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Neighborhood and Parental Influences on Diet and Physical Activity Behaviors in Young Low-Income Pediatric Patients

Nakiya N. Showell, MD, MPH, MHS¹, Katie Washington Cole, BS¹, Katherine Johnson, PhD², Lisa Ross DeCamp, MD, MSPH¹, Megan Bair-Merritt, MD, MSCE³, and Rachel L. J. Thornton, MD, PhD¹

¹Johns Hopkins University School of Medicine, Baltimore, MD, USA

²Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, USA

³Boston Medical Center, Boston, MA, USA

Abstract

This study explores the relationship between neighborhood characteristics and caregiver preferences for establishing diet and physical activity behaviors among low-income African American and Hispanic young children (2–5 years). Primary caregivers of young children were recruited from 2 urban pediatric clinics to participate in focus groups (n = 33). Thematic analysis of transcripts identified 3 themes: neighborhood constraints on desired behaviors, caregivers' strategies in response to neighborhoods, and caregivers' sense of agency in the face of neighborhood constraints. This study elucidates the dynamic relationship between neighborhoods and caregiver preferences, their interrelated impacts on establishment of diet and physical activity behaviors among young children, and the important role of caregiver agency in establishing behaviors among young children. To effectively address obesity disparities among young children, primary care behavioral interventions must leverage and support such resilient caregiver responses to neighborhood constraints in order to optimally address racial/ethnic and socioeconomic disparities in obesity among young children.

Keywords

primary care; child; obesity; neighborhood; intervention

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Corresponding Author: Nakiya N. Showell, Division of General Pediatrics and Adolescent Medicine, David Rubenstein Child Health Building, 200 North Wolfe Street, Room 2023, Baltimore, MD 21287, USA. nshowell1@jhmi.edu.

Author Contributions

NNS: Dr. Showell conceptualized and designed the study, carried out the study analyses, drafted and reviewed the initial manuscript and approved the final manuscript as submitted. KWC: Ms. Cole acquired, interpreted and analyzed the data. Additionally, she critically reviewed the manuscript and approved the final manuscript as submitted. KJ: Dr. Johnson analyzed and interpreted the data, critically reviewed the manuscript and approved the final manuscript as submitted. LRD: Dr. DeCamp analyzed and interpreted the data. Additionally, she critically reviewed the manuscript and approved of the final manuscript as submitted. MBM: Dr. Bair-Merritt contributed to the study design, analyzed and interpreted the data and critically reviewed the manuscript. She approved the final manuscript as submitted. RLJT: Dr. Thornton conceptualized and designed the study, analyzed and interpreted the data and critically reviewed the manuscript. She approved of the final manuscript as submitted.

Declaration of Conflicting Interests

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Introduction

Childhood obesity is a major public health concern. Among children aged 2 to 5 years, more than 20% are overweight or obese, placing them at higher risk of becoming obese adults.¹ Despite recent declines in obesity rates among preschool-aged children, racial/ ethnic minority and low-income children remain disproportionately burdened by obesity and are resultantly at greater risk for obesity-related complications.¹ Understanding factors that influence obesity and related behaviors (eg, diet and physical activity [PA]), particularly among young low-income minority children is a key component of effectively addressing the child obesity epidemic.

Multilevel factors, including individual- (eg, child diet and PA behaviors), parent/family- (eg, parent diet and PA role modeling), and neighborhood-level factors (eg, neighborhood food and PA environments) can influence obesity risk in childhood.^{2,3} Among low-income racial/ethnic minority children, neighborhood-level factors, may play a particularly important role in obesity disparities given the higher likelihood of children from these groups living in impoverished neighborhoods, which are more likely to lack adequate access to healthy foods and to have higher violent crime rates.⁴

There is limited and inconsistent empiric evidence linking neighborhood healthy food availability and crime to obesity risk among young children.^{5,6} Furthermore, despite the salience of neighborhood factors, few studies have clearly explored how these factors interrelate with caregiver factors to constrain or promote parents' ability to establish healthy diet and PA behaviors among their young children. Gaining a more nuanced understanding of the way neighborhood factors and caregiver preferences interrelate to influence diet and PA behaviors among young children is essential for developing highly effective obesity interventions that address disparities in child obesity risk.

In this study, we explored, using focus groups, the dynamic relationship between neighborhood characteristics and caregiver preferences in shaping low-income African American and Latino caregivers' establishment of diet and PA behaviors among their preschool-aged children.

Materials and Methods

Setting

Between August 2013 and October 2014, we conducted focus groups in English and Spanish with participants from 2 urban hospital-based general pediatrics clinics (site 1 and site 2) in Baltimore, Maryland. Site 1 serves a population that is 65% Hispanic, 25% non-Hispanic black and 10% non-Hispanic white. Hispanic patients reside primarily in immigrant families with parents with limited English proficiency (LEP). Site 2 serves a patient population that is 91% non-Hispanic black, 4% non-Hispanic white, and 1% Hispanic. Both sites serve predominantly low-income populations; more than 80% of patients at each site receive health insurance through the state Medicaid program.

Participants

We identified predominant neighborhoods of residence as those where the highest proportion of 2- to 5-year-old clinic patients reside. This was defined using Community Statistical Areas (CSAs)—administrative boundaries based on US Census Tracts designed to be consistent with residents' definitions of neighborhood boundaries.⁷ To contextualize focus group discussions with environmental characteristics of participants' neighborhoods, the food environment and safety profile of predominant neighborhoods were characterized. We used the Baltimore City Healthy Food Availability Index (HFAI)⁷ to characterize participants' neighborhood food environment and to compare obtained values to those for the entire Baltimore City area. The HFAI is a composite score (0–28.5) depicting the quality of food available at Baltimore City food retailers in a given neighborhood.⁷ A higher HFAI score indicates greater availability of healthy food. Using Baltimore City data, we established low, moderate, and high HFAI values based on tertiles at the CSA level. We used violent crime data (average crime counts/1000 residents from 2010–2013) from the Baltimore City Police Department⁷ to characterize neighborhood safety. As with HFAI, we used data for Baltimore City to establish low, moderate, and high crime values based on tertiles at the CSA level.

Using purposive sampling, we recruited primary caregivers residing in predominant neighborhoods, and who were members of the majority clinic population for each site (site 1—LEP Latino, site 2—non-Hispanic Black.) Additional inclusion criteria were: age ≥ 18 years and caregiver of at least 1 child aged 2 to 5 years who receives primary care at 1 of the 2 clinic sites.

Focus groups included participants from the same or nearby neighborhoods, as defined by CSA assignment, to allow for discussions of neighborhood factors based on similar exposures. Five Spanish-language focus groups were held with participants from site 1 (range: 4–8 participants per group). Two English-language focus groups were held with site 2 participants (range 4–5 participants per group). Institutional review board approval was obtained from the Johns Hopkins University School of Medicine. Informed consent was obtained from each participant prior to the start of each focus group. Participants received a \$50 gift card as remuneration for participation.

Discussions and Data Analysis

Prior to the group discussions, participants provided demographic data through the completion of a 14-item survey. Experienced moderators used a standardized interview guide to facilitate discussions designed to examine how neighborhood factors modified or influenced caregivers' abilities to establish preferred diet and PA (ie, indoor or outdoor play) norms for their young children. Participants were probed about physical (eg, provision of play spaces) and social (eg, perceived safety) aspects of their neighborhood environment. Participants were also asked to describe their personal preferences for establishing dietary and PA behaviors for their children and the factors (eg, family routines) that were influential in shaping these preferences. Sample interview questions are shown in Table 1. The approximately 1-hour discussions were digitally recorded and transcribed verbatim. The transcripts from the Spanish-language groups were translated to English by a native Spanish

speaker and verified through back-translation by another native Spanish speaker. Each transcript was verified by at least 1 person other than the transcriber/translator to ensure completeness.

The coding team which, included 2 doctoral-level research assistants with extensive training in qualitative methods, reviewed each transcript for familiarity. Initial codes, derived from the focus group guide and the initial transcript review were applied to 2 of the 7 transcripts (1 per site), which contained some of the richest discussion. The research assistants independently coded each of the remaining transcripts (n = 5). The codebook was revised iteratively with oversight from other study team members and through consultation with a qualitative research expert not involved in the project. The resultant coding schema was then used to code all transcripts. Rather than employing a measure of intercoder reliability, all coding differences were adjudicated through discussion to achieve consensus.^{8,9} Given the variability in the number and size of focus groups at site 1 compared with site 2, we specifically assessed consistency of themes across sites and achievement of thematic saturation during the coding process in order to determine the appropriateness of using all focus groups in this analysis. On completion of coding, the research team summarized and organized the codes into overarching themes and subthemes. Atlas.ti, software (version 7)¹⁰ was used to assist in the data analytic process.

Results

Description of Participants

Five focus groups (24 caregivers total) were conducted at site 1, and 2 focus groups (9 caregivers total) were conducted at site 2. Participants from site 1 were all immigrant Latina women. Most of these caregivers noted Spanish as their primary language (76%), were from Mexico (81%), and had less than a high school education (57%). All site 2 participants self-identified as African American and reported English as their primary language.

Approximately one-third of site 2 participants had less than a high school education. Participants from both sites ranged in age from 18 to 49 years. The majority of participants from both sites resided in neighborhoods with low or moderate healthy food availability (site 1, 79%; site 2, 88%) and in neighborhoods with high crime rates (site 1, 92%; site 2, 78%) (Table 2).

Transcript Analysis

Analyses of transcripts yielded 3 central themes: (1) neighborhood constraints to caregiver PA and diet preferences (Table 3), (2) caregiver strategies for supporting/facilitating desired PA and diet behavioral outcomes in response to neighborhoods (Table 4), and (3) caregivers' perception of their agency or control over their children's PA and diet behaviors in the face of neighborhood constraints (Table 5).

Theme 1: Neighborhood Constraints to Caregiver PA and Diet Preferences

Caregiver interviews identified several neighborhood factors that constrained their ability to promote outdoor play, including witnessing violence (eg, shootings) and criminal activity (eg, drug trades) (subtheme 1):

... And sometimes they have done that [selling drugs] in front of my children. Indeed my children know how he sells it [drugs] ... where he puts it in ... and what I do is say let's go inside. You do not have to be seeing that. (site 1)

In addition to *observed* neighborhood violence or criminal activity, overall neighborhood safety (sub-theme 2) influenced caregivers' perceptions of whether their neighborhood was a desirable place. For example, in describing their ideal neighborhood, many caregivers stated a preference for living in safer neighborhoods, that is, neighborhoods in which "violence is not normal." (site 2)

Other caregivers associated neighborhood safety with a sense of social cohesion and a reliance on collaborative supervision of children's outdoor play among neighbors:

That's my ideal neighborhood, back from 40 some years ago. You can play if you want to. Our parents were all together on their thing. Everybody would just stick together and take care of the kids. (site 2)

The lack of such social support and collaborative supervision were specifically cited as a disadvantage of current neighborhood conditions and an inhibitor of outdoor play (subtheme 3).

The presence of disrespectful children and concern regarding the potential influence of other children's behavior on their own also deterred caregivers from allowing their children to engage in outdoor play:

He cannot go outside to play because children who live on that street are mainly are very rude too, so obviously I do not want that for my son ... " (site 1)

Lack of cleanliness (subtheme 4) was another commonly cited neighborhood constraint on children's outdoor play. The lack of cleanliness of both formal play areas (eg, playgrounds, parks) and informal play areas (eg, residential block or alleyways in front of their homes) negatively affected outdoor play in the neighborhood (Table 3).

The following issues emerged from caregivers' discussion of neighborhood constraints on establishing preferred dietary norms among their children: freshness and/or quality of foods in neighborhood food stores, and proximity of preferred food markets (subtheme 5). Foreign-born Latina caregivers from site 1 commented that there were noticeable differences in the foods available for their children in the United States compared with those that were available to them during their own childhoods in their native countries:

Here we do not know where it comes from or how long it has been in the shop. Even when they say it is fresh ... well, no." (site 1)

Both Latino and African American caregivers reported that food retailers were available in their neighborhoods. However, some site 2 caregivers commented that the quality of foods offered in their neighborhoods was suboptimal, so they chose to travel farther distances to buy better quality foods:

I was going to say [and] out of the area. The quality of the food in certain areas [and] I'm not buying this. I'm not feeding this to my children. I wouldn't even let a cat eat it. (site 2)

In spite of clearly defined neighborhood constraints that emerged from the data, many caregivers implemented strategies to facilitate establishment of preferred diet and physical activity norms among their young children.

Theme 2: Caregiver Strategies to Support/ Facilitate Desired PA and Diet Behavioral Outcomes in Response to Neighborhoods

Caregivers described a variety of proactive strategies for achieving preferred diet and PA behaviors among their children. The following subthemes summarize predominant strategies: (1) Promotion of Indoor Play, (2) Accessing Play Activities in Other Neighborhoods, (3) Utilizing Available Neighborhood Resources, and (4) Accessing Preferred Food Sources in Other Neighborhoods (Table 4).

Many caregivers described actively accessing activities and resources in order to buffer their children from negative neighborhood exposures. In some instances, these alternatives supported children being physically active, and others represented alternative activities that were more sedentary. A key motive for employing these strategies and providing alternatives to neighborhood-based outdoor play was minimizing children's exposure to criminal activity or violence.

In addition to serving as a safe haven from unsafe neighborhood environments, some caregivers conceptualized their homes as a prime venue for indoor play and enrichment activities (eg, television watching) (subtheme 1) and placed greater value on their home environment compared to that of their residential neighborhood. Another strategy implemented by caregivers to minimize their children's exposure to unsafe neighborhood environments and negative socialization with other children was traveling outside of their neighborhood to access play locations and/or organized sports activities (subtheme 2).

Although the majority of caregivers alluded to at least one negative aspect of their neighborhood environment, some described utilization of neighborhood resources to facilitate adoption of desired PA and diet behaviors for their children (subtheme 3). Caregivers who described positive elements of their neighborhood commonly associated positive attributes with (1) neighborhood cleanliness and/or quietness—"What I really love about my neighborhood is I can look directly out my window, and the alley is clean." (site 1) or (2) proximity to play venues or food markets—"I actually just moved back into the city, so everything is a lot more closer, actually and more accessible because there is public transportation." (site 2)

Finally, caregivers report several strategies to overcome neighborhood-based constraints on their children's diet (subtheme 4). Caregivers reported that they were able to access preferred foods either by public transportation or by carpooling with other caregivers. Notably, the majority of caregivers, both African American and Latino relied heavily on their own knowledge of what children should eat, which was often derived from their own childhood experiences to guide their children's dietary behaviors:

... And I fed him and insisted so I gave him lots of vegetables at home. Because in my house, my grandmother had diabetes, so I learned to eat in a certain way as well. (site 1)

In contrast to African American caregivers, Latino caregivers also endorsed familial role modeling as a salient influence on their children's dietary behaviors: "Just like their dad eats everything, now they see him and grab whatever is there" (site 1). Furthermore, Latina caregivers acknowledged the importance of cultural traditions from their country of origin on their children's diet and the potential discrepancies that were made apparent when these culturally based influences did not complement their own preferences:

We are from Argentina and it is one thing we eat, meat grilled with fat. He dies to eat meat. I want him to eat salad for example and he does not like it. (site 1)

Theme 3: Caregivers' Perception of Their Agency or Control Over Their Children's PA and Diet Behaviors in the Face of Neighborhood Constraints

As exemplified through previously described caregiver strategies, both African American and Latino caregivers, heavily relied on their own personal decision making and agency (ie, exertion of authority) to buffer their children from negative neighborhood exposures and to promote adoption of preferred diet/PA behaviors (Table 5). For example, in response to a question related to preferred indoor activities, one caregiver stated the following:

Mostly we stay in, but that's my choice, but it's not because I don't want to go there. I just want it to be my choice. (site 2)

Similarly, caregivers reference their parental authority in governing what foods they purchase and choose for their children:

And we have control when we buy food at the market, what we bring. Because what is in the house is what you are going to eat, so if we get healthy meals, that is what they will eat. (site 1)

Discussion

This study explores the dynamic relationship between neighborhood factors and caregiver preferences in shaping urban low-income African American and Hispanic caregivers' establishment of diet and physical activity behaviors among their young children (age 2–5 years). Our results suggest that neighborhood factors, including violence and access to preferred food sources, play important roles as barriers and facilitators in shaping caregivers' strategies for establishing preferred diet and PA behaviors among their children. Caregivers demonstrated a variety of resilience strategies for keeping their children safe, some of which were also associated with establishing behaviors that might decrease obesity risk and others of which might put children at increased risk of obesity.

Our results uniquely contribute to the existing early childhood obesity literature by elucidating the decision-making process that caregivers use to promote preferred behavior change for their children in the presence of adverse neighborhood conditions. Additionally, our qualitative findings corroborate findings from previous research demonstrating the

influential role of caregivers on the development of diet and PA behavioral norms during early childhood.^{3,11} In particular, caregivers in our study reported provision of specific food types and use of parental role modeling as important determinants of their children's dietary behaviors. Furthermore, our findings clearly illustrated the relationship between caregivers' perception of their neighborhood social environment (eg, neighborhood safety) and their willingness to promote outdoor play. There is an emerging body of literature examining correlates of neighborhood social factors and child PA behaviors, but the association between neighborhood safety/crime and child physical activity is inconsistent.^{5,6,12–14} Existing studies may be unable to fully capture the complexities that shape parent's decision making regarding where, when and how their children play.

Caregivers' descriptions of the impact of neighborhood criminal activity and violence on children's outdoor play exemplified the constraining impact of neighborhood crime on caregivers' willingness to allow their children to play outdoors in their neighborhoods. Caregivers' place great value on avoiding negative socialization experiences (eg, witnessed neighborhood violence, unruly children) even at the expense of promoting more obesogenic behaviors (eg, indoor play and engagement in sedentary behavior).

Additionally, caregivers routinely considered potential consequences of their children's play behaviors and may have believed they were implementing well-informed choices to promote indoor sedentary play/ activities. Some caregivers chose to implement strategies that resulted in ongoing access to opportunities for PA (eg, joining a sports team in another neighborhood). The ability to seek out sports teams in other communities may reflect differential access to other social or financial resources among participants, rather than different priorities for PA, but we were not able to ascertain this in our current study.

Although several themes emerged *across* discussions with African American and Latino caregivers, some thematic differences were noted. African American caregivers more commonly described indoor activities and accessing outdoor play activities outside their neighborhood as responsive strategies to neighborhood constraints. While these dissimilarities may be attributable to minor objective differences in neighborhood safety profiles, it is likely that differences in neighborhood perceptions among caregivers also play a role. For example, many African American caregivers originate from families native to Baltimore. Therefore, compared with foreign-born Hispanic caregivers, African American caregivers may possess a deeper knowledge about neighborhoods, which in turn can influence their perspectives regarding neighborhood assets and opportunities.

Implications

The findings from this study have several implications for healthy diet and physical activity interventions targeting young children in pediatric health care settings. First, while neighborhood contextual factors may present barriers to adoption of preferred child diet and PA behaviors, understanding caregivers' priorities with respect to children's diet and PA behaviors is critical. Second, targeting parents as important agents of change and capitalizing on their intuitive resilience to promote healthy diet and PA behavior change for their children are strategies that should be implemented in tandem with targeted

neighborhood-level interventions to support such changes (eg, policy interventions addressing neighborhood healthy food availability or safety concerns).

Strengths and Limitations

This study is subject to limitations inherent of qualitative studies. The findings may not be transferable beyond African American and Hispanic caregivers in urban pediatric primary care settings. Additional limitations to this study were the smaller sample sizes of caregivers at site 2 compared with site 1. However, thematic saturation and consistence of emergent themes across the 2 populations supports including both sites in our analysis despite sample size differences.

The strengths of this study include: the representation of both English- and Spanish-speaking participants and a clinic-based sample, which augments the relevance of these findings to clinic-based populations. Additionally, we used neighborhood-mapping techniques. Use of such techniques allowed for participant grouping and detection of variation in caregivers' perceptions of environmental barriers to healthy eating and PA for preschoolers who live in the same or similar neighborhoods with respect to healthy food availability and crime.

Conclusion

Although physical *and* social aspects of neighborhood environments shape African American and Hispanic caregivers' strategies for establishing diet and PA norms for their young children, many caregivers still perceive great value in their own power to mold their children's behaviors and even override negative neighborhood exposures. These strategies can have positive, negative, or neutral implications for obesity risk but demonstrate the potential for resilient responses to adverse neighborhood environments. As such, they suggest important strategies for harnessing parental agency to reduce obesity risk while also addressing neighborhood level factors that can constrain behavior and make healthy diet and physical activity behaviors more difficult for parents of young children to establish. Our findings demonstrate the complex ways in which neighborhood factors are associated with child obesity and diet and PA behaviors. Such exploratory work plays a major role in better delineating the way that caregiver behaviors and responses to neighborhood environments mediate or moderate the relationship between neighborhood factors and child obesity-related behavioral outcomes.

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Table 1

Sample Questions From Focus Group Guide.

A. Neighborhood context influencing food choices and physical activity behaviors	
“We would like to learn more about things in your neighborhood that affects what your children eat and where they play. For example, some families say where they shop for groceries depends on what kind of transportation is in their neighborhoods.”	
1	Tell me about your neighborhood. What’s it like where you live?
2	Where do you go to buy food for your child? How do you decide where you buy food for your child?
3	Describe where your child plays?
4	How do you decide what play activities your child participates in? If your child plays indoors or outdoors?
5	If you were able to move to a different neighborhood what kind of neighborhood would it be and why?
B. Cultural factors and personal preferences influencing food choices	
“Now, we would like to know more about what your child eats. So, sometimes kids eat what we want them to eat and sometimes they don’t.”	
1	Tell me about your child and what they often eat
2	How do you make sure your child eats what you want them to eat?
3	What kind of information do you use to decide what foods you give your child?
4	Is there something about where you live that makes it harder for you to give your child the food you want to give them? If so, explain. Is there something about where you live that makes it easier for you to do this? If so explain.
“Many people also have family routines related to the food that they eat or how they eat it or prepare it—For example, family dinner on Sundays. Others don’t.”	
5	Tell me about any family routines you had growing up
6	How are these [family routines] the same or different than the ones you practice with your child?

Table 2Demographic Characteristics of Caregivers (n = 30; 3 Missing Surveys).^a

	Total Sample (n = 30); n (%)	Site 1 (n = 21); n (%)	Site 2 (n = 9); n (%)
Age, years			
18–29	12 (40)	8 (38)	4 (44)
30–39	14 (47)	11 (52)	3 (33)
40–49	4 (13)	2 (10)	2 (22)
Gender			
Female	30 (100)	21 (100)	9 (100)
Relationship to child			
Mother	29 (97)	21 (100)	8 (89)
Grandparent	1 (3)	0 (0)	1 (11)
Race/ethnicity			
African American	9 (30)	0 (0)	9 (100)
Hispanic	21 (70)	21 (100)	0 (0)
Country of origin if foreign born			
United States	9 (30)	0 (0)	9 (100)
Mexico	17 (57)	17 (81)	0 (0)
Other ^b	4 (13)	4 (19)	0 (0)
Spoken language			
Spanish	16 (53)	16 (76)	0 (0)
English	14 (47)	5 (24)	9 (100)
Marital status			
Married or cohabitating with partner	20 (67)	18 (86)	2 (22)
Single or not married	9 (30)	2 (9)	7 (78)
Divorced/widowed/separated	1 (3)	1 (5)	0 (0)
Education			
Less than a high school diploma	15 (50)	12 (57)	3 (33)
High school diploma or GED	3 (10)	2 (9)	1 (11)
Some college	5 (17)	0 (0)	5 (56)
Other	7 (23)	7 (33)	0 (0)
Employment status			
Unemployed	25 (83)	19 (91)	6 (67)
Household income, \$ ^c			
30 000	14 (47)	8 (38)	6 (67)
31 000–50 000	3 (10)	1 (5)	2 (22)
>50 000	1 (3)	0 (0)	1 (11)
Insurance			
Medical assistance	27 (90)	19 (90)	8 (89)
Healthy Food Availability Index (HFAI) ^d			
Low	23 (70)	19 (79)	4 (44)
Moderate	4 (12)	0 (0)	4 (44)

	Total Sample (n = 30); n (%)	Site 1 (n = 21); n (%)	Site 2 (n = 9); n (%)
High	6 (18)	5 (21)	1 (11)
Violent crime ^e			
Low	0 (0)	0 (0)	0 (0)
Moderate	4 (12)	2 (8)	2 (22)
High	29 (88)	22 (92)	7 (78)

^aSurveys not completed for 3 site 1 participants.

^bOther includes site 1 participants born in Honduras, El Salvador, and Argentina.

^cTwelve participants at site 1 did not answer this question.

^dTotal n = 33; HFAI is composite score (0–28.5) depicting quantity and quality of healthy foods in Baltimore food outlets. Higher scores indicate more availability of healthy and whole food in food store (low, <8.8; moderate, 8.9–11.5; high, 11.6–24.8).

^eTotal n = 33; violent crimes/1000 residents in neighborhood (homicide, rape, aggravated assault, robbery) (low <10.66; moderate, 11.38–19.03; high, 19.06).

Table 3**Neighborhood Constraints to Caregiver Physical Activity and Diet Preferences—Exemplar Quotes.**

Subtheme 1: Witnessed Violence or Criminal Activity

“Me and our kids actually—we saw a police officer shoot a guy. The news was out there and everything. We actually saw the police officer shoot this guy. We were all out there and he just shot the guy. After that it was a big shock for my son. Now he thinks the police is going to shoot him. I don’t know how he got that perception. I guess from what he saw. I just don’t want them to be comfortable. I want them to know that in the future we are going to be moving. This is not going to be your place. It’s going to be something greater and something better.” (site 2, African American)

Subtheme 2: Neighborhood Safety

“There are also many people who are driving drugged and drunk . . . One time on a weekend we went to the store with my husband . . . We decided to leave the car at home and go walking. We went with the girls. He carried the little one, and I had the big one, when a guy passed by close to our house at the maximum speed. We were there and you have to wait there because usually there is a ‘stop’ but he did not wait, he just flew right by it.” (site 1, Hispanic)

Subtheme 3: Negative Socialization Experiences

“But my three-year-old I don’t let her go out and play because the kids where I live at are ratchet, which means bad. They throw rocks on the playground. They urinate on the playground. I don’t need that. I don’t let her go to that playground.” (site 2, African American)

Subtheme 4: Neighborhood Cleanliness

“We have some neighbors who have dogs . . . and they don’t clean the dog’s poop. The smell of dog waste is unbearable . . . outside in the yard. And then with the heat the smells get worse.” (site 1, Hispanic)

Subtheme 5: Access and Characteristics of Preferred Food Sources

Participant 1: “The area I live in, there’s a cheap market across the street. You’ve got to get what they give, so you’re going to need transportation to get to a good supermarket.” (site 2, African American)

Participant 2: “You got to have transportation to get, like she said, to a good market.” (site 2, African American)

Table 4**Caregiver Strategies to Support/Facilitate Desired Physical Activity and Diet Behavioral Outcomes in Response to Neighborhoods—Exemplar Quotes.**

Subtheme 1: Promoting Indoor Play and/or Enrichment Activities

“Most of the time we’re in the house. I go to the Wal-Mart or the DVD man and we’ll get movies and sit in the house and have a movie night. We bake cakes and cookies.” (site 2, African American)

Subtheme 2: Accessing Outdoor Play Activities Outside Neighborhood

“So he play for them [sports team outside of neighborhood] but we go all the way up there and play for someone else even though he could play for somebody on the corner. I don’t even want him in that type of environment.” (site 2, African American)

Subtheme 3: Utilization of Neighborhood Resources

“No. Where I live it is also quiet . . . my daughter is happy because the park is close by.” (Site 1, Hispanic)

Subtheme 4: Accessing Preferred Food Sources Outside Neighborhood

“I think they could have a better market for the neighborhood. I travel to at least two or three different markets because there’s not one market I can go to go get everything I need. Like she was saying, when it’s not like that, some people don’t have jobs and all they’re dependent on is their food stamps. So if a market is not close, people are selling their food stamps just to get to the market.” (site 2, African American)

Table 5

Caregivers’ Perception of their Agency or Control Over Their Children’s Physical Activity and Diet Behaviors in the Face of Neighborhood Constraints—Exemplar Quotes.

“Sometimes because there are many children and she wants to do the same thing the others are doing. That is when we say no, not there. We are going to another place [park] that is more secluded.” (site 1, Hispanic)
“I’m not going to lie, that’s going to be your breakfast when you get up. You not going to waste no food . . . This is what you’re going to eat.” (site 2, African American)
“It’s not really the food in there, it’s what I choose to feed them from out of that [neighborhood] market.” (site 2, African American)