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# ***Identifying Barriers That Hinder Onsite Parental Involvement in a School-Based Health Promotion Program***

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*We investigated whether barriers to onsite parental involvement in the Bienestar Health Program Parent Component could be identified and whether participation rates could be increased by addressing these barriers. All nonparticipating parents of fourth-grade students of San Antonio Independent School District from 4 schools, which were selected randomly from 20 intervention schools in Bienestar, were invited to take part in this study. A total of 47 of 223 (21%) parents engaged in one of four focus groups offered. Parents identified barriers to their involvement in Bienestar that fit into five descriptive categories: (a) low value, (b) high cost, (c) competing family demands, (d) concerns about the program design, and (e) social role norms. The Bienestar Parent Component was then modified according to the focus group findings, which resulted in a marked increase in parental involvement from 17% to 37% overall. These findings suggest that even when parents are involved in the initial design of parent-friendly and culturally sensitive programs, as was the case for Bienestar, maximizing parental involvement may require additional assessment, identification, and remediation of barriers.*

**Keywords:** *parental involvement; barriers to parental involvement; school-based health programs; type 2 diabetes mellitus in children; effective strategies*

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**T**he prevalence of obesity and associated type 2 diabetes mellitus is increasing rapidly (Mokdad et al., 2003), with type 2 diabetes now affecting even children (Fagot-Campagna, Pettit, Engelgau, Burrows, & Popkin, 2000; Hotu, Carter, Watson, Cutfield, & Cundy, 2004; Pinhas-Hamiel et al., 1996; Treviño et al., 2004). These rising rates have been linked to changes in diet (Nielsen, Siega-Riz, & Popkin, 2002) and physical inactivity (Eisenmann & Bartee, 2002). Also alarming is the fact that approximately one in three people born in the United States in 2000 (and one of every two African Americans, American Indians, Hispanic/Mexican Americans [MAs], and Asian Americans) are projected to develop diabetes in their lifetime (Narayan, Boyle, Thompson, Sorensen, & Williamson, 2003).

Studies have reported low levels of physical activity in low-income MA children at home (McKenzie, Nader, Broyles, & Nelson, 1992) and at school (McKenzie et al., 1992; Treviño et al., 1998; Treviño, Hernandez, Zenong, Garcia, & Hernandez, 2005). At home, 4-year-old MA children spend significantly more time lying down, watching television, and being indoors, whereas non-Hispanic White children spend significantly more time walking, being active, and engaging in moderate to vigorous physical activity (McKenzie et al., 1992). At school, MA children spend less time walking and engaging in moderate to vigorous physical activity and more time sitting than non-Hispanic White children (McKenzie et al., 1992). Similarly, Trevino and colleagues (2005)

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reported that 9-11-year-old low-income MA children, when compared with their middle-income counterparts, spend significantly less time being involved in moderate to vigorous activities and more time viewing TV (Trevino et al., 1999). Poor physical fitness and dietary patterns, such as low fruit and vegetable intake and high dietary fat intake, in low-income MA children have also been reported in fourth-grade students (Treviño et al., 1998, Treviño et al., 2004, Treviño et al., 2005). It is imperative that these trends be reversed. School-based health programs, including those with a parent component, have the potential to play a key role in facilitating positive behavioral changes in children to help prevent obesity and all its associated consequences (Baranowski et al., 2000; Baranowski & Stables, 2000; Bere, Veierød, Bjelland, & Klepp, 2006; Davis et al., 2000; Donnermeyer, 2000; Haines, Neumark-Sztainer, Perry, Hannan, & Levine, 2006; Lytle et al., 2004; Nader et al., 1989; Nicklas & O'Neil, 2000; Perry et al., 1989; Stone et al., 1996; Story et al., 2000; Treviño et al., 1998, Treviño et al., 2004, Treviño et al., 2005; U.S. Department of Education, 2004; Ward et al., 2006).

### **► BACKGROUND**

Studies report a significant positive association between parental involvement overall and a student's academic achievement (Cassity & Harris, 2000; Jeynes, 2005; Trusty, Maximino, & Salazar, 2003). This relationship

is observed for both nonminority White and minority students, including MA students, and for boys and girls (Jeynes, 2005). Furthermore, a meta-analysis of 41 studies examining the relationship between parental involvement and the academic achievement of urban elementary school children showed that this positive relationship held across different cultures, backgrounds, and situations (Jeynes, 2005). With regard to behavioral changes involving diet and exercise, school-based programs with a parent component show improvements in a student's dietary and physical activity pattern (Treviño et al., 1998, Treviño et al., 2004, Treviño et al., 2005). These reported findings may be used by behavioral interventionist to nurture a "buy-in" for parents to participate in parent-related opportunities offered at schools.

### **Reported Benefits of Parental Involvement in Schools**

Parental involvement in a student's education benefits the entire school community (Karther & Lowden, 1997). For example, Karther and Lowden (1997) reported student attainment gains, increased parent self-confidence and satisfaction with schools, and overall school improvement as benefits of parental involvement. Similarly, other researchers reported improvements in test scores and grades; attendance rates; lower drop-out rates; and improvement in student motivation, attitude, classroom behavior, and self-esteem as benefits (Cassity & Harris, 2000; Gettinger & Guetschow, 1998). Furthermore, benefits of parental involvement in a student's health and well-being have also been reported. These include improvements in a student's physical fitness level (Treviño et al., 2005), reversal of hyperglycemia (abnormal fasting glucose levels; Treviño et al., 1998, Treviño et al., 2004), improvements in dietary patterns (e.g., increases in dietary fruit and vegetable intake; Baranowski et al., 2000; Treviño et al., 1998, Treviño et al., 2004, Treviño et al., 2005) and decreases in dietary saturated fat intake (Treviño et al., 1998, Treviño et al., 2004), decreases in body fat (Treviño et al., 2004, Treviño et al., 2005), and improvements in a student's level of awareness regarding diabetes and obesity prevention (Treviño et al., 1998; Treviño et al., 2004).

### **Reported Barriers to Parental Involvement Overall in Schools**

Although benefits of parental involvement in schools have been recognized, it remains low; this may be because of an array of barriers. Barriers to involvement in schools reported include, but not limited to, transportation, negative attitudes toward or bad experience with schools, cultural or language barriers, economic

and/or time constraints, parents' inflexible work schedules, blaming parents for their children's difficulties in school, parents' negative attitudes toward the school or vice versa, unmatched expectations between school's policy and practices and parents' concepts of parental involvement, and the school's inability to adapt to societal change (Cassity & Harris, 2000; Gettinger & Guetschow, 1998; Wheeler, 1992). Mental barriers have also been reported, including the lack of two-way communication and involvement opportunities between the parent and the school that benefits the student's social, emotional, and cognitive growth (Jennings, 1992).

Effective strategies aimed to minimize and/or eliminate barriers to parental involvement overall in schools have been reported. These are grouped into four thematic units (Cassity & Harris, 2000): (a) Build school-home partnerships, (b) bridge the language and cultural gap, (c) expand family involvement, and (d) restructure school settings. According to Cassity and Harris (2000), successful strategies for building bridges to low-income parents include setting clear goals to develop school-family partnerships; expand the services to children and families to include health services, social services, and family support; celebrating cultural differences; and teaching the parents. Another strategy requires school leaders to schedule parental involvement opportunities on weekends, early mornings, or evenings to facilitate two-way communication with working parents (Cassity & Harris, 2000; Pape, 1999). Providing parents with good reasons why they should participate or attend parental opportunities' offers is another strategy (Jennings, 1992). Successful strategies for building bridges to close the language and culture gap include promoting involvement of minority parents by using bilingual personnel to assist communication when needed (Cassity & Harris, 2000). Pape (1999) reported four strategies to improve involvement: Meet parents at their own community setting, make schools parent-friendly, hire support personnel to reach out to immigrant families in their own language and help them adapt to the school settings, and involve the parent in the decision making. Strategies for restructuring the school settings may include creating or using an onsite parent or family center, a place designated in schools that provides parent and community participants with a selection of activities that support family life and offers program information (i.e., procedures and expectations) as well as adult education programs for General Educational Diploma (GED) and English as a Second Language (ESL) classes (Johnson, 1996). In general, successful programs typically incorporate all of the following components of parental involvement: parent empowerment, two-way communication, learning activities at home, and socialization at home

(Birman & Espino, 2007; Jennings, 1992; Jaynes, 2005; Lopez, Scribner, & Mahitivanichcha, 2001).

### ***Reported Barriers to Parental Involvement in School-Based Child Health Programs With a Parent Component***

Few studies directly identify specific barriers to parental involvement in school-based programs, with only broad references being made to, for instance, family dynamics and demands on parental time (Baranowski et al., 2000; Davis et al., 2000; Weeks et al., 1997). In addition, difficulties in reaching and recruiting parents and sustaining their participation have also been highlighted (Nader et al., 1989).

School-based health programs have in general included a parent component (Baranowski et al., 2000; Baranowski & Stables, 2000; Bere et al., 2006; Davis et al., 2000; Donnermeyer, 2000; Haines et al., 2006; Nader et al., 1989; Nicklas & O'Neil, 2000; Lytle et al., 2004; Perry et al., 1989; Stone et al., 1996; Story et al., 2000; Treviño et al., 1998; Ward et al., 2006); however, studies demonstrate only low levels of onsite parental or family participation in these programs (Baranowski et al., 2000; Baranowski & Stables, 2000; Davis et al., 2000; Donnermeyer, 2000; Haines et al., 2006; Nader et al., 1989; Nicklas & O'Neil, 2000; Perry et al., 1989; Treviño et al., 1998; Ward et al., 2006).

In this study, we examined the specific barriers to parental involvement that were still present in a program developed with input from parents—in other words, a significant attempt had already been made to make the program tailored and sensitive to the needs of parents. We also explored whether addressing the remaining barriers could increase parental involvement beyond its baseline level. The term “parent” throughout this article refers to parent or guardian or another person with significant parenting responsibility.

## **► METHOD**

### ***The Bienestar Program***

The Bienestar Health Program, a school-based diabetes prevention research study, was developed in 1997 to determine whether type 2 diabetes can be delayed or even prevented in high-risk children (Treviño et al., 1998; Treviño et al., 2004). Bienestar targets school-aged MA children (and their families) residing in low-income neighborhoods in San Antonio, Texas, and enrolled them in the San Antonio Independent School District (SAISD) elementary schools. The schools were in the same geographic regions of the city and were the feeder schools to three middle schools and one high school.

The program's objectives are to increase dietary fiber intake, increase physical fitness, and decrease body fat in these children. Bienestar was developed by the Social and Health Research Center (SHRC), a nonprofit health promotion and health education as well as childhood development research center, which conducts randomized clinical trials targeting school-aged children. In the Bienestar study, schools were randomized to either the Bienestar program or no intervention. Of note, the Bienestar randomized control trial was funded by the National Institutes of Health, and thus, all activities in the school-based intervention programs were free of charge to students and their families.

### ***Theoretical Framework***

Social cognitive theory (SCT) was selected as a guiding theory because it is commonly used by interventionists targeting behavioral change, particularly lifestyle changes involving variables of diet and exercise of school-aged children at risk of diabetes, obesity, low dietary fruit and vegetable intake, and physical inactivity (Baranowski et al., 2000; Baranowski & Stables, 2000; Davis et al., 2000; Nader et al., 1989; Perry et al., 1989; Treviño et al., 1998). In SCT, the concept of behavioral capability maintains that if a person is to perform a particular behavior, he or she must know what the behavior is (knowledge of the behavior) and how to perform it (skill; Glanz, Rimer, & Lewis, 2002). SCT posits that portions of an individual's knowledge acquisition can be directly related to observing others within the context of social interactions, experiences, and outside media influences (Glanz et al., 2002).

Parents act as role models (positive or negative) for their children, and children directly observe parental behavior (Glanz et al., 2002). Bienestar consists of a school health curriculum and an after-school health club and cafeteria programs for children and parents, so that parents and cafeteria staff can help positively influence the children rather than accidentally or purposefully undermining the desired change (see Table 1; for detailed descriptions see Treviño et al., 1998, Treviño et al., 2004). Bienestar aims to change the behavior of children, partially through teaching parents to be positive role models. The Bienestar parent activities aim to change the parents' (and their family members') risky behavior. Because parents directly influence their child's behavior, including their dietary and physical activity patterns, it is necessary to include both the student and their families in the Bienestar parent program so that better outcomes may be achieved.

The parent component of the 20 Bienestar interventions SAISD schools is the focus of this study. According to the information on participating elementary schools

provided by the school district, families reported participation of an average 3.5 persons per household and more than 95% in United States Department of Agriculture food assistance programs. In this study, nearly all (97%) parents reported that they were MA, 72% reported that they had less than a high school diploma and 8% more than a high school education, and 28% of households reported that none of their residents was employed.

Bienestar obtained parent input from focus groups, "town hall" style meetings and surveys, as well as input from parent advocates during the initial design phase of the main intervention (described in more detail elsewhere; Treviño et al., 1998, Treviño et al., 2004, Treviño et al., 2005). Not only general input was sought, but also specific input regarding the Bienestar parent component. This allowed Bienestar staff to tailor that component to the suggestions of the parents (Treviño et al., 1998). However, parents providing input typically already had some degree of parental involvement in schools. Although the design of the main Bienestar study incorporated this extensive effort to obtain parental input and the Bienestar study had been ongoing for 4 years prior to this inquiry, parental involvement in the Bienestar parent component was only 17% overall in the year preceding this project, a rate that is only slightly higher than the typical 7-15% overall for other school-based parent health programs (Baranowski et al., 2000; Davis et al., 2000; Perry et al., 1989).

### ***Participants***

To identify and examine barriers that hindered parental involvement in the parent component of Bienestar, we gathered information in focus group meetings with parents who had no involvement at all during the previous Bienestar academic year. For this study, parental involvement was defined as onsite participation of at least one member of the family of the student (including extended family) in at least one parental activity offered during the 9-month intervention based on an attendance log.

In April 2002, school nurses and liaisons, who are assigned the role of onsite facilitators and point of contact persons for Bienestar by the school principals, invited in person, by postal mail, and/or by telephone call all nonparticipating parents of fourth-grade students (or grandparents or extended family members possessing guardianship) at 4 elementary schools randomly selected from 20 Bienestar intervention elementary schools to take part in this study. Forty-seven of two hundred and twenty-three (21%) nonparticipating parents consented, and each parent represented one separate family.

**TABLE 1**  
**Objectives, Description, and Schedules of Bienestar's Four Programs**

<i>Program</i>	<i>Content</i>	<i>Description</i>	<i>Schedules</i>
Bienestar health class	Includes a teacher's physical and health education manual, transparencies, a student's workbook, student knowledge tests, and other support instructional material	It is based on thematic instruction, and experiential and multicultural learning The 16 lesson plans cover nutrition, physical activity, self-image, and diabetes	Health classes for students are held 45 min/day, 5 days/week Of these, actual physical education classes are held 3 times a week and health classes 2 times a week for the entire school year
Bienestar health club	Includes instructor's manual and student's workbook	The 32 lesson plans expand in-school learning through instruction that is aimed at rehearsing and reinforcing classroom learning and promoting leisure time to moderate to vigorous physical activity Activities include games, dancing, singing, art crafts, puppet shows, and plays	The club meetings are held once a week after-school for 1 hr from 3:00 to 4:00 p.m. These lessons are for students only
Bienestar parent program (this is the component that we targeted for this study)	Includes an instructor's manual and a parent's workbook	Diabetes, nutrition, and physical fitness-related interactive activities (such as cooking classes, role modeling, roller skating, swimming, and health fairs and La Tiendita) specifically designed for students' families	Weekdays on a monthly basis in the school cafeteria during normal school hours. A total of 9 events were offered Note: As a result of the finding of this study, 4 interactive activities are now held on Saturday mornings between 10 a.m. and noon and weekdays between 5 p.m. and 6 p.m. for parents and their families
Bienestar food cafeteria component	Includes instructor's diabetes, nutrition, and health education manuals for instructing cafeteria staff in diabetes, nutrition, and health education, a parent's workbook, test, keys, transparencies, and other support material	It is based on thematic instruction, and experiential and multicultural learning The 9 lesson plans cover nutrition, diabetes, physical activity, and obesity prevention	Cafeteria staff health classes are held once a month for 1 hr and 45 min during in-service These classes are for staff members only

### **Focus Groups**

Each parent engaged in one of four focus groups conducted over a 2-week period. Focus group meetings were held at the SHRC or school campuses for the convenience of the focus group parents. Parents' responses were recorded and transcribed. The Bienestar parent component was modified using these focus group

findings and implemented in all Bienestar intervention schools during the following 9-month school year.

The focus groups varied in size from 8 to 17 participants: that is, focus group #1 ( $n = 10$ ), focus group #2 ( $n = 12$ ), focus group #3 ( $n = 8$ ), and focus group #4 ( $n = 17$ ). Each focus group also had one facilitator and two recorders. The same facilitators (who had previous experience working with focus groups of this size) and

recorders (Bienestar staff members) conducted each of the four focus groups. To increase the free expression and comfort of the focus group parents, we attempted to create a nurturing and nonthreatening environment by providing dinner and an informal atmosphere at a round discussion/dinner table. Parents were gathered and asked to introduce themselves. The facilitator began the focus group by introducing the objectives, the purpose for the focus group, and the five questions selected for the focus group discussion:

1. Are you aware that Bienestar conducts parent activities on a monthly basis?
2. What are some challenges that parents face and stop them from attending the monthly meetings?
3. Taking into account all the demands currently placed on parents, what are some things we can do to make it easier for parents to attend the monthly meetings?
4. Do you see the monthly parent meeting as being valuable to parents?
5. What type of activities would you like to have at the monthly meetings?

Each question was written in English on a separate tablet chart sheet that was hung on the wall to act as a visual cue and a response record. The facilitator introduced each question and guided the discussion for each question, redirecting the group to the question whenever the discussion began to digress from its focus. The facilitator asked the parents to summarize their responses to each question to ensure that what was recorded on the tablet chart was truly representative of what was said. Only when the group unanimously agreed that what was recorded was correct did the group proceed to the next question. The duration for each meeting including the informal dinner and Q&A ranged between 45 and 60 min.

Following each focus group session, two SHRC-trained staff members with a minimum of 3 years' working experience, other than the facilitator and recorders, analyzed the collected data. Although these individuals were not directly associated with the present study, they were familiar with the Bienestar purpose, implementation, and particular activities of each of the four components of the program. These employees were asked to *list the responses* and *group* them into appropriate descriptive categories using content analysis (Brown, Cozby, Kee, & Worden, 1999, pp. 95-96). This was done for content validity. In addition, a third staff member reviewed the list of responses and groups provided by the two staff members and then cross-checked the data to ensure that participants' responses were not (a) omitted, (b) duplicated, and/or (c) incorrectly grouped. Finally, these descriptive categories were

further grouped into five thematic units (see column 1 in Table 2).

### ***Parent Component Changed***

The parent component of Bienestar was changed for the following academic year based on the findings from these focus groups, and attendance was reevaluated (see Table 3).

### ***Data Analysis***

SPSS 14.0 was used for descriptive statistics. Content analysis (Brown et al., 1999, pp. 95-96) was used to analyze the qualitative data.

## **► RESULTS**

The 47 parents who agreed to contribute to the focus groups consisted of 7 males and 40 females, representing both biological (72%) and extended family members (4 grandmothers, 6 aunts, and 3 uncles) possessing guardianship and parental rights. Twelve of these forty-seven parents (26%) were not aware of the Bienestar monthly meetings.

Table 2 presents a list of barriers or disincentives to onsite parental involvement in the Bienestar parent program as identified by these nonparticipating parents. Content analyses led to the grouping of identified barriers into thematic units (column 2 in Table 2). These were then further grouped into five descriptive categories (column 1 in Table 2): low value, high cost, competing family demands, concerns about the program design, and social role norms. Each of these barriers is discussed in more detail in the following sections.

### ***Low Value***

A concern raised by the parents involved misconceptions about the purpose of the parental program. They thought that the purpose of the program was to "help the family with diabetes manage the disease," or "teach and help kids with diabetes get well," and therefore they "did not attend the meetings because they did not have diabetes." Also there was concern that the purpose was to identify which parents are "good parents" (i.e., parents with kids that "eat good and are not overweight") or "bad parents" (i.e., parents with kids that "eat poorly, are overweight or have diabetes"). "Fear of diabetes or of getting it" was also a concern for some.

### ***High Cost***

With regard to high cost, lack of transportation, babysitting, and limited income and resources were all

**TABLE 2**  
**Barriers Affecting Parental Involvement in Bienestar Health Program Parent Component**  
**as Identified by Nonparticipating Parents**

<i>Descriptive Categories</i>	<i>Perceived Barriers</i>
Low value	Misconception about the purpose of the parent program Meetings useful only to the person with or at risk for type 2 diabetes Fear of diabetes or of getting it
High cost	Lack of transportation Lack of babysitting Limited income and other resources
Competing family demands	Time constraints Work schedule conflicts; no days off and parents with multiple jobs Too many meetings offered
Concerns about the program design	Fear of attending because of limited education and literacy of the parent Language barriers Low value of teacher-centered meetings Exclusion of family members For biological parents only Program design limits decision-making input from parent Lack of rewards/incentives Expected lack of “hands-on” learning Lack of visual aids and colorful teaching material School environment too sterile
Social role norms	For “females” only Social roles (marital and family related) Fear of getting into trouble by spouse for attending meeting

NOTE: Note that many are misconceptions or fears rather than actual barriers.

identified as barriers. Parents reported that they “did not have two vehicles in their family” and “had to depend on others or the city bus to go to and from the meetings.” Parents also expected the meetings to be “for adults only” where “children were not allowed to attend,” and therefore parents reported that “they did not attend the meetings because they could not find a babysitter to watch the kids.”

Furthermore, parents reported that they expected to have to “pay out of their pocket” for meeting expenses and therefore did not attend the meetings because “they did not have money” to pay for fees and related costs for attending the meetings, materials for the exercise activities, supplies for arts and crafts or food items for the cooking classes; they “would attend the meetings” if they “had the money needed” to participate, but had to prioritize paying for their living expenses over the related cost for attending the program.

### ***Competing Family Demands***

In the category of competing family demands, focus group parents identified time constraints, work schedule

conflicts and no days off, and parents with multiple jobs as well as too many parental involvement meetings offered as barriers. Parents reported that when it comes to onsite participation, “less is more.” That is, parents reported that they would be more willing to attend “four events throughout the school year instead of nine monthly meetings,” indicating that offering fewer events was more “realistic” and “sensitive” to parents with competing family demands.

### ***Concerns About the Program Design***

Focus group parents reported several fears and concerns in this category. These included the parents’ fear of participation because of a lack of self-esteem because of low levels of education and literacy of the parent and concern about language barriers (i.e., would there be bilingual curriculum and instruction). Another concern was that the meetings were for biological parents only and not for guardians, including extended family members (e.g., grandmothers, aunts, and uncles) possessing guardianship and parental rights. Parents reported that they expected the meetings

**TABLE 3**  
**Effective Strategies Used to Minimize and/or Eliminate the Perceived Barriers in the**  
**Bienestar Health Program Parent Component**

<i>Descriptive Categories</i>	<i>Strategies to Minimize and/or Eliminate the Perceived Barriers in Follow-Up School Year</i>
Low value	Use variety of channels to send messages to parents, that is, post cards, phone calls, print materials (i.e., posters, flyers, newsletters, and brochures), announcements on the school marquise, reminders to parents by school staff, and health report (with child's diabetes screening results) to parents by the school nurse Clarify diabetes prevention efforts are valuable to targeted children and their families Counteract/reduce fear with health promotion, and offer health fairs for diabetes screening and education for appropriate self-care behaviors
High cost	Offer carpool services organized by parents Clarify that children are invited Clarify that program is free of charge
Competing family demands	Be sensitive toward the job/work schedule of the participant and offer meetings on weekdays and weekends, and during morning, afternoon, and evening hours Reduce number of parental involvement opportunities from 9 to 4 during the school year
Concerns about the program design	Clarify use of appropriate curriculum that targets the reading, grade level, and learning style of the participant Clarify curriculum and instruction are bilingual; health experts conduct lessons in English and Spanish Clarify that lessons are participant centered with hands-on opportunity Place emphasis on the "family unit" Include input from parents/guardians and their families in program design Solicit <i>continuous</i> feedback from parents (and their families) and other stakeholders during all phases of program design and implementation Clarify opportunity for reward incentives Include additional local and community-based facilities (e.g., indoor swimming pool, skating rink, park, and banquet halls) Make learning environment welcoming and nurturing (nonthreatening)
Social role norms	Clarify program is inclusive of all family members where "everyone" is invited. Be sensitive toward inviting the participant's spouse, friends, and extended family members

to be "inflexible" with no opportunities for parent input during any of the decision making. Additional concerns raised by the parents were that the meetings would lack rewards or incentives for attendance, and the instructional materials would not use visual aids and colorful teaching material, both culturally based and important issues.

Finally, parents feared the "school environment [would be] too sterile (unwelcoming)." Parents reported a dislike for teacher-centered (didactic) meetings and expected the meetings to be boring and without any opportunity for interaction or discussion. They expected the lessons to be conducted in a traditional manner where the "teacher lectures the entire time and we the parent, just sit there and do nothing." Parents also reported that they enjoy learning and love hands-on

opportunities. For example, they "want to be involved" and "help out with things like the cooking classes instead of just sitting there and having the teacher stand in front of us and do things like cook or read or measure or demonstrate stuff for us."

#### **Social Role Norms**

Focus group parents also identified social role norms (marital and family related) as barriers. For example, the parents expected the parent meetings to be for females only (rather than also for males). Fear of getting into trouble with spouse for attending the parent meetings was also identified as a barrier. To our understanding, based on the female responses, the degree of the fear was related to the general male



dominance in the MA culture and fear of reprimand more so than a serious threat of domestic violence.

The Bienestar parent component was modified according to these focus group findings (see column 2 in Table 3) and parental involvement increased from 17% (of 9 opportunities baseline school year) to 37% (of 4 opportunities, follow-up school year) overall.

## ► DISCUSSION

In this study, we investigated whether barriers to onsite parental involvement in the existing parent component of the Bienestar school-based diabetes and obesity prevention program could be identified, and in turn, whether parental involvement could be increased. We found that barriers or disincentives to parental involvement remained even when parents were involved in the initial design to make the program parent friendly and culturally sensitive. However, many of these barriers were fears and concerns rather than actual problems. We placed the identified barriers into five categories: (a) perceived low value of attendance, (b) high cost, (c) competing family demands, (d) misconceptions of the program design, and (e) family culture mismatch. These findings are consistent with those reported by others (Cassity & Harris, 2000; Jennings, 1992; Pape, 1999).

As a result of this study, we incorporated into the Bienestar parent program all of the strategies proposed by the parents to minimize or eliminate their perceived barriers to and fears and concerns about participation in the program. To reiterate, even unsubstantiated concerns and fears expressed by parents were identified as barriers and subsequently addressed. Many of the strategies that were employed to overcome these barriers focused on such simple steps as talking with parents about the program with their concerns in mind. These strategies appeared to increase parental involvement. These findings support the importance of two-way communication between the parent and the school administrator, or in this case school-based program administration, as reported by others (Cassity & Harris, 2000; Lopez et al., 2001; Pape, 1999).

As shown in Table 3, other changes were made to the parent component. The three most difficult to accomplish were reducing the number of opportunities for parental involvement from nine to four during the school year, thereby making each meeting more special, changing the meeting times for parental activities to outside normal work hours, and including the family unit in those activities. Reducing the number of opportunities for parental involvement from nine to four during the school year required that staff cover the same amount of diabetes, nutrition, and physical activity-related instructional material in less time. However, feedback

from parents indicated that when it comes to onsite parental involvement, less is more. Feedback from parents also indicated that offering four 1-hr and 45-min sessions with a 15-min break was better than nine 1-hr monthly meetings. Lengthening the parent meetings allowed the staff the same amount of time as the nine sessions to cover all the instructional material required. Hosting parental involvement opportunities outside the school required us to establish new partnerships with traditional and nontraditional community-based organizations and leaders overseeing the “outside the school” facilities where the parental involvement events would take place (i.e., parks and other recreational facilities). Again, feedback from parents indicated that community-based settings were more welcoming and nonthreatening compared to the school setting. This change required the Bienestar program staff to work evening hours and on weekends as opposed to working just weekday school hours, but they were willing to do so, provided their work schedules were adjusted accordingly. These findings were consistent with others stating that parental involvement opportunities should also be provided on weekends, early mornings, or evenings to facilitate two-way communication with working parents (Cassity & Harris, 2000; Pape, 1999).

Also worthy of additional discussion is the issue of incentives, which actually were part of the initial design. School-based health parent programs (Baranowski et al., 2000; Baranowski & Stables, 2000; Bere et al., 2006; Davis et al., 2000; Donnermeyer, 2000; Haines et al., 2006; Lytle et al., 2004; Nader et al., 1989; Nicklas & O’Neil, 2000; Perry et al., 1989; Stone et al., 1996; Story et al., 2000; Treviño et al., 1998; Ward et al., 2006) have used extrinsic rewards (from babysitting and carpooling services; Baranowski et al., 1990) to prizes, such as educational books and/or redemption coupons for donated merchandise in Bienestar (Treviño et al., 1998; Ward et al., 2006), to motivate or reinforce positive behaviors. Parents reported in this study that they “expected” rewards for their participation for two reasons. First, the prize is seen as a reward, a type of positive reinforcement for doing something good, in this case for attending the meeting. Second, however, prizes were actually seen by parents as useful “conversation” pieces that parents could use to spread the word for a particular cause—in this case the cause of diabetes and obesity prevention. The focus group parents defined a reward as any item (however grand or small) that represented a token of appreciation and/or provided a sense of accomplishment. Thus, the issue of rewards to promote participation is worthy of additional study.

There are several strengths to this study. First, we identified barriers to onsite parental involvement when parents were involved in the initial design to make the

program parent friendly and culturally sensitive. We found that barriers or disincentives to parental involvement remained even when parents were so involved, though many of these barriers were actually unfounded fears. Second, we specifically investigated barriers to onsite parental involvement, which tends to be low (Baranowski et al., 2000; Davis et al., 2000; Perry et al., 1989), rather than parental involvement by mailings or take-home activities (typically sent home with students) that typically have relatively high levels of parental participation—more than 50% in most cases (Nader et al., 1989; Perry et al., 1989; Story et al., 2000) and more than 90% in some cases (Baranowski et al., 2000; Baranowski & Stables, 2000; Treviño et al., 1998). Third, this study included feedback from not only biological parents but also extended family members (e.g., grandmothers, aunts, and uncles) possessing guardianship or parental rights.

Five limitations must be noted. First, we did not examine whether Bienestar obesity and metabolic endpoints were related to the level of parental involvement or were improved with enhanced involvement; of note, some studies have documented that enhanced health outcomes can be achieved with limited or no parental involvement (Baranowski et al., 2000; Davis et al., 2000; Perry et al., 1989; Weeks et al., 1997), which speaks to the influential role of the school regardless of parent participation (Weeks et al., 1997). Whether increased levels of parental involvement yield better outcomes is at this point unknown. Second, we only examined a small self-selected sample of 47 parents and guardians from the full 223 nonparticipating parents. Thus, the parents who informed this study might not have been representative of all nonparticipating parents. However, changing the parent program based on the barriers identified by this group did improve the participation of parents overall. Third, we did not assess whether our MA parents were first-, second- or third-generation immigrants and thus cannot comment on their level of acculturation. Similarly, we did not assess whether these MA parents received any additional formal education in another country in addition to the education received here in the United States and thus cannot comment on this either. Fourth, there were no formal assessments of the reported fear of getting into trouble with their spouse; thus we cannot comment on the type or degree of fear being expressed. However, the strategies offered by participants to overcome this particular barrier were simply to allow spouses (and the entire family) to attend the parent meetings. This may imply that the degree of fear was related to the general male dominance in MA culture and the fear of reprimand more so than a serious threat of domestic violence. Last, this study was a one time feedback cycle demonstrating that feedback about low

parental involvement can improve onsite participation. Whether parental involvement can be further improved with continuous or repeated cyclical feedback from parents is unknown, but is worthy of further study.

## ► CONCLUSION

In conclusion, the findings presented here add to the understanding of barriers to onsite parental involvement in school-based child health promotion programs, specifically in an obesity and diabetes prevention program. One in four parents did not even know the program existed. Even when parents are involved in the initial design to make the program parent friendly and culturally sensitive, additional barriers to parental involvement can be identified though many are fears and concerns rather than actual problems. Program staff viewed parent education aimed at fears that were unsubstantiated (based on limited information or incorrect assumptions) and those that were substantiated as equally important barriers; addressing both improved participation. Thus, parent education to address fears that were unsubstantiated and based on lack of information or parent's incorrect assumptions were as relevant as education to address substantiated barriers; doing both improved participation. Ongoing or at least periodic exploration of barriers, fears, and concerns may be a strategy for improving parental participation during the total duration of a study. Conversely, a one-time initial effort to design a program with parent input does not appear to be adequate to achieve optimal maximal participation.

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