesity and diabetes.^{11, 12} To identify mechanisms relating acculturation to diabetes risk, it is necessary to understand the social and economic context in which lifestyle behaviors occur, and how that context is changed by acculturation. An influential social context is the family,¹³ which occupies an especially important place in Latino culture and undergoes significant changes during acculturation.¹⁴ Therefore, studying the shared influence of acculturation on both Latinas' lifestyle behaviors and their families may suggest potential intervention targets to help prevent diabetes in Latinas.

This study's overarching goal was to investigate how acculturation may shape diabetes risk among urban, immigrant Latinas—the target population for the authors' adaptation of the DPP lifestyle intervention. The specific objectives were: 1) to examine changes in participants' lifestyle behaviors since moving to the U.S. and their underlying motivations for those behavioral changes; and 2) to explore changing family roles and responsibilities during acculturation, and understand how they impact Latinas' diet and physical activity behaviors. No qualitative studies have focused on mechanisms linking acculturation and

diabetes risk among Latinas, which represents a critical gap in our knowledge about how to prevent diabetes in the most affected demographic group.

Methods

Research Design

Focus groups were conducted with 26 urban, immigrant Latinas who all had high clinical risk of developing diabetes. Focus groups are group discussions led by a facilitator that explore a specific topic while capitalizing on the interaction between participants.¹⁵ This facilitated group process helps participants explore and clarify their views more naturally than individual interviews.¹⁶ Focus groups are especially useful when studying individuals' experiences of health and disease within a common cultural framework.¹⁷ The authors chose this qualitative method because they felt it would most effectively elicit the cultural context surrounding diabetes risk in the target population. This topic is not a particularly sensitive one where group discussion may inhibit individuals' contributions in a group setting. Therefore, the authors did not consider the individual in-depth interview method for this study.

Participants

Participants were recruited by research staff at Puentes de Salud ("Bridges of Health", www.puentesdesalud.org), a community health center in Philadelphia, PA that provides primary health care, education, and social service programs to recent immigrant Latino families.¹⁸ A study team member was present at the clinic two days per week throughout the recruitment period. All women seeking care at the clinic were approached by this study team member (S.J.S.), who determined their eligibility during the clinic's medical triage process. Eligibility criteria were as follows: female gender, age ≥ 25 years, Hispanic/Latino ethnicity, Spanish language fluency, and measured body mass index (BMI) ≥ 25.0 kg/m². Latinas who met these criteria then completed the 7-item 2011 American Diabetes Association risk screening tool,¹⁹ and those at high clinical risk of developing diabetes were invited to participate. Participants were assigned to focus groups consecutively as they were deemed eligible, without stratification by sociodemographic characteristics. Before each focus group session, research staff obtained written informed consent from the women who agreed to participate in the study. Participants received a small compensation (\$20) for their time. The study was approved by Temple University's Institutional Review Board.

Data Collection

Between November 2012 and January 2013, five focus groups were conducted at Puentes de Salud, and each group ranged in size from 4 to 9 participants. The interview guide focused on two domains that are known to change with acculturation: 1) diet and physical activity behaviors; and 2) family roles and responsibilities (Table 1). All five focus groups were facilitated in Spanish by an experienced bilingual and bicultural investigator (V.A.A.), who has conducted extensive qualitative research with Latinas evaluating federal maternal and child health programs. Each group lasted between 90 and 120 minutes and was digitally recorded. No further focus groups were conducted after reaching saturation (i.e. when no new themes emerged during group discussion), which occurred after completing five groups

with a total of 26 participants. Field notes were kept by two investigators (M.J.O., S.J.S.) during the focus group discussions and compared during debriefing sessions after each group.

Following the focus groups, research staff administered a brief demographic questionnaire in Spanish to collect data on acculturation level, marital status, parity, employment, educational attainment, country of birth, and duration of U.S. residence. Acculturation was measured using the Short Acculturation Scale for Hispanics, an instrument assessing language preference in a variety of scenarios and social settings, including the family.²⁰ In this instrument, acculturation is assessed on a Likert scale from 1 (lowest) to 5 (highest).

Analysis

The five focus group discussions were recorded using digital audio recorders. Less than one week after completing each group, audiotapes were professionally transcribed in Spanish (Spanish by Native, LLC, Philadelphia, PA). One author (S.J.S.) compared the resulting transcripts with the original audio recordings to ensure accuracy. Atlas.ti® (v. 6, Berlin, GDR) was used to assist with organizing and analyzing the data. The data analysis was guided by principles from grounded theory.²¹ The authors analyzed transcripts using an inductive method of open coding to identify themes from participants' responses rather than any prior conceptual categories.²² The transcripts were read independently by three bilingual authors (M.J.O., S.J.S., D.M.B.) with previous qualitative research experience. The three readers independently coded the participants' responses and organized similarly coded quotes into distinct categories. Each category was labeled with a descriptive statement (e.g. "Now able to afford less healthy behaviors"), which was intended to express an underlying theme. In a series of iterative, face-to-face meetings conducted exclusively in Spanish, the three readers then worked together to establish common themes across all focus groups. Themes were only established where supporting evidence (quotes) was found in each of the five focus groups. All themes and supporting quotes were then translated into English by one author (S.J.S.). The three readers met to develop consensus on the wording of all text elements in English. This group then met face-to-face with the senior author (R.C.W.) to agree upon the final themes and meta-themes, and to select the most representative quotes supporting each theme.

Results

Participant Characteristics

Twenty one of the 26 Latina participants were currently married or living with a partner, and 25 had children (Table 2). All 26 women reported low levels of acculturation (mean score <3 on the Short Acculturation Scale for Hispanics).²³ All had a BMI of 25.0 kg/m² or greater and 22 had a family history of diabetes. There were 6 themes which reflected 2 meta-themes.

Meta-theme 1: Acculturation impacts diet and physical activity behaviors (Table 3)

Theme 1: Now able to afford less healthy behaviors: Most participants reported that after moving to the U.S., they more often consumed less healthy foods (1.1, 1.2) and adopted more sedentary lifestyles (1.3, 1.4). While energy-dense foods and sugary drinks were available in their home countries, these items were more expensive there (1.1, 1.2) and typically only consumed on special occasions. Some participants noted that opportunities to eat less healthy foods and take public transportation were not as readily available in their countries of origin (1.2, 1.3). But for most participants, the primary factor enabling the adoption of less healthy diet and physical activity behaviors was their newfound ability to afford them (1.1, 1.2, 1.3, 1.4). Some of the participants' suggested that having the financial means to change their lifestyles in this way engendered a sense of pride and belonging in the U.S.

Theme 2: Increasing consumption of sugar-sweetened beverages: The most commonly reported dietary change after arriving in the U.S. was the increased consumption of sugar-sweetened beverages (SSB) (2.1, 2.2, 2.3, 2.4). According to the participants, both affordability and availability of SSB in their new environment enabled this abrupt dietary change (2.1, 2.3). Many participants described starting to drink SSB frequently upon their arrival (2.1, 2.2). And after increasing their SSB consumption, many women quickly developed cravings for these drinks (2.1, 2.2, 2.3, 2.4). One participant used the word "addicted" to describe her attraction to SSB in the U.S., and her current strategy for quitting was reminiscent of that used by some to quit smoking (2.2). Another participant described her craving for SSB as "something that I cannot explain" (2.3). These comments (2.2, 2.3) imply individuals' loss of control over SSB consumption since moving to the U.S.

Theme 3: Changing methods of food preparation: In addition to changing the types of foods and drinks they consume since arriving in the U.S., participants also noted abandoning traditional food preparation practices (3.1, 3.2). Participants fondly recalled their process for making tortillas (3.2), sausage, and other foods in their home countries. Two other points about food preparation were evident during the group discussions. First, the traditional methods require time which women no longer have (3.1, 3.2). And second, women felt that losing these traditional methods in favor of more convenient ones may sacrifice their health and that of their families (3.2, 3.3). In addition to having limited time for cooking, the availability of prepared foods was another factor impacting participants' food preparation practices (3.1, 3.2, 3.3).

Meta-theme 2: Acculturation impacts family roles and responsibilities (Table 3)

Theme 4: Women's influence in the family: Women expressed both pride and a great sense of responsibility when talking about their influence on family members. There was a prevailing sense that women are responsible for promoting the health of both their children and partners (4.1, 4.2). These women sought to ensure their family members' health by determining their dietary and activity behaviors (4.2), and by meeting all of their needs (4.1). Several women explained that they now share this influence over their families' health

and health behavior with their husbands (4.3), which was not a common practice in their home countries. Many expressed the impression that they could use this influence to promote health among family members and help lower their risk of diabetes (4.4).

Theme 5: Shifting responsibilities of women and partners: The participants described many changes in their responsibilities and those of their partners during the acculturation process. Many women explained that they were currently working outside the home and earning independent income for the first time in their lives. In their countries of origin, these women were accustomed to working only in the home to fulfill their families' needs (5.1). Those now working outside the home often commented on how this experience caused them to change their priorities (5.2) and spend less time on tasks that were previously their focus at home (5.4). Some participants explained that their husbands have taken on more home-based responsibilities since arriving in the U.S. (5.1, 5.3).

Theme 6: Parents as role models in a dynamic social environment: Latinas strongly believed that children learn important health lessons from their parents, which lay the foundation for lifelong health. Some participants felt that modeling healthy behaviors for their children was an important way to teach them how to prevent diabetes as they grow and age (6.3). Other women believed they needed to play a more active role in imparting knowledge about healthy behaviors to their children (6.1, 6.2). Many of the women admitted that they needed more education about healthy habits before being able to teach their children (6.1). There was a tension between those who felt that they (i.e. mothers) should be the primary role models for their children (6.1, 6.2) and those who considered this a shared responsibility with their partners (6.3).

Discussion

Data from focus groups of urban, immigrant Latinas with a high clinical risk of diabetes suggest that acculturation changes both lifestyle behaviors and the family context in which those behaviors are shaped. The participants believed that the foods and drinks they now consume, and their new methods for preparing food, may threaten their health and increase their diabetes risk. Using public transportation in place of walking was a common experience, noted by many as having potential adverse effects on their health. These women also expressed concern about how their lifestyle changes will impact the health of their partners and children. Shifting work responsibilities between participants and their partners—both inside and outside the home—have expanded the range of foods they can afford while constraining the time available to prepare foods in a way they view as healthy. There was a consensus among the participants that families represent an important setting where health knowledge is shared and long-term health is molded. Some participants believed that their family context provided unique opportunities to prevent diabetes.

Acculturation and its impact on diet and physical activity behaviors

While a large body of evidence in U.S. Latinos outlines the negative association between acculturation and various health behaviors and outcomes,⁹ less research has focused on the economic and family context in which acculturation may impact diabetes risk. As other

studies of acculturation and lifestyle behaviors have reported,^{24, 25} immigrant Latinas in this analysis engaged in less active transportation and ate less healthy foods frequently in the U.S. However, unlike previous studies exploring Latinas' motivations for such lifestyle changes, the participants almost always discussed changing health behaviors in the context of their relative economic prosperity in the U.S. This is a particularly interesting finding, given that none of the questions or prompts in the focus group guide was related to personal finances (Table 1). These women presented their new lifestyle behaviors as opportunities made possible by having more money than they did in their home countries. One recent national survey reported that the perception of relative economic prosperity is widespread among foreign-born Mexican Americans,²⁶ who constituted the majority of our sample. This belief accurately reflects an observed increase in Mexican-Americans' household income over time.²⁷

Most research on acculturation and health behavior in Latinos emphasizes the negative consequences of adopting lifestyle behaviors that are prevalent in the U.S. Indeed, the Latina participants here acknowledged that their new diets and limited physical activity may ultimately increase their diabetes risk. But the participants also highlighted positive aspects of adopting less healthy dietary and activity behaviors that may reflect their underlying motivations. In the participants' home countries, consuming less healthy foods and drinks was usually reserved for special occasions, which has been reported elsewhere.^{28, 29} Several women noted that eating these foods in the U.S. provided frequent reminders of happy times with their families back home. Some also suggested that their newfound ability to afford soda or fast food regularly engendered a sense of pride and belonging in their new environment. Echoing these sentiments, Latina participants in another qualitative study described these as "high status foods."²⁹ The positive psychological associations the participants held with their new and relatively less healthy lifestyles reveals a central tension—that Latinas feel conflicted about the economic circumstances acculturation has enabled.

Acculturation and its impact on Latino families

This analysis supports the important role of Latino families in shaping their members' lifestyle behaviors and associated diabetes risk. Within this family unit, Latinas often bear the primary responsibility for the wellness of their partners and children, sometimes at the expense of their own—a cultural concept known as *marianismo*.^{30, 31} Previous studies of Latinas have documented their myriad family responsibilities, which include caring for children and educating them, providing food, and doing housework.³² The participants believed that some of these duties—particularly educating children about nutrition, providing food for the family, and serving as role models for their children—may help family members prevent diabetes. Some Latina participants noted that in the U.S. their husbands or partners now play an increasing role in these home-based activities. Previous research has suggested that such partner support allows Latinas to engage in self-care behaviors that they otherwise might not prioritize.^{33, 34} Another qualitative study reported that Latinos identify "taking care of yourself" as a strategy for preventing diabetes.³⁵ In this way, changing family responsibilities in the setting of acculturation may have a positive influence on Latinas' health by promoting lifestyle behaviors that lower their diabetes risk.

Other changes within Latino families during the acculturation process may promote less healthy lifestyle behaviors and increase family members' diabetes risk. Some Latina participants reported working outside their homes for the first time, which represents another departure from prevailing family roles in their home countries. Those who worked noted resulting economic benefits, increasing their families' net income and also enabling a degree of financial independence from their partners. But all working mothers acknowledged the tradeoff of spending less time with their families. They perceived that working outside the home left less time for food preparation and provision, causing them to sacrifice healthy food choices for more convenient options. Other qualitative research with working Latinas have found similar changes to family meal offerings and routines.^{36–38} However, these studies did not report that financial considerations influenced Latinas' decision to work outside the home or their ability to afford less healthy, prepared foods.

Acculturation's economic impact crosses both meta-themes

The focus group discussions illustrated that acculturation and socioeconomic status are strongly intertwined among Latinas—an observation that has been previously reported.³⁹ Through the acculturation process, these Latinas have achieved a new level of economic prosperity that now shapes both their lifestyle behaviors and the family context in which those behaviors are realized. They suggested that the greatest influence on their changing diet and physical activity behaviors in the U.S. was their newfound ability to afford them. Acculturation has provided Latinas relative affluence that has brought a highly desirable, but less healthy lifestyle within their reach. Acculturation and its associated economic benefits have also changed the Latino family unit in ways that may impact diabetes risk among its members. Some Latina participants were working outside the home for the first time, which contributed to household income but constrained their options for serving foods they consider healthy. These same social forces described by our Latina participants—increasing work demands, shifting family responsibilities, and fast-paced lifestyles—have dominated the prevailing U.S. culture⁴⁰ and may have promoted an increasing burden of chronic illness.⁴¹ Despite the potentially harmful health effects of acculturation and its economic benefits, the participants still believed they could promote health and help prevent diabetes within the family setting.

Limitations

The study findings reflect the experience and opinions of a small convenience sample of urban, immigrant Latinas who were at high clinical risk for developing diabetes. Therefore, the results may not apply to a larger population of Latinas, even those meeting our eligibility criteria. One participant was not a mother and may therefore have had limited experience with changing family roles and responsibilities while living in the U.S. The authors chose not to videotape participants so that they could speak freely and not fear breaches in confidentiality. As a result, they could not identify the voices of specific participants in the audio recording.

Conclusions and implications for practice

The relationship between acculturation and Latino health has mostly been studied quantitatively using proxy measures of acculturation, such as language use and duration of

U.S. residence, to measure a complex social process. This qualitative analysis of urban, immigrant Latinas suggests mechanisms through which acculturation impacts their high clinical risk of diabetes, and also identifies potential intervention targets to prevent diabetes in this population. Lifestyle interventions like the Diabetes Prevention Program may benefit from adaptations that address Latinas' unique social and economic circumstances. For example, such programs could include exercises to help Latinas budget for family food purchases while addressing factors that motivate and enable less healthy dietary behaviors. Such programs could also integrate messages and activities that acknowledge changes within Latinas' families during acculturation. Including partners and other family members in diabetes prevention efforts may help Latinas lower their own diabetes risk and that of their family members, which they identified as a potential opportunity within the family context. Health professionals may also apply knowledge about Latinas' dynamic financial or family circumstances in their clinical counseling efforts to promote healthy diets and physical activity. Because of the consistently documented influence of acculturation on Latinas' health, designing intervention strategies that target their acculturation experiences and resulting changes in lifestyle behaviors may improve the effectiveness of diabetes prevention efforts in this high-risk population.

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Table 1

Sample questions and prompts from interview guide

Domain	Corresponding questions and prompts
Diet and physical activity behaviors	<p>Do you think the culture where you grew up was more supportive of a healthy lifestyle than the U.S. culture? Why or why not?</p> <p>How often did you do each of these things in your home country compared to now?</p> <p><u>Prompts:</u></p> <ul style="list-style-type: none"> • Walk or bike to get places • Walk or do other physical activity for pleasure • Eat fast food • Drink sodas, juices, or other sugary drinks • Prepare and eat meals at home • Eat in restaurants or order take-out <p>What explains these differences?</p>
Family roles and responsibilities	<p>Which of these activities do you perform in your family?</p> <p><u>Prompts:</u></p> <ul style="list-style-type: none"> • Provide child care • Buy and prepare food • Do housework • Give medications to family members • Support family members' health in other ways <p>Does your partner or anyone else in your family share in doing these activities? Why or why not?</p> <p>Do you think you spend more time taking care of/looking after yourself or other family members? Why?</p> <p>What would help you take better care of yourself?</p>

Table 2

Characteristics of Latina participants (n=26)

Clinical risk factors for diabetes	n (%)
Obesity (BMI ≥ 30 kg/m ²)	14 (54)
History of gestational diabetes	5 (19)
Family history of diabetes	22 (85)
High blood pressure	9 (35)
Physically inactive	19 (73)
Sociodemographic characteristics	
Marital status	
Married or living with partner	21 (81)
Widowed, separated, or divorced	5 (19)
Parous	
Yes	25 (96)
No	1 (4)
Employed	
Yes	13 (50)
No	13 (50)
Educational attainment (years)	
< 12	21 (81)
12	5 (19)
Birthplace	
Mexico	23 (88)
Other Latin American country	3 (11)
Duration of U.S. residence (years)	
< 10	18 (69)
10	8 (31)

Table 3

Meta-themes, themes, and supporting quotes

Meta-Themes	Themes and Supporting Quotes
Acculturation impacts diet and physical activity behaviors	Theme 1: Now able to afford less healthy behaviors <ol style="list-style-type: none"> 1.1 We think that we have to drink water or natural drinks because there is no money. You have this idea that money makes everything better, and so you will have soda every time that you eat. You will have soda or juice because there is money. 1.2 It is easy to go to McDonald's, buy fried chicken, and there's money for it. You get paid every week. [In Mexico] pizza, calzones, hamburgers, everything is expensive. 1.3 The bus is nearby, so I take the bus. I don't walk any more, and I think that has a lot to do with it. There's more transportation here. The economy is better. 1.4 You take a taxi, which is something that you couldn't do over there. It would cost more and you didn't have money... here you can take taxis because you have money and you can pay.
	Theme 2: Increasing consumption of sugar sweetened beverages <ol style="list-style-type: none"> 2.1 I think that we crave soda more when we first arrive [to the United States] because we didn't have it over there [Mexico]. 2.2 When I first arrived, I became very addicted to Coca-Cola; yes, I am now trying to quit. I buy a bottle of soda, but only take one or two sips and I throw away the rest. But by the time we realize that it is affecting us, that's when we want to change and it is hard. It is hard to go for the water. 2.3 Here, perhaps if I have enough [money], I go and I buy the bottle of soda... You get this craving, like all sweets attract you, no? So now, choosing water is difficult. 2.4 The truth is that [wanting to drink soda] is something that I cannot explain. Like I feel the need of wanting something sweet. I would go and grab a soda... just so that the sensation would go away, like the craving.
	Theme 3: Changing methods of food preparation <ol style="list-style-type: none"> 3.1 [In Mexico] you have to grow and prepare foods fresh. You have to dedicate more time to preparing meals. Now, we don't have time, we just go out and look for food in a place where it's already made. 3.2 For me, what is healthy about over there [...] is that things are natural. Let's say to make a 'tortilla,' it takes a whole process. Cooking the 'nixtamal,' taking it to the mill so that it becomes dough and then make the 'tortillas.' Here, that does not happen, because you just go and buy them. It's something quick. 3.3 It's harder to be healthy here because everything is so easily available... Everything is already prepared, you only need to come home and boil the water.
Acculturation impacts family roles and responsibilities	Theme 4: Women's influence in the family <ol style="list-style-type: none"> 4.1 Sometimes you're a nurse because you take care of them when they are sick; you feed them... And you're also a teacher once you begin to help them, they start talking at an early age... We're important people for our family. 4.2 I believe that our role as mothers, wives, and friends really influences how to bring nutritional and physical health to our families. I believe that is our major responsibility. 4.3 Yes, I think that communication with the father is important... I also think that the two of us have the same [parenting] responsibility. I think that it is the two of us, because we are a pair, together. 4.4 The most important is nutritional education and that we teach them what kinds of exercise will benefit them to make sure they don't get diabetes. This is the most important thing.
	Theme 5: Shifting responsibilities of women and partners <ol style="list-style-type: none"> 5.1 Leaving there and coming here, there is a big difference because men now share the same chores as women. Back there it is only the woman. She is the one to cook for them, wash for them, or iron for them... Therefore coming here is different. 5.2 Women are becoming lazier here. I say that... because I've done it myself. In order to save time for something else, we open a can for dinner and boom... Later I say "I made a big mistake." 5.3 At home, my husband also has [the responsibility of cooking] because when I do not have enough time to cook, he cooks. Every time that he cooks we have enough vegetables to eat for an entire week. He says 'that's what you have to eat'.

Meta-Themes	Themes and Supporting Quotes
	<p>5.4 In my house we eat healthy. But in the street or in the restaurant where I work, I can't give [my kids] healthy food. There they eat what there is or what they are given.</p>
	<p>Theme 6: Parents as role models in a dynamic social environment</p> <p>6.1 It's up to us what information [the children] have and what habits they learn. That's why we have to educate ourselves as much as we can. Depending on that, they will have a healthy life and would be happier in other areas as well.</p> <p>6.2 We have the responsibility [to provide] basic education about foods, and trying to put healthy things on the table. Talk to them [the children] about what could cause them harm.</p> <p>6.3 We started to change our habits...It is this worry that my kids don't develop this disease because diabetes is also seen in children. So if we take care of them starting now, they are going to be better.</p>