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A qualitative study to explore Puerto Rican caregiver needs and supports to better feed their children

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Nelly E. Carmona
A Qualitative Study to Explore
Puerto Rican Caregivers Needs
and Supports to Better Feed Their
Children

ABSTRACT

“The worldwide prevalence of childhood overweight and obesity increased 10% between 1990 and 2010”. Boneta, Toro, Garcia, Torres, & Palacios (2015). According to the authors, "Obesity rates of Puerto Rican children residing in mainland US and in Puerto Rico are among the highest (23-32%) when compared to other racial groups/ethnic groups". (p.2)

The purpose of this research is to first primarily understand the challenges that Puerto Rican caregivers' have in providing a diet with high nutritional content for their school age children. A secondary purpose is to use these perspectives of Puerto Rican caregivers to inform social work practice as to how to better serve the needs of this population. Specifically, the question is what are the needs and strengths of low income Puerto Rican caregivers' ability to better feed their children, in Holyoke Ma?

**A Qualitative Study to Explore Puerto Rican Caregiver Needs and Supports to Better
Feed Their Children**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work

Nelly Carmona

Smith College School for Social Work

Northampton, Massachusetts 01063

2017

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Chapter I

Introduction

The purpose of this research study is to focus on Puerto Rican caregivers' behaviors related to; food purchasing practices, access and availability to natural foods, eating behaviors, family engagement, healthy eating, and physical activity, as well as perceived needs and strengths to healthy eating. Ultimately, I'm interested in determining how these behaviors may inform obesity prevention strategies that social worker can engage with caregivers' and their families. My research question is: What are the needs and strengths of low income Puerto Rican caregivers' to help better feed their children, in Holyoke MA? According to Flores, Maldonado, & Duran (2015) "Not enough is known about what Latino parents consider to be healthy eating, engagement of physical activity, and weightmanagement for overweight obese children. A recent exhaustive systemic review of interventions for treating obesity concluded that a largely unanswered question is, what interventions are most effective for specific ethnicities or culturally diverse populations" (p.81) Through this research I expect to gain insight into the challenges that Puerto Rican caregivers face in providing healthier food so as enable social work practice to better assist these caregivers. I also hope to identify appropriate resources and address the needs of Puerto Rican families on the needs to help better feed their children. To date I have not found literature that specifically looks solely at what Puerto Rican identified caregivers, perceive they need to help with obesity prevention. I have been able to find research on obesity prevention with other Latino populations, but not specifically on the Puerto Rican

Population. There are several possibilities as to why the literature has not specifically looked at obesity prevention strategies amongst Puerto Rican caregivers'. One possibility is that the Puerto Rican race is often misrepresented because of its incorporated status with the United States. In 1898, Puerto Rico became a territory (Commonwealth) of the United States of America and Puerto Ricans have common citizenship, currency and defense.

I conducted a qualitative study where three focus groups were held for discussion, with a total of eighteen participants. The focus groups consisted of Puerto Rican identified caregivers of school aged children. For the purpose of this study, "caretakers - who will be referred to as caregivers – included a (a)parent, (b) stepparent, (c) guardian, (d) a foster home, or any other comparable setting. The "caretaker" definition is meant to be construed broadly and inclusively to encompass any person who is, at the time in question, entrusted with a degree of responsibility for the child." Massachusetts Department of Children and Families (2014). The participants were able to discuss, and comment on, from personal experiences, what they believe they need to help with obesity prevention strategies. I asked 19, specific, pre-drafted, question about caregiver behaviors related to; food purchasing and practices, access and availability to natural foods, eating behaviors, and physical activity.

Literature Review

Chapter II

According to Flores, Maldonado, & Duran (2015) "Not enough is known about what Latino parents consider to be healthy eating, engagement of physical activity, and weightmanagement for overweight obese children. A recent exhaustive systematic review of interventions for treating obesity concluded that a largely unanswered question is, what interventions are most effective for specific ethnicities or culturally diverse populations" (p.81). Through this research I expect to gain insight into the challenges that Puerto Rican caregivers face in providing healthier food so as enable social work practice to better assist these caregivers. I also hope to identify appropriate resources and address the needs of Puerto Rican families on these needs to help better feed their children.

The literature reviewed below relates to access and availability to natural foods, lack of parental knowledge, food purchasing practice, eating behaviors, family engagement, healthy eating, physical activity and food related attitudes of low income families. The literature below highlights common themes seen in childhood obesity such as over eating, lack of exercise, television viewing, and socio-economic status. all common themes contributing to the national epidemic and health care crisis of childhood obesity. However, the literature does not discuss what supports caregivers need to help better feed their children, specifically Puerto Rican identified caregivers. The gaps in the literature support the need for a study to help identify the supports and needs of Puerto Rican caregivers to help feed their children a more natural healthier diet, which may help to decrease obesity rates in Puerto Rican school aged children.

Causes of Childhood Obesity

Torres, et al., (2014) completed an island wide, cross sectional study in Puerto Rico in which they examined oral health, dietary practices, and weight status in a sample of 1,550 children, aged 12 years, enrolled in academic year 2010-2011, the diet quality was examined by the Healthy Eating Index (HEI-2005). The authors studied whether diet quality had relationships with social determinants, by completing a 24-hour diet recall as part of their study. The authors interviewed the children at school as part of their study to determine what food and beverages were consumed by the children within the last 24 hours of the interview. (Parents were not part of the interviews). The study showed that the sample consumed a higher amount of sugary beverages, sodium and meats compared to the dietary recommendations at that time. The authors speculated that access and availability were a cause of the overweight and obese sample as the children who were considered to be of lower socio-economic status (children who attend public schools) compared to children who were from a higher socio-economic status (children who attended private schools) had lower levels of obesity rates and consumed a higher score of fruits, whole grain, and dark green vegetables. The authors speculated that children from the public school system had lower obesity rates because they were part of the National School Lunch Program (NSLP) which includes a fruit and vegetable in every meal served compared to the children who attend private school which is known to be limited in serving fruits, and vegetables. However, the study did not explore parental food choices and food related attitudes and behaviors of caregivers. The study showed that social determinants such as access, availability and accessibility of foods, and parental socio economic status were correlated with the overall quality of diet. However, this study did not include caregivers' perceptions or interpretations of what they believe a healthy

diet consists of or what the common barriers are to feeding their children a healthy diet. The gaps in this study support the need for my research. Because I will seek answers directly from caregivers' perspectives my study will help answer my question of what parental supports are needed to help better feed their children.

Research by Hayter et al. (2015) discusses a qualitative study that they completed which explored reasoning for eating habits among low income preschool aged children in the UK with hopes of informing the development of a nutrition intervention. Key themes in this study that the authors explored and that support my study include “affordability of food, supermarkets, food shopping, and food marketing; and parental role modelling.” According Hayter et al., (2015), affordability was a recurring dominant theme. Parents discussed foods they wished to buy such as natural fruits and vegetables but could not afford to do so based on their monthly income. One of the study participants thought that fruits and vegetables were cheaper to purchase due to access to cheaper local markets. The authors discussed food marketing and supermarket promotions having an effect on purchasing behaviors, especially if the children were present with them. Family influences and challenges to parental practices was another barrier that mentioned by participants in the study. This study concluded that poor eating habits of preschool age children were not solely correlated with lack of parental knowledge, or social supports, but were also attributed to coping strategies, and affordability. This study further supports the need for a study to explore food related attitudes and behaviors of Puerto Rican caretakers and school aged children.

According to Boneta. E., R., A., Toro. J., M., Garcia. O., Torres. R., & Palacios. C (2015), "The worldwide prevalence of childhood overweight and obesity increased 10%

between 1990 and 2010" (p. 1) "During the last 30 years, childhood obesity in the US has more than doubled and has quadrupled in adolescents. The authors wrote, "Obesity rates of Puerto Rican children residing in mainland US and in Puerto Rico are among the highest (2332%) when compared to other racial groups/ethnic groups". The authors examined a study where the objectives were to establish the BMI prevalence on 12-year olds residing in Puerto Rico and to determine BMI difference by sex, public-private school type and geographic regions. According to the authors "The prevalence of overweight or obesity of 12-year-olds residing in Puerto Rico were 18.8% and 24.3% respectively; higher than in the U.S. (by groups). Boys were at higher risk of obesity than girls", (p.1) Similar to study completed by Torres, et. al., (2014) were the authors found that children who attend private school have a higher prevalence of being overweight and obese than those attending public schools. According to Boneta. E., R., A., Toro. J., M., Garcia. O., Torres. R., & Palacios. C (2015), parents of a higher socio-economic status have a "higher purchasing power" leaving their kids with more opportunity to consume fast foods and junk foods, leading to increased obesity rates. Boneta. E., R., A., Toro. J., M., Garcia. O., Torres. R., & Palacios. C (2015) also references The National School Lunch Program (NSLP) which the authors also considered to be a factor in the difference in obesity rates between children who attend private school compared to those who attend public school as the NSLP is known to provide balanced meals that include fruits and vegetables with every meal served which may be contributing to lower rates of children who are overweight or obese. In this same study the authors found higher rates of obesity in the Northeast, Northwest, and Ponce regions of Puerto Rico compared to those living in the mountain and Southwest regions of the Island. The researchers considered possible factors contributing to obesity to be the children's access and availability to healthy

and unhealthy foods and food outlets, and access to recreational activities. With my study I will also explore whether or not factors such as access and availability to healthy and unhealthy foods, and access to recreational activities (specifically with Puerto Rican caregivers' who reside in a metropolitan area) are contributing factors to the obesity rates seen in Puerto Rican school aged children residing in Holyoke Massachusetts.

Research by Beals. H., J. & Kulick. R. (2013) The authors discuss the relationship between television viewing and childhood obesity. The study that was discussed in this article found that children ages seven and older who view television have a higher Body Mass Index(BMI) compared to children who did not view television. In this same article, the authors studied whether advertising is the causal mechanism for this result by comparing the BMI of children who watched live television with those who viewed similar programming on video or DVDs. The authors found that the restrictions on advertising played a small role with the fight against childhood obesity. This authors in this study used data which was collected from the Panel Study of Income Dynamics (PSID) "The PSID is a nationally representative sample that has followed 9,000 families since 1968." This study uses secondary data from a different context and time where the context was historically and culturally different. My study will explore caregivers in a different historical context through focus groups on the relationship between physical activity and childhood obesity, specifically asking questions about time spent watching television and exploring the challenges that caregivers face on getting children to engage in physical activity to help determine if there is a relationship between television viewing, playing video games, or using the computer contributing to the obesity rates seen amongst Puerto Rican school aged children.

Access and Availability to Healthy Foods

Lin, Ploeg, Kasteridis, & Yen (2014) cite environmental factors such as food access and availability, neighborhood safety, and extracurricular activities for children as potential contributing factors to health and nutrition disparities. The authors use mixed results from a number of studies previously conducted associated with limited supermarket access in food purchases and food intake in low income communities. The study they conducted was to prove that for a healthy diet intake in low income households, the foods should be available and priced affordably. The findings from this study did conclude that food prices were determinants of food budgets and barriers to food access have only limited effects on food budget allocation among SNAP participants. My study will explore through focus groups with low income families who reside in a shelter setting if poverty is associated with food insecurities among low income Puerto Rican caregivers who reside in Holyoke Massachusetts.

Handbury, Rahkovsky, & Schnell, (2015) discuss poor nutrition and its possible correlation to limited access to healthy foods. The authors in this working paper try to prove that increasing access to retail stores selling healthy food will have a positive impact on the nutritional diet across the entire socioeconomic spectrum. The authors note “Contrary to this assumption, our analysis suggests that disparities in nutritional consumption are not driven by differential access to healthy food products across different demographic groups.”(P. 29) In this study, the authors linked food disparities to low education and socio-economic status. My study will fill the cultural gap, among Puerto Rican caregivers to help determine what are the strengths and needs to help better feed their children a healthier nutritional diet.

Lack of Parental Knowledge

According to Flores, Maldonado, & Duran (2016), "Latinos continue to be amongst the most overweight racial/ethnic groups of US children" (p.81) Just as my study will, this study examined through focus groups, parental perspectives on healthy eating, physical activity and weight management strategies for overweight Latino children. Caregivers' in this study were asked a series of 33 questions and sampled four healthy substitutes for traditional Latino foods. Parents identified strategies to help overweight children lose weight, and strategies overweight children can do to help themselves lose weight. the study informs practice research for managing a child who is already overweight and obese and does not talk about what a caregiver can do to avoid a child from reaching the being overweight or obese. In this same study, the authors explored with caregivers' specific substitutions such as whole wheat instead of flour tortillas, brown rice instead of white rice, tortilla made with oil instead of lard, reductions in meat consumption, increasing vegetables and fruits in meals, and consuming water and low-calorie drink mixes instead of sugary beverages. In this study the authors substitute traditional foods, implying that their foods and ways of eating are unhealthy rather than exploring what the strengths and needs of the caregivers to help better feed their children. The gaps in the study show the need for my research which will seek answers directly from a caregiver's perception of what their strengths and needs are while specifically exploring their behaviors related to food purchasing practices and food choices

Write, Donley, Gualtier, & Strickhouser (2016), discuss 24 peer-reviewed studies which examined neighborhood disparities in access to fast-food outlets and convenience stores. Nine of those studies involved American participants in which the authors reviewed racial and ethnic disparities in exposure to fast food and convenience stores. All nine studies

linked higher consumption of unhealthy foods to communities where fast food and convenience food were heavily promoted. In this same article, the authors also discuss how this exposure and habits are causes of poor nutrition in low income communities. A few studies that were reviewed by the authors in this article connected poor nutrition to lack of parental nutritional knowledge. The article also reviewed similar studies that showed opposite findings, in one of the studies it was concluded that African American women with low income status had an understanding of healthy foods but choose to continue to eat in an unhealthy way. The article linked economics of eating healthy, class, race, lack of parental knowledge and food cultures in relations to poor nutrition and nutritional accessibility. Similarly, my study will explore with caregivers' access and availability, family engagement and food insecurities to help determine caregiver strength and needs to help better feed their children.

Bender, Naderm, Kennedy & Gahagan, (2012) evaluated the feasibility of culturally relevant 9-month intervention program aimed at improving health behaviors in a low income Mexican community. They used a pilot pre-test/post-test that assessed the consumption of sugar-sweetened beverages(SSB), mothers' pedometer steps, and BMI which included 33 mother-child dyads who were enrolled in a California urban health center. The results of this study concluded that as a baseline children were drinking on average 3.3 ounces a day of soda, 8.8 ounces a day of 100% juice, 6.4 ounces a day of other sugary drinks, 19.8 ounces a day of water and 14.3 ounces a day of milk. At post intervention, the consumption of soda declined 82%, 30% for 100% juice, and by 73% of other sugary drinks. The water consumption increased by 46%. At the 6-month post-intervention the children maintained the levels of consumption for sugary drinks, water and milk but the soda and 100% juice reverted to

baseline. The findings of this study showed that at the post intervention children's consumption of SSB decreased while the consumption of water and milk increased, but these results were not fully sustained at the 6-month post intervention follow up as some of the behaviors did revert back to the baseline behaviors of consumption. If these supports were ongoing and available, the outcome could look different. My study will address the gaps in this research seeking answers directly from caregivers to try and understand what supports could be implemented to help better feed their children, to help inform obesity prevention strategies amongst the Puerto Rican community in Holyoke Ma.

Moyer, Carbone, Anliker, & Goff, (2016) review results from a qualitative study on the impact in mandated BMI testing and notification of Massachusetts school age children had on caregivers. The study relied on caregiver focus groups convened to understand how caregivers felt about and responded to a mandated body-mass index (BMI) screening of students. The study also took into consideration how well caregivers understood what was contained within the notification, assessing "readability" and comprehension of the material. The study explored common themes and emotions between the caregivers and the material used. The study concluded that many caregivers did not understand the material that was sent home with their children informing them of their children's BMI results. Common emotional reactions included acceptance, denial, and anger as some parents believed that this information should not be coming from the school, yet the information, but rather from a pediatrician or family physician. This shows the need for my research as it will answer the gaps between caregivers' perception and further explore with them what they believe they need for support to help better feed their children. My study will seek to address those gaps identified in this literature.

[do you want to say “how they use the information provided to them to better feed their children instead of the wording you have chosen?]

Increase in Over-Processed Food Consumption

Cortés, Ferro, Schneider, Vega, & Caballero, (2013) conducted a pilot study to better understand food shopping practices amongst Spanish speaking, low income families. The authors examined the amount of highly processed foods being purchased in low income homes. The authors analyzed shopping practices of twenty families to help determine what supports may be helpful for low income families in order to make healthier purchases (such as budgeting, identification of healthier options etc...) Over the course of six months, the families received nutrition education, three to five home-visits, and a grocery store tour. After the study was done, the authors found that with nutrition education and the grocery store tour families reduced the number of calories consumed and calorie intake per dollar per purchase. The study found that with social support and nutrition education about foods that are purchased, families did decrease the daily calorie intake. My study seeks to identify ' behaviors related to food purchasing practices, access and availability to natural foods, eating behaviors, family engagement, healthy eating, and levels of physical activity as well as perceived needs and strengths for healthy eating to explore caregivers' strengths and needs help to better feed their children.

Engagement of Physical Activity

Brown, Schiff, & Sluijs, (2015), discuss the importance of children's activity levels in social, health, and educational benefits as being key incentives for involvement in children's physical activity. This study explored through focus groups with families the barriers to and benefits of being involved in physical activity along with the development of effective

recruitment and retention strategies for children and their families. According to the authors, the study showed that increased time commitment or scheduling difficulties were quoted as the most pertinent barriers to involvement in physical activity research. [This study shows the need for my research because it will explore barriers caregivers' face with getting children involved in physical activity, exploring directly with caregivers how these behaviors may inform obesity prevention strategies allowing for social workers to engage with caregivers and their families which may inform obesity prevention strategies.

McGarvey, et. al., (2006) discuss a study that explored qualitatively maternal feeding practices and beliefs. The purpose of the study to help develop an obesity prevention program, specifically for multi- ethnic parents receiving benefits under a federal supplemental nutrition program. The authors used a focus group approach where they collected perspectives on (a) infant and child feeding practices, (b) childhood overweight, (c) healthy dietary intake, (d) physical activity and in activity and (e) infant feeding information services (2006). Common themes that were heard across all participant ethnic groups were lack [*of understanding*] of the connection between physical activity and health, lack of parental control of children's eating habits when in school, and using food as a means to control a child's behaviors. In this same study, when the authors spoke about parent and child free time and physical activity, it was noted that the Hispanic ethnic group did not respond to the parent and child free time and physical activity portion of the study. The common barrier that the other parents of the ethnic groups spoke about in the study, was neighborhood safety, and lack of time to engage in such activity. It was noted that physical activity was not related to healthy weight status with their children. My study will explore with caregivers what parent and child free time looks like, what challenges they face with getting their children to exercise, and

what supports will be useful to help with increasing levels of family engagement in physical activity to help inform obesity prevention strategies.

Case Study of Holyoke

Demographics

According to the 2010 United States Census Bureau, the city of Holyoke has 39,878 people, 14,977 households, and 9,478 resident families. The racial makeup was 61.76% White, (Non-Hispanic White 47.1%), 5.8% African American (Non-Hispanic 3.4%), 0.38% Native American, 1.81% Asian, 0.12% Pacific Islander, and 6.81% from two or more races. Hispanic or Latino of any race were 47.4% of the population. The median income for a household in the city was \$33,242, and the median income for a family was \$39,130. The per capita income for the city was \$16,913. About 22.6% of families and 26.4% of the population were below the poverty line including 41.7% of those under age 18. According to the Massachusetts Department of Public Health Massachusetts Community Health Information Profile (MassCHIP) for Essential School Health Services(ESHS) data report for the city of Holyoke, 21.5 % of the Holyoke children are obese, compared to the 16.3% for the state as a whole and 21.1% are overweight, compared to the 17.1% of children who are overweight in the state. In Massachusetts in 2011, black adults were 43% more likely to be obese, and Hispanic adults were 40% more likely to be obese than white adults (2011 MA BRFSS).

Conclusion

This research review summarized the findings of many studies that examined the correlation between obesity and nutritional behaviors of caregivers related to food purchasing practice, access and available to natural foods, eating behaviors, family engagement, healthy eating habits and physical activity. This research provides a foundation for further exploring

the question: What Are the Needs and Supports of Puerto Rican Caregivers to Better Feed Their Children in Holyoke Massachusetts? The various themes and findings reviewed in the literature support and critique the rationale regarding the central question of my thesis. This review also exposes some important areas of support that caregivers needs such as food substitutes, written information for caregivers from food support organizations in their community, for increased parental knowledge and access to safe areas for children to engage in physical activity as dietary and physical activity behaviors of children and adolescents are influenced by many sectors of society, including families, communities, schools, health-care providers, the media, and the food and beverage and entertainment industries. Childhood obesity continues to be a national epidemic, and health care crisis and there continues to be a critical need for childhood obesity interventions that include the societal change.

Good nutrition and healthy eating habits is a key factor to preventing obesity as well as the chronic diseases related to it. Poor nutrition in children and resulting obesity may be caused by lack of parental knowledge, access and availability to food, an increase in over processed food consumption in the last 30 years and lack of social supports. All caretakers no matter their socio economic status or level of education must have access to the social supports related to providing healthy nutrition to their children so their children can perform better physically and mentally, maintain wellness and help their bodies fight diseases. This study will explore the strengths and needs of Puerto Rican caregivers' as they work towards improved diets for feeding their children. The study will also provide insight from the perspective of Puerto Rican caregivers in Holyoke of school-age children to inform social work practice in better meeting the caregivers needs which in turn can help inform social workers to identify appropriate resources and address family needs.

Chapter III

Methodology

The purpose of this research is to first primarily understand the challenges that Puerto Rican caregivers' have in providing a diet with high nutritional content for their school age children. A secondary purpose is to use these perspectives of Puerto Rican caregivers to inform social work practice as to how to better serve the needs of this population. Specifically, the question is what are the needs and strengths of low income Puerto Rican caregivers' ability to better feed their children, in Holyoke, Ma? This study will provide insight while meeting and supporting caregiver needs. The research method I intend to use to conduct my research includes a qualitative exploratory study of supports caregivers need to better feed

their children. I chose a qualitative study as I would like to explore through focus groups' with caregivers and their perspectives. According to Liamputtong (2011) "Focus group methodology is useful in exploring and examining what people think, how they think, and why they think the way they do about the issue of importance to them without pressuring them into making decisions or reaching a consensus" (P.5). The use of a focus group will allow me the opportunity to gather data on different perceptions regarding the eating habits of Puerto Rican caregivers and points of views on what supports they feel they need to better feed their children. My questions will include how these caregivers define obesity, access to vegetables and fruit, engagement with physical activity, and needs, strengths and recommendations. According to Krueger and Casey (2009) "The purpose of conducting a focus group is to listen and gather information. It is a way to better understand how people feel or think about an issue, product, or service. Focus groups are used to gather opinions". My focus groups will allow for opinions of caregivers' which will help inform social workers to identify appropriate resources and address Puerto Rican family needs. The focus groups will also help with exploring potential ways to increase awareness of the eating behaviors of Puerto Rican school aged children, related to; food purchasing practice, access and availability to natural foods, family engagement, as well as perceived needs and strength to healthy eating.

Sampling and Questions

The study will utilize purposive sampling, selecting members of the community who will provide the best information on this research. Volunteers will also selfselect by responding to flyers posted on the boards of community-based agencies and word of mouth to represent the caregivers. For the purpose of this study, caretakers - who will be referred to as caregivers – can include a (a)parent, (b) stepparent, (c) guardian, (d) a foster home, or any

other comparable setting. The “caretaker” definition is meant to be construed broadly and inclusively to encompass any person who is, at the time in question, entrusted with a degree of responsibility for the child. (Mass. Gov. 2008 Department of Children and Families) In addition to being a caregiver, participants will have to identify as being Puerto Rican. Rubin & Rubin (1995) suggest three guidelines for selecting information when designing any purposive sampling strategy. Informants should be knowledgeable about the cultural arena or situation or experience being studied, willing to talk, and represent [ative of] the range of points of view.

According to Krueger & Casey (2009) “The ideal size of a focus group for most noncommercial topics is five to eight participants.” Data will be collected by conducting between two and three focus groups with six to ten participants in each group with a goal of interviewing sixteen to twenty-four adult caregivers. The study sample will specifically include; Puerto Rican identified caregivers, who have school age children in their home, and who reside in Holyoke Massachusetts. The focus groups, will include eighteen questions which are intended to be clearly understood by the respondent, allow for the respondent to be able to articulate an answer, and will insure that I as the interviewer will be able to understand the answers. The questions are intended to evoke conversation, be clear, short, and open-ended. Participants who I will be excluding are juvenile parents under the age of 18, non-Puerto Rican identified participants, and participants who live outside of the Holyoke area. Questions will be in both English and Spanish and will be short and uncomplicated. The questions will allow me to seek in-depth information on feelings, experiences and perceptions to better understand the caregivers’ nutritional habits of how they feed their children and the reasons surrounding such habits.

Table 1: Demographics of Focus Group One

Gender (N=6)	Number	Percent
Female	5	83.3%
Male	1	16.6%
Age (N=6)	Number	Percent
18-24		
25-34	2	33.3%
35-44	3	50.0%
45-54	1	16.6%
55-64		
65-74		
75+		
Marital status (N=6)	Number	Percent
Single, never married	3	50.0%
Married or domestic partnership	1	16.6%
Widowed		
Divorced		
Separated	2	33.3%
Income (N=6)	Number	Percent
Under \$25,000	6	100.0%
\$25,000-\$40,000		
\$40,000-\$60,000		
More than \$60,000		
Food assistance (N=6)	Number	Percent
SNAP Benefits	4	66.6%

WIC Benefits		
	Number	Percent
None	1	16.6%
Other	1	16.6%
Grocery store (N=6)		
	Number	Percent
C-Town	2	33.3%
Stop and Shop	2	33.3%
Cuba Supermarket		
Neighborhood Bodega		
Other	2	33.3%
Neighborhood (N=6)		
	Number	Percent
Flats		
Elmwood		
Highlands		
Homestead Ave		
Jarvis Ave		
South Holyoke	6	100%
Springdale		
Whitening Farms		
Other		

Table one is a description of demographics from the first focus group, which was held on March 27, 2017. This First focus group was held in the community resource room in a shelter based setting. Families have their own apartments but have many rules such as check in and check outs every time they leave the building, they have curfew and do have to pay a portion of their income towards cost of living. This group represented five female caregivers, and one male caregiver. 33.3% of the caregivers reported to being between the ages of 25-34 years old, 50% of the caregivers reported to being between the ages of 35-44 and 16.6% reported being between the ages of 45-54 years of age. 50% of the caregivers reported being single, never married, 33.3% reported being separated, and 16.6% reported being married. 100% of the caregivers reported an income of under \$25,000. 66.6% of the caregivers reported to receiving Supplemental Nutrition Assistance Program(SNAP) benefits, 16.6% reported other, reporting to receiving both SNAP and disability for food assistance. 16.6% reported to not receiving any food assistance. When asked about what grocery store the caregiver shops at, 33.3% reported to shopping at C-Town supermarket, 33.3% reported to shopping at Stop & Shop and 33.3% reported other, one caregiver marked down Sam's Club and another reported C-Town and Meat-Outlet. When asked about what neighborhood they lived in, 100% of the participants reported to living in the South Holyoke neighborhood of Holyok

Table 2: Demographics of Focus Group Two

Gender (N=6)		
	Number	Percent
Female	6	100%
Male		
Age (N=6)		
	Number	Percent
18-24		
25-34	4	66.6%
35-44	1	16.6%
45-54	1	16.6%

55-64
65-74
75+

Marital status (N=6)	Number	Percent
Single, never married	3	50.0%
Married or domestic partnership	2	33.3%
Widowed Divorced Separated	1	16.6%

Income (N=6)	Number	Percent
Under \$25,000	6	100.0%
\$25,000-\$40,000		
\$40,000-\$60,000		
More than \$60,000		

Food assistance (N=6)	Number	Percent
SNAP Benefits	6	100.0%
WIC Benefits		
None		
Other		

Grocery store (N=6)	Number	Percent
C-Town	2	33.3%
Stop and Shop Cuba Supermarket Neighborhood Bodega Other	4	66.6%

Neighborhood (N=6)	Number	Percent
Flats	2	33.3%
Elmwood Highlands Homestead Ave Jarvis Ave South Holyoke Springdale Whitening Farms Other	4	66.6%

Table 2 is a description of the demographics of the second group which was also held at a community housing shelter placement. This Focus group had 6 participants who all identified as female caregivers. 66.6% of the participants were reported to be between the ages of 25-34, 16.6% reported to be between the ages of 35-44 and another 16.6% reported to be between the ages of 45-54. 50% of the participants reported being single, never married, 33.3% reported being married or in a domestic partnership and 16.6% reported to be widowed. All 6 caregivers reported a yearly income of under \$25,000, and all 6 caregivers reported receiving Supplemental Nutritional Assistance Program(SNAP) benefits. When asked which grocery store the caregivers shop at, 33.3%reported shopping at C-Town Supermarket, and 66.6% reported to shopping at other places, these places included Bj's, Save-A-Lot, both C-Town and Stop & Shop, and Stop & Shop, C-Town, and Bodega. When asked about what neighborhood they lived in, 33.3% reported living in the flats section of Holyoke while 66.6% reported living in South Holyoke.

Table 3: Demographics of Focus Group three.

Gender (N=6)		Number	Percent
Female	Male	6	100%

Age (N=6)		Number	Percent
18-24			
25-34		1	16.6%
35-44		2	33.3%
45-54		2	33.3%
55-64		1	16.6%
65-74			
75+			

Marital status (N=6)		Number	Percent
Single, never married		2	33.3%
Married or domestic partnership		2	33.3%
Widowed			
Divorced		2	
Separated			33.3%

Income (N=6)		Number	Percent
Under \$25,000		5	83.3%
\$25,000-\$40,000		1	16.6%
\$40,000-\$60,000			
More than \$60,000			

Food assistance (N=6)		Number	Percent
SNAP Benefits		5	83.3%
WIC Benefits		1	16.6%
None			
Other			

Grocery store (N=6)		Number	Percent
C-Town		2	33.3%
Stop and Shop		1	

Cuba Supermarket
 Neighborhood Bodega
 Other

Neighborhood (N=6)	Number	Percent
	3	50.0%
Flats	6	100%
Elmwood		
Highlands		
Homestead Ave		
Jarvis		
Ave		
South Holyoke		
Springdale		
Whitening Farms Other		

Table 3 is a description of the findings of the third focus group I held. This Focus group was held in a community resource center in Holyoke. There were 6 participants present for this group, all identified as being female caregivers. 16.6% of the caregivers' reported to being between the age of 25-43, 33.3% reported being between the ages of 35-44, another 33.3% reported being between the ages of 45-54 and 16.6% reported being between the ages of 55-64. 33.3% reported being single, another 33.3% reported being married and another 33.3% reported being separated. 83.3% reported an annual income of under \$25,000 and 16.6% reported an annual income between \$25,000-\$40,000. When asked if the caregivers receive food assistance, 83.3% of the participants reported receiving Supplemental Nutrition Assistance Program benefits, and 16.6% reported receiving Woman Infant and Children(WIC) benefits. When asked which grocery store they shopped at, 33.3% reported to shopping at C-Town supermarket, 16.6% reported to shopping at Stop & Shop, and 50% reported to shopping at other, this included Price Rite, C-Town and Stop & Shop, and C-Town and Price Rite. All 6 participants reported to residing in South Holyoke.

Demographic Questioner [See Appendix_ G]

A demographic questionnaire was included to obtain specific data about participants' age, gender, marital status, geographic location, employment status, which supermarket they shop at, and a question on supplemental services. The demographic questionnaire will help me determine factors that could influence a respondent's choice of answers which in turn will allow me to split the respondent's answers into certain groups, and see how these groups vary. Specific demographic questions include Q.1 which supermarket do you shop at for your groceries, Q.2 What part of Holyoke do you live in, Q.3 Do you receive any food assistance? If so which one? Q.4 Employment Status and household income range, Q.5. What is your gender? Q.6 What is your age? Q.7 What is your marital status? The demographic data will

be used to help me answer my research question as it is intended to help describe the study sample so that readers might be able to account for similarities and differences across studies.

Focus Group Guide [See Appendix_ D]

The Focus Group Guide asks participants to define obesity, respond to questions concerning access and availability to vegetables and fruits, define the level of physical activity, and electronic activity, including common challenges and barriers, level of family engagement in terms of eating together, or being physically active with each other and discussing perceived needs and strengths.

Data Collection Procedures

Before beginning data collection efforts, HSRB was approved through the Smith College Human Subjects Review Board. After obtaining permission to conduct the study from the HSRB, flyers were posted by organizations who gave approval for permission to post; The Department of Children and Families, The Holyoke Public School Department, The Mayor's Office, Holyoke Health Center, and New England Farm Workers Council. Flyers were available in both English and Spanish, (see appendix_ E Focus Group Flyers). The flyers will have offered my direct contact information, the title of my study, the length of each focus group, and two tentative dates for the focus groups I will be hosting. Once participants are identified, I will host between two and three focus groups lasting between 60-90 minutes, for the discussions where participants will be able to freely discuss and comment on from personal experiences. With permission from participants, I plan on audio recording caregivers' responses, and taking notes. Once given permission to record, I will start the

recording as soon as I start to lead the discussion. I will lead the discussion by asking questions one at a time, have an open-ended discussion, take notes, and after 15 minutes move forward with the next question. I will repeat the note taking process. I will then go home and within five days transcribe the audio recording. Participants will also be offered the ability to attend a second meeting, a voluntary attendance meeting, which will be opened to the community to disseminate my findings. I will ensure to inform caregivers of the community meeting at each focus group held.

Limitations

There are some limitations to this study may affect the generalizability of the results. The small sample size does not represent the larger population, discussions can be difficult to navigate or control, causing for a loss of time to answers or discussions that may be offtopic. Participants in the focus group may also behave differently from how they would normally behave because they are in a setting where they are being watched and may not feel comfortable being themselves which can affect the quality of the research results.

Ethical Considerations

“The National Association of Social Workers (NASW) acknowledges the importance of social worker’s contribution to knowledge as well as monitoring and evaluating practice and policy implementations. Given that social workers may be actively engaged in evaluation and research, The NASW has incorporated the four guide lines listed below into its ethical code”. 1) to protect research Subject, 2) TO maintain honesty and openness, 3) To achieve valid results, and 4) to encourage appropriate application of the findings. Schutt

& Engal.(2017). This study was deemed by Smith College Institutional Review Board (IRB) to pose “minimal risk” defined as “no more risk than you would encounter on an ordinary day of living. “Those who participate in the study, must be informed of the study rewards and risks, told the study is voluntary and confidential, and told they can quit participating at any time.” Krueger & Casey, 2009 There may be some risk and ethical considerations through-out the study which will be taken into account. For example, caregivers in the study may be at risk for disclosing possible neglect, and caregivers’ may feel uncomfortable socially in sharing challenges with fellow participants. As a result, consideration had been given to insure that participation in the study does not trigger participants prior to consenting to the study. Taking this into account potential risk will be outlined for participants prior to consenting in the study. Additionally, a list of food and mental health resources will be offered at the end of the focus groups in case participants experience any emotional stress or desire to know ways to nutritional supports.

Data Analysis

“Many approaches to qualitative data analysis share five different techniques: 1) Documentation of the date and the process of data collection, 2) Organization/ categorization/condensation of the data into concepts, 3) Examination and display of relationships between concepts, 4) Corroboration/legitimization of conclusions by evaluating alternative explanations and disconfirming evidence and searching for negative cases, 5) reflection of the researchers role”. Schutt & Engal., 2017. Data will be collected for the study through the utilization of focus groups. Myself along with a volunteer, Paola Gallego (please see appendix_ H for signed, Volunteer or Professional Transcriber’s Assurance of research Confidentiality Form) will be taking notes through-out each group. All research material

including recordings, transcripts analysis and consent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period they will be kept secured until no longer needed, and then destroyed All electronically stored data will be password protected during the storage period. The qualitative data will be transcribed in written form for closer study. there will be a coded sheet based on major themes which may emerge during the study. The researcher will code the themes from each focus group.

As participants enter the space, I will have a table set up at the entrance of the space set up with name labels. I will request for each caregiver to fill out a name label with a pseudonym names in order to maintain everyone identity for this research. (I will provide labels, and markers). Bottles of water, coffee and tea will also available for caregivers. I will also request for caregivers to fill out a short demographic form which will allow for me to identify their names, (real and fake) gender, number of children in their household, range of income, and food assistance status. This will also be at the table. I will request for caregivers to fill out, and hand in prior to the group commencing. After the group is settled and all caregivers are seated and ready to commence, I will start the audio recording. I will then begin the group with an introduction of who I am, where I am employed, the reason for my study, (for part of my thesis completion). I will also introduce my note taking volunteer. After the introductions, I will go over group guideline (please see appendix_ D), and inform participants that the length of the group. I will ask caregivers to review and sign the Focus Group Confidentiality Form, if they agree to the terms, thank them in advance for their time and allow for five to ten minutes for questions, if they have any. I will then lead the discussions by asking questions one at a time, have an open discussion, take notes, and after

about fifteen minutes' move forward with the next question. I will repeat the note taking process. I will then go home and within five days transcribe the audio recording. All research materials including recording, transcriptions, and analyses documents will be stored in a secure location for three years in accordance to federal regulations. Consent forms will be stored separately in a secure location for three years as according to the federal regulations. If materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period.

Chapter IV

Findings

Table 1 is a description of participants' demographics. Most participants identified as female caregivers, one identified as male. Some participants reported to being between the ages of 24-34, some reported to be between the ages of 35-44, few reported to being between 45-54, and one reported to being between the ages of 55 and 64. Some participants reported to being single, never married, some reported to being married, few reported to being widowed and some reported to being separated. Most of the participants reported to residing in South Holyoke while few reported to living in the Flats neighborhood of Holyoke. Most participants reported a yearly income of under \$25,000, while little reported a yearly income of between \$25,000 and \$40,000. Some participants reported to shopping at C-Town Supermarket, some reported to shopping at Stop and Shop, and half of the participants reported to shopping at other places, these places included; Price Rite, BJ's, Sam's Club, Save-A-Lot, and Meat Outlet. In appendix one, the table is broken down further into each focus group so you can see the representation of demographics broken down by each group. See appendix one.

Table 4: Demographics of Puerto Rican Care Givers, in Holyoke, MA

Grocery store (N=18)		
	Number	Percent
C-Town	6	33.3%
Stop & Shop	3	16.6%
Cuba Supermarket		
Neighborhood Bodega		
Other	9	50%
Neighborhood (N=18)		
	Number	Percent
Flats	2	11.1%
Elmwood		
Highlands		
Homestead Ave		
Jarvis Ave		
South Holyoke		
Springdale	16	
Whitening Farms		
Other		88.8%
Food Assistance (N=18)		
	Number	Percent
SNAP benefits	15	83.3%
WIC benefits	1	5.55%
Other	3	16.6%
Average household income (N=18)		
	Number	Percent
Under \$25,000	17	94.4%
\$25,000-40,000	1	5.55%
40,000-60,000		
More than 60,000		
Gender (N=18)		
	Number	Percent
Male	1	5.55%
Female	17	94.4%
Other		
Age (N=18)		
	Number	Percent

18-24		
25-34	7	38.8%
35-44	6	33.3%
45-54	4	22.2%
55-64	1	5.5%
65-74		
75+		
Marital Status (N=18)	Number	Percent
Single, never married	8	44.4%
Married	5	38.8%
Widowed	1	5.5%
Divorce		
Separated	4	22.2%

Table 1 is a description of participants' demographics. 33.3% of the participants reported that they shopped at C-Town Supermarket, 16.6% reported to shopping at Stop and Shop, 50% of the participants reported to shopping at other places, these places include; Price Rite, BJ's, Sam's Club, Save-A-Lot, and Meat Outlet. 88.8% of the participants reported to living in South Holyoke while 11.1% reported to living in the Flats neighborhood of Holyoke. 83% of participants reported receiving benefits from the Supplemental Nutrition Assistance Program (SNAP), 5.5% reported to receiving Women Infants and Children (WIC) benefits and 16.6% reported to receiving other benefits which included disability, and both WIC and SNAP benefits combined. 94.4% of participants reported a yearly income of under \$25,000, while 5.5% reported to a yearly income of between \$25,000 and \$40,000. 94.4% of the participants identified as female caregivers, while 5.5% identified as male. 38.8% reported to be between the age of 24-34, 33.3% reported to be between the ages of 35-44, 22.2% reported to be between the ages of 45-54, and 5.5% reported to be between the ages of 55 and 64. 44.4% reported to being single, never married, 38.8% reported to being married, 5.5% reported to being widowed and 22.2% reported to being separated.

This chapter documents the findings from three focus groups which included a total of 18 Puerto Rican identified caregivers all with school aged children, who reside in Holyoke Massachusetts. All participants agreed to be part of one of three focus groups which explored their perspectives related to food purchasing practices, access and availability to natural foods, eating behaviors, family engagement, healthy eating, physical activity and perceived needs and strengths to healthy eating. Common themes that emerged from the groups included caregivers not being physically engaged as much with their children, parents needing help with modeling behaviors and many foods having a high sugar content. Overarching challenges included technology, finances, and lack of parental knowledge.

At the beginning of each focus group, participants were asked to fill out a demographic questioner that included demographic data about the participants. The focus group questions consisted of five sections: A) Defining Obesity, B) Access to Vegetables and Fruit,

C) Physical Activity, D) Family Engagement, and E) Needs, Strengths, and Recommendations. In total there were 19 questions. Questions were all open ended yielding qualitative data. The first two focus groups were bilingual focus groups, Spanish/English, the third was conducted primarily in Spanish.

Demographic Data about Caregivers

Of the total of 18 participants who participated in the focus groups, 17(94.4%) were cisgender, female identified with a mean age of 25-35. One participant (5.5%) identified as a male care taker. Seven (38.8%) of the participants reported to being between the ages of 25-34, six (33.3%) participants reported to being between the ages of 34-44, four (22.2%) of the participants reported to being between the ages of 45-54, and one (5.5%) reported being between the ages of 55-64. Ages of participant were 18-24, 25-34, 35-44, 45-54, 55-64, 65-75, and 75+. All participants identified as Puerto Rican caregivers of school-aged children. Eight of the caretakers (44.4%) reported to be single, never married, five (38.8%) reported to being married, one (5.5%) reported to be widowed, and four (22.2%) reported to be separated. None of the caregivers reported being divorced. 17 (94.4%) of the participants reported an annual income of participants were grouped as follows: under \$25,000, one (5.5%) reported an annual income between \$25,000-\$40,000. Income of participants were under \$25,000, \$25,000-\$40,000, \$40,000-\$60,000 or more than \$60,000. When asked about food assistance, 15(83.3%) Participants reported receiving Supplemental Nutritional Assistance Program (SNAP) benefits, one participant (5.5%) reported to receiving Women Infant and Children (WIC) benefits, and three participants reported to receiving other benefits. This included one (5.5%) participant reporting to receiving both SNAP and WIC benefits, one

(5.5%) participant receiving SNAP and disability benefits, and one (5.5%) participant reporting to not receiving any food assistance. Six (33.3%) participants reported that they primarily did their grocery shopping at C-Town, three (16.6%) participants reported to shopping at Stop & Shop, and nine participants (50%) reported to shopping at other places. What did stand out was nine (50%) participants reported to shopping at multiple places which included BJ's, Save-A-Lot, C-town and Big-Y, C-Town and Stop & Shop, C-Town and PriceRite, Stop & Shop and Meat Outlet, and Stop & Shop, Save-A-Lot, and Price Rite. Lastly, when asked about what neighborhood participants lived in, two (11.1%) reported to living in the flats section of Holyoke, and 16 (88.8%) reported to living in South Holyoke. Neighborhoods included; Flats, Elmwood, Highlands, Homestead Ave, Jarvis Ave, South Holyoke, Springdale, whiting Farms, and other.

Section A. Defining Obesity

When asked about defining obesity, in the first focus group, one out of the six caregivers reported eating too much, one reported not having a delicate balance of intake and exercise. Another caregiver reported it could be hereditary, and another reported that children needed to stop eating too much junk, instead of drinking soda, they should have some milk or something natural. This same caregiver went on to say s/he should not feed children sugar, chips, soda or Cheetos.

In the second group, two out of the six participants said moderation, one participant said it's what you eat daily, one participant said it starts at home, and having the access and availability to healthy foods, two participants said it's what you use and how you cook your food.

In the third group two out of the six participants said obesity meant that they were overweight, two said it meant unhealthy, one said not eating right, another said eating a lot of junk, and one said it depends on one's metabolism.

Section B. Access to Vegetables and Fruits

Participants were also asked about how many days per week their children usually eat vegetables (including fresh, frozen, and canned). In the first focus group, one out of the six caregivers said never, two said it depends on which child, both reporting that one child eats vegetables every day, the others' do not ever eat vegetables. One caregiver reported their child eats vegetables every day. One of the caregivers started to list the types of vegetables their child eats.

In the second group, three out of the six caregivers reported their children eat vegetables every day. One caregiver said it was hard to provide vegetables every day, she went on to state, "I want to try to live back in an area, and this does not come up in housing. But I want to try to live back in an area where I can walk and at least once a day or every other day get the fresh fruits and vegetables for that day because that is what I used to do before moving into housing."

In the third group, two out of the six participants said their children never eat vegetables, one said their children eat vegetables every day, one said once a week, and two caregivers agreed that their children eat vegetables, just not every day. These two did not specify how often their children eat vegetables.

Participants were also asked what types of vegetables their children eat, and if they were canned or fresh. Four out of the six caregivers in the first group reported to eating fresh

vegetables, and two caregivers reported to eating both canned, and fresh. The types of vegetables caregivers in this group listed were broccoli, potatoes, corn, and root vegetables.

In the second group, four out of the six caregivers reported their children eat both fresh and canned, two caregivers' reported only fresh vegetables. In this group one caregiver reported that her children eat broccoli, two reported to eating Brussel sprouts, one caregiver reported her children eat fresh broccoli, and both canned, and fresh string beans. One caregiver reported to her children eating kidney beans, pinto beans, cucumbers, and cauliflower, lastly one caregiver reported her children eats corn on the cob.

In the third group, two out of the six caregiver's reported to eating fresh vegetables, three caregivers reported to eating canned vegetables. Caregivers in this group reported their children eating fresh lettuce, tomatoes, squash, and broccoli and eating canned corn, beans, broccoli and carrots.

Participants were also asked how many days each week do their children usually eat fruit (including fresh, frozen, or canned). In the first group, three out of the six caregivers reported to three days a week. One caregiver reported two times a week, and two caregivers reported three times a week.

In the second group three out of six caregivers reported to eating fruit every day, three caregivers did not answer this question.

In the third group, one caregiver reported to their children eating fruit twice a week, one said between two and three times a week, one caregiver reported five days a week, and one caregiver reported to her children always eating fruit. Three out of the six caregivers reported to their children eating fresh fruit. Two caregivers reported their children eat canned fruits.

Participants were also asked what types of fruits do their children eat, and if they were canned or fresh. In the first group one caregiver reported fresh bananas, three caregivers reported fresh oranges, three reported apples, two caregivers reported to their children eating fresh cherries and grapes. One caregiver reported that their children eat canned pineapple.

In the second group, one caregiver reported to her children eating blueberries, three reported apples, one reported oranges, one reported quenepas, (a fruit-bearing tree in the soapberry family) and one caregiver reported that their children eat fresh mangos and canned guava.

In the third group, two out of the six caregivers reported they feed their children fresh apples, one caregiver reported fresh apples, oranges, and lime. One caregiver reported to their children eating fresh kiwi and grapes, one caregiver reported that her children eat all types of fresh fruit, and one reported to their children eating fresh blueberries and raspberries.

Participants were also asked how often they let their children decide what foods they eat, and if they were canned or fresh. Five out of the six caregivers in the first group reported they never allow their children to choose what foods they eat. One caregiver added that if they were to let their children choose, they would choose french fries, chips and cookies. One of the six caregivers reported that she allows her children to choose what they want to eat, once a week as a reward.

In the second group, four of the six caregivers reported that they do not allow their children to choose what to eat, one said they can choose what they want for breakfast but usually have an option, and one caregiver reported that her children usually just eats what she cooks but sometimes she will ask for suggestions.

In the third group, four out of the six participants said they never allow their children to choose what they want to eat. One caregiver reported that “lo que yo concino, tiene que comer” “What I cook is what they have to eat” In the third group, one caregiver reported to her children choosing macaroni and cheese, one caregiver reported "if my children choose, it's always junk food, so I choose what to cook." The other caregivers do not allow their children choose what foods to eat.

Participants were also asked what foods would their children usually choose if they were given the option to choose. Two of the six caregivers in the first group reported that their children would choose pasta, such as macaroni and cheese. One caregiver reported chips, cookies, and pancakes.

In the second group, one caregiver reported to their children choosing spaghetti and meatballs, one reported roman noodles, two reported macaroni and cheese, one reported fresh soup, and one caregiver reported yogurt, pancakes and eggs.

In the third group, one out of the six caregivers reported that her children always aske to eat macaroni and cheese, another caregiver reported "if they choose, it's always junk food which is why I choose what they will eat."

Section C. Physical Activity

Participants were asked how much time do their children spend watching television, using the computer or playing videogames. Two out of six caregivers in the first group reported that their children never spend time watching television, using the computer, or playing video games. Two caregivers reported that their children spend 24/7, watching television, or playing video games. Two caregivers reported they find their children are

always on electronics, one caregiver reported never because she does not own any of the electronics listed above.

In the second group, two out of the six caregivers reported their children watch television, or play video games every day, as soon as they get home from school. One caregiver reported that her child has a phone which she is always on but reported that she is very active with her phone; playing music, and dancing. One caregiver reported that her kids are often on playing with electronics but reports that she tries to limit her kids every day. Two caregivers did not respond to this question.

In the third group, two out of the six caregivers reported, “if I let them, they would be on it all day,” two reported that their children watch television and play videogames all day, and all night. One of the caregivers reported that it varies, they let go of one and pick up the other. One participant said everything is electronic now a day so she finds her children always on electronics.

When asked how often are their kids are physically active for at least 60 minutes a day- active (defined as that they breathe a little harder or their heartbeats faster) all six caregivers in the first group reported that their children are physically active every-day for at least 60 minutes a day.

In the second group one out of the six caregivers reported every day, “even while playing with the Wii or X-box they are physically active running around”. One caregiver reported that her daughter is running around all the time being physically active, two caregivers agreed with the previous caregiver, reporting that their children are running around all the time being physically active. Two caregivers did not respond to this question.

In the third group, one caregiver reported “Since we moved to the city, my kids are not as active as they used to be. Now it’s like they can’t go outside unless I’m with them.” Reporting her children are less active now that they are living in the city." Three of the six caregivers reported that their children are physically active every day, reporting that their children spend most their time after school outside running around. Two care givers did not respond to this question.

Participants were also asked what were the challenges to getting their children to exercise. In the first group, three out of the six caregivers reported they do not have any challenges. One caregiver reported to electronics; like the phone and TV being a barrier to getting them to exercise. One caregiver reported that if she is not doing it with them, then they do not find interest in exercising, she reported “because if I am involved they want to compete with me, if I am not involved, they do not want to engage in any physical activities or exercise.”

In the second group, one out of the six participant said transportation has always been her challenge, two of the six participants reported that technology was a common challenge to getting her children to exercise. Three caregivers did not answer the question.

In the third group, one out of the six caregiver reported that it was a challenge to get their children off the phone and get them outside to exercise. One caregiver said not having transportation is a barrier with getting them to exercise. Another caregiver reported that the television can be a challenge to getting them to exercise, as they rather be watching television then going outside. Another participant said you invite them outside to play and they rather be watching junk TV, three participants agreed with the previous participant’s response.

Section D. Family Engagement

Caregivers were asked how often their children usually eat takeout, delivery, or fast foods (such as burgers, fried chicken, pizza, fried rice). In group one, Three out of six caregivers reported once a week. One caregiver reported three to four times a week, and one caregiver reported that her family eats some form of take fast food every-day because she buys something almost every day she steps out, which is every day, this caregiver laughed as she reported. One caregiver did not respond to this question.

In the second group, one out of the six caregivers reported that she and her children eat out every day. One caregiver reported to her family eating out twice a month. One caregiver reported that her children do not eat out often but occasionally with eat take out/ fast food, (this caregiver did not specify how often) another caregiver reported that her family eats take out only on Fridays and Saturdays. Another caregiver reported that she and her family eat out a lot but did not reported not report how often was a-lot.

In the third group, one out of the six caregivers reported to her family eating out takeout or delivery once a month, three caregivers reported to their family eating take out once a week, reporting that they do not cook on Fridays, so they order pizza on Fridays. One caregiver reported she does not ever go out to eat, or does not eat takeout because it cost too much. One caregiver did not answer this question.

When asked to describe the importance of sitting and eating together with their children, in the first group, three out of the six caregivers reported that it was very important to sit and eat with their children. One caregiver went on stating that it was important because “kids start talking when you are sitting together at the table, they start telling on themselves”. Another caregiver reported that “In this millennium phones are more present at

the table then what family members are, people are paying less attention to one another at the table which takes away from the importance of sitting together.” Another caregiver reported that technology at the table takes away from the importance of family time which is why she does not allow technology at her table when they sit and have dinner together.

In the second group, when asked to describe the importance of eating together with their children, four out of the six caregiver said it was very important, one further elaborated by stating that it's important because her kids will talk. One caregiver reported that it's important because it's a chance to bond with her children. Another caregiver reported that sitting together is important to her because its a good time for gratification, and positive reinforcement, by letting them know they did well with eating their dinner, it's a chance for her family to bond, she reported.

In the third group, one caregiver reported, “when I serve, I serve everyone at once so we can eat together, it's very important to me.” Two caregivers reported that it was important to them that their family ate together, one caregiver reported, “We eat all meals together”, while another caregiver disagreed and reported that eating together was not important with her family.

When asked how often do they eat together at least one meal day, four out of the six caregivers from group one reported they eat at least one meal a day together, two of the caregivers did not answer the question.

In group two, all six caregivers reported they eat at least one meal together, every day.

In group three, three out of the six caregivers reported they eat at least one meal every day together. One caregiver reported that her family will eat at least one meal together if they

everyone is home, one caregiver reported she eats alone, another caregiver reported that her children eat in their room reporting mostly eats alone.

Participants were asked how often they are physically active together, and what type of physical activities do they engage in with their children (e.g., Soccer, football, gym). Two of the six caregivers in the first group reported that they are physically active at the gym together, but did not specify the frequency. One caregiver reported that they are physically active at least once a week, playing sports such as football and basketball two caregivers reported they are physically active every day, walking with their children.

In the second group, one out of the six caregivers reported her children play baseball together, she reports that she sometimes will join in, but did not specify the frequency of being physically active with her children. Two caregivers reported being physically active by walking everyday with their children, three caregivers reported they are not physically active with their children but their children are physically active everyday playing sports, running around, and walking to and from school.

In the third group, four out of the six caregivers reported they are not physically active together with their children, two caregivers choose not to answer the question.

Section E. Needs, Strengths, and Recommendations

Participants were asked what was their biggest struggle to providing healthy foods to their children. In the first group two of the six caregivers reported trying to get their children to try something new was their biggest struggle, two caregivers reported to no struggle because their children always have food on their plate which makes them healthy. One caregiver reported their struggle being with trying to teach their children that they only

need to eat three times a day, and that they don't have to eat every two hours, also adding teaching them how to eat so they could make good decisions on their own. One caregiver reported their struggle being getting their children to eat what they cooked because their children prefer fast food and will ask to have something other than what they cooked.

In the second group, three out of the six caregivers reported having access to healthy foods, one caregiver reported being able to afford healthy foods is her biggest struggle, two caregivers did not to answer this question.

In the third group, one out of the six caregivers reported her struggle being with her child not liking to eat healthy foods. One caregiver reported their struggle is trying to look for healthy foods her children would like, another caregiver reported struggling because her child is a fussy eater, and one caregiver reported her struggle is having to hide the healthy foods in order for them to eat it.

When asked what types of support do they need to help feed their children more nutritional foods, two out of the six caregivers reported funding, one caregiver reported parental knowledge about what type of foods one should be eating, and two caregivers reported modeling behaviors. One caregiver did not answer the question.

In the second group, one out of six caregivers reported needing help with savings, three-reported needing financial assistance, one caregiver reported needing more program assistance, and one caregiver reported that the economy needed to be fixed in order for her to help feed her children more nutritional foods.

In the third group, two out of the six caregivers reported to needing more financial assistance, one caregiver reported having information on food banks, one caregiver said salvation army services, two caregivers reported an increase in Supplemental Nutritional

Assistance Program (SNAP) benefits, and one caregiver reported extended Woman Infants and Children(WIC) benefits would help with feeding their children a more nutritional food.

When asked what were the things they did to help their children eat better, in the first group, only two participants answered the question, they both reported they help their children eat better by modeling the right food choices to them.

In the second group, two out of the six caregivers reported to feeding their children healthy foods, one caregiver reported to cooking fresh foods for her children, one caregiver reported not buying un-healthy snacks.

In the third group, two out of the six participants reported they help their children by eating healthy with them, another caregiver reported to cooking the same healthy food for everyone, one caregiver reported eating together. Two participants choose not to answer the question.

When asked what are some food alternatives that they use to help their children eat better, three of the six caregivers in the first group reported to baking instead of frying, one caregiver reported providing alternative food options with meals such as, instead of French fries, give them a go-gurt, or apple slices. Two caregivers did not answer this question.

In the second group, one out of the six caregivers reported to feeding their children sweet potatoes, rather than regular potatoes, one caregiver reported feeding their children vegetables and dip rather than chips and dip, another said frozen fruits for dessert rather than candy or sweets. Three caregivers did not answer the question.

In the third group, one out of the six participants reported hiding healthy foods in the foods they cook and serve, one participant said making their children try new things. Four participants did not to answer the question.

Participants were also asked what recommendations do they have for other caregivers' struggling with providing healthy food to feed their children. In the first group one out of the six caregivers reported that they did not have any recommendations and wanted the feedback themselves. One caregiver reported not letting children move from the dinner table until they were completely done with their meal. One suggested starting them off early with trying different foods. Another caregiver reported modeling good healthy behavior. One caregiver spoke about nutrition programs that were offered for children and caregivers.

In the second group, one out of the six caregivers suggested to other caregivers to look into food assistance, one suggested couponing, one suggested easy access, such as having fresh fruit cut up and ready in the refrigerator, two caregivers reported food modeling.

In the third group, one out of the six caregivers suggested eating with your children, another suggested making one meal and not offering more than that one meal. Another caregiver suggested making children try different foods early on in life. Three participants choose not to answer the question.

Summary

Major findings from three focus groups which were conducted with eighteen Puerto Rican identified caregivers of school aged children, residing in Holyoke, Massachusetts have been presented in this chapter. Significant themes identified include caregivers' feeding their children fruits that are high in sugar content. Caregivers' do not allow children to choose what foods their children eat. Caregivers are not physically engaged as much. Policy issues around types and quality of foods being offered, and biological references. In the discussion chapter will explore interpretation and we will look more closely at the findings and provide

more detail about the data analysis that emerged around of A) Defining Obesity, B) Access to Vegetables and Fruit, C) Physical Activity, D) Family Engagement, and E) Needs, Strengths, and Recommendations, as well as compare and contrast significant findings to gain a further understanding. Additionally, the strengths and limitations of this study will be addressed. Lastly, suggestions for the future research will be presented.

Chapter V

Discussion

This chapter provides a discussion regarding key study findings and their relevance to existing literature. Implications for social work practice, limitations of this study along with recommendations for social work practice, and policy. Following this, there will be a conclusion summarizing this study.

The purpose of this qualitative study was to identify factors in the environment of Puerto Rican children residing in Holyoke, MA that could be modified to produce a more conducive, healthy lifestyle and reduce the burden of obesity. An exploratory study, through focus groups with a sample of 18, Puerto Rican identified caregivers who reside in Holyoke Massachusetts was conducted. While similar methods caregivers discussed were found in the literature, additional methods, as well as caregivers discussing, and commenting on, their personal experiences through the interview process form part of my discussions.

Key Findings: Comparison with the Previous Literature

According to Flores, Maldonado, & Duran (2015), “Latinos are among the most overweight racial group/ethnic groups of US children” (p. 81). The authors add, “Not enough is known, however, about what Latinos parents consider to be healthy eating, physical activity, and weight-management strategies for overweigh and obese children” (p. 81).

In this study, the perspectives of Puerto Rican caregivers were explored to try to understand challenges that they have in providing a diet with high nutritional content for their school aged children. The following themes emerged as part of the discussions: a common overall definition of obesity, lack of access and availability to fresh fruits and vegetables, technology as a problem, caregivers not allowing children to choose the foods they eat, lack of caregivers being physically engaged with their children, caregivers not having control over their own eating habits, modeling behaviors, and implications related to policy and practice.

The results of this study showed that the majority of caregivers were quite negative when they provided their definition of obesity, and they offered few solutions for solving the obesity problem. Biology was mentioned on a few occasions, but most caregivers associated

obesity with food over-consumption, like eating too much over processed foods, and caregivers spoke about obesity being something one can't change. What I found most interesting was that these caregivers did not believe that obesity was an issue in their community.

Lack of access to fruits and vegetables was also a reoccurring theme. Some caregivers spoke about not having the direct access to fresh fruits and vegetables, while others focused on the high cost and the type and quality of vegetables available to them. During the discussion around access and availability, caregivers complained about how when they would buy fresh fruit, not only was it expensive but it also went bad within the first few days of purchase. Caregivers elaborated on the lack of quality being one of the reason why they don't bother to buy fresh fruits and vegetables. From my nine years of work experience in Holyoke, two of the three grocery stores in Holyoke are discounted grocery stores, and have been known to the community not only to sell cheap, off brand labels, but to also sell expired, or close to expired foods as well, which are the only grocery stores some have access to. Another interesting fact is the fruits that caregivers reported to their children eating, such as bananas, grapes, mangoes, apples and pineapples are all fruits known to have a high sugar content.

Another reoccurring theme that I discovered was that most if not all but one of the caregivers did not allow their children to choose the foods they eat, but did not have any control over their children's obesity. The caregivers spoke about not allowing the kids to go shopping with them because it's more work to have the children present and rather kept them at home, reporting that they are the ones who pick out the foods for the household, including what they purchase for drinks which included juice, soda, and milk. They did not often mention buying water.

Flores, Maldonado, & Duran.(2015) report, “Parental input on the most important things that children and parents can do to help children lose weight and on challenges faced in trying to get children to exercise might provide valuable guidance in devising effective, evidence-based interventions that are likely to be adhered to (p.81). Most caregivers reported to not being physically engaged with their children, and many reported their children were on the phone or playing video games when they were home rather than being outside or engaged with physical activity. It surprised me to hear that some caregivers counted being on the phone or playing video games as a form of physical activity. When asked how often their kids were active, defined as engaging in activities that caused them to breathe a little harder or have their hearts beat faster, caregivers counted phone applications such as music or playing video games as of form of physical activity, because their children were standing up, jumping around and using hand movements which they constituted as being physically active. Caregivers were not involved in lacked the key of role modeling for active lifestyles, and allowing themselves to be convinced that being on the phone or playing video games provides their children with physical activity sets their children up and puts them at risk of poor physical, psychological and social benefits. Some caregivers also spoke about themselves being overweight. These same caregivers were the ones who reported not being physically active, or not involved in any physical activity with their children and seem to model their same eating habits and physical inactivity habits to their children. It was uncommon to see children have better eating habits then their caregivers. Caregivers may believe that they themselves can get away with making unhealthy choices, but children are always watching and observing. If parents are being good role models, that can have a huge impact on what a child does. Being healthy should be a family affair, the entire family should work together at

eating better and being more physically active. Keeping small children active is an essential part of preventing childhood obesity. Most caregivers reported to struggling with healthy eating habits. When I started the focus groups, I started with an “ice breaker” question, asking caregivers what their favorite food to eat was. Caregivers named foods such as pizza, pasta, rice, and lasagna, all starchy foods high in calories. All caregivers also spoke to not allowing their children to pick foods that they want to eat, and most caregivers reported to what they cook is what they have to eat. As a Puerto Rican identified woman, who was raised by Puerto Rican caregivers, I ate a large portion of rice, beans, and poultry three to four times a week. (Our cultural staple food is rice and beans). It’s a meal that is cheap in price to buy, and filling for the entire family, and anyone who stops by. In the Puerto Rican culture, healthy is not about eating certain foods, and having a certain body mass index (BMI). We are taught that if one has food on one’s plate, and if one is on the thicker side, one is healthy. If a child is on the thinner side, then one’s family is spoken about. in terms of them not having enough food to eat. Thus, caregivers of such children may be seen as neglectful, or it may be assumed that a thinner person is sick or on drugs. Caregivers play a critical role at home in preventing childhood obesity. By better understanding their own role in influencing their children’s food intake caregivers can create a healthful nutrition environment in their home which can help curb obesity.

Implications

This study has generated a number of implications that would be of interest to social workers, policy makers, trainers, educators, and consumers. Below are ideas that are intended to stimulate thinking on how this study might impact some caregivers of the Puerto Rican community, residing in Holyoke Ma.

The results of obesity prevention have been disappointing worldwide and public policy should be looked into and modified in order to help address the world wide epidemic of childhood obesity. Looking at policy issues around what funding is being offered, the types and quality of foods being offered, and types of voucher programs is also essential to helping caregivers better feed their children. Public policy should be shaped to address eating habits, neighborhood safety, and resources available to low-income and vulnerable populations. Public policy makers, with in the health care profession, stakeholders, social workers, and educators who have interest in the childhood obesity phenomenon need to be lobbied and educated. Financial investment, resources being offered, and social nature needs to be deeply examined and re-implemented.

When looking at social work practice, it is important to look at what practice means for social workers. How can social workers be more culturally sensitive when working with other cultures or communities on physical and mental health issues? How can they not devalue clients' cultures but add to them and help caregivers make healthy choices on what is nutritionally and economically appropriate and available to this community? Many of the caregivers spoke about needing more financial support to help better feed their children. It is imperative that social work professionals not just look for the needs, but rather look for the strengths in what people do and how they do it. A question that we as social workers should be asking is how can we help people transition to healthy options, in new settings, in the context of being low income, and adapting and adjusting to the main land.

The results of obesity prevention have been disappointing worldwide and public policy should be looked into and modified in order to help address the world wide epidemic of childhood obesity. Looking at policy issues around what funding is being offered, and the

types and quality of foods being offered to low income communities, and seeing if voucher programs are caught up and stay together in healthy food choices is also essential with helping caregivers better feed their children. Public policy should be looked at into addressing the eating habits, neighborhood safety, and resources available to low-income and vulnerable populations in order to address the high obesity rates seen with-in this population. Public policy makers, with in the health care profession, stakeholders, social workers, and educators who have interest in the childhood obesity phenomenon need to be influenced and educated. Final investment, resources being offered, and social nature needs to be deeply examined and re-implemented.

Using the Centers for Disease Control and Prevention (CDC) five-level SocialEcological Model (SEM) to address and understand the issues of overweight and obesity could help with identifying and incorporating social norms into programing planning. The levels start with the Individual, moves on to Interpersonal, then Community, Organizational and lastly Policy/Enabling Environment, to help better understand effects of personal and environmental factors. As a social worker, it's important to ask ourselves how we move our clients from just knowing to actually attending and applying? This would include having to be culturally competent and working with what they have available to them as a community. From a researcher's perspective, I was able to witness how qualitative and community based research can actually build community connections. In one of my focus groups the group appeared to form a support group with one another and provided each other with, information about programs that are offered within the community that caregivers had access to, and not all caregivers were informed about.

Additionally, evaluating the current benefit programs that are currently available to these families would also be important. Providing opportunity for caregivers to be engaged in the process is also imperative, catering to the needs of the clients is what will get them to better understand and engage in healthy eating practices. Better understanding caregivers' roles in influencing their children's dietary practice will help caregivers create a healthier environment for their children.

Lastly, because technology came up as being a problem for caregivers. Children being on their phones too often, or children playing video games rather than going outside to play, or children playing on their tablet or computer were all common disclosure made by the caregivers. As a Social Worker, it would be important to try to identify electronic resources in which would allow parents to engage in healthy food choices with their children. Meeting individuals where they are, is important in trying to get these caregivers involved.

All caregivers in my focus groups agreed that healthy food practices start in the home. Before criticizing, discussion, or change, caregivers and social workers have to be on the same page. Caregivers have a critical role in influencing healthy food practices with their children, with the direct support, education, and encouragement from community supports children and families will have the opportunity and availability to live a healthier lifestyle.

Limitations

There are several limitations of this study that merit attention. I would first start with my perspective as a researcher. As a Puerto Rican identified social worker, there were many biases that could have played a role in the data collection process. Although I identify as Puerto Rican by culture, I do not share the same lived experience of living in a community based shelter, or having to rely on certain benefits to make certain ends meet, as

do the caregivers who were part of my research, but I do identify with the culture in terms of language and food. Due to my insider perspective, caregivers might have felt more comfortable with me because I do identify with the culture and do speak the language and understand how we are representatives of a disadvantaged population. Due to my outsider perspective, caregivers may have felt as if I do not relate to them, because I do not live the same life experiences that they do. I can speak English without an accent and my focus groups were held in both English and Spanish. I went in with my own biases, believing that all participants would be Spanish speaking only, but that was not the outcome. Groups had to be held in both English and Spanish, there was a lot of back and forth going on, not everyone who spoke Spanish spoke or understood the English language, and not everyone who spoke English spoke or understood Spanish. Groups had to be held in English, Spanish and I even had to use Spanglish on many occasions. One of the bigger limitations I found was difficulties with obtaining caregivers from the Puerto Rican community to participate in my research. (Time, child care, and transportation were some of the common reasons why participants could not engage.) What I did find frustrating was when I was speaking with individuals from the Puerto Rican community and when I was recruiting caregivers, they often expressed many concerns around my topic, and how they wanted to see change, and needed the help, but did not want to put effort into the process for change.

Gender norms were also another limitation in terms of discussions around physical activity and food shopping. The one male caregiver spoke more about being physically active with his children, and involved in sports, the female caregiver spoke more about doing the food shopping, and cooking for their children. This limitation also had me thinking about gender norms, and how that may have played a role in how the male caregiver responded and

if he would have responded differently to the questions if there were other males present with whom he could have related more.

I also found not asking for the age of children in the demographic questionnaire was another limitation. Being able to compare high school vs middle school, vs grade school children could have been helpful in being able to compare if there were any differences between age groups in terms of physical activity, parental role modeling, food intake, and preferences. Lastly, not asking caregivers their definition of what healthy eating meant to them, and what their healthy food choices were was another limitation. Asking caregivers these specific questions would have allowed for me to obtain individual interpretations and understandings of their eating habits.

Conclusion

This research shows that social workers need to spend more time on research around the strengths and needs of Puerto Rican caregivers to help with better feeding their children. This study shows that these caregivers do have strengths, but there is clearly a disconnect between what they view as culturally appropriate and what is physically healthy. There was also a disconnect between what is being promoted by the food industry, and the desirability caregivers and children have of unhealthy foods vs healthy foods. Authors Torres, Santos, Orraca, Elias, & Palacios, C. (2014). Wrote, “Overweight and obesity are serious public health issues in the

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APPENDIX A



School for Social Work
Smith College
Northampton, Massachusetts 01063

February 6, 2017
Nelly Carmona

Dear Nelly,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,



Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Tamarah Moss, Research Advisor

APPENDIX B

CONSENT FORM

Informed Consent/English

2016-2017

**Consent to Participate in a Research Study
Smith College School for Social Work • Northampton, MA**

.....

Title of Study: A qualitative study to explore Puerto Rican caregiver needs and supports to better feed their children

.....

Introduction: You are being asked to be in a research study of by way of a focus group discussion to explore what Puerto Rican Caregivers' needs and supports are related to helping you better feed your children. This means that you and other caregivers' will meet with a facilitator to share your needs and areas of support to help with better feeding your children. You were invited to share after receiving your response to a focus group flyer in search of volunteers. Given that the focus is on Puerto Rican families, you meet the requirements of being a Puerto Rican caregiver, living in Holyoke Massachusetts, and currently have school aged children/child. We ask that you read this form and ask any questions that you may have before agreeing to and participation in the study's focus group discussion..

Purpose of Study:

1. To explore the needs of Puerto Rican caregivers' to help better feed their children, in terms of high nutritional content for healthy diets
2. To explore the strengths of Puerto Rican caregivers' as they work towards better feeding their children, in terms of high nutritional content for health diets
3. Provide insight from the perspective of Puerto Rican caregivers of school-age children to inform social work practice in better meeting clients' needs

This study is being conducted as a research requirement for my master's in social work degree. Ultimately, this research may be published or presented at a professional conference.

Description of the Study Procedures: If you agree to be in this study, you will be asked to meet for one of no more than three focus groups. (The focus group is an in-depth interview accomplished in a group). The length of participation will be between 60 and 90 minutes for each focus group

held. You may also be asked to meet in-person or on the phone with me to clarify any comments.

The focus group will involve audio recording of the focus group. These recordings will not be used in public without additional permission from you.

Risks/Discomforts of Being in this Study: The study covered by this permission form must be deemed by the Smith College Institutional Review Board (IRB) to pose "minimal risk" defined as "no more risk than you would encounter on an ordinary day of living. This means that the study procedures must not cause physical, (e.g., pain), emotional distress, or social distress and there are no foreseeable expected risk with this study. Any study posing higher risk will require separate written permission from you (beyond this form).

Caregivers' may feel uncomfortable socially in sharing challenges with their peers. If any point a participant feels uncomfortable, I will encourage them to stop. I will also allow for an additional 15 minutes after each focus group for any participant who may want to share any additional information that they did not feel comfortable sharing in an open group.

Benefits of Being in the Study: It is hoped that your participation in this research will lead to improvements in your families eating habits. This group will allow for you to have an opportunity to freely talk about what supports are needed and discuss your ideas and opinions towards obesity. This study will also allow for those who use English as a second language to talk freely in their native (Spanish) language as their will be a Spanish speaking researcher at each focus group. Yet, the degree of benefit that may result from any particular study is unknown.

The potential benefits for the researcher in conducting this study is being able to research and find areas of support in which the identified population can use, to help curve obesity and other health risk factors, and by adding supplemental data

to this type of research is rewarding and beneficial as the researcher.

Confidentiality: This study is confidential. Any identifying information will be kept in a locked physical file or password protected computer file. Identifying information will be kept separate from other research data (e.g., discussion responses, short form). Data will only be accessed by researcher, research advisor and Smith College School for Social Work administrators. No information will be presented or published that would identify you or your child. As noted above, the researchers may contact you in the future to seek your permission to display recording from research.

Payments/gift: You will not receive any financial payment for your participation.

Right to Refuse or Withdraw: The decision to participate in this study is entirely up to you. You may refuse to answer any question or withdraw from the study at *any time* without effecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. If this is an interview and you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by before February 2, 2017. After that date, your information will be part of the thesis, dissertation or final report.

Right to Ask Questions and Report Concerns: You have the right to ask questions about this research study and to have those questions answered by me before, during, or after the research. If you have any further questions about the study, at any time feel free to contact the researcher Nelly Carmona at (413) 977-2477 or email at ncarmona@smith.edu or by telephone at (413) 977-2477. If you would like a summary of the study results, one will be sent to you once the study is completed. If you

have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent: We hope that this form makes clear that we are extremely vigilant in protecting the rights and welfare of human subjects and that you will be informed about ALL research in which you participate. We hope you will consent to participate in research outlined above but you are under no obligation to do so. We thank you for your understanding and considering supporting my research on Puerto Rican families. Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above.

.....

Name of Participant
(print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

.....

[if using audio or video recording, use next section for signatures:]

1. I agree to be [audio or video] taped for this interview:

Name of Participant
(print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

2. I agree to be interviewed, but I do not want the interview to be taped, In this case, you agree to an individual interview:

Name of Participant

(print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

APPENDIX C

INFORMED CONSENT

Informed Consent/Spanish

2016-2017

**Consentimiento para participar en un estudio de investigación
Escuela de Smith College para el trabajo social • Northampton, MA**

.....
Título del estudio: Un estudio cualitativo para explorar las necesidades puertorriqueñas de los padres y apoyo para alimentar mejor a sus hijos
.....

Introducción: Se le pide que participe en un estudio de investigación a través de un grupo de discusión para explorar qué necesidades y apoyos de Puerto están relacionados con ayudarlo a alimentar mejor a sus hijos. Esto significa que usted y otros padres se reunirán con un facilitador para compartir sus necesidades y áreas de apoyo para ayudar con una mejor alimentación de sus hijos. Usted fue invitado a compartir después de recibir su respuesta a un folleto del grupo focal en busca de voluntarios. Dado que el enfoque en las familias puertorriqueñas, que cumplen con los requisitos de ser un cuidador puertorriqueño, que viven en Holyoke Massachusetts, y actualmente tienen niños en edad escolar. Le pedimos que lea este formulario y haga cualquier pregunta que pueda tener antes de aceptar y participar en la discusión del grupo de discusión del estudio.

Propósito del estudio:

1. Explorar las necesidades de los cuidadores puertorriqueños para ayudar a alimentar mejor a sus hijos, en términos de alto contenido nutricional para dietas saludables
2. Explorar las fortalezas de los cuidadores puertorriqueños a medida que trabajan para mejorar la alimentación de sus hijos, en términos de alto contenido nutricional para las dietas saludables
3. Proporcionar una visión desde la perspectiva de los cuidadores puertorriqueños de niños en edad escolar para informar la práctica del trabajo social para satisfacer mejor las necesidades de los clientes

Este estudio se está llevando a cabo como un requisito de investigación para mi maestría en el grado de trabajo social. En última instancia, esta investigación puede ser publicada o presentada en una conferencia profesional.

Descripción de los Procedimientos del Estudio: Si usted acepta participar en este estudio, se le pedirá que se reúna para uno de no más de tres grupos de enfoque. (El grupo focal es una entrevista en profundidad realizada en un grupo). La duración de la participación será de 60 a 90 minutos para cada grupo de discusión. También se le puede pedir que se reúna en persona o por teléfono conmigo para aclarar cualquier comentario.

El grupo de enfoque incluirá la grabación de audio del grupo focal. Estas grabaciones no se utilizarán en público sin su permiso adicional.

Riesgos / molestias de estar en este estudio: El estudio cubierto por este formulario de permiso debe ser considerado por la Junta de Revisión Institucional de Smith College (IRB) para plantear un "riesgo mínimo" definido como "no más riesgo de lo que se encontraría en un día ordinario. Esto significa que los procedimientos de estudio no deben causar problemas físicos (por ejemplo, dolor), angustia emocional o angustia social y no hay riesgo previsible esperado con este estudio. Cualquier estudio que plantee un riesgo mayor requerirá un permiso escrito por separado de usted (más allá de este formulario).

Beneficios de estar en el estudio: Se espera que su participación en esta investigación conduzca a mejoras en sus hábitos alimenticios de las familias. Este grupo le permitirá tener la oportunidad de hablar libremente sobre qué apoyos son necesarios y discutir sus ideas y opiniones hacia la obesidad. Este estudio también permitirá a aquellos que usan el inglés como segunda lengua hablar libremente en su idioma nativo (español) ya que será un investigador de habla española en cada grupo de enfoque. Sin embargo, el grado de beneficio que puede resultar de cualquier estudio en particular es desconocido.

Los beneficios potenciales para el investigador en la realización de este estudio es poder investigar y encontrar áreas de apoyo en las que la población identificada puede utilizar, ayudar a curvar la obesidad y otros factores de riesgo para la salud y agregar datos suplementarios a este tipo de investigación es gratificante y beneficioso como el investigador.

Confidencialidad: Este estudio es confidencial. Cualquier información de identificación se mantendrá en un archivo físico bloqueado o en un archivo de computadora protegido por contraseña. La información de identificación se mantendrá separada de otros datos de investigación (por ejemplo, respuestas de discusión, forma abreviada). Los datos solo serán consultados por el investigador, el asesor de investigación y los administradores de Smith College School para Trabajo Social. No se presentará ni publicará ninguna información que le identifique a usted o a su hijo. Como se señaló anteriormente, los investigadores pueden ponerse en contacto con usted en la función para solicitar su permiso para mostrar la grabación de la investigación.

Pagos / regalos: Usted no recibirá ningún pago financiero por su participación.

Derecho a rechazar o retirarse: La decisión de participar en este estudio depende exclusivamente de usted. Usted puede negarse a contestar cualquier pregunta o retirarse del estudio *en cualquier momento* sin afectar su relación con los investigadores de este estudio o de Smith College. Su decisión de rechazar no resultará en ninguna pérdida de beneficios

(incluyendo el acceso a servicios) a los cuales usted tiene derecho. Si se trata de una entrevista y usted elige retirarse, no usaré ninguna de su información recopilada para este estudio. Usted debe notificarme de su decisión de retirar por correo electrónico o por teléfono antes del 2 de febrero del 2017. Después de esa fecha, su información será parte de la tesis, disertación o informe final.

Derecho a formular preguntas y a reportar preocupaciones. Usted tiene el derecho de hacer preguntas sobre este estudio de investigación y de responder a esas preguntas por mí antes, durante o después de la investigación. Si tiene alguna otra pregunta sobre el estudio, en cualquier momento no dude en comunicarse con la investigadora Nelly Carmona por correo electrónico a ncarmona@smith.edu o por teléfono al (xxx) xxx-xxxx. Si desea obtener un resumen de los resultados del estudio, se le enviará una vez que se complete el estudio. Si tiene alguna otra inquietud acerca de sus derechos como participante en la investigación o si tiene algún problema como resultado de su participación, puede comunicarse con el Presidente del Comité de Asuntos Humanos de la Escuela para el Trabajo Social de Smith College al (413) 585-7974.

Consentimiento: Esperamos que este formulario aclare que estamos extremadamente vigilantes en la protección de los derechos y el bienestar de los sujetos humanos y que usted será informado sobre TODAS las investigaciones en las que participe. Esperamos que usted consienta en participar en el esquema de investigación anterior pero no está obligado a hacerlo. Le agradecemos por su comprensión y consideración para apoyar mi investigación sobre las familias puertorriqueñas. Su firma a continuación indica que ha decidido ser voluntario como participante de investigación para este estudio y que ha leído y entendido la información proporcionada anteriormente.

.....

Nombre del Participante (imprimir):

Firma del participante: _____ Fecha: _____
Firma del (de los) investigador (es): _____ Fecha: _____

.....

[Si usa grabaciones de audio o video, use la siguiente sección para firmas:]

1. **Estoy de acuerdo en ser [audio o video] grabado para esta entrevista:**

Nombre del Participante (imprimir):

Firma del participante: _____ Fecha: _____

Firma del (de los) investigador (es): _____ Fecha: _____

2. **Estoy de acuerdo en ser entrevistado, pero no quiero que la entrevista sea grabada, En este caso, usted acepta una entrevista individual:**

Nombre del Participante (imprimir):

Firma del participante: _____ Fecha: _____

Firma del (de los) investigador (es): _____ Fecha: _____

APPENDIX D

FOCUS GROUP GUIDE

Focus Group Guide

Study Title: A qualitative study to explore Puerto Rican caregiver needs and supports to better feed their children. As participants enter the space, I will have a table set up with name labels. I will request for each participant to fill out a name label with a Pseudonym names (a made up name) in order to maintain everyone's identity for this research. (I will provide labels, and markers). Bottles of water will be provided. I will also request caregivers to fill out a short demographic sheet which will allow for me to identify, their name, (real and fake) gender, number of children in their household, range of income, and food assistance status. This will also be at the table and I will ask caregivers to fill out, and hand in prior to the group commencing.

Introduction:

Welcome, My name is Nelly Carmona. I am a second year masters student with Smith College School for Social Work (SCCSW). Research shows that Latino children have some of the highest rates of obesity. As a Puerto Rican identified researcher, I have a deep interest in research that can help improve the lives of Puerto Rican families who are often underrepresented or misunderstood, which is why I have decided to complete my research study on trying to help determine what supports Puerto Rican caregivers need to better feed their children to try to help link causes of obesity within the Puerto Rican race. This focus group will run about between 60 and 90 minutes. I have a colleague who is also present in the room, who will be audio recording our conversation and taking notes as well. I will ask a series of questions to start our discussion. (Please see Appendix_H Signed Colleague Consent Form) (Read over signed consent form. Make sure that everyone verbally agrees and understand forms and their right to leave this voluntary focus group at any time.) I want to thank you in advance for coming out and volunteering your time and for supporting my research. We will be using preselected pseudonym names (fake names) which everyone is wearing a name label that identifies the name we will be

using in order to maintain confidentiality of your identity.

Are there any questions?

Group Guidelines

(in order to ensure that a safe respectful space is offered by everyone.)

I would like to start with introductions, go around and have everyone say their pretendname.

Before we start, there are some guidelines for us to have in place.

1) Confidentiality of all group members must be maintained. Nothingsaid in the group by another member may be disclosed to anyone outside of the group.

2) Give the person speaking your undivided attention, do no interrupt each other.

3) Focus on your present feelings, thoughts, and reactions.

4) Please remember that this is voluntary and you can leave at any time.

Ask if anyone would like to add any additional rules?

FOCUS GROUP DISCUSSIONS

A. Defining Obesity

QA1. What comes to mind when you hear the word "over weight" or "obesity"? What comes to mind when you think about childhood obesity?

B. Access to Vegetables and Fruit

QB1. How many days each week do your children usually eat vegetables (including fresh, frozen, and canned)

QB2. What types of vegetables do your children eat? Are they canned or fresh?

QB3. How many days each week do your children usually eat fruit (including fresh, frozen, and canned)

QB4. What types of fruits do your children eat?

QB5. How often do you let your children decide what foods they eat? Are they canned or fresh?
QB6. What foods do they usually choose?

C. Physical Activity

QC1. How much time do your children spend watching television, using the computer or playing videogames?

QC2. How often are your kids physically active for at least 60 minutes a day- active enough that they breathe a little harder or their heart beats faster?

QC3. What are the challenges to getting your children to exercise?

D. Family Engagement

QD1. How often do your children usually eat takeout, delivery, or fat foods (such as burgers, fried chicken, pizza, fried rice)?

QD2. Describe the importance of sitting and eating together with your children?

QD3. How often do you eat together with your children for at least 1 meal a day?

QD4. How often are you physically active together? What type of physical activities do you engage in with your children? (Soccer, football, gym)?

E. Needs, Strengths, and Recommendations

QE1. What is your biggest struggle to providing healthy foods to feed your children?

QE2. What types of support do you need to help you feed your children more nutritional foods?

QE3. What are things you do to help your children eat better?

QE4. What are some food alternatives that you use to help your children eat better?

QE5. What recommendations do you have to other caregivers' struggling with providing healthy food to feed their children?

After Questions

Thank the group again, remind them of the plan of transcribing information, sharing the information on a short report, holding a group after to share the findings with them.

Inform the that the research findings may be published or presented at a meeting.

Inform them that if they have any questions they can call this researcher.

Also, Inform them of the list of food and mental health resources (please see appendix F) available for them to take home.

End the group have business cards on the table so participants can have researchers contact information.

Make sure that participant has a copy of their consent form with all signatures. Two copies will be made available on the day for the research to have, and one for the participant

This study protocol has been reviewed and approved by the
Smith College School for Social Work Human Subjects Review Board (HSRB)

APPENDIX E

FOCUS GROUP GUIDE SPAINSH

Título del estudio: Un estudio cualitativo para explorar las necesidades y apoyos de los cuidadores puertorriqueños para alimentar mejor a sus hijos

Cuando los participantes entren en el espacio, tendré una mesa con etiquetas de nombre. Pediré a cada participante que llene una etiqueta con nombres de Pseudónimo (un nombre inventado) para mantener la identidad de todos para esta investigación. (Voy a proporcionar etiquetas, y marcadores). Se proporcionarán botellas de agua.

También les pediré a los cuidadores que llenen una breve hoja demográfica que me permita identificar, su nombre, género (real y falso), número de niños en su hogar, rango de ingresos y estado de asistencia alimentaria. Esto también estará en la mesa y les pediré a los cuidadores que la llenen, y la entreguen antes de que el grupo comience.

Introducción:

Bienvenido, Mi nombre es Nelly Carmona. Soy un estudiante de segundo año de maestría con la Escuela de Colegio de Smith para el Trabajo Social (SCCSW). La investigación muestra que los niños latinos tienen algunas de las tasas más altas de obesidad. Como investigadora identificada puertorriqueña, tengo un profundo interés en la investigación que puede ayudar a mejorar las vidas de familias puertorriqueñas que a menudo están mal representadas o mal entendidas, por lo que he decidido completar mi estudio de investigación tratando de ayudar a determinar qué apoyo los cuidadores puertorriqueños necesitan para alimentar mejor a sus niños para intentar ayudar a ligar causas de la obesidad dentro de la raza puertorriqueña.

Este grupo de enfoque se ejecutará entre 60 y 90 minutos. Tengo un colega que también está presente en la sala, que estará audio grabando nuestra conversación y tomará notas también. Haré una serie de preguntas para comenzar nuestra discusión. (Por favor vea el Apéndice __H Formulario de Consentimiento de Colegas Firmados)

(Lea el formulario de consentimiento firmado y asegúrese de que todos estén de acuerdo verbalmente y entiendan las formas y su derecho a dejar este grupo de enfoque voluntario en cualquier momento).

Quiero agradecerle por adelantado por haber salido y ofrecido su tiempo y por apoyar mi investigación. Utilizaremos nombres de pseudónimo preseleccionados (nombres falsos) la

cual cada uno lleva una etiqueta de nombre que identifica el nombre que usaremos para mantener la confidencialidad de su identidad.

¿Hay alguna pregunta?

Pautas del grupo

(Para asegurar que todos ofrezcan un espacio respetuoso y seguro).

Me gustaría empezar con las presentaciones, dar la vuelta y hacer que todos digan su nombre pretendido.

Antes de comenzar, hay algunas pautas para que tengamos en su lugar.

- 1) Se debe mantener la confidencialidad de todos los miembros del grupo. Nada de lo dicho en el grupo por otro miembro puede ser revelado a alguien fuera del grupo.
- 2) Dar a la persona que habla su atención, no se interrumpen entre sí.
- 3) Concéntrese en sus sentimientos, pensamientos y reacciones actuales.
- 4) Recuerde que esto es voluntario y que puede salir en cualquier momento.

Pregúntale si a alguien le gustaría añadir alguna regla adicional.

DISCUSIONES DEL GRUPO FOCAL

A. Definición de la obesidad

QA1. ¿Qué viene a la mente cuando se oye la palabra "sobre peso" o "obesidad"? ¿Qué le viene a la mente cuando piensa en la obesidad infantil?

B. Acceso a vegetales y frutas

QB1. ¿Cuántos días cada semana sus hijos usualmente comen vegetales (incluyendo frescos, congelados y enlatados)

QB2. ¿Qué tipos de vegetales comen sus hijos? ¿Están enlatados o frescos?

QB3. ¿Cuántos días cada semana sus hijos usualmente comen frutas (incluyendo frescas, congeladas y enlatadas)

QB4. ¿Qué tipos de frutas comen sus hijos?

QB5. ¿Con qué frecuencia deja que sus hijos decidan qué alimentos comen? ¿Están enlatados o frescos?

QB6. ¿Qué alimentos eligen generalmente?

C. Actividad física

QC1. ¿Cuánto tiempo pasan sus hijos viendo televisión, usando la computadora o jugando videojuegos?

QC2. ¿Con qué frecuencia sus hijos están físicamente activos durante al menos 60 minutos al día- lo suficientemente activo para respirar un poco más difícil o su corazón late más rápido?

QC3. ¿Cuáles son los desafíos para hacer que sus hijos hagan ejercicio?

D. Participación de la familia

QD1. ¿Con qué frecuencia suelen comer alimentos para llevar, o comida rápida (como hamburguesas, pollo frito, pizza, arroz frito)?

QD2. Describa la importancia de sentarse y comer junto con sus hijos?

QD3. ¿Con qué frecuencia comes junto con tus hijos por lo menos 1 comida al día?

QD4. ¿Con qué frecuencia estás físicamente activo/a juntos? ¿Qué tipo de actividades físicas realiza usted con sus hijos? (Fútbol, fútbol americano, gimnasio)?

E. Necesidades, fortalezas y recomendaciones

QE1. ¿Cuál es su mayor esfuerzo para proporcionar alimentos saludables para alimentar a sus hijos?

QE2. ¿Qué tipo de apoyo necesita para ayudarle a alimentar a sus hijos con más alimentos nutritivos?

QE3. ¿Qué cosas haces para ayudar a tus hijos a comer mejor?

QE4. ¿Cuáles son algunas de las alternativas alimenticias que usa para ayudar a sus hijos a comer mejor?

QE5. ¿Qué recomendaciones tiene usted a otros cuidadores que luchan por proporcionar alimentos saludables para alimentar a sus hijos?

Después de las preguntas

Agradezca nuevamente al grupo, recuerde el plan de transcribir la información, compartiendo la información en un breve informe, sosteniendo un grupo después de compartir los hallazgos con ellos.

Infórmeles que los resultados de la investigación pueden ser publicados o presentados en una reunión.

Infórmeles que si tienen alguna pregunta pueden llamar a este investigador.

Asimismo, infórmeles de la lista de alimentos y recursos de salud mental (por favor vea en el apéndice F) disponibles para que los lleven a casa.

Finalice el grupo, tenga tarjetas de negocio en la mesa para que los participantes puedan tener información de contacto de los investigadores.

Asegúrese de que el participante tenga una copia de su formulario de consentimiento con todas las firmas. Dos copias se pondrán a disposición para tener el día de la investigación, y uno para el participante

Este protocolo de estudio ha sido revisado y aprobado por la Junta de Trabajo Social de Revisión de Asuntos Humanos del Colegio de Smith College (HSR)

APPENDIX F

Focus Group Flyer/English

ATTENTION MOMS, DADS & CAREGIVERS



We want to hear from you!

Become a volunteer in a discussion group that focuses on a research study on childhood obesity

- Are you Puerto Rican?
- Are you a parent or caregiver of a school age child?
- Do you live in Holyoke?

If you answered yes to the questions above, we invite you to attend a discussion lasting between 60-90 minutes, to hear your feedback on what caregiver supports and needs are to address childhood obesity prevention.

Sessions will be held on

Date: March 27th, & March 29, 2017
Time: 6:00 pm
Location: 5 Adams Street, Holyoke

Please RSVP to Nelly Carmona at (xxx) xxx-xxxx

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Board (HSRB)

APPENDIX G

FOCUS GROUP FLYER/ Spanish

ATENCIÓN MAMÁS, PAPAS Y CUIDADORES



¡Queremos escuchar de ti!

Conviértase en un voluntario en un grupo de discusión que se concentra en un estudio de investigación sobre la obesidad infantil

- ¿Es puertorriqueño?
- ¿Es usted un padre o cuidador de un niño en edad escolar?
- ¿Vives en Holyoke?

Si respondió afirmativamente a las preguntas anteriores, le invitamos a asistir a una decisión que durará entre 60 y 90 minutos, para escuchar su opinión acerca de cuáles son los apoyos y necesidades de los cuidadores para atender la prevención de la obesidad infantil.

Las sesiones se celebrarán en

Fecha: El 27 Y el 29 de Marzo de 2017

Hora: 6:00am

Ubicación: 5 Adams Street, Holyoke MA

Por favor RSVP a Nelly Carmona al (xxx) xxx-xxxx

Este protocolo de estudio ha sido revisado y aprobado por la Junta de Trabajo Social de Revisión de Asuntos Humanos del Colegio de Smith College

APPENDIX H

DEMOGRAPHIC FORM

Caregiver Demographic Form

Please provide your answer, by putting a circle around the option as your response.

Q.1 Which Supermarket do you shop at for your grocery shopping?

- C-Town
- Stop and Shop
- Cuba Supermarket
- Neighborhood bodega
- Other (please describe): _____

Q.2 What part of Holyoke do you live in?

- Flats
- Elmwood
- Highlands
- Homestead Ave
- Jarvis Ave
- South Holyoke
- Springdale
- Whitening Farms

- Other (please provide the name): _____

Q.3 Do you receive any food assistance? If so which one?

- SNAP Benefits
- WIC Benefits
- Other (please provide the name): _____

Q.4 Employment Status: Household range of income?

- Under \$25,000
- \$25,000-\$40,000
- \$40,000-\$60,000
- More than \$60,000

Q.5 What is your Gender?

- Male
- Female
- Other (please provide): _____

Q.6 Age: What is your age?

- 18-24 years old
- 25-34 years old
- 35-44 years old
- 45-54 years old
- 55-64 years old
- 65-74 years old
- 75 years or older

Q.7 Marital Status: What is your marital status?

- Single, never married
- Married or domestic partnership
- Widowed
- Divorced
- Separated

APPENDIX I

CITY OF HOLYOKE FOOD & MENTAL HEALTH RESOURCES

City of Holyoke Food Resources

Department of Transitional Assistance (administers Food Stamps)

72-100 Front Street Holyoke, Ma

(413) 552-5400

www.mass.gov/dta

Holyoke Food and Fitness Policy Council
245 High Street Holyoke
(413) 420-2861 www.holyokefoodandfitness.org

Margaret's Pantry (Food Pantry)
56 Cabot Street Holyoke
(413) 538-8026 www.provministries.com

Nuestras Raices Farm
329 Main Street Holyoke
(413) 535-1789 www.nuestras-raices.org

WIC (Women, Infants and Children) Program
300 High Street, 1st
Floor (413) 534-2460
www.fns.usda.gov/wic

**This study protocol has been reviewed and approved by the
Smith College School for Social Work
Human Subjects Review Board (HSRB)**

